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Janet L. Dolgin*

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* Barnard College, B.A. (philosophy); Princeton University, M.A., Ph.D. (anthropology); Yale Law School, J.D. Jack and Freda Dicker Distinguished Professor of Health Care Law, Maurice A. Deane School of Law at Hofstra University; Professor of Science Education, Hofstra Northwell School of Medicine, Co-director, Hofstra Bioethics Center, Director, Gitenstein Institute for Health Law and Society. I am appreciative to Maria Carney, Melissa Kessler, and Steven Waterstein, members of the CHAT Steering Committee, for their commitment and their wisdom as we have shaped Conversations: Health And Treatment (CHAT). I am appreciative as well to those whose knowledge and dedication have been central in the development and implementation of CHAT—Brendan Barnes, Isma Chaudhry, Adam Kahn, Corinne Kyriacou, Ada Kozic, Pam Leikowicz, Renee McLeod, Renee Pekmezaris, Samuel Packer, and Anthony Serrano. I am very thankful to Toni Aiello, Reference Librarian, the Maurice A. Deane School of Law at Hofstra University, for sharing the results of her remarkable research skills.
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Ah, Lord, teach us to consider that we must die, so that we might become wise.¹

I. INTRODUCTION

During the last four decades, the law has erected a framework that facilitates medical decision making for terribly ill persons who lack the capacity to make decisions on their own. As a practical matter, attorneys in every state can now guide clients through the process of advance care planning. The details vary from state to state, but uniformly throughout the states people can identify surrogate decision makers and delineate preferences for surrogates to follow should the principal need medical care while the principal lacks decision-making capacity. Still, this body of law has been only partially successful in easing the process of dying for patients, the burden on family members, and the choices facing clinicians.

Alongside the law’s responses, clinicians²—and the health care facilities within which they work—increasingly consider how best to respond to the needs of dying or terribly ill patients who lack capacity. Attitudes among clinicians toward end-of-life care have transformed dramatically in the last four decades. When New Jersey’s highest court entertained the case of Karen Ann Quinlan in the mid-1970s,³ the court reported that Karen’s clinicians, as well as experts who testified, agreed that withdrawing respiratory support “would not conform to medical practices, standards and traditions.”⁴ Now, most clinicians endorse withholding and withdrawing care from terminally ill patients as an accepted part of end-of-life care (assuming that the patient voices or once voiced that preference).⁵ Many hospitals now offer educational programs that guide clinicians through the difficult task of assisting patients and their

¹ Johann Sebastian Bach, Bach Cantata BWV 106 (“Gottes Zeit Ist die Allerbeste Zeit”), The language is a liberal translation of Psalm 90:12.
² This Article uses the term clinicians to refer to health care professionals, especially to physicians, nurses, and physician assistants.
⁴ Quinlan, 355 A.2d at 655. At the time, Karen was in a persistent vegetative state. Her treating neurologist refused to be part of any order to remove Karen’s respirator. In re Quinlan, 348 A.2d 801, 819 (N.J. Super. Ct. Ch. Div. 1975). Even at the time some clinicians differentiated cases such as Karen’s involving a persistent vegetative patient from cases involving terminally ill patients. See David Orentlicher et al., Bioethics and Public Health Law 271 (2d ed. 2008); see also infra Part IV.B.1.a (summarizing Quinlan).
Changes in the approaches of law and medicine to appropriate care for terminally ill patients developed within a larger socio-cultural frame. Within that frame, autonomous individuality has largely trumped the primacy of communal hierarchy within the world of health care. The informed consent doctrine constitutes a central outgrowth of that shift. More generally, new understandings of personhood and community, spawned by the Enlightenment and the Industrial Revolution, facilitated changes in society’s understanding of death and dying. This Article considers the development of advance-care-planning laws within the context of shifting visions of death and dying in the Western world.

Curiously, the most dramatic shift in visions of death and dying—one that has privileged dying over death as the focus of public attention—seems to have appeared as much as a century before the development of medical technology that actually facilitated the prolongation of dying long beyond that which was previously possible. Society’s focus on dying—a part of living, however particular—rather than on death serves a variety of functions. Today, that focus responds to practical challenges faced by most dying people. Less transparently, it may serve to displace anxiety about death and even to mask the inevitability of death—a matter largely entertained through the lens of religious belief before the nineteenth century. The focus on dying’s demands has produced a series of responses from law, medicine, and society. These responses, in turn, reflect attitudes about illness, health care, the clinician-patient relationship, and personhood.

Part II of this Article contextualizes consideration of advance care planning within the broad sweep of Western history’s shifting visions of death, and then later of dying. Then, Part III offers basic demographic facts about the reality of death and dying in the contemporary United States. Further, it describes developments in medicine that facilitated a number of demographic changes, beginning in the second half of the twentieth century. In the last three or four decades of the twentieth century, the law began to respond to the new reality of dying. Part IV details the judicial and legislative responses to medical decision making for patients without capacity that culminated in every state’s providing for advance care planning by the end of the twentieth century.

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6 For the most part, advance care planning is assumed to pertain to end-of-life decision making. In addition to that, however, advance care planning can be important for very ill patients without capacity who are not facing terminal conditions.

7 See infra Part IV.A.
Despite the ubiquity of advance care planning laws, most people still fail to complete advance directives, and even those who do complete these legal forms do not necessarily talk with their prospective surrogate decision makers or with their clinicians about their preferences and needs. Part V reviews a crucial development—long awaited and only partially in place at this time\(^8\)—that will effectively define advance care planning as a component of good health care. An important component of that development, discussed in Part VI, involves paying clinicians to engage in advance-care-planning conversations with patients. In July 2015, Medicare proposed two billing codes that will pay clinicians to engage in such conversations.\(^9\) The codes are limited, but offer promise that other insurers will follow this lead and that the Medicare codes will be broadened over time. Finally, the last Part of this Article considers an interdisciplinary model for educating the public and professionals about the significance of advance care planning. Only through open conversations about medical preferences and end-of-life choices among patients (or potential patients), surrogate decision makers, and clinicians can those in the latter two groups gain the knowledge needed to wisely translate a patient’s wishes into actual decisions in concrete situations that often differ from those referenced on the face of advance directives. This, simply put, is part of and a model for good health care.

II. CHANGING PERSPECTIVES ON DEATH AND DYING

Societies throughout time and space have responded in various ways to death. Only recently has dying (as contrasted with death) received significant attention. Until the twentieth century, few people experienced long periods of dying, and no one died connected to life-support machines. Throughout human history, death has occasioned a panoply of emotions and has variously been feared, celebrated, bemoaned, or welcomed.

In much of the world today, death has been medicalized and legalized. These processes have not developed \textit{ex nihilo}. They reflect broader trends and respond to deeply embedded assumptions about personhood.\(^{10}\)

A central feature of death in the modern world is the frequency with which it is preceded by a sustained period of illness, often chronic ill-

\(^8\) See infra Part V.

\(^9\) See infra notes 274–282 and accompanying text.

\(^{10}\) Those assumptions contrast with assumptions of other cultures and of Western culture in earlier centuries. See infra Part III.
ness. Further, in contrast with responses to death during almost all of the last millennium in the West, death, although understood as inevitable, is often unexpected when it arrives. The long process of dying that precedes many contemporary deaths, has not conditioned society to accept death. Rather it has conditioned people to presume (despite the ubiquity of death) that death can always be held at bay a while longer. This not only differentiates contemporary understandings and experiences of dying and death from those of earlier times and other places, but it contains clues that explain contemporary approaches—both medical and popular—to end-of-life medical decision making and to the laws that channel those approaches.

This part offers a very brief summary of shifting attitudes toward death and dying over time. Section A reviews predominant attitudes toward death from the medieval period to modern times. Then, Section B examines shifting attitudes toward death and dying in the nineteenth century. Finally, Section C of this Part considers assumptions in the U.S. today about death and how people die and how they should die. Contemporary attitudes about death and about the process of dying undergird the law’s developing rules about medical decision making for people without capacity, as well as medicine’s responses to dying patients.

A. Approaches to Death and Dying in an Historic Context

In The Hour of Death, a remarkable history of attitudes toward death, Philippe Aries calls attention to an “ancient attitude toward death”—dominant during the early Middle Ages—extending back to ancient history and perhaps, even to prehistory. During this long period of time, explains Aries, the “common ordinary death” (conceived as a “good” death) was preceded, shortly before death approached, by a warning to the person about to die. That person would then acknowledge that death’s warning had been issued and would communicate that fact to those surrounding the sick-bed. Aries illustrates this approach to the good death through reference to Chanson de Roland, the poems of Tristan, and stories of the Knights of the Round Table. Id. at 5–6.
or her. “Neither [the dying man’s] doctor nor his friends nor the priests . . . know as much about it as he.”

Deaths that did not warn were viewed as “the absurd instrument of chance.” Such deaths—known as *mors repentina* (sudden death)—were liable to bring shame and ignominy. Indeed, a *mors repentina* was likely to have been met with silence rather than with the elaborate rituals that generally surrounded a death that properly warned a dying person of its imminent arrival. Here Aries remarks quite stunningly: “Anyone who is aware of the ostentatious displays of mourning that characterized this period can judge the significance of this silence, which *seems modern*.” That is, the comparative silence that so generally accompanies death in the contemporary world accompanied only a death deemed ignominious in earlier ages. Even more remarkable, Aries explains that in the modern world, the “sudden” death—for instance, death in an automobile accident or by way of a gunshot wound—is viewed as extraordinary. Modern responses to unexpected, sudden deaths tend to be more outspoken and public than responses to other deaths.

Aries found references to a good death as a death that warned before it separated a dying person from life in the literature of the Middle Ages, including the Song of Roland, the poems of Tristan, and tales of the Round Table. Sometimes, death’s warning came in the form of apparitions or dreams. Sometimes, as in the case of Roland, death announced itself as a feeling that death had begun to “invad[e] [the] body.”

Aries suggests that changes in attitudes toward death are glacial.

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15 Id. at 6. With exceptions, Aries relies on male pronouns. It is hard to know whether that reflects a different experience for dying women or simply that Aries did not know about, or chose not to focus on, women’s death experiences. Were it the case that females experienced death differently than males and were that difference generally known, Aries would likely have described the difference. He does, however, consider images depicting the death of the Virgin. *ARIES, supra* note 12, at 141, 250, 311.
16 Id. at 6.
17 Id. at 10.
18 Id. at 10.
19 See *ARIES, supra* note 12, at 11.
20 Id. at 11 (emphasis added).
21 See id. at 6.
22 Id. at 11. Such deaths in the modern world—deaths in car accidents or plane crashes or deaths due to violence—generally receive more publicity than other deaths.
23 See *ARIES, supra* note 12, at 6.
24 Id. at 6–7.
25 Id.
26 Id. at xvi (“Changes in man’s attitude toward death either take place very slowly or else occur between long periods of immobility. Contemporaries do not notice these changes...
Even as late as the eighteenth century, it was considered impressive to have fore-knowledge about the timing of one’s death.\textsuperscript{27} By this period, new attitudes toward death were becoming evident, existing for some time alongside the old attitudes. The new attitudes flourished in the context of broad changes in society, law, and medicine. All of these changes evolved rapidly in the twentieth century.\textsuperscript{28}

\textbf{B. Transitional Attitudes Toward Death}

Tolstoy’s 1886 novella, \textit{The Death of Ivan Ilyich}, narrates the story of one man’s death.\textsuperscript{29} The novella reflects an attitude toward death that echoed that which had been—as well as that which would soon become—far more common. By this time, there were significant changes in the personnel surrounding death. In place of, or at least alongside the role once occupied by the priest, Aries points to that of the doctor.\textsuperscript{30} By the end of the nineteenth century, the process of medicalizing death had begun.\textsuperscript{31}

Ironically, with the medicalization of death, came a fierce effort to mask, and indeed to deny, death. With the prophetic vision of the great novelist, Tolstoy, who wrote the story of Ivan Ilyich’s death at the end of the nineteenth century, remarked on both the disguise of death and on its medicalization.\textsuperscript{32} The constancy of the pretense that surrounded the death of Ivan Ilyich—that he was not dying when he clearly was—succeeded in “degrad[ing] the formidable and solemn act of [Ilyich’s] death.”\textsuperscript{33} Today, the tenacity of that lie and its frightful power to disguise the truth is abating, but it has not disappeared from contemporary responses to dying. Tolstoy mined that lie. The narrative of the novella focused not on Ilyich’s death, but on Ilyich’s living, indeed Ilyich’s coming to life for the first time, as he combatted the lies imposed on the process of his dying.

Almost a century after Tolstoy wrote \textit{The Death of Ivan Ilyich}, a French priest, Father Francois de Dainville, spoke with another priest because these periods of immobility span several generations and thus exceed the capacity of the collective memory.”).

\textsuperscript{27} See ARIES, supra note 12, at 9.
\textsuperscript{28} See infra Part III.
\textsuperscript{30} ARIES, supra note 12, at 564.
\textsuperscript{31} Id. at 563.
\textsuperscript{32} Id. at 567.
\textsuperscript{33} Id. (quoting TOLSTOY, supra note 29, at 142–43).
about a salient consequence of Dainville’s own medicalized dying: “They are cheating me out of my own death.”

Father Dainville died in the early 1970s in a hospital’s intensive-care unit, invaded by a myriad of tubes aimed at sustaining life. The lie that characterized Ilyich’s fictional dying can be equated with the lie about which Father Dainville complained. The lies were of a similar sort. But the lie that compromised Dainville’s dying was imposed in a new manner; it was a lie grounded in the life-sustaining tubes that characterized Dainville’s dying and death. The medicalization of dying—a process now defined by life-sustaining technology—wrapped the end-point in a new variant of the lie that had aimed to mask Ivan Ilyich’s fictional death a century earlier.

The two variants—the effort to mask death (the lie, as it were) along with the prolongation of dying through the use of life-sustaining treatments merged in the twentieth century with the routine hospitalization of dying people. In 1900, most people in the United States died at home; however, by the start of the twentieth century, most died in hospitals. The hospital death facilitated society’s interest in hiding death from the public gaze. And by the middle of the twentieth century, increasingly effective forms of life-sustaining care within hospitals encouraged the myth that death, much like disease, could be conquered by science and technology.

Thus, in the worlds inhabited by Roland, Tristan, and the Knights of the Round Table, a dying person was expected to intuit his own death and to announce death’s arrival. That attitude toward death survived into the eighteenth century. But soon, alternative attitudes toward death were competing with those that defined death during the previous millennium.

Soon, the medicalization of death—which began even before the development of sophisticated life-sustaining technology—rendered dying as significant as death for most people. By the twentieth century, these new attitudes toward death and the increased significance paid to the period of dying harmonized with the move toward a society in which large segments of the population found themselves (or chose to be)

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34 ARIES, supra note 12, at 567.
35 Id. at 572.
36 See infra Part III.B.
38 See supra notes 13–19 and accompanying text.
39 See supra notes 29–31 and accompanying text.
largely bereft of religious and other traditional anchors. Further, the traditional approach to death as described by Aries was transformed by new understandings of personhood, focused on autonomous individuality rather than on community and connection.40

C. Contemporary Attitudes Toward Death and Dying in the United States

Yet, curiously some aspects of the methods through which contemporary Americans are urged to prepare for dying and death (for instance, through attention to advance care planning in the late twentieth and early twenty-first centuries) might seem to be a modern equivalent of the hope or expectation of the ancient and medieval worlds that death warns dying people of its approach.41 The differences are fundamental, of course, but still some similarities can be noted, even as contemporary law and medicine have responded with a distinctly modern idiom.

1. The Old and the New, Compared

The “good death” of previous centuries—one that relied on dreams and visions to warn a person about to die as death arrived42—is neither common nor deemed better than other deaths by the contemporary world. That antiquated vision of death was grounded on assumptions about the after-world and religious powers that survive only in pockets of the largely secular, contemporary United States.43 The preface to the Institute of Medicine’s 2014 report on dying in America notes that “[f]ew people really have the opportunity to know when their death will

40 In the second half of the twentieth century, society broadly displaced “traditional” values that defined family relationships and doctor-patient relationships in terms that valued hierarchy and community with values that focused on relationships through the lens of autonomous individuality. See, e.g., Lindsay F. Wiley, Health Law as Social Justice, 24 CORNELL J.L. & PUB. POL’Y 47, 105 (2014) (noting significance of individualism to world of health care as a focus that impoverishes the notion of community and displaces it with a notion of autonomous relationships); see also Janet L. Dolgin, Biological Evaluations: Blood, Genes, and Family, 41 AKRON L. REV. 347, 354–66 (2008) (considering these cultural shifts in context of twentieth century family).

41 See supra Part II.A.

42 See supra notes 23–24 and accompanying text.

43 Philippe Aries reports on sociological studies that showed that members of contemporary Christian society have continued to have faith in God more often and more fully than they have continued to believe in an afterlife. ARIES, supra note 12, at 573. Aries further reports, however, that belief in an afterlife is more common among dying people than among others in the population. Id.
At least one important function lurking in an earlier age’s commitment to a notion of the “good death” has parallels in the modern world. These parallels attempt—as did the notion of a good death in Europe in earlier centuries—to make sense of death, to presume an order of a blessed sort when faced with the potential chaos death might suggest. Although death no longer warns as impressively as it once did, physicians and nurses may be aware that a patient will soon die. There is still reluctance among physicians to advise patients that death will likely soon arrive, even when physicians are aware of that reality. Increasingly, however, they are being encouraged to be forthright with dying patients or patients’ loved ones in the event that the patient is not able to communicate or understand medical information. Elisabeth Kubler-Ross documents another instance of modernity’s awareness of death’s proximity with her delineation of the stages of responding to death’s approach.

Even more than these examples, advance care planning offers a plan for the good death in the twenty-first century. That death, as defined by Ellen Goodman, a founder of the Conversation Project, contrasts with a “hard death.” The good death is one in which the patient’s “wishes were expressed and respected. Whether they’d had a conversation about how they wanted to live toward the end.” Both the notion of the good death of the medieval world and the planned-for death (or rather, dying) of the contemporary world presume the preservation of a social order and some control over it, death notwithstanding.

2. New Attitudes Toward Life, New Attitudes Toward Death

Modernity’s understandings of a good death have been shaped in response to challenges created by life-sustaining medical technology, developed in the middle years of the twentieth century. That development furthered the medicalization of dying, which began in the late nine-
teenth century, long before the appearance of life-sustaining technology. By the second half of the twentieth century, the process of dying in hospitals offered discomforting images to patients’ families and friends, as well as even to patients’ health care providers. Yet, too often those images were not acknowledged by health care professionals, leaving family members confused and helpless.

By the second half of the twentieth century, American medicine, which had made stunning strides in treating illness, seemed increasingly anxious to “treat” dying with the “miracles” of modern medicine—“miracles” such as antibiotics, dialysis, vaccines, and new surgical possibilities—as if it were but another serious illness. Even as virtually everyone knew that death had not been, and could not be, conquered, it began to seem as if dying could—and sometimes should—be prolonged for years and even decades. That vision harmonized with a vision of a new medicine that could advance without limits. But soon, medical professionals as well as the loved ones of dying patients began to question the wisdom of unrelieved aggressive care for dying patients, especially for those dying in pain.

III. DEATH AND DYING: DEMOGRAPHIC CHANGE, SOCIAL CHANGE, AND MEDICAL INNOVATIONS

Before reviewing broad changes in the law that encouraged people to engage in advance care planning by the end of the twentieth century, this Part examines shifts in the demographics of dying and death that accompanied changes in social understandings of those matters. The most significant changes in this regard include increases in the average lifespan, with death often preceded by long periods of chronic illness, and, correlatively, the extension of the process of dying. This Part reviews those changes and notes several medical developments that facili-
tated the demographic changes.

A. Shifting Patterns of Dying and Death

The average lifespan in the United States increased from 47 years in 1900 to 75 years in 2000.\textsuperscript{54} Death during childhood was far more common in the early decades of the twentieth century than it was in the last part of the century.\textsuperscript{55} Before World War II, many people who survived childhood lived into their sixties, but far fewer of them than is the case today lived into their eighties and nineties.\textsuperscript{56}

As the average lifespan expanded, society increasingly assumed that death, though inevitable, would occur only years in the future. Even clinicians were beset with concern that they failed their profession and their patients if they could not “save their patients from death.”\textsuperscript{57} Many physicians, reflecting on, and perhaps also furthering, society’s shifting presumptions about death, accepted “the control of death as [their] mission in life.”\textsuperscript{58} Even today, over a quarter of adults in the United States have given almost no thought to their own deaths.\textsuperscript{59} And a large percentage of the population has not completed advance care planning documents.\textsuperscript{60} A 2013 survey of adults forty years of age or older found that less than half of that population had signed advance-directive forms.\textsuperscript{61}

This is the case even though images of a hospital death are both familiar and discomforting to most people, especially those who have visited dying friends or family members not enrolled in hospice or palliative care. More than three decades ago, Philippe Aries remarked that people in the modern world do not generally imagine the manner of their own deaths.\textsuperscript{62} They are, however, privy to hospital scenes of death that involve friends and loved ones “dying in a tangle of tubes all over [the] body, breathing artificially.”\textsuperscript{63}

Palliative care and hospice care offer options to very sick patients not comfortable with aggressive care. Yet, even as clinicians and the public seem ready to forego CPR and assistance with nutrition at the end

\begin{itemize}
\item \textsuperscript{54} See Lupu, supra note 37.
\item \textsuperscript{55} See End of Life in America, supra note 51.
\item \textsuperscript{56} See id.
\item \textsuperscript{57} Id.
\item \textsuperscript{58} ARIES, supra note 12, at 586 (writing about the second half of the twentieth century).
\item \textsuperscript{59} DYING IN AMERICA, supra note 44, at 3.
\item \textsuperscript{60} Id. at 11.
\item \textsuperscript{61} Id. at 127 tbl.3-1.
\item \textsuperscript{62} ARIES, supra note 12, at 593.
\item \textsuperscript{63} Id.
\end{itemize}
of life, the nation has not witnessed a widespread pattern of less aggressive care for terminal patients. In the first decade of the twenty-first century, although a higher percent of people aged 65 and older died at home than in the previous decade and a half, utilization of intensive care units by patients at or near the end of life increased.

B. Medical Developments

The average lifespan in the U.S. increased in the twentieth century as a result of various new medications, as well as improved sanitation, and other public health efforts. In particular, the availability of antibiotics by the 1940s gave medicine a powerful tool for controlling infectious diseases. Diseases such as pneumonia to which elderly people had often succumbed, comparatively free of distress, became treatable conditions. As a result patients with a slew of life-threatening conditions lived to linger, connected to life-sustaining technology.

The modern intensive care unit (“ICU”) emerged in the 1960s. Its creation was more or less coincident with the development of new modes of providing ventilator support for patients with diminished respiratory function. This development, along with that of percutaneous gastrostomy (“PEG”) tubes for feeding patients unable to swallow, revolutionized life-sustaining care for terribly sick and dying patients.

By the 1930s, so called iron lungs—essentially tanks that surrounded patients’ upper bodies—provided respiratory support to some patients, but these machines could not compensate for complete respiratory failure, and they were most effective for patients who were conscious. By the 1960s, positive-pressure ventilation replaced the iron lung in

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65 See id. at 473 tbl.2.

66 End of Life in America, supra note 51.

67 See id.


69 Id. at 2.

70 See Sylvia Kuo et al., Natural History of Feeding Tube Use in Nursing Home Residents with Advanced Dementia, 10 J. AM. MED. DIRECTORS ASS’N 264 (May 2009), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733212/.

71 See Marini, supra note 68, at 1.
newly fashioned ICUs. Throughout the last decades of the twentieth century and into the twenty-first century, technological developments offered patients improved modes of respiratory support.

Development of feeding tubes (enteral feeding) that could easily be inserted into a patient’s body further facilitated sustaining life for very ill and dying people. Enteral feeding provides nutrition to patients without the ability to swallow or swallow easily. PEG tubes, developed by two Cleveland physicians in 1979, offered a viable alternative to feeding tubes that required surgery, accompanied by anesthesia. The two physicians who developed PEG tubes intended them to be used for pediatric patients who had difficulty swallowing. They specifically aimed to create a feeding tube that would eliminate the risks of surgery and anesthesia for young children and babies. About 25 years after the first use of the PEG tube, its developers opined that its use had far exceeded their intentions. In a 2006 news story about the use of PEG tubes for patients such as Terri Schiavo (a young woman, diagnosed as having been in a persistent vegetative state for many years), the developers of the PEG tube expressed concern. Their concern centered on the ethical dilemmas occasioned by the availability of PEG tubes for persistently vegetative patients who could not breathe or eat without life-sustaining tubes in place but who could now be kept alive for decades if connected to such tubes.

Further, there is growing consensus that feeding tubes are not rec-
ommended even for some patients with significant difficulty swallowing, and that they may not routinely improve outcomes.\textsuperscript{82} Studies have challenged the use of feeding tubes, for instance, for patients with advanced dementia.\textsuperscript{83} A variety of other end-of-life treatments and responses, including cardio-pulmonary resuscitation (“CPR”), continues to be provided to dying patients even in situations in which a patient’s treating clinicians view the care being provided as essentially futile.\textsuperscript{84}

As a result of the availability of such modes of treatment for dying patients (including ventilators, PEG tubes, and CPR), clinicians, patients, and family members of patients face a series of challenges about medical decision making for patients who lack the capacity to make their own decisions. Who should make such decisions and how they should be made have emerged as some of the most discomforting and controversial issues that have been occasioned by developments in treatment and medical technology that offer life-sustaining care to dying patients.

Patients, if capable, have the right to participate actively in medical decisions about their care. Many dying patients as well as patients diagnosed as persistently vegetative, however, are without capacity or have diminished capacity to make medical decisions. The majority of court cases involving end-of-life decision making have been occasioned by disputes between a patient’s loved ones and health care providers\textsuperscript{85} or among a patient’s loved ones.\textsuperscript{86}

IV. SOCIAL AND LEGAL RESPONSES TO DEATH AND DYING

The law’s responses to decision making for patients without capacity grew out of the jurisprudence of informed consent, implemented in

\textsuperscript{82} See Kuo et al., supra note 74.

\textsuperscript{83} See id.

\textsuperscript{84} Gina Kolata, Murky Path in Deciding on Care at the End, N.Y. TIMES (Feb. 23, 2010), http://query.nytimes.com/gst/fullpage.html?res=9D04E1DF173AF930A15751C0A9669D8B6. In ICUs, it is not unusual to find patients given aggressive care even though the patient’s clinicians concluded days or even weeks earlier that the treatment would not return the patient to health. Id. (quoting Dr. Paul R. Helft, an oncologist at the Indiana University School of Medicine). On the other hand, aggressive care, including CPR for patients almost certain to die with or without CPR can offer emotional support to survivors who believe that “everything” was done for their loved one. Id. Such care is for families (or even sometimes for clinicians), not for patients, and may even substitute for care that would better serve a patient’s survivors. Id. (referring to comments by Dr. Robert Truog).

\textsuperscript{85} See, e.g., In re Quinlan, 355 A.2d 647, 655 (N.J. 1976) (allowing the father of a woman in persistent vegetative state to make medical decisions, including decision to terminate ventilator care, for his daughter).

\textsuperscript{86} See, e.g., Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1223 (11th Cir. 2005). The case of Terri Schiavo is discussed infra Part IV.B.3.
the last three decades of the twentieth century. The law has struggled to shape appropriate responses for patients without capacity. This Part reviews the development of legal responses to decision making for patients who lack the capacity to make their own decisions.

A. Informed Consent and Patient Autonomy

Development of the informed consent doctrine followed from the increasingly important notion in the last decades of the twentieth century that the physician-patient relationship should reflect patient autonomy and individuality at least as much as physician authority.87 More than a half-century earlier, the kernel of the informed consent doctrine was shaped by Judge (later Justice) Cardozo in a case in which he obligated physicians to obtain a patient’s consent before operating on that patient.88 Judge Cardozo’s decision in Schloendorff did not require the patient’s clinicians to provide her with information about her condition and about the care recommended.89 The decision offered an assessment of the value of patient consent, however, that later became important in the development of the informed consent doctrine. Judge Cardozo intoned: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages.”90

The notion gained little attention for over four decades. Then in 1957, a California court used the term “informed consent,” apparently for the first time in reference to the medical arena.91 The court required physicians to provide patients with “facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”92

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88 Schloendorff v. Soc'y of N.Y. Hosps., 105 N.E. 92, 93 (N.Y. 1914), overruled by Bing v. Thunig 143 N.E.2d 3 (N.Y. 1957). Schloendorff was later overruled but the opinion expressed by Justice Cardozo helped spurn the development of the informed consent doctrine.
89 See id. at 95.
90 Id. at 93.
92 Id. In distinction with later rules about informed consent, the Salgo court significantly limited the reach of its rule. The court stressed the significance of physician “discretion” to
Fifteen years passed before courts and legislatures formulated concrete rules for determining the scope of the informed consent requirement. *Canterbury v. Spence*,\(^93\) decided in 1972 by a federal court, offered a broad interpretation of the informed consent doctrine.\(^94\) After *Canterbury*, courts\(^95\) and legislatures\(^96\) throughout the nation institutionalized the notion that a patient’s consent to medical care must reflect autonomous choice, deemed impossible unless the patient has been informed about the scope and implications of his or her health condition and about the care being recommended.\(^97\)

**B. Respecting Patient “Autonomy”: Patients Without Capacity**

The informed consent doctrine rests on the presumption that a basic respect owed to patients obligates health care professionals to inform a patient about his or her medical condition and about recommended medical tests and treatments before seeking patient consent to care.\(^98\) It predicates implementation of care on patients’ informed agreement.\(^99\) The presumption that guided development of the informed consent doctrine cannot be applied easily to the situation of patients who lack decision-making capacity.

Yet, soon after the law clearly framed the informed consent doctrine, courts faced with cases involving very ill patients without capacity

\(^{93}\) 464 F.2d 772 (D.C. Cir. 1972).
\(^{94}\) Id. at 787. In the same year in which the circuit court for the District of Columbia decided *Canterbury v. Spence*, the California Supreme Court reached a similar conclusion in another informed consent case. *See* *Cobbs v. Grant*, 502 P.2d 1, 10-11 (Cal. 1972). In *Cobbs*, the California court required physicians to give patients information on which a consent or refusal could be predicated and concluded that a jury (without need for expert testimony on the informed consent issue) was positioned to decide whether the information communicated to the patient by the physician was adequate. *Id.*


\(^{96}\) See, e.g., N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2015) (limiting the right of action to recover for medical, dental, or podiatric malpractice based on a lack of informed consent).

\(^{97}\) Well-recognized exceptions to the requirement that patients consent to care before it is provided include emergency situations. *Canterbury*, 464 F.2d at 788–89.


\(^{99}\) *Id.* at 86.
or permanently unconscious patients crafted an alternative response that paid homage to the informed consent doctrine while re-shaping its parameters for application to these patient populations. This response depended on the authorization of surrogate decision makers who were directed to effect the principal’s wishes where those had been delineated or to act in the principal’s best interest in cases in which the principal had not expressed his or her preferences for health care decisions relevant to the actual medical situation that pertained.

Much of this law was voiced by judges before it was entertained by legislatures. In addressing areas of life that implicate significant social challenges—disputes, for instance, about end-of-life care or care for persistently vegetative patients as well as disputes about a variety of domestic matters, including those occasioned by reproductive technology—courts often render decisions before legislators respond adequately or at all. There are many reasons for this. Among them, courts do not generally have the option, enjoyed to a greater extent by legislators, of postponing consideration of controversial matters.

The first important decision by a state’s highest court that responded to such a dispute involved the case of Karen Ann Quinlan in the New Jersey courts. Quinlan was decided in 1976, and is one among a number of cases that were occasioned by a request to discontinue life-sustaining care for a patient without capacity. A number of similar cases received widespread media attention in the last decades of the twentieth century and the early years of the twenty-first century. Perhaps because Quinlan was the first of these cases decided by a state’s highest court, it brought public attention to the issues at stake. Even

100 In such cases, especially those involving disputes occasioned by reproductive technology, judges often implore state legislatures to entertain and provide statutory rules to channel the issues at stake. See, e.g., R.R. v. M.H., 689 N.E.2d 790, 797 (Mass. 1998); In re Marriage of Moschetta, 30 Cal. Rptr. 2d 893, 903 (Cal. Ct. App. 1994); In re Adoption of Baby Girl L.J., 505 N.Y.S.2d 813, 818 (N.Y. Surr. Ct. 1986).


103 In addition to Quinlan, see, for example, Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261 (1990); and Schiavo ex rel. Schindler v. Schiavo, 357 F. Supp. 2d 1378 (M.D. Fla. 2005). A suggestive, and potentially troubling, aspect of the three cases—though one beyond the scope of this Article—is the widespread media attention given to these cases (but not others), in that each of the three involved a young, middle-class, white woman, rendered vegetative in the prime of her life.

104 See David Masci, The Right-to-Die Debate and the Tenth Anniversary of Oregon’s
more, Quinlan was the first of a set of cases, including Cruzan\textsuperscript{106} and Schiavo\textsuperscript{107} that involved disputes regarding the continuation of life-sustaining care for someone in a persistent vegetative state. This Section will focus on three of these cases, that of Karen Quinlan, that of Nancy Cruzan, a Missouri case considered by the U.S. Supreme Court in 1990, and that of Terri Schiavo (decided in Florida in the early twenty-first century).\textsuperscript{108} Then the Section considers statutory responses to the dilemmas presented by end-of-life medical decision making.

1. \textit{Quinlan} and its Context

The story of Karen Ann Quinlan was not the first disagreement made known to the public between the loved ones of an incapable, dying patient and the hospital in which that patient was being cared for. In 1957, a widow, publishing anonymously in the \textit{Atlantic Monthly}, wrote about her husband’s death in a hospital:

As [the dead] fight for spiritual release, and are constantly dragged back by modern medicine to try again, does their agony augment? To those who stand and watch, this seems like a ghastly imposition against God’s will be done. Apparently there is no mercy which the family may bestow at such a time.\textsuperscript{109}

An editorial in the \textit{New England Journal of Medicine} in the same year recommended that all physicians read the anonymously authored \textit{Atlantic Monthly} essay.\textsuperscript{110} The editorial explained:

Today’s [medical school] graduate falls heir—and with no extra effort—to the immaculate, modern aseptic skills that can keep a diseased, half-dead, cancerous body alive, by intravenous nourishment and with the magic of penicillin and round-the-clock special nursing, so long that the doctor may emerge in the eyes of kin with little resemblance to the wise and understanding family physician of yesteryear.\textsuperscript{111}

The widow who wrote \textit{A Way of Dying}, to which the 1957 New
England Journal of Medicine editorial referred, did not initiate a legal case with the hope of changing the sort of care her dying husband was receiving.112 Her husband’s physician explained that continuing care, even for dying, delirious, or unconscious patients (viewed as “torture” by the anonymous author of the Atlantic Monthly essay), was necessary to sustain life.113 When a nurse arrived, ready to give the author’s husband medication, the wife-author, though wanting to kick the nurse from the room, “staggered” out herself.114 “There was,” she explained, “nothing else to do.”115

a. Karen Quinlan’s Story

In contrast, the parents of Karen Quinlan, Joseph and Julia Quinlan, decided to seek judicial help in their effort to have life-sustaining treatment withdrawn from their daughter’s body. Joseph Quinlan, Karen’s father, sought a declaratory judgment against New Jersey, the county, the treating physicians, and the hospital caring for Karen.116 He requested appointment as his daughter’s guardian and further, asked that the court expressly grant him authority to “discontinu[e] . . . all extraordinary means of sustaining the vital processes of his daughter.”117

The sudden failure of Karen Quinlan’s health occurred in the spring of 1975 when Karen, then 21 years old, unexpectedly collapsed.118 Friends called an ambulance immediately.119 By the time that the ambulance arrived at a local hospital, Karen had been without oxygen for two 15-minute periods.120 The cause of her collapse was never discerned.121 All parties agreed that Karen was completely unable to participate in decisions concerning her care.122 Karen’s treating neurologist testified at trial that he could not prognosticate about Karen’s future with certainty but he was unaware of any treatment that would rehabilitate her and did
not “see how her condition [could] be reversed.”123

The trial court relied on Kennedy Memorial Hospital v. Heston,124 a 1971 New Jersey Supreme Court decision, and rejected Joseph Quinlan’s claim, offered on behalf of his daughter that she enjoyed a constitutional “right to die” and that this right supported his effort to have their daughter’s life-sustaining care withdrawn.125 Judge Muir, writing for the trial court, described all of the defendants as having viewed the potential termination of Quinlan’s life support as “homicide and an act of euthanasia.”126

Further, Judge Muir grounded his decision to reject Joseph Quinlan’s petition on his understanding of the role of the physician.127 He explained:

There is a higher standard, a higher duty, that encompasses the uniqueness of human life, the integrity of the medical profession and the attitude of society toward the physician, and therefore the morals of society. A patient is placed, or places himself, in the care of a physician with the expectation that he (the physician) will do everything in his power, everything that is known to modern medicine, to protect the patient’s life. He will do all within his human power to favor life against death.128

Accordingly, Judge Muir placed great importance on the view of Dr. Morse, Karen’s neurologist, that “medical tradition” could not “justify” the removal of Karen’s ventilator.129

The trial court’s response to Karen’s pre-incapacity assertion, reported to the court by Karen’s mother, that she would not want to be kept alive in a situation similar to the one in which she existed, deserves note.130 The court essentially interpreted Karen’s reported preference as the musings of a young woman (20 years old at the time), who was “full of life” and had not seriously contemplated her own death.131 Judge Muir’s view in Quinlan is significant as an historical matter. It suggests the remarkable shift in social and legal views of advance care planning (views that gainsay Judge Muir’s position) that emerged even as soon as the state supreme court’s decision in Quinlan.

123 Quinlan, 348 A.2d at 811.
125 Quinlan, 348 A.2d at 814.
126 Id.
127 Id. at 818.
128 Id. (footnote omitted).
129 Id.
130 Id.
131 Id.
b. *Quinlan in New Jersey’s Highest Court*

Justice Hughes, writing for the New Jersey Supreme Court, noted early in his opinion that Karen’s physicians as well as experts who testified at trial all agreed that to withdraw respiratory support from Karen would conflict with “medical practices, standards and traditions.” Yet, Justice Hughes, in a remarkable decision reflecting, and perhaps shaping, responses in the decades to follow rather than those extant when he wrote *Quinlan*, named Karen’s father as guardian for his daughter and expressly provided authority for him to request termination of respiratory support for Karen. That authority was conditioned by Joseph Quinlan’s obtaining the agreement of the hospital’s “Ethics Committee” or like body” and by the consensus of Karen’s physicians that there was “no reasonable possibility” of her “emerging from her . . . comatose condition to a cognitive, sapient state.”

Justice Hughes’ decision conflicted with the almost unanimous view among physicians at the time regarding the withdrawal of life-sustaining care. It was not considered acceptable medical practice to withdraw life support from a patient who was not brain dead. Dr. Sidney Diamond, an expert witness for the State, testified that withholding or withdrawing respiratory support from Karen was outside the parameters of ethical medical practice. Dr. Morse, Karen’s treating neurologist agreed. Yet, when the Quinlans, who were practicing Catholics, consulted with their priest and with the hospital’s chaplain, both assured them that their Church’s tenets supported their wish to have Karen’s respiratory support terminated.

Justice Hughes affirmed that were Karen competent, she would have enjoyed the right to request termination of life-sustaining care. Fourteen years later, that position was “assumed” by the U.S. Supreme

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133 *Id.* at 655.
134 *Id.* at 671.
135 *Id.* at 672.
136 In *Quinlan*, itself, all of Karen’s doctors as well as the hospital and the state, opposed Joseph Quinlan’s effort to have life-sustaining care for his daughter withdrawn. *See Quinlan*, 355 A.2d 647.
137 *Id.* at 656.
138 *Id.* at 657.
139 *Id.*
140 Quinlan, 355 A.2d at 658. The court noted that it entertained the views of the Catholic Church only insofar as those views bore on Joseph Quinlan’s “character, motivations and purposes as relevant to his qualification and suitability as guardian.” *Id.* at 660.
141 *Id.* at 663.
Court in *Cruzan v. Dir., Mo. Dep't of Health.*\(^{142}\) Further, Justice Hughes noted—while at the same time acknowledging that testimony about previous conversations between Karen and her friends did not provide probative evidence regarding Karen’s views on life-sustaining care—he was absolutely sure that were Karen competent just long enough to assess her situation and her prognosis, she would ask that respiratory support be discontinued.\(^{143}\) Thus, he concluded that Karen’s privacy right to refuse care would be vitiated were it not transferred to her father, whom the court viewed as a fit guardian for his daughter.\(^{144}\)

Karen’s physicians testified at trial that she would likely not survive for long without the respirator.\(^{145}\) After Judge Hughes’ decision, Karen’s father authorized withdrawal of Karen’s respiratory support.\(^{146}\) Karen was successfully weaned from the respirator and lived for almost a decade.\(^{147}\) She died of pneumonia in 1985.\(^{148}\)

c. *Confusion About the Meaning of Death: “Brain Death”*

Initially, Joseph Quinlan’s petition to the New Jersey Superior Court for appointment as his daughter’s guardian described Karen as already dead.\(^{149}\) Later, he acknowledged that Karen “[w]as not dead ‘according to any legal standard recognized by the State of New Jersey.’”\(^{150}\) The *Quinlan* case commenced less than a decade after an Ad Hoc Committee at the Harvard Medical School defined “brain death” as an alternative to cessation of respiration and cardiac activity for establishing death.\(^{151}\) The criteria delineated in the Ad Hoc Committee’s report for establishing brain death included the absence of breathing, movement, and reflexes that could be elicited, as well as a flat electroencephalogram (repeated 24 hours after the first test, with no change).\(^{152}\) Yet, the Ad

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\(^{143}\) *Quinlan*, 355 A.2d at 663.

\(^{144}\) *Id.* at 664, 671.

\(^{145}\) *Id.* at 655.


\(^{148}\) *Id.*


\(^{150}\) *Id.*


\(^{152}\) *Id.* at 337–38.
Hoc Committee’s delineation of “brain death” left many people confused. Justice Hughes expressly noted in Quinlan that new technology had obscured traditional understandings of death. Although Karen was not brain dead, the possibility of declaring someone dead whose heart continued to pump blood (albeit with technological assistance) had opened up a slew of possibilities heretofore not easily imaginable. Not only, for instance, did the parents’ original petition in Quinlan contend that Karen was dead, but others, reviewing the Quinlans’ story, have agreed with that contention. Arguing that Karen should have been declared dead before the respirator was withdrawn, one critic explained:

The currently accepted criteria of death, one must conclude, are underinclusive. The influential Harvard Report sanctions pronouncement of death once there is irreversible coma, which exists, according to the Report, when there is no discernible central nervous system activity. But if we accept that the essential qualities of life are cognition and sapience, our criteria for death may be broadened. Death, we may say, shall be pronounced when there is no longer any reasonable possibility of a present or future cognitive, sapient state, whether or not the nervous system shows signs of activity.

2. Cruzan

In 1990 the United States Supreme Court reviewed a Missouri case that involved another young woman who became persistently vegetative—in Nancy Cruzan’s case, the result of an automobile accident. Nancy’s parents, much like Karen’s parents before them, requested that life-sustaining care be withdrawn. Missouri courts required clear and convincing evidence that a patient without capacity would have wanted the withdrawal of life-sustaining care before such care could be withdrawn. The Missouri courts read that standard stringently.

Unlike Karen Ann Quinlan, Nancy was able to breathe without re-
Nancy’s parents asked that her feeding tube be withdrawn. The hospital sought court approval for the withdrawal. Invoking a state policy “favoring life,” the Missouri Supreme Court, overruling the trial court decision, held against Nancy’s parents. The Cruzans challenged the Missouri decision in the United States Supreme Court.

_Cruzan_ is the only Supreme Court case focused on the right of a surrogate decision maker to refuse end-of-life care, and the implications of its holding have been difficult to interpret. The case has probably been most important for the Court’s “assumption” that capable adults have the right to refuse care or to have life-sustaining care withdrawn.

