Accountability through Information:
What the Health Care Industry Can Learn from Securities Regulation

By William M. Sage

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Foreword

This report explores the relevance for the health sector of federal policy to regulate the securities industry. Regulatory policy in the health sector is the cause of considerable frustration among many health professionals, leaders of provider organizations and regulators in the states and the federal government. Advocates of regulatory reform in the health sector frequently urge attention to the information-based regulatory policy of the Securities Exchange Commission (SEC) and the Financial Accounting Standards Board (FASB).

This report is an outgrowth of a meeting convened by the Fund and co-chaired by Carolyn Boone Lewis and William Sage. Lewis has firsthand experience with regulatory policy in both the securities and health industries. During a long career at the SEC she helped to devise policy for regulating mutual funds. During these years she was also a member and officer of a hospital and health system board and active in hospital associations. This year she chairs the board of the American Hospital Association. She joined the board of the Milbank Memorial Fund in 1998.

Lewis, Sage, and the Fund convened current and former senior officials of the SEC with state and federal officials who regulate the health sector. As a result of this meeting, Sage, a lawyer and physician who practiced securities law before joining the faculty of law at Columbia University, wrote this report. He has written extensively about both health and securities law.

Participants in the meeting that preceded this report reviewed it in draft. They are listed in the Acknowledgments. The analysis and conclusions of the report, however, are entirely Sage's.

Sage emphasizes the differences between the securities industry and the policies that regulate it and the health sector. These differences include the nature of patients' encounters with physicians and other health professionals and the relationships, which are often confrontational, between health care providers and the Health Care Financing Administration.

Readers in search of a regulatory panacea for the health sector will be disappointed by Sage's conclusion that the "principal value" of the analogy between securities and health sector regulation "resides at a conceptual level, not a programmatic one." Nevertheless, he draws practical conclusions that should stimulate reflection and debate among leaders in the health sector. In Carolyn Boone Lewis's words, "While I agree that the principal value of the analogy is conceptual, I think that this, in itself, will inform the debate for the health care sector significantly. A panacea—no. But [this report is] a well-drawn road map through the securities/mutual fund regulatory scheme that clearly charts some fertile ground for health care, even as it dispels the notion of a 'panacea.'"

Daniel M. Fox
President

Samuel L. Milbank
Chair

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Barry P. Barbash, Director, Division of Investment Management, Securities and Exchange Commission, Washington, D.C.; James D. Bentley, Senior Vice President for Strategic Policy Planning, American Hospital Association, Washington, D.C.; Stephen Choi, Assistant Professor of Law, University of Chicago Law School; John M. Colmers, Executive Director, Maryland Health Care Commission; Mark Gibson, Policy Advisor for Health Care, Human Services and Labor, Office of the Governor of Oregon; Carolyn Boone Lewis, Chair, American Hospital Association; Kathryn McGrath, Partner, Morgan, Lewis and Bockius, LLP, Washington, D.C.; Tracy Miller, Clinical Associate Professor, Department of Health Policy, Mount Sinai School of Medicine, New York; Kim Monk, Senior Health Policy Analyst, Pension and Welfare Benefits Administration, Department of Labor, Washington, D.C.; Charles T. Wood, Waquoit, Mass.

EXECUTIVE SUMMARY

Laws requiring health plans, hospitals, and physicians to disclose extensive information to their customers or the broader public have become extremely popular. The reason for this lies in politics, not policy: disclosure laws suggest a less intrusive role for government and greater reliance on individual choice and free markets than do other oversight mechanisms. This strikes a responsive chord in today's antiregulatory political climate. At a policy level, however, few health care disclosure laws have been carefully designed to achieve specific objectives.

Disclosure enthusiasts often point to the federal securities laws as a model, and suggest that Congress create for health care a regulatory agency similar to the Securities and Exchange Commission (SEC) or the Financial Accounting Standards Board (FASB). Indeed, securities regulation can shed light on the pros and cons of using information disclosure to guarantee accountability.

The principal value of the analogy resides at a conceptual level, not a programmatic one. Experience with securities regulation teaches us what to expect, and not to expect, from health care disclosure in light of four possible goals:

- Facilitating market competition
- Monitoring conflicts of interest
- Improving health system performance
- Enhancing democratic deliberation

Mapping health care onto the template of securities disclosure leads to the following four conclusions:

First, disclosure laws may not improve marketplace processes in health care, especially for individual consumers. Although standardized information and information that can be used by large employers and other purchasing groups may have competitive benefit, the health care system lacks the pricing mechanisms and entrepreneurial incentives that help disseminate information in securities markets, while suffering from additional problems regarding feasibility of disclosure and usefulness of disclosed information.

Second, the greatest success of mandatory disclosure is likely to flow from its ability to facilitate information-sharing and spur performance in specific areas targeted for improvement. An old business maxim says, "You manage what you measure"; disclosure laws can channel measurement in particular directions so that management will follow. This instrumental use of disclosure rests on assumptions that are very different from those on which competitive uses are based, but it accords well with other attempts to reduce variability in clinical practice and achieve important public health goals.

Third, professional processes and values are essential to achieving public benefits from disclosure. No amount of information will convert patients' encounters with the health care system into arms-length, market transactions. But well-designed information requirements can serve therapeutic goals regarding openness, trust, and participation and can remind physicians and other health professionals of the tensions between their daily practice environment and their overarching ethical obligations.

Fourth, government must play a delicate role in administering disclosure laws. Once one acknowledges that disclosure may have goals other than encouraging competition, government is no longer merely an honest broker or a policeman of private transactions. Rather, government must work with health care providers to establish priorities for performance improvement, educate the public about social issues inherent in health care decisions, and refrain from allowing budgetary interests to intrude unduly on citizens' rights to privacy and self-determination.

INTRODUCTION

Although the health care system still lags behind many other industries in information and communications technology, the era of blind trust in physicians and equally blind payment for medical services is fading from view, its passage accelerating with the spread of the Internet. Choices among health plans, hospitals, physicians, and treatments are increasingly based on data.

Why this explosion of information available to insurance subscribers, patients, payers, and the public at large? Good business? Patient demand? Professional ethics? Often, the law requires it. Or, rather, many different laws require it. Some, such as state insurance statutes, the Employee Retirement Income Security Act of 1974 (ERISA), and the rules of the Medicare+Choice program, govern health plans. Other laws—state licensing statutes, health facility review requirements, and informed consent obligations—regulate hospitals and physicians. The scope and detail of mandatory disclosure expand each year as state legislatures and Congress enact information requirements for managed care as a central component of "patient protection" legislation.

But does all this compulsory information exchange do any good? Who uses it, and to what ends? Do its benefits outweigh its costs? We can begin to answer these questions, and to identify other equally important ones, by looking to other activities that are regulated using disclosure. Foremost among these are the public capital markets, oversight of which has relied primarily on mandatory disclosure since the enactment of the federal securities laws in the 1930s. Over the past seven decades, moreover, securities oversight has evolved a mature regulatory system and has generated an extensive critical literature. In fact, securities law and the regulatory agency that enforces it—the Securities and Exchange Commission (SEC)—are often put forward as models for health care regulation.

This report analyzes mandatory disclosure in health care through the lens of securities law. The report begins by outlining the basics of disclosure as a regulatory strategy in the health care and securities industries. The paper then turns to an evaluation of four important justifications for disclosure. (Readers familiar with the mechanics of health care and securities disclosure laws should feel free to skip ahead to the heart of the paper.) The report carefully examines the most common justification, a competitive paradigm that employs informational strategies to overcome imbalances in knowledge between buyers and sellers in the marketplace. As the report reveals, competition-motivated disclosure mandates for securities trading have come under fire, and these kinds of regulations face still greater conceptual and logistical hurdles in health care. Where many analyses stop at this point, however, this report goes on to consider three other justifications for disclosure, which I call the agency, performance, and democratic rationales. These rationales, which are demonstrable in securities regulation, have far greater applicability to health care. Finally, the report discusses a handful of major issues relating to implementation of disclosure laws.

The principal conclusion that emerges from this approach is that, even for financial products, the role of information is more complex than simple economic models of transactions between informed buyers and sellers would predict. In health care, which is both beset and blessed by rapidly changing capabilities, strong professional traditions, and compelling distributional concerns, the best uses of disclosure transcend private market processes. This point is often missed in current debates over disclosure mandates for two reasons. First, proponents of disclosure tend to lump instrumental, goal-setting uses of disclosure together with deferential, market-facilitating uses, despite their inconsistent assumptions and objectives. Second, many commentators overlook the convergence of regulatory reporting requirements with public disclosure programs in an electronic, Internet-based environment and therefore fail to note both the synergies and the tensions inherent in combining public and private applications of information. A third take-home message is that an SEC-like process cannot simply be grafted onto health care regulation. Rather, the power of the SEC experience lies mainly in the limits of the analogy, affirming the importance of setting clear goals for informational requirements in health care.

DISCLOSURE AS A REGULATORY STRATEGY

Mandatory disclosure is a common approach to regulating social and economic problems ranging from workplace safety to environmental protection. Disclosure laws are attractive in today's antiregulatory climate, at least on cursory examination, because they presume a lesser role for government: rather than setting standards directly, government facilitates personal choices, usually in voluntary, marketplace transactions. Disclosure laws also appeal broadly across the political spectrum—the political right can applaud their general deference to private decision-making, while the left can support their goal of empowerment. Moreover, because disclosure laws are not as ideologically threatening or as costly to comply with as substantive mandates, interest groups tend to resist them less fiercely.

The tenor of disclosure-based regulation therefore suits the fractiousness of today's partisan politics and the public's diminished faith in both the honesty and the competence of government. Disclosure laws exemplify, for better or worse, what President Bill Clinton in his second inaugural address described as "a government humble enough not to try to solve all our problems for us but strong enough to give us the tools to solve our problems for ourselves." Information gleaned from disclosure also helps educate the government as well as the governed when conditions are uncertain, so that disclosure laws offer flexibility in the face of change and hold out the promise of better-designed substantive regulation in the future.

Health Care Disclosure

Recent changes in the direction of the American health care system—away from a professional and toward a market orientation—have engendered parallel adjustments to that system's regulatory compass. Specifically, government's role in bolstering the accountability of the individuals and organizations responsible for health care services has broadened beyond laws that support or reproduce self-regulatory efforts, such as professional licensure statutes and health facility certification requirements. Contemporary oversight includes a variety of measures primarily intended to assist private decision-making, whether the decisions have to do with purchasing insurance, accessing professional services, or exercising autonomy in choices about intimate, health-related matters.

An important manifestation of this process of regulatory diversification is the rising popularity of laws that require disclosure of information to patients and consumers. Particularly in response to the growth of managed care, comprehensive information requirements have been added to enrollment oversight of insurance companies, HMOs, and ERISA plans; to regulation ensuring the quality and safety of hospitals and physicians; and to the law governing treatment decisions by patients. The principal problem with current health care disclosure laws, however, is that they are scattershot, reflecting short-term political compromises or the equities of individual lawsuits rather than a coherent understanding of the purposes served by mandatory disclosure and the conditions necessary to achieve desired effects.

History of Health Care Disclosure

While the health care system shares many of the characteristics that have made information-based regulation attractive in other parts of the economy, health care disclosure has its own unique heritage.

Mandatory disclosure laws derive from several sources. Foremost is the ascendancy of markets in American health policy. The stirrings of competition in health care during the early 1970s coincided with a more general consumer movement in American society, that saw both "caveat emptor" and consumer protection legislation as meaningless without information. When health care expenditures continued to rise despite economic recession and ballooning deficits in the late 1970s and early 1980s, insurers, employers, and government began to hold health care providers accountable for their costs and results. Once medical practice became subject to review by nonprofessional parties rather than solely through confidential peer review processes, the genie was out of the bottle. Information became a critical need.

A second factor leading to the popularity of disclosure was the resurgence of the political rhetoric of individualism and self-reliance in the late 1980s and 1990s. This reflected diminished expectations of government and skepticism regarding public programs and public institutions, as became evident with the failure of the Clinton health plan in 1994. Private "health reform" through managed care fed on these emotions and grew. This left average Americans between a rock and a hard place, since their suspicion of government was matched only by their distaste for concentrated corporate power. In an environment of growing distrust but limited opportunity for direct public control, information was one of the few weapons available.

These real-world trends acted in synergy with two intellectual developments. First, the 1970s witnessed the emergence of a new discipline, health services research, that applied methods from economics and the social sciences to the study of the health care system. The success of this research enterprise depended on the availability of comprehensive, reliable data. Second, bioethics began to emphasize patient autonomy and self-determination as guiding principles for clinical medicine, which necessitated greater sharing of information between doctor and patient, with analogous disclosure by hospitals and nursing homes to protect the rights of the institutionalized.

Types of Disclosure Laws

Responding to these forces, Congress and state legislatures have passed a broad range of laws that require insurance organizations and health care providers to disclose information to enrollees and to patients (see table 1). One should note that managed care's blending of health care financing with delivery of services—resulting in practices such as utilization review, selective contracting with designated networks, and sharing insurance risk with providers—renders the distinction between information about insurance and information about services somewhat artificial. Nonetheless, as discussed in greater detail below, whether insurance or health services are nominally at issue often determines not only the applicable legal regime but also the optimal timing and content of information needed to support specific choices among health plans, hospitals, physicians, and/or treatments. This has important implications for the practicality and effectiveness of disclosure mandates.

Table 1. Health Care Disclosure Laws

STATE LAWS
Insurance and HMO regulation
Explanation of coverage
Restrictions on fraudulent or misleading marketing
Gag clause prohibitions
Consumer fraud laws
Hospital report cards
Physician report cards
Physician malpractice and disciplinary records
Physician self-referral laws
Informed consent requirements
Hospitalized patients' bills of rights
Nonprofit corporation law (community benefit)
FEDERAL LAWS
ERISA
Summary plan description
Material disclosure required by fiduciary duty
Medicare+Choice
Explanation of coverage
Marketing restrictions
Gag clause prohibitions
Performance assessment and reporting
Medicaid managed care
Explanation of coverage
Marketing restrictions
Patient Self-Determination Act (right to refuse treatment)
Internal Revenue Code (for tax-exempt organizations)
Form 990 sources and uses of funds

Furthermore, legal obligations to report data to regulators increasingly blur with duties of direct disclosure to the public. Prior to the electronic era, "publicly available" documents on file with regulators were

geographically remote from potential users, most of whom were not aware of their right to receive the information or even of its existence. By contrast, electronic databases containing information conveyed to regulators, and reports derived from that information, can be indexed and posted on the Internet quickly and cheaply, ready for the public to view and search. For example, regulators in several states now provide Internet access to physician disciplinary records, including malpractice claims and settlements, and the federal government posts health facility survey results on the Web. (This is also happening in securities regulation, where the EDGAR system for electronic filing has revolutionized public access to information that, while long available on formal request, had not previously been widely disseminated.)

Health plan disclosure laws are primarily an outgrowth of traditional state insurance regulation and consumer fraud laws, which require that the content of insurance policies be clearly communicated to the people who buy them. Analogously, federal ERISA law obligates trustees of employee benefit plans to describe the plans' principal features to beneficiaries. Managed care magnifies the complexity of this disclosure by introducing utilization review, selective provider panels, gatekeeper requirements, variable cost-sharing, and similar constraints (see table 2).

Table 2: Required Insurance Disclosure in Managed Care

TRADITIONAL
Covered benefits
Cost-sharing
Claims procedures
Grievance procedures
Participating providers
MANAGED CARE REGULATION
Utilization review/preauthorization procedures
Appeals rights
Outcomes of appeals
Provider financial incentives
Experimental treatment coverage standards
Drug formularies
Quality assurance plans
Provider qualifications
Gag clause prohibitions

Interest in health plan disclosure has been heightened by the growing availability of quantitative as well as descriptive information. Innovative approaches to quality measurement developed mainly by large

employers and other private sector purchasers, including clinical measurement tools such as the Health Plan Employee Data and Information Set (HEDIS) and patient satisfaction indices such as the Consumer Assessment of Health Plans (CAHPS), have inspired a host of legal requirements regarding communication of comparative information on the structure, process, and outcome of care.

Health care providers, predominantly hospitals and physicians, face a similar expansion of disclosure obligations. Laws governing provider-patient communication have different origins than do those of health plan disclosure requirements, the former principally reflecting concerns over autonomy and bodily integrity as embodied in "patients' bill of rights" statutes and the legal doctrine of informed consent. Again, distrust of managed care has altered the tone of this disclosure to include explanations of nonclinical matters such as contractual obligations, qualifications, and compensation. Quantitative and comparative data reporting—including disclosure of hospital and physician mortality statistics and malpractice histories—has also proliferated in the provider sector. Public regulators such as health planning agencies and licensing bodies have taken the lead in these initiatives—as they have not in health plan disclosure efforts—because of the attenuated link between provider-level data and private insurance purchasing, as well as the much larger number of reporting entities.

Recent Disclosure Initiatives

Several bills debated in the 106th Congress applied broad disclosure duties to private insurance programs and/or self-insured ERISA plans. Disclosure obligations also constituted a major part of nearly all the reform bills considered by the 105th Congress in 1997 and 1998. In addition, approximately half the states have passed omnibus managed care legislation in the last few years, with most of these laws including consumer information requirements for managed care plans. Even the American Medical Association places "full disclosure of plan details" at the top of its most recent health reform proposal. Informational requirements regarding health professionals are also on the rise, particularly in the aftermath of the Institute of Medicine's 1999 report on medical error and patient safety (Institute of Medicine 1999).

The strongest statement of belief in information as a regulatory strategy is the Consumer Bill of Rights and Responsibilities announced in 1997 by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. "Information disclosure" was listed first among the eight areas in which the commission urged the adoption of new consumer rights (Advisory Commission 1997). These ideas were refined in the commission's Final Report, which recommended (1) identification of core sets of quality measures for standardized reporting by each sector of the health care industry; (2) development of a framework and capacity for quality measurement and reporting; (3) broad industry participation in quality measurement, including at the individual practitioner level; (4) establishment of a public-private mechanism to establish reporting requirements and standards; and (5) widespread availability of comparative information on health care quality (Advisory Commission 1998). President Clinton subsequently issued an executive memorandum that directed federal agencies to apply the commission's recommendations to all federal programs.

Recently enacted changes in the Medicare program also make a strong commitment to information reporting and disclosure. In the Balanced Budget Act provisions establishing the Medicare+Choice program, Congress specifically required the Health Care Financing Administration (HCFA) to prepare detailed explanations of the new options and to communicate them to Medicare's 40 million beneficiaries in order to promote informed consumer choice. In addition, HCFA announced extensive reporting and disclosure requirements for participating organizations. As part of HCFA's continuing development of a Quality Improvement System for Managed Care (QISMC), each organization must measure and report its performance to HCFA, information that HCFA anticipates disclosing to beneficiaries (HCFA 2000).

Securities Disclosure

The economic instability of the 1930s ushered in a new era of federal control over the public capital markets. President Franklin D. Roosevelt's words to Congress on March 29, 1933, transmitting his proposed Securities Act, strike political chords familiar to proponents of health care disclosure today:

> Of course, the Federal Government cannot and should not take any action which might be construed as approving or guaranteeing that newly issued securities are sound. . . . There is, however, an obligation upon us to insist that every issue of new securities to be sold in interstate commerce shall be accompanied by full publicity and information and that no essentially important element attending the issue shall be concealed from the buying public. . .

> . The purpose of the legislation I suggest is to protect the public with the least possible interference to honest business.

Seven decades later, securities regulation represents a seasoned approach to accountability through information, possessing both a well-developed theoretical framework and a coherent, workable administrative structure. The SEC's mission is conceptually simple: protect investors by informing them. This philosophy, which combines clear means with clear goals, suffuses not only public understanding and endorsement of securities regulation but also the day-to-day behavior of the regulators themselves, making it comparatively easy to train young investigators and entrust them with responsibility. By exploring in greater detail what it means to "protect" investors and how securities disclosure accomplishes that objective, one can begin to appreciate the likely benefits and limitations of disclosure laws in health care.

The Securities Act of 1933 establishes rules for the issuance of corporate stocks and bonds, while the Securities Exchange Act of 1934 governs secondary trading of issued securities listed on exchanges, as well as the ongoing responsibilities of public companies, brokers, and dealers. The Investment Company Act and the Investment Advisers Act, both adopted in 1940, regulate mutual funds and other investment professionals. These statutes emphasize abundant and accurate information as the key to consumer protection, combined to varying degrees with direct regulatory oversight (Brown 1999; Nash 1977). The SEC is the independent administrative agency charged with implementing and enforcing federal securities law. (State governments also regulate corporate and tax-exempt securities, although mutual funds are under exclusive federal control.) If securities laws are violated, the SEC or an appropriate self-regulatory organization may commence enforcement actions, and investors suffering financial injury often may file suit in federal court.

Over the past half-century, this framework has accommodated tremendous growth in the capital markets and has adapted to rapid changes in the mode and diversity of securities transactions. Its basic structure, however, remains largely unaltered. At their most elemental level, the disclosure provisions of the federal securities laws involve three issues: what must be said, what may be said, and what cannot be said. The securities statutes themselves set forth basic disclosure duties, and additional requirements have been created under the SEC's rule-making authority. In addition to disclosing specific items identified in the statute or rules, securities issuers and "reporting companies" whose securities are traded in the public markets are subject to prohibitions on fraud that create a general obligation to disclose all "material" information. These provisions not only punish material misstatements of fact but also material omissions, and they explicitly recognize that nominally accurate statements may be misleading if not placed in context. For example, mutual fund rules prohibit statements implying a government guarantee or other government connection simply because the fund invests in government securities.

In addition, disclosure obligations imposed by securities law frequently specify the time, place, and manner of information exchange. Federal laws that regulate issuance and sale to the public of stocks, bonds, mutual fund shares, and other securities emphasize disclosure in a printed prospectus that must be distributed to offerees and buyers. The prospectus requirements are liberally supplemented with obligations that issuers file additional information with the SEC, which is available to the public on request. Laws that regulate secondary market trading not directly involving the issuer rely primarily on periodic reporting by the issuer to the SEC, which constitutes the basis for the issuer's annual report to shareholders and which is publicly available when filed. In each case, disclosure must take the form required by SEC rules; in particular, financial reporting must comply with formal accounting standards to ensure accuracy and comparability. Moreover, information distributed by regulated entities apart from the required disclosure—such as promotional literature and statements to analysts—is still subject to antifraud enforcement and under certain conditions may be constrained in the interests of giving the market equal, timely access to accurate information. For example, during the "quiet period" that precedes public offerings of new securities, the delivery of preliminary prospectuses and the placement of staid "tombstone" advertising announcing the transaction are virtually the only communications that may take place (although this requirement is increasingly difficult to enforce in the free-flowing world of Internet communications).

The relationship between the SEC and the private sector is a striking feature of federal securities law. Both the securities and the health care industries face the challenge of fostering a productive, nonadversarial relationship between regulators and regulated entities while still asserting the primacy of consumer and public interests. Securities regulators have been generally successful at maintaining this balance, which has enabled open, spirited, and progressive dialogue with the private sector. The SEC's practice has been to establish general policies, not specific rules, and to defer to standard-setting activities by private organizations unless and until a clear need to intervene arises. The federal securities laws are structured as

"gatekeeper statutes" establishing qualifications for participation in the securities industry. Consequently, securities law delegates considerable authority to self-regulatory organizations (again, except for mutual fund regulation, which is performed directly by the SEC). In part, this reflects the SEC's desire to leverage limited resources. In addition, it keeps new standards from becoming mired in litigation, which is a common complication of traditional rule-making by administrative agencies.

The National Association of Securities Dealers (NASD) and the national securities exchanges are quasi-governmental bodies supervised by the SEC. Their activities include formulating and enforcing rules of fair practice, operating trading systems, performing inspections, and bringing enforcement and disciplinary actions that can result in exclusion from the industry. Although these self-regulatory organizations typically act independently, any new rules they adopt must be sent to the SEC for comment and approval, and the SEC has the authority to overturn or amend existing rules. Further, member firms may appeal disciplinary actions taken by self-regulatory organizations to the SEC and from there to the federal courts.

The SEC also works with various expert standing committees and periodically convenes task forces to study emerging issues. The most important standing committee is the Financial Accounting Standards Board (FASB), which establishes rules for calculating and reporting financial statement information in disclosure documents. FASB initiatives are given force of law on formal acceptance by the SEC and therefore obviate the need for direct SEC rule-making, much as private accreditation in health care is often deemed sufficient compliance with state or federal licensure or certification standards. However, the SEC reserves the right to overrule FASB's formulations and to adopt other requirements in the public interest.

FOUR USES OF MANDATORY DISCLOSURE

The remainder of this report identifies important conceptual issues that remain unsettled in health care disclosure, resolution of which may draw productively from experience gained in securities regulation (Sage 1997, 1999a). Political consensus as to the desirability of disclosure as an alternative to substantive restrictions on health plans and providers is often based on vague notions of the value of information. The hard questions have not yet been asked, much less answered.