Even the implications of that assertion, however, were not transparent insofar as the Court “assumed,” but did not expressly declare, a competent adult’s right to refuse life-sustaining care.

In any event, the issue at stake in the _Cruzan_ case went beyond any assertion about the right of a capable patient to participate in his or her medical decisions in that _Cruzan_ involved the right of a surrogate decision maker to enjoy the same authority that a capable patient enjoys.

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the [clear and convincing evidence] standard of proof [set by Missouri] reflect the importance of a particular adjudication, it also serves as “a societal judgment about how the risk of error should be distributed between the litigants.”

The Court’s decision in _Cruzan_ permits, but does not require, states to demand clear and convincing evidence of a patient’s pre-
incompetency wishes before permitting a surrogate to authorize withdrawal of life-sustaining care. Interestingly, a subsequent proceeding in Missouri, brought by Nancy’s parents on the basis of new evidence about Nancy’s pre-incompetency wishes, resulted in a Missouri court finding that the requirements of the state’s clear and convincing evidence standard had been met. Subsequently, Nancy’s feeding tube was withdrawn. She died in late 1990.

3. Schiavo

The story of Terri Schiavo resembles those of Karen Quinlan and Nancy Cruzan in that all of them were young, healthy, white, middle-class women, and all of them were in their twenties when they entered into a persistent vegetative state from which they never emerged. In two of the cases—those involving Karen Ann Quinlan and Terri Schiavo—the cause was never clarified with certainty. Terri Schiavo’s story, however, departs from that of Karen Ann Quinlan and Nancy Cruzan in that the dispute that brought the case to court was between family members—in particular, Terri’s parents on one side and her husband on the other—rather than between family members and the patient’s health care providers.

State and federal courts entertained a variety of questions occasioned by the dispute between Terri Schiavo’s parents and her husband.

Laws 752 (McKinney) (codified as N.Y. PUB. HEALTH LAW § 2981 (McKinney 2015)), and again in 2010 with passage of the Family Health Care Decisions Act (FHCDA), 2010 N.Y. Sess. Laws ch. 8 (McKinney) (codified as N.Y. PUB. HEALTH LAW § 2994-a et seq. (McKinney 2015)).


172 Id.; Lawlor, supra note 170, at 76 n.65.

173 It was clear that Terri Schiavo suffered a cardiac arrest, perhaps due to a potassium imbalance. See Schiavo Timeline, Part 1, U. MIAMI: ETHICS PROGRAMS, http://www.miami.edu/index.php/ethics/projects/schiavo/schiavo_timeline/ (last visited Jan. 7, 2016). The cause of her cardiac arrest, however, has been disputed. A website set up by the Schindlers, Terri’s parents, characterized her collapse as “a mysterious cardio-respiratory arrest for which no cause has ever been determined.” See Terry Schiavo’s Story, TERRY SCHIAVO LIFE & HOPE NETWORK, http://www.lifeandhope.com/terri_schiavo (last visited Jan. 22, 2016); see also MARK FUHRMAN, SILENT WITNESS: THE UNTOLD STORY OF TERRI SCHIAVO’S DEATH, 225–26 (2005) (suggesting that Michael Schiavo may have borne responsibility for Terri’s collapse).

over a period of many years before Terri’s death in 2005.175 The Schiavo story garnered significant public attention, especially in the few years before Terri’s death.176 Unlike the Quinlan case, and more like the case of Nancy Cruzan, the legal saga that defined Terri Schiavo’s last twelve years of life, made little new law.177 The Schiavo narrative, however, provides a view of the trauma experienced by family, clinicians, and society more broadly occasioned by disputes about medical decision making for patients without capacity.

In 1990, Terri Schindler Schiavo, then 26 years old and married since the age of 20 to Michael Schiavo, suffered a cardiac arrest and entered into a persistent vegetative state.178 She was unable to eat or drink; a feeding tube provided Terri with nourishment and hydration.179 Terri was, however, able to breathe without respiratory support.180 Michael Schiavo, as Terri’s husband, became her legal guardian and medical decision maker under Florida law.181 For a few years, Michael cooperated with Terri’s parents in providing care for Terri.182 Then, in 1993, relationships soured, perhaps as the result of disagreements concerning money.183 By the end of the decade, Michael Schiavo sought to have Terri’s life-sustaining care withdrawn.184 Michael contended that he wanted to accomplish only what Terri herself would have wanted.185 The story, however, was complicated. Even as Michael declined to yield his role as Terri’s guardian and requested withdrawal of life-sustaining care for Terri, he was cohabiting with another woman, with whom he had two


177 Because the Schiavo case—though it was entertained in federal and state courts—made little new law, this section focuses on the story. Relevant legal documents as well as a timeline of the Schiavo story can be found online at Schiavo Timeline, Part 1, supra note 173, and Schiavo Timeline, Part 2, supra note 175.


179 Id.

180 See In re Guardianship of Schiavo, 780 So. 2d 176, 177 (Fla. Dist. Ct. App.), review denied, 789 So. 2d 348 (Fla. 2001).

181 See Schiavo Timeline, Part 1, supra note 173.


183 Id. Michael began a large malpractice action against physicians who had been treating Terri before her collapse. Id. About a million dollars was awarded between Terri and Michael. Id.

184 See Schiavo, 780 So. 2d at 177.

In 2000, Judge Greer for a Florida trial court concluded that Terri’s statements before she became incompetent provided “clear and convincing evidence” that she would choose, in the circumstances in which she existed at the time of the legal case, to discontinue life-sustaining care.187 Thus, he sided with Michael, Terri’s husband, authorizing the withdrawal of Terri’s feeding tube.188 Terri’s parents appealed Judge Greer’s decision, but the Florida appellate court affirmed it.189 Before the case concluded with Terri’s death in 2005, the Schiavo-Schindler dispute was entertained by every level of the Florida court system and by several federal courts, the U.S. Congress, and the nation’s President.190 Beyond all else, the Schiavo tale and the legal battles that accompanied it suggested the extent of confusion within the law and society about how best to handle disputes about the withdrawal of life-sustaining care.191 In March 2005, five years after Judge Greer found clear and convincing evidence that Terri would not have wanted to be kept alive in the condition she was in, Terri’s feeding tube was removed.192

4. The Lessons of Quinlan, Cruzan, and Schiavo

Quinlan made new law193 and provided a model for states ready to

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188 Id. at *6–7.
189 Schiavo, 780 So. 2d at 177.
190 See Schiavo Timeline, Part 1, supra note 173; see also Schiavo Timeline, Part 2, supra note 175.
192 The feeding tube had been removed twice previously. Each time a court order led to the withdrawal of the feeding tube. Schiavo Timeline, Part I, supra note 173. On March 31, 2005, almost two weeks after removal of Terri’s feeding tube, she passed away. Terry Schiavo’s Story, supra note 173.
193 But see In re Conroy, 486 A.2d 1209, 1228–30 (N.J. 1985) (distinguishing Quinlan from case of patient who could “interact with [her] environment to a limited extent, but whose
concede that life-sustaining care, once inserted, could be removed prior to the patient being declared dead from causes not related to the withdrawal of that care. *Cruzan* is important because the Supreme Court entertained the case, but the Court’s ruling provided little guidance to the nation about how the law might best handle such cases. Neither Judge Greer’s 2000 decision to order the withdrawal of Terri Schiavo’s feeding tube nor the many judicial proceedings, legislative responses, and executive acts that followed re-shape state law. Further, they did not re-shape the nation’s understanding of how the law might respond effectively and wisely to the issues at stake. The case came to an end only in 2005 when the U.S. Supreme Court refused to review the Eleventh Circuit’s decision that facilitated the order to withdraw Terri Schiavo’s care.

Although *Schiavo* did not re-shape Florida laws regarding end-of-life decision making, the case was extraordinarily important in other regards. In particular, it drew public attention to the challenge presented by a patient—here a young woman—who entered into a persistent vegetative state without having completed an advance directive and without having engaged in serious, in-depth conversations with family members about her medical preferences should she need care and lack the capacity to make her own decisions. The lessons of Terri’s case apply equally to patients suffering from serious medical conditions but incapable of making their own medical decisions.

Karen Quinlan and Nancy Cruzan died before the internet existed. *Terri Schiavo* did not. Terri’s story, through blogs, photos, news stories, and comments, populated the internet for the last several years of her life and continues to garner attention. The legal issues in the case,
as stated by a Florida appellate court, could be described simply. The implications of the issues, however, have been extraordinarily challenging. Judge Altenbernd for a Florida appellate court wrote:

In the final analysis, the difficult question that faced the trial court was whether Theresa Marie Schindler Schiavo, not after a few weeks in a coma, but after ten years in a persistent vegetative state . . . would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives. After due consideration, we conclude that the trial judge had clear and convincing evidence to answer this question as he did.\(^{199}\)

C. Legislative Responses

In Quinlan, New Jersey Supreme Court Chief Justice Hughes reported that at the time (1976) there was a “relative paucity of legislative and judicial guides and standards” relating to the matters at issue in the case.\(^{200}\) Soon, however—and perhaps in some part because of Justice Hughes’ Quinlan decision—states began widely to promulgate laws pertaining to advance care planning. Generally framed as end-of-life law, a body of rules and legal options developed within the states.\(^{201}\)

Quinlan, Cruzan, and Schiavo, all involving young persons, make it clear that planning for medical decisions, should one become ill and incapable of making decisions, is not a process that should be reserved only for elderly or sick people. Certainly, old people are more likely to die...
than younger people. Young people, however, do die; they may fall into persistent vegetative states; and they may be seriously ill—but not terminally ill—and in need of surrogate decision making regarding their care. Advance care planning should be entertained by every adult.\(^{202}\)

Federal law requires health care facilities that accept Medicare and Medicaid patients to inform patients about advance care planning and about the opportunity to complete advance directives.\(^{203}\) The details of the process follow from the laws of the relevant state. By the beginning of the twenty-first century, every state provided for some form of advance care planning.\(^{204}\) Broadly, these laws provide for competent adults to name a surrogate decision maker and to provide instructions for medical care should they lose capacity to make medical decisions.\(^{205}\) These laws, however, do not mandate advance care planning.\(^{206}\) In general, state laws direct a surrogate to make decisions in harmony with the principal’s pre-incompetency preferences and wishes or, if those are not clear, in harmony with the principal’s best interests.\(^{207}\)

\(^{202}\) Since elderly people as a group are more likely than younger people to face serious illness and death, advance care planning becomes an even more essential matter for the nation as its population ages. In 1900, 100,000 people in the U.S. were 85 or older. In 2012, there were 5.9 million people in that age group. And by 2050, it is expected that 18 million people will be 85 or older. See Hoffman, supra note 11, at xv. The extended years of life enjoyed by the population as a whole are often accompanied by chronic health conditions, including coronary disease, renal disease, lung conditions, and cancer. Id. at xvi.

\(^{203}\) The Patient Self-Determination Act, passed in 1990, requires hospitals that receive federal funding (including hospitals that accept Medicare patients) to honor advance directives and to provide information to patients about advance care planning, including information about advance directives, when patients enter the facility. Patient Self-Determination Act of 1990 (Omnibus Budget Reconciliation Act, 1990), Pub. L. No. 101-508 § 4206, 104 Stat. 1388 (1990) (codified as amended in scattered sections of 42 U.S.C.).


\(^{205}\) The specifics vary. For instance, some states provide for appointment of a durable power of attorney. See, e.g., ALASKA STAT. ANN. § 13.52.300 (West 2014) (providing for appointment of a durable power of attorney); see also, ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES, ADVANCE DIRECTIVE FOR HEALTH CARE FORM, http://dhss.alaska.gov/dph/Director/Documents/advancedirective.pdf (last visited Jan. 22, 2016). Others provide, for instance, for health proxies, see, e.g., ALA. CODE § 22-8A-4(h) (West 2015), or “surrogates,” see, e.g., FLA. STAT. ANN. § 765.202 (West 2015). By statute, Florida prescribes a form to appoint a surrogate. Id. § 765.203.

\(^{206}\) Noah, supra note 204, at 9.

\(^{207}\) Cantor, supra note 204, at 189.
guideline, presumptively objective, offers little concrete assistance. But it does offer a means for reaching a decision in cases in which there is inadequate or no evidence about a no-longer-competent patient’s pre-incompetency preferences.

An additional set of state laws identifies default surrogate decision makers for patients without advance directives. The Uniform Health-Care Decisions Act (UHCD), presented by the Uniform Law Commission in 1993, delineates default surrogate decision makers in order of priority for patients who have not identified a surrogate and who lack capacity. The act lists a patient’s spouse as the privileged decision maker; if the patient does not have a spouse, the act identifies, in this order, an adult child, a parent, and then an adult sibling. If none of these is available, an adult who cared about the patient and who is familiar with his or her health care preferences is authorized to serve as a surrogate decision maker. Only six states have adopted the UHCD. Most states and the District of Columbia, however, now provide for default decision makers, more or less reflecting the order of priority noted in the UHCD.

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209 The first end-of-life laws provided for people, while competent, to create “living wills.” It was passed in California in 1976. See Jennison, supra note 201, at 304. A second type of law aimed at providing for end-of-life decision making for people without capacity appeared about a decade later and followed the model of a power of attorney. Powers of attorney do not survive the principal’s incompetency. Thus, states created durable powers of attorney that would authorize surrogates to make decisions for incapable patients. See Sabatino, supra note 201, at 214–15.

By the last decade of the twentieth century, states began also to provide for do-not-resuscitate orders. Id. at 215. The so-called POLST form (Physician Orders for Life-Sustaining Treatment) was offered first in Oregon in the 1990s, and is now in place or under development in many other states. Id. at 228–31. Similar options are available outside Oregon under different names, including West Virginia’s POST (Physician Orders for Scope of Treatment) and Vermont’s COLST (Clinical Orders for Life Sustaining Treatment). Id. at 230, n.10. In New York, the forms are called MOLSTs (medical orders for life-sustaining treatment). See, e.g., Medical Orders for Life-Sustaining Treatment (MOLST), N.Y. DEP’T HEALTH, https://www.health.ny.gov/professionals/patients/patient_rights/molst/ (last visited June 15, 2015). The option to complete a POLST or comparable form does not exist in Alabama, Alaska, Arkansas, Nebraska, and South Dakota. See POLST: PROGRAM IN YOUR STATE, http://www.polst.org/programs-in-your-state/ (last visited Jan. 22, 2016).
211 Id.
212 Id.
213 These states are Alaska, Hawaii, Maine, Mississippi, New Mexico and Wyoming. Id.
214 NAT’L ASSOC. OF CHRONIC DISEASE & CDC HEALTHY AGING PROGRAM, ADVANCE CARE PLANNING: ENSURING YOUR WISHES ARE KNOWN AND HONORED IF YOU ARE UNABLE TO SPEAK FOR YOURSELF, 13 (2012), http://www.cdc.gov/aging/pdf/advanced-care-
Promulgated over several decades, states’ end-of-life laws provide a legal frame for the appointment of surrogate decision makers; facilitate identification of decision makers in cases in which a patient had not designated a surrogate while competent; encourage the provision of pre-incompetency instructions about preferences and wishes regarding medical care, including end-of-life care; and provide for the refusal of care, including cardio-pulmonary resuscitation in hospital and non-hospital settings. With such laws, states have attempted to ensure that advance care plans, if documented pursuant to law, will be followed.

This body of law—though important to the facilitation of advance care planning—has occasioned several concerns. Commentators have noted the discomfort provoked by the subjunctive at the center of most advance care planning (e.g., “were I ill and incapable, I would want . . .”). The presumption that the preferences set forth by the once-capable patient harmonize with what the now-ill, incompetent patient would want were he or she offered a moment of lucidity for decision making cannot easily be sustained. That presumption harmonizes poorly with the notion of autonomous choice—the putative rationale for the movement to encourage advance care planning. Further, the completion of advance directives does not always preclude disputes among family members or between surrogates and clinicians. Despite such concerns, there is a continuing need for advance care planning that includes “the inherent and immediate benefit to the individual of thinking about and executing an advance directive.”

Even more, advance care planning has been only partially successful because most adults do not complete advance directives or discuss their health care preferences with loved ones and clinicians. Discussing one’s own dying and death are discomforting topics for most people and for their loved ones. In addition, advance care planning has been con-

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215 The laws considered here in Part IV.C are referred to as “end-of-life” laws because they have been promulgated with end-of-life issues in mind. See Lois Shepherd, The End of End-of-Life Law, 92 N.C. L. REV. 1693, 1695–96 (2014) (noting that these statutes concern issues regarding end-of-life decision making).

216 See id. at 1696–97 (delineating the variety of names by which these forms are known in the states).


218 Noah, supra note 204, at 12.

219 See id. at 6–7.

220 Id. at 7–8.
flated, mistakenly, with physician-assisted suicide and euthanasia.

D. Physician-assisted Suicide and Euthanasia: A “Slippery Slope” or a Different Matter?

This confusion—between advance care planning and physician-assisted suicide and euthanasia—has burdened efforts to encourage people to contemplate and discuss their medical wishes should they lose the capacity to make their own medical decisions. Moreover, it has created anxiety among many people about signing advance directives, as a practical matter. This is unfortunate in that advance care planning is an important component of good health care. Even more, it can obviate a patient’s interest in physician-assisted suicide or in euthanasia.

In 1997, the United States Supreme Court declined to find a constitutional right to physician-assisted suicide. This left the states free to choose whether to enact such laws. Oregon, Washington, and Vermont have legalized physician-assisted suicide. Physician-assisted suicide is also legal in Montana and New Mexico, as a result of court cases.

\[^{221}\] Sarah Palin’s “death panel” claim is illustrative. See infra Part V.A.1.

\[^{222}\] See, e.g., Jonathan Moreno, Who’s to Choose?: Surrogate Decisionmaking in New York State, 5 HASTINGS CTR. RPT., no. 1, Jan.–Feb. 2013, at 5 (noting concern about slippery slope should laws provide for withdrawal or withholding of life-sustaining care).

\[^{223}\] The confusion was fueled by claims from critics of health care reform that the government would use advance care planning to ration resources for elderly patients. See, e.g., Sarah Palin, Concerning the “Death Panels,” FACEBOOK (Aug. 12, 2009), https://www.facebook.com/note.php?note_id=116471698434; see also infra Part V (considering opposition to Medicare’s paying clinicians for holding conversations with patients about advance care planning). These claims were grounded on mistaken or self-consciously twisted information. See infra Section V.A.1. (considering claims that paying for advance care planning sessions constituted “death panels”).


\[^{226}\] See Death with Dignity Around the U.S., supra note 225 (noting that about half of the state legislatures are scheduled to consider the matter in 2015). No state in the U.S. provides for euthanasia. Id. A number of other countries also legalized physician-assisted suicide, and a few, including the Netherlands and Belgium, have legalized euthanasia. See, e.g., Termination of Life on Request and Assisted Suicide Act of 2002 (Neth.); Euthanasia Act of 2002 (Belg.). There is still controversy about laws that have legalized physician-assisted suicide and about their implications for public policy. In the states that have legalized physician-assisted suicide, however, there is no evidence of abuse. As of February 2015, 1,327 people in Oregon had filled prescriptions pursuant to the Death with Dignity Act. 859 patients died as a result of using these prescribed medications. See OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT–2014, (2014), https://public.health.oregon.gov/ProviderPartnerResources/
Claims grounded in ideological interests have clouded the matter.227 There is no evidence, however, that supports a link between advance care planning and physician-assisted suicide or between physician-assisted suicide and euthanasia. The matters are distinct. In fact, advance care planning—by offering patients options for palliative and hospice care—can further the development of a medical setting that should diminish interest in physician-assisted suicide or euthanasia.

A good death, in the contemporary context, should not be confused with physician-assisted suicide. As John Arras wrote in the same year that Oregon legalized physician-assisted suicide:

"Physicians must learn how to really listen to their patients, to unflinchingly engage them in sensitive discussions of their needs and the meaning of their requests for assisted death, to deliver appropriate palliative care, to distinguish fact from fiction in the ethics and law of pain relief, to diagnose and treat clinical depression, and, finally, to ascertain and respect their patients’ wishes for control regarding the forgoing of life-sustaining treatment."

Such care, now routinely provided by hospice, does not involve the ingestion of lethal medication. Rather, it depends only on the discontinuance, at a patient’s request (or at the request of a patient’s surrogate) that aggressive care be discontinued so that patients “may take advantage of their next naturally occurring opportunity to die.”229 Such requests, however, must be based on the patient’s (or his or her surrogate’s) understanding of the patient’s medical situation and available treatment options. In most cases, that depends on patients having discussed their health care preferences with loved ones and clinicians before a medical crisis develops. This is more likely to occur if clinicians are reimbursed for the time devoted to such conversations. That reimbursement will make it clear that advance care planning can be an essential component of good health care.

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227 See infra Part V.
229 Yale Kamisar, Are the Distinctions Drawn in the Debate about End-of-life Decision Making “Principled”? If Not, How Much Does it Matter?, 40 J.L. MED. & ETHICS 66, 67 (quoting JEANNE FITZPATRICK & EILEEN M. FITZPATRICK, A BETTER WAY TO DIE 41 (2009)).
The American health care system generally reimburses clinicians and health care facilities for tests and examinations aimed at diagnosis of illness (and a few, such as mammography, aimed at early diagnosis), as well as for a patient’s hospitalization and for procedures and medications provided by health care facilities. Far fewer funds are available to pay clinicians for attending to patient’s most pressing needs near the end of life than are available for continuing—often essentially useless—treatments. Dale Lupu has compared services generally considered reimbursable—“procedures, chemotherapy, clinic visits, emergency room”—with those generally not reimbursed or not reimbursed adequately given the needs of patients near the end of life—“caregiving, communication and pain control, home visits, and 24-hour on-call nursing.” Patients would receive better health care were the latter set of services reimbursable.

Paying clinicians for time spent speaking with patients—as a general matter and with regard to end-of-life care, as a particular matter—would significantly increase patient satisfaction, inform patients about medical options, and enrich the patient-clinician relationship. In addition to its most obvious purpose (reimbursement for the time of a skilled professional), availability of payment for such conversations between patients and clinicians would categorize these conversations as a component of good health care (which they are). Yet, just that sort of suggestion—that Medicare pay clinicians to talk with patients about advance care planning—resulted in charges of governmental “death panels” and fueled unfounded patient concern about the government’s role under the bill that became the Patient Protection and Affordable Care Act.

A. Advance Care Planning and Fabricated Claims: Serving Partisan Political Ends

This Section details the 2009 proposal to pay clinicians for engaging in conversations about advance care planning with patients, and it details public responses to that proposal. Further it describes a Centers
for Medicare and Medicaid Services ("CMS") proposed regulation (released in July 2015 and finalized that November) to provide for such payments beginning in 2016.\textsuperscript{232} The matter is basic since willingness to pay for advance care planning consultations provides compelling evidence of society’s commitment to meeting the needs of very sick patients and their families and, more important even, its commitment to a health care system that assumes that patients and clinicians should converse with each other about the patient’s health care.

1. Social Media: Defeating the Coverage Provision

A comment, posted on Facebook in August of 2009 by Sarah Palin (the 2008 Republican candidate for vice-president), inspired almost one-third of the nation to conclude that the Patient Protection and Affordable Care Act ("PPACA"), if promulgated, would sanction "death panels," aimed at limiting care for the elderly.\textsuperscript{233} Palin’s Facebook comment alleged:

"The Democrats promise that a government health care system will reduce the cost of health care, but as the economist Thomas Sowell has pointed out, government health care will not reduce the cost; it will simply refuse to pay the cost. And who will suffer the most when they ration care? The sick, the elderly, and the disabled, of course. The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s “death panel” so his bureaucrats can decide, based on a subjective judgment of their “level of productivity in society,” whether they are worthy of health care. Such a system is downright evil."

A few days later, again on Facebook, she elaborated on her earlier post.

"Yesterday President Obama responded to my statement that Democratic health care proposals would lead to rationed care; that the sick, the elderly, and the disabled would suffer the most under such rationing; and that under such a system these “unproductive” members of society could face the prospect of government bureaucrats determining whether they deserve health care. The..."
President made light of these concerns.235

The “death panel” claim—or myth, as some have referred to it—seems to have been first voiced in public media not by Palin, but, a month before Palin’s Facebook comments, by Elizabeth McCaughey (a former New York lieutenant government). McCaughey, interviewed in July 2009 on former Senator Fred Thompson’s radio program, opined about the health reform bill in Congress in 2009.237

And one of the most shocking things I found in this bill, and there were many, is on Page 425, where the Congress would make it mandatory—absolutely require—that every five years, people in Medicare have a required counseling session that will tell them how to end their life sooner, how to decline nutrition, how to decline being hydrated, how to go in to hospice care. And by the way, the bill expressly says that if you get sick somewhere in that five-year period—if you get a cancer diagnosis, for example—you have to go through that session again. All to do what’s in society’s best interest or your family’s best interest and cut your life short. These are such sacred issues of life and death. Government should have nothing to do with this.238

McCaughey’s central assertions, all false, were broadcast widely and provided fuel for the claim that the PPACA would have devastating consequences for Americans’ health care. Palin’s Facebook post that the provisions at issue would create “death panels”239 provided additional fuel for PPACA opponents. The “death panel” claim, though based on a serious misreading of the proposed law, resonated with large segments of the public, in part because it echoed concerns already in the air that Obama’s health reform efforts would result in rationing, especially for elderly and other vulnerable people.240

A key claim at the center of the “death panel” claim—the assertion that counseling for Medicare recipients about advance care planning would be mandatory every five years or perhaps more often—was fabricated. Yet, according to a July 2010 Kaiser Family poll, a year after both McCaughey’s assertion about mandatory end-of-life counseling sessions and Palin’s death panel claim on Facebook, 36% of seniors believed that

235 See Palin, supra note 223.
236 Nyhan, supra note 233, at 10.
237 Fredthompson, Fred Thompson, Betsy McCaughey Interview, YOUTUBE (July 27, 2009), https://www.youtube.com/watch?v=89hpyOljiGk.
238 See Nyhan, supra note 233, at 8.
239 See Palin, supra note 223.
the law would permit the government to make decisions about care at the end of life for Medicare recipients.

In fact, the provision at issue said nothing about rationing and did not require anyone—neither patients nor clinicians—ever to talk about advance care planning. It simply provided for paying physicians for time devoted to conversations with Medicare patients about advance care planning. More specifically, the provision did not mandate advance-care-planning conversations every five years. Rather, the provision limited payment for such conversations to once every five years, allowing for payment more often if the patient was diagnosed with a serious illness. In the end, the provision was deleted before Congress promulgated the PPACA. The Senate did not include the provision in its bill, passed in December 2009, and renamed it the “Patient Protection and Affordable Care Act” (the name of the act that the President signed in 2010).

The disparaged provision would only have paid clinicians for conversations about advance care planning, but could well have provided inspiration for a more general effort to encourage patient-centered care focused around communication between patients and their primary-care doctors, and, sometimes, between patients and other clinicians. Communication about advance care planning is not fundamentally distinct from other patient-clinician conversations about health and health care more generally. On this, it is instructive to compare language from the 2009 House Bill 3200 with more recent discussions of patient-centered care. Section 1233 of the House bill described consultations in which practitioners would explain advance care planning to their patients, describe available “end-of-life services and supports,” offer “information

241 By July 2010, the date of the Kaiser Family Foundation poll, the Act had been promulgated. 118 Pub. L. No. 11-1148, 124 Stat. 119 (2010).
242 KAISER HEALTH TRACKING POLL, supra note 240, at 5. Less than half of those polled found the claim to have been false. Id.
245 In October 2009, the House replaced H.R. 3200, which contained the advance care reimbursement provision, with House Bill 3962. See H.R. 3962, 111th Cong. (2009). The bill that passed in the Senate in December 2009—the Patient Protection and Affordable Care Act—was House Bill 3590, which, prior to amendment, was a tax credit proposal for service members. See John Cannan, A Legislative History of the Affordable Care Act, 105 LAW LIBR. J. 131, 140, 153 (2013). House Bill 3590, as passed, mostly comprised Senate Amendment 2786, which included some content from the previous bills. Id. at 153–58. That bill passed in the Senate on Dec. 23, 2009. Id. at 158. It did not include a provision to pay physicians for conversations about advance care planning.
needed for an individual or legal surrogate to make informed decisions” about advance care planning, and inform a patient about state resources relevant to effecting the “treatment wishes of that individual” should he or she be “unable to communicate those wishes.”246 Patient-centered care has been similarly described as “revolv[ing] around the patient” in such a way that “care is generally defined by or in consultation with patients rather than by physician dependent tools or standards.”247 In 2001, the Institute of Medicine defined “patient-centeredness” as “health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.”248 And a 2007 report on patient-centered care delineates its key components to include “involvement of family and friends,” “sensitivity to nonmedical and spiritual dimensions of care,” and “respect for patient needs and preferences.”249

The negative publicity that followed the death panel claim slanted the debate and conditioned large segments of the nation to oppose the proposal to pay clinicians for advance-care-planning conversations with their patients. Part of the force of anti-PPACA publicity in general and of that opposing the advance-care-planning payment proposal, in particular, stemmed from the attempt to incorporate these matters into a larger ideological platform. Thus the debate about advance-care-planning payments was conflated with the longstanding debate about abortion.

2. Death Panels and the Abortion Debate

The death panel claimants assumed, or self-consciously selected, a set of metaphors that invoked pro-life language in criticizing both Section 1233 of House Bill 3200 and then five years later, in criticizing a renewed effort—one initiated by the American Medical Association (“AMA”)—to have Medicare develop billing codes for discussions be-

246 H.R. 3200 § 1233(a)(1).
tween clinicians and patients about advance care planning. In the summer of 2009, North Carolina Representative Virginia Foxx (R), described a Republican bill that would have replaced the Democrats’ health care reform bills described as “pro-life because it will not put seniors in a position of being put to death by their government.” And in 2014, in response to the AMA proposal, some public voices echoed Palin’s 2009 rhetoric. In 2014, Burke Balch, then-director of the Powell Center for Medical Ethics at the National Right to Life Committee explained that the 2014 provision that proposed paying physicians for conversations about advance care planning could result in “subtle efforts to pressure some of the most vulnerable patients to surrender their right to life.”

The similarity to language used in other contexts to describe abortion’s consequences for fetuses is readily apparent. Thus, again, rhetoric about end-of-life decision making was shaped in light of claims associated with the pro-life movement. As in the context of earlier cases

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252 The Powell Center website explains that the Center “serves as NRLC’s arm in fighting to protect the vulnerable born from both direct killing and denial of lifesaving medical treatment, food and fluids.” Robert Powell Center for Medical Ethics, NAT’L RIGHT TO LIFE COMM., http://www.nrlc.org/medethics/ (last visited Jan. 22, 2016).


254 See, e.g., Press Release, Rep. Lynn Westmoreland, Westmoreland Votes to Protect Americas Unborn Children (May 18, 2015) (available at http://westmoreland.house.gov/press-releases/westmoreland-votes-to-protect-americas-unborn-children/) (quoting House of Representative Lynn Westmoreland (R.-Ga.) that “Sanctity of Life Act” would offer life to “innocent children,” and that “[t]heir lives are the most vulnerable and we must be the voice for the voiceless”); National Right to Life Mission Statement, NAT’L RIGHT TO LIFE COMM., http://www.nrlc.org/about/mission/ (last visited Jan. 24, 2016) (stating that the National Right to Life Committee is committed to “protect and defend the most fundamental right of humankind, the right to life of every innocent human being from the beginning of life to natural death”). The organization’s mission statement continues:

National Right to Life carries out its lifesaving mission by promoting respect for the worth and dignity of every individual human being, born or unborn, including unborn children from their beginning; those newly born; persons with disabilities; older people; and other vulnerable people, especially those who cannot defend themselves.

Id.
about care for vegetative patients (such as Terri Schiavo) in which the pro-life movement presumed to equate abortion with end-of-life choices that limit the continuing use of life-sustaining treatment, those opposing payment for advance-care-planning conversations invoked pro-life comparisons to undermine statutory and regulatory proposals to have Medicare pay for such conversations.

3. The Irony of the “Death Panel” Claim and the Implications of its Success

Perhaps, the most poignant—and most disturbing—aspect of “Obamacare” opponents’ peculiar critique of the legislative effort to pay clinicians for discussing advance care planning with patients—in effect, a proposal to pay clinicians to talk with patients about health care matters—is that that payment proposal would have echoed and perhaps even revivified a very positive and life-giving component of old-fashioned medicine. The notion of patient-centered care for patients with capacity depends on clinicians and patients talking with each other.

Remarkably, the death panel claimants and their compatriots disparaged an element of health care reform that seems almost expressly aimed at preserving—or more accurately, re-creating—aspects of the doctor-patient relationship prized before the widespread “social transformation” of American medicine in the second half of the twentieth century. Even more, good health care depends on conversations between clinicians and patients. The proposal to pay clinicians for conversations with patients about advance care planning offers a powerful model for the clinician-patient relationship that assumes communication

255 See supra Part IV.B.3. (detailing Schiavo’s legal story about life-sustaining care for a woman diagnosed to have been in a persistent vegetative state). Randall Terry, founder of Operation Rescue, a pro-life group, organized demonstrations outside the facility in which Terri Schiavo resided and equated her dying with the death of a fetus. See Smith, supra note 186; Andrew Seifter, Who is Randall Terry?, MEDIA MATTERS AMERICA (Mar. 21, 2005), http://mediamatters.org/research/2005/03/21/who-is-randall-terry/132921. Wesley Smith noted that pro-choice groups were joined, in opposing withdrawal of care for Terri Schiavo, by disability rights groups. See Smith, supra note 186.


is a central component of good health care.

B. Revivifying the Coverage Provision

A year before McCaughey and Palin suggested to the nation (with significant effect) that paying clinicians for consultations with patients about advance care planning was tantamount to creating “death panels,” Congress had provided for one Medicare payment to clinicians to address such issues with new Medicare recipients. Efforts to implement a broader provision—one that would pay clinicians for periodic advance-care-planning conversations with patients—faced strong opposition. Yet, a proposal published by CMS in July 2015 to create two billing codes that cover advance-care planning conversations has been finalized and extends a welcome beginning. This Part reviews efforts to provide for Medicare payments for advance-care-planning conversations between 2010 and 2015 in light of the deletion of the provision from the law that became the PPACA.

1. Proposals that Failed to Receive Adequate Support

In 2010, the CMS relied on regulatory processes to propose paying clinicians for advance-care-planning conversations. Supporters of the regulation worried that publicity, revived from the 2009 fracas about “death panels,” could stymie the new regulatory effort. Indeed, that happened. In December 2010, a story appeared in the New York Times describing the proposed Medicare regulation. Other media outlets soon reported on it. In early January, CMS, expressly bowing to public concern about the regulation, deleted it from the 2011 Physician Fee Schedule.

Two bills, one introduced in the House and one in the Senate in

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[262] Id.
2013, would have provided payment for consultations regarding advance care planning. The House bill, “Personalize Your Care Act of 2013,” proposed coverage to physicians, nurse practitioners, and physician assistants for voluntary consultations about advance care planning for both Medicare and Medicaid patients. The bill defined “voluntary advance care planning consultation” potentially to include (subject to the specification of the Agency’s Secretary):

(A) An explanation by the practitioner of advance care planning and the uses of advance directives. (B) An explanation by the practitioner of the role and responsibilities of a proxy or surrogate. (C) An explanation by the practitioner of the services and supports available under this title during chronic and serious illness, including palliative care, home care, long-term care, and hospice care. (D) An explanation by the practitioner of physician orders for life-sustaining treatment or similar orders in States where such orders or similar orders exist. (E) Facilitation by the practitioner of shared decisionmaking with the patient (or proxy or surrogate) . . . .

The Senate bill, “Care Planning Act of 2015,” provided coverage for voluntary planning services not more often than once every 12 months (unless the patient’s medical situation changed less than 12 months following an advance-care-planning conversation with his or her clinician). The Senate bill included among its findings the assertion that the government as the “largest purchaser of health care services” in the nation must “encourage health care providers to furnish more supportive and comprehensive advanced illness care to improve the efficacy and quality of health care delivered for generations of Americans to come.”

In 2014, payment to clinicians for discussions about advance care planning was again attempted through the regulatory process. At that

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266 Id. § 2(a)(1)(B).
267 Id.
269 Id. § 3(a)(2).
270 Id. § 2(9).
271 See Support for Medicare Coverage of End of Life Discussions Among Providers, LIFE MATTERS MEDIA (Sept. 9, 2014), http://www.lifemattersmedia.org/2014/09/support-medicare-coverage-end-life-discussions-among-providers/. Two codes were proposed, in fact. The first (99497) would have provided for payment for discussion about “advance directives such as standard forms . . . by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family members(s), and/or surrogate.” The second (99498) would have provided payment for discussion that extended beyond 30 minutes. See Medicare Declines to Reimburse Physicians for End of Life Discussions in 2015, LIFE MATTERS MEDIA (Dec. 9, 2014), http://www.lifemattersmedia.org/2014/12/medicare-
time, the American Medical Association ("AMA") submitted billing codes to CMS that would have paid medical providers for time spent discussing advance care planning with Medicare patients. The AMA proposed that Medicare pay for a 30-minute discussion about such planning with Medicare patients. In late 2014, CMS tabled the proposal. The reasons for that action remain unclear though CMS claims it needed more time to garner comments on reimbursements under the two codes.

2. 2015: A New CMS Proposal and a Finalized Rule

In July 2015, CMS again relied on the regulatory process to propose two codes that would allow clinicians to bill for advance-care-planning conversations. A letter to Sylvia Burwell, Secretary of Health and Human Services, sent two months earlier and signed by over 60 health care organizations, including the AMA, the American Nurses Association ("ANS"), and the AARP, urged that Medicare offer the codes developed by the AMA. The letter explained:

declines-reimburse-physicians-end-life-discussions-2015/.

272 See Support for Medicare Coverage of End of Life Discussions Among Providers, supra note 271.

273 Id.

274 Id.

275 Life Matters Media quotes Thaddeus Pope, a law professor at Hamline University, to have opined that CMS’s response could have reflected “implementation issues or politics.” Id. Pope further suggested that the code might be accepted and implemented by CMS by 2016. Support for Medicare Coverage of End of Life Discussions Among Providers, supra note 271.


277 The codes, suggested to HHS by the AMA, are numbered 99497 and 99498. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 41,686 (proposed July 15, 2015) [hereinafter CY 2016 CMS Codes]. The CMS proposal describes the codes at issue:

CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate); and an add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional . . .).

Id. at 41,773.

Published, peer-reviewed research shows that [advance care planning (ACP)] leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression and lost productivity. ACP is particularly important for Medicare beneficiaries because many have multiple chronic illnesses, receive care at home from family and other caregivers, and their children and other family members are often involved in making medical decisions.\[279\]

CMS proposed that the two codes “should be reported when the described service is reasonable and necessary for the diagnosis or treatment of illness or injury.”\[280\] The proposal provided illustrations:

For example, this could occur in conjunction with the management of a patient’s current condition, such as a 68 year old male with heart failure and diabetes on multiple medications seen by his physician for the evaluation and management of these two diseases, including adjusting medications as appropriate. In addition to discussing the patient’s short-term treatment options, the patient expresses interest in discussing long-term treatment options and planning, such as the possibility of a heart transplant if his congestive heart failure worsens and advance care planning including the patient’s desire for care and treatment if he suffers a health event that adversely affects his decision-making capacity.\[281\]

Thus, the proposal expressly presented the codes as providing coverage for health care thereby making it clear that clinician-patient conversations about the patients’ medical situation and proposed care are part of the practice of good health care. The proposed codes did not cover conversations held “at the beneficiary’s discretion, . . . under section 1861(hhh)(2)(G) of the Act”\[282\] (concerning Medicare patients’ annual wellness visit). CMS responded to comments on the proposed codes that favored providing for reimbursement for advance care planning during a patient’s annual wellness visit. That possibility was added to the codes, as finalized in November 2015.\[283\] The codes thus cover consultations about advance care planning in conjunction with Evaluation and Management services or as an optional component of the annual wellness visit.\[284\] Medicare’s paying for these conversations will enrich the clinician-patient relationship and, correlativey, promises to improve health

\[279\] Id.
\[280\] See CY 2016 CMS Codes, 80 Fed. Reg. at 41,773.
\[281\] Id.
\[282\] Id.
\[284\] Id.
In short, the new codes serve important purposes. Most obviously, they provide for reimbursing clinicians for time given to an essential part of health care—talking with patients. Second, the CMS codes explicitly categorize such conversations, at least in a limited context, as central to health care. To the extent that that message is more widely internalized among clinicians and patients, it will more likely be accepted and even generalized by other payers.

The next Part of this Article describes a number of models for effecting advance care planning. It focuses on one model that is being developed in New York State. This model is unusual in that it depends on the integrated work of interdisciplinary teams; these teams include lawyers, clinicians, public health professionals, and social science researchers, working with the assistance of university graduate and professional students.

VI. ADVANCE CARE PLANNING: EDUCATION AND IMPLEMENTATION

Broad changes in responses to advance care planning will be furthered as the public becomes increasingly aware of the value of advance care planning and of the centrality of conversations between patients and clinicians—as well as conversations between patients and potential surrogates—to advance care planning. This Part presents several approaches developed to educate the public about advance care planning and to increase the percent of adults who have completed advance directive forms and engaged in honest conversations about their health care preferences with their clinicians and surrogate(s).

Each of the models described in this Part encourages people to complete advance care directives and to discuss health care preferences with potential surrogates and with clinicians—especially primary care providers. Further, each would seem to further the goals set by the Institute of Medicine’s 2014 report on dying in America:

For most people, death results from one or more diseases that must be managed carefully over weeks, months, or even years. Ideally, health care harmonizes with social, psychological, and spiritual support as the end of life approaches. . . .

As much as people may want and expect to be in control of decisions about their own care throughout their lives, numerous factors can work against realizing that desire. Many people nearing the end of life are not physically or cognitively able to make their own care decisions. It is often difficult to recognize or identify when the end of life is approaching, making clinician-patient communication and advance care planning so important. . . . Understanding
that advance care planning can reduce confusion and guilt among family members forced to make decisions about care can be sufficient motivation for ill individuals to make their wishes clear . . . .

A. Encouraging Conversations About Advance Care Planning

“Respecting Choices,”286 a program developed in LaCrosse, Wisconsin, in the 1990s has provided a model for other programs.287 Bud Hammes, a medical ethicist at the Gundersen Lutheran Health System in LaCrosse, created Respecting Choices in response to a set of conundrums facing the loved ones and health care providers of very ill patients without capacity to make medical decisions for themselves.288 Clinicians in LaCrosse found that patients’ family members were often ignorant of their loved ones’ pre-incapacity health care preferences.289 That made medical decision making extraordinarily burdensome for patients’ health care agents.290 In response, a cadre of clinicians, attorneys, clergy, and others working in LaCrosse joined together in order to educate the community about medical choices, especially in end-of-life situations.291

Respecting Choices has been remarkably successful. In LaCrosse, by 2009, over 95% of adults had completed advance directives.292 That compares with about 25 to 30% of adults in the nation.293 The success in LaCrosse has not resulted in health care professionals rationing care to the elderly and dying people.294 Moreover, in LaCrosse, the average lifespan is about a year longer than the national average lifespan.295 Yet, patients in LaCrosse spend less time in the hospital near the end of life than do patients in other places, and the cost of hospitalization for LaCrosse’s elderly population is “unusually low.”296

285 DYING IN AMERICA, supra note 44, at S-1–S-2.
288 Id.
289 Id.
290 Id.
291 Id.
292 See Hatkoff et al., supra note 287.
293 Id.; see also DYING IN AMERICA, supra note 44, at 3–7 (noting that fewer than 30% of adults have had conversations about end-of-life care).
294 See Shapiro, supra note 289.
296 Id.
Atul Gawande reports that the intensive care unit (“ICU”) at the Gundersen Lutheran Hospital in LaCrosse seems to resemble many others in the nation—until one looks more carefully. When Gawande visited the Gundersen ICU, all of the patients were terribly ill, but none had a terminal condition. ICU patients in LaCrosse are far more likely to recover than to linger. The transformation in LaCrosse has depended almost entirely on a focused and committed effort to educate community members (not just old, sick people, but everyone) about advance care planning and, in that way, to encourage everyone to engage in conversations about advance care planning. In LaCrosse, “[e]veryone talks about it.”

Since Respecting Choices was created, similar programs have been developed elsewhere. The Conversation Project suggests that implementing care without talking with a patient about his or her “care wishes” or delivering care not in harmony with a patient’s expressed wishes is “on a par with medical errors.” The Conversation Project offers a “Starter Kit,” available online, to help people engage in conversations about advance care planning.

The Project’s website offers some straightforward statistics that make the need for conversations about advance care planning transparent. For instance, although the great majority of people (90%) assert that talking to loved ones about advance care planning is important, only about a quarter have actually engaged in such a conversation. Similarly, most people (82%) say that it is important to put in writing their end-of-life wishes.

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297 Id. at 178–89.
298 Id.
299 GAWANDE, supra note 295, at 179.
300 See Hatkoff et al., supra note 287.
301 See Respecting Choices Advance Care Planning, supra note 286.
302 See About Us, CONVERSATION PROJECT, http://theconversationproject.org/about/ (last visited Jan. 27, 2016). The Project was created by journalist Ellen Goodman and others. Beginning in 2011, the Conversation Project has worked in partnership with the Institute for Healthcare Improvement (“IHI”). IHI is a non-profit committed to improving health and health care in the US and elsewhere. Id.
305 Id.
306 See id.
of-life preferences, but very few have spoken to a clinician about it (7%). A number of other projects further this work in various parts of the country.

B. The CHAT Project

This Section focuses on a recent addition to the models created throughout the country in the wake of the success of Respecting Choices in LaCrosse, Wisconsin. Conversations: Health And Treatment (“CHAT”), developed by an interdisciplinary team of attorneys, clinicians, public health professionals, social science researchers, and university students, was developed as the result of a partnership between the Maurice A. Deane School of Law at Hofstra University and the Northwell Health, both in Nassau County, N.Y. CHAT is unusual among

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307 See id.
308 See, e.g., Empath Choices for Care, EMPATH HEALTH, https://www.empathchoicesforcare.org/ (last visited Jan. 27, 2016); EPEC PROJECT, EDUCATION FOR PHYSICIANs ON END-OF-LIFE CARE (EPEC) PARTICIPANT’S HANDBOOK (1999), http://www.ama-assn.org/ethic/epec/download/module_1.pdf. The Institute for Ethics at the American Medical Association created the EPEC project. Id.
309 Dr. Patricia Bomba has spearheaded a focus on end-of-life planning in New York State. She now leads a program (“Compassion and Support at the End of Life”). “The Community-Wide End of Life/Palliative Care Initiative” was originally co-led by Excellus BlueCross BlueShield and the Rochester Health Commission. About Us, COMPASSION & SUPPORT, https://www.compassionandsupport.org/index.php/about_us/leadership (last visited Jan. 27, 2016). The Initiative encourages health care communities to have advance directive forms, accepted by all health care institutions and clinicians providing care within the community. About Us: Core Principles and Goals, COMPASSION & SUPPORT, https://www.compassionandsupport.org/index.php/about_us/core_principles_goals (last visited Jan. 27, 2016). Further, Dr. Bomba played a crucial role in bringing the MOLST form (“Medical Orders for Life-Sustaining Treatment”) to New York State. MOLSTs are physician orders that allow patients to provide for the refusal of life-sustaining treatment. Within nursing homes and hospitals, MOLSTs can provide for any physician order about life-sustaining care. Outside of hospitals, they provide for Do Not Resuscitate (“DNR”) and Do Not Intubate (“DNI”) orders. Medical Orders for Life-Sustaining Treatment (MOLST), N.Y STATE DEP’T HEALTH, http://www.health.ny.gov/professionals/patients/patient_rights/molst/ (last visited Jan. 27, 2016).
309 The CHAT project has been developed by the Gitenstein Institute for Health Law & Policy at the Maurice A. Deane School of Law at Hofstra University and the Northwell Health (previously known as the North Shore-LIJ Health System). As Director of the Gitenstein Institute, I have worked with CHAT from its start and have participated in or closely observed the creation of the program’s various parameters, as outlined in this Section. More attention is paid to CHAT in this Part of the Article than to other programs offering similar services because CHAT is the program with which I am most familiar. Although the various programs encouraging advance care planning differ in services provided and in their approaches, all aim to effect similar goals. See Our Mission, CHAT, http://www.thechatproject.org (last visited Jan. 27, 2016).
310 See id.
programs encouraging advance care planning in that it relies on the resources of several university professional schools and departments as well as on the resources of a major health care system. The program, now operating in a few counties in southern New York State, strives to educate communal, professional, academic, governmental, and patient groups about advance care planning; to encourage “chats” about advance care planning; to offer one-on-one assistance to people ready to complete New York State’s advance-care-planning forms; to encourage people to reexamine and, if appropriate, re-draft advance-care-planning documents over time; and to identify and remedy gaps in state laws that pertain to advance care planning. CHAT responds to the concerns of a heterogeneous population. Reviewing a few of CHAT’s legal, clinical, and communal foci provides a broad overview of the effort to make advance care planning a routine and comfortable process in a community with many ethnic, religious, and language groups and a steep socioeconomic hierarchy.

1. The Law and Advance Care Planning

CHAT’s work reflects the multi-dimensional parameters of advance care planning. CHAT participants engage in education, advocacy, individual consultations, and research. The legal arm of CHAT offers education about advance care planning laws, conducts research aimed at identifying laws most likely to serve the needs of patients, their loved ones and their clinicians, and advocates for change once gaps in the law are identified. CHAT participants are now working in geographic areas surrounding Hofstra University and the North Shore-LIJ Health System.

311 CHAT participants are now working in geographic areas surrounding Hofstra University and the North Shore-LIJ Health System.


313 The county’s population in 2014 was about 1,358,000. In 2013, the population included African Americans (12.6%), American Indians or Alaska Natives (0.5%), Asian (9.1%), Native Hawaiian and Other Pacific Island (0.1%), Two or More Races (1.7%), Hispanic or Latino (16.1%), and White (62.3%). Over one-fifth of the population was foreign born (1990–2013). The median household income (2009–2013) was high—$97,690. Yet, 6% of the population lived below the federal poverty level. State and County Quick Facts, Nassau County, New York, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/36/36059.html (last visited July 6, 2015).

314 This Section focuses on the development and parameters of the CHAT project. It also, however, refers to other programs, some of which have provided models for CHAT, and it refers to broader research results that have offered valuable data in shaping CHAT.

315 These services are offered through the Maurice A. Deane School of Law at Hofstra University as part of a clinic and a special problems seminar. The services are offered without cost.
have been identified. Law students, supervised by attorneys, offer one-on-one consultations with anyone desirous of such guidance. New York state laws govern these consultations.

A brief review, noting highlights only of New York’s advance-care-planning laws, suggests the broad outlines of most states’ responses to medical decision making for patients without capacity. (Details vary from state to state.) New York is unusual among the states in requiring physicians to “offer” to provide terminally ill patients with “information and counseling regarding palliative care and end-of-life options appropriate to the patient.”

In 1990, New York passed the Health Care Proxy Act. That law authorizes a competent adult to appoint a health care agent through completion of a health care proxy form and to delineate “wishes or instructions about health care decisions.” A remarkable percentage (86%, by one estimate) of medical decisions about the withholding or withdrawal of life-sustaining care is made by surrogates, not by the patient. The burden on surrogates can be terrible. Studies have correlated


317 CHAT operates in New York. Thus, New York advance-care-planning laws are central to CHAT’s work.

318 The provision presumes all adults to be competent for this purpose unless they have been “adjudged incompetent or otherwise adjudged not competent to appoint a health care agent” or have been subject to the appointment of a committee or guardian of the person pursuant to Article 78 of the state’s mental hygiene law or Article 17-A of the surrogate’s court procedure act. PUB. HEALTH LAW § 2981(1).

319 State law directs that the form be signed, dated, and witnessed by two adults who also must sign the document. Notarization is not necessary. Id. § 2981(2). The statute further provides:

(a) The health care proxy shall: (i) identify the principal and agent; and (ii) indicate that the principal intends the agent to have authority to make health care decisions on the principal’s behalf, (b) The health care proxy may include the principal’s wishes or instructions about health care decisions, and limitations upon the agent’s authority, (c) The health care proxy may provide that it expires upon a specified date or upon the occurrence of a certain condition. If no such date or condition is set forth in the proxy, the proxy shall remain in effect until revoked. If, prior to the expiration of a proxy, the authority of the agent has commenced, the proxy shall not expire while the principal lacks capacity.

Id. § 2981(5). Section 2981(5)(d) offers a model proxy form but does not require use of the model for implementation of an effective proxy. The law further allows for appointment of an “alternative agent.” Id. § 2981(6). The state’s model proxy form and instructions related to completing it can be found at http://www.health.ny.gov/forms/doh-1430.pdf.

320 See Michael H. Limerick, The Process Used by Surrogate Decision Makers to Withhold and Withdraw Life-Sustaining Measures in an Intensive Care Environment, 34
the “surrogate experience” with “the surrogate’s level of confidence in his or her knowledge of which treatment the patient would have wanted.”321 Among significant stressors that make the surrogate’s role more difficult, several—such as “uncertainty of patient’s preferences” and “conflict with clinicians and family,”322—can be mitigated by advance care planning that includes honest conversations with potential surrogates and with the patient’s clinicians. 323 All CHAT participants direct anyone ready to complete advance directive forms to examine and understand the forms and then wait to complete them until one has engaged in conversations with one’s potential surrogates and one’s clinicians.

So-called living wills are not expressly provided for by New York’s law, but they can be drafted as supplements to instructions for one’s agent that are provided on the proxy form or in lieu of express instructions on the form itself.324 Many New York lawyers advise their use.325 Living wills are sometimes preferred to including relevant instructions on the proxy form because a living will can be re-drafted over time without the need to complete a new, witnessed proxy form. Living wills, however, if not composed with care, can limit an agent’s discretion by providing the agent with instructions that, in the nature of the case, were not composed in light of the patient’s actual medical situation at the time that medical decision making becomes necessary or of medical options when health care decisions are actually needed.326

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322 Id. at 344.

323 Those decisions are to be made in concert with the principal’s pre-incompetency wishes or, if those are not known, in concern with the principal’s best interests. PUB. HEALTH LAW § 2982(2). A principal’s pre-incompetency preference about the withdrawal of assisted nutrition and hydration can be stated on the face of the proxy form or in a living will. One can provide simply that one’s agent is aware of one’s wishes regarding artificial nutrition and hydration. However, the agent is not authorized to order the withdrawal of artificial nutrition and hydration unless it is known that the principal, while competent, would have wanted that to happen. Id.


325 See id.

326 Id.
the principal, if capable, would not want. Attorneys, clinicians, or others helping patients complete proxy forms, should be aware of and able to recommend some of the programs that guide people through such conversations comfortably.

Those counseling clients about advance care planning in New York should address some limits of the law with clients. First, anyone who has completed a proxy form should be urged to re-examine it over time. An individual’s preferences may change as his or her health status changes, and the principal may want to re-consider the agent named on the form. An agent may die or move away or simply lose contact with the principal. Further, a proxy form is of little use if it cannot be located when needed. At a minimum, copies of the form should be given to the proxy, any alternate proxy, and the principal’s primary care clinician.

Should a person fail to complete a health proxy form in New York and thus not name a proxy decision maker, a surrogate decision maker is identified pursuant to the Family Health Care Decisions Act. This law has been important to health care facilities and family members, but the act’s prescriptions may not reflect the pre-incompetency preferences of a particular patient. The surrogate decision maker chosen pursuant to the priority assigned by the law may not be someone whom the principal would have wanted to make important decisions for him or her. Moreover, a patient without a completed health care proxy form is probably less likely than those with advance directives to have engaged in open and honest conversation with potential surrogates about his or her preferences.

327 Id. Engaging in such conversations further ensures that the agent identified on a proxy form will not learn of his or her appointment only after the principle has lost capacity and is in need of medical decision making. New York law does not require the agent to sign or even read the principal’s health care proxy form. This can obviously lead to confusion and significant discomfort for the agent if he or she is unaware of the appointment before his or her services are needed.


329 N.Y. PUB. HEALTH LAW § 2994-a et seq. (McKinney 2015).

330 In order of priority, New York law identifies as the decision maker for a patient without capacity, who did not complete an advance directive: 1. a guardian appointed pursuant to the mental hygiene law, a spouse, if not legally separated from the patient, or the patient’s domestic partner; 3. an adult child; 4. a parent; 5. an adult sibling; 6. a close friend. Id. § 2994-d.
CHAT’s advocacy arm has identified several gaps in federal and state law. First, all insurers should pay clinicians for time devoted to conversations with patients about advance care planning.331 Further, advance-care-planning laws should require primary care clinicians to offer to discuss advance care planning with each patient whenever that patient has a change in his or her health situation or a change that suggests a need to identify a new surrogate, as well as periodically (e.g., every five years). Moreover, in order to ensure the availability of a person’s advance-care-planning document when it is needed, clinicians should use electronic health records that facilitate inclusion of these documents. The generalization of these improvements depends on legislative activity and education for clinicians about the significance of advance care planning. Each of these developments can best be accomplished through interdisciplinary teams, such as those developed within CHAT. Such teams allow attorneys to share their expertise about state law with clinicians, public health professionals, social workers, clergy, and others.332

2. Clinicians and Advance Care Planning

CHAT’s clinical participants work within a health care system committed to helping patients and patients’ surrogates understand medical options and advance care planning and to programs that guide clinicians in how best to do this.333 The Institute for Healthcare Improvement (“IHI”) delineates five “core principles” that can direct health care institutions to guide patients through conversations about end-of-life care; safeguard information discerned during those conversations; and then respect patients’ preferences “at the appropriate time.”334

IHI’s core principles harmonize with CHAT’s goals. The first principle recognizes the importance of guiding patients and their families (hopefully long before the end of life) to consider “what matters most to them about care at the end of life.”335 IHI’s second core principal—serving as a steward for information about patients’ preferences—is de-
scribed to be as fundamental as “knowing, confirming, and documenting [a patient’s] allergies.” The third principle focuses on the significance of constructing “a patient centered plan of care” and on a commitment to implementing that plan (or a transformation of it if patient preferences change over time). The fourth IHI principle advises clinicians to complement their guidance to patients in advance care planning by themselves engaging in advance care planning.

This raises some interesting questions about clinicians’ own preferences for end-of-life care. Those preferences, at least in the abstract, do not seem to differ dramatically from those of the nation’s majority. Physicians, unlike many non-physicians, however, almost all actually do refuse aggressive care when diagnosed with a terminal illness.

In 2011, Ken Murray, a California family practice physician, authored a short piece entitled How Doctors Die that went viral quickly. Doctors, Murray noted, have access to health care and know the medical options. They do not “want to die; they want to live.” Yet, they do not die “like the rest of us.”

Murray writes:

[T]hey know enough about death to know what all people fear most: dying in pain, and dying alone. They’ve talked about this with their families. They want to be sure, when the time comes, that no heroic measures will happen—that they will never experience, during their last moments on earth someone breaking their ribs in an attempt to resuscitate them with CPR (that’s what happens if CPR is done right).

Murray’s commentary strongly supports training clinicians that it is acceptable to treat patients as they, themselves, would want to be treated.

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336 Id.
337 MCCUTCHEON ADAMS ET AL., supra note 303, at 13.
338 Id.
339 Id.
340 Murray, supra note 53.
341 O’Neill, supra note 339.
342 Murray, supra note 53.
343 Id.
344 Id.
345 Responses to Ken Murray’s blog, though largely laudatory, included a few sharp comments from critics. One person, identifying himself as an ICU physician, commenting on Murray’s blog piece, took umbrage. Identified as Edward Omron, this blog commenter asserted that Murray had “maligned and insulted the field of critical care medicine” and “confuse[d] our excellent ICU care with the ethical questions of informed medical decision making, ad-
Finally, the fifth IHI principle recommends attention to culturally sensitive connections with patients:

Providers can fall short of their aim of providing patient-centered end-of-life care if they do not account for cultural influences—religious, ethnic, socioeconomic, educational, and geographic—that impact how a patient approaches end-of-life care. This area of work is vital for becoming Conversation Ready.346

These concerns suggest the need to develop training programs in advance care planning for staff at health care facilities.347 The Institute of Medicine report titled Dying in America reports that too often physicians provide inadequate end-of-life care, “fail[ing] to have compassionate and caring communication with patients and family members about what to expect and how to respond as disease progresses.”348 The consequences are unfortunate for everyone. “If end-of-life discussions were an experimental drug,” suggests Atul Gawande, “the FDA would approve it.”349

3. The Community, Advance Care Planning, and Public Health

Public health professionals and social science researchers working within CHAT350 use their training in epidemiology, biostatistics, and research methodology to assess the project’s successes and limitations (gaged, for instance, by patient satisfaction with advance care planning sessions and by surrogate and clinician satisfaction with medical care for

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346 MCCUTCHEON ADAMS ET AL., supra note 303, at 13.
347 Id. at 14. A 4-hour training program developed by the IHI focuses on these matter. For further discussion of POLST forms, see supra note 209 and accompanying text. In New York State MOLST forms serve as the equivalent to POLST forms. See id.
348 DYING IN AMERICA, supra note 44, at 16 (citation omitted).
349 GAWANDE, supra note 295, at 178.
350 Much of this work has been undertaken by students in Hofstra’s Master of Public Health program. In this work, they are supervised and directed by University professors in public health and law and by clinicians and researchers at Northwell Health (previously known as the Northshore-LIJ Health System). See supra note 309–310 and accompanying text (describing composition of CHAT program’s representatives).
incapable patients as well as by rates of hospice care utilization). Further, their training in public health administration equips them to manage a growing interdisciplinary project based at several locations and geared toward serving a large, heterogeneous population.

A focus on population health—one that complements a focus on individual health—is a crucial parameter of almost any community-wide project aimed at improving health care and health care experiences for patients and clinicians. The community in which CHAT operates is characterized by a broad socio-economic spectrum, many language groups, a variety of religions—some of which have clear positions about end-of-life care—and many racial and ethnic sub-communities. Framing responses that meet the particular needs of diverse communities within the larger community is a crucial component of the project’s work.

C. Implications for the Cost of Good Health Care?

Accusations such as Palin’s “death panel” claim in 2009—based on the presumption that advance care planning serves to ration care for the sake of cost savings—are bogus. Some commentators have argued that effective advance care planning is likely to encourage people near the end of life to consider palliative care and hospice care sooner than they otherwise might. Even if that is so—and advance care planning aims to further patients’ preferences, not to stymie them—it is a mistake blithely to assume that palliative and hospice care decrease end-of-life costs. But quite as important, hospice care at the end of life does sometimes lengthen patients’ lifespans.

There is still no unanimity of opinion among researchers or policy advocates about the consequences of advance care planning for the nation’s health care costs. In LaCrosse, advance-care-planning conversations between clinicians and patients are routine and expensive.

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351 See supra notes 233–235 and accompanying text.
352 See Amol K. Narang et al., Trends in Advance Care Planning in Patients with Cancer: Results from a National Longitudinal Survey, 1 JAMA ONCOLOGY 601, 602–07 (2015) (finding completion of durable powers of attorney did not necessarily correlate with end-of-life decisions about care, in large part because of the absence of serious conversations between patients and clinicians and surrogates and clinicians; in short, the default position, absent informative discussions, is to treat aggressively).
353 Charles F. Von Gunten et al., Why Oncologists Should Refer Patients Earlier for Hospice Care, CANCER NETWORK (Nov. 30, 2011), http://www.cancernetwork.com/end-of-life-care/why-oncologists-should-refer-patients-earlier-hospice-care (“[H]ospice care does not shorten life expectancy. For certain diagnoses, hospice enrollment is actually associated with longer survival times.”).
354 See Shapiro, supra note 289 (reporting that advance care planning conversations cost
hospitals in LaCrosse, however, also spend far less in the last two years of
patients’ lives than does any other place in the nation.355

The Institute of Medicine’s 2014 report on dying in the U.S. notes
that “[i]n the absence of adequate documented advance care planning,
the default decision is to treat a disease or condition, no matter how
hopeless or painful.”356 The report then suggests that “[b]ecause most
people who participate in effective advance care planning choose max-
imizing independence and quality of life over living longer, advance
care planning can potentially save health care costs associated with un-
necessary and unwanted interventions.”357

It may be that advance care planning will result in lower health care
costs. Some researchers, however, have suggested that it may increase
costs. One study of fee-for-service Medicare recipients residing in nurs-
ing homes in 2004 and 2009 found an increase in costs among those in
hospice care at the end of life.358 Nursing home decedents not electing
hospice in 2009 saw a mean increase in expenditures of $3,143, as com-
pared with a $9,906 increase among those electing hospice in 2009 (de-
fining increases “relative to their matched 2004 non-hospice users, for a
net adjusted increase of $6,761”).359 Some part of the increase might
have been a consequence of Medicare’s payment design.360

The landscape of hospice providers in the United States had changed, from
small not-for-profit providers to increasingly for-profit hospice chains. The
percent of persons receiving hospice care in a nursing home tripled from 14%
of Medicare decedents in 1999 to nearly 40% in 2009. Medicare pays a per-
diem rate for routine hospice care, regardless of whether services are provided,
which raises the policy concern that profit motives may be driving selective
enrollment of nursing home residents without cancer, who have longer hospice
lengths of stay.361

Whether or not hospice participation increases costs, there is pow-
erful “evidence that hospice improves the quality of care.”362 Similarly,
whether advance care planning proves ultimately to decrease or to increase the nation’s health care budget, it improves health care and serves clinicians, patients, and patients’ loved ones.

VII. CONCLUSION

By the early nineteenth century, modernity had ushered in an age that was displacing religions’ role in defining and monitoring society’s most fundamental values and beliefs with secular truths, often identified by science, analyzed by philosophy and its cousin disciplines among the humanities, and regulated by a civil polity increasingly committed to autonomous individuality and dependent on the presumption of consensus rule making. Those changes reset the social axis in terms of which people understood themselves and their world. The consequences were revolutionary.

Almost inevitably new visions of death emerged—or more accurately, new options for dying largely encompassed visions of death. These changes were evident even before technological developments facilitated understandings of dying as a process that could ward off death for long periods.363 Almost no one expressly refuted the inevitability of death—at least not until recently.364 But beginning in the middle decades of the twentieth century, advances in medicine and technology made it possible to hold death at bay with life-sustaining treatments for months or even years.365

Over time it became clear to many, including the clinicians and loved ones of dying patients that far less was being gained than had once been imagined by the prolongation of the dying process. Yet, requests to withhold or withdraw life-sustaining care were met with resistance in cases in which those requests were made by surrogates for terminal and permanently vegetative patients without capacity. State legislatures responded by providing for advance directives that facilitated the appointment of a surrogate and provided for the delineation of medical preferences by capable adults contemplating the need for medical deci-

363 See supra notes 29–33 and accompanying text.
365 See supra Part III.B.
sions complicated by the loss of capacity.\textsuperscript{366}

Yet, legal provision for advance care planning has not adequately encouraged people to engage in the process. Almost all (about 90\%) of Americans say they hope to die at home.\textsuperscript{367} Yet, only about one-third of Medicare recipients (65 and older) do die at home.\textsuperscript{368} Many people never complete advance directives.\textsuperscript{369} Furthermore, successful advance care planning—planning that serves the once-competent patient as well as his or her surrogates and clinicians—depends both on completion of advance directives and on honest conversations—sometimes more than a few conversations\textsuperscript{370}—with potential surrogates and clinicians.

Changes in federal and state law can facilitate this. Insurers, including government insurers, should cover periodic and episodic advance-care-planning conversations between clinicians and patients for all adults.\textsuperscript{371} Additionally, state laws should require clinicians to offer to engage in conversations with patients about advance care planning. The conversations should not be mandatory, but clinicians should be encouraged to suggest to patients the usefulness of such conversations at least once every five years (and more frequently if a patient’s health status changes). Further, all adults should be encouraged (by lawyers, clinicians, and public health experts) to engage in serious conversations about medical preferences with potential surrogates and with their primary care clinician as well as others involved in their health care. Excellent models for beginning and carrying out these conversations are available.\textsuperscript{372}

Dying should not be prolonged simply because it can be. This is ever the more compelling for patients who may be in pain, even though not capable of entertaining their own medical decisions. Patients who,

\textsuperscript{366} See supra Part IV.B.
\textsuperscript{368} Id.
\textsuperscript{369} Id. African-Americans and Hispanics complete advance directives less often than whites; those in lower-income groups and with less education also complete advance directives less often than people with more money and/or more education. Id.
\textsuperscript{370} Some patients need to engage in repeated conversations with clinicians about advance care planning before they understand the issues and can knowledgably offer personal responses. See 10 FAQs, supra note 367.
\textsuperscript{371} These conversations should be covered for older, sick children as well. The complexities of pediatric decision making, even for older adolescents, however, are beyond the scope of this Article.
\textsuperscript{372} See supra Part VI.
while capable, would have chosen to discontinue life-sustaining care should have that choice made for them after they lose capacity to make it for themselves. And surrogates and clinicians, working together, should have the solace of knowing, and the authority to act in accord with, the pre-incompetency medical wishes of the patients for whom they are making decisions—whether those wishes suggest that care should be discontinued or that specific sorts of care should be provided.

Interdisciplinary efforts to review, improve, and develop advance-care-planning tools will encourage improvements in existing laws, support clinicians who are ready to engage in advance-care-planning conversations with their patients, and encourage everyone to “CHAT” with his or her clinicians and with potential surrogate decision makers. These developments are extraordinarily important in and of themselves. They also provide models of good health care.
EVERYTHING OLD IS NEW AGAIN: WILL NARROW NETWORKS SUCCEED WHERE HMOs FAILED?

Deborah Farringer*

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If history repeats itself, and the unexpected always happens, how

* Deborah R. Farringer is an Assistant Professor of Law at Belmont University College of Law in Nashville, TN. J.D., Vanderbilt University Law School; B.A. University of San Diego. I would like to thank my research assistants Eli Gibbons, Lauren Walker, and Caitlin Patenaude for all of their work and assistance in connection with this article. Thanks also to Nicholas Lombard and his excellent editorial staff at Quinnipiac Law Review for their insightful and helpful comments and edits to this piece. Finally, thank you to my husband and children for their patience with me through this process.
In much the same way that the phrase “Read my lips: no new taxes” will forever be associated with President George H.W. Bush and his notorious campaign promise, few phrases from President Barack Obama’s national tour promoting health care reform will be remembered like “. . . if you like your health care plan, you keep your health care plan. Nobody is going to force you to leave your health care plan. If you like your doctor, you keep seeing your doctor.” Just as critics harangued Bush when he raised taxes two years after his then-famous speech, critics vilified Obama for his 2009 statement when, three years following the enactment of the Patient Protection and Affordable Care

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2 Bush was elected following the speech he made at the Republican National Convention. Two years after his election, with a struggling economy, a large military presence in Saudi Arabia, and a Democratic Congress, he reneged on his earlier promise and signed a budget that included raising taxes. See Ken Blackwell & Bob Morrison, Broken Promises/Broken Presidencies, HUFFINGTON POST (Nov. 4, 2013), http://www.huffingtonpost.com/ken-blackwell/broken-promisesbroken-pre_b_4181566.html.


5 The phrase quoted above was named by PolitiFact as the 2013 Lie of the Year, stating that President Obama’s description was an oversimplification of this complex law and the promise became too sweeping. Angie Drobnic Holan, Lie of the Year: ‘If you like your health care plan, you can keep it,’ POLITIFACT (Dec. 12, 2013), http://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/. President Obama later clarified his comments, stating that the ACA does in fact allow individuals to stay on their existing plans, but also requires that to the extent that an insurer wants to make changes to its plan(s), such plans must meet certain minimum quality standards to ensure the individuals do not just have insurance, but have sufficient insurance. See Barack Obama, U.S. President, Remarks by the President to ACA Coalition Partners and Supporters (Nov. 4, 2013) (transcript available at http://www.whitehouse.gov/the-press-office/2013/11/04/remarks-president-aca-coalition-partners-and-supporters).
Act ("ACA"), anywhere from 2.5 to 4 million individuals had their health plans cancelled due to insurance requirements under the ACA. Now, as the ACA enters its fifth year, critics are vocal again as more and more health plans are creating networks that limit the number of physicians and providers who are participating in the plans, thereby forcing individuals to choose new doctors when purchasing certain health plans.

Highlighting this problem were stories such as that of the Blank family. The Blank family resided in Washington state and sought to purchase insurance on their state health insurance exchange after their insurance policy was cancelled in 2013 for failure to provide certain mandated benefits. The Blanks soon discovered, however, that their daughter Zoe’s current health care provider, Seattle Children’s Hospital ("SCH"), was not offered as an in-network provider on any of the available health plan options on the state exchange. While perhaps not a problem for many, the Blank’s daughter, Zoe, has a rare bone condition and requires specialty care, which she historically had received at SCH. For the Blanks, they were forced to decide between affordable

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10. See id.
11. Id.
insurance that would not provide access to Zoe’s specialists or forego needed subsidies in order to find insurance that would assure Zoe access to certain doctors.¹²

As more stories and situations like those of the Blank family emerge, industry observers are noting what appears to be a new reality for insurance plans in the age of health care reform.¹³ As health insurers try to navigate the new limitations set forth under the ACA, including prohibitions on denying individuals with pre-existing conditions and limitations on the rating of patients,¹⁴ insurers are looking towards models that will enable them to control costs without access to their usual tools.¹⁵ What they have developed is not so much a new insurance model, but actually a concept that first arose during the rise of managed care; that is, limited provider networks utilized within health maintenance organizations (“HMOs”).¹⁶ These “new” insurance products, often referred to as narrow networks or high-performance networks,¹⁷ offer benefici-

¹² See id. (noting that to the extent SCH was not included on the insurance plans available on the insurance exchange, the Blanks will either have to purchase insurance outside the exchange offerings or consider a job change that would enable Mr. Blank to have employer coverage that would include SCH).


¹⁵ “Rating” is a process that insurers engage in to determine risk levels of certain individuals. Historically, health insurers would “rate” patients by a number of factors including previous medical history, family medical history, age, gender, tobacco use, and other health-related factors for purposes of purchasing insurance. Insurers would then use this rating to either deny coverage altogether or, alternatively, charge individuals substantially higher premiums. See BARRY R. FURROW ET AL., THE LAW OF HEALTHCARE ORGANIZATION AND FINANCE 271–72 (7th ed. 2013).

¹⁶ See Jose L. Gonzalez, A Managed Care Organization’s Medical Malpractice Liability for Denial of Care: The Lost World, 35 HOUS. L. REV. 715, 729 (1998). While HMOs actually date back to the 1920s, they became more popular in the late 1970s and experienced even greater popularity during the mid to late 1980s. Id. (citing Vernellia R. Randall, Managed Care Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries, 17 U. PUGET SOUND L. REV. 1, 21 & n.82 (1993)) (noting that the number of individuals enrolled in an HMO went from 13 million enrollees in 1980 to 31 million by 1988).

¹⁷ NOAM BAUMAN ET AL., MCKINSEY & CO., MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, HOSPITAL NETWORKS: UPDATED NATIONAL VIEW OF CONFIGURATIONS ON THE EXCHANGES (June 2014), http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-
ies a more limited network of physicians typically in exchange for lower premiums. These insurance plans are becoming increasingly common both on the federal and state health insurance exchanges as well as in insurance product offerings outside the exchanges. As these limited provider networks become more prevalent, there is evidence of a number of similarities between the narrow networks of today and the HMOs that increased in popularity during the 1980s and 1990s.

But, if narrow networks are in fact simply a redux of HMOs, can it be surmised that narrow networks are likely be a short-lived trend? Will narrow networks fall into disfavor and suffer the same consumer backlash and financial challenges as the HMOs of twenty-plus years ago? Or, is there something unique and distinct about the narrow networks arising in the current health insurance market that will create greater longevity for these insurance products that was not achievable with HMOs, despite their similarities? This article argues that the narrow networks that have emerged in the current healthcare marketplace are indeed unique and distinct from their HMO predecessors and, because of such distinctions, appear poised to experience greater success and longevity than HMOs.

Part II of this article will examine the history of limited provider organizations, specifically HMOs, including their rapid rise and then subsequent descent into disfavor with consumers and providers alike. It will then review the movement back towards limited provider networks, defining what constitutes a narrow network and highlighting current prevalence of these products on the insurance market.

Part III will then review the existing legal structure (much of which
arose during the time of HMOs) surrounding narrow networks, including examination of a few recent lawsuits against insurers under both federal and state law and the state and federal statutes designed to protect both providers and consumers. This Part will identify some of the challenges for providers and consumers with the existing legal structure in connection with taking action against limited provider networks.

Next, Part IV will consider the advantages and disadvantages of narrow networks and forecast the potential outlook for narrow networks based on such factors. Part IV will also examine the current activities of certain “high-cost providers,” such as academic medical centers, to create their own alternative networks or alternative product offerings, and what impact such activities might have on the sustainability of narrow networks.

Finally, in Part V, this article will conclude that narrow networks are likely to realize more sustained longevity and success than their HMO predecessors because of the following three distinctions between narrow networks and HMOs: (a) unlike HMOs, narrow networks, especially those offered on federal and state health insurance exchanges, are consumer-driven products, responding to a specific need for insurance offerings at a lower cost; (b) existing laws in place to protect against potential ills of limited provider networks are either too narrowly focused on HMOs or too discretionary for consistent application and enforcement against modern narrow network products; and (c) so long as large and influential high-cost providers continue to create alternative structures rather than fight exclusion from narrow networks, there is a greater likelihood of a co-existence of both narrow networks and alternative networks (which cater to different segments of the population) and thus greater longevity of narrow networks.

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21 See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 421 (1997) (noting that HMOs were marketed to and largely purchased by large employers and government entities, not individual consumers).

22 While transparency is still an issue in terms of communication from insurers to consumers regarding insurance products (discussed in more detail below), an online exchange in which consumers can compare insurance options side-by-side and compare premiums provides greater transparency than the previous small group and individual insurance markets of the past. Karen Pollitz & Larry Levitt, Health Insurance Transparency under the Affordable Care Act, HENRY J. KAISER FAM. FOUND. (Mar. 8, 2012), http://kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/ (last visited Sept. 1, 2015).

23 It is acknowledged that a consumer-driven response to the need for these high-cost providers in their networks could arise, but such challenges could be more dubious in terms of success without support of the high-cost providers themselves.

24 While it is outside the scope of this article, for a discussion of the potential ethical issues created by the possibility of a system in which narrow networks and other alternative
II. HISTORY OF LIMITED PROVIDER NETWORKS: PRECURSORS TO NARROW NETWORKS

As narrow networks have increasingly started to generate headlines, both proponents and critics note that networks limiting or restricting the selection of providers are not new in the health care industry.\(^{25}\) One of the first examples of a limited provider network was the HMO.\(^ {26} \) HMOs are generally defined as an entity that limits its members to “an exclusive network of providers, permitting their member to go to non-network providers only in special circumstances, like medical emergencies.”\(^ {27} \) While HMOs can vary in their structure and organization, HMOs are typically associated with a payment scheme in which the network providers are paid a “capitated” monthly rate—a flat-fee per month for each beneficiary/enrollee\(^ {28} \) of the HMO—regardless of the cost of services provided to such beneficiary during the particular month.\(^ {29} \) In fact, many state laws include capitation payment as part of the definition of an HMO.\(^ {30} \) Thus, an entity that restricts its enrollees to receiving care from


\(^{26}\) See *Furrow et al.*, supra note 15, at 268.

\(^{27}\) The terms “beneficiary” and “enrollee” mean individuals who are enrolled in or a beneficiary of a health plan. The terms are often used interchangeably when addressing individuals who have purchased health insurance and, for purposes of this article, such terms have the same meaning.

\(^{28}\) See *Furrow et al.*, supra note 15, at 314 (defining capitation and stating that under this model “the provider becomes the true insurer – i.e. risk bearer – with respect to the patient”).

\(^{29}\) See, e.g., TENN. CODE ANN. § 56-32-102(8) (West 2015) (requiring that services are paid on a prepaid basis); N.Y. PUB. HEALTH LAW § 4401(2) (McKinney 2013) (defining an HMO plan as one in which the enrolled member is entitled to services “in consideration for a basis advance or periodic charge”); KY. REV. STAT. ANN. § 304.38-030(5) (West 2010) (defining HMO as undertaking to provide services that are paid “on a per capita or a predeter-
a specific limited set of providers may nevertheless fail to qualify as an HMO so long as it does not reimburse such providers on a capitated or prepaid basis.\textsuperscript{31}

The concept of the HMO first developed in the 1920s with the development of pre-paid group practice health plans.\textsuperscript{32} Because of views by the American Medical Association (“AMA”) that such prepaid plans were akin to “communism,” there was little wide-spread adoption of HMOs until the 1970s.\textsuperscript{33} HMOs moved into more wide-spread acceptance in the 1970s when the United States Congress enacted a law requiring employers with more than twenty-five employees to offer their employees at least one federally-qualified HMO.\textsuperscript{34} Following this legislation, HMOs saw an increase not only in the number of enrollees electing HMOs, but also the number of entities organizing as HMOs.\textsuperscript{35}

Just as HMOs began to hit their stride, however, they came under fire by consumer advocates and other disgruntled employees due to the lack of consumer choice regarding providers and care.\textsuperscript{36} Part of this
angst was fueled by stories from the media about the “horrors” of HMOs. An investigative reporter for the New York Post published a series of articles titled “What You Don’t Know About HMOs Could Kill You,” featuring stories of managed care companies that made promises to consumers in their promotional materials, only to fail to deliver the care when the policy holders became ill. The stories were shocking to consumers, complete with pictures of victims, including one of a dead baby and the baby’s grieving parents, and one of a woman who was denied a badly needed spinal surgery. One article told the story of Tom Kerwin who saw his primary care physician through Health Insurance Plan of Greater New York (“HIP”), then one of the largest HMOs in the area. Mr. Kerwin was told he had a common cold, but continued to get sicker and sicker. Finally, Mr. Kerwin went to an out-of-network physician, who did some blood tests and promptly sent Mr. Kerwin to the hospital following a diagnosis of hepatitis. Mr. Kerwin was at NYU Medical Center for one month, but his insurer, HIP, refused to pay for the services, presumably because he received his diagnosis from an out-of-network physician. Many stories such as these were circulated during the mid to late-1990s regarding some of the issues that enrollees faced in connection with their HMOs, including denial of necessary services, high medical bills for receiving services from out-of-network providers, and delayed services due to limitation in the network.

See supra note 37 and accompanying text; see also Cathy Burke, Dying Woman Denied Doc She Needs, N.Y. POST, Sept. 21, 1995, at 5 (sharing the story of a 30-year old wom-
Around the same time, some of the new plans that appeared during the HMO boom began to experience financial difficulties. In fact, a sister organization of HIP, Health Insurance Plan of New Jersey (“HIP-NJ”) collapsed about a year after the exposé in the *New York Post*, citing various reasons including poor management, increased competition, and too little financing in the face of the increased competition in the HMO field. Director of the Standard & Poor’s health industry unit stated at the time, “All over the country, the solvency guidelines are a joke and we have found that one-third of the H.M.O. companies do not have adequate capital. It’s like treating managed care as if it has the same risk characteristics as selling Coca-Cola.” As new HMOs flooded the market, insurers would try to control costs by driving down prices paid to providers, but the resulting competition forced many of these newly formed organizations into financial ruin, rendering many insolvent.

an whose HMO, Health Insurance Plan of New Jersey, refused to authorize anyone other than its own neurosurgeon to perform a delicate tumor procedure even though he had never done a similar surgery before and the woman’s physician had done the surgery over 500 times); William Sherman, *Mom Recalls How Baby Died as She Pleased for Help*, *N.Y. Post*, Sept. 18, 1995, at 4 (telling the story of a baby whose heart condition was not diagnosed timely following a discharge from the hospital just one day after discharge per requirements of the family’s HMO plan); William Sherman, *Ex-New Yorker is Told: Get Castrated so we can Save*, *N.Y. Post*, Sept. 18, 1995, at 5 (telling the story of a 76-year old man who was told by his HMO that rather than take the physician-prescribed medication to keep his prostate cancer at bay he should undergo castration as a “cost effective” alternative to the costly medication). The articles from September 1995 were part of a series titled *HMOs: What you don’t know can kill you.*

45 See Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1246 (1997); see also Wayne Guglielmo, *The HMO Graveyard: What Caused the Biggest Failure Yet*, MED. ECON. (Oct. 25, 1999), http://medicaleconomics.modernmedicine.com/medical-economics/content/hmo-graveyard-what-caused-biggest-failure-yet?page=full (“[T]he Florida-based Weiss Ratings, an insurance rating agency, recently ranked 576 of the nation’s HMOs on their fiscal solvency. One hundred [of those ranked] failed to make the grade.”). New Jersey Citizen Action’s Anthony Wright stated, “For many HMOs, it has become harder and harder to achieve the savings they once sought. Companies that aren’t especially well managed will fail.” *Id.* Guglielmo noted that one possible solution to the HMO solvency problem might be a “Darwinian struggle—with stronger companies muscling aside or taking over weaker ones.” *Id.*


47 *Id.* Part of the issue highlighted in the article was one of HIP-NJ’s former partners, Pinnacle Health Enterprises, who was in the midst of bankruptcy liquidation proceedings and had been acquiring most of HIP’s assets; when the state asked Pinnacle Health Enterprises to put up a large cash reserve in order to assure continued care of its insureds, Pinnacle refused, as they were not subject to state regulation. *Id.*

48 See Guglielmo, *supra* note 45; see also James B. Ross & Criss Woodruff, *Analysis of
To guard against these insolvencies, and the risks that many consumers’ claims would go unpaid, states began enacting laws in the 1990s designed to protect states and consumers from HMO financial instability and from the ill effects of cost-cutting measures, like those highlighted by the *New York Post*. Model legislation known as the Model HMO Act swept through the states, resulting in forty-seven states enacting some sort of HMO legislation to govern the operation and requirements for HMOs. In addition to extensive provisions protecting providers and consumers against insolvency, there were provisions that protected consumers from denials of payment for care at out-of-network providers and other aspects of HMO management that enabled HMOs to put cost savings before coverage for services. Thus,

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49 To the extent that the HMO was unable to pay a claim to a provider for services rendered, the provider would then seek payment from the consumer for unpaid medical claims. See John C. Van Gieson, *Lawmakers Tackle HMO Problem*, ORLANDO SENTINEL (May 8, 1988), http://articles.orlandosentinel.com/1988-05-08/business/0040050042_1_hmo-gunter-subscribers (noting lobbying efforts with state legislatures intending advocating for subscribers of bankrupt HMOs who are targeted for collection). Many states enacted balance billing laws in order to protect against patients from having to be responsible for HMO insolvency. Balance billing is when a health care provider seeks payment from the patient for the difference between the amount the provider charges and the amount that the insurer reimburses the provider for the service. *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAM. FOUND. (2013), http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/. Forty-nine states and the District of Columbia prohibit HMOs from balance billing patients for services provided by in-network providers. Id. Notably, only thirteen of the states have the same restrictions for out-of-network providers. Id.


51 Developed by the National Association of Insurance Commissioners (“NAIC”), the HMO Model Act, among other things, required HMOs to seek a certificate of operation and further contained certain network requirements to protect against insolvency See *HEALTH MAINT. ORG. MODEL ACT § 1 et seq. (NAT’L ASS’N OF INS. COMM’RS 2003).* http://www.naic.org/store/free/MDL-430.pdf.