Experience with securities regulation suggests four rationales for disclosure, which have enjoyed varying levels of popular approval and expert endorsement during the decades since the enactment of the federal securities laws:

- Facilitating market competition
- Monitoring agents and intermediaries
- Improving corporate governance
- Preserving political stability and enhancing democratic deliberation

These "missions" of securities disclosure did not spring full-grown from the head of Congress. Rather, a supportive public and a well-designed administrative agency promoted the evolution of what is generally, though by no means universally, regarded as a successful application of regulatory theory. Additionally, use of disclosure to further particular objectives—and the balance between information-based regulation and substantive standards—has changed over time to match industry conditions and the surrounding political and policy environment.

Each of the four rationales supporting securities disclosure has a health care parallel. The goals of information requirements in health care have been poorly articulated, however, so the design of many existing laws is flawed. Moreover, disclosure laws implemented with the hope of accomplishing one group of objectives, such as competition, can conflict with other potential uses of those same laws, such as performance improvement or public deliberation. Examining the four rationales in both securities and health care regulation reveals that the search for accountability through information is a dynamic process, and provides a framework for setting clear goals in health care disclosure and for crafting specific interventions to achieve those goals.

INFORMATION AND COMPETITION

Laws mandating that the public be told truthfully and completely about the goods and services it purchases follow logically from economic theory. Perfectly competitive markets require perfect information. If information known to sellers is withheld from buyers or is deliberately falsified, society's resources will not be deployed to their most valued ends. Economists refer to this as "market failure" leading to "allocative inefficiency." Private parties often cannot obtain information without incurring high search costs. Full disclosure required by law, on the other hand, can give consumers the information they need to assess price, determine quality, and evaluate the tradeoffs between them.

Securities Regulation

The SEC's commitment to mandatory disclosure is based on these assumptions (Coffee 1984). Securities law does not seek to tell investors what is worth buying but seeks instead to give them information to make decisions for themselves. In securities regulation, mandatory disclosure was a response to the separation of ownership from control in large, publicly owned corporations (Clark 1981). Shareholders remote from day-to-day management were at a disadvantage vis-à-vis corporate insiders with respect to information, despite the fact that they retained formal rights to elect the corporation's directors. Furthermore, even though individual shareholders had little meaningful opportunity to influence corporate policy, informed investors could still make their voices heard by exit—that is, by selling their shares.

Beginning in the 1960s, scholars subjected this market-facilitating role of mandatory disclosure in securities regulation to a strong theoretical and empirical critique. The most vehement criticism questioned government's competence and efficiency as a monitor of information (Stigler 1964). Even if information is imperfect and asymmetrical between sellers and buyers, it is not clear that government is better able than the market itself to redress these imbalances. New economic models of market efficiency postulated that securities prices already incorporate even private, insider knowledge (Fama 1970) and suggested that shareholders would not be rewarded for bearing the company-specific risks to which disclosure might alert them. This opened SEC requirements (other than general laws prohibiting fraud) to accusations of being misdirected, burdensome, and generally inferior to the private sector in rooting out and disseminating relevant, useful information (Kripke 1979).

Another set of objections challenged the behavior of investors rather than attacking the hubris of regulators. Mounting evidence questioned market rationality and thus raised doubts about investors' ability to act on disclosed information (Langevoort 1992). For example, consumers often "satisfice," meaning that they short-cut decisional processes rather than weighing alternatives in detail. In addition, the ability to sell shares ("exit voice") may not be an effective substitute for day-to-day involvement in corporate affairs, highlighting the importance of having appropriate means to respond to disclosed information (Hirschman 1970).

Recently, the pendulum has begun to swing in favor of SEC-mandated disclosure once again, although observers now acknowledge that the role of information in functioning markets is complex. In light of prior criticism, securities law has undergone some changes. The SEC streamlined or otherwise redesigned many of its rules to improve the usefulness of disclosure documents and reduce the costs of compliance. For example, well-known companies with good track records are permitted to issue securities with abbreviated disclosure and may reference documents already on file with regulators in lieu of repeating their content. Similarly, the SEC overcame its initial concerns about unverifiable or less-than-comprehensive disclosure and now encourages the inclusion of forward-looking information, such as earnings projections, and the use of summaries and plain language rather than "legalese." In addition, globalization of capital markets allows many securities issuers to choose the country whose laws they will obey, in essence permitting investors to select the amount of information disclosure they desire and the strength of the enforcement warranty that accompanies it (Fox 1999).

At the same time, securities law practitioners and legal scholars are voicing renewed appreciation of the SEC's role. Because it is difficult for companies to withdraw from SEC oversight once they subject themselves to it, the market may view initial compliance as a credible, and hence valuable, commitment to openness and abundant information disclosure in the future (Rock 2000). Moreover, corporate governance has apparently improved as a result of SEC disclosure requirements, in part because poor corporate performance as revealed by disclosed information now attracts widespread attention in the media, raising the threat of mass exit (Lowenstein 2000). One might even argue that the specifics of SEC-mandated disclosure matter less than its continuing effect; the public now expects to be informed and reacts negatively

if information is withheld.

Furthermore, regulators have become more aware of the role expert intermediaries play in assisting individual securities buyers. For example, modern securities law gives prominence to the informational value of associating "certification intermediaries" with securities transactions, obligating regulated entities to employ lawyers and accountants to review disclosed information and ensure compliance with legal requirements. These parties, along with the investment banks and brokerage firms that finance and market securities, generally have strong reputational and professional interests in maintaining market integrity and may incur legal liability for abetting malfeasance by securities issuers.

Similarly, securities law has followed developments in general corporate law that look to large, institutional investors to take a more active role in corporate governance. Moreover, mutual funds account for an increasing proportion of individual stock owners' investments, introducing another set of intermediaries to securities transactions (whose role in many ways resembles that of group purchasers of health coverage). These trends have forced the SEC to address the problem of multiple audiences whose ability to comprehend and interpret disclosed information varies widely. For example, information made available pursuant to the corporate securities provisions of the Securities and Exchange Acts is typically used by sophisticated parties, such as stock analysts, institutional investors, rating agencies, and—no surprise—class-action lawyers, who scrutinize legal documents after a sharp price decline for any justification for attempting to recover losses through litigation. Small investors typically find these dense documents off-putting (though the SEC has recently mandated plain English disclosure for prospectuses filed under the Securities Act, hoping to make this information accessible to ordinary individuals).

By contrast, mutual fund disclosure has long been directed at a less educated, less professional audience, leaving more sophisticated parties to parse supplemental material or to procure information in other ways. Mutual fund disclosure deals with a few fundamental issues: what the fund invests in, who manages it, what types and degrees of risk are present, and what fees and expenses are charged to investors. In 1983, the SEC revised mutual fund regulations to require "split disclosure": a basic prospectus mailed to all investors, and a more comprehensive "statement of additional information" filed with the SEC. In 1998, the SEC introduced an even shorter form of disclosure, the "profile." For these more concise documents, the SEC encourages short, straightforward statements in plain English rather than comprehensive, stylized disclosure (common in corporate securities practice) that is unreadable to a layperson.

Health Care Regulation

These changes in sercurities disclosure law and practice carry valuable lessons for health care, where the current push for mandatory disclosure has focused almost single-mindedly on benefits to competition (Curtis, Kurtz, and Stepnick 1998). This is not surprising, given the severe informational asymmetries and deficits that plague clinical decision-making (Arrow 1963). Moreover, the health care system's recent, rapid transition to market governance means that accounting practices for hospital and health plans have lagged behind more competitive sectors of the economy (Wood 1998). For several reasons, however, laws intended to foster price competition and to generate appropriate price-quality tradeoffs by providing appropriate information to market participants are likely to encounter much greater obstacles in health care than in securities regulation. Some concerns relate to the feasibility and effectiveness of government efforts to facilitate private health care transactions. Other objections stem from the still-strained application of market models to health care, though whether these problems represent residual discomfort or a fundamental incompatibility remains an open issue.

Minimum Quality Standards

A disclosure-based regulatory regime presumes that informed consumers will make sensible choices or at least that informed consumers should have no one to blame for their foolishness but themselves. For example, the federal securities laws in theory permit companies with no reasonable prospects of profitability to sell securities to the public, as long as their poor quality is fully disclosed. (State regulators—but not the SEC—may review the substantive merit of proposed offerings and prohibit the sale of low-quality securities to state residents [Hilke 1987].) Furthermore, the marketplace often views diversity of available offerings (product differentiation) as itself a hallmark of quality, since it allows consumers to indulge their specific preferences. By contrast, traditional health care regulation focuses on facilitating professional control over quality, not on consumer sovereignty, and has accommodated patient autonomy out of respect for personhood, not deference to the fashions of the marketplace (Glied 1997; Sage and Hammer 1999). Because it considers consumers vulnerable (especially when beset by illness) and medical science

definitive, health care regulation typically sets minimum standards for quality and seldom allows consumers to commit themselves in advance to receiving less than standard care, such as by purchasing insurance with significant restrictions on coverage (Hall and Anderson 1992).

Mandatory disclosure laws can be compatible with minimum quality standards, but only if the goals of each are clearly acknowledged. For example, the SEC takes a more "merit-based" approach to consumer protection in the mutual fund area than in corporate disclosure, foreclosing the sale of products not meeting certain substantive requirements (SEC 1992). This makes sense because mutual fund purchasers tend to be less sophisticated than buyers of corporate securities. At the same time, the SEC requires fewer items to be disclosed to mutual fund purchasers than to those who buy corporate securities. By contrast, many managed care reform proposals purport to fully empower individual consumers to make their own choices by mandating exchange of highly detailed information, but such proposals ignore the tension between extensive disclosure and substantive regulation that restricts available alternatives.

Diverse Consumer Preferences

A major feasibility barrier to health care disclosure is that health care consumers vary greatly in their clinical circumstances and hence have differing information needs. SEC-mandated disclosure historically has been generic, not customized to particular recipients, because most investors are interested primarily in the risk associated with a given security and the financial return offered to assume it. (Some difficulties still arise with respect to new derivative products whose value is highly sensitive to changes in economic conditions and the individual circumstances of the buyer.) By contrast, a given purchaser of health insurance or health care services may care deeply about the quality of diabetic care, the availability of infertility services, a particular physician's office hours, or any of a thousand other things. Specifying all of these items for mandated disclosure is impractical, especially considering their technical complexity, while imposing a general threshold of "materiality" would obligate regulated entities to provide markedly different information to different beneficiaries.

The absence of a "price equivalent" for health insurance and health care—a single number that captures the value of the product—exacerbates the problems of complex information and heterogeneous preferences. For corporate stocks and bonds, all available information and the aggregate public reaction to it are reflected in the price at which a security trades on the open market (Philips and Zecher 1981). Furthermore, the securities markets offer huge financial rewards to whoever is the first to learn about a company's good or bad prospects, which creates significant incentives to root out information and helps supplement the disclosure required by law. Similar incentives do not exist for consumer goods, such as health insurance and health care, that can be used by the purchaser but cannot be traded for profit.

These considerations again suggest that mutual fund regulation provides a closer analogy to health care regulation than does regulation of corporate securities. Like health insurance, mutual fund shares do not have a secondary market price but may only be bought from the fund itself. Nonetheless, the qualities that consumers value in mutual funds—return, lack of volatility, tax benefits, prudent administration—are few in number and relatively consistent from person to person. Mutual fund disclosure, like securities law in general, employs a concept of "suitability" to bridge the gap between generic and customized disclosure (Lowenfels and Bromberg 1999). Funds are required to state that a particular product is "best" for people with particular goals and characteristics and "not suitable" for others. (This disclosure obligation complements other efforts by the SEC to deter unscrupulous salespeople from urging elderly or otherwise vulnerable investors to select high-risk funds.)

New technologies hold promise for low-cost "pinpoint" disclosure in both securities and health care regulation that customizes information to match recipients' needs and circumstances. For example, the SEC is considering requiring mutual funds to send investors individualized statements regarding fees and fund performance. Even in a Web-based world, however, problems remain. Given the close connection between investment information and profit potential, the SEC faces the special challenge of promoting disclosure of customized information without selectively advantaging some recipients of information over others. For example, the SEC's newly adopted "fair disclosure" rule prohibits senior management from releasing information to favored parties such as large investors and securities analysts in advance of full public disclosure. Whether health care disclosure regulation should be concerned about "informational equity" is another unanswered question. Moreover, pinpoint disclosure in health care may intrude on medical privacy and may expose insurance markets to heightened risk-selection if beneficiaries reveal their health status through their information requests. Without adequate legal protections, therefore, disclosure laws designed to help consumers choose health plans may instead help health plans choose consumers.