52 Note that District of Columbia, Hawaii, Oregon, and Wisconsin did not adopt the Model HMO Act, but have similar laws in each of those jurisdictions that govern HMOs (like those governing insurance companies). See Howard, supra note 50, at 95.

53 See *HEALTH MAINT. ORG. MODEL ACT §§ 8, 13–14, 16, 18–19* (requiring, for example, (1) certain net worth amounts; (2) minimum deposit; (3) hold-harmless clause be contained in all contracts between providers and enrollees from HMO debts; (4) assurances regarding continuation of services in event of insolvency; and (5) minimum notice requirements for cancellation of policies).

54 See *HEALTH MAINT. ORG. MODEL ACT §§ 8–9, 13* (requiring each enrollee have a contract within thirty days of enrollment, contract terms be fair and not misleading or decep-
with new regulations enacted, declining market acceptance, and increased insolvency, HMOs began to decline in the early 2000s.\footnote{55 CTRS. FOR MEDICARE AND MEDICAID SERVS., OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING AND EVALUATION, AN OVERVIEW OF THE U.S. HEALTH CARE SYSTEM CHART BOOK 26 tbl.1.18 (Jan. 31, 2007), http://www.slideshare.net/johnny1090/HealthCareChartBook01312007.}

\section*{A. Movement Towards Narrow Networks}

As HMOs began to fall out of favor, preferred provider organizations (“PPOs”\footnote{56 A PPO is a system of “health care providers who agree to provide services on a discounted basis to subscribers.” FURROW ET AL., supra note 15, at 269. A PPO does not typically limit its subscribers to seeing in-plan providers, but out-of-network providers may cost the subscriber more in out-of-pocket expenses. Id.})\footnote{57 See Robert E. Hurley et al., The Puzzling Popularity of the PPO, 23 HEALTH AFF., no. 2, Mar. 2004, at 56--68, http://content.healthaffairs.org/content/23/2/56.full.html.} began to emerge as the dominant managed care plan for group plan insurance.\footnote{58 Id. at 56 (noting that “more than 100 million people[,] now receive their care through [PPO] arrangements, far surpassing enrollment in health maintenance organizations”).} Towards the early to mid-2000s, the PPO became the “health benefit design of choice for private employers and consumers.”\footnote{59 See id.} Many cite the rise in popularity of the PPO over the years as being a result of the reaction and backlash towards the restrictive and limiting HMO products.\footnote{60 See id. at 56–57.} For example, the PPO provides nearly an unlimited choice of providers (although at differing costs) for consumers and fewer risks to providers based on a fee-for-service reimbursement structure.\footnote{61 See GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 2, 77 ex.5.1 (2014).} This popularity for PPOs has remained true for the last decade.\footnote{62 Id. at 70. It should be noted that 85% of all firms surveyed offer only one type of health plan. Small firms (3–199 workers) were most likely to offer only one plan at 86%, whereas only 56% of all large firms (200 or more workers) offered only one plan. Id. at 71 ex.4.1.} The Kaiser Employer Health Benefits 2014 Annual Survey noted that 77% of employees with health insurance provided by their employers work in firms that offer one or more PPO plans\footnote{63 Id. at 73 ex.4.3.} and 55% of all firms offer a PPO plan (with 73% of large firms (200 or more workers) offering a PPO plan).\footnote{64 See id. at 56–57.} While PPOs have been a popular offering, the rise in the prevalence of PPOs has come in a decade where health care...
costs have also been soaring nationally. Many believe that the reimbursement mechanisms and structure of PPOs have been contributing factors to such run-away spending, thus leading to the need for reforms under the ACA in 2010. Thus, rising health care costs and some of the changes to the insurance marketplace that have come about as a result of the ACA have led the insurance industry to revisit the idea of limited provider networks akin to HMOs.

As the name implies, a narrow network is generally a health insurance plan that incentivizes or requires its beneficiaries or subscribers to use a limited number of physicians, hospitals, or other providers. McKinsey & Company has categorized narrow networks into three types (collectively, “Narrow Networks”): (a) narrow network—approximately 31% to 70% of hospitals participating in the network; (b) ultra-narrow network—less than 30% of the hospitals participating in the network; and (c) tiered network—hospitals are listed in tiers, with different co-payment requirements depending on the tier in which the hospital is listed. Because of an increasing emphasis on quality, cost, and efficiency of care, Narrow Networks are also sometimes referred to as “high performance networks.”

Narrow Networks represent approximately 48% of all federal and state exchange networks in the United States and an even larger percentage (60%) of exchange networks in the largest city in each state. This finding is likely due, in part, to the manner in which a Narrow Network is defined. Because a Narrow Network must exclude, by definition, approximately 30% of the hospitals in a given area, a Narrow Network option is simply not possible in certain geographic areas of the country.

64 See Hurley, supra note 57, at 64–65 (“Thus, it does not appear that PPO arrangements have played much of a role in cost containment despite the fact that more than half of all commercially covered lives are in PPOs. What they do seem to deliver is cost displacement by moving costs from employer-sponsors to individuals, which, nonetheless, has the real effect of moderating the rate of increase in employers’ contributions for benefits.”).
65 See id.; see also Cathy Schoen et al., Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System, COMMONWEALTH FUND (Jan. 10, 2013), http://www.commonwealthfund.org/publications/fund-reports/2013/jan/confronting-costs (noting some possible reforms to reimbursement to combat runaway health care spending).
66 BAUMAN ET AL., supra note 17, at 2.
67 See EGGEBER & MORRIS, supra note 13, at 1.
68 BAUMAN ET AL., supra note 17, at 4.
69 See Bob Semro, Narrowing Provider Networks Is All About Cutting Costs, But It Also Can Lead to Lower Premiums, HUFFINGTON POST (Oct. 3, 2014), http://www.huffingtonpost.com/bob-semro/narrowing-provider-network_b_5928554.html (“In rural areas, where provider competition can be limited, narrower networks will be much harder to create. For example, one insurer in Colorado intends to maintain its broad networks in

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64 See Hurley, supra note 57, at 64–65 (“Thus, it does not appear that PPO arrangements have played much of a role in cost containment despite the fact that more than half of all commercially covered lives are in PPOs. What they do seem to deliver is cost displacement by moving costs from employer-sponsors to individuals, which, nonetheless, has the real effect of moderating the rate of increase in employers’ contributions for benefits.”).
65 See id.; see also Cathy Schoen et al., Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System, COMMONWEALTH FUND (Jan. 10, 2013), http://www.commonwealthfund.org/publications/fund-reports/2013/jan/confronting-costs (noting some possible reforms to reimbursement to combat runaway health care spending).
66 BAUMAN ET AL., supra note 17, at 2.
67 See EGGEBER & MORRIS, supra note 13, at 1.
68 BAUMAN ET AL., supra note 17, at 4.
69 See Bob Semro, Narrowing Provider Networks Is All About Cutting Costs, But It Also Can Lead to Lower Premiums, HUFFINGTON POST (Oct. 3, 2014), http://www.huffingtonpost.com/bob-semro/narrowing-provider-network_b_5928554.html (“In rural areas, where provider competition can be limited, narrower networks will be much harder to create. For example, one insurer in Colorado intends to maintain its broad networks in
While quite prevalent on the federal and state exchanges, Narrow Networks have also seen some growth in insurance plan offerings of large employers.70 According to the Kaiser Family Foundation, from 2007 to 2014 the percentage of employers whose largest plan included a Narrow Network increased 4% (from 15% in 2007 to 19% in 2014).71 The highest prevalence of Narrow Network options for employers is in the Northeast, where 27% of employers’ largest plan includes a Narrow Network.72 Conversely, employers with their largest plan including a Narrow Network plan actually decreased for employers in the Midwest to only 8% of employers in 2014, from a high of 17% in 2010.73 For those employers that do offer a Narrow Network as their largest plan, 59% reported that both quality and cost/efficiency were criteria in their decision to offer the network.74

Despite some increases, employers still remain somewhat cautious of Narrow Network options, with only 6% of employers with 50 or more employees reporting that they believe Narrow Networks will be an effective cost containment strategy.75 One phenomenon emerging in the large employer market that may impact plan selection and plan offerings is employers offering benefits through a “private exchange.” A “private exchange,” created most commonly by a consultant or insurer, allows employees to choose between various health benefit options, often times coupled with a defined contribution.76 While it is estimated that only 2% of large employers utilized a private exchange in 2014 (including notables such as Walgreen’s, Sears, and DineEquity), 13% are considering

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70 See CLAXTON ET AL., supra note 61, at 220 ex.14.5.
71 Id. It should be noted that the increase from 2007 to 2013 was an 8% increase from 15% to 23%. Overall the statistics from 2013 to 2014 were noted to not be statistically significant. Id.
72 Id.
73 CLAXTON ET AL., supra note 61, at 220 ex.14.5 (noting the following percentages: 13% in 2007, 17% in 2010, 12% in 2011, 15% in 2013, and 8% in 2014).
74 Id. at 221 ex.14.6. It should be noted that when broken down between cost/efficiency vs. quality, only 3% of employers noted that they were choosing Narrow Networks for quality reasons whereas 33% of employers noted they were choosing the network for cost/efficiency purposes. Id.
75 Id. at 7.
76 CLAXTON ET AL., supra note 61, at 7–8; see also ALEX ALVARADO ET AL., KAISER FAMILY FOUND., EXAMINING PRIVATE EXCHANGES IN THE EMPLOYER-Sponsored INSURANCE MARKET (Sept. 2014), http://files.kff.org/attachment/examining-private-exchanges-in-the-employer-sponsored-insurance-market-report. A defined benefit contribution is where the employer pays the employee a fixed amount of money per month towards health and ancillary benefits (e.g., $300) and then the employee is responsible for paying any difference between the defined benefit (e.g., $300) and the total cost for which the employee is responsible (e.g., $600). Id. at 1.
offering benefits through an exchange and such exchanges are expected to have significant growth, with some projecting that nearly 40 million individuals will purchase insurance through private exchanges by 2018.77

Employees purchasing through a private exchange are making choices regarding health insurance in much the same way as individuals purchasing insurance on a federal or state exchange.78 To the extent that an employee can compare a variety of insurance options, including the associated premiums, that individual is more likely to make a selection based on premium costs than in a situation where the employee can only select one option or can only choose between two different types of plans (e.g., PPO vs. HMO).79 With the projected growth of private exchanges and the continued use of federal and state insurance networks, increases in Narrow Network offerings may not be spurred solely by insurers in an effort to control costs, but also in reaction to an increasing demand on the part of consumers who, when able to compare and contrast plans, desire to purchase insurance that is more cost effective.80 Thus, unlike HMOs, which were focused on cost containment for employers and government entities, Narrow Networks are responding to a specific consumer demand through federal and state exchanges and potentially through the emergence of private exchanges.

III. LEGAL RESTRICTIONS ON NARROW NETWORKS

The recent re-emergence of Narrow Networks has revealed that consumers and providers still remain relatively skeptical of networks that limit provider choice.81 Thus, determining whether Narrow Networks will experience more sustained success than HMOs will be greatly impacted by the current legal structure and potential legal challenges.

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77 See ALVARADO ET AL., supra note 76, at 2–4.
79 This is especially true since the enactment of the ACA. With individuals facing the possibility of penalties for failure to maintain health insurance and regulations imposed on employers to prevent individuals from abandoning employer coverage due to costs, individuals are less likely to simply forego employer-sponsored coverage. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1501, 1511, 124 Stat. 119, 244, 252 (2010).
80 See Semro, supra note 69.
to these types of organizations.

A. ACA Compliance Challenges

Since the launch of the health care insurance exchange in 2014, two major lawsuits have been filed in response to the formation and operation of Narrow Networks. On October 4, 2013, Seattle Children’s Hospital (“SCH”) filed a lawsuit against the Washington State Insurance Commissioner, alleging violations of the ACA related to exclusion of SCH as an in-network provider from nearly all insurers participating in Washington state’s health care insurance exchange, Washington Healthplanfinder.\(^\text{82}\) Specifically, SCH argued that: (a) the ACA requires that all “qualified health plans” included in Washington Healthplanfinder are required to include ten “essential health benefits” and “essential community providers”;\(^\text{83}\) (b) included in the definition of “essential health benefits” are “pediatric services, including oral and vision care”,\(^\text{84}\) (c) included in the definition of “essential community providers” is “community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in [42 U.S.C. § 256b(a)(4)],”\(^\text{85}\) which definition includes “[a] children’s hospital excluded from the Medicare prospective payment system”;\(^\text{86}\) (d) SCH meets the definition of both providing “essential health benefits” and is an “essential community provider” under the ACA;\(^\text{87}\) and therefore (e) the Washington State Office of the Insurance Commissioner is required to include SCH in each of its qualified health plans on the insurance exchange due to requirements under the ACA.\(^\text{88}\)

As a result of this improper exclusion, SCH officials argued that families enrolling in the plans will face significantly higher cost-sharing amounts in order to receive care at SCH as opposed to other hospitals that were

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\(^\text{84}\) 42 U.S.C. § 18022(b)(1).

\(^\text{85}\) Id. § 18031(c)(1).

\(^\text{86}\) Id. § 256b(a)(4)(M).

\(^\text{87}\) SCH Petition for Review, supra note 83, at 5.

\(^\text{88}\) Id.
considered in-network for the plans.\textsuperscript{89} About a month after SCH filed its lawsuit, \textit{The Washington Post} ran its story about the Blank family, highlighting the difficulty of maintaining the right balance of access to care and cost control.\textsuperscript{90}

From the perspective of the insurance companies and the Office of the Insurance Commissioner, including high-cost providers like SCH as an in-network provider can be extremely costly under the current reimbursement structure.\textsuperscript{91} SCH, and other academic medical centers (“AMCs”), typically have a much higher overhead due to the highly specialized services they provide.\textsuperscript{92} Specialty services typically require more expensive medical equipment and more medical testing and diagnostic capabilities, as well as additional costs associated with teaching and training of residents and medical students.\textsuperscript{93} Because of the higher prices associated with specialty providers, networks that include such providers typically charge consumers higher premiums than networks including less costly and less specialized providers.\textsuperscript{94} Thus, in the case of SCH, the Office of the Insurance Commissioner has an interest in assuring that the insurance offerings on the exchange are affordable to consumers and insurers on the exchange have an interest in assuring that they have a product that will be appropriately competitive in terms of quality and price with other insurance offerings in the marketplace.\textsuperscript{95}

\textsuperscript{89} Id. at 4.
\textsuperscript{90} See Somashekhar & Cha, supra note 9.
\textsuperscript{91} Id. (noting that a pediatric appendectomy at SCH costs about $23,000, while at another community hospital, the cost is closer to $14,200).
\textsuperscript{92} See generally John A. Kastor, \textit{Accountable Care Organizations at Academic Medical Centers}, 364 NEW ENGL. J. MED. e11(1) (Feb. 17, 2011).
\textsuperscript{93} See \textit{ASSOCIATED PRESS}, Mayo’s Dominance Skews Health Insurance Exchange in SE Minnesota, TWINCITIES.COM (Oct. 28, 2013), http://www.twincities.com/localnews/ci_24405205/mayos-dominance-skews-health-insurance-exchange-southeastern-minnesota (noting that Mayo Clinic’s costs are higher on average than other non-academic settings, thus increasing premiums of exchange plan offerings in the Rochester area); see also Kastor, supra note 92, at e11(2) (“The supervision and teaching of trainees, whether in the hospital or in an outpatient clinic, take time, and time costs money.”).
\textsuperscript{94} See \textit{ASSOCIATED PRESS}, supra note 93.
\textsuperscript{95} Bridgespan Health Company explained its position that it met network adequacy rules under state and federal law when it stated:

Consistent with the emphasis on consumer access, the state network adequacy rule allows for an adequate carrier network even where “the health carrier has an absence of or insufficient number or type of participating providers or facilities to provide a particular covered health care service,” provided the carrier ensures “the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities . . . .” BridgeSpan Health Co.’s Memorandum, Seattle Children’s Hospital’s Appeal of OIC’s Ap-
Therefore, the Insurance Commissioner and insurers both argued that including high cost providers like SCH thwarts each party’s efforts to provide necessary coverage on the exchange.96

It is difficult to glean what the outcome would have been in connection with this case. Following an administrative law judge’s order denying the State of Washington’s motion to dismiss, and ordering a hearing regarding whether the Office of the Insurance Commissioner was in fact complying with the ACA,97 SCH settled the case against the insurers and the commissioner when each of the insurers elected to include SCH as an in-network provider in its exchange offerings.98 While SCH could not confirm at the time that the settlement meant that SCH was in all of the network offerings on Washington Healthfinder, an SCH spokesperson, Stacey Dinuzzo, did state, “we know we are in the plans that will cover the majority of the population that will utilize the exchange.”99

B. Network Adequacy Challenges

While the SCH dispute centered primarily on specific required services and providers under the ACA, there are other federal laws,100 in addition to certain state laws,101 that impose obligations on insurers to maintain an “adequate” insurance network, also known as “network adequacy” standards.102 Network adequacy is generally understood as the ability of a health insurance plan to provide the benefits indicated in the plan through access to a sufficient number of physicians and other providers as participants in the network (also known as “in-network”).103

96 See Somashekhar & Cha, supra note 9.
98 Lisa Stiffler, Seattle Children’s, Regence Settle Dispute Over Insurance Networks, SEATTLE TIMES (Sept. 2, 2014), http://blogs.seattletimes.com/healthcarecheckup/2014/09/02/childrens-hospital-regence-settle-dispute-over-insurance-networks/. SCH settled first with Coordinated Care Corporation and Premera Blue Cross (and its subsidiary LifeWise) as well as signed a contract with Molina Healthcare of Washington. Id. Finally, in September of 2014, SCH settled with Cambia Health Solutions, which is the parent company of Regence BlueShield and BridgeSpan Health. Id.
99 Id.
101 “Network adequacy” laws vary from state to state. For a description of various approaches, see Blake, supra note 20, at 95–100.
103 SALLY MCCARTY & MAX FARRIS, STATE HEALTH REFORM ASSISTANCE NETWORK, ISSUE BRIEF: ACA IMPLICATIONS FOR STATE NETWORK ADEQUACY STANDARDS 1 (Aug.
For example, under the ACA, plans on the federal and state exchanges are required to maintain a network that is “sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”

While network adequacy laws were drafted to specifically guard against insurers limiting access to certain providers as a means of cutting costs, utilization of the laws for the purpose of taking action against limited provider networks has seen minimal success. One of the biggest challenges with enforcement of these laws is that what constitutes “sufficient” remains somewhat opaque. The law under the ACA, for example, gives states and insurers broad discretion in determining the adequacy of their network for compliance with this rule, making it difficult for any uniformity in application. The Centers for Medicare & Medicaid Services (“CMS”) have identified that this lack of clarity has led to some confusion in implementation and has indicated publicly that it will become more involved in network adequacy reviews.

Network adequacy is not limited to the ACA context, but also arises in connection with Medicaid, more commonly in connection with the means by which states set their rates for Medicaid. Title 42 U.S.C. § 1396a(a)(30)(A) requires that states adopt payment rates that “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Like the provision under the ACA, enforcement of this provision has been challenging at best, both for consumers in an effort to assure a sufficient number of providers are participating and for providers in an effort to assure that
they are paid sufficiently for services provided. In a recent U.S. Supreme Court opinion, *Armstrong v. Exceptional Child Center, Inc.*, the Court held that there is no implied private right of action under the Supremacy Clause for individuals (in this instance, Medicaid providers) alleging that states’ reimbursement rates for certain services failed to comply with section 1396a(a)(30)(A), known as Section 30(A), nor is there an ability to proceed in equity under the Medicaid Act. Thus, with no private right of action, the only enforcement mechanism left to require states to pay sufficient rates to enable network adequacy is through the internal administrative process through CMS and possible revocation of a state’s Medicaid funding.

States have also enacted differing laws regarding requirements for health insurers operating in their states to maintain an adequate network. The NAIC has proposed a model law intended to address network adequacy, which has been adopted by some states. Even in those states in which it has not been adopted, many states have existing laws that are related to network adequacy. Many are limited, however, to only certain kinds of plans, such as HMOs or PPOs. The extent of these plans can vary greatly by state law and can range in the kinds of limitations imposed, including but not limited to provider-to-enrollee ratios, maximum travel distances, maximum appointment wait times, minimum number of providers willing to accept new patients, and minimum percentages of providers in the network’s service area.

While there are a number of laws and areas of that law that contain network adequacy requirements, enforcement of such requirements is

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112 Id. at 1385–87.
113 Id. at 1387.
115 See MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 2 (NAT’L ASS’N OF INS. COMM’RS 1996), http://www.naic.org/store/free/MDL-74.pdf. As of the first quarter of 2015, Colorado, Mississippi, Missouri, Montana, Nebraska, and Tennessee had enacted all or parts of the proposed model act. Id. app. ST.
116 Id. Additionally, the following states have adopted related laws, although not portions of the model act: Alabama, Arkansas, Florida, Georgia, Illinois, Kansas, Louisiana, Maine, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, and Washington. Id.
117 See MCCARTY & FARRIS, supra note 103.
118 See id.
often subjective in nature, challenging for individuals to enforce, and limited to only certain types of organizations. For example, New Hampshire insurance law requires health carriers to “maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.” Despite the requirements of this law, New Hampshire experienced some challenges with the narrow offerings provided through its exchange plans in 2014. Following complaints from excluded providers and consumers alike, The Boston Globe reported that ten of the state’s twenty-six hospitals were excluded from insurer Anthem’s network, resulting in many residents having to drive miles to receive care that could have been provided closer. Anthem stated that its network was “adequate” under state law because most specialists are accessible within a one-hour drive for 90% of the plan’s membership. While individual attempts to remedy the situation were unsuccessful during the plan year, the Department of Insurance reported in late

\[\text{\textsuperscript{119}}\text{ New Hampshire defines “health carrier” as “an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.” See N.H. REV. STAT. ANN. \textsection 420-J:3 (West 2015).}\]

\[\text{\textsuperscript{120}}\text{ Id. \textsection 420-J:7. The statute also requires New Hampshire’s insurance commissioner to develop rules establishing (a) waiting times for appointments for non-emergency care; (b) choice of and access to providers for specialty care, specifically addressing the needs of the chronically ill, mentally ill, developmentally disabled or those with a life threatening illness; (c) standards for geographic accessibility, which shall include standards for access to the provision of durable medical equipment requiring a prescription . . . ; (d) hours of operation for the carrier, including any entities performing prior approval or pre-authorization functions.}\]


\[\text{\textsuperscript{122}}\text{ Petition for Hearing, In re Frisbie Mem’l Hosp., No. 13-038-AR (N.H. Ins. Dep’t Nov. 6, 2013). The petition was denied. See In re Frisbie Mem’l Hosp., No. 13-038-AR (N.H. Ins. Dep’t Dec. 11, 2013) (agency order) (denying petition on the basis that neither Frisbie Memorial Hospital nor Ms. McCarthy was an “aggrieved person” and therefore the department was not required to conduct a hearing).}\]

\[\text{\textsuperscript{123}}\text{ See Jan, supra note 121 (noting that the policy that Nancy Petro purchased on the health insurance exchange, while only $26 a month once subsidies were applied, requires Petro to drive 50 miles for blood work when there’s a hospital three miles from Petro’s house).}\]

\[\text{\textsuperscript{124}}\text{ Id. (noting Anthem has further argued that while ten hospitals may be excluded, the network still covers 77% of the state’s primary care physicians and 87% of its specialists).}\]

\[\text{\textsuperscript{125}}\text{ See Petition for Hearing, supra note 122, at 6.}\]
2014 that there would be “increased competition and selection during 2015.” It further noted that New Hampshire’s health insurance exchange offerings in 2015 include five carriers (as opposed to only Anthem in 2014), sixty medical plans, and all twenty-six acute care hospitals.

C. Antitrust

In addition to laws regarding network adequacy, another area of federal law that may impact the sustainability of Narrow Networks is antitrust law. Although antitrust challenges against health plans have had an inconsistent history due to application of the McCarran-Ferguson Act, which exempts the business of insurance from most aspects of antitrust law, a class action was recently filed against the Blue Cross Blue Shield Association and its affiliates (collectively, the “Blues”) alleging that the Blues have engaged in an anti-competitive conspiracy to lower prices paid to providers and increase premiums paid by beneficiaries. The plaintiffs, providers and suppliers, assert two per se violations of Section 1 of the Sherman Act: namely, a market allocation conspiracy and a price fixing conspiracy. In connection with the claims, plaintiffs argue that the Blues have carved up the insurance market (“market allocation”) resulting in a decrease of competition in the market for healthcare insurance. By way of example, the plaintiffs note that under Blue Cross Blue Shield of Alabama (the state in which the lawsuit was filed) “at least 93 percent of the Alabama residents who subscribe to full-service commercial health (whether through group plans or through individual policies) are subscribers of BCBS-AL.” The plaintiffs further claim that this market dominance has reduced the number of healthcare professionals that practice in certain areas due to the fact that when the Blues’ plans dominate certain service areas, they pay lower

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127 Id.
128 See 15 U.S.C. §§ 1012, 1013 (2012). The McCarran-Ferguson Act exempts from application of antitrust law activities that are in the “business of insurance,” so long as such activities do not constitute “boycott, coercion, or intimidation.” Id. § 1013.
132 Id. at 4.
133 Id. at 14.
than competitive prices. The case is still in the midst of litigation and thus its outcome is as of yet unknown, but the federal district court in Alabama rejected the defendants’ attempt to claim exemption under the McCarran-Ferguson Act, finding its conduct did not meet the factors for the “business of insurance.” Thus, Narrow Networks may have some vulnerability under antitrust law; however, the McCarran-Ferguson Act and the preemption applicable to laws that regulate insurance could still make actions against insurers in a particular state dubious from an antitrust perspective.

D. State Consumer Protection Laws

In addition to federal laws, there are a number of state laws that also could impact the ability of Narrow Networks to sustain long term growth. State consumer protection laws were frequently used to target HMOs in the past and now are being used to target Narrow Networks. In the recent case of Brown v. Blue Cross of California d/b/a Anthem

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134 See id. at 133.


136 In re Blue Cross Blue Shield Antitrust Litig., 26 F. Supp. 3d 1172, 1193 (N.D. Ala. 2014). The McCarran-Ferguson Act exempts certain conduct of insurers from antitrust scrutiny. 15 U.S.C. §§ 1012, 1013 (2012). In order for the exemption to apply, the conduct must (1) be regulated by state law, (2) constitute the “business of insurance,” and (3) not constitute a “boycott, coercion, or intimidation.” See id. Therefore, to the extent an insurer’s conduct does not constitute the “business of insurance,” the insurer is not immune from broader antitrust liability. Critically, not all conduct by an insurance business constitutes the “business of insurance.” See Grp. Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979) (“The exemption is for the ‘business of insurance,’ not the ‘business of insurers.’”). In order to determine what constitutes the “business of insurance,” the Supreme Court has set forth a three factor test: “first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.” Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982). In Blue Cross Blue Shield of Alabama’s case, the district court found that the allegations against Blue Cross of geographic market allocation do not constitute the “business of insurance” because such conduct does not relate to the spreading of risk. See Blue Cross Blue Shield Antitrust Litig., 26 F. Supp. 3d at 1193. Thus, the plaintiffs survived a motion to dismiss and the litigation has proceeded.

137 See Paul Demko, Reform Update: Narrow-Network Concerns Spur Legal, Regulatory, Political Action, MOD. HEALTHCARE (Sept. 26, 2014), http://www.modernhealthcare.com/article/20140926/NEWS/309269967 (noting that in addition to recent legislation and the Brown lawsuits filed in California, concerns are arising in other parts of the country; and the National Association of Insurance Commissioners is in the process of revising its model regulations).
Blue Cross, the plaintiffs filed a lawsuit on August 19, 2014, against Blue Cross of California d/b/a Anthem Blue Cross (collectively, “Anthem”) alleging that Anthem misled consumers regarding the breadth of its provider networks, resulting in individuals being stuck with a plan without access to the physicians and providers with whom they have already established patient relationships. The plaintiffs are all individuals who claimed that they relied on Anthem’s misrepresentations; many of whom were previously insured with Anthem in PPO plans, and argued that Anthem effectively cancelled their PPO plans and transitioned their plans into exclusive provider organization (“EPO”) plans without the enrollees’ knowledge. The complaint alleged against the defendant insurers violations of four California state laws: (1) breach of the implied covenant of good faith and fair dealing; (2) breach of contract; (3) engaging in unlawful, unfair, or fraudulent business acts or untrue or misleading marketing; and (4) negligence and negligent misrepresentation. The plaintiffs asserted that they were effectively “uninsured” because they were unable to access the providers from whom they wish to receive services.

In response to the plaintiff’s assertions that Anthem gave misleading or incorrect information about the plans, Anthem claimed that the enrollees had all necessary materials at the time of enrollment and that Anthem had clearly stated that the plan was an EPO plan with limited out-of-network benefits. In response to related consumer complaints, the California Department of Managed Health Care (“DMHC”) investigated network-related complaints and a state senator backed a Senate bill (SB 964) that attempted to increase enforcement efforts regarding existing laws concerning insurers maintaining adequate networks.

139 Id. at 2–3 (stating that “Anthem foisted their Obamacare or ‘skinny’ networks of providers on their individual members[,] . . . without access to the providers on which they have relied for years or decades”).
140 Id. at 40–44.
141 Id. at 3.
144 Cal. S. Res. 964 (authorizing DHMC to develop standardized methodologies to be used by health plans in making annual reports on compliance). It further authorizes DHMC,
November of 2014, the DMHC issued a report finding that Anthem violated state law by misleading consumers about the size of the provider network and were referred to the Office of Enforcement for Anthem’s uncorrected deficiencies. DMHC’s findings were based upon a telephone survey in which it found that almost 13% of the physicians listed in Anthem’s Covered California directory were not in the location listed, and that nearly 13% of the physicians listed in the directory reported that they were not willing to accept new patients enrolled in plans from Covered California.

In response to the allegations, Anthem raised several issues with the statistical analysis and also with the accuracy of DMHC’s information. Perhaps the most convincing argument Anthem made was that it cannot control what physician/provider offices say in response to a survey. DMHC forwarded to Anthem all “negative” responses during the two-month pendency of the DMHC survey to enable Anthem to take necessary corrective action during the process of the investigation. When Anthem reviewed these responses, it reported that 99% of the physicians/providers who were identified as “not available” in the DMHC survey did in fact have contracts with Anthem. Based on this information, it appears possible that Anthem is not providing misleading

among other things, to establish timeline requirements, including (1) waiting times for physician appointments; (2) timeliness of care in the event of illness; and (3) waiting time prior to screen or triage a patient needing care. See id.

146 Id. at 18.
147 Id. The deficiencies that were cited as “not corrected” were (1) Anthem “operated as at variance when its internet website and online Provider Directory informed enrollees that numerous physicians were participating in [Anthem’s] Covered California products, when and they were not” (in violation of section 1386(b)(1) of the California Health & Safety Code); (2) Anthem “failed to correct inaccuracies in its online Provider Directory, [Anthem] used (or permitted the use of) written or printed statements or items of information that were either untrue or misleading and which were disseminated, at least in part, for the purpose of inducing persons to enroll in [Anthem]” (in violation of section 1360(a)(1-2) and (b) of the Health & Safety Code); and (3) Anthem “failed to meet its statutory obligation to provide enrollees with accurate contracted provider lists, either upon request, or through provider listings set forth on [Anthem’s] internet website” (in violation of section 1367.26 of the Health & Safety Code). Id. at 4.
149 See id.
150 Id.
151 Id.
or false information to consumers; but that certain physician/provider offices are either confused by the plans with which they maintain a contract, or physician/provider offices do not want to accept patients from such plans for whatever reason and communicate to consumers untrue or misleading information. Therefore, consumer challenges, like the Brown case alleging that the insurer has failed to provide sufficient coverage, may be difficult to prove where there is evidence that at least some of the miscommunication and misinformation to the consumers may actually be the result of physician/provider communication and not solely insurer communication.

E. State Any Willing Provider Laws and Freedom of Choice Laws

As abuses by, and frustrations with, HMOs began to peak in the mid-to-late 1990s, there was a national movement pushed by the National Association of Insurance Commissioners (“NAIC”) to attempt to address these problems through state legislation. The HMO Model Act prompted nearly all of the states to enact legislation that limits the actions and activities of HMOs. Given that Narrow Networks have at least some commonalities with HMOs in terms of their network structure (although Narrow Networks may have a unique or distinct reimbursement structure), Narrow Networks must at least be generally aware of applicable state laws governing HMOs in order to ensure compliance with such laws.

One type of law that first emerged in response to the rise of HMOs and is now experiencing a reemergence in various states is a law known generally as an “any willing provider” law (“AWP Law”). While such laws may vary by state, AWP Laws generally require insurers to open their networks to any provider who is willing to accept the network’s terms and conditions, including proposed payment rates. Many state AWP Laws date back a number of years, with many limiting application of such laws to only specific kinds of providers, such as pharmacy and chiropractors. As states struggle with the policy implications of Nar-

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152 Brown Complaint, supra note 138.
154 See Howard, supra note 50, at 95.
156 See id. (noting that 27 states have some version of an “any willing provider” law).
157 Id. For example, Connecticut law is limited only to pharmacies, as are the laws in the
row Networks resulting from health care reform, a number of states have or are considering adopting, or fortifying, existing AWP Laws. In fact, several states, including Alabama, Missouri, South Dakota, Texas, and Utah have all enacted new AWP Laws or amended existing laws within the last two years. The most recent example is Measure 17 in South Dakota, which requires that insurers accept in their network plans all health care providers in a particular geographic area who are willing and qualified to meet the insurer’s conditions for participation.

In the same way that AWP Laws are designed to protect providers and suppliers from exclusion, there are similar laws intended to protect the ability of consumers to choose their providers. These laws are typically referred to as “freedom of choice” laws (“FOC Laws”). FOC Laws endeavor to assure that a health plan’s enrollees have an ability to receive patient care services from any qualified health care provider. Although FOC Laws do protect an individual’s choice of a particular provider or physician, the laws often times do not contain provisions guarding against any high out-of-pocket costs related to seeing an out-of-network provider. While legislatures do not seem as focused on amending existing or enacting new FOC Laws, as with AWP Laws, many states still maintain actively enforced FOC Laws, which could potentially affect that ability of a Narrow Network to operate as contemplated.

Although both AWP Laws and FOC Laws were drafted in hopes of protecting providers and consumers, the laws themselves tend to be lim-
ited in their application and have shown to drive up healthcare costs. For example, given that most AWP Laws contain requirements regarding minimum qualifications and conditions, insurers can create quality metrics or other established criteria that will limit the number of providers that will be eligible without being in violation of the laws. Moreover, to the extent that Narrow Networks are premised on the idea that the providers in the network are less costly, providers may be unwilling to join the networks based on the financial terms established by the insurer for purposes of participation. Lastly, the penalties that are associated with violations of these laws are limited (typically only enforced through lawsuits by aggrieved parties) and thus provide little incentives for the insurers to dedicate much effort to compliance with the laws.

In addition to the narrow application, the impact of AWP Laws and FOC Laws is even further diminished due to limitations under the Employee Retirement Income Security Act (“ERISA”). ERISA regulates employer-sponsored benefit plans, including the provision of health ins-

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166 Christopher J. Gearon, Hospitals Get the Squeeze from Insurers’ Narrow Networks, U.S. NEWS & WORLD REP. (Apr. 10, 2014), http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/04/10/hospitals-get-the-squeeze-from-insurers-narrow-networks (“For hospitals, network exclusion can hit the bottom line, affecting patient referrals and declining volume, and increase costs. Patients going to non-network providers pay significantly higher out-of-pocket costs—sometimes the full tab—under many new ACA exchange plans. Hospital officials in some markets say if they don’t agree to significantly lower reimbursements, insurers are excluding them from networks.”).

167 See, e.g., Matthew Heller, Blue Cross Hit With $3.8M Verdict for Excluding Doctor, LAW360 (Apr. 8, 2013), http://www.law360.com/articles/431183/blue-cross-hit-with-3-8m-verdict-for-excluding-doctor. In the case of Nordella v. Anthem Blue Cross, No. BC444364 (Cal. Super. Ct. 2010), Dr. Jeffrey Nordella filed a lawsuit against Anthem Blue Cross when he was excluded from its network on the basis that he “did not have board certification in family medicine, the medical specialty for which he applied to be listed in the network directory, and Anthem had a sufficient number of general practitioners.” Id. Nordella filed a rather novel claim, stating that Anthem Blue Cross violated his right of fair procedure under California law when it denied his application to join the network. Id. According to Nordella’s attorney, this was the first fair procedure case in California to result in a plaintiff’s verdict since a jury awarded $1.3 million to a clinic in 2005. Id.; see also Edwin Brooks et al., Health Briefs e-Newsletter, AM. HEALTH LAW. ASS’N (May 7, 2013), https://www.healthlawyers.org/Members/PracticeGroups/Documents/Pgpubs/Health_Briefs.pdf (noting that the reach of Nordella, which was decided via a jury verdict, may be confined to California or laws that include fair procedures language, but also cautioning providers to document their reasons for exclusion or termination).

In an effort to create a comprehensive scheme that would apply to all employee benefit plans (and thus encourage employers to create employee benefit packages), ERISA broadly preempts state laws from regulating employer-sponsored health plans. As an exception to this broad prohibition, however, the law “saves” from preemption any state laws that regulate the business of insurance. Thus, state laws that regulate managed care may be preempted under ERISA, unless a court determines that the law is “saved” on the basis that it regulates insurance. Kentucky’s AWP Law was reviewed for this very question in 2003 in which the U.S. Supreme Court upheld the law as being saved from ERISA preemption. Such victory has not completely quieted this debate in connection with other similar laws, however, and still does not address such laws relative to an employer’s self-insured plan.

Despite the enactment of new laws under the ACA, existing federal laws regarding network adequacy, antitrust, AWP Laws, and FOC Laws, and various state laws, all of which are designed to protect against the creation of limited networks that exclude providers and limit patient choice, providers and consumers are finding limited enforcement abilities under these laws. Newly-enacted laws under the ACA and existing network adequacy laws are vague in their application, leaving a great deal of discretion to regulators and administrators to determine adequacy. Moreover, antitrust law has limited application due to an exception that largely cedes enforcement and regulation regarding the business of insurance to the states. Additionally, many of the state laws designed to address consumer protection and preserve physician/provider and patient choice were designed with HMOs in mind and do not reach the structural features of Narrow Networks in the same way or contain sufficient allowances that insurers are able to design plans that meet the strictures of the statutes. Thus, the seemingly dizzying array of laws available to
consumers for purposes of seeking action against a Narrow Network is actually quite limited due to application of the various laws.

IV. PROSPECTS FOR NARROW NETWORKS

As insurers have rolled out their Narrow Networks, critics have been concerned that the U.S. is just repeating the mistakes of its HMO past.177 Indeed, many of the arguments from the Brown plaintiffs and cases involving network adequacy seem as if these are cases that could have been filed in 1988.178 While these cases have some apparent similarities to past challenges against HMOs, the Narrow Network movement is sufficiently distinct from its predecessor movement. In analyzing the distinctions between HMOs and Narrow Networks, it seems clear that Narrow Networks may evade many of the historic challenges to other limited provider organizations.

A. Potential Advantages of Narrow Networks

Although the restrictive nature of HMOs was a large factor in why HMOs began to lose favor, there are some potential advantages for consumers in connection with Narrow Networks that might make consumers, now two decades later, willing to accept certain restrictions and limitations. Perhaps the most important aspect of Narrow Networks, especially for the millions of individuals previously unable to purchase health insurance (either because it was cost prohibitive or because they had pre-existing conditions), is the fact that Narrow Networks tend to have much lower premiums.179 According to a study by McKinsey & Company, insurance products with a broad network180 have average premiums that are 13% to 17% higher than Narrow Network offerings.181 Moreover, nearly 70% of the lowest-priced products on the

MAG. (Apr. 1996), http://www.managedcaremag.com/archives/9604/9604.awp.html (“Arkansas’ newly enacted law, for instance, requires plans to accept any provider who agrees to comply with the plans’ terms and conditions. ‘Since that language ‘can be read in lots of ways,’ says Prudential’s Yukon, ‘we believe it can be interpreted as providing us with geographic access options.’”).

177 See McQueen, supra note 25.
179 See BAUMAN ET AL., supra note 19, at 6–7.
180 A “broad network” is defined in the report as having more than 90% of the hospitals in the area participating in the applicable plan. Id. at 4.
181 Id. at 6.
health insurance exchanges include Narrow Networks. The ability of insurers and plan sponsors to keep these costs low is critical and essential to the structure and design of a Narrow Network. In order for the insurer to negotiate lower prices with providers, the insurer needs to be able to assure the provider of a sufficient volume of patients, in exchange for the lower rate. Further, the insurer needs to ensure that the care will be of a sufficient quality and efficiency, such that the selected providers will not be wasteful or otherwise harmful to the patients (which will in turn increase costs).

Many Narrow Network advocates argue that formation of these limited networks, at lower premiums, is actually a necessary aspect of health care reform. They argue that Narrow Networks fulfill goals of health care reform by virtue of their ability to utilize select groups of providers to drive down health care expenditures and move the industry towards a focus on value-based care. A small network of providers and suppliers could also fulfill health care reform goals of better coordination of care, given that referrals outside the network are limited.

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182 Id.
184 See Jan, supra note 121 (“Anthem was only able to negotiate lower rates with in-network hospitals in exchange for the assurance that they would benefit from an influx of new patients by increasing the size of their service area. In other words, these hospitals had to be guaranteed greater market share.”).
185 See id.
186 See Kliff, supra note 8; Jonathan Gruber & Robin McKnight, Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees 4 (Nat’l Bureau of Econ. Research, Working Paper No. 20462, Sept. 2014), http://www.nber.org/papers/w20462.pdf (“Overall, the findings suggest that the switch to limited network plans reduced spending without harming access to primary care or inducing shifts to more expensive tertiary care.”).
188 Care coordination among providers should reduce duplication of services, and therefore, reduce spending on such duplicative services. See Better Care at Lower Cost: Is it Possible?, COMMONWEALTH FUND, http://www.commonwealthfund.org/publications/health-reform-and-you/better-care-at-lower-cost (last accessed July 10, 2015) (“[T]he costs for [chronically ill] patients really skyrocket when the care they receive is poorly coordinated: when patients are referred by their primary care provider to a specialist, move in and out of the hospital, and transition from the hospital to home care or a long-term care facility, all with little oversight or communication between providers. In this environment, patients may undergo the same lab tests multiple times, they may get the wrong combination of medications,
Thus, the providers within the network will work together for the care of all of the patients, which coordination may be aided through reimbursement mechanisms. 189

Lower premiums do not simply provide benefits to the insurance industry and health care reform efforts generally; many consumers are also realizing the benefits. While critics contend that these Narrow Networks represent a loss of choice by the consumer, 190 proponents view these increased network options as an opportunity to provide more consumer control over health care spending and insert the consumer into the process of controlling health care costs overall. 191 Many of the HMO products that were rolled out in the 1980s and 1990s were subscribed to by employers that changed from broader, more expensive plans, to more narrow HMO offerings. 192 HMOs, most of which were defined by their capitation reimbursement structure, gave self-funded employers the ability to control health care costs due to the transfer of risk that enabled employers to push the responsibility to maintain health care costs to the providers. 193 Thus, many individuals found themselves in an HMO due to the fact that such HMO had been selected by their employer. 194

In contrast, many of those selecting Narrow Networks today are doing so of their own volition. According to McKinsey & Company, almost half of the individuals who purchased Narrow Networks on a health insurance exchange were aware that they were purchasing a more limited network. 195 The primary driver for selection of these plans is cost; many consumers are willing to accept more restricted provider se-

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189 See CMS Press Release, supra note 187.
191 See Done Right, Narrow Networks Have Advantages for Patients, ADVISORY BOARD COMPANY (Sept. 11, 2014), https://www.advisory.com/daily-briefing/2014/09/11/done-right-narrow-networks-have-advantages-for-patients (noting that in addition to saving money, patients involved in narrow networks visited their primary care provider more often and used the emergency department less than other patients).
193 Capitation enabled employers and states the ability to budget known health care expenses because, under the model, the state or self-funded employer paid only a flat monthly fee for each patient and the provider was then responsible for controlling costs under the flat fee. See Furrow et al., supra note 110, at 657.
194 See Bodenheimer & Sullivan, supra note 192, at 1004.
195 See Bauman et al., supra note 17, at 3.
lections in order to realize lower premiums.\footnote{Id. at 6–7; see also LIZ HAMEL ET AL., HENRY J. KAISER FAMILY FOUND., SURVEY OF NON-GROUP HEALTH INSURANCE ENROLLEES app. tbl.6 (June 19, 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/06/survey-of-non-group-health-insurance-enrollees-appendix-tables-final1.pdf (finding that at least 29% of respondents in the survey were “not too confident” or “not at all confident” that they will have enough money to cover medical costs for self and family, and 41% of the same respondents were “not too confident” or “not at all confident” that they will have enough money to pay for a major illness); Jan, supra note 121 (“[Anthem] formed its narrow hospital network after extensive market research, when consumers indicated they would be willing to trade a full network for lower premiums, said Lisa Guertin, president of Anthem in New Hampshire. The result is a 30 percent savings for individuals buying coverage in the marketplace . . . .”).} Moreover, the evidence fails to support a finding, at present, that consumers who are choosing lower-premium options are required to choose between quality and price.\footnote{See BAUMAN ET AL., supra note 19, at 6–9.} Preliminary reporting data suggests that Narrow Network options are performing at quality levels comparable to those of other broader networks.\footnote{Id. at 9.} In fact, one of the distinctions noted of “high-performance” networks is the fact that these organizations appear to have a greater focus on meeting identified quality metrics or measures in the provision of care and on promoting high-value care through alternative reimbursement mechanisms such as bundled payments and outcome driven payment (e.g., pay-for-performance programs).\footnote{See CORLETTE, supra note 36, at 3.} Thus, there has been a shift to improving quality, reducing care variances, and minimizing unnecessary care.\footnote{Id.} Some of this might be in reaction to or in response to AWP Laws, which only require insurers to include “any willing provider” so long as the provider can meet the insurer’s qualifications or criteria.\footnote{Id. at 9.} To the extent that insurers create quality metrics and require compliance with such networks, insurers have an ability to limit the network to only such providers who are able to meet such standards.\footnote{See Coleman, supra note 176.}

\section*{B. Remaining Challenges of Narrow Networks}

Despite many of the distinctions and advantages of Narrow Networks, there are nevertheless challenges and criticisms that remain. The primary critiques have been largely similar to those issues raised by the Blank family; that is, individuals and families are forced to choose between health insurance options that are affordable and ones that may...
provide access to providers that might be necessary or at least desirable from a care perspective.\textsuperscript{203} The specific dilemma for the Blanks was described as the following: “So, Blank must make a choice. Should he take his insurer’s suggestion and lose access to [SCH]? Should he go with one of the plans on the exchange that includes [SCH], even if that means picking an insurance company he has never heard of?”

He is leaning toward a third option: buying a private plan with Premera outside the exchange with a broader network, but that would force him to give up the estimated $400-per-month subsidy he would be eligible for under the health law.\textsuperscript{204} In fact, critics have commented that the situation with the Blank family was precisely what the ACA endeavored to avoid.\textsuperscript{205} If one of the goals of the ACA was to expand coverage to those individuals who were uninsured \textit{and} underinsured, a system that enables only those who can afford greater access to receive it or a system that maintains job-lock in order for individuals to avoid a situation of having insufficient options on a healthcare exchange arguably does not fulfill that goal.\textsuperscript{206}

Additionally, although the intent of an exchange is to create greater transparency and opportunities to compare products, it appears that many individuals remain either confused or entirely unaware of what insurance product they are buying.\textsuperscript{207} Consumer studies have shown that of those individuals who purchased Narrow Network options on a health insurance exchange, approximately 26\% were unaware of the breadth of their selected network.\textsuperscript{208} Not surprisingly, those individuals who were previously uninsured were twice as likely to be unaware of the breadth of their health insurance as individuals who were previously insured.\textsuperscript{209} These results suggest consumers are selecting plans based on the cost of the premium, but may be unaware that purchasing a particular policy

\textsuperscript{203}See Somashekhar & Cha, supra note 9; see also Blake, supra note 20, at 69 (noting that Narrow Networks create a distributive justice problem that prevents the sickest of patients from receiving necessary tertiary care because they are unable to pay for it).

\textsuperscript{204}See Somashekhar & Cha, supra note 9.

\textsuperscript{205}See Blake, supra note 20, at 66–67, 70 (noting that creation of a dual system in which those who can afford more specialty services will have access to such specialty services seems contrary to the intention behind health care reform).

\textsuperscript{206}See CENTENNIAL, HARVARD BUS. SCH., REPORT ON GLOBAL BUSINESS SUMMIT: IMPACT OF PUBLIC POLICY ON CONSUMER-DRIVEN HEALTH CARE 1 (2008), http://www.hbs.edu_centennial/businesssummit/healthcare/impact-of-public-policy-on-consumer-driven-health-care.html (noting that an estimated eleven million people reported wanting to change jobs, but feeling locked in their current job because they need to keep their insurance).

\textsuperscript{207}See BAUMAN ET AL., supra note 19, at 13–14.

\textsuperscript{208}Id. at 14.

\textsuperscript{209}Id.
may inhibit them from seeing their treating physician or from seeking care at the same hospital as they did before.\textsuperscript{210}

While the ACA was intended to create more transparency in the health care market, it is evident from the Brown lawsuit that network selection and insurance plan structure remains confusing for many.\textsuperscript{211} The Brown case also highlights the challenges in trying to achieve greater transparency. The issues cited by the plaintiffs seem to be a result of a multitude of factors including challenges with consumer knowledge, consistent and up-to-date information from insurers regarding providers in a particular network, and both knowledge and communication from providers themselves regarding such networks.\textsuperscript{212} With such an array of issues, it can be challenging to consider what sort of additional information or communication would drastically alter the current situation.

\textbf{C. Current Outlook for Narrow Networks}

Between “essential provider” lawsuits, antitrust lawsuits, state consumer protection lawsuits, AWP Laws, FOC Laws, HMO Model Act restrictions, and other state consumer protection laws, there are a dizzying array of legal avenues available to aggrieved consumers and providers against Narrow Networks. Despite the many avenues, litigants often face an arduous battle in achieving success against exclusive provider networks, such as Narrow Networks. As addressed in Part III above, many of the existing laws were drafted in reaction to complaints and frustrations brought about by HMOs and other limitations posed by managed care plans in the 1980s and 1990s, and are inadequate to address limited provider networks that insurers have been establishing in recent years.\textsuperscript{213} Even those laws that were put in place as part of health care reform, such as laws addressing network adequacy, remain challenging to enforce due to the large amount of subjectivity that is applied in connection with enforcement.\textsuperscript{214} Thus, if Narrow Networks either maintain current pace or continue to rise both on and off exchanges, there are few existing legal barriers to their continued growth at the present time.

\textsuperscript{210}See id. at 15. This statement is not to suggest that insurance companies are necessarily hiding the breadth of their networks or not providing sufficient information to the consumer that the plan might be a more limited network. Rather, it is simply stating that individuals sometimes are unaware of what they are purchasing, which can be the result of a multitude of factors.

\textsuperscript{211}See Brown Complaint, supra note 138, at 2–3.

\textsuperscript{212}See supra text accompanying notes 148–152.

\textsuperscript{213}See generally supra Part III.

\textsuperscript{214}See supra notes 119–127 and accompanying text.
Moreover, the presence of health care insurance exchanges as a means for individuals to purchase insurance has drastically changed the dynamics since the height of HMO popularity. In the past, individuals who did not have access to insurance through their employer or a government program were forced into the individual and small group markets, which often times meant high premiums and significant challenges in the ability to compare one plan to another. Now, on the exchanges, without barriers such as denials or premium hikes due to pre-existing conditions, individuals are able to compare insurance plans and know at the point of enrollment what the monthly premiums will be for the respective plans. Challenges with transparency remain, but evidence suggests that the majority of individuals who are purchasing Narrow Networks are purchasing these plans with knowledge that the network is more limited than broader networks, primarily (or perhaps exclusively) because the premium is more affordable. Of the millions of Americans who are now able to access more cost-effective health insurance, many still fear that they will not be able to cover related medical expenses, despite having insurance coverage and despite expected subsidies and credits. Thus, although Narrow Networks may have re-emerged for reasons similar to the initial rise of HMOs (namely public policy and industry concerns regarding rising costs), much of the success of Narrow Networks is being driven by consumer demand for these products. The cost savings under HMOs were being realized not by consumers, but by large employers, state governments, and insurers.

215 See Blake, supra note 20, at 72 (“Historically, insurers have used a variety of techniques to [manage risk]: denying sick people coverage altogether; imposing preexisting condition, annual, or lifetime coverage limits; heightening cost-sharing; and refusing to cover certain procedures. This effect was felt most strongly in individual and group markets, where no pool was large enough to spread the risk.”(footnote omitted)).

216 Id.

217 It should be noted that while an individual does know at the time of enrollment the amount the monthly premium will be for the year, this amount may not be the amount paid once the individual pays his/her taxes. All subsidies and credits provided to a particular individual are determined based on the individual’s stated income at the time of enrollment. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213 (2010). To the extent that the individual has an annual income for the year that was different than the income estimated at the time of enrollment (either higher or lower), then the subsidies and credits available may be different than originally predicted. Thus, the individual may owe more, as reimbursements for subsidies and credits paid, but not owed under the law, or less, if the estimated income was actually greater than predicted.

218 See BAUMAN ET AL., supra note 19, at 14.

219 Id.

220 See Hamel, supra note 196, at app. tbl.6.

221 See Bodenheimer & Sullivan, supra note 194, at 1003.

222 Id. at 1004.
contrast, while insurers are also motivated by cost savings, at least some of the Narrow Network trend is being facilitated by the market that has been created for a low-cost insurance option. The presence of a consumer-driven market in which individuals are given the option of purchasing limited provider networks at a lower cost makes this movement distinct from limited provider networks of the past.

D. Reaction of Excluded Providers

In addition to consumer-driven demand, Narrow Networks are potentially being fueled by some of the unlikeliest of providers: namely, AMCs and other high-cost specialty providers (collectively “High-Cost Providers”). Ordinarily, High-Cost Providers would seem to be the best litigants to fight exclusion from a Narrow Network for two reasons: (a) they are likely to be the most commonly excluded from Narrow Networks due to their high cost of services relative to other providers rendering the same or similar services; and (b) they are usually large organizations with greater financial resources than smaller community providers, which may provide these High-Cost Providers with the requisite bargaining power and litigation wherewithal to withstand a lengthy and potentially costly legal action with a large insurer. High-Cost Providers appear to be pursuing other business models in lieu of Narrow Network participation, however, which may have a significant impact on the ability for providers more generally to object to or fight Narrow Network exclusion.

Just as modern Narrow Networks are looking to exclude High-Cost Providers, these same providers were targeted in the 1990s as HMOs attempted to squeeze out specialty providers due to their more expensive rates. Many High-Cost Providers at the time responded by attempting

223 See BAUMAN ET AL., supra note 19, at 10 (noting that AMCs are included in 96% of all broad networks in the country, but are only included in 40% of ultra-narrow networks, and noting further that products including AMCs have premiums that are, on average, 9% higher than products without AMCs).

224 See Chapin White et al., Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein In Costs, 33 HEALTH AFF. 324, 330 (2014) (“But high-price hospitals also clearly enjoyed dominant market positions. Both their large size and their membership in even larger hospital systems made it difficult for health plans to negotiate lower prices with them.”).

225 See, e.g., Stiffler, supra note 98; see also Tammy Worth, Cash-Only Looks Good to Doctors, HEALTHCARE FIN. (June 30, 2014), http://www.healthcarefinancenews.com/news/cash-only-looks-good-doctors.

226 See Milt Freudenheim, Longtime Missions Pressed by H.M.O.’s [sic], N.Y. TIMES (May 20, 1997), http://www.nytimes.com/1997/05/20/business/longtime-missions-pressed-by-hmo-s.html (“The squeeze on academic medical centers like New England Medical is particu-
to compete with other providers to obtain more HMO patients in order to maintain market share, largely by making an effort to reduce expenses. Such efforts were met with mixed results, as many High-Cost Providers were unable to provide services to HMOs at a price that would compete effectively with other providers and thus, lost market share and resulting revenues. Other High-Cost Providers were forced to shut down or merge with other entities as they witnessed volumes dry up and were unable to sustain their businesses.

Rather than again try to fight exclusion or compete in the market with lower-cost providers, High-Cost Providers today seem to be instead charting new paths outside the individual insurance market and promoting their services to a market entirely different than insurers. For example, while the Mayo Clinic is participating in one Narrow Network option in its area through Medica, the Mayo Clinic’s involvement in the state exchange plans has been somewhat limited. In fact, its presence in the area seemed to increase premiums on average for exchange plans in that region, even for plans in which the Mayo Clinic was not participating. Therefore, rather than focus on participation in plans offered on the health insurance exchanges, the Mayo Clinic seems to instead be adopting an alternative approach outside its state health insurance exchange.

The Mayo Clinic has developed the Mayo Clinic Care Network,
which is described as “a network of like-minded organizations which share a common commitment to improving the delivery of health care in their communities through high-quality, data-driven, evidence-based medical care.” The Mayo Clinic Care Network currently has thirty-six member organizations. “Membership” allows the member-entities certain opportunities, including: the ability to advertise as a member of the Mayo Clinic Care Network; access to disease management protocols, clinical care guidelines, treatment recommendations, and reference materials, all developed at the Mayo Clinic; and access to Mayo Clinic physicians for purposes of treatment advice and consultation. The benefits for the Mayo Clinic are to create brand recognition and to collaborate with the medical community and patients outside of Rochester, Minnesota, which it hopes will lead to an increase in more complex and challenging cases being referred for treatment at the Mayo Clinic’s main facilities in Minnesota, Arizona, and Florida. This pipeline for cases is helpful and beneficial for the Mayo Clinic, as an AMC, because those more complex and challenging cases provide good training for residents and also valuable medical information for fulfilling its research mission. So long as the Mayo Clinic is receiving a sufficient volume of patient referrals outside of local insurance exchange networks, being part of its local exchange networks, including some Narrow Network offerings, is not so critical for purposes of long-term sustainability.
The Mayo Clinic is not alone in forging new opportunities to grow patient volumes outside of the more traditional routes of network participation. In the wake of health care reform and emergence of accountable care organizations (“ACOs”), some AMC’s have formed ACO-like organizations often referred to as clinically integrated networks (“CINs”). The goal of these CINs is not dissimilar to the goal of the Mayo Clinic Care Network: that is, to provide coordination of care among providers so that complex and specialized care that can only be provided at AMCs is available when necessary, while more common and standard care that is available at community hospitals must be utilized at such hospitals. One example of this model can be seen in the Vanderbilt Health Affiliated Network (“VHAN”), which is associated with Vanderbilt University Medical Center in Nashville, Tennessee (“VUMC”). VHAN is the “largest provider-organized network of doctors, regional health systems and other health care providers in Tennessee and seven surrounding states” with twelve participating provider organizations and over forty hospitals. The network is intended to promote more efficient and better coordinated care for patients of the member organizations and for its participating providers through the use of technology, enabling access to medical records and coordinated clinical protocols.

While CINs like VHAN may contract with insurance companies, the primary “client” or target for this type of organization is frequently large employers. Indeed, VHAN is the network that is offered to all

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240 Historically, AMCs are similar to most other providers in that they rely primarily on receiving a significant volume of patients through participation in local insurance networks. As noted above, because AMCs are a critical provider in many areas of the country, they generally have had success in negotiating high rates from insurers that help compensate for high overhead. See, e.g., NELSON, supra note 239, at 2.


242 See id.


244 Id.

245 Id.

246 Id.; see also O’Hara, supra note 241.

Vanderbilt University employees and is also the primary network offered to many of its member organizations. By marketing this network to large employers, such as local municipalities and large corporations within the service area, the member organizations and physicians are seeking patients from a market entirely outside of any local health insurance exchange product. Similar to the Mayo Clinic, the goal behind this sort of organization for VUMC is to limit those services provided by VUMC (an AMC) to only those highly specialized and complex cases that require such care while all other care is provided at a lower cost facility. Because the organization is being marketed to employers as opposed to individuals, the value proposition to the employer-consumer is that VHAN’s care will be more efficient and of better quality, thus saving employers money and ensuring healthier and more productive employees. Therefore, CINs are able to shift the focus away from premiums by emphasizing savings that may be achieved through overall cost of care managed across a continuum of providers.

One other example of High-Cost Providers trying to focus on opportunities outside of the individual insurance marketplace is an organization known as Vivity. Anthem Blue Cross describes Vivity as “an integrated health system in Los Angeles and Orange counties . . . [that is] a first-in-the-nation partnership between an insurer and seven competing hospital systems that will align financial risk/gain to enhance the health of Anthem Blue Cross Vivity members.” Like the previously-described networks, the member organizations include hospitals typically considered High-Cost Providers that might otherwise be fearful about exclusion from Narrow Networks. Vivity is unique and distinct from other types of provider groups because it focuses on a reimbursement structure that is not paid based on traditional fee-for-service reimbursement. Rather, its reimbursement structure is based on providing financial incentives to the member organizations encouraging them to work together to better coordinate care, thereby providing more efficient and less costly care. Like VHAN and other CINs, the primary target audi-

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248 See Vanderbilt Health Affiliated Network, supra note 243.
249 Id.
250 See Butts, supra note 247.
251 See O’Hara, supra note 241.
253 Id.
254 The member organizations include Cedars-Sinai, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center, and UCLA Health. See id.
255 Id.
ence for Vivity is large group employers; thus, it is not currently included in individual health insurance exchanges.256

Although the Mayo Clinic Care Network, VHAN, and Vivity are each diverse in terms of their legal structure, affiliations, and associations of their member organizations, there are several notable common goals of each. Each organization involves historically High-Cost Providers that recognized that, under health care reform, there was a need to provide a different solution in order to avoid a situation under which they were being excluded from insurance networks due to costs.257 Each provider has also focused on the fact that it is unlikely that High-Cost Providers can eliminate much of what makes them High-Cost Providers. If, instead, care can be coordinated in a way that provides “the right care, at the right time, in the right place, at the right price”258 then such High-Cost Providers can nevertheless provide a value proposition to certain consumers for networks that include their services. Lastly, these organizations are not organizations that are competing in the same market as those products being offered on the individual marketplace.259

To the extent that High-Cost Providers can realize success outside of Narrow Networks, opposition to these organizations will be lacking the voice of large providers such as the Mayo Clinic260 and institutions

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256 See Vivity FAQs, supra note 252.
257 To the extent that High-Cost Providers are excluded from Narrow Networks and Narrow Networks become the dominant type of network, both on and off the health insurance exchanges, the ability for such High-Cost Providers to sustain themselves is at risk due to a lack of patients who are able to seek care with High-Cost Providers due to limitations in those patients’ networks. Therefore, if High-Cost Providers are economically incapable of lowering their costs, it becomes necessary for the High-Cost Providers to consider alternative methods to ensure that patients are able to seek their services and that the High-Cost Providers are still able to bill and collect for such services. See Robertson, supra note 231.
258 This phrase could be considered a variation on the “Triple Aim,” which was a concept first proposed by Donald M. Berwick and the Institute for Healthcare Improvement in 2008. See Donald M. Berwick et al., The Triple Aim: Care, Health, And Cost, 27 HEALTH AFF. 759 (2008). The “Triple Aim” is a framework for the provision of health care services that seeks three goals: (1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and (3) reducing the per capita cost of health care. See The IHI Triple Aim, INST. HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx (last accessed Jan. 16, 2016).
259 See generally Mayo Clinic Care Network, supra note 233; Vanderbilt Health Affiliated Network, supra note 243; Vivity FAQs, supra note 252.
260 In 2014, the Mayo Clinic treated 1.3 million people from all 50 states and 143 countries. They have 4,200 staff physicians and scientists, 2,400 residents, fellows, and other trainees, and 52,900 allied health staff (clinic and hospitals). See Mayo Clinic Facts, MAYO CLINIC, http://www.mayoclinic.org/about-mayo-clinic/facts-statistics (last visited Jan. 16, 2016). The Mayo Clinic reported total revenue from current activities of $9,760,600,000 and $834,800,000 in income from current activities. Id.
like Cedars-Sinai as a member of Vivity to effectively negotiate or bargain with large insurers and will feature fewer health care industry leaders speaking out against Narrow Networks. While the negative impact on High-Cost Providers as a result of the HMO movement in the 1990s helped to spur action of legislatures across the country to enact laws that would greatly limit the activities of HMOs, current High-Cost Providers are not affected proportionally to the extent that they are successful in selling their services to a different segment of the market and such services provide sufficient financial stability.

V. CONCLUSION

Insurers, providers, and consumers are all attempting to predict the future of healthcare as health care reform and the health insurance exchanges start to take shape. If current trends continue, Narrow Networks appear to be a key aspect in that future marketplace. According to a McKinsey Center for U.S. Health System Reform study, 90% of networks considered “broad” in 2014 remained broad in 2015 and 83% of Narrow Networks in 2014 remained narrow in 2015. For those who are assuming, predicting, or just hoping that Narrow Networks are simply “HMOs 2.0” and will quickly fall out of disfavor just like HMOs in the late 1990s, it appears unlikely under the current legal and business landscape. While there are certainly similarities between these organization types, there are some key distinctions and differences that seem to indicate that the outlook for Narrow Networks appears quite distinct from the fate of HMOs.

Perhaps the most important change from today versus the managed care movement of the 1980s and 1990s is that aspect of individual choice that is present in today’s individual insurance marketplace. Unlike HMOs, which were largely adopted by public and private employers

261 Anthem Blue Cross Vivity includes participation of seven hospitals, all ranked in the top 30 in Los Angeles and Orange County areas by U.S. News & World Report, each with affiliated entity networks. See Vivity FAQs, supra note 252. The network includes 6,000 doctors and a total of 14 hospitals. See Austin Frakt, Some Facts About Vivity, INCIDENTAL ECONOMIST (Oct. 2, 2014), http://theincidentaleconomist.com/wordpress/some-facts-about-vivity/.

262 See Reuter & Gaskin, supra note 227, at 248–50.

in an attempt to save money and curb increases in health care expenditures, individuals today are able to access health insurance options through federal and state exchanges and make a conscious choice for narrower network products because such products offer a lower premium.264 Thus, Narrow Networks are responding to a consumer demand for low cost options, despite the fact that such options may involve some limitations. Moreover, the public outcry related to these networks and the limitations that such networks impose that became so much a part of the descent of HMOs265 is quieted somewhat by the fact that individuals are knowingly electing limitations in exchange for the cost savings. Unlike an employee who is unknowingly forced into a limited provider network due to the decision of his/her employer and is then harmed as a result of such limitations, an individual who knowingly purchases a Narrow Network because it is sold at a lower premium is hard-pressed to feign disgust and disappointment when the limitations that were explained to the consumer in the beginning are then imposed.266

Another key factor in the potential success of Narrow Networks lies in the legal remedies available to consumers and providers aggrieved by Narrow Networks. While there appears to be any number of legal remedies available to disgruntled consumers, excluded providers, or others negatively impacted by Narrow Networks, such legal remedies remain elusive as meaningful challenges to these types of organizations. Many existing state laws were drafted specifically to address issues related to HMOs and are thus too narrow to apply to Narrow Networks. Even older laws and more newly enacted laws that appear broader in scope afford a great deal of discretion to insurers and government agencies for purposes of interpretation of the law, making enforcement of such laws challenging. Moreover, although allegations such as those in the Brown case in California have yet to be adjudicated in court, and despite the fact that SCH seemed to declare victory after being added to the Washington State exchange plans, there are a number of factual distinctions between those two cases that render dubious the applicability of those facts to a great deal of other cases.267 Lastly, insurers are now keenly aware of existing legal restrictions in place regarding exclusion of providers and the

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264 See Furrow et al., supra note 15, at 347–49.
265 See supra notes 36–44 and accompanying text.
266 An exception, of course, to this would be those consumers who were unaware of the breadth of their network at the time of purchase. Like the Brown litigants, however, plaintiffs in these scenarios may find it difficult to prevail in a lawsuit where the insurer can show that the information provided was sufficient to appropriately inform a reasonable consumer about the type of plan that was being purchased.
267 See supra text accompanying note 24.
need to provide information to consumers regarding the breadth of a network. Many of these laws date back over ten years and thus, insurers are aware of the limitations and how such networks would need to be structured in order to be less susceptible to legal challenge.

Finally, one other key distinction lies at the provider level. In the 1980s and 1990s, many providers felt as though they had few options as HMOs and limited networks began to spread rapidly.268 Many feared that failure to join a network might result in so few patients that maintaining a practice would be next to impossible.269 Then, after joining en masse, many of those providers lost so much money through capitation that it was nearly impossible to continue providing services through the HMO and maintain a viable business.270 Unlike HMOs, nearly all Narrow Network models contemplate alternative reimbursement structures that may include some capitation or bundled payment models, but not solely capitation. Thus, providers are potentially more willing to participate in these networks, which appear to contain somewhat less risk than previous models.271 More importantly, those providers who are most likely to be excluded due to cost, such as academic medical centers, seem to have anticipated that limited provider networks under health care reform would come to pass. Therefore, many of these High-Cost Providers are pivoting their business model to insulate themselves from an anticipated and fateful exclusion from various networks. Assuming their shifts in focus to other models and other consumers, namely large self-funded employers, are successful, High-Cost Providers are unlikely to feel the need to take action when excluded from Narrow Network options.

This confluence of increased consumer choice on the individual marketplace, alternative reimbursement structures, and alternative mod-

268 Elisabeth Rosenthal, Doctors Slow to Join H.M.O.’s Now Often Find Doors Shut, N.Y. TIMES, June 25, 1994, at 1 (noting that private doctors who had originally spurned HMOs found themselves with a severe drop in volume when they failed to join, leaving them desperate to join).

269 Id.

270 See Ken Terry, Do Doctors Give HMO Patients a Fair Shake, MED. ECON. (Feb. 21, 2000), http://medicaleconomics.modernmedicine.com/medical-economics/content/do-doctors-give-hmo-patients-fair-shake?page=full (noting an example of a physician who changed her practice by setting a hard cap on the amount of time she would spend with HMO patients due to the low reimbursements she received from those patients providers).

271 This is not to say that insurers are not still shifting risk from the insurer to the providers in many of these new reimbursement models. Perhaps somewhat less risky than capitation, value-based purchasing, shared savings, and bundled payment models all shift risk to the providers to provide more coordinated and less costly care in order to collect for services rendered. See FURROW ET AL., supra note 161, at 657–59.
els for High-Cost Providers indicates that Narrow Networks appear poised to experience more sustained and long-term growth than HMOs. As these new models begin to take shape, what is clear is that insurers and providers learned enough from the HMO movement that they are likely to avoid some of the same challenges that plagued limited provider models of the past.
MANAGING THE DISTINCTION BETWEEN GOVERNMENT SPEECH AND PRIVATE PARTY SPEECH

R. George Wright*

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I. INTRODUCTION: THE WALKER CASE AND THE NEED FOR BROADER PERSPECTIVE

The distinction between speech by the government itself and speech by private parties is often of substantial importance from the perspective of free speech law. Other constitutional problems aside, governments are largely free to say whatever they wish, and to refuse to say whatever they do not wish to say, independent of judicial scrutiny for free speech

* Lawrence A. Jegen Professor of Law, Indiana University Robert H. McKinney School of Law.

1 In light of the Establishment Clause, there are more substantial limits on what a government itself may say with respect to religious orthodoxy. See, e.g., Town of Greece, N.Y. v. Galloway, 134 S. Ct. 1811 (2014).

2 There may be cases of constitutionally justifiable compelled speech by government officials, whether such a case would be justiciable or not. Consider, e.g., the case of a President who simply refused to ever convey to Congress any information regarding the State of the Union. See U.S. CONST. art. II, § 3.
violations. In sharp contrast, government regulation of the speech of private parties may, depending upon context, be subjected to rigorous judicial scrutiny under the Free Speech Clause. Judicial mistakes in applying this basic distinction might either impair ordinary governmental policymaking and functioning, or else lead to the unnecessary humiliation, alienation, and objectification of a number of private persons. The worst imaginable cases might involve what would amount to the government seizure and expropriation of vital private speech.

The importance of the government speech versus private party speech distinction has not, however, been matched by its clarity. The Supreme Court recently addressed this distinction in the specialty license plate case of *Walker v. Texas Division, Sons of Confederate Veterans, Inc.* Justice Breyer wrote the opinion for a five member majority, with Justice Alito writing the sole opinion for the four dissenters.

Justice Breyer’s majority opinion begins by distinguishing among ordinary license plates issued more or less at random; individualized or vanity license plates with unique combinations of letters or numbers; and the various sorts of specialty or group-focused license plates, with only the latter being at issue in *Walker.* Thus Justice Breyer’s opinion on its own terms does not purport to address a wide range of distinguishable license plate programs, let alone government speech versus private speech issues in contexts such as the use of public school classrooms by private groups, or the exclusion of unpopular speaker-groups from


4 See, for example, the treatment of government regulation of private party speech in traditional public fora in *Perry Educ. Ass’n v. Perry Local Educators’ Ass’n*, 460 U.S. 37, 45–46 (1980).

5 *See* *Walker*, 135 S. Ct. at 2246 (“Were the Free Speech Clause interpreted otherwise, government would not work.”).

6 See, for example, the “Live Free or Die” required license plate motto case of *Wooley v. Maynard*, 430 U.S. 705, 715 (1977).


8 *See* *Walker*, 135 S. Ct. at 2243. Justice Thomas, interestingly, provided the necessary fifth vote. *Id.*

9 *Id.* at 2254 (Alito, J., dissenting).

10 *Id.* at 2244 (majority opinion).

11 *Walker*, 135 S. Ct. at 2244.

12 *Id.* For a hint of the wide variation in specialty license plate programs among the states, see *id.* and the programs discussed in the cases cited *infra* Part II.A.

13 *Walker*, 135 S. Ct. at 2244.

14 *See,* e.g., *Good News Club v. Milford Cent. Sch.*, 533 U.S. 98 (2011); Bd. of Educ. of
government “adopt-a-highway” programs. 15

In *Walker* itself, the relevant Texas administrative board had rejected the specialty license plate design proposed by the Sons of Confederate Veterans, 16 and specifically the Confederate flag portion thereof. 17 The board based its rejection on the grounds of widespread reasonable public offense and related public perceptions of the flag as associated with hateful or demeaning expression. 18

Justice Breyer began his constitutional analysis by emphasizing the importance of the government speech versus private party speech distinction. In particular, Justice Breyer referred to the extent to which government speech, in its own name and on its own behalf, is not subject to regulation under the Free Speech Clause. 19 The Court relied heavily, for this point and for its further analysis, on the recent *Summum* case 20 involving a number of permanent monuments on display in a particular city park. 21 In general, the Breyer majority case law analysis was primar-

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Westside Cmty. Schs. v. Mergens, 496 U.S. 226 (1990); Widmar v. Vincent, 454 U.S. 263 (1981); Bronx Household of Faith v. Bd. of Educ. of City of N.Y., 650 F.3d 30 (2d Cir. 2011) (exclusion of worship service community group from public schools was a permissible content-based, but crucially, not viewpoint-based, restriction on speech).

15 As well, in the public bus and train context, consider the various possibilities implicit in the political advertising prohibition case of Am. Freedom Def. Initiative v. Metro. Transp. Auth., 109 F. Supp. 3d 626 (S.D.N.Y. 2015). For an interesting contrast with the *Walker* majority opinion, see *Cuffley v. Mickes*, 208 F.3d 702 (8th Cir. 2000). *Cuffley* involved a request by the Ku Klux Klan to participate in an official adopt-a-highway program. The court held that Klan participation in the program would not amount to state action. *Id* at 709. We discuss state action and related concepts *infra* Part II.B. The court then went on to hold that the denial of the Klan’s application constituted unjustified viewpoint discrimination and thus a free speech violation. *Cuffley*, 208 F.3d at 712; see also David Millward, *Ku Klux Klan Fights for Right to ‘Adopt a Highway,’* TELEGRAPH (July 9, 2015), www.telegraph.co.uk/news/worldnews/northamerica/usa (citing continuing Georgia litigation). Consider also the possible evolution of trademarks and trademark decisions as government speech. For background, see Christine Haight Farley, *Stabilizing Morality in Trademark Law*, 63 AM. U. L. REV. 1019 (2014).


17 See *Walker*, 135 S. Ct. at 2245.

18 See *id*. For citations to speech cases involving restriction of Confederate flag clothing and regalia in the public schools, see, for example, *Hardwick v. Heyward*, 711 F.3d 426 (4th Cir. 2013); *Defoe v. Spiva*, 625 F.3d 324 (6th Cir. 2010); *A.M. ex rel. McAllum v. Cash*, 585 F.3d 214 (5th Cir. 2009); *B.W.A. v. Farmington R-7 Sch. Dist.*, 554 F.3d 734 (8th Cir. 2009); *Barr v. Lafon*, 538 F.3d 554 (8th Cir. 2008); *Scott v. Sch. Bd. of Alachua Cty.*, 324 F.3d 1246 (11th Cir. 2003); *Denno v. Sch. Bd. of Volusia Cty.*, *Fla.*, 218 F.3d 1267 (11th Cir. 2000); *West v. Derby Unified Sch. Dist. No. 260*, 206 F.3d 1358 (10th Cir. 2000).

19 See *Walker*, 135 S. Ct. at 2245–46; but see, e.g., *supra* notes 1–2.


21 *Id.* at 464–65. The particular monument at issue in *Summum* was of a religious charac-
ily “top-down,” as opposed to “bottom-up,” in the sense that more attention was devoted to Supreme Court precedents, even at some factually and analytically greater remove, than to much closer court of appeals cases.22

As Justice Breyer recounted the prior Summum case, the Court had in that case rejected the idea that in accepting fifteen privately donated permanent monuments of various sorts for the small23 city park, the city had thereby provided some sort of public forum for speech by private parties.24 Rather, in accepting monuments offered by interested private-group sponsors, the city was engaging in expressive conduct or speech of its own,25 and thus was engaging in government speech26 not typically subject to judicial review under the free speech clause.27

The Court’s conclusion in Summum was said to be based on the weighing of a number of factors,28 as was the Court’s own disposition in Walker.29 Among the relevant factors in Walker was the long history of license plates communicating state messages.30 Second, and conjointly, license plates themselves are owned by the state31 as are the designs on such plates;32 the plates are all issued by the state;33 display of the license plate is mandatory;34 the state’s name itself is uniformly conspicuously displayed;35 the plate designs are often closely associated with the state in the public mind;36 and the plates function, in essence, as government IDs.37

For citations to a number of the recent controversial license plate cases, admittedly in varying contexts, see infra Part II.A.

22 Merely 2.5 acres, and thus perhaps a limited capacity site for some purposes. See Walker, 135 S. Ct. at 2247.
23 Walker, 135 S. Ct. at 2247.
24 Id.
25 Id.
26 Id.
27 Walker, 135 S. Ct. at 2248.
28 See id. at 2248–49.
29 Id. at 2248.
30 Walker, 135 S. Ct. at 2248.
31 Id.
32 Id.
33 Id.
34 Id.
35 Walker, 135 S. Ct. at 2248.
36 Id.
37 See id. at 2249. Note that drivers’ licenses could also be said, even more literally, to constitute state ID. This leaves open, however, whether speech on a particular driver’s license, such as an unambiguously expressed wish to become an organ donor under particular circumstances, should count as speech by the government itself, rather than speech by the license holder that is also endorsed, or encouraged by, the state. If we conclude that an organ donation request counts as both government speech and private party speech, may we still not ask
The Breyer opinion then interestingly, and quite plausibly, observed that private parties generally have a clear incentive to obtain state approval of their proposed license plate designs. In particular, a person who displays a message on a Texas license plate likely intends to convey to the public that the State has endorsed that message. If not, the individual could simply display the message in question in larger letters on a bumper sticker right next to the plate.

This logic convincingly establishes that at least some, if not all, specialty license plates may carry, or be thought to carry, a state endorsement of a pre-existing message articulated and promoted at the initiative of a private party. What this logic does not at all establish, however, is that the pre-existing message being endorsed by the state is not that of the private party requesting the plate. Even less does the logic establish that the endorsed speech is not also, in one measure or another, that of the requesting private party, along with the state.

whether it is the state or the private party that is ultimately most closely associated with a particular license holder’s publicized decision to donate?

Suppose, though, that even in such a case it is somehow thought to be primarily the state itself that is speaking, and not merely endorsing or encouraging speech by private parties. Would there not then arise a serious logical complication in the case of any license holder who explicitly rejects the option of organ donation? Would that also be predominantly state speech despite its tension with the assumed state policy of affirmatively encouraging organ donations?

For discussion of the reasonable perception of government endorsement or approval of a message typically assumed to be articulated and expressed by a private party speaker, see, for example, Hazelwood Sch. Dist. v. Kuhlmeier, 484 U.S. 260 (1988), with commentary thereon in Morse v. Frederick, 551 U.S. 393, 405–06 (2007). See also Hosty v. Carter, 412 F.3d 731 (7th Cir. 2005) (en banc) (apparently validating the paradigm of speech by students that may then be endorsed or disapproved of on one ground or another by relevant government actors). For discussion, see Emily Gold Waldman, Returning to Hazelwood’s Core: A New Approach to Restrictions on School-Sponsored Speech, 60 FLA. L. REV. 63 (2008); Emily Gold Waldman, University Imprimaturs On Student Speech: The Certification Cases, 11 FIRST AMEND. L. REV. 382 (2013). For discussion in the Establishment Clause context, see Andrew Koppelman, Endorsing the Endorsement Test, 7 CHARLESTON L. REV. 719 (2013).

At least hypothetically, the state could simultaneously approve of two different specialty license plates carrying plainly and inescapably contradictory messages. We can certainly imagine political, or merely financial, incentives in a state consciously so doing. But it is unclear whether a patent self-contradiction can be, or be perceived as, much of an endorsement. Of course, many persons may not be aware of both messages, or their mutual incompatibility.

If it is imagined that a given instance of speech cannot be attributed, imputed, or ascribed to more than one party, consider any number of cases of joint or shared authorship; many commercial advertisements; multiple defendant defamation cases, including N.Y. Times v. Sullivan, 376 U.S. 254 (1964); adopted treaties and conventions; some but not all public displays of explicitly quoted language; lyric sampling; or any number of other shared or joint responsibility cases.
Finally, the Court noted that Texas had actively exercised direct, and in some respects sole, control over specialty license plates. In particular, the relevant administrative board “must approve every specialty plate design proposal before the design can appear on a Texas plate.”

The basic problem, though, at this point, is that the very idea of officially approving a design seems to logically require a separate designer. Presumably the state is not in all cases approving something that is entirely of its own design. And presumably, the proposed design is sometimes tendered by a private party, and not—or at least not entirely—by the government. We thus need some further theory as to why a private party taking the initiative to propose and eventually display its favored and perhaps idiosyncratic message should never be considered, to any degree, as a speaker of its own desired message.

The Court in *Walker* nevertheless concluded that the state was “speaking on its own behalf” in the specialty license plate program. Of even greater interest, however, the Court apparently assumed that because the government was itself speaking through the specialty license plate program, it must follow that no private party could also be speaking, for free speech purposes, through the program.

The Court rejected in particular the very idea of applying what is called public forum doctrine, which is often applied in cases of speech by private persons on or through government owned property. Nonetheless, the Court then proceeded, perhaps in dicta, to deny that the specialty license plate program involved, respectively, a traditional public forum; a designated public forum; a limited (purpose) public forum; or what is called a nonpublic (public) forum. Oddly, though, if

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42 See *Walker*, 135 S. Ct. at 2249.
43 Id.
44 Of course, one level or branch of government may overrule another on the merits, or change its own mind. A single agency’s approving (or rejecting) what it has, purportedly, itself simultaneously proposed is another, less comprehensible matter.
45 See *Walker*, 135 S. Ct. at 2250.
46 Id.
47 Though not always. For example, restrictions on speech by a public school student in a classroom context may be judged by the distinct standards of *Tinker v. Des Moines Indep. Cnty. Sch. Dist.*, 393 U.S. 503 (1969), and its progeny. For commentary, see, for example, R. George Wright, *Post-Tinker*, 10 STAN J. CIV. RTS. & CIV. LIBERTIES 1 (2014).
48 See *Walker*, 135 S. Ct. at 2250. The Court rejected the claim of the presence of private party speech and in particular concluded that “forum analysis is misplaced here. Because the State is speaking on its own behalf, the First Amendment strictures that attend the various types of government-established forums do not apply.” Id.
49 See id.
50 See id.
51 *Walker*, 135 S. Ct. at 2250. In contrast, Justice Alito’s dissenting opinion would classi-
we know that one or more items of speech are indeed government speech—perhaps the State of the Union message—as the majority at this point may assume, it hardly matters that the government speech is being delivered in any sort of public forum—perhaps a public park—broadly open to speech by private persons.

The majority then observed that “[t]he fact that private parties take part in the design and propagation of a message does not extinguish the governmental nature of the message or transform the government’s role into that of a mere forum-provider.” That the state wishes to convey many, perhaps hundreds, of governmental messages through its specialty license plate program also does not establish that the various messages are not government speech. Here, as elsewhere in Walker, there may again be an implied suggestion that if we know that an item of speech is attributable to the government, that means that the speech in question cannot also be that of private parties as well.

The Walker majority then pointed out that “each specialty license plate design is formally approved by and stamped with the imprimatur of Texas before incidentally granting that the rights of private persons might well be implicated in compelled speech cases in which private persons are legally required to bear messages contrary to their con-

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52 See Walker, 135 S. Ct. at 2251. Here in particular, the Court considered, among other factors, “observers’ reasonable interpretation of the messages conveyed by Texas specialty plates” in determining that no nonpublic forum had been created.

53 See supra note 2.

54 See Perry, 460 U.S. at 45–46.

55 See id.

56 Imagine perhaps a State of the Union message that consisted, in part, of responses to private journalists’ questions, and that was freely conveyed to the world by various private media companies.

57 Walker, 135 S. Ct. at 2251 (footnote added).

58 See id. The dissenting opinion in Walker cites a figure of 350 current such varieties.

Id. at 2255, 2257 (Alito, J., dissenting).