Inaccuracy

Another feasibility issue arises from the difficulty of ensuring the accuracy of disclosed information. Some accuracy problems are inevitable in regulatory systems based on disclosure because fully verifiable and verified information may become stale by the time it is available to assist consumers. In securities disclosure, there is frequently a tradeoff between relevance and reliability. For example, mutual funds are prohibited from describing to potential investors the theoretical models they use to predict future performance on the grounds that these are unverifiable and might well be fraudulent. Even for corporate disclosure, the SEC has only grudgingly permitted earnings projections and other forward-looking information, and it has required that such projections be accompanied by prominent disclaimers. Yet these are arguably the things that investors most want to know.

Accuracy problems in health care disclosure are potentially greater and stem from several factors. Most important, technical measures of health care quality remain underdeveloped and poorly validated, especially in terms of risk- or severity-adjustment. In addition, difficulties with data collection and transmission continue to hinder the expansion of quality measurement beyond the research setting. For example, many errors were discovered in unaudited HEDIS data released to Medicare beneficiaries (Williams 1998).

These problems are compounded by the difficulty of determining the appropriate level within health systems at which disclosure should occur: health plans, hospitals, physician groups, or individual professionals. Because they believe physicians determine the quality of care, consumers generally prefer information about specific practitioners. Yet recent studies have demonstrated that the small number of patients treated by each physician renders "report card" information inaccurate as a guide to quality (Hofer et al. 1999). Aggregated data at the health plan level have greater statistical significance—and may even reveal increasing institutional influence over clinical decisions—but such data gloss over variability within plans and fail to account for rapid turnover in physician networks and hospital affiliations. Securities disclosure, by contrast, has well-developed mechanisms for collecting and reporting data. Moreover, the disclosing unit falls naturally at the corporate level at which investment occurs, although the SEC has increasingly required sector reporting for conglomerate and multinational businesses, so that it is harder for regulated entities to conceal variability in performance between business units.

Audit requirements, which are common in securities law, have the potential to reduce but not eliminate these problems. As mentioned above, independent accountants must audit reporting companies at least annually and must prepare and certify financial statements in disclosure documents filed under the securities laws. In health care, external audits of data reported by health plans have revealed significant lapses, including both unintentional errors and deliberate manipulation, which adds support for an audit requirement. Based on this evidence, the President's Advisory Commission recommended data auditing in its final report on consumer protection (Advisory Commission 1998), and HCFA announced that Medicare+Choice plans will be required to submit audited quality data beginning in 2000.

Health Illiteracy

Even if these feasibility concerns were addressed, and complete, accurate information were available at reasonable cost, most people would be hard-pressed to become savvy health care consumers. Economic theory does not require every purchaser to be fully informed to yield overall efficiency. The SEC has had to accept the fact that the meaning of intricate corporate disclosure may elude unsophisticated recipients, especially as larger segments of the population purchase securities. As discussed above, however, the absence of a secondary market pricing mechanism in health care reduces the ability of a few sophisticated parties—such as large employers or government purchasers—to discipline the entire market (and those few have lesser incentives to achieve informational superiority than in the world of stock trading). Even the mutual fund industry, moreover, caters to a narrower band of competence than the universal audience for health care disclosure that current laws seem to contemplate.

Evidence is mounting that the American public is poorly informed about modern health care financing and delivery, let alone clinical matters, and that it largely lacks baseline information that could provide context for required disclosure (Hibbard et al. 1997). Therefore, health care consumers can easily misinterpret even accurate data. In one example, potential enrollees regarded report card data showing high hospitalization rates of health plan enrollees for pneumonia as showing leniency in approving inpatient treatment rather than demonstrating failure to administer vaccinations. In some ways, lack of widespread understanding heightens the importance of disclosure requirements. Health care consumers seldom draw adverse inferences from the absence of information, which discourages voluntary disclosure because the first party

to disclose may find itself penalized rather than rewarded in the marketplace (Baird, Gertner, and Picker 1994). Still, overcoming the current degree of public ignorance is a weighty challenge for a disclosure regime. This is particularly true because the least educated users of health care often have the greatest health needs and are vulnerable both to risk-selection in insurance and to substandard provision of care.

Misperception of Risk

An issue related to general health literacy has to do with how people interpret probability statistics, especially when those probabilities affect health or safety. The field of behavioral economics (Jolls, Sunstein, and Thaler 1998), an outgrowth of a well-developed literature in psychology (Tversky and Kahneman 1982), reveals that people make striking and predictable errors when evaluating risks and either accepting, rejecting, or taking action to reduce them. These "cognitive biases" can be divided into "framing errors," which lead people to ignore actual probabilities and overestimate the likelihood of events that are familiar or salient, and "valuation errors," which induce people to overpay to avoid small, near-certain losses or lock in small, near-certain gains, to live with significant risks that they mistakenly believe they can control, or to insist on eliminating minuscule risks of especially dreaded events (Sunstein 1996).

Cognitive biases certainly influence investment decisions (Bainbridge 1999), but they present a much smaller challenge for securities disclosure than for health care regulation. Although the "bubbles" created by mass irrationality in securities trading are by definition unstable, they are eventually self-correcting. As a general rule, moreover, society accepts without question the exogenous, subjective preferences that determine securities valuation, while the secondary market pricing mechanism compensates for individual framing biases in response to disclosed information.

In health care disclosure, by contrast, cognitive biases may render disclosed information meaningless or even counterproductive. But distinguishing idiosyncratic preferences from hazardous misperceptions is chancy. For example, are exaggerated fears of ovarian cancer in young women framing problems based on high-profile reporting of celebrity illnesses or valuation choices because of the disease's intimate associations and psychologically devastating effects? Should the health care system allow people to chance accidental injuries and incur self-inflicted diseases simply because they fear those risks less than very low probability events such as nuclear radiation exposure?

Adjusting the presentation of information to correct major distortions in framing while still respecting subjective valuation decisions is exceedingly difficult and consequently vulnerable to manipulation. Furthermore, rationality may be overvalued in health care, where glib recitals of informational market failures are often used to justify government intrusion (Robinson 2001). Many enrollees and patients prefer amorphous qualities, such as trust, to "objective" information. Consequently, even well-intentioned, socially beneficial efforts to construct disclosure that prompts more rational choices may be fundamentally incompatible with a market-facilitation justification for disclosure.

Constrained Choices

A qualitatively different obstacle to effective disclosure in health care is the restricted range of choices possessed by many recipients of information. As discussed in subsequent sections of this report that explain the agency and democratic rationales for disclosure, information can be beneficial even when actions in response are limited. Arguments for a right-to-know unconnected from a potential decision (often called "dignitary theories"), however, have no place in a market paradigm. Giving people information to help them purchase wisely assumes that they have meaningful opportunities to make consumption decisions. In the securities context, disclosure has value because investors can sell their holdings or refrain from purchasing (exit voice), even if they lack the ability to influence day-to-day management of the companies in which they invest.

Health care choices are restricted in many ways, particularly for the individual consumers who are the intended beneficiaries of current disclosure laws. Most privately insured Americans receive health coverage through the workplace, so that choice of health plan belongs in the first instance to the employer. Although many working families have some choice among health plans, that choice is often limited, and employees of smaller firms usually have fewer options. Despite the enactment of portability and small group reform legislation at the state and federal level, moreover, availability and price primarily drive decisions by individually insured beneficiaries. Nor do all public enrollees have meaningful choices: although Medicare+Choice is premised on a variety of options, multiple plans are not always available, and several state Medicaid programs contract with a single managed care plan or a limited selection of plans. Finally,

physician selection decisions, even if unconstrained by insurance considerations, tend to be undertaken during periods of illness, when patients are under emotional stress and reluctant to jeopardize existing therapeutic relationships and therefore may not act on disclosed information. This is quite different from how people make decisions about financial investments.

What Can Be Done

The preceding discussion demonstrates that "aiding competition" is an oversimplified justification for mandatory disclosure laws in health care and suggests that many of the information requirements being added to current managed care legislation are unlikely to succeed. Still, information made available pursuant to government mandates can have competitive value. Two areas deserve attention from regulators and industry participants: (1) data standardization and (2) information to assist group (rather than individual) purchasing decisions.

Standardized Information

Mandatory disclosure laws are more likely to address informational failures in competitive markets if they contain requirements and mechanisms for standardizing reported data. Standardization improves the efficiency of both information production and information consumption (Kindleberger 1983). On the supply side, it facilitates collection and processing of data, as well as regulatory oversight. On the demand side, it maximizes comparability across competing organizations. Although industries frequently adopt standards voluntarily (subject to antitrust law), government action may nonetheless be necessary. If information disclosed by one firm can be used by consumers to value its competitors, for example, then the benefits of standardization to society outweigh those to the disclosing organizations. This type of situation, involving a "public good," commonly justifies regulatory intervention.

Standards are central to securities disclosure. Standards for nonfinancial disclosure are established by the SEC itself, while authority to prescribe financial reporting practices is delegated to the FASB. Several commentators have therefore recommended establishing an FASB-equivalent for health care (Etheredge 1997; Eddy 1998). Standards for quality-related information could ameliorate problems of data inaccuracy and lack of comparability, particularly with respect to risk- and severity-adjustment. As noted previously, moreover, true accounting standards for health care organizations are long overdue. Recently, initial planning was completed for a nonprofit Forum for Health Care Quality Measurement and Reporting, whose primary mission will be to develop standardized measures of quality for competitive use (Miller and Leatherman 1999). Because proposed legislation chartering a public, SEC-like body to accompany the private Forum was never enacted, however, the Forum's activities will be a test of whether private purchasing power can stimulate standardization, production, and use of quality-related information without direct government fiat.

Information Intermediaries

Many of the barriers relating to feasibility and effectiveness of disclosure discussed above, such as heterogeneity of preferences, health illiteracy, and lack of meaningful choice, apply with greater force to individual consumers than to purchasing groups. Corporate and securities law recognizes the value of sophisticated intermediaries, such as institutional investors, who can threaten mass exit if reported results disappoint and can even use acquired information to press for direct improvement. Similarly, despite the fact that political rhetoric surrounding health care disclosure laws typically invokes benefit to individuals (and assumes that larger parties can fend for themselves), private employers and other group purchasers may turn out to be the best audience for legally mandated disclosure.

Although one should resist idealizing their role, group purchasers are among the most effective information users and information intermediaries in today's health care system. Some large employers have taken the lead in quality measurement and value-based purchasing (Millenson 1997), though many have failed to follow (Meyer, Rybowski, and Eichler 1998). A few, such as the Federal Employees Health Benefit Plan (FEHBP), allow any willing health plan to compete for enrollment and provide extensive comparative information to beneficiaries. Others, like General Electric, gather information and offer employees only the one or two plans that seem best, disclosing how and why the selection was made.

Compared to the lowest-common-denominator approach of individual disclosure, information aimed at group purchasers can be more complex and therefore more discriminating. Maryland, for example, takes a layered approach to health care disclosure by producing three different health plan report cards from required data.

One, for individual consumers, offers plan-to-plan comparisons with brief, plain English descriptions and easy-to-understand graphics encompassing four areas of demonstrated relevance to decision making: general satisfaction, relationships with providers (e.g., choice among physicians, availability of appointments), clinical performance, and caring for the sick (access to specialist referrals, care for chronic illness). A second, for employers, provides extensive audited statistical data supporting each of these categories and arguably has the greatest competitive significance. The third, for policymakers and the public, displays plans' aggregate performance against a national benchmark and primarily serves rationales other than competition, as described below.

Any argument for targeting informational mandates toward group purchasers must acknowledge the major failings of America's less-than-universal, employment-based health system (Reinhardt 1998). A self-insured employer (or one that purchases experience-rated coverage) has a financial interest in conserving resources that does not necessarily match the views of its workers. Moreover, although diversity of health care preferences presents less of a feasibility barrier to disclosure when information is directed at groups rather than individuals, it remains an important policy consideration because employers who base their decisions on the preferences of the average worker inevitably disregard the opinions of much of the distribution curve. (Similar problems arise in corporate law when institutional investors are expected to police corporate behavior on behalf of a broader community [Black 1992].) Still, employee groups are relatively resistant to adverse selection and seemingly accept the redistributive implications of health insurance risk-pooling more readily than does the voting public as a whole. Consequently, developments that discourage active employer participation in health care purchasing—whether the threat of liability for involvement in coverage decisions or trends in premium growth that push employers toward a defined-contribution approach to insurance sponsorship—potentially reduce the competitive utility of mandatory disclosure laws.