59 See id. at 2251–52 (majority opinion).

60 Walker, 135 S. Ct. at 2252.

The problem, though, is again that in some contexts, the precise language of government approval and imprimatur is used not with regard to government speech, but with regard to government approval of the speech of private actors.63

The majority opinion in Walker thus leaves the reader with a sense of unfinished business, and of unanswered questions. The sole dissenting opinion in Walker, authored by Justice Alito,64 begins by declaring that “[t]he Court’s decision passes off private speech as government speech and . . . establishes a precedent that threatens private speech that government finds displeasing.”65

The Alito dissenting opinion then asks us to imagine the conclusions we would likely reach, as ordinary reasonable observers, as to who is doing the speaking through particular specialty license plates.66 Does the state, through its diverse specialty license plates, really wish to say, or even endorse the sentiment, that “I’d rather be golfing”?67 Who, in such a case, is the ‘I’? Does the State of Texas itself really seek to endorse rival schools including Brigham Young University68 and the University of Notre Dame,69 Establishment Clause issues aside?70 What is the Texas governmental speech interest in NASCAR driver Jeff Gordon, as distinct from any other driver,71 or in one college fraternity over another,72 or in the Masons,73 or, Establishment Clause issues again aside,

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62 Walker, 135 S. Ct. at 2251 (citing Wooley, 430 U.S. at 715).
63 See supra note 38 and accompanying text. The specific language of approval and imprimatur, real or perceived, of private speech occurs in Hazelwood Sch. Dist. v. Kuhlmeier, 484 U.S. 258, 271 (1988). See also id. at 281 (Brennan, J., dissenting). For a more recent such use, see the non-governmental speech case of Morse v. Frederick, 551 U.S. 393, 405 (2007). Chief Justice Roberts delivered the opinion of the Court in Morse. Id. at 395.
64 Chief Justice Roberts and Justices Scalia and Kennedy joined Justice Alito. See Walker, 135 S. Ct. at 2254 (Alito, J., dissenting).
65 Id.
66 Id. at 2255. It is possible that the overall specialty license plate program in general carries a government message, even if some of the particular specialty license plates do not. Note also that the problem of compelled speech, as in Wooley, remains even if all observers realize that a particular car owner rejects the uniform state-mandated message he or she is required to display.
67 See id. (“Rather Be Golfing”).
68 See Walker, 135 S. Ct. at 2257 (Alito, J., dissenting).
69 See id. at 2255.
70 See supra note 1 and accompanying text.
72 See Walker, 135 S. Ct. at 2255 (Alito, J., dissenting).
73 See id.
the Knights of Columbus.74

Presumably the typical reasonable and informed observer of such plates would think of the specialized message portions of license plates, at least in some cases, as speech that is at least as much of the requesting private party—whether as a group,75 or at the level of the individual vehicle owner—as that of the state government. It is easier to imagine, say, some Notre Dame alumni, collectively or individually, as interested in promoting the University of Notre Dame than it is to imagine the State of Texas in such a role, or even endorsing such a sentiment in others.76

More broadly, Justice Alito suggests that “there is a big difference between government speech (that is, speech by the government in furtherance of its programs) and governmental blessing (or condemnation) of private speech.”77 His conclusion on behalf of the dissenting Justices was thus that the “[m]essages that are proposed by private parties and placed on Texas specialty plates are private speech, not government speech,”78 and thus not subject to governmental regulation based on viewpoint.79

While Justices Breyer and Alito thus reached opposing results, their opinions were in a crucial underlying respect apparently in complete accord. Both Justices evidently concluded that a specialty license plate program itself, or the particular items of speech on a given specialty license plate, must in any given respect be either government speech, or else the speech of one or more private parties. More nuanced possibilities did not make the final cut. Thus both Justices Breyer and Alito, and by extension, the entire Court adopted what we might call a strictly binary, or rigidly dichotomous, view of the distinction.

About this apparently unanimous conclusion, however, there is more to be said.80 Further below, we seek additional perspective on the

74 See id.
75 In some cases, commissioned specialty license plates in Texas may cost $8,000. See id. at 2260. Willingness to pay any such amount, and the willingness to receive it, may in itself suggest who should be treated as the primary speaker in such cases.
77 Walker, 135 S. Ct. at 2261 (Alito, J., dissenting). The constitutional significance of this distinction is suggested in the public school context by Hazelwood and related cases cited supra note 38.
78 See Walker, 135 S. Ct. at 2263 (Alito, J., dissenting).
79 See id.
80 See infra Section II.C. The Fourth Circuit, and Judge Daniel Luttig in particular, has.
government speech versus private party speech distinction from several possible angles. First is what we might call a conceptual or analytical perspective. From this perspective, we briefly explore the concepts of state action, state responsibility, and the most relevant senses of responsibility and related ideas in an attempt to shed light on the legitimate scope of the government speech. Second, at an admittedly further remove, is what we might call a (remote) natural science analogue perspective. Here, we look to the closest available natural science analogy as a possible source of illumination. And third and finally, we briefly consider what we might call a pragmatic or political choice-based approach to problems of responsibility in general and of governmental responsibility and authorship more specifically.

Before considering these three supplementary perspectives, though, we should enrich the scope of the underlying jurisprudential options by recognizing judicial approaches to license plate speech issues beyond those emphasized in Walker. We thus consider several such judicial approaches immediately below.

been at the forefront of exploring the possibility of “mixed” or “hybrid” government-private-party speech. See ACLU of N.C. v. Tata, 742 F.3d 563 (4th Cir. 2014), vacated sub nom. Berger v. ACLU of N.C. 135 S. Ct. 2886 (2015) (relying exclusively on Walker); Planned Parenthood of S.C., Inc. v. Rose, 361 F.3d 786, 800 (4th Cir. 2004) (Luttig, J., concurring in the judgment) (“Where the private speech component is substantial and the government speech component is less than compelling, viewpoint discrimination by the state is prohibited.” (citing earlier opinions)). This is akin to some nonpublic fora.

81 See infra Section II.B.
82 See infra Section II.B.
83 See infra Section II.C.
84 See infra Section II.C.
85 See infra Section II.D.
86 See infra Section II.D. Consider also the possibility that even if none of these three perspectives is thought to illuminate the government speech versus private party speech distinction, descriptively or normatively, some combination of the three perspectives might.

II. OPTIONS FOR BETTER PERSPECTIVE ON THE DISTINCTION BETWEEN GOVERNMENT SPEECH AND PRIVATE PARTY SPEECH

A. Broadening the Range of Judicial Approaches

As we have seen, the *Walker* case suggests two separate approaches to the government speech versus private party speech distinction. Very roughly put, Justice Breyer adopts some of the considerations previously weighed in *Summum*,88 based upon what he takes to be those considerations that are either generally relevant to putative government speech cases, or else that are the most contextually relevant in *Walker*. Thus Justice Breyer factored in a long history of state messaging through license plates;89 state ownership, issuance, and compulsoriness of display of license plates and their designs;90 and the active, direct, and in some cases exclusive control exercised by the state over specialty license plates and their design.91

Justice Alito, in dissent, covers much of this ground while in the end reaching an opposed ultimate conclusion. But as we have seen, Justice Alito also asks us, crucially, to perform something of a thought experiment.92 We are to ask what conclusions as to speaker identity and authorship would likely to be reached by reasonable and informed observers of the displayed license plates.93 While this thought experiment need not always be construed as a complete and self-contained constitutional test, the law often crucially considers the judgments of reasonable and informed observers.94

The basic Alito thought experiment flows from relevant preexisting case law, including the Fifth Circuit’s underlying opinion in *Walker*,95

88 See supra notes 28–43 and accompanying text.
89 See supra note 30 and accompanying text.
90 See supra notes 31–37 and accompanying text.
91 See supra notes 42–45 and accompanying text; see also Note, Three's a Crowd, supra note 87, at 818–26 (noting and approving of the Court’s emphasis on careful state control of a particular medium of communication).
93 See supra notes 66–76.
separate appellate court authority,96 and a concurring opinion in Summum itself.97 Justice Souter had thus written in Summum that “the best approach that occurs to me is to ask whether a reasonable and fully informed observer would understand the expression to be government speech, as distinct from private speech the government chooses to oblige.”98

Beyond the fairly straightforward thought-experiment alternative, there is also the Johanns government determination-and-control test.99 This test, construed as separate and independent from other considerations, holds that speech counts as government speech rather than private speech when the government retains and exercises the authority to determine and control the entirety of the message in question, as disseminated through the communications medium in question.100 The potential problem, however, in seeking to apply the Johanns case logic in general is that the Johanns test was developed for instances of government-compelled subsidization by private parties of the speech at issue,101 unlike in most of the license plate and sundry related cases.

A final broad judicial alternative would involve adopting some more or less flexible, perhaps not exhaustive, list of relevant factors akin to but distinct from the considerations upon which Justice Breyer focused in Walker.102 Several appellate circuits have developed a four-part test that considers the “central purpose” of the program in question;103 the “degree of editorial control exercised by the government;”104 the “identity of the literal speaker;”105 and the bearer of “ultimate responsi-

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96 See, e.g., Children First Found., Inc. v. Fiala, 790 F.3d 328, 338 (2d Cir.), vacated, 611 F. App’x 741 (2d Cir. 2015); Roach v. Stouffer, 560 F.3d 860, 867 (8th Cir. 2009) (“Our analysis boils down to one key question: whether, under all the circumstances, a reasonable and fully informed observer would consider the speaker to be the government or a private party.”); Choose Life Ill., Inc. v. White, 547 F.3d 853, 863 (7th Cir. 2008) (asking “[u]nder all the circumstances, would a reasonable person consider the speaker to be the government or a private party”).


98 Id. at 487.


100 See id. at 561–62; see also ACLU of Tenn. v. Bredesen, 441 F.3d. 370, 375 (6th Cir. 2006).

101 See Johanns, 544 U.S. at 557. For further discussion, see Paramount Land Co. v. Cal. Pistachio Comm’n, 491 F.3d 1003, 1009–12 (9th Cir. 2007).

102 See supra notes 29–45 and accompanying text.


104 Id.

105 Id.
bility for the speech content of the speech” in question.106

As with all such tests, the broad scope of coverage of these four test factors comes at some cost in greater ambiguity and indeterminacy. Even if we can select a central purpose for a program with more than one crucial purpose, including revenue, identifying the “literal” speaker is still likely to be a contested matter, and perhaps simply a restatement of the basic issue. Allocating the (presumably unshared) “ultimate” responsibility for the speech content can also verge on merely restating the underlying issue. Nor would it much matter that the government is somehow ultimately responsible for the speech if private parties could still be sued107 for the speech in question.108

There are thus available a number of judicial tests for distinguishing government from private party speech. While each such test has its adherents, even at their best, the tests tend toward ambiguity, excessive openness, and an uncomfortable degree of indeterminacy, if not near emptiness. Below, we briefly consider three less purely judicial supplementary perspectives, including, first, whether the basic concepts of state action, responsibility, and related notions can remedy or mitigate the defects in the proposed judicial tests.

B. The State Action and Responsibility Perspective

The judicial doctrine of state action is very roughly a measure of one form or another of state responsibility for some particular act, outcome, or condition.109 The idea of state responsibility, ultimate or other-

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106 Id.
107 As in, hypothetically, a case of defamation, trademark infringement, or copyright violation.
108 For further discussion of this four factor test, see, for example, Tata, 742 F.3d at 569–75. See also Ariz. Life Coal., Inc. v. Stanton, 515 F.3d 956, 964–65 (9th Cir. 2008); Planned Parenthood of S.C. Inc. v. Rose, 361 F.3d 786, 792–94 (4th Cir. 2004); Sons of Confederate Veterans, Inc. ex rel. Griffin v. Comm’r of Va. Dep’t of Motor Vehicles, 288 F.3d 610, 618–21 (4th Cir. 2002); Knights of the Ku Klux Klan v. Curators of the Univ. of Mo., 203 F.3d 1085, 1093–94 (8th Cir. 2000). One variation on this four part formulation, in the form of a non-exhaustive listing of three factors, was adopted by the Seventh Circuit. In Choose Life Ill., Inc. v. White, 547 F.3d 853, 863 (7th Cir. 2008), the court focused on “the degree to which the message originates with the government, the degree to which the government exercises editorial control over the message, and whether the government or a private party communicates the message.”
wise, is clearly at work in a number of the judicial tests for government speech. If we had a clear and defensible understanding of state action and of state responsibility in general, we could make progress in developing a more satisfactory doctrine of government versus private party speech.

A crucial element of this approach, however, is that causal, moral, and legal responsibility all seem to present cases in which one party, perhaps a government, can bear some degree of responsibility for an event, without bearing all, or even most, of the relevant responsibility. As Professor Brian Barry once observed in the context of moral responsibility, “Attributing moral responsibility . . . is not a fixed-sum game. . . . Just as there can be overdetermination of events there can, so to speak, be overresponsibility for outcomes.”

The state action case law also brings to our attention an important, but often obscured, element of a number of the government speech versus private speech cases. This is the matter of race. In a way, it is hardly surprising that the obvious racial civil rights elements of a number of the cases do not factor explicitly into the analysis. Courts addressing free speech cases are understandably reluctant to take judicial account of the egregiousness of the speech at issue.

Upon reflection, though, it should become clear that taking fundamental racial civil rights elements into account need not involve direct judicial judgments on the lack of substantive merit of the speech in question. Instead, state action as state responsibility should quite sensibly reflect the possibility that history, and the obvious seriousness of civil rights contexts, can legitimately make a difference in the proper scope of governmental as well as personal responsibility.

Consider to begin with a simple personal example. Suppose that at very low cost, we can prevent someone’s mild headache, and that we fail

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110 See supra notes 106–108 and accompanying text.


112 See, classically, the language of Justice Holmes in United States v. Schwimmer, 279 U.S. 644, 654–55 (1929) (Holmes, J., dissenting) (“[I]f there is any principle of the Constitution that more imperatively calls for attachment than any other it is the principle of free thought—not free thought for those who agree with us but freedom for the thought that we hate.”). The Schwimmer majority, incidentally, was overruled in Girouard v. United States, 328 U.S. 61 (1946).

113 See Wright, supra note 109, at 703–04.
to do so. If this is our sole relationship to the headache and to the victim in question, it is unlikely to be widely held that we are genuinely morally or legally responsible for the headache. But if at the same low cost, we alone could have prevented the accidental drowning death of the same child, the claim that we are to some degree morally or legally responsible for that accidental death seems entirely in order. The key change here seems to be in the gravity of the situation.114

If this is so, there may be room for a judicial judgment that governmental responsibility, in light of history, for basic racial rights-related acts, events, outcomes, and conditions may well be generally greater than in other sorts of cases.115 On such a view, it is less credible for a government to wash its hands of, and to disclaim any responsibility regarding, state accommodations for, say, Klan speech, when the Klan is arguably seeking some sort of official legitimation, or an official imprimatur,116 for its image and activities. At least in this respect, the scope of state responsibility may properly vary with the moral and historical weight of the context and circumstances.

Of course, things may not always be this simple. The idea of responsibility, whether used in causal, moral, legal, or mixed senses, can be further refined in various ways. Near synonyms, and closely related ideas, may allow for refinements that the specific term “responsibility” does not. Thus, we might think of the government as a joint author, with other authors, of a particular item of speech.117 We might reconceive of government responsibility in slightly variant terms, such as attributability, or ascribability.118 Causation, too, can be linked to responsibility,

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114 See id.


116 See, e.g., supra text accompanying notes 38–39, 60.

117 For a brief discussion of concurrent speech ownership in copyrights, see, for example, Co-Authors, Collaboration, and Joint Authorship – Part I of All That, WRITER-IN-LAW (Sept. 5, 2013), http://writerinlaw.com/2013/09/05/co-authors-collaboration-and-joint-authorship-part-i-of-all-that/.

118 For general background, see T.M. SCANLON, MORAL DIMENSIONS: PERMISSIBILITY, MEANING, BLAME 202 (2008); Neil Levy, The Good, the Bad and the Blameworthy, 1 J. ETHICS & SOC. PHIL., no. 2, 2005, at 2; David Shoemaker, Attributability, Answerability, and Accountability: Toward A Wider Theory of Moral Responsibility, 121 ETHICS 602 (2011); ANGELA M. SMITH, Attributability, Answerability, and Accountability: In Defense of a Unified Account, 122 ETHICS 575 (2012). In particular, see Michael J. Zimmerman, Varieties of Moral Responsibility (noting claims are often formulated not in terms of moral responsibility,
and can be ascribed to parties in various degrees.\textsuperscript{119}

Regardless of these complications, and of how we conceive of responsibility and related ideas, the main implications thus far for government speech problems still seem to be two. First, courts should more commonly consider the possibility of non-binary analyses, in which both the government and private parties are to one degree or another identified with the speech in question, even if such courts ultimately reject non-binary solutions. And second, courts should more clearly and consistently bear in mind that history, culture, and moral theory may, as in the area of racial discrimination, impose special, unavoidable, non-disclaimable responsibilities on governments. In such cases, governments may not as often be merely innocent bystanders to otherwise private party speech.

C. A Remote Natural Science Analogue to the Problem: The Question of Wave-Particle Duality

As it happens, a number of physicists and philosophers spent much of the last century considering a problem of how to characterize light and other phenomena. The apparently binary category at issue suggested classifying light, etc. as either a particle, or as a wave.\textsuperscript{120} Below, we very


briefly describe a few complications therein, along with possible lessons for courts currently seeking to classify particular instances of speech as either that of the government or that of private parties.

In the case of light, electrons, and other entities, there seemed to be a mismatch between the relevant binary categories and typical observations. Light, for example, seems to exhibit some behavioral characteristics of waves, but also some behavioral characteristics of discrete particles, if perhaps not observably both at the same time. Thus, the great physicist Niels Bohr concluded that “optical phenomena require the notion of wave propagation, while the laws of transmission of momentum and energy in atomic photo-effects refer to the mechanical conception of particles.”

Otherwise put, as long as we insist on applying pre-established familiar categories, such as waves and particles, it will be difficult if not impossible to verbally describe with clarity what our laboratory and mathematical results amount to. We face “the apparently mysterious dual nature exhibited in the microphysics of matter and radiation.” Thus, depending on what we choose to measure, “radiation behaves in some respects—interference, diffraction, etc.—like a wave process governed by the classical Maxwell equations of an electromagnetic field, and in other respects—photoelectric effect, Compton scattering, etc.—like a beam of particles, the so-called quanta or photons.”

This is not to say that quantum entities really are waves, or that they really are particles, or both, independent of our purposes, interests, and measurements. Thus the natural science analogy, in itself, does not guarantee that if we examine the case circumstances carefully enough, we will discover that a given government program or instance of speech

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121 For some complications, see the sources cited supra note 120.
122 See Physical Science and the Problem of Life, supra note 120, at 98.
123 See Aspect & Grangier, supra note 120, at 15 (“[T]he problem of incompatible descriptions arises only if we insist on using classical concepts such as waves or particles.”).
124 Redhead, supra note 120, at 65.
125 Id.
126 See, e.g., Gribbin, supra note 120, at 429.
really is government speech, or really is private party speech, or even really is hybrid or mixed government-and-private party speech.

The natural science analogy to the government speech—private party speech problem may thus suggest a certain sort of pragmatism or instrumentalism, in the sense that our legal outcomes may also reflect what we choose to measure, and how we choose to measure it, as perhaps steered, as in physics, by our underlying interests. It is also sensible to very loosely infer from the natural science analogy the reasonableness of considering the possibility that not all speech should be dichotomously classed as either government speech, or else as private party speech, whatever our interests may be.

D. A Political Choice-Based Approach to the Government Speech—Private Party Speech Problem

The above wave-particle natural science analogy may thus suggest to some persons that we cannot always carve up the world in ways that match our pre-existing categories, including those of real responsibility, real state action, and even real government, as distinct from private party speech. These categories may, in the end, reflect group norms and what we take to be our group interests, rather than independent, pre-existing legal realities we hope to discover.

In a much broader context, Professor Marion Smiley has thus recommended that we “stop thinking about responsibility as a purely factual discovery” and that we instead think of judgments of responsibility as parts of “practical judgments that we ourselves make on the basis of our own social and political points of view.” Where we commonly imagine that we are seeking objective, causal analyses of events, “we in fact import into our causal analysis an assortment of more purely conven-

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127 For one possible line of development, see infra Part II.D. For background, see R. George Wright, Pragmatism and Freedom of Speech, 80 N.D. L. REV. 103 (2004).
128 Consider Judge Luttig’s discussion of the typical judicial “oversimplification[] that all speech must be either that of a private individual or that of the government, and that a speech event cannot be both private and governmental at the same time.” Sons of Confederate Veterans, Inc. ex rel. Griffin v. Comm’r of Va. Dep’t of Motor Vehicle, 305 F.3d 241, 244–45 (4th Cir. 2002) (Luttig, J., respecting the denial of rehearing en banc) (emphasis in the original); see also Planned Parenthood of S.C. v. Rose, 361 F.3d 786, 800 (4th Cir. 2004) (“[S]ome speech acts constitute both private and government speech . . . .”) (Luttig, J., concurring in the judgment).
130 Id.
tional attitudes about whose interests count in society.”

There do seem to be relevant cases in which the courts arguably seem to be pursuing some pre-existing legal truth. As one controversial example, consider the judicial assumption that prohibiting the expression, via license plates, of all points of view on a given subject matter amounts to a viewpoint neutral restriction on speech. Courts may well typically believe in such cases that it is independently and pre-existingly true that prohibiting the raising of a subject, from any viewpoint or perspective, is a rule that is objectively neutral as to viewpoint.

But it is also possible that a thoughtful court might assume instead that there is no objective fact of the matter as to whether license plate subject matter prohibitions are viewpoint neutral. We all appreciate that the subtle political effects of silencing all discussion of a subject in some forum will vary, depending upon power relationships and the status quo. Perhaps a judgment that the silencing is viewpoint neutral thus amounts, in some cases, to a practical judgment that whatever effects on different viewpoints a subject matter prohibition may have are somehow politically acceptable.

To the extent, though, that judicial decisions should aspire to encompass more than just practical political judgments about favored and disfavored interests, social norms, and conventions, all purely political choice-based approaches to our cases will be at best incomplete. Judges admittedly do not discover inherently dispositive facts of the matter in controversial free speech cases, independent of anyone’s interests, in the sense that physicists discover principled limits on the precision with which states of affairs can be described. But it is also not clear that courts should be content to resolve conflicts of political norms on the basis merely of other political norms and conventions. These generalizations, collectively, should encompass the government speech and private

131 Id. at 255. In the context of discussions of egalitarianism, John Roemer has similarly suggested that judgments of responsibility should be made politically, rather than on the basis of metaphysical assumptions and arguments. See John E. Roemer, Equality and Responsibility, Bos. Rev., http://new.bostonreview.net/BR20.2/roemer.html (last visited Jan. 23, 2016).
133 See SMILEY, supra note 129, at 4.
134 Id.
party speech cases in particular.

More broadly, there thus seem to be useful lessons to be drawn from each of the ways in which we have sought additional perspective on the government speech versus private party speech cases. But in turn, there are also plainly limits to the usefulness of those additional perspectives, alone or in combination. Below, we seek further progress from a different angle by arguing for a change in emphasis in one of the basic judicial tests commonly applied to restrictions on private party speech. This change in emphasis holds promise for drawing much of the controversy from many of the license plate and related sorts of cases.

III. A PRACTICAL CONCLUSION: ALTERNATIVE SPEECH CHANNEL ANALYSIS AND THE PERSUASIVE RESOLUTION OF GOVERNMENT SPEECH VERSUS PRIVATE PARTY SPEECH CASES

The Court majority in *Walker* found the more or less typical Texas specialty license plate program to involve government speech, and not private speech. At a very practical level, this resolution allows the states to maintain similar programs without the expense, inconvenience, and sheer embarrassment of litigation against more or less controversial, and in some cases, morally appalling, groups or individual persons.

This practical benefit to state governments, however, comes at the expense, in the eyes of some, of reduced analytical persuasiveness. It is not clear, merely for example, what to do with the central fact that many persons choose to pay extra for license plate messages that they could more conspicuously, more articulately, more effectively, and more cheaply express through one or more bumper stickers on either side of an ordinary license plate. One obvious possibility is that some such persons are not paying merely for the chance to speak their mind, or to publicly identify with a group—bumper stickers would in such cases be better alternatives from a free speech standpoint. Instead, some persons are presumably willing to pay the required premium because of the appearance, if not the reality, of an official government endorsement, approval, imprimatur, or similar recognition, of one sort or another, of a

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137 See id. at 2254 (Alito, J., dissenting).
138 For background, see R. George Wright, *The Unnecessary Complexity of Free Speech Law and the Central Importance of Alternative Speech Channels*, 9 PACE L. REV. 57 (1989). Apparently, no one has seriously argued, either, for some sort of synergistic or holistic effect from a license plate-bumper sticker combination.
This line of analysis, by itself, raises the possibility that such speech can, for important constitutional purposes, be treated as, at least in part, that of private actors, but with a desire on their part to somehow implicate or entangle the state in the message conveyed, whether the state wishes to convey its own message through the specialty plate program or not. Entanglements of various sorts are inherently untidy. It may thus seem that any thoughtful judicial resolution of typical government speech versus private party speech cases, at least in the various sorts of specialty or individual vanity license plate contexts, must be complex.

A sensible shift in the judicial focus in many such cases, however, may lead to well-justified adjudicative outcomes. Much of the practical controversy evaporates, after all, if the most reasonable alternative approaches to the case actually lead to the same case outcome. And in many of our cases, a confluence in the results of broadly different judicial approaches should in fact be possible. Let us simply assume, in a typical specialty or individual vanity license plate case, or in any related context, that the best analysis in a particular case results in a finding of government, and not private party, speech. In such a case, complications aside, the private party loses. Complications arise, however, if we decide instead that the speech in such a case is in substantial measure, if not entirely, that of a private party. Such a finding then invokes all the complications of the public forum categories, along with the law of subject-matter-based, content-based, and viewpoint-based restrictions, and then as well perhaps the vagaries of compelling governmental interest and sufficiently narrow tailoring inquiries.

Many of these latter complications can, however, often be bypassed if we are willing to rethink the stakes in typical private party speech cases. The private party speech cases involving various sorts of license plates currently look at the supposed nature or basis of the speech restriction, along with the supposed weight of any relevant government interests, the degree of likely interest advancement, and some appropriate degree of tailoring or “fit” between the scope of the government interests and the scope of the free speech impact, effect, or burden of the restriction.

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139 See, e.g., Choose Life Ill., Inc. v. White, 547 F.3d 853, 856 (7th Cir. 2008); see also supra notes 38, 63 and accompanying text.

140 See, e.g., Walker, 135 S. Ct. at 2246–52.

141 For background, see R. George Wright, Why the Content-Based/Content-Neutral Distinction Does Not Matter, 67 FLA. L. REV. (forthcoming 2016).

142 For background, see R. George Wright, Electoral Lies and the Broader Problem of Strict Scrutiny, 64 FLA. L. REV. 759 (2012).
All of these nature, weight, advancement, and tailoring inquiries are more complex and debatable than we typically care to admit.143 But these inquiries, remarkably, can and should be simply bypassed whenever the private party speaker retains entirely realistic and affordable alternative channels, equally valuable from the standpoint of the speaker’s own various legitimate free speech interests and values,144 and those of the actual and potential listeners, through which to speak.145 No substantial free speech-based net harms, overall, occur in such cases.

Would this general logic apply, though, in the cases of specialty or individual vanity license plate purchasers, and to many private speakers in related contexts?146 It would, as is neatly illustrated by reflecting on the available alternative speech channel of one or more bumper stickers.147 Compared to any sort of license plate, and any message conveyable thereby, bumper stickers can be larger overall, more colorful, larger print, more elaborate and detailed, more articulate, less “crowded,” and certainly less expensive. Bumper stickers will, in the typical case, thus promote, at least as well as any sort of license plate or related medium, any legitimate, basic free speech interests and values148 endorsed by the speaker. What bumper stickers realistically cannot do, in typical cases, is to illegitimately implicate a government, or to arguably invoke a government’s endorsement or imprimatur, with respect to the private party message in question. But this is broadly a feature, rather than a bug.

The upshot, then, is this: In any of the typical cases in which the purported private party speaker has available a constitutionally fully ad-

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144 For a mainstream inventory of the basic interests or values promoted through free speech, see Kent Greenawalt, Free Speech Justifications, 89 COLUM. L. REV. 119 (1989). Pursuit of truth, self-realization, and democratic government are among such values. See id.
145 Consider a case in which the government’s interest is a bit less than it should be, and the scope of its speech regulation is substantially broader than necessary. How much, really, should this matter, from the standpoint of free speech and its value, if the affected speaker retains alternative means of conveying the intended message that are at least as valuable, from the standpoint of the speaker’s (and listeners’ own) legitimate free speech values and interests, as the speech channels that are now restricted? If the government unnecessarily prevents Bill Gates from speaking (only) through the specific channel of tacking up posters on telephone poles across the country, what is Bill Gates’ free speech harm, in terms of his realistic ability to convey, precisely and powerfully, his message to the national audience? Or the free speech harm to actual or potential viewers or listeners, overall? For elaborate discussion, see Wright, supra note 138. Or one could think, more broadly, in terms of the broader idea of opportunity costs. See, e.g., David R. Henderson, Opportunity Cost, in THE CONCISE ENCYCLOPEDIA OF ECONOMICS (2d ed. 2008) (ebook), http://www.econlib.org/library/Enc/OpportunityCost.html.
146 See, e.g., supra notes 14–15 and accompanying text.
147 See supra notes 138–139 and accompanying text.
148 For discussion, see Greenawalt, supra note 144.
equate remaining alternative speech channel, the courts need not bother to make the often murky and complex choice between classifying the speech in question as government speech or as private party speech. The outcome would be the same on either basic classification. The purported private party speaker should, in either scenario, given the above assumptions, lose the free speech case at issue.

149 Note that it is entirely possible that regulation of speech may be substantially overbroad, or not at all narrowly tailored, and yet leave the private party speaker with one or more highly satisfactory channels through which to convey the message in question.
MISTAKES, AIRFARES, AND CONSUMERS: RESTORING THE
DEPARTMENT OF TRANSPORTATION’S ROLE IN
REGULATING UNFAIR TRADE PRACTICES

Terence Lau*

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* Terence Lau is the Associate Dean of Undergraduate Programs at the University of Dayton School of Business Administration in Dayton, OH. J.D., Syracuse University College of Law; B.A., Wright State University.
If you want to be a millionaire, start with a billion dollars and open an airline.
– Richard Branson, founder of Virgin Airlines

If, whatever a man’s real intention may be, he so conducts himself that a reasonable man would believe that he was assenting to the terms proposed by the other party, and that other party upon that belief enters into the contract with him, the man thus conducting himself would be equally bound as if he had intended to agree to the other party’s terms.
– Smith v. Hughes

I. INTRODUCTION

Price mistakes in contracting raise difficult legal questions. When someone buys something that turns out to be worth more than they paid for it, questions of equity and law quickly surface. The prospect of striking it rich suddenly has captured the public imagination, with the growth of reality television shows specializing in “sudden windfall” stories. There is no shortage of examples in the media. Take, for example, the case of Zach Norris, who purchased a watch from a Goodwill thrift store for $5.99, only to find out later it was worth $35,000. Goodwill did not attempt to take back its purchase, but a car dealership in Virginia was not quite as charitable. In September 2012, a Chevrolet dealership in Chesapeake mistakenly sold a new vehicle to a customer for thousands of dollars less than it intended. When the customer refused to sign a new contract for the right price, the dealership asked the police to arrest

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2 Smith v. Hughes (1871) 6 L.R. Q.B. 597, 607 (Blackburn, J.).

3 See generally Benjamin Groebner, Oops! The Legal Consequences of and Solutions to Online Pricing Errors, 1 SHIDLER J.L. COM. & TECH. 1 (2004) (discussing protective contract formation methods and unilateral mistake); see also Melvin A. Eisenberg, Mistake in Contract Law, 91 CALIF. L. REV. 1573, 1575 (2003) (discussing the complex nature of the mistake analysis).


the customer, who then spent hours in jail.\(^6\) The charges were dropped, but the customer filed a $2.2 million suit against the dealership alleging malicious prosecution, slander, defamation, and abuse of process.\(^7\)

What happens when computers automate the process of price contracting and millions of the same or similar items are sold daily? The airline industry grapples with this question when its tickets are mispriced and consumers snatch them up in pursuit of a bargain. This Article addresses questions raised when airlines misprice their airfares.

The airline industry remains an important force in the U.S. economy. In the wake of the Great Recession of 2008, the airline industry in the U.S. suffered through one of its most difficult periods, as business demand dried up and prices dropped.\(^8\) In 2009, the industry experienced a steep 16.1% decline in revenue.\(^9\) By 2014, the airline industry finally seemed to be on the mend as revenues rose 3.0% to $150.68 billion.\(^10\) Consolidation in the industry reduced the number of major airlines to just four companies (American, Delta, United, and Southwest) holding nearly 70% of the market.\(^11\) The combination of increased efficiencies and lower oil prices meant that the global airline sector returned handsome profits of $19.9 billion to shareholders in 2014, and is poised to increase that figure to $25 billion in 2015.\(^12\)

These profits are generated by staggering numbers of passengers. In 2014, airlines serving the United States carried an all-time high of 848.1 million passengers system-wide (domestic and international), a 2.5% increase from 2013 and 1.2% more than the previous record high of 838.4 million in 2007.\(^13\) Notably, “[i]n 1991, planes flew on average at 56 percent full, but now average nearly 85 percent full.”\(^14\) Average fares have risen from $307.31 in 2005 to $390.61 in 2014.\(^15\)

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\(^7\) See Zeeshan Haider, IBISWorld Industry Report 48111B: Domestic Airlines in the U.S. 7 (May 2015).

\(^8\) Id. at 37.

\(^9\) Id.

\(^10\) Id. at 26.


\(^14\) At a Glance: Average Air Fares, BUREAU TRANSP. STATISTICS,
This Article traces the problem of mistake airfares and the federal government’s response to airlines that cancel tickets for erroneous fares. Part II of the Article explores airline pricing generally, and argues that airline tickets are a unique form of commodity good, one where there is no consumer expectation of a reasonable price. The dynamic nature of airline yield management means that prices for the exact same seat on an airplane can vary dramatically based on a variety of circumstances and factors that are beyond the knowledge, control, or comprehension of the ordinary consumer. Then, Part II investigates several well-known examples of mistake airfare pricing, and discusses the Department of Transportation’s (“DOT”) regulations on airfare pricing. In Part III, the Article analyzes the DOT’s regulations in light of the common law of mistake in contracts and concludes that those regulations are well-grounded in traditional contract law. Part IV of the Article explores the DOT’s newly evolving thinking on mistake fares, including the DOT’s proposal to revise regulation on those fares. The Article argues that the DOT should not move away from its pro-consumer stance, which has served consumers well for nearly four years. Finally, in Part V, the Article makes some common-sense suggestions for how the DOT can approach the problem of mistake airfares in a way that strikes a proper balance between consumers and airlines.

II. THE PROBLEM OF MISTAKE AIRLINE AIRFARES

A. Airline Pricing Generally

Every day, millions of air passengers purchase tickets from airlines entitling them to passage from their point of origin to their destination. Originally printed on paper, the industry moved to 100 percent e-ticketing in May 2008 (resulting in $3 billion annual savings). In addition to information about the flights on which the passenger has purchased passage, airline e-ticket systems typically store a passenger’s name, address, date of birth, gender, frequent flyer information, seat assignment, and class of travel. When passengers arrive at the airport, the e-ticket is retrieved and used to issue a boarding pass to the passenger.
The industry distinguishes a reservation from an e-ticket. Some airlines permit reservations to be made and held without payment, while others require reservations to be paid for immediately. When a customer makes payment, e-tickets (each e-ticket has a separate and unique number attached) are typically issued shortly thereafter.

The price a consumer pays for an e-ticket is highly variable due to the capacity constraint on the airline industry. An airline has a certain number of seats between two points to sell, which restrains its revenue creating capacity. While airline ancillary pricing (such as checked bag fees) has created tremendous opportunities for additional revenue growth, ultimately airline revenue is driven by seat capacity. Once an airplane door closes and the airliner leaves the gate, the airline can no longer generate revenue by selling seats on that plane. As Jim Compton, a senior vice president of pricing and revenue at Continental Airlines (now merged with United) said, “I have a really perishable product. It’s gone when the door of the plane closes. An empty seat is lost revenue.”

This was not always the case. When the federal government regulated the airline industry, ticket prices for those seats remained fairly constant. “In 1974, [for example,] it was illegal for an airline to charge less than $1,442 in inflation-adjusted dollars for a flight between New York and Los Angeles.” Airline deregulation in 1978 gave pricing control to the airlines, and subsequently had profound effects on Americans. In 1965, only 20 percent of Americans had ever flown in an airplane, but by 2000, half of Americans took at least one round-trip flight in that year. This is because since 1978 airline prices have dropped by approximately 50 percent. That pricing, however, has become much more dynamic, and is now driven by a philosophy known as yield man-

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19 American Airlines, for example, permits most tickets to be placed on a 24-hour hold before purchase and ticketing. When a customer chooses this option, a reservation is created but the e-ticket is not issued until the customer pays the fare quoted for the reservation. Hold Your Reservation On aa.com, AM. AIRLINES, https://www.aa.com/hold (last visited Oct. 29, 2015).


22 For an excellent exposition on national airline policy, see generally Timothy M. Ravi-ch, National Airline Policy, 23 U. MIAMI BUS. L. REV. 1 (2014).


24 Id.

25 See id.
agement or revenue management. Put simply, airlines want to sell each seat for as much money as possible, without pricing it so high that the seat flies empty. If a seat cannot sell, the airline may decide to make it available to its frequent fliers who redeem accumulated miles for those seats.

With revenue maximization as the goal, airlines may change fares many times a day in hopes of selling the most seats at the highest price. Competitive forces play a factor as well, as airlines change prices to capture customers from other airlines or launch new routes. Unlike many other consumer commodity items, airline customers very rarely pay the same price for the same good or service they have previously purchased, or the same price as the customer seated next to them has paid. A myriad of factors can affect the price a customer pays for a seat, ranging from the time of day or week they are flying, the route they are flying, their point of origin, their destination, competitive forces or sales promotions, or even the size of their frequent flyer accounts. As flights fill up, seats become scarcer and pricing rises accordingly. Generally, this means that fares for last-minute ticket purchases are more expensive than fares for tickets purchased in advance, but in some cases airlines will cut prices at the last minute to fill a plane. Since airline pricing is not regulated, airlines are free to offer a seat at any price, and consumers are free to accept or reject that offer. On any given day, there are more than 100 million fares offered for sale to consumers, with prices updated hourly.

Consider one modern example: In 2003, Continental Airlines flew 2000 flights per day, with each flight having between 10 and 20 filed prices. The airline begins offering seats for sale 330 days in advance of a flight, and prices vary based on the precise day of a flight. "At any given moment . . . , Continental may have nearly 7 million prices in the mar-

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26 See Fishman, supra note 21 (discussing methodology of calculating fares).
28 See Fishman, supra note 21 (noting that airlines participate in a fare clearinghouse, ATPCO, that allows fares to change multiple times every day).
30 Id.
32 See Fishman, supra note 21.
33 See id. “Monday is a different kind of day than Tuesday; the Wednesday before Thanksgiving is different from the Wednesday before that.” Id.
ket.  Collectively, the airlines change 75,000 prices a day.  

The industry’s revenue model has three clear impacts to consumers. First, there is often no relationship between the cost to the airline to transport the passenger and the price charged. A short flight between a hub city and a captive destination with little competition that costs the airline far less in labor and fuel may be priced much higher than a longer flight between cities where competition requires lower pricing. Likewise, an airline may charge more for a direct flight than an itinerary with multiple segments despite the fact that the latter incurs higher labor and fuel costs and, moreover, requires the passenger to occupy an additional seat that the airline could otherwise sell. As a general principle of consumer transactions, a consumer can expect to pay more for receiving more products or services. In the airline business, however, the relationship between price and miles flown seemingly does not exist.

The second impact on consumers is that the product they purchase comes with more conditions than virtually any other consumer commodity. Some examples will illustrate this point. If a consumer purchased a concert ticket, that consumer could give away the ticket to a friend to attend the concert instead. Airlines do not permit name changes on tickets. When a customer purchases bagels at the end of the day when the food is about to be discarded that customer may expect a discount, but with airlines the price of the seat usually increases as the flight’s departure draws closer. When a customer purchases a can of soda from a vending machine that customer is welcome to throw away unused portions, but with airline tickets, a customer who intentionally discards the last portion of a ticket (a practice known as throw-away ticketing or “hidden city” ticketing) is violating the terms of their contract with the airline and could face penalties. When a customer purchases two cans of soda, they are welcome to consume the product in any order they wish, but

34 See id.
35 See Fishman, supra note 21.
37 See id. (discussing the variables airlines consider when determining the price of a flight).
38 See id.
39 See Hobica, supra note 29.
when an airline customer purchases two tickets and flies them in different order (a practice known as nesting or back to back ticketing), airlines consider that a violation of ticketing rules and subject to penalties. When a customer purchases goods at retail, they almost always have a right to return those goods if they change their minds, while the vast majority of airline tickets are nonrefundable or come with steep change penalties. The airlines have a need to protect revenue from a perishable product, and therefore impose onerous terms and conditions that most other industries would never contemplate.

The third impact on consumers, and perhaps the most important for purposes of this discussion, is that it is very hard, or even impossible, to discern a reasonable or prevailing price for any given ticket. It can be more expensive to fly between Washington and Hartford than to fly between Washington and Spain. Consumers rarely check the fare basis for the ticket they purchase, which all come with their own set of rules and restrictions. With most consumer goods and services, consumers approach a transaction with an expectation of what price they will be asked to pay. With airline pricing, however, ticket prices are so unpredictable and variable that there is very little expectation other than to be surprised.

B. Examples of Mistake Airfares

With millions of tickets sold every day for passage between thousands of destinations, airlines face a dauntingly large task of yield management. Most airlines hire revenue managers to oversee the task, aided by sophisticated computer programs that constantly monitor sales channels and loads to suggest changes. Every so often, an airline makes a mistake in updating a fare, resulting in a fare offered for sale that is low-

42 See generally McCartney, supra note 36 (discussing the difficulty in determining how airlines set ticket prices).
43 See id.
46 See Hobica, supra note 29.
er than the airline intended.47 These so-called mistake fares are then purchased by consumers through normal retail channels such as from the airline (i.e., through the airline’s website, phone reservations, or in person at a ticket counter) or a travel agent (i.e., an online travel agency Travelocity.com or Orbitz.com).

The growth of internet-based bulletin boards where consumers can share experiences and trade information has made the presence of mistakenly filed airfares almost immediately available. The below list of mistake airfares is by no means exhaustive, because many mistakes are not widely reported or discussed.

In May 2004, Icelandair filed a $0 fare for round-trip economy class travel between New York and Iceland.48 With taxes and fees, tickets were sold for approximately $61.49 The airline honored the fare.50

In April 2005, Air Pacific (now Fiji Airways) offered a promotion whereby a passenger purchasing a roundtrip economy class ticket from Los Angeles to Fiji would receive a free companion ticket.51 Online travel agent Travelocity mistakenly offered the “free” companion ticket for sale, which meant customers could purchase the $0 ticket for approximately $50 in taxes and fees.52 Travelocity honored the fare.53

Also in April 2005, US Airways filed fares from Lebanon, New Hampshire, to virtually everywhere in the United States for between $2 and $22.54 Transcontinental flights priced at the same level, and travel on partner United Airlines was permitted.55 The airline honored the

47 See id.
49 See id.
53 Id.
55 See MileageAddict, Post to Fare Gone!–US: LEB (Lebanon, NH) to just about anywhere USA Fares–$2–$22, FLYERTALK (Apr. 16, 2005 4:43 AM),
fare.56

In May 2005, Spain-based airline Air Europa filed a fare for a flight between Boston and Madrid for $115 roundtrip in economy class.57 This is a route the airline itself did not fly, but the fare rules permitted travel on partner airline Continental Airlines.58 Although not bookable with the airline itself, the fare was bookable through any travel agent including online travel agencies.59 The airline honored the fare.60

In October 2005, the now-defunct British airline bmi offered tickets between Chicago and Manchester for approximately $220 round-trip in premium economy class.61 The fare was filed as $0 because the ticket fare class was for a mileage redemption ticket rather than a ticket for cash sale.62 The airline honored the fare.63

In April 2006, Italy-based airline Alitalia mistakenly filed a business class fare between Toronto and Cyprus for $33 instead of $3,300.64 After initially canceling the tickets, the airline decided to honor the tickets and even permitted changes at one point, until reversing course and not allowing changes.65 Hundreds of tickets were sold in a 12-hour win-
In September 2007, Air France filed a fare as $0 between New York and Rome for economy class travel. With fuel surcharges, taxes, and fees, the tickets priced at around $280 each, roundtrip. Air France honored the tickets.

In late April 2012, as a result of a currency fluctuation, a one-way first-class ticket from Yangon, Myanmar, to Los Angeles could be purchased for $254, while a round-trip ticket was pricing at $450. The tickets were widely available on multiple online travel agencies, and since the transition happened just before a weekend, the tickets were available for at least three days before the pricing error was fixed. Many tickets were sold on behalf of Korean Airlines, which had the most available routings on the fare. Although Korean Airlines initially cancelled the tickets and refunded customers’ money once it discovered the mistake, it eventually decided to honor all tickets issued under the fare.