INFORMATION AND CONFLICTS OF INTEREST

The foregoing discussion of group purchasers as information recipients leads us into the second major rationale for mandatory disclosure laws: to help principal parties monitor the behavior of their private representatives. Informational asymmetries are inevitable in modern society, which requires specialization of skills and pooling of interests to create and distribute products efficiently (Frankel 1983). As a result, end-users are increasingly removed from producers and must rely on a chain of expert intermediaries to procure and deliver goods and services. Each such relationship widens the knowledge gap for ordinary people.

Disclosure laws, however, cannot and should not fill every informational crevice. The sine qua non of effective disclosure regulation is to focus government mandates on kinds of information that will not be disclosed voluntarily. Prime among these is information about the intermediaries themselves, particularly information that reveals conflicts of interest between agents and the principal parties they are supposed to represent. As intermediaries become more specialized, moreover, principal parties' search and verification costs rise, and as pooling of interests increases, each principal's incentive to cover those costs diminishes. Properly focused, mandatory disclosure laws therefore constitute an "agency cost reduction" strategy, potentially overcoming barriers to efficient monitoring of intermediaries by imposing a duty to disclose on the best informed parties, the intermediaries themselves.

Securities Regulation

The concept of agency cost reduction was influential in rehabilitating the SEC's reputation following the attacks levied on the agency's efficiency in the 1970s (Mahoney 1995). Conflicts of interest are frequent between investors and the brokers, underwriters, investment advisers, and corporate managers on whom they rely, and information concerning these agents is both highly relevant and likely to be concealed. Because the costs of monitoring intermediaries are large, mandatory disclosure laws efficiently complement private oversight mechanisms.

Rampant self-dealing in the securities industry was an impetus for the passage of the Securities and Exchange Acts in the 1930s. Required disclosure by corporations issuing securities therefore focuses on potentially self-serving transactions such as promotional fees, management fees, executive compensation, nepotism, interlocking directorates, and contracts between corporations and their officers or directors. Similarly, mutual fund disclosure emphasizes information that indicates whether or not the fund is acting as a

loyal and prudent representative of investors, such as portfolio fees, portfolio turnover, and manager qualifications, in addition to general performance information such as historical returns and investment goals. Recently, securities regulators have become concerned about conflicts of interest affecting certification intermediaries such as accountants, lawyers, and investment bankers. For example, the SEC recently proposed a new rule requiring disclosure of the growing practice by accounting firms of providing lucrative consulting services to companies for which they also serve as "independent" auditors.

Disclosure is not the only solution to conflicts of interest and other agency problems in business and finance. State law imposes substantive duties of care and loyalty on corporate managers. However, much as federal securities law regards information relating to agency obligations purely in economic terms, valuable only for its usefulness in improving the efficiency of private transactions, most substantive prohibitions against conflicts of interest are default rules only and may be changed by agreement of the parties. A fully informed investor may choose to purchase shares despite a conflict of interest, just as existing shareholders may ratify a self-dealing transaction.

Rarely, securities law protects investors from themselves. For example, the fiduciary duties borne by mutual funds combine non-waivable substantive restrictions with disclosure requirements (Rock 1995). Among other things, mutual funds are precluded from shuffling their holdings to favor the ownership interests of the manager. This reflects the lesser sophistication of mutual fund purchasers and the absence of a secondary trading market, both of which support a more trustee-like conception of the fund manager's role. Similarly, stock exchange and NASD rules require investment advisers to serve the "best interests" of investors, including steering them away from unsuitable investments, and not merely to respect investors' poor (albeit fully informed) judgment. Unlike the disclosure provisions of the federal securities laws, however, these duties are not enforceable by private lawsuits.

Health Care Regulation

Disclosure laws can be efficiently targeted to overcome specific market failures related to the proliferation of agents and intermediaries in the health care system. These include not only the growing ranks of specialized physicians, other health professionals, and institutional health care providers but also the employers, government sponsors, and insurance entities that pool health risks and finance necessary treatment. Disclosure of physician financial incentives, utilization review procedures, coverage guidelines, and the like can alert enrollees and patients to ways in which their interests may diverge from those of their health plans and health care providers (Rodwin 1993). Studies suggest that many of these matters are not routinely discussed (GAO 1998).

There are two principal reasons, however, why agency cost reduction as a justification for mandatory disclosure is more complex in health care than in securities regulation. First, the integration of collective financing with individual delivery of services in managed care has not been accompanied by a clear consensus regarding the loyalties of particular intermediaries in today's health care system, especially when the interests of identified patients are in tension with those of defined populations. Second, patients' unavoidable reliance on physician professionalism calls into question the logic of curing conflicts of interest through disclosure alone, but the same phenomenon opens up important opportunities for information to reinforce traditional medical ethics and peer review processes.

Feasibility and Significance

Health care disclosure limited to agency issues avoids some of the feasibility problems inherent in government-mandated information requirements. Information about financial incentives, utilization review procedures, and other potential conflicts of interest between health care consumers and insurers or providers is usually descriptive and is therefore easier to produce and disseminate than quantitative performance indicators such as HEDIS scores. Still, a dizzying range of provider payment methods now exist in managed care, few of which are comprehensible to the average consumer. (Securities regulators face a similar problem trying to craft proxy disclosure requirements that both accurately and comprehensibly convey information regarding the ever more complicated realm of stock options and other management compensation.)

Another problem in health care, given its incomplete integration, is that it is difficult to monitor each tier of agents through disclosure. For example, the most important financial incentives to disclose to patients are those paid to individual physicians, not those paid to physician organizations. But a relatively small number of major insurers and HMOs may contract for services with hundreds of independent medical groups, which

are harder to track and therefore less accountable to regulators. Efforts to require licensed entities to report these subcontracts, while common, may fail because medical groups have strong competitive interests in keeping the details of their physician compensation and other potentially relevant pieces of information confidential. Fly-by-night operations aside, the mainstream financial services community is less professionalized, less fragmented, and more subject to strict corporate control. For example, the SEC collects extensive information on individual brokers from brokerage firms and makes that information generally available. To stimulate compliance, the agency gives limited immunity to firms that file reports on their employees.

In addition, the link between financial incentives and over- or under-provision of services is less clear in the professional arena than is true for typical self-dealing transactions in corporate America. And, of course, clinical judgments are fraught with uncertainty, so evidence that particular incentives influence physician behavior may not prove that such incentives have an adverse effect on health outcomes. Although empirical research to test these propositions is under way, the significance of physician compensation remains speculative. Disclosure requirements should therefore rely in part on justifications other than consumer response, such as the professional effects outlined below.

Distinguishing Individual from Group Conflicts

Reconciling the tension between resources devoted to particular individuals and those available to serve society as a whole is the core challenge of national health policy. As is not the case with the securities industry, however, this tension is also a feature of private health care transactions. Shareholders tend to be similarly situated, so self-dealing by promoters or management affects them all adversely and proportionately. By contrast, conflicts in health insurance often put beneficiaries at odds with one another as well as with the physicians or managers who serve them. These "conflicts of obligation" (Morreim 1998) have always been present—and indeed are acceptable—in private insurance relationships because of the moral hazard afflicting insured parties when someone else is bearing the cost of covered losses; for health insurance (unlike casualty insurance), moral hazard manifests itself in overuse of services rather than risk-taking behavior. Managed care complicates this situation because of the direct involvement of insurance organizations such as HMOs in specific clinical decisions and the fact that health professionals are contractually responsible for patient groups as well as for individuals. Unfortunately, neither insurers nor health professionals seem particularly comfortable with their blended roles, with some of the former continuing to disclaim responsibility for care (as opposed to payment) and some of the latter condemning collectivist ethics as capitulation to the marketplace (Kassirer 1998). On the other hand, it is doubtful that an adversarial system that pits physicians as "patient advocates" against insurers representing financial interests is a superior design (Sage 1999b).

Role instability is a challenge for agency cost-reducing regulation because the public's general discomfort with managed care does not translate easily to a clear assignment of disclosure obligations or to a sensible imposition of substantive fiduciary duties. For example, disclosure of physician financial incentives has emerged primarily as a responsibility of managed care organizations under state insurance and HMO regulations (Miller and Sage 1999) and of employers and third-party administrators under ERISA, even though the fiduciary duties those organizations owe their participants and beneficiaries are owed to the group, not to individuals. Although this is explainable as a doctrinal matter (e.g., ERISA requires disclosure of "material information"), courts tend to discuss managed care incentives in terms of potential disloyalty and self-dealing. In the most contorted reasoning to date, the federal appeals court in *Herdrich v. Pegram* ruled that a physician-owned health plan serving ERISA beneficiaries and paying its own doctors incentives to conserve on referrals somehow breached its fiduciary duty to the ERISA plan as a whole by "self-dealing." This holding, which was overturned on narrower grounds by the Supreme Court, ignored both the plan's arguable duty under ERISA to avoid wasting its assets and the prevailing wisdom that physician management of health plans should be encouraged, not condemned (Sage 2000). At the same time, courts have been slow to impose a duty to disclose conflicts of interest or other nonclinical information directly on physicians under informed consent law, even though physicians have a clearer fiduciary obligation to individual patients than do health plans. (Several state statutes, however, require disclosure by physicians of self-referral arrangements that encourage overutilization of services.)

Patient Vulnerability and the Illusion of Consent

Corporate law, like general contract law, presumes that parties to a marketplace transaction should be entitled to determine the conditions under which that transaction occurs. In these situations, law merely creates "default rules," which are rules that apply only if the parties have not reached a different

understanding. Occasionally, the law considers two parties to an ongoing relationship sufficiently disparate in power that the more powerful party is held to strict fiduciary standards of conduct regardless of the weaker party's ostensible agreement to the contrary, but even in these situations the law generally allows the parties substantial latitude to set the original terms of the relationship. The purpose of mandatory disclosure laws in commercial contexts is therefore to give the principal party enough information about the agent's incentives so as to make an intelligent choice about discharging (or not retaining) the agent or refining the agent's mission. For example, a potential investor who is advised that the corporation selling stock to the public does most of its business with companies controlled by a relative of the CEO can nonetheless decide that other indicators of profitability outweigh the risk of self-dealing, in essence "consenting" to the suspect arrangement. (An issuer, however, may not ask buyers to waive their rights to sue for fraud or related violations of securities law, because the knowing acceptance of other terms of the transaction depends on the strength of the issuer's warranty regarding the information it provides.)

This is a very different model from medicine, where the decisions to seek help from a physician and to follow that physician's clinical recommendations are frequently made in a vulnerable emotional state, which compounds unavoidable imbalances in technical knowledge. Even though many bioethicists aspire to an autonomy-centered view of the patient-physician relationship, practical limits on patients' control over physicians' decisions make that relationship resemble a trust rather than a true agency (DeMott 1998; Schneider 1998). A trustee's obligations of loyalty to the trust's beneficiaries are typically absolute and not subject to modification even with the consent of the beneficiaries. In health care, therefore, disclosure of many agency-related matters, particularly conflicts of interest, cannot be justified on the theory that an informed patient may reasonably decide to consult the physician or accept the physician's recommendations despite the conflict. A physician making such disclosure would in essence be saying, "You need to trust me, but do you mind that I may not be trustworthy?"

This wrinkle in agency-related disclosure connects to a broader debate concerning the appropriate limits of contractual freedom in health care (Hall 1997; Havighurst 1995) and its relationship to established professional duties (sometimes called "fiduciary contracting") (Mehlman 1990). On one hand, allowing supposedly "informed" enrollees to subject themselves to rationed care at a cheaper price presents risks of deception, particularly in life-threatening situations. On the other hand, maintaining a unitary "standard of care" for managed health coverage like that used in malpractice litigation visits the costs of perfection on a host of parties in addition to the patient. Physicians must therefore simultaneously be trustees for patients and agents for payers, a very uncomfortable position. Even aligning physicians' incentives with patients' medical interests by paying only for successful outcomes would not solve the problem—someone other than the patient, generally an insurer, must still foot the bill. Seen in this light, mandatory disclosure of nonobvious conflicts of interest in health care relationships—whether tending toward excessive utilization of services (e.g., physician self-referral to affiliated businesses) or insufficient utilization (e.g., physician capitation)—constitutes a warning to the broader society about the minimum quality standards it enforces (and therefore the price-quality tradeoffs it forecloses) in addition to alerting the individuals whose care is directly affected.

What Can Be Done

Despite these shortcomings, agency-enhancing disclosure can be extremely important to the health care system. To become so, however, it must distinguish itself in both intent and design from its more straightforward counterpart in securities law. This entails linking it more closely to other legal mechanisms for promoting self-help in today's managed health care system and recognizing its potential to further professional, largely noneconomic, values in medicine.

Information about Legal Rights and Self-help

Disclosure laws frequently require better-informed parties to notify those with whom they transact business of their legal rights and remedies. This is a fruitful avenue of agency-enhancing disclosure in health care because it empowers consumers and patients to help themselves rather than relying entirely on the intermediaries whose motives or activities have been called into question. Use of disclosure laws to advise patients of their rights is a familiar device in health care regulation, recalling debates over bodily self-determination and deinstitutionalization and the "patients' bill of rights" legislation they have prompted. It is also well adapted to managed care reform, especially as legislatures expand the substantive rights available to consumers and patients.

For example, laws increasingly require disclosure in health plan enrollment materials and subsequent correspondence regarding the availability of ombudsman services, government consumer assistance, and

disclosure of rights to appeal coverage denials both internally and to an independent review body. Another recent trend is to require disclosure of the number, character, and outcome of grievances and appeals filed against the health plan, so that consumers can assess the fairness of internal procedures. (Grievance information, however, must be stripped of patient identifiers to preserve privacy and can be misleading because health plans may reduce the likelihood of patients filing appeals by adopting financial incentives that discourage physicians from recommending treatment in the first place.)

More generally, well-designed disclosure can constitute an important navigational tool for users of an increasingly complicated health care system. Simple, descriptive disclosure regarding physician payment, for example, can help consumers understand the structure of managed care, appreciate the links among various intermediaries, and focus on the flash points where their own interests may differ from those of health care organizations and professionals. Among other things, this kind of structural information can prompt patients to question their physicians, employers, and others more closely about available options and their clinical and economic consequences.

Therapeutic Goals and Professional Values

Securities regulation does not assign a central place to ethical safeguards against malfeasance (though it does rely extensively on binding self-regulation). Certification requirements and ethical standards exist for some of the participants in securities transactions, such as accountants and financial planners, but overall the SEC places little emphasis on the education, training, or professional socialization of personnel under its regulatory authority.

By contrast, the fact that many agents are professionals with established ethical codes holds promise for agency-related disclosure laws in health care. Much as one can view communication that fulfills physicians' informed consent obligations less as deferring to patient autonomy than as making physicians aware of patient concerns and priorities and improving patients' confidence in and compliance with the therapy selected, so, too, can one conceive of other disclosure laws in a therapeutic light.

For example, much of the quality information common to current disclosure requirements is sterile compared with people's emotional investment in health care. "Report card" measures tend to emphasize disease states and the processes that prevent or treat them, even though consumers in focus groups show limited interest in or ability to interpret technical information divorced from their individual circumstances (Hibbard et al. 1998). Instead, ordinary people seem to prefer subjective, relational information from "people like them," perhaps because this kind of information more closely approximates the personal recommendations that traditionally guided choice of physician (Edgman-Levitan and Cleary 1996). (By contrast, the SEC specifically prohibits testimonials in mutual fund disclosure.) This may partly account for the popularity of consumer satisfaction scores, despite the potential for those scores to skew results toward the opinions of the majority of members who are low utilizers of services. The public does retain an appetite for quantitative information with sufficient salience, such as rates of serious medical errors, but the utility of that data for ordinary health care decisions is doubtful (Brennan 2000).

Similarly, a wild card in the disclosure of information about physician financial incentives is its effect on trust between physician and patient. Evidence suggests that patients are poorly informed about physician payment in managed care, and only about half say they want to know such details (Kao et al. 2000). On one hand, blunt depictions of physician profit-making might alarm patients who are currently unaware of the possibility of professional disloyalty and might thereby jeopardize therapeutic relationships. On the other hand, accurate yet gentle disclosure that places financial incentives in the context of the overall health care system could provide reassurance to patients who currently have significant doubts. In either event, requiring disclosure in connection with every clinical encounter would distract both parties from more important discussion and interaction.

One clear lesson nonetheless emerges. Although patients need to know the truth about their medical condition, their therapeutic alternatives, and the clinical or contractual standards that determine the availability of coverage, presenting that information compassionately—as if it were coming from a health professional rather than a commercial enterprise—would help patients more than the current tendency to engage in rote compliance with regulatory requirements and to adopt a defensive posture against possible litigation. This is particularly true for information disclosed in connection with coverage denials and subsequent appeals.

In addition, medical professionalism makes it possible that disclosure obligations with respect to agency

issues could yield therapeutic benefits by changing physician behavior, even without a preceding change in consumer demand. Physicians have high ethical expectations of themselves and often accept peer review processes even if they resist control from outside the medical profession. Currently, physicians enter into contracts with managed care organizations more or less indiscriminately, trusting their own moral compasses to avoid problems, even ones that are predictable from the text of the agreement or the structure of the relationship. Requiring disclosure to patients of potentially problematic practices achieves two goals: it forces potential conflicts of interest into physicians' consciousness, and it exposes them to criticism from their peers. Ideally, the outcome of this process would be to deter physicians from entering into arrangements that they would be embarrassed to have widely known (Hall and Berenson 1998). A caveat is that a disclosure requirement would obligate physicians to familiarize themselves with the financial incentives affecting each patient in order to communicate them accurately, thereby focusing them to a greater degree on the economic consequences of particular care decisions than patients or policymakers might desire.

These considerations raise the issue of whether it is necessary to impose a legal obligation on physicians to disclose conflicts of interest or whether an ethical obligation would suffice. It is a close question. An ethical obligation has the advantages of allowing flexibility in physician response and avoiding boilerplate compliance that does not further therapeutic goals. On the other hand, the Code of Medical Ethics already requires disclosure to patients of financial incentives (American Medical Association 1995), yet it appears that such information is seldom shared. In addition, the ethics of organizations that increasingly influence health care delivery—including by employing physicians—remain largely inchoate, suggesting that the force of law may be needed, at least in the short term, to stimulate the development of an adequate "institutional professionalism." This discussion begins to awaken us to beneficial uses of disclosure that go beyond the traditional buyer-seller model. The next two sections of the report develop this insight in greater detail.

INFORMATION AND PERFORMANCE IMPROVEMENT

Although disclosure laws are generally regarded as less intrusive regulatory interventions than are price or quality standards that foreclose certain options to consumers, the enactment of a mandatory disclosure obligation nonetheless influences the mix of price and quality attributes available in the marketplace. For a host of reasons, both economic and sociological, people try to excel at activities if their performance will be evaluated and publicized. This channeling effect is an incidental by-product of many disclosure laws (particularly those involving quantitative information), because they create strong incentives to concentrate attention on the items to be disclosed, even at the risk of neglecting other important tasks. But improving "productive efficiency" also can be a deliberate, theoretically coherent use of disclosure regulation. (This is different from "allocative efficiency," which is the goal of competitively motivated disclosure obligations.)

Information is what economists call a "public good"; as such, it tends to be underproduced by society because those who generate it cannot capture its full value (Gilson and Kraakman 1984). Consequently, standardized data and accessible systems for exchanging it may not be developed by private parties despite the information's collective value. Mandatory disclosure laws can overcome these obstacles, potentially triggering a positive feedback loop in which information promotes industrial restructuring and captures network externalities, leading to even better information and continued innovation. Regulators frequently use performance standards to ensure that certain quality levels will be met while giving regulated entities flexibility to achieve those levels in the most efficient manner. Disclosure requirements allow discretion in ends as well as means, yet they still propel regulated entities toward superior performance. One can even view disclosure as the basis for a reinvigorated federalism that allows fluid yet productive oversight of private activities by multiple layers of government (Dorf and Sabel 1998), which is an important concern in health care (Rich and White 1996). These uses of mandatory disclosure are openly instrumental, however, and seek to change supply and demand rather than merely facilitating matches between existing consumer preferences and current production possibilities.

Securities Regulation

The ends-forcing potential of mandatory disclosure is apparent from experience with securities regulation. "You manage what you measure" is axiomatic in business administration, and disclosure laws force the issue of data collection and analysis (Lowenstein 1996; Fox 2000). In addition to citing direct effects on

investment decisions, supporters of SEC disclosure requirements credit them with fostering communication within firms, particularly between operating units and senior management, leading to overall improvements in corporate governance and managerial accountability. According to this theory, moreover, the intense scrutiny to which the media subject corporate earnings reports and other disclosed information—now that Wall Street performance has become a matter of general interest—heightens the motivating effect of disclosure requirements and yields even greater productivity dividends (Lowenstein 2000).

An important qualification is that securities regulators generally refrain from using their power to dictate disclosure as a conscious tool to channel corporate performance in directions unwarranted by investors' informational needs. Accordingly, the standard of materiality that securities law imposes on corporate disclosure is based on the reasonable expectations of investors, not the lofty aspirations of the SEC. Nonetheless, securities regulators recognize that consumer protection relates to a broader mission: benefiting the public by improving the process by which American business raises capital. For example, plain English mutual fund disclosure can be seen as part of a concerted effort by the SEC to educate investors and thereby broaden the pool of available investment funds (Fanto 1998; Frankel 1999). In addition, several aspects of securities disclosure are inadvertently directive. First, the securities statutes specify certain categories and items of required disclosure in addition to a materiality catchall, and the SEC has expanded these by administrative process. Second, fear of provoking lawsuits alleging securities fraud despite full disclosure curtails the sale of particularly risky securities, even at prices that would be attractive to investors. Third, issuers of many securities routinely submit their disclosure documents to SEC staff in draft form for review and comment and model their proposed disclosure language on similar transactions that have survived SEC scrutiny, producing de facto SEC standards that are relatively rigid. Fourth, FASB standards for financial reporting are often adopted in response to misleading or manipulative accounting practices and thus have the intended effect of changing corporate conduct. Finally, the financial resources and experience needed to comply with extensive disclosure requirements, like any other complex regulatory mandate, favor large, established issuers over newcomers.

Health Care Regulation

A critical insight for health care regulation is that mandatory disclosure laws may have greater usefulness in aiding productivity than in facilitating competition (Marshall et al. 2000). This should be unsurprising, since compulsory data reporting in health care has stronger roots in health services research (and perhaps fraud prevention) than in market competition. Gains in productive efficiency resulting from health care information disclosure are potentially great because of the health care system's structural fragmentation, marked clinical variation, and underdeveloped cost-discipline, while the system's professional orientation is likely to motivate improvement to a greater degree than might be true in other industries. Disclosure requirements can help identify and disseminate best practices, leading to productive partnerships and stimulating additional innovation. This is particularly true if they are targeted at matters within the control of the disclosing entities and if they are linked to mechanisms for information pooling and feedback (sometimes called "experimentalism"), both among private organizations and between those organizations and regulators (Dorf and Sabel 1998). Of course, disclosure aimed at expert, professional constituencies must achieve a high level of rigor and credibility in order to motivate and guide practice improvement.

The performance rationale for disclosure deserves more credit than it has received. In recent years, the once-proud instrumentalism associated with information disclosure (whether to regulators, to the public, or to both through electronic media) has often been subsumed by the more politically acceptable rhetoric of informed consumerism. During the Clinton administration's failed 1993–1994 health reform effort, for example, repeated efforts to persuade the president's health care guru, Ira Magaziner, that informational requirements could help improve system performance were ridiculed as mindless bureaucracy, while virtually identical mandates were enthusiastically received when accompanied by a "mock-up" of a consumer report card. Quality experts therefore have expressed concern about health plans' "gaming" disclosure requirements by gearing their improvement efforts to reportable measures (Eddy 1998) but have paid less attention to the potential for using such behavior constructively to direct resources where they are most needed. Similarly, HCFA's QISMC regulations for the Medicare+Choice program have been attacked on the grounds that the only entities capable of measuring and reporting performance as required are HMOs and other integrated organizations. Rather than pausing to consider whether health plans that have this informational capacity are likely to perform better, however, HCFA simply retreated and reaffirmed its commitment not to influence the availability of market choices. The performance rationale for disclosure therefore merits closer examination.

Setting Goals

Because performance-motivated disclosure requirements substitute the regulator's goals for those of the marketplace, the goals that are selected and the process for determining them become critical. For example, goals can be set in either public or private forums, and can reflect either expert judgment or lay preferences. The SEC has generally confined its standard-setting processes to expert, nonpolitical arenas (Khademian 1992). Despite its overall reliance on self-regulatory organizations, for example, securities regulation offers scant opportunity for direct public input (except, of course, in notice and comment rule-making). FASB is dominated by expert accountants and does not even broadly represent market participants, much less the general populace. Nor does the SEC maintain an organized consumer mechanism to solicit input from individual investors. (Recently, however, proposals have been made to admit public members to the NASD.)