In September 2013, United Airlines filed $5–10 fares for many destinations, resulting in free or nearly free tickets being sold on its website. The airline decided to honor the tickets. Online social media and forums picked up the fare within 30 minutes, but the airline did not discover it for 50 minutes. It then took 20 minutes to fix the problem, and
the airline lost $2.9 million in that time.  

In November 2013, a small Norwegian online travel agency sold tickets without fuel surcharges, resulting in very inexpensive flights on United Airlines, such as New York to Milan for $149. A transaction processor for multiple airlines, Amadeus, was the source of the computer error. Thousands of consumers booked the tickets, which were ultimately honored by the airline.

In December 2013, Delta Airlines loaded $0 fares for many destinations, allowing round-trip cross-country flights to be sold for $25. The airline honored the tickets.

In February 2014, Etihad Airways, based in the United Arab Emirates, filed a fare for first class travel between Colombo, Sri Lanka, and Dallas for $1,450, cheaper than their normal economy class fare for the route. The airline honored the fare, but informed customers they would not receive other perks that came with first class travel such as chauffeur service or lounge access at the airport.

In November 2014, Singapore Airlines mistakenly listed business class seats for sale at economy-class prices between Sydney and London. Although the seats were not cheap, about $3,268, they were about half of what the correct price should have been. About 400 tickets were sold at the incorrect price.

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79 Id.

80 Id.


82 Id.


84 Id.


86 Id. The recited example was 4,000 Australian Dollars (AUD). On December 31, 2004, the exchange rate was 1 AUD equaled 0.81715 USD. See Australian Dollars (AUD) to US
The airline initially demanded extra payment from customers, but ultimately backed down and honored the tickets. In March 2015, American Airlines published business class fares for travel between Washington and Beijing for $450 roundtrip. The fare was quickly recognized as a mistake and widely publicized on social media and blogs. The airline quickly announced it would honor the deal for all ticketed reservations.

Not all mistake fares are honored, however. In December 2009, Swiss Airlines sold tickets from Toronto to several European cities for $0 plus taxes and fees. Seventy-eight tickets were sold before the airline corrected the mistake. Swiss cancelled all the tickets, although it relented on those sold through online travel agencies once the Canadian Transportation Agency stepped in and asked Swiss to resolve the matter. In October 2013, Qatar Airways filed a business class fare for the relatively short (132 miles) flight between Ho Chi Minh City in Vietnam and Phnom Penh in Cambodia for $245. The flight operates as a “tag” flight, allowing the airline to pick up customers in two relatively small markets before continuing to a larger destination. The fare, however, allowed routing through Qatar’s hub in Doha, so that a customer could book Phnom Penh-Doha-Ho Chi Minh City for $250 (more than 7,000 miles of flying). Three weeks after the fare was discovered and publicized, the airline announced it was not honoring tickets issued under the

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**Dollars (USD) Exchange Rate for December 31, 2014**, EXCHANGE-RATES.ORG (Dec. 31, 2014), http://www.exchange-rates.org/Rate/AUD/USD/12-31-2014. Therefore, the cost of the flights was 3,268 USD.

87 Pearlman, supra note 85.
88 Id.
91 Id.
93 Id.
94 Id.
fare. It blamed the mistake on “an error in our system, outside the control of Qatar Airways.” An industry observer categorized that explanation as a “flat out falsehood,” noting that the error occurred as a result of the “way that Qatar filed the routing rules for the fare.”

C. Airfare Pricing Mistakes Not Similar to Other Pricing Mistakes

Of course, pricing mistakes take place in many commercial and retail transactions. For example, in 2009, Best Buy mistakenly advertised a 52-inch TV for $9.99 on its website, instead of the intended price of $1799.99 (apparently someone dropped off the first “179” from the price). Best Buy refused to honor the advertised price.

In 2010, Sears mistakenly advertised snow blowers for 50% off on its website, allowed customers to purchase the snow blowers, and even sent customers confirmation emails telling them their snow blowers were ready to be picked up. Several customers were able to pick up their snow blowers before Sears started canceling orders.

Some retailers have taken a different approach and honor pricing mistakes as a gesture of goodwill. In 2010, for example, online shoe retailer Zappos.com mistakenly capped every item on its website at $49.95. The mistake was live for six hours, during which time Zappos, in deciding to honor the orders, lost $1.6 million. Advertisements, however, are not offers and do not create the power of acceptance in the public that sees the advertisement. In addition, most retailers specifically reserve the right to cancel orders resulting from pricing errors. Sears, for example, includes the following language on its website:

99 Id.
100 Id.
102 Id.
104 Id.
106 Id.
Pricing errors may occur on the Sears Site from time to time, on items sold by Sears, or items sold by third party sellers on Sears Marketplace. Sears attempts to correct all pricing errors as soon as they are discovered, or as soon as Sears receives notice of an error. Sears reserves the right to cancel any orders containing pricing errors, with no further obligations to you, even after your receipt of an order confirmation or shipping notice from Sears. Any payments you make to Sears for orders that are cancelled due to pricing errors will be refunded.\(^{107}\)

Even without this disclaimer language in the website’s terms and conditions section, however, Sears and other retailers are not liable for pricing mistakes in advertisements on their websites. It is well-settled law that advertisements are not contract offers.\(^{108}\) The law is not settled as to the precise moment in time a contract is consummated in e-commerce; it is dependent upon the facts and circumstances surrounding the transaction and the applicable state law.\(^{109}\) Nevertheless, actual shipment of goods can constitute as acceptance of the customer’s offer to pay the advertised (albeit mistakenly) price for the goods.\(^{110}\)

Applying these principles to the realm of airfare mistakes, it is easy to conclude that a customer’s purchase of an offered price for an air ticket is not binding. At the time an e-ticket is issued to the customer, along with an e-ticket number, however, should be the equivalent of a merchant shipping goods, and cancellation of the ticket or demanding the customer pay a higher price is no longer appropriate. Additionally, pricing mistakes in retail advertisements typically relate to goods whose value is easily ascertainable, whether it is a television or snowblowers. The analogy to airline tickets falls apart because, as explained above, the value of an airline ticket is not as easily ascertainable by a reasonable person.


\(^{108}\) See 1 Samuel Williston, The Law of Contracts § 27 (1920) (“The construction is rather favored that such an advertisement is a mere invitation to enter into a bargain rather than an offer.”).


\(^{110}\) U.C.C. § 2-206(1)(b) (“[A]n order or other offer to buy goods for prompt or current shipment shall be construed as inviting acceptance either by a prompt promise to ship or by the prompt or current shipment of conforming or non-conforming goods, but such a shipment of non-conforming goods does not constitute an acceptance if the seller seasonably notifies the buyer that the shipment is offered only as an accommodation to the buyer.”).
D. The DOT’s Response

After airline deregulation, the DOT maintained authority to prohibit unfair or deceptive practices.111 After a string of bad publicity surrounding passengers stranded on the tarmac during storms, the DOT moved in 2009 to begin creating passenger-friendly rules and regulations.112 A new regulation allowing fines of $27,500 per passenger on flights stranded for more than three hours resulted in a dramatic decline in tarmac delays in 2010.113 These regulations were followed by a second set of regulations in 2011. After many years of not actively regulating in the arena of mistake airfares, the DOT issued broad new regulations (known as Enhancing Airline Passenger Protections, or EAPP) in April 2011 that required disclosure of the total price of airfare in advertising, and required airlines to allow passengers 24 hours to seek a refund on purchased airfare.114 Low-cost carrier Spirit Airlines quickly challenged the rules, arguing that the regulations infringed on the company’s First Amendment rights and “undermine[d] the pro-competitive mandates of the Deregulation Act.”115 Spirit lost the case before a three-judge panel of the U.S. Court of Appeals for the District of Columbia Circuit, which ruled that the DOT did not act arbitrarily and capriciously in adopting the regulations.116 The court also held that the full-fare rule did not violate the First Amendment since it “did not prohibit airlines from saying anything.”117 Additional regulations have been proposed by the DOT.118

When the DOT first announced the total-fare rule, most attention was paid to the litigation by low-cost carriers dissatisfied with having to disclose the complete airfare in advertising. Another portion of the regulations, however, had a dramatic effect on mistake fare pricing. That portion prohibited collecting additional money after a ticket was issued. The

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113 Id.
115 Id. at 12. For more discussion on this case, see Case Comment, D.C. Circuit Holds that Rule Prohibiting Airlines from Displaying Taxes ‘Prominently’ Does Not Violate the First Amendment, 126 HARV. L. REV. 1422, 1423 (2013).
117 Id. at 414.
regulation, 14 C.F.R. § 399.88(a), took full effect in January 2012 and includes a prohibition against post-purchase price increases. The regulation states:

It is an unfair and deceptive practice within the meaning of 49 U.S.C. 41712 for any seller of scheduled air transportation within, to or from the United States, or of a tour (i.e., a combination of air transportation and ground or cruise accommodations), or tour component (e.g., a hotel stay) that includes scheduled air transportation within, to or from the United States, to increase the price of that air transportation, tour or tour component to a consumer, including but not limited to an increase in the price of the seat, an increase in the price for the carriage of passenger baggage, or an increase in an applicable fuel surcharge, after the air transportation has been purchased by the consumer, except in the case of an increase in a government-imposed tax or fee. A purchase is deemed to have occurred when the full amount agreed upon has been paid by the consumer.119

The promulgation of the post-purchase price increase rule coincided with a mistake fare case that was handled in a particularly poor manner by the airline involved. In 2011, Korean Airlines published a fare between the United States and Palau for $450 to $600. The fare was quickly discussed on websites, and more than 300 tickets were sold.120 Although the fare was correct, the ticket was designated “AD 75,” which means it was a fare reserved for sale only to travel agents and not the general public.121 Unfortunately, the fare was distributed for sale widely, and consumers bought tickets at that price. It is likely that some consumers knew the fare was a mistake, while others likely did not know it was a mistake. Two months after the episode (in November 2011), Korean Airlines began cancelling the tickets.122 The airline promised to reimburse any non-reimbursable expenses, and gave customers a $200 voucher.123 It is impossible to say if this episode of an airline behaving badly gave rise to additional clarification from the DOT about the prohibition against post-purchase price increases, but it likely played a role.

In January 2012, the DOT issued a clarification on its website in a section called Frequently Asked Questions, that specifically addressed its position on mistake airfares:

121 Id.
122 Id.
123 Id.
Does the prohibition on post-purchase price increases in section 399.88(a) apply in the situation where a carrier mistakenly offers an airfare due to a computer problem or human error and a consumer purchases the ticket at that fare before the carrier is able to fix the mistake?

Section 399.88(a) states that it is an unfair and deceptive practice for any seller of scheduled air transportation within, to, or from the United States, or of a tour or tour component that includes scheduled air transportation within, to, or from the United States, to increase the price of that air transportation to a consumer after the air transportation has been purchased by the consumer, except in the case of a government-imposed tax or fee and only if the passenger is advised of a possible increase before purchasing a ticket. A purchase occurs when the full amount agreed upon has been paid by the consumer. Therefore, if a consumer purchases a fare and that consumer receives confirmation (such as a confirmation email and/or the purchase appears on their credit card statement or online account summary) of their purchase, then the seller of air transportation cannot increase the price of that air transportation to that consumer, even when the fare is a “mistake.”

A contract of carriage provision that reserves the right to cancel such ticketed purchases or reserves the right to raise the fare cannot legalize the practice described above. The Enforcement Office would consider any contract of carriage provision that attempts to relieve a carrier of the prohibition against post-purchase price increase to be an unfair and deceptive practice in violation of 49 U.S.C. § 41712.124

After staying quiet for many years, the DOT took a strong pro-consumer stance by protecting consumers who booked mistaken airfares. The publication of the FAQ in January 2012, especially, appeared to be dispositive: Airlines must honor mistake airfares, even if the mistake was genuine or unintended.

This resolve would see its biggest test almost immediately when perhaps the biggest example of a mistake fare—which attracted significant attention on social media and blogs and eventually led to litigation and further regulatory action—took place in April 2012. The government of Myanmar, after decades of maintaining an artificially high official exchange rate for the currency, the Kyat, finally permitted the Kyat value to be regulated by the market.125 Unfortunately for airlines, the new exchange rate was not updated in the global distribution system.

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used by airlines to sell airfares. Overnight, tickets originating from Myanmar’s capital city Yangon became very cheap.\footnote{See VIE380, Post to (Gone) RGN - SFO in F $450 one way AI; other N. America cities included, FLYERTALK (April 30, 2012, 8:30 PM), http://www.flyertalk.com/forum/mileage-run-discussion/1341617-gone-rgn-sfo-f-450-one-way-ai-other-n-america-cities-included.html.} The new exchange rate of approximately $1 to 800 Kyats had not been updated from the previous fixed rate, which was $1 to 6.5 Kyats.\footnote{See Mendor, Post to (Gone) RGN - SFO in F $450 one way AI; other N. America cities included, FLYERTALK (May 1, 2012, 10:10 AM), http://www.flyertalk.com/forum/18492513-post235.html.} The underlying fare for the tickets did not change, but when the exchange rate changed, a ticket for 110,000 Kyats went from $18,000 to $133.\footnote{See KevinInRI, Post to (Gone) RGN - SFO in F $450 one way AI; other N. America cities included, FLYERTALK (May 1, 2012, 3:47 PM), http://www.flyertalk.com/forum/18492513-post451.html.} Korean Airlines, which issued many of the tickets, immediately began canceling the tickets just as it had with the Palau fare a few short months earlier.\footnote{Off to Burma, supra note 70.}

Within a few short months of § 399.88(a) coming into full effect, the DOT was presented with a test case of massive proportion.\footnote{See Seth Miller, What is the Real Impact of 49 CFR 41712 § 399.88(a) for Travelers, BOARDING AREA: WANDERING ARAMEAN (May 12, 2012), http://blog.wandr.me/2012/05/what-is-the-real-impact-of-49-u-s-c-41712-399-88a-for-travelers.} Reacting to years of bad publicity surrounding tarmac delays and deceptive advertising, the DOT had published consumer-friendly regulations on a wide array of airline operations including the sale of tickets. One of those regulations, § 399.88(a), and the accompanying Frequently Asked Questions prohibited airlines from cancelling tickets simply because they were the result of a mistake. Would the DOT step in to enforce tickets that had been canceled? Within 10 days of cancelling tickets, the answer became evident when Korean Airlines communicated with customers that it would honor all previously canceled tickets.\footnote{Off to Burma, supra note 70.}

In the ensuing months, several further mistake fares continued to test the DOT’s rules, and, through interpretive guidance, the DOT began to clarify what the rules meant in application. First, there was a clarification from the DOT that the rules do in fact apply to tickets issued under “frequent flyer tickets, particularly when they also entail cash payments.”\footnote{See Genevieve Shaw Brown, 4 Miles and $43 to Hong Kong, Should United Honor?, ABC NEWS (Jul. 18, 2012), http://abcnews.go.com/Travel/hong-kong-miles-43-united-honor-mistake/story?id=16801963#.UAhDyr_gJT5.} That clarification came amidst a mistake on United Airlines’ website that allowed any award ticket to, from, or through Hong Kong,
Beijing, and Shanghai to be sold for 4 miles.\textsuperscript{133} Several days after the website glitch, United canceled the tickets,\textsuperscript{134} resulting in consumer complaints to the DOT under § 399.88(a).\textsuperscript{135}

According to the airline, it would honor tickets for customers who had already begun travel, but would cancel all other tickets.\textsuperscript{136} The distinction, according to the airline, was that the actual price for the ticket in miles was never in error. The airline said, “Unlike other widely reported ‘mistake fares,’ the number of miles required for these awards—the correct purchase price—was clearly disclosed to customers throughout the MileagePlus award redemption process and is also available on our MileagePlus travel award chart.”\textsuperscript{137}

The DOT seemed to agree with United in this case, even as it claimed § 399.88(a) reached tickets issued under frequent flier programs. In response to consumer complaints about canceled tickets, the DOT wrote:

We have completed our review of United’s conduct regarding its recent Frequent Flyer fare sale to Hong Kong from the United States on its website. Our review found that the actual price of the advertised fare was never clearly stated during the booking process, thereby creating ambiguous circumstances in which it could be reasonably interpreted that the actual price of the fare was significantly more than the amount consumers paid at the time they attempted to purchase the fare, e.g., $40 plus 4 frequent flyer miles. Therefore, we are not able to establish that consumers, in fact, paid the full amount of the offered fare at the time of purchase. Accordingly, the evidence does not support a finding that United engaged in an unfair and deceptive practice in violation of the relevant statute. Please note that, regardless of the outcome of our investigation, consumers are free to pursue claims (e.g., a breach of contract claim) against the airline in an appropriate civil court for monetary damages and other

\textsuperscript{133} See Short hair Francis, Post to Eminem Has His 8 Mile, I’ll Take My 4 Mile (United Int’l and Premium Service F), FLYERTALK (July 22, 2012, 11:14 AM), http://www.flyertalk.com/forum/trip-reports/1369003-eminem-has-his-8-mile-i-ll-take-my-4-mile-united-int-l-premium-service-f.html.

\textsuperscript{134} See Gary Leff, United Won’t Honor the 4 Mile Award Tickets to/through Hong Kong, BOARDINGAREA: VIEW FROM THE WING (July 16, 2012), http://viewfromthewing.boardingarea.com/2012/07/16/united-wont-honor-the-4-mile-award-tickets-to-through-hong-kong.


\textsuperscript{136} Id.

\textsuperscript{137} See UA Insider, Post to UAs Official Response to HKG Ticketing/IT Error: Redeem @ Correct Amount or Redeposit, FLYERTALK (July 16, 2012, 7:08 PM), http://www.flyertalk.com/forum/18965497-post2.html.
remedies particular to their situation.138

According to the DOT, customers must actually pay a mistake fare in full in order to invoke the protections of § 399.88(a). In the United Airlines 4 mile case, the actual amount of the ticket price was ambiguous, and thus, customers had not paid the full amount at the time of purchase. Communications obtained pursuant to a Freedom of Information Act (“FOIA”) request to the DOT appeared to confirm this reasoning.139

In September 2012, barely five months after the DOT intervened and forced Korean Airlines to honor cancelled tickets originating in Yangon, the same mistake once again allowed customers to purchase cheap tickets from Yangon.140 Remarkably, airlines appeared to not have learned from the first round of these tickets. For more than 6 days (from September 21 to September 26, 2012), customers could purchase first class tickets as long as they originated in Yangon and ended in a few select cities in Canada.141 More than 1,000 passengers did just that, filling more than 30 percent of annual travel on certain routes for one airline’s first class cabin.142 Unlike the first round where many tickets were issued by Korean Airlines, this time most tickets were issued by Swiss Airlines.143 One week after tickets were issued, Swiss cancelled the tickets.144 The company’s communication to consumers stated in part:

Subject: Cancellation of your ticket due to erroneous fare

Dear Sir/Madam,

We are writing in regards to the travel you recently booked with Swiss International Air Lines Ltd. from Yangon (RGN), Myanmar. Unfortunately, as you must have been aware of, the fare you purchased was incorrect and result-

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139 See id.; see also E-Mail from Jonathan Dols, U.S. Dep’t of Transp. to Jonathan Linde, United Airways (July 19, 2012) (available at https://docs.google.com/file/d/0B1cqSPD8xsbuVlJkWG9ZQ2dDUDQ/edit).
143 See Klint, supra note 141.
144 See id.
ed from an inadvertent error that was out of our control. While SWISS honors its commitment to the highest level of customer service and safety in air travel, it must also honor its obligations to its employees and shareholders.

We are not obligated to provide our services for compensation that is obviously erroneously published and commercially infeasible. We are aware that good travel bargains are quickly recognized and booked, however principles of fair bargaining dictate that a service provider does not give away its services for almost free or at a loss.

Because the fare you booked was not valid, we will unfortunately have to cancel your reservation and ticket. We are extremely sorry for this error and we are not increasing the price of your ticket; rather we will promptly issue you a full refund for the total price you paid for the ticket. The full amount will be automatically credited using your original form of payment. In the event that you would like to rebook your itinerary at the appropriate price, please contact your nearest SWISS service center or your travel agent.

SWISS deeply regrets the inconvenience caused by the publication of the erroneous fare to the passengers who may have thought they had booked and purchased a valid ticket for an erroneous cost. We apologize for this unfortunate situation and trust your future travel on SWISS is comfortable.145

Some consumers argued this was not a mistake fare, since the ticket was sold for 130,000 Kyats, which was the correct price.146 Swiss, however, maintained that the fare was “incorrect and resulted from an inadvertent error that was [beyond] our control.”147 The airline also deliberately stated that it would not be “increasing the price of [the consumer’s] ticket,”148 perhaps in an attempt to evade the prohibition on post-purchase price increases set forth in § 399.88(a).149

In response to consumer complaints, the DOT took a different approach than it did with Korean Airlines and the first round of Yangon tickets. The agency took the position that because the tickets originated

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146 See Klint, supra note 141.
147 See id.
148 See id.
149 Swiss Airlines appeared determined to not honor the Yangon tickets. Several customers filed complaints against Swiss in the Canadian Transportation Agency. The proceedings stretched on for more than two years, resulting in several early wins for consumers before the Agency finally settled the matter in favor of Swiss Airlines. See Seth Miller, Mistake Fares Really are Mistakes in Canada, BOARDINGAREA: WANDERING ARAMEAN (May 27, 2014), http://blog.wandr.me/2014/05/mistake-fares-really-are-mistakes-in-canada.
in Yangon and ended in Canada, it would not assert jurisdiction even if the ticket had a stopover in the United States. The agency informed consumers:

We are sorry to hear of your dissatisfaction. However, our jurisdiction is limited to air transportation within, to, or from the United States. Because it appears that your itinerary is for air transportation between two or more non-U.S. points, the regulations enforced by our office do not apply to your transportation. Please contact the carrier directly.  

As 2012 drew to a close, the DOT’s rules on mistake fares seemed clear-cut and easily understood. Through the Yangon mistake fare and the United 4 mile award ticket cases, it was clear that the DOT would hold any mistake ticket that touched the United States enforceable as long as the customer was unaware of the real price of the ticket and had made full payment.

III. ORDINARY CONTRACT PRINCIPLES SUPPORT
14 C.F.R. § 399.88(A)

A. Offer and Acceptance—Protecting Consumers’ Reasonable Expectations

First-year law students learn that contracts begin with an offer. “An offer is the manifestation of willingness to enter into a bargain, so made as to justify another person in understanding that his assent to that bargain is invited and will conclude it.” Critically, an offer is valid if the offeree understands that his assent is invited and will conclude the agreement. The offeror does not always have to have the specific or subjective intent to be bound by the contract. As Judge Learned Hand once wrote, a contract has “nothing to do with the personal, or individual, intent of the parties.” If it were proved by “twenty bishops that either party, when he used the words, intended something else than the usual meaning which the law imposes upon them, he would still be held, unless there were some mutual mistake, or something else of the sort.” In Lucy v. Zehmer, a party was held to a contract for the sale of land even though he thought he was joking, because a reasonable person

\[^{150}\text{See Klint, supra note 141.}\]
\[^{151}\text{RESTATEMENT (SECOND) OF CONTRACTS § 24 (AM. LAW INST. 1981).}\]
\[^{152}\text{See generally Wayne Barnes, The Objective Theory of Contracts, 76 U. CIN. L. REV. 1119 (2008).}\]
\[^{153}\text{Hotchkiss v. Nat’l City Bank, 200 F. 287, 293 (S.D.N.Y. 1911).}\]
\[^{154}\text{Id.}\]
would have believed that the offer to sell the land was genuine. In Leonard v. Pepsico, a company was held to not be liable for an advertisement for the sale of a Harrier jet airplane for the equivalent of $700,000 (far below market value) because the commercial was clearly a farce. In the context of an advertisement (such as an offer for airfare presented on a website), “the essential question in assessing the rule is whether a reasonable person understands that a merchant manifests the intention to create a binding relationship when it publishes an advertisement specific as to subject matter and price but containing no more details.”

Another important principle in contract law is consideration. Put simply, “the law does not inquire into the adequacy of consideration, and a peppercorn may constitute [adequate] consideration.” As a general matter of policy, government and its instrumentalities do not interfere with freedom of contract by determining whether a price is fair or reasonable. Similarly, the courts or government agencies are poor places to determine whether a consumer reasonably considered whether an offered fare was a mistake.

The concept of “reasonable expectation” is important here as well. Reasonable expectations are derived from the “court’s perceptions of what a typical consumer believes or is entitled to believe based on normal usage in the marketplace.” Given how difficult it is for consumers to grasp normal or reasonable airfare for any specific ticket, the objective theory of contracts would dictate that as long as a typical consumer is entitled to believe that a mistake fare is in fact offered for sale, and subsequently ticketed, that the contract should be honored as a binding agreement. The reasonable expectation is further reinforced by the airlines’ choice to use e-ticketing. If an airline contacted a customer after the customer paid for a ticket online but before the ticket was issued and informed the customer that the price was an error and would be corrected, a consumer might reasonably expect that there is in fact, no contract. When millions of tickets are sold through automatic e-ticketing, however, then a consumer might reasonably expect that if a mistake fare is

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159 See Feinman & Brill, supra note 157, at 77 (citing E. ALLAN FARNsworth, FARNsworth ON CONTRACTS § 3.6, at 208–12 (3d ed. 2004)).
ticketed, that it is valid for travel because a binding contract has been formed. Once a contract is formed parties must fulfill their contractual duties and cannot unilaterally cancel the contract. The airlines themselves seem to understand this perfectly well, since they generally do not permit customers to cancel tickets because a consumer made a mistake in buying the tickets in the first place.

B. Implied Covenant of Good Faith

Some commentators have called customers who purchase mistake airfares “thieves.”160 This criticism suggests that customers may be technically correct in asserting a contract interest, but equity somehow should intervene to prevent them from enjoying the contract. They may find some help in this argument in the Restatement (Second) of Contracts: “Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.”161 Starting with the seminal New York case of Wood v. Lucy, Lady Duff-Gordon,162 the implied duty of good faith enjoys widespread acceptance in modern American law, “allow[ing] a degree of flexibility in contract interpretation that was previously shunned.”163

Airlines, however, have purposefully disclaimed the implied duty of good faith in their frequent flyer programs. That was precisely the position taken by Northwest Airlines (which has since merged with Delta Airlines) before the Supreme Court in Northwest, Inc. v. Ginsberg.164 In that case, Northwest Airlines unilaterally terminated a relationship with a customer it felt was complaining too frequently, revoking his membership in the WorldPerks frequent flier membership program.165 The customer sued Northwest, claiming in part that Northwest had breached its implied duty of good faith.166 After initially losing at the Ninth Circuit Court of Appeals,167 the airline argued successfully at the Supreme Court that a claim for breach of the implied duty of good faith could not proceed because it was a state action preempted by the federal Airline

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162 118 N.E. 214 (N.Y. 1917).
165 Id. at 1426–27.
166 Id. at 1427.
167 Id. at 1428.
Deregulation Act.\textsuperscript{168}

In his majority opinion, Justice Alito invited airlines to consider contracting out of the implied duty of good faith:

A State’s implied covenant rules will escape pre-emption only if the law of the relevant State permits an airline to contract around those rules in its frequent flyer program agreement, and if an airline’s agreement is governed by the law of such a State, the airline can specify that the agreement does not incorporate the covenant. While the inclusion of such a provision may impose transaction costs and presumably would not enhance the attractiveness of the program, an airline can decide whether the benefits of such a provision are worth the potential costs.\textsuperscript{169}

In April 2015, American Airlines accepted Justice Alito’s invitation. It updated its terms and conditions for the American AAdvantage program to include this language: “To the full extent allowed by law, these Terms and Conditions disclaim any duty of good faith as well as any implied contractual terms or obligations.”\textsuperscript{170} Apparently, American Airlines decided that the benefits of such a provision are worth the potential costs.

If an airline disclaims any duty of good faith with respect to customers in its frequent flyer program, it logically follows that customers similarly do not owe that airline a duty of good faith.\textsuperscript{171} This is a critical point for the DOT to consider as it examines whether customers exhibit bad faith in intentionally booking mistake airfares. Admittedly, this analysis is limited at this stage to customers in frequent flyer programs looking to take advantage of benefits that solely apply to frequent flyers, such as upgrades and free or discounted tickets. It does not take much imagination, however, to predict that airlines will also disclaim the duty of good faith in the general conditions of carriage as well. Once airlines begin this practice, the argument that customers owe those airlines a duty of good faith flies out the window.

\textsuperscript{168} Ginsberg, 134 S. Ct. at 1433. For an excellent examination of frequent flyer programs and consumers’ expectations out of those programs, see generally Ann Morales Olazábal et al., Frequent Flyer Programs: Empirically Assessing Consumers’ Reasonable Expectations, 51 Am. Bus. L.J. 175 (2014).

\textsuperscript{169} Ginsberg, 134 S. Ct. at 1433.


\textsuperscript{171} This is especially so when an airline generally disclaims all implied obligations, not just the implied obligations of the airline.
C. Why the Doctrine of Mistake Should Not Protect Airlines

Several commentators have observed that § 399.88(a) is inconsistent with well-established contract law on the doctrine of mistake.172 Young and Grunewald, for example, labeled the requirement that airlines disclose the total price of an air ticket “pernicious.”173 Yet, a close review of the requirements of § 399.88(a) reveals no inconsistency with existing law of mistake in contracts, particularly post-ticketing.

It is well-established that when both parties are genuinely mistaken as to the value of an item they are buying and selling, the contract is not voidable simply because the item turns out to be more valuable than either party realized. In the seminal case, *Wood v. Boynton*, for example, a woman sold a stone she believed was a topaz to a jeweler for $1 in 1885.174 The jeweler testified credibly that he had never seen an uncut diamond, and therefore he did not know the worth of the stone.175 Later, the jeweler discovered the true nature of the stone and discovered that it was actually worth $700.176 Nevertheless, the woman lost the suit to recover the stone.177

Modern contract law on mistakes is summarized in the Restatement (Second) of Contracts, where § 153 states:

Where a mistake of one party at the time a contract was made as to a basic assumption on which he made the contract has a material effect on the agreed exchange of performances that is adverse to him, the contract is voidable by him if he does not bear the risk of the mistake under the rule stated in § 154, and (a) the effect of the mistake is such that enforcement of the contract would be unconscionable, or (b) the other party had reason to know of the mistake or his fault caused the mistake.178

Applying this rule to airline mistake fares, one ground for permitting an airline to void a mistake fare would be unconscionability, although this doctrine is typically applied to protect consumers from excessive pricing.179 Courts generally find a contract to be unconscionable when there is “an absence of meaningful choice on the part of one of the  

172 See, e.g., Young & Grunewald, supra note 114, at 1.
173 *Id.* at 13.
175 *Id.*
176 *Id.*
177 *Id.*
parties together with contract terms which are unreasonably favorable to
the other party.” 180 “[T]he meaningfulness of the choice [can be] negated
by a gross inequality of bargaining power.” 181 The manner of entering a
contract is relevant as well. If important terms are “hidden in a maze of
fine print and minimized by deceptive sales practices” or if a party with
little bargaining power and no real choice signs a “commercially unreas-
onable contract with little or no knowledge of its terms, it is hardly like-
ly that his consent, or even an objective manifestation of his consent,
was ever given to all the terms.” 182 Applying these principles to a sce-
nario in which a consumer pays for and is issued a ticket from an airline
at a quoted price, it would be difficult to argue that the airline should be
excused from performance on the grounds that the contract is uncon-
scionable.

A second argument that airlines could make is that the customer
had reason to know of the mistake. 183 Here, this argument would be
much stronger since many mistaken fares are well-publicized and dis-
cussed in blog posts. Nevertheless, the problem with this argument is
that it remains exceedingly difficult, from an evidentiary perspective, to
prove that a specific customer had reason to know that a fare was a mis-
take. As discussed in Part II.A., airline ticket pricing has nearly no rela-
tionship to the cost to the airline to transport the passenger. 184 Ticket
pricing is driven by complicated price algorithms designed to sell each
seat for as much money as possible, and seats on any given airplane on
any given flight will range from non-revenue generating seats to seats
that generate thousands of dollars. 185 Unlike a lost masterpiece painting
or an uncut diamond or a hidden oil field in farmland or a barren cow,
each of which have actual market values that can be readily determined,
there simply is no way to determine the market value for a particular seat
on a particular plane on a particular date. As previously illustrated, a seat
that is sold at a mistake fare is worth more to the airline than that same
seat which leaves the gate empty. If we accept that there is no way for a
reasonable customer to have a reasonable expectation of what price a
particular ticket should command, then there is no meaningful way for
an airline to demonstrate that a specific customer “had reason to know”
of the mistake. This doctrine can only apply when a reasonable person

181 Id.
182 Id.
183 See RESTATEMENT (SECOND) OF CONTRACTS § 153(b) (AM. LAW INST. 1981).
184 See supra note 36 and accompanying text.
185 See id.
can determine the reasonable price for a good or service, which is nearly impossible in airline ticket pricing.

In any case, airlines can only avail themselves of the benefits of § 153 of the Restatement if they can demonstrate that they do “not bear the risk of mistake under the rule stated in § 154.” Section 154 of the Restatement states that:

A party bears the risk of a mistake when: (a) the risk is allocated to him by agreement of the parties; or (b) he is aware, at the time the contract is made, that he has only limited knowledge with respect to the facts to which the mistake relates but treats his limited knowledge as sufficient, or (c) the risk is allocated to him by the court on the ground that it is reasonable in the circumstances to do so.

In airline mistake fares, the fares typically arise because of a typing error, fare code error, or currency exchange error. Regardless of how the error arises, the customer is presented with an offer for a ticket that is cheaper than what the seller intended. These circumstances could reasonably be categorized as falling into subsection (b) above, where the seller has only limited knowledge with respect to the facts to which the mistake relates. Take, for example, the case of Swiss Airlines and the second round of mistake fares originating in Yangon. There, five months had passed since the first round of mistakes had arisen with respect to the devaluation of the local Kyat currency. Nevertheless, Swiss continued to sell tickets priced under a pre-devaluation exchange rate five months later. Under subsection (b) above, the airline could be held to bear the risk of mistake because it has treated its limited knowledge of the facts as sufficient to continue contracting.

A party also bears the risk of mistake when the “risk is allocated to him by the court on the ground that it is reasonable in the circumstances to do so.” Courts hold that when

[C]onsidering whether to allocate the risk of mistake to the party who made the mistake, the question is whether “under the totality of the circumstances, it

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187 Id. § 154.
188 See, e.g., Travis, How to Find Mistake Fares and Fly Cheap, BOARDINGAREA: ONE MILE AT A TIME (July 25, 2015), http://onemileatatime.boardingarea.com/2015/07/25/find-mistake-fares/; see also supra Part II.B.
189 See supra notes 125–129 and accompanying text.
190 See id.
191 Id.
192 Id. § 154.
193 Id. § 153.
would be more equitable or reasonable to do so.” Here, relevant factors include who drafted the agreement, the relative sophistication of the parties, any communications the parties had concerning the proposed agreement, and the effect of the error on the parties.194

Since airlines draft the conditions of carriage and are generally considered more sophisticated than consumers,195 it would be appropriate for courts to hold airlines responsible for bearing the risk of mistakes in mistake airfares.

Applying these principles found in the Restatement to § 399.889(a), it is clear that the DOT regulations governing mistake fares are entirely consistent with the Restatement. Before ticketing, airlines might be able to argue that mistake fares are merely invitations to offer. Post-ticketing, however, issued tickets are binding contracts for carriage. Starting from the position that contracts should be enforced as written, forcing airlines to honor mistake airfares does not present any unconscionability questions given the nature of the parties and the contract they are entering into. The nature of airline ticket pricing and the ascertainability of the value of an airline seat make it impossible to rely on the obvious mistake doctrine for a specific customer. Finally, the risk of mistake should be allocated to airlines given the totality of circumstances surrounding the sale of an e-ticket.

IV. DOT PREPARES TO REVISE § 399.88(a)

A. The Tide Turns

After the DOT had provided a very strong pro-consumer response in 2012, by 2014 the pendulum began to swing the other way.196 Perhaps as the result of the mistake fare cases in 2012–2014, including Swiss Airlines’ successful defense of its actions in canceling over one thousand tickets from Yangon to Canada, the DOT began considering revisions to the mistake fare rule in 2014. On May 23, 2014, the Department published a Notice of Proposed Rulemaking (“NPRM”) that sought comments on a number of new regulatory proposals.197 The NPRM indicated
the DOT’s increasing belief that customers were engaging in “bad faith” when purchasing mistake fares:

The Enforcement Office has become concerned that increasingly mistaken fares are getting posted on frequent-flyer community blogs and travel-deal sites, and individuals are purchasing these tickets in bad faith and not on the mistaken belief that a good deal is now available. We solicit comments on how best to address the problem of individual bad actors while ensuring that airlines and other sellers of air transportation are required to honor mistaken fares that were reasonably relied upon by customers.  

The NPRM also indicated that the DOT was considering defining “air transportation within, to, or from the United States” to mean “any transportation that begins or ends in the United States or involves a connection or stopover in the United States that is 24 hours or longer.” This definition would bring § 399.88(a) in line with the DOT’s position on the Swiss Airlines Yangon case (where tickets originated in Myanmar and ended in Canada), and would likely address criticism of the regulation’s extraterritorial reach. The comment period for the proposed changes closed September 29, 2014, but the DOT had extended the comment period to allow interested parties to review the summary of an industry meeting held during the original comment period.

A few months after the NPRM, the DOT was faced with another case in which it believed it saw bad faith in customers. In February 2015, a third-party software vendor loaded incorrect exchange rates on the British Pound and Danish Kroner to the United Airlines website. Customers who set the Danish Kroner as their local currency and used Denmark as the billing address for their payment credit card, were able to price tickets originating in the United Kingdom at extremely low prices, such as $51 for Newcastle to Newark in first class, or $193 for London to Honolulu first class. Once it discovered the mistake, United began voiding tickets, even if they had been issued and ticketed. United insisted that the fares were properly filed, and that the errors resulted from currency exchange rates filed by the third-party vendor, implying it

198 Id. at 29,991.
199 Id.
201 See Ben Mutzabaugh, United to Void Absurdly Cheap 1st-class Mistake Fares, USA TODAY (Feb. 12, 2015), http://www.usatoday.com/story/todayinthesky/2015/02/11/mistake-fares-united-1st-class-to-europe-sold-for-just-68/23234223/.
202 See id.
203 See id.
was beyond their control.204 The mistake was quickly publicized on popular blogs and websites, with detailed instructions on how consumers could purchase the tickets.205

The DOT responded quickly when consumers began filing complaints under § 399.88(a). Two weeks after the complaints began, the DOT posted a notice to its website indicating that “thousands” of consumers had complained about United’s cancellation of the tickets, and that it was not going to require United to honor the tickets.206 In justifying its decision, the DOT wrote:

The mistaken fares appeared on a website that was not marketed to consumers in the United States. In order to purchase a ticket, individuals had to go to United’s Denmark website which had fares listed in Danish Krone throughout the purchasing process. In addition, only people who identified “Denmark” as their location/country where billing statements were received when entering billing information at the completion of the purchase process were able to complete their purchase at the mistaken fare levels. Consistent with the Office’s treatment of fare advertisements and disclosure of baggage fees, it does not intend to enforce the rule in question (the post-purchase price increase prohibition) when the fare offer is not marketed to consumers in the United States. Additionally, the Office is concerned that to obtain the fare, some purchasers had to manipulate the search process on the website in order to force the conversion error to Danish Krone by misrepresenting their billing address country as Denmark when, in fact, Denmark was not their billing address country. This evidence of bad faith by the large majority of purchasers contributed to the Enforcement Office’s decision.207

In response to FOIA requests, the DOT suggests that its thinking was influenced by the widespread attention the fare received on social media websites and blogs.208 The released documents include many pages of printouts from these sites explaining how consumers could book the tickets.209 Unfortunately, the released documents only hint at the DOT’s thinking, because information that is pre-decisional or delibera-

204 See id.
207 Id.
209 See id.
tive in nature is exempt from FOIA requests.\textsuperscript{210}

\textbf{B. The Other Shoe Drops}

In May 2015, the DOT decided to suspend its rule on mistake airfares. In a notice posted on its website, the agency stated:

The Assistant General Counsel has decided not to enforce section 399.88 with respect to mistaken fares while the Department completes the aforementioned rulemaking process. As a matter of prosecutorial discretion, the Enforcement Office will not enforce the requirement of section 399.88 with regard to mistaken fares occurring on or after the date of this notice so long as the airline or seller of air transportation: (1) demonstrates that the fare was a mistaken fare; and (2) reimburses all consumers who purchased a mistaken fare ticket for any reasonable, actual, and verifiable out-of-pocket expenses that were made in reliance upon the ticket purchase, in addition to refunding the purchase price of the ticket. These expenses include, but are not limited to, non-refundable hotel reservations, destination tour packages or activities, cancellation fees for non-refundable connecting air travel and visa or other international travel fees. The airline may ask the consumer requesting out-of-pocket expenses to provide evidence (i.e. receipts or proof of cancellations) of actual costs incurred by the consumer. In essence, the airline or seller of air transportation is required to make the consumer “whole” by restoring the consumer to the position he or she was in prior to the purchase of the mistaken fare.\textsuperscript{211}

In its notice, the DOT noted that the suspension of enforcement on mistaken fares is “temporary and will remain in effect only until the Department issues a final rule that specifically addresses mistake fares.”\textsuperscript{212}

The DOT seems to be heavily influenced by the distinction between a customer who acts in bad faith as opposed to a customer who acts under the mistaken belief that a good deal has become available.\textsuperscript{213} It is unclear, however, how a customer knows it is a mistake (presumably bad faith in the DOT’s view) rather than just a good deal (and not in bad faith)? Airlines generally want their good deals posted on social media websites. Can the DOT really distinguish between one and the other? “The mere discussion of the fare in frequent flyer forums is insufficient

\textsuperscript{210}See generally Brennan Ctr. for Justice at N.Y.U. Sch. of Law v. U.S. Dep’t of Justice, 697 F.3d 184, 194–202 (2d Cir. 2012) (discussing the basic principles of the deliberative process exemption to FOIA).


\textsuperscript{212}Id.

to demonstrate that a fare was known to be a mistake. Unless the person making this mistake itself claims ownership, how can the DOT determine whether or not a genuine mistake has taken place? Can airlines distinguish mistakes that were made intentionally, recklessly, or negligently, and should it matter? Can anyone label a fare a mistake even if it is not? Presumably, the DOT will address these questions when it issues a final rule. Meanwhile, it may be useful for the DOT to review the concept of bad faith in customer actions.

C. Consumers Who Purchase Fares Offered for Sale Are Not Bad Faith Consumers

The DOT is not alone in suggesting that customers who intentionally take advantage of well-publicized mistake airfares are engaging in bad faith. Several observers have commented that customers who intentionally book mistake airfares are engaging in morally dubious behavior or even theft. Sahr and Derco characterize these customers as “aggressive” and “unscrupulous” who “troll” the Internet looking to take advantage of mistake fares. Christopher Elliott, a travel industry expert, believes that at some point, a fare is so low that it has to be obvious to the customer that a mistake has taken place. He cites the example of one of his readers of who purchased a $9,470 first class ticket from Myanmar for $13. Unfortunately, his example is disingenuous since that $13 fare was just the base fare. When taxes and surcharges were included, his reader actually paid $586 for the ticket. Given the fact that complexities of airline pricing support the proposition that there is no reasonable expectation for airfare pricing, there can be no argument that a customer has stolen from an airline by purchasing a mistake fare.

There are, of course, customers who engage in bad faith in dealing with airlines. In 1981, for example, cash-strapped American Airlines sold the lifetime unlimited AAirpass for $250,000, with the possibility to

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215 See, e.g., Elliott, supra note 160.