In health care, goals might be established by expert professional bodies, by leading purchasers and other consumer representatives, or by the broader society. For example, a recent evaluation of the process for setting National Institutes of Health (NIH) funding priorities recommended a widely distributed process with full public involvement, in part because purportedly objective current practices appear to be swayed by particular advocacy groups (Dresser 1999). The outcome of such a process is far from certain: goals in health care are inherently more subjective, controversial, and politically manipulable than goals in financial performance. Fully resolving these issues would therefore require revisiting the longstanding tensions in health law and policy among professional control, market hegemony, and social solidarity (Rosenblatt, Law, and Rosenbaum 1997).

Because competition is the dominant discourse in managed care, HEDIS measures and other standards for health plan accreditation largely represent the viewpoint of large employers and other purchasing groups. The new Health Care Quality Forum has similar origins but has broadened its governance considerably (Miller and Leatherman 1999). Certainly, the extent of public investment in health care and the marked inequities of access that persist argue for an expansive definition of the health system's objectives and, hence, for disclosure requirements that include measures of public health and well-being. As noted above, Maryland devotes one of its three report cards to benchmarking the state's performance against national progress toward achieving health goals. As a similar step in the direction of using disclosure to improve public health, the National Committee for Quality Assurance (NCQA) has mandated reporting of patient LDL cholesterol levels (Lee et al. 2000).

Personal Privacy

Instrumental uses of disclosure raise particularly thorny privacy concerns. Few analogs to the privacy issues that arise in health care exist in securities regulation. Mandatory disclosure laws widen the audience for information and potentially expose disaggregated data to various intermediary parties such as attorneys, auditors, and consultants. Apart from mandatory disclosure with respect to the qualifications and financial interests of officers, directors, and other controlling persons, however, SEC rules allow regulated entities to conceal information if its publication would infringe personal privacy. The SEC has the right to inspect that information but may not reveal individual investors' identities to the public.

Patient privacy may be more threatened by health plan disclosure requirements than by narrow provider mandates because large insurance organizations tend to invest in sophisticated information systems and because integrating insurance operations with the provision of care makes clinical information accessible to parties who can use it for improper purposes, whether commercial sale or discrimination in insurance or employment (Gostin 1995; Schwartz 1995). Given the diversity of individual preferences discussed above, for example, customized information about insurance is potentially more useful to consumers than a one-size-fits-all disclosure document, particularly if it is made available electronically using interactive software. But the process of requesting customized information requires a sacrifice of privacy by users, who must reveal their circumstances and concerns. On the other hand, the possibility exists that health plans will raise privacy issues strategically in order to avoid disclosing information that is highly relevant to consumers, such as the outcomes of grievances and appeals.

Although privacy is a significant concern whatever the theoretical justification for health care disclosure, these problems may be magnified when information is used as a tool to enhance performance. Akin to the business concept of managing what one measures, part of the instrumental value of disclosure is to involve the regulated entity deeply in setting up information systems and collecting and evaluating data, in addition to reporting the results. This arguably exposes personally identifiable information to a wider audience and increases the potential for misuse. Furthermore, disseminating the lessons learned from this process—another important goal of instrumental disclosure—may itself require sharing of raw data, with attendant

privacy concerns. (The current debate over public availability of federally funded research data presents similar issues.)

Tensions with Competitive Disclosure

Instrumental uses of information disclosure elevate quality improvement over other objectives. This raises the risk of conflict both with consumers' desires and with the commercial self-interest of disclosing entities in a competitive environment. Securities regulation recognizes that disclosure requirements can erode proprietary value. For example, mutual funds resist disclosing details of their portfolios, even though this is arguably the most important information for consumers to know, because they would be giving away for free the valuable investment skills that lead investors to them in the first place. The SEC therefore allows companies to submit confidential treatment requests that would shield proprietary information from public availability under an exception to the Freedom of Information Act, although it construes this exception narrowly. In the case of mutual fund portfolios, the SEC takes the position that information may be disclosed with a time lag sufficient to allay funds' fears about losing proprietary value.

Entities subject to disclosure requirements in health care are likely to assert similar claims. Health plans may be protective of market share data, while physicians might be sensitive about their reimbursement rates and other financial details of their contracts. Disclosure laws intended to advance competition should reasonably accommodate these considerations, although regulators should be alert to the "emperor's new clothes" phenomenon, meaning that regulated entities might oppose publicizing utilization review standards or practice guidelines on competitive grounds, when their actual fear is revealing that supposedly sophisticated management tools are in fact arbitrary, inconsistent, or imaginary. On the other hand, a performance-oriented disclosure regime might conclude that proprietary interests are outweighed by the potential for information to stimulate broader change. As the debate over medical process patents demonstrates, moreover, the tendency of competitive organizations to guard their management tools is also in tension with professional traditions of information-sharing in medicine. In addition, the sizable investment of public dollars arguably stakes society to a claim in nominally private information. A similar tension between productivity and equity exists in biomedical research, where the Bayh-Dole Act allows private firms to patent publicly funded inventions (Eisenberg 1997). Reconciling these interests is difficult and relates to an ongoing debate in organizational theory as to whether open architectures and free flows of information are superior to proprietary models of quality control and improvement (Helper, MacDuffie, and Sabel 1997).

An equally sticky problem involves designing a disclosure system in a way that maximizes communication within organizations, particularly with respect to identifying poor performance and attempting to remedy it. According to an emerging literature that applies lessons from other "high-reliability industries" to medicine, a prerequisite to institutional error reduction and quality improvement is encouraging responsible individuals to alert the organization to hazardous situations (Berwick 1999; Institute of Medicine 1999). This implies shielding them from blame, which runs counter to both the tradition of individual accountability in medicine and the public's current thirst for information about physician quality. Consequently, performance-oriented disclosure may need to restrain access to particular categories of information in order to accomplish its larger goals. (This does not mean that injured patients should lack legal recourse, only that certain information would be off-limits, as is already the case with qualified peer review activities, which are privileged from discovery in litigation.)

Demand Modification

A final issue raised by instrumental justifications for disclosure stems from the fact that the production function in health care is highly sensitive to the behavior of those who receive services. Health care "works better" when patients adhere to a healthy lifestyle, obtain preventive care and early treatment, and comply with recommended therapy. Health insurance "works better" when insured individuals resist moral hazard and refrain from making unreasonable claims on common assets. Securities regulation has no parallel for these phenomena, since shareholders of a public company are by definition passive owners with no operational influence over the company's performance (except tangentially insofar as market capitalization determines business opportunities).

Obviously, information can influence the behavior of consumers and patients. Indeed, the managed care industry is investing heavily in disease management and demand modification programs that rely on information to train health plan members to be more prudent and competent users of services (while the pharmaceutical industry is waging an opposite media campaign to promote consumption of prescription drugs). These voluntary efforts present few problems for competitively oriented disclosure laws, except with

respect to antifraud enforcement, and productivity-related disclosure laws could adopt similar strategies to achieve overall system goals. These regulatory efforts might go well beyond mere "consumer education" and attempt to change people's core beliefs regarding the goals of and appropriate level of reliance on health care (Fries et al. 1998). Whether this is an appropriate role for government and, if so, how it should be advanced are important unanswered questions.

INFORMATION AND DEMOCRACY

The productivity-enhancing potential of mandatory disclosure laws—in which government plays a constitutive and not merely facilitative role—provides the first inkling in our discussion that information can have public as well as private meaning in health care. Generally speaking, information supports the deliberation that is essential to participatory democracy and therefore helps guarantee the integrity and effectiveness of government (Pateman 1970; March and Olsen 1995). Recalling Justice Louis Brandeis's aphorism that "sunshine is the best disinfectant" (Brandeis 1914), this function of information is most frequently associated with disclosure by or about political institutions, such as freedom-of-information statutes, open meeting acts, campaign finance disclosure requirements, and other "sunshine laws." It applies as well to activities whose scale, scope, and character make them indispensable contributors to the nation's welfare. The democratic justification for information disclosure is therefore closely related to the agency cost-reducing strategy discussed above, except it is concerned with monitoring public rather than private agents. Pro-democratic, public agency–protecting uses of information are particularly meaningful in health care because of the substantial foundation of public investment and public expectation that rests beneath the American health care system's facade of private control.

Securities Regulation

Enacted in the wake of the stock market crash of 1929, the federal securities laws responded to perceptions of widespread fraud and cronyism in the stock exchanges and are generally credited with restoring confidence in financial services and stabilizing the public capital markets. Although the competitive benefits of the laws' disclosure requirements remain debatable, one can make a cogent argument that the government's commitment to full disclosure accomplished a greater goal. America's expectations of integrity, fairness, and transparency in its financial markets are fundamental, not merely instrumental. An explicit government commitment to securing these benefits through information reassured the public that the modern regulatory state would serve general rather than special interests and, beyond its specific effect on securities transactions, may have helped preserve social harmony.

Today's SEC shies away from politics and instead cultivates an image of neutral expertise. This partly reflects its status as an independent, nonpartisan agency rather than a creature of the executive branch, while also arguably deriving from industry participants' and many investors' ideological preference for minimalist government. In any event, few traces remain of the agency's activist history. Regulation of investment companies in the 1930s and 1940s, for example, included not only disclosure but strict limits on shareholdings and boardroom activism in order to deter the concentration of economic power—and therefore political influence—in a few investment banks and other elite institutions (Roe 1991). (A subsequent upsurge in open-ended companies with more fluid, diversified holdings and a larger number of less wealthy investors—today's mutual funds—allowed regulators to relax these restrictions.)

Consequently, the disclosure requirements in modern securities regulation are self-consciously devoid of public meaning. Significantly, this is possible only because government's direct role in the securities markets is slight. To be sure, pension funds for public employees are important institutional investors, and government is the largest issuer of debt securities (which are, however, exempt from most disclosure requirements). Nonetheless, politicians have little reason to second-guess the market; to the contrary, the market thrives when it feels the economy is free of political manipulation. If government were immersed in the securities markets to the same extent as in health care, SEC oversight would likely take on heightened political significance, with attendant risks as well as opportunities. One can view the debate over investing Social Security funds in the stock market in these terms. Wall Street likes the idea of a trillion-dollar cash infusion but is extremely suspicious of the political distortions that a public investment of that magnitude would introduce.

Health Care Regulation

Although the sense of crisis that permeated American politics in the 1930s and permitted the enactment of the federal securities laws and other New Deal legislation is absent from today's health care debate, the securities law experience is again relevant. As happened to the securities industry following the 1929 crash, the introduction of competition and cost-consciousness through managed care has produced widespread distrust and suspicion of many institutions and incentives. To the extent that transparency through disclosure dispels some of these fears and stabilizes the system, it could tangibly benefit the public even if the specific information disclosed is not optimal for consumer decision-making. Moreover, government's greater financial involvement in health care than in the securities industry means that disclosure could also help the public monitor the generous subsidies its tax dollars provide and thus satisfy itself that decisions about the allocation of these resources are fair and reasonable. However, the public meaning of disclosed information has largely been lost in the rhetoric of privatization and competition. In the campaign to educate beneficiaries about their options under the new Medicare+Choice program, for example, commentators have been blind to the fact that the recipients of information are not just consumers—they are also voters, and the information they receive will influence their political actions as much as their marketplace behavior.

A democratic theory of disclosure sees shared information as an opportunity for the public to consent to important decisions that affect it. This use of information presents a dilemma with respect to government's role, however. When disclosure is used to improve competition and oversee private agents, government is well positioned to serve as an honest broker of information. In fact, placing responsibility for processing and distributing information on the private organizations that are the objects of regulation—a central feature of securities law—worries consumer advocates, who recall marketing abuses by HMOs and therefore prefer that government control information flow with respect to managed care. Similarly, assuming that goals have been legitimately established, performance-improving justifications are compatible with a strong government role. On the other hand, reinforcing democratic values through disclosure implies that government is not neutral; in fact, information *about* government is at issue, so government should not control it. This reinforces the importance of multiple information sources—including a free and vigorous press—to prevent abuses. But it also raises a difficult question for political theorists: whether democratic representation means respecting the will of the people as it exists or leading the public to loftier ideals and achievements (Pitkin 1967).

Setting Limits

Several commentators emphasize information disclosure as a prerequisite for consent to health care rationing (Elhauge 1994; Hall 1997) and have even recommended harnessing electronic information technologies to facilitate this process (Rai 1999). Indeed, issues of allocation have taken on heightened importance in recent years as managed care has substituted explicit controls for traditional "bedside rationing," including coverage decisions involving high-cost treatments for life-threatening illnesses. Even though health plans are private entities, the public and many ethicists regard them as carrying out a social function that requires moral legitimacy as well as clinical accuracy and economic efficiency. Openness, including public accessibility of the grounds for coverage decisions, is a prerequisite to legitimacy (Daniels and Sabin 1997). Disclosure laws involving utilization review standards, coverage decision processes, and grievance and appeals mechanisms therefore serve an important public purpose. Moreover, the public meaning of this information is increasing as beneficiaries of public entitlement programs enroll in managed care plans, which may thereby become "state actors" subject to constitutional due process requirements.

Because information is a hallmark of fair process, disclosure may be valuable even if citizens cannot meaningfully ratify rationing systems. Again, there are close parallels between private health care decisions and public allocation mechanisms. The preceding discussion of private agency relationships emphasized the potential therapeutic value of disclosure even where true "informed consent" is impossible. A similar concept of "dignitary value" exists in the public realm (Mashaw 1981). According to this theory, administrative due process should be directed at measures that further human dignity, including each individual's right to understand the reasons for public decisions that affect him or her. On a global level, however, arguments have been made that rationing health care resources is morally incompatible with full, open discussion of its means and processes (Calabresi and Bobbitt 1978). Democratic conceptions of information must acknowledge and address this possibility.

Public Spending

Public dollars now represent more than half of total health care spending. The extent of public funding is not widely known (Bernstein and Stevens 1999; Blendon et al. 1997)—especially the billions of dollars of foregone revenue that result from tax subsidies for employer-sponsored health insurance and nonprofit health facilities and the even larger sums allocated to Medicare from general funds, which belie the rhetoric of a self-perpetuating "trust fund." Information regarding this substantial outlay of resources could be important in helping the public monitor its investment, both to avoid waste and to track progress toward the accomplishment of public goals. For example, the IRS recently strengthened its disclosure requirements for tax-exempt organizations, and several states have enacted information mandates as a part of efforts to verify "community benefit."

Disclosure regarding public spending, however, presents a conflict of interest for government in its dual roles as health care regulator and health care purchaser, with the potential to contaminate information requirements that more profitably serve other ends. For example, HCFA's current efforts to reconfigure its coding requirements for evaluation and management services have mired it in controversy with physicians, who view the proposed reporting mandates as a subterfuge to enforce draconian antifraud laws against overburdened professionals. The DHHS Office of the Inspector General's plans to construct a Healthcare Integrity and Protection Data Bank, which would use mandatory reporting to achieve for fraud prevention what the National Practitioner Data Bank hoped to accomplish for physician quality, were recently put on hold for similar reasons. If government becomes narrowly focused on disclosure as a way to root out and punish fraud and abuse, potentially more valuable justifications for disclosure may wither. In particular, the cooperation necessary for performance-oriented disclosure to have its desired effects would erode quickly in the punitive environment of antifraud enforcement.

Taking a broader perspective, it is also hard to predict how detailed information about funding would affect public opinion regarding universal access to health coverage. The income redistribution implicit in entitlement programs and provider-level cross-subsidies in health care is both a great asset and a closely guarded secret (Vladeck 1999). Exposing these issues to full public view without simultaneously raising awareness of the deeper social issues involved will not necessarily raise the level of discourse or lead to more rational health policy. This brings front and center the issue of public instruction as part of any meaningful commitment to an information-rich environment for citizens.

DISCLOSURE LAWS IN OPERATION

The preceding discussion attests to the importance of matching the design of mandatory disclosure laws to their desired purpose. To that end, securities regulation provides a useful mirror for health care regulation. As a final matter, let us consider a few key aspects of how disclosure requirements work in practice.

The golden age of regulation arguably has passed. The core assumption of New Deal legislation—that administrative bodies can exercise neutral expertise for the public good—has been challenged by both the scholarly skepticism of public choice theorists and the pragmatic pessimism of post-Reaganite politics. Yet the SEC has survived, not unscathed but with its mandate and its integrity intact. In doing so, it has navigated a tight channel between overintrusiveness and passivity, becoming neither the bane of the securities industry nor its lackey.

Whether this success can be replicated in health care regulation is an important question. The absence of consensus over the nature—and indeed the existence—of crisis in health care differs significantly from the environment that incubated the federal securities laws. It is unlikely, for example, that health care regulators would be given the degree of discretion allowed the SEC in its early days. Nonetheless, securities law sets a useful example by showing that government's role in consumer protection can change over time and that a commitment to abundant information disclosure can serve as a rudder for these adjustments. Making disclosure a centerpiece of health care regulation may allow outdated rules to be abandoned with fewer misgivings and hasten the adoption of new measures by educating both regulators and voters about the diversity and effects of industry practices. Imposing disclosure mandates at a time of system transition may also make substantive regulation less necessary by accustoming the private sector to demanding and using information.

Compliance Costs

Like any unfamiliar regulatory mandate, proposals for extensive disclosure requirements provoke objections from those on whom the burden of compliance, any associated liability, or the costs of enforcement are likely to fall. Experience with securities regulation suggests that new disclosure rules frequently foment controversy over feasibility and usefulness. These concerns generally fade over time, however, as the industry adapts to the new requirements and the regulators refine them. Nonetheless, start-up costs can be high for both private parties and government. Evaluating one recent managed care reform proposal, the Congressional Budget Office estimated that quality assurance mandates and requirements to collect standardized data, including HEDIS measures and consumer health and satisfaction surveys, would raise private insurance premiums by 0.5 percent annually (CBO 1998). Maryland's report card project cost the state $900,000 in the first year and $450,000 in the second. It is difficult to cut corners. One cannot simply take an existing data source and expect it to serve purposes vastly different from those for which it was designed. For example, The Joint Committee on Accreditation of Healthcare Organizations (JCAHO) was unable to distill its survey data into a short report card because of concerns about severity adjustment and other imprecisions. Similarly, commentators have criticized attempts to use National Practitioner Data Bank reports to generate consumer information (Smarr 1997).

Protests about the costs of compliance frequently come from smaller entities, which are less likely to have the necessary infrastructure already in place and for whom the continuing costs of compliance tend to represent a larger percentage of revenue. When these parties also happen to be politically favored, they may be able to secure exemptions from regulation. In securities regulation, municipalities and other public debt issuers were spared the disclosure requirements of the Securities Act (although they remain subject to the antifraud provisions), a concession that came under fire as abuses surfaced. The securities laws also contain less burdensome requirements for small businesses. The irony however, is that the market knows far less about those organizations than it does about large companies, which might argue for a stronger, not weaker, oversight regime (Choi 1997). In health care, analogous complaints are likely to come from financially strapped public facilities, from the nonprofit community, and from the medical profession. For example, proposed accreditation standards for preferred provider organizations (PPOs) are prompting complaints from physicians about the costs of gathering and processing required data. These groups have the political power to reduce their legal burdens, but such sympathy votes come at a price, particularly if forcing the health system to measure and improve its performance is one of the motivators for disclosure laws.

Remedies and Enforcement

Disclosure laws must have teeth. Several countries have made a formal commitment to securities disclosure along the lines of the U.S. model, but virtually none enforces it to the same degree. Simply enacting a legal right to information means little without some assurance that the right will be honored, whether through direct government verification, audit and certification requirements, civil or criminal penalties for noncompliance, or a private right to sue. All of these mechanisms create enforcement costs, although their magnitude and distribution between government and private parties vary considerably.

Rather than disseminating information directly, the SEC requires regulated parties to do it themselves, and it gives them strong incentives to do it right. These include the SEC's power to suspend trading in particular securities, to exclude firms and individuals from the securities industry, and to impose criminal penalties, as well as exposure to private lawsuits that can create liability not only for corporate violators but also for their officers and directors personally. The existence of a private right of action also reinforces the direct enforcement authority of the SEC. For example, detailed review of prospectuses by the SEC prior to an offering, with subsequent amendments to address agency questions and comments, is not mandatory. Nonetheless, virtually all first-time corporate issuers request and respond to comments, in large part to reduce the risk of subsequent liability to private plaintiffs. In addition, the threat of private lawsuits induces most issuers to settle allegations brought by the agency as quickly as possible, which the SEC allows them to do without admitting guilt.

On the other hand, extreme penalties and sizable liability do not necessarily promote better information. Private litigation in particular can be an expensive method of law enforcement, without necessarily producing commensurate benefits in the quality of disclosed information. For example, securities disclosure has become highly stylized, closely tracking what has previously passed muster with the SEC and exalting consistency over all other qualities, on the theory that using the same words every time will limit semantic nitpicking by plaintiffs' lawyers. This is a far cry from the type of contextualized, sensitive, and useful disclosure needed by health care consumers. Similarly, imposing personal liability on corporate directors may be in tension with efforts to broaden representation on governing bodies of health plans and providers

because it discourages qualified individuals from participating.

Congress curtailed class action suits for securities law violations in 1995 because of concern over abuses by the plaintiffs' bar (Phillips and Miller 1996). Among other things, the reform legislation reduces "aiding and abetting liability," which potentially exposes certification intermediaries with deep pockets (such as accounting and law firms) to nuisance claims. The threat of frivolous litigation may be especially problematic given our voluntary, employer-based health care system. Although any increase in premiums resulting from new regulation may lead employers to drop coverage at the margin, the specter of legal liability for employers' acts or omissions relating to health coverage may have an even worse impact than the direct cost of compliance because it strikes an exposed nerve. At the same time, however, relying on professional ethics to render disclosure requirements self-enforcing is likely to prove effective only in limited circumstances.

Capture by Special Interests

Compliance and enforcement costs connect to the broader questions of whom regulations actually serve and how to distinguish cooperation from capture. Despite the severity of the economic crisis that spurred their enactment and the low political capital of the financial services industry at the time, even the federal securities laws can be viewed as interest-group legislation (Mahoney 2000). Combining disclosure with substantive regulation, for example, the SEC set brokerage commissions until 1975, when it finally realized that price regulation originally designed to protect consumers had over time been converted to a subsidy for special interests. Subsequent deregulation of commissions loosened the hold of cartels that had controlled the major securities exchanges and fostered competition from other trading forums. Less overt forms of capture may be inevitable, however, because any complex regulatory scheme advantages parties already familiar with it. Current industry participants, particularly those whose size allows them comfortably to bear the cost of complying with disclosure mandates, can therefore use regulation to perpetuate barriers to entry by potential competitors. Disclosure mandates also can predispose to capture by hangers-on apart from the regulated entities themselves. In addition to the plaintiff's bar, for example, transactional lawyers, accountants, and consultants are among the biggest beneficiaries of arcane requirements and draconian liabilities in the securities arena.

All these risks are applicable to health care disclosure requirements. Large, established HMOs and insurers that are already investing in information systems and complying with disclosure obligations to employers and other group purchasers are much more accepting of government mandates than less integrated organizations such as PPOs or truly fragmented hospitals and physicians. Lawyers and consultants are eagerly marketing compliance plans for new informational requirements, much as they exploited similar instability in antitrust and fraud law. And the plaintiff's bar is filing class action lawsuits based on faulty disclosure that test state consumer fraud and federal racketeering laws, while pushing Congress to repeal ERISA preemption of personal injury claims against health plans.

CONCLUSION

Mandatory disclosure laws are becoming so common in health care regulation that they can easily be taken for granted. Skeptics may dismiss them as hasty political compromises between otherwise irreconcilable factions, while more trusting souls may simply assume that information is always a good thing. The truth, of course, lies between. Disclosure-based regulation can serve varied and sophisticated purposes, but only if objectives are clearly articulated and laws carefully designed to achieve them. To illustrate the complexity but also the promise of disclosure, this report has surveyed justifications for mandatory disclosure laws in the securities industry and in the health care system, looking at the "big picture" for commonalities and differences between them. The lessons that emerge lay a useful foundation for future efforts to regulate health care using information.

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THE AUTHOR

William M. Sage, M.D., J.D., is an Associate Professor of Law at Columbia University, where he teaches courses in health law, regulatory policy, and professionalism. His areas of expertise are managed care, health care information, antitrust, medical malpractice, insurance coverage determinations, and the regulation of health care professionals. His current projects include analyzing mandatory disclosure laws in health care, adapting insurance coverage law to managed care, assessing physicians' professional competence to serve as "patient advocates," and formulating a competition policy for health care that accounts for quality and other non-price considerations. In connection with the last project, Sage received a 1998 Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation. Sage is a member of the editorial board of *Health Affairs* and serves as a peer reviewer for several clinical and policy journals.

Sage received his A.B. from Harvard College in 1982 and his medical and law degrees from Stanford University in 1988. He completed internship at Mercy Hospital and Medical Center in San Diego and served as a resident in anesthesiology and critical care medicine at the Johns Hopkins Hospital. Prior to joining the Columbia faculty, he practiced health care and general corporate law at O'Melveny & Myers in Los Angeles and, in 1993, served on the White House Task Force on Health Care Reform.

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