216 Sahr & Derco, supra note 142.

217 See Elliott, supra note 160.

218 Id.

219 Id.

220 Id.

221 See supra Part II.A.
add a companion for an extra $150,000. The program entitled holders to fly unlimited number of flights in First Class for their lifetime. Savvy customers soon realized the value of what they had, and began engaging in practices such as selling their companion seats or miles earned from their flying (in some cases customers earned more than 30 million miles). The airline responded by cancelling several customers’ Airpass memberships for fraud. In another case, a customer booked a fully refundable first class ticket, used the ticket to gain access to the airline’s first class lounge to eat, and thereafter canceled the ticket for a full refund. The customer then rebooked a ticket for the next day, and repeated the same course of action. He did this for approximately one year before the airline discovered what he was doing. There was also the case of the American Airlines customer who repeatedly made fictitious reservations to block premium seats for the sole purpose of obtaining mileage upgrades. Another example came in 2010, when an airfare website revealed that it was possible for customers to avoid paying fuel surcharges (saving hundreds of dollars in international airfares) by reserving complicated itineraries that customers may not have any intention to fly, a practice known as “fuel dumping.” In another case, a United Airlines customer discovered a way to manipulate United’s website to sell tickets between San Francisco and Honolulu for $80. Finally, there are customers who routinely engage in practices specifically prohibited by airlines such as selling their miles or upgrades for cash.

223 Id.
224 Id.
225 Id.
226 Id.
227 Id.
231 Elliott Rodriguez, Selling Frequent Flyer Miles Can Earn You Cash But It’s Risky, CBS MIAMI (July 18, 2014), http://miami.cbslocal.com/2014/07/18/selling-frequent-flyer-
These practices to make personal profit or otherwise exploit airline programs appear to fall square within the meaning of “bad faith.” On the other hand, it is hard to see how purchasing a fare offered for sale through an airline’s website, an act that happens millions of times daily, is “bad faith” simply because the consumer heard about the fare through a website. The DOT first surfaced the “bad faith” issue when it responded to United’s cancelation of tickets issued in Denmark. The agency stated it was concerned that customers had to change their billing address to Denmark in order to force the website to display fares in Danish Krone. In reality, however, customers could see the fares even if they were in the United States with the US set as their country.

Although it is hard to argue that customers acted truly in bad faith in that case, the facts are that United’s fare mistake was beyond its control. That may be a stronger basis upon which to release United from the liability of honoring that fare. These reforms are discussed below.

V. SUGGESTED REFORMS AND CONCLUSION

As this Article has demonstrated, a rule that relies on the “obviousness” of a mistake fare is probably unenforceable. The problem of mistake airfares is ripe for just and fair reform. Without regulation, airlines would be free to unilaterally cancel tickets at any time, including when travelers are in the middle of their journeys, simply by calling the ticket a mistake. This stance is unsupportable under the law of contracts, which requires contract sanctity to be upheld whenever possible. The DOT is statutorily charged with preventing unfair and deceptive trade practices, and should use that regulatory power to level the playing field between two parties of inherently unequal bargaining power.

On the other hand, the DOT’s initial muscularly pro-consumer stand in § 399.88(a) and the accompanying Frequently Asked Questions, requiring all airlines to honor mistake fares in all circumstances, may leave airlines without any protection for mistake fares that are beyond their ability to control or influence. The rise of social media means these fares can be distributed with rapid speed (the United Airlines Danish Krone mistake fare alone generated over 1000 consumer complaints and

232 See Mutzabaugh, supra note 201.
234 See Mutzabaugh, supra note 201.
an astounding 15,000 consumer opinions), further underscoring the clear need for real reform. Industry observer Gary Leff suggests airlines should be able to cancel tickets issued for mistake fares only under certain circumstances. First, only those fares that were discounted more than 80% from the full fare and discovered within 24 hours of issuance should be eligible for cancellation. Then, the airline must immediately communicate with the customer regarding the mistake. Finally, the airline should affirm under oath to the DOT that a bona fide mistake has occurred. In addition to these sound suggestions, the DOT should limit airlines to only honoring one reservation per customer, in order to prevent customers from repeatedly exploiting a mistake airfare.

Airlines can also take steps to mitigate their damages from mistake airfares. Airlines should use better technology, such as United Airlines, which has already implemented a high-tech team of overseers. In April 2015, United Airlines announced it was creating a Digital Operations Center to “ensure the airline loses a lot less money when it makes silly mistakes, like selling free or deeply discounted fares filed in error.” At the facility, staff will use specialized software and hardware to detect and prevent mistake fares. Airlines should also delay ticketing, so that they only issue tickets after a fare verification process ensures that the right fare has been quoted to the customer. Since many customers book multiple mistake fares for the purpose of accumulating miles and accruing elite status, airlines can discourage this behavior by not granting award mileage bonuses on mistake fares, as American Airlines announced in May 2015.

As the DOT contemplates its next steps towards a final rule on mistake airfares, it is important for the DOT to keep in mind the policy reasons for which it promulgated § 399.88(a) in the first place. The airlines,

235 See Ben Schlappig, How Many DOT Complaints Were Filed Over One Mistake Fare, BOARDINGAREA: ONE MILE AT A TIME (Apr. 30, 2015), http://onemileatatime.boardingarea.com/2015/04/30/how-many-dot-complaints-were-filed-over-one-mistake-fare.


237 Id.

238 Id.

239 Id., supra note 76.

240 See id.

through the adoption of complicated revenue management strategies, have created enough confusion among customers regarding airfare prices that customers rarely have an expectation for a reasonable value for a given route. The industry’s adoption of e-ticketing means that airlines have robbed themselves of any opportunity to correct for mistake fares before binding contracts (tickets) are consummated with customers. Requiring airlines to honor mistake fares is wholly consistent with existing contract law, especially in light of airlines’ positions that they do not owe customers a duty of good faith. For these reasons, the DOT should consider a final rule that fulfills its role in preventing deceptive and unfair trade practices.
Note


Tatiana M. Fonseca da Silva*

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* J.D. Candidate, May 2016, Quinnipiac University School of Law; M.A., Art History, University of Toronto; H.B.A., Art History, University of Toronto. I thank the entire editorial board and staff of the Quinnipiac Law Review and Professor John Morgan for their assistance with this Note.

The analysis and recommendations included in this Note should not be interpreted as reflecting the views of my past, current, or future employers. Those employers may or may not agree with some or all of the analysis I have included here.
VI. CONCLUSION

I. INTRODUCTION

In 1966, the 3,200-year-old funerary mask of Ka-Nefer-Nefer, registered as Egyptian property, was placed in a box with the label “fifty-four” in Cairo, Egypt.1 Seven years later, the box was inventoried, whereupon it was discovered that the mask was missing.2 The mask did not come to light again until the St. Louis Art Museum3 purchased it in 1998 for $499,000.4 On March 16, 2011, after the St. Louis Art Museum repeatedly refused the Egyptian government’s requests to return the mask, the United States government began litigation seeking forfeiture of the mask in order to return it to Egypt.5

Pursuant to 19 U.S.C. § 1595a(c),6 the United States government may seek the forfeiture of merchandise that has been introduced into the country contrary to law. This includes merchandise that “is stolen, smuggled, or clandestinely imported or introduced.”7 In United States v. Mask of Ka-Nefer-Nefer,8 the government argued that the mask should be forfeited because the circumstances indicated that, at the time it was imported into the United States, the mask was stolen property.9 Both the

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3 The official full name of the museum is the Art Museum Subdistrict of the Metropolitan Zoological Park and Museum District and the County of St. Louis.
6 The statute states in relevant part, “(c) Merchandise introduced contrary to law. Merchandise which is introduced or attempted to be introduced into the United States contrary to law shall be treated as follows: (1) The merchandise shall be seized and forfeited if it—(A) is stolen, smuggled, or clandestinely imported or introduced . . . .” 19 U.S.C § 1595a(c) (2012).
7 Id.
8 The case name lists the Mask of Ka-Nefer-Nefer, not the St. Louis Art Museum, as the defendant. As one will see, many times objects are named as the defendants in art and antiquities related litigation. This naming of the object as defendant is proper when the object itself is the subject of the action and the court is seeking to recognize a change in the ownership of the object. Matthew P. Harrington, Rethinking In Rem: The Supreme Court’s New (and Misguided) Approach to Civil Forfeiture, 12 YALE L. & POL’Y REV. 281, 286 (1994).
United States District Court for the Eastern District of Missouri and the United States Court of Appeals for the Eighth Circuit disagreed and found for the St. Louis Art Museum on the grounds that the United States government failed to establish that the mask had been brought into the United States illegally or that it was stolen from Egypt.\footnote{United States v. Mask of Ka-Nefer-Nefer, 752 F.3d 737, 744 (8th Cir. 2014); Mask of Ka-Nefer-Nefer, 2012 U.S. Dist. LEXIS 47012, at *10.}

Despite the victory of the St. Louis Art Museum, *United States v. Mask of Ka-Nefer-Nefer* exemplifies the growing force of the government against holders of art and antiquities. The government based its case on the claim that it was appropriate to infer that the mask was stolen because it went missing, without alleging any facts that supported the conclusion that the mask was missing \emph{because} it was stolen.\footnote{Mask of Ka-Nefer-Nefer, 2012 U.S. Dist. LEXIS 47012, at *7–8.} Circuit Judge Loken noted that this argument exemplifies one of the fastest growing concerns in the international art market: the government was attempting “to expand . . . forfeiture powers at the likely expense of museums and other good faith purchasers.”\footnote{Mask of Ka-Nefer-Nefer, 752 F.3d at 738.} Had the government won in *United States v. Mask of Ka-Nefer-Nefer*, entities such as museums and other good-faith purchasers may have been placed in positions where they would potentially lose art and artifacts in which they had invested because the known facts about the work might give rise to an inference that the work fell into one of the categories of 19 U.S.C. § 1595a(c). If museums and good-faith purchasers act on this fear, would the works in their possession be lost to the public?

This Note addresses Judge Loken’s concern and how such attempts to expand the government’s forfeiture powers pursuant 19 U.S.C. § 1595a(c) affect museums, sellers, and good-faith purchasers. Part II of this Note will provide a background on the illicit private art and antiquities trade, and the international protections that have been put in place in an attempt to not only stymie this unlawful market, but to also return property that has moved through it. Part III will analyze 19 U.S.C. § 1595a(c) and its use in litigation pertaining to art and antiquities. This discussion will include a consideration of identifiable repercussions of these judicial decisions on entities against whom an action for forfeiture is brought. Part IV will analyze government attempts to expand its forfeiture powers pursuant to 19 U.S.C. § 1595a(c). Part V will focus on the ramifications of potential forfeiture not only as to museums and good-faith purchasers, but also as to the public and its access to works of art.
II. BACKGROUND

A. The International Art Market

Deborah A. DeMott, a Professor of Law at Duke University, has separated the participants in the art market into two main groups: the transactional intermediaries and the end-collectors. Common among the transactional intermediaries are auction houses, galleries, and art dealers. The most common end-collectors are museums and good-faith purchasers. A transaction in the art market generally proceeds in the following manner: an individual or entity purporting to be the owner of an art object or antiquity places the item in the custody of an auction house or dealer. While in the hands of this intermediary, the object is often verified for its authenticity. A significant aspect of this is the verification of the provenance of the object: the market history of the object is traced to its original owner or, as is often the case with antiquities, to the time in which its location of origin was excavated. The two primary purposes of provenance are to ensure that the object is authentic and to ensure that it has always passed through the market legitimately. Once this authentication is complete, the intermediary seeks out a willing buyer for the item, which most often is either a museum or a pri-
The concept of illicit trade within the art world, however, expands beyond the traditional notion of objects being sold from one individual or entity to another. Janet Ulph, a Professor of Commercial Law at the University of Leicester, distinguishes three categories that are encompassed in the phrase “illicit trade in cultural property.” First, the phrase may be used to describe the stealing or misappropriation of paintings, statues, and cultural objects. Second, the phrase may be used to describe the trade of antiquities that have been secretly removed from an archaeological site. Third, the phrase may be used to describe the exporting of objects without permission or without complying with export regulations.

These categories can be condensed into two terms describing the illicit art market: theft and smuggling. When one thinks of theft, instances come to mind such as the thirteen works of art that were stolen from the Isabella Stewart Gardner Museum in 1990 or Vincenzo Peruggia’s famous heist of Leonardo da Vinci’s Mona Lisa from the Louvre in 1911. Such thefts do occur and do impact the art market, but an even more lucrative area of theft is in the looting of antiquities. One of the greatest opportunities for looting is during political upheaval. This has occurred since the time of Ramses II, ruler of Egypt from 1279 BCE to...
1213 BCE, when conquered regions were looted for their spoils. The practice of gathering the “spoils” of war is one that spans many centuries and cultures, from Egyptian pharaohs to Adolf Hitler. It still occurs today, with one of the most notable and devastating modern lootings being that of the National Museum of Iraq in April of 2003.

Looting, however, does not always involve taking objects from institutions or individuals. In fact, the most prominent forms of modern looting now occur in the excavation of archaeological sites, where individuals are knowingly removing the object from the site without permission. Sometimes sophisticated thieves systematically engage in secret excavations. The most common manner of archaeological looting, however, is haphazard and careless excavation of sites that leads to not only the loss of the artifacts, but also the loss of the site. For example, Iraq is a region with some of the most destroyed archaeological sites, with Sumerian sites in the southern part of the country being looted shortly after the Iraq War started in 2003. These culturally rich sites represent one of the earliest known civilizations and date back to the 4th and 3rd millennia BCE. The haphazard nature of these lootings is evident by the fact that the sites were ransacked for as many as 400,000 to 600,000 objects, but items such as the cuneiform tablets, slabs of clay with one of the earliest known writing systems pressed into them, were left behind because they were not considered sellable on the international art market. These forms of looting are perhaps the most difficult to detect and recover from, for even if an illegal excavation site is discovered, no record will exist of what was taken.

30 Id. at 191.
31 Id. at 191–92.
32 Id. at 193, 199. For additional history on looting since ancient times, see generally Roehrenbeck, supra note 29, at 191–93.
34 Id. at 283–85.
35 Id. at 284–86, 292–95 (arguing that the consequence of looting archaeological sites is a greater detriment to civilization than the looting of museums).
36 Id. at 292–94.
37 From Bamiyan to Baghdad, supra note 33, at 293.
38 Id. at 293–94. The F.B.I. director at the time concluded “there is a link between the removal and transport of cultural objects and the funding of terrorism.” An estimated tens of millions of dollars were pumped into the underground economy by illegally obtained Iraq art objects and antiquities. The objects were being sold for cash or even exchanged for weapons. David Johnston, Picking Up the Stolen Pieces of Iraq’s Cultural Heritage, N.Y. TIMES (Feb. 14, 2005), http://www.nytimes.com/2005/02/14/international/middleeast/14artifact.html.
39 From Bamiyan to Baghdad, supra note 33, at 292–93.
40 NOAH CHARNEY, ART AND CRIME: EXPLORING THE DARK SIDE OF THE ART WORLD
Theft also occurs when excavated objects, whether obtained lawfully or not, are removed from the site in which the objects are being kept without permission.\(^{41}\) An instance that has garnered the most recent international attention is that related to Marion True, an ex-curator at the J. Paul Getty Museum in Los Angeles (“The Getty”).\(^{42}\) True allegedly knowingly received illegally obtained antiquities from the raiding and illegal excavation of ancient tombs in Italy.\(^{43}\) The legitimacy of at least forty objects in The Getty’s ancient art collections, built largely by True and another curator, were disputed as a result of the allegations.\(^{44}\) In response, The Getty returned the objects that Italy claimed had been looted.\(^{45}\)

In certain ways, smuggling can be similar to theft. The distinction between the two is that smuggling primarily concerns the export and import of objects. Many countries, especially those rich in cultural objects, have export restrictions with specific provisions for art objects and antiquities. Such restrictions can include disallowing the permanent export of objects and allowing only temporary export for exhibition.\(^{46}\) An example of such a regulation is Egypt’s Law of Protection of Antiquities, which provides that antiquities found after 1983 belong to Egypt.\(^{47}\) In turn, such objects cannot enter the ownership of international private collectors.\(^{48}\) In the 1990s, a New York City art dealer, Frederick Schultz, and his partner altered the exterior appearance of Egyptian antiquities to make them look like cheap souvenirs in order to smuggle the objects out of the country in evasion of this law.\(^{49}\) The items were successfully taken out of Egypt and sold to private collectors.\(^{50}\)

\(^{41}\) PATTY GERSTENBLITH, ART, CULTURAL HERITAGE, AND THE LAW 568 (2004).
\(^{43}\) Id. at 753.
\(^{44}\) Id.
\(^{46}\) See, e.g., Law No. 117 of 1983 (Law on the Protection of Antiquities), al-Jaridah al-Rasmiyya, 11 Aug. 1983, art. 8, 10 (Egypt).
\(^{47}\) Id. art. 6.
\(^{48}\) See id. art. 8, 15.
\(^{49}\) United States v. Schultz, 333 F.3d 393, 396–98 (2d Cir. 2003). The antiquities were made to look like souvenirs by coating them with plastic. Once the antiquities left Egypt, Schultz and his partner restored the objects and made them look as if they had been found in the 1920s in order to enhance the false provenance assigned to them. This case also presents a scenario in which the transactional intermediary does not fulfill his duty of authentication. Id.
\(^{50}\) Id. Schultz sold a head of the Egyptian Pharaoh, Amenhotep III, for $1.2 million. Antiquities Dealer Frederick Schultz Case, ARCHAEOLOGICAL INST. AM. (June 25, 2003), http://www.archaeological.org/news/advocacy/104.
In *United States v. Schultz*, Egypt was fortunate that the British government acknowledged Egyptian law and recognized that the objects were stolen.\(^{51}\) England was willing to begin an investigation into Shultz, and he was later convicted in the United States for conspiracy to receive stolen property.\(^{52}\) Issues arise, however, when the export controls of one country are not enforced by another country. That is, the fact that an item is illegally exported from one country does not necessarily make it a crime enforceable in another country.\(^{53}\) Rather, the second country must first acknowledge the violation of the export controls of the first country.\(^{54}\) This Note addresses the complexity of the interactions of different nations’ laws below in Part II.B.

Smuggling also occurs when an object is illegally imported into a country, meaning it is brought into a country in a manner contrary to that country’s laws.\(^{55}\) The logic behind the use of the language “illegally importing” is that it encompasses a variety of activities.\(^{56}\) For example, an individual may have excavated the object from an archaeological site without permission, making the object stolen. The stolen status of the object, in turn, makes it illegal for any person to import it. Alternatively, the object may be exported legally from its country of origin but then stolen from the foreign institution in which it was kept. The language of 19 U.S.C. § 1595a(c) enables the United States government to target this particular aspect of the illicit art market, to be further discussed below in Part III.\(^{57}\)

These statutes addressing illegal importation encompass the actions of the same members of the art market discussed above: dealers, museums, curators, and excavators. Nevertheless, these statutes also bring the focus on the final player in the illicit art market: the potentially good-

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\(^{52}\) *Schultz*, 333 F.3d at 416; see also Crumpton, *supra* note 51.

\(^{53}\) GERSTENBLITH, *supra* note 41, at 568.

\(^{54}\) See, e.g., Cunning, *supra* note 51, at 452–53 (the United States has only agreed to honor certain foreign export restrictions on cultural property on a limited basis).

\(^{55}\) See 19 U.S.C. § 1595a(c) (2012).

\(^{56}\) A more detailed analysis of this language as it appears in 19 U.S.C. § 1595a(c) is discussed *infra* Part III. The following hypotheticals are generic examples meant to emphasize the broad reach countries have with statutes related to illegal importing.

\(^{57}\) The United States government may seize and have forfeited “merchandise which is introduced or attempted to be introduced into the United States contrary to law . . . .” 19 U.S.C. § 1595a(c).
faith, but perhaps careless, purchaser. While thieves, looters, and smugglers are facilitating the illicit entry of art objects and antiquities into the market, the careless purchaser is the one who continues the movement of the objects through the market. A likely careless purchaser is a wealthy, private individual who inquires about the authenticity of an object, but does not consider inquiring about the background of the object and its legality or fails to take precautions beyond trusting the seller. Sometimes the lack of inquiry is due to the purchaser’s lack of concern regarding whether the object has passed through legitimate means. Perhaps the purchaser suspects that there may be issues with the object’s provenance, but the matter is irrelevant to him. Other times, the purchaser may be a novice who does not know to inquire, and thus becomes the victim of fraud.58 Either way, the careless purchaser may facilitate the movement of objects through the art market for quite some time before a glitch in provenance is found.

B. International Conventions

International steps have been taken to curb the illicit movement of art objects and antiquities. Three conventions in particular have proven most effective: the 1954 Hague Convention; the 1970 United Nations Educational, Scientific, and Cultural Organization Convention (“UNESCO”); and the 1995 International Institute for the Unification of Private Law Convention (“UNIDROIT”).

The 1954 Hague Convention was the first international agreement on the protection of cultural property, springing from the extensive looting and destruction of cultural sites that occurred during World War II.59 The definition given to cultural property in the convention is rather broad, including “movable or immovable property of great importance to the cultural heritage of every people.”60 Examples include monuments, art, archaeological sites, books, archives, and groups of buildings.61 The policy behind protecting cultural property is that cultural heritage is im-

58 The argument that the buyer did not know to inquire is a rather thin one and unlikely to succeed. Often times, the purchasers of art objects and antiquities are wealthy investors who are building a private art collection. Moreover, they often have an interest in art and are knowledgeable in the field of art history. In turn, such an individual is unlikely to be unaware of the need to make such an inquiry.


60 Id. ch. I, art. 1(a).

61 Id.
important to all of mankind, not just the peoples of the country of origin, and thus to lose such objects and artifacts is a detriment to the culture of the world.62

The 1970 UNESCO Convention focuses on protecting cultural property in the context of exporting from countries of origin and importing into other countries.63 It provides a much more extensive list of objects that qualify as cultural property than the 1954 Hague Convention.64 Moreover, the UNESCO Convention primarily addresses the international movement of cultural property, including the looting of archaeological sites and the illicit trade of objects.65 The policy behind the UNESCO Convention is that the illicit removal and trade of cultural property is to the detriment of cultural heritage.66 Most of the nations that have signed the convention have done so in recognition of other signatory nations’ export regulations. Thus, before allowing an object to be imported, many nations require the importer to present an export license from the country of origin.67

Carol A. Roehrenbeck, a Professor of Law at Rutgers University, argues that the UNESCO Convention has caused controversy.68 For example, museums were initially wary of the convention because of its effect on the flow of antiquities.69 Others criticized the convention for favoring the country of origin at the expense of market countries.70 Underlying this concern is a rather common and widely criticized belief by some art experts that the market and end-collector countries are in better positions and have better resources to care for the art objects.71

62 See id. ch. I, art. 2.
64 See id. art. 1.
65 Id. pmbl.
66 Id. art. 2.
67 Roehrenbeck, supra note 29, at 196.
68 Id.
69 Id.
70 Id.
71 Art professionals in end-collector or market countries have a bit of a superiority complex in this respect. That is, they argue that museums within which art objects and antiquities are held have the infrastructure to safeguard the objects and to facilitate accessibility beyond the reach of the originating country. Some critics dub this the “neocolonial attitude.” This “neocolonial attitude,” while still in existence, is gradually becoming a thing of the past. More Western museums are now acknowledging that countries of origin should have objects returned, especially when the objects left the country of origin under dubious circumstances. An example of an institution returning objects is the Yale Peabody Museum of Natural History returning thousands of Machu Picchu objects to Peru in 2010. Rachel Donadio, Vision of Home: Repatriated Works Back to Countries of Origin, N.Y. TIMES (Apr. 17, 2014),
Despite these criticisms, many view the UNESCO Convention as the foundation for international law concerning the illegal export of cultural property.\textsuperscript{72}

The 1995 UNIDROIT Convention is one of the most recent attempts to regulate the international art market and is viewed by some as a supplement to the UNESCO Convention.\textsuperscript{73} The purpose of the convention is to reinforce the obligation on importing nations to respect other nations’ exporting regulations.\textsuperscript{74} It also sets forth uniform rules for claims of private individuals seeking the return of cultural property stolen from them that has ended up in foreign countries.\textsuperscript{75} The policy behind the convention is that cultural property helps understanding between peoples and that dissemination of cultures promotes the progress of civilization.\textsuperscript{76}

While the guidelines provided by the conventions offer protection to cultural property on an international scale, nations must also implement legislation so that the international agreements are given domestic effect.\textsuperscript{77} Thus far, 126 nations have signed the 1954 Hague Convention,\textsuperscript{78} 129 nations have signed the 1970 UNESCO Convention,\textsuperscript{79} and 37 nations have signed the 1995 UNIDROIT Convention.\textsuperscript{80} While this is a substantial number of participating nations, until all nations sign the conventions and adopt any necessary local regulations, the conventions’ attempts to control the illicit possession and trade of cultural property

\begin{itemize}
\item \textsuperscript{72} Alexander MacKintosh Ritchie, Victorious Youth in Peril: Analyzing Arguments Used in Cultural Property Disputes to Resolve the Case of the Getty Bronze, 9 PEPP. DISP. RESOL. L.J. 325, 334 (2009).
\item \textsuperscript{73} Id. at 334–35.
\item \textsuperscript{74} See Convention on Stolen or Illegally Exported Cultural Objects pmbl., June 24, 1995, 34 I.L.M. 1322 [hereinafter 1995 UNIDRIOT Convention].
\item \textsuperscript{75} Id. ch. II, art. 3.
\item \textsuperscript{76} See id. pmbl.
\item \textsuperscript{77} Ritchie, supra note 72, at 335.
\item \textsuperscript{80} UNIDROIT Convention on Stolen or Illegally Exported Cultural Objects (Rome, 1995) – Status, UNIDRIOT (last updated Sept. 12, 2015), http://www.unidroit.org/status-cp. The United States has signed the 1954 Hague Convention and the 1970 UNESCO Convention, but it has not signed the 1995 UNIDROIT Convention.
\end{itemize}
may not be given full effect.

The countries that have signed, however, have begun to take the necessary steps to adopt domestic laws to implement these conventions, and these laws are making a difference. For example, in *United States v. Schultz*, discussed above, the outcome partially rested on the United States’ Cultural Property Implementation Act (“CPIA”),81 which is Congress’s implementation of UNESCO.82 CPIA provides the United States government with a procedure by which it may establish import restrictions on cultural property at the request of another UNESCO nation.83 Following the regulations set forth in UNESCO, the object would require an export license or must leave the country of origin before the date on which export controls84 became effective.85 Requiring stringent documentation encourages individuals to document legitimate transactions and discourages looting.

Moreover, many museums have adopted voluntary measures to help implement the conventions. In order to assure that the works they acquire come through the proper legal channels, museums have adopted policies that require rigorous provenance research.86 For example, the Association of Art Museum Directors adopted the 1970 UNESCO Convention and recommends that museums purchase antiquities only if the institution can prove that they were legally exported after 1970 or removed from the country of origin before 1970.87 These measures will help countries protect the art objects and antiquities of their cultures by discouraging end-collectors from acquiring items of suspect provenance thereby reducing the lucrative black market demand that ordinarily incentivizes illicit conduct such as theft or smuggling. Of course, there is still the issue of private collectors, especially the careless purchaser. Nevertheless, stopping the purchase of illegally obtained or marketed items by museums—a large purchasing group within the market—can only help bring an end to the illicit side of international art trade. The specific policies that some museums have put in place and those poli-

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84 Export control dates with respect to objects subject to the Convention are those dates on which the Convention was adopted and thus the regulations set forth in the Convention became effective.
86 See Roehrenbeck, *supra* note 29, at 198 (listing some of the voluntary measures that museums and associations have taken).
87 See id.
cies’ connections to 19 U.S.C. § 1595a(c) will be further discussed below in Part V.A.

III. THE FORFEITURE POWERS UNDER 19 U.S.C. § 1595A(c) AND ITS USE IN ART LITIGATION

Pursuant to 19 U.S.C. § 1595a(c), the United States government may seize and have forfeited “[m]erchandise which is introduced or attempted to be introduced into the United States contrary to law.”88 This includes merchandise that is “stolen, smuggled, or clandestinely imported or introduced.”89 This is a customs statute designed to regulate the flow of goods in and out of the United States. Courts have interpreted the language of the statute to find a violation if any item is introduced into the country contrary to law.

A. Interpreting the Language of 19 U.S.C. § 1595a(c)

In United States v. Davis,90 the Second Circuit helped to define the terms used in the statute, and in turn revealed the statute’s most distinctive feature: its breadth. The Second Circuit introduced the general principle that governs the statutory interpretation of § 1595a(c): the language is to be read literally.91 While the court did not decide the specific issue of what “contrary to law” means, it conceded that the government’s argument on the language was persuasive.92 That is, an object has entered the United States “contrary to law” when it has come into the country “unlawfully” or by some manner that “conflict[s] with established law.”93 The court did note, however, that the use of the verb “is” in § 1595a(c)(1)(A) indicates that the legal status of the object is to be considered at the point when the property enters the United States.94 In turn, one could conclude that whether the object’s status was unlawful before it entered the United States or at the actual time of forfeiture is of no

88 19 U.S.C. § 1595a(c) (2012). For the entire relevant text of the statute, see supra note 6.
90 648 F.3d 84, 89–92 (2d Cir. 2011).
91 Id. at 89.
92 Id. at 89–90.
93 Id.
94 Davis, 648 F.3d at 91–92.
As discussed above, § 1595a(c) is applicable to merchandise of three specific statuses: stolen, smuggled, or clandestinely imported. Different meanings of stolen and smuggled can be found in the above discussion where one can see that the two statuses encompass a variety of actions.95 The third status, “clandestinely imported or introduced,” is even broader. For an object to be clandestine, it must be one that is kept secret.96 Often, definitions for clandestine contemplate that the secret is kept because the activity is illicit.97 In turn, this final phrase is a type of catchall provision, allowing the government to seize any object unlawfully brought into the United States.

B. 19 U.S.C. § 1595a(c) and the National Stolen Property Act

Title 19 U.S.C. § 1595a(c) not only affects the movement of art objects and antiquities in the market, but also complements the regulations and policies of the 1954 Hague Convention and the 1970 UNESCO Convention.98 For this reason, the statute has been cited frequently in art litigation. As one will see, often when the government is seeking civil forfeiture of art objects and antiquities pursuant to § 1595a(c), it is at the request of a foreign nation or organization. Thus through the statute, the United States government is addressing the need to enforce the laws of other nations in the context of the illegal movement of art objects and antiquities in order to demonstrate its commitment to the proper respect for source countries’ interests in their own cultural objects. In essence, nations work together through statutes like § 1595a(c) to enforce the laws of other nations. Otherwise, an object that is stolen from or smuggled out of one nation could freely move into another nation where the actor may no longer be held liable for his wrongful actions.

In order for § 1595a(c) to be properly applied in litigation, the claimant must identify the legal basis for its action. That is, a predicate violation must be cited alongside § 1595a(c) in order for the government to prove that the object has entered the country contrary to law. On multiple occasions, the government has focused its § 1595a(c) argument on

95 See supra Part II.A.
96 Clandestine, BLACK’S LAW DICTIONARY (10th ed. 2014).
97 See, e.g., id.
98 This is not to suggest that 19 U.S.C. § 1595a(c) was enacted to implement the conventions that the United States has signed. In fact, § 1595a was enacted as part of the Tariff Act of 1930, Pub. L. No. 71-361, 46 Stat. 590 (1930). Nevertheless, the government, equipped with the authority of the statute, has effected the goals and policies of the conventions through art litigation.
the object’s entrance into the United States being in violation of the National Stolen Property Act (“NSPA”). In 1948, Congress passed the NSPA in response to the billion-dollar industry of illegal importation of cultural property, and the strain this industry created between source countries and the United States. In essence, the NSPA criminalizes the possession or sale of stolen goods and takes source country patrimony laws into consideration. An NSPA violation pursuant to 18 U.S.C. § 2314 consists of three elements: (1) transportation of the property in commerce, (2) the property is valued at $5,000 or more, and (3) the property is transported with knowledge that it was “stolen, converted, or taken by fraud.”

The NSPA includes the language of § 1595a(c) in its third element. By invoking an NSPA violation in conjunction with § 1595a(c), however, the government must prove not only that the object entered the United States contrary to law pursuant to § 1595a(c), but also that the actor moved the object in commerce with knowledge that the object was stolen pursuant to NSPA. This language means that, in order for the government to successfully seek forfeiture, it must prove that the defendant knew that the object was stolen. In turn, the language is narrow in that actual knowledge must be present and proven. While circumstantial evidence may be adduced, the party seeking forfeiture must prove knowledge by a preponderance of the evidence or else the claim fails. At the same time, however, the NSPA interpretation of forfeiture is broad because the claimant does not need to be the party that originally took the object. Rather, the claimant merely needs to know that the provenance of the object involves an unlawful taking.


One such case in which § 1595a and the NSPA were both used by the government in an attempt to have an art object forfeited is United...
States v. Portrait of Wally. Egon Schiele’s Portrait of Wally (“Wally”)\(^\text{106}\) had originally belonged to Lea Bondi, a Jewish woman living in Vienna, but in March of 1938, the painting changed possession from Bondi to Fredrick Welz, a Nazi Party member to whom Bondi sold her art gallery after Austria was annexed to Germany.\(^\text{107}\) This transaction was allegedly involuntary.\(^\text{108}\) In 1997, Wally resurfaced in the Museum of Modern Art (“MoMA”) in New York City, where it was on loan from the Leopold Museum in Vienna, Austria. When the painting appeared in MoMA, the descendants of Bondi petitioned the museum to return the painting to the family.\(^\text{109}\) When MoMA did not do so, the descendants went to the United States government for help, and thus § 1595a(c) and the NSPA became a part of one of the longest lawsuits in Nazi restitution.\(^\text{110}\) The United States government seized Wally as stolen property that had been imported into the United States in violation of NSPA.\(^\text{111}\) The government sought permanent forfeiture under § 1595a(c), claiming that the Leopold Museum (the “Leopold”) knowingly imported Wally contrary to law when it brought the painting into the United States to be put on loan to MoMA.\(^\text{112}\)

The court determined that the United States government fulfilled its burden of proof\(^\text{113}\) that Wally was stolen when the Leopold exported the painting and that it remained as stolen under Austrian law when it en-


\(^{107}\) Portrait of Wally, 663 F. Supp. 2d at 232, 236–46 (giving a full account of the history of the painting).

\(^{108}\) Id. There is some uncertainty as to whether Bondi sold the painting and gallery willingly, or whether it was an involuntary act because the gallery was designated as “non-Aryan” during the occupation and was subject to confiscation. Bondi sold the gallery after this occurred. Id. at 238.


\(^{111}\) Portrait of Wally, 663 F. Supp. 2d at 250.

\(^{112}\) Id.

\(^{113}\) In United States v. Portrait of Wally, the burden of proof was merely probable cause, rather than a preponderance of evidence. This is because the government commenced the forfeiture action prior to the enactment in 2000 of the Civil Asset Forfeiture Reform Act (“CAFRA”), Pub. L. No. 106-185, 114 Stat. 202 (2000). In forfeiture actions commenced after the enactment of CAFRA, the government’s burden is a preponderance of evidence. See 18 U.S.C. § 983(c) (2012).
tered the United States. The government, however, was unable to satisfy its burden in showing that the Leopold knew Wally was stolen when it shipped the painting to the MoMA, as is required by NSPA. The government argued that the Leopold had knowledge by claiming that Dr. Rudolf Leopold, a prolific art collector of Schiele paintings who sold Wally along with his 5,000 piece art collection to the Austrian government, did not perform an adequate investigation to remove reasonable suspicion that Wally belonged to Bondi. Yet, the government did not offer evidence that indicated Bondi told Dr. Leopold how she lost Wally. While such direct evidence of an expressed telling is not necessary, the government did not even suggest that interactions with Bondi would have put Dr. Leopold on reasonable notice that Wally was stolen. Thus, the court denied the government’s motion for summary judgment. Litigation ceased after the court’s ruling, and in 2010, the Leopold agreed to pay Bondi’s heirs nineteen million dollars as restitution for the painting.

D. 19 U.S.C. § 1595a(c) and its Use Against Innocent-Owner Claimants

What if the individual or institution with possession of the object clearly did not know that the object was brought into the United States contrary to law? In United States v. Davis, the government sought forfeiture of a painting that Sharyl Davis had hanging in her home for ten years without any knowledge that the painting was stolen. Davis had purchased Camille Pissarro’s Le Marché from an antiques and art gallery in San Antonio, Texas. Before coming to the United States and being

114 Portrait of Wally, 663 F. Supp. 2d at 256.
115 See id. at 276.
116 Id. at 269.
117 Id. at 269.
118 Portrait of Wally, 663 F. Supp. 2d at 271–73.
119 Both parties had moved for summary judgment, and both of their motions where denied. See id. at 237.
121 United States v. Davis, 648 F.3d 84, 87 (2d Cir. 2011).
122 Id. For an image of the painting, see Nathaniel Herzberg, Le Retour Triomphal du “Marché aux Poissons,” LE MONDE (Mar. 24, 2012), http://www.lemonde.fr/culture/article/2012/03/24/le-retour-triomphal-du-marche-aux-
consigned, the painting had been stolen from the Musée Faure in France.\textsuperscript{123} When Davis consigned the work to Sotheby’s to sell at auction,\textsuperscript{124} the French National Police informed the United States Department of Homeland Security of the impending sale and requested the work be withdrawn from auction.\textsuperscript{125} Davis claimed that even if the painting was subject to forfeiture pursuant to 19 U.S.C. § 1595a(c), she was entitled to assert an innocent-owner defense.\textsuperscript{126}

The Second Circuit disagreed and held that an innocent-owner defense was not available for § 1595a(c).\textsuperscript{127} The court considered the language of the statute, noting that while many statutes contain language that explicitly provides an innocent-owner defense, § 1595a(c) has no such language.\textsuperscript{128} Even when the statute was amended, Congress did not add language suggesting this defense existed.\textsuperscript{129} Moreover, Congress included the word “shall” in the statute, intending forfeiture to be a matter of course and not susceptible to an interpretation that forfeiture may be overcome by a legitimate possession by an innocent owner.\textsuperscript{130} Finally, Davis argued that the innocent-owner defense—enacted as part of the Civil Asset Forfeiture Reform Act of 2000\textsuperscript{131}—applied; the court concluded that the “customs carve-out”\textsuperscript{132} of the act establishes that any law codified in Title 19, including § 1595a, is not subject to this defense.\textsuperscript{133} In turn, the court affirmed the district court’s judgment of forfeiture, and the painting was removed from Davis’ possession.\textsuperscript{134}

\begin{footnotes}
\item[123] See Davis, 648 F.3d at 87.
\item[125] Davis, 648 F.3d at 87.
\item[126] Id. at 93.
\item[127] Id.
\item[128] Id. In considering the language of the statute, the Second Circuit looked to its earlier decision in United States v. An Antique Platter of Gold. In that case, the Court considered the innocent owner defense in relation to 18 U.S.C. § 545. It concluded that when the language of the statute does not explicitly include the innocent-owner defense, the omission was deliberate. See United States v. Antique Platter of Gold, 184 F.3d 131, 138–39 (2d Cir. 1998).
\item[129] Davis, 648 F.3d at 93.
\item[130] Id. Reinforcing this argument is a United States Supreme Court case concerning another provision of the Tariff Act of 1930, in which the Court held that forfeiture is enforced even against innocent owners. See Gen. Motors Acceptance Corp. v. United States, 286 U.S. 49, 57 (1932).
\item[133] Davis, 648 F.3d at 94.
\item[134] Id. at 98.
\end{footnotes}
United States v. Davis illustrates that in determining the rightful owner of a work of art between two innocent parties, someone may be left with nothing, even if it appears that the individual is being unfairly required to bear the loss. That is, even if one is a good-faith purchaser of a stolen art object or antiquity, if the true owner is successful in re-obtaining the object, the true owner has no obligation to the good-faith purchaser to reimburse him or her as a condition of having the work returned.135 Sharyl Davis invested $8,200 in the painting when she bought it, and Sotheby’s estimated a worth of $60,000 to $80,000. After being denied recovery of legal fees, Davis stated that “her $100,000 asset turned into a $100,000 liability.”136 What Davis failed to see, however, is that thieves cannot convey good title, and thus any subsequent transferees down to the San Antonio gallery lacked good title. The fact that she may have acted in good faith is inconsequential because in a battle between two innocent victims of a theft, the original victim who suffered will be the one who prevails.137 Thus, through United States v. Davis, one can see the unforgiving consequences of § 1595a(c), seemingly punishing innocent actors for the misconduct of third parties.

IV. ATTEMPTED GOVERNMENT EXPANSION OF ITS FORFEITURE POWER UNDER 19 U.S.C. § 1595A(C)

The previous analysis demonstrates how 19 U.S.C. § 1595a(c) and art litigation come together; the statute can apply to those who do and those who do not have knowledge or reason to know that the art object was stolen, smuggled, or brought into the United States contrary to law. Through these cases, however, one also begins to see how the government attempts to go beyond the language of the statute and its intricacies, and to ensnare objects whose provenance is unclear, but not necessarily illustrative of illicit activity.

Returning to United States v. Portrait of Wally, one began to see the government’s attempted expansion of the statute when it argued that the evidence it presented showed that there was no genuine issue of material fact as to whether Dr. Leopold knew that Wally was stolen.138 The government relied on the haste with which Dr. Leopold acquired the painting; the correspondence with Bondi and Hunna,—the attorney whom she

135 See DeMott, supra note 13, at 612.
137 See DeMott, supra note 13, at 609–18.
hired to help her recover the painting—and Dr. Leopold’s subsequent publications of the painting’s provenance. While the court found that such circumstantial evidence was enough to satisfy its burden to prove that Dr. Leopold knew or consciously avoided knowing that Wally was stolen, it was not enough for a court to grant a motion for summary judgment. In fact, the court found that whether Dr. Leopold knew such information constituted a genuine issue of material fact for a jury to decide.

In United States v. Portrait of Wally, the government’s attempt to expand its forfeiture powers is subtle because it appears as if the government is simply making the best possible argument for its case. More than likely, that is what it came down to; the government was trying to use what evidence it had to fulfill the elements of an NSPA violation. Yet, perhaps it is in these strained attempts to make out a NSPA forfeiture case on such tenuous facts that the government began to stretch the forfeiture power to the extent seen in United States v. Mask of Ka-Nefer-Nefer.

In 1952, the 3,200-year-old funerary mask of Ka-Nefer-Nefer was legally excavated in Saqqara, Egypt, and then placed in storage. In 1966, the mask was placed in a box labeled “fifty-four” in Cairo, Egypt. When the box was inventoried seven years later, the mask was no longer inside. The register was checked, and no evidence was found that the mask had been sold or given to any private party between the years of 1966 and 1973. In 1998, the mask reappeared and the St. Louis Art Museum purchased it for $499,000. On March 16, 2011, after the Museum repeatedly refused the Egyptian government’s requests to return the mask, the United States government sought forfeiture pursuant to 19 U.S.C. § 1595a(c).

The crux of the government’s argument was that circumstantial ev-

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139 Id. at 269–70.
140 Id. at 271.
141 Id.
143 Between the excavation in 1952 and the placement in the box labeled “fifty-four” in 1966, the mask did move around a bit. In 1959, it was packed for shipping to Cairo, where the police guards received it in July of that year. The mask remained in Cairo until 1962, when it was sent back to Saqqara and placed in the box labeled “fifty-four.” Id. at *1.
144 Id. at *2.
145 Id. at *3.
idence indicated that the mask was stolen property at the time that it was imported into the United States.\textsuperscript{148} The United States government, however, did not rely on circumstantial evidence, but rather on its own arbitrary conclusions. The “complaint alleged that the Mask was ‘missing’ after 1966 because it had been stolen and smuggled out of Egypt, [and] ‘because the mask was stolen . . . it could not have been lawfully exported from Egypt or lawfully imported into the United States.”\textsuperscript{149} This argument lacked logical connections between the alleged facts and the legal conclusion. The government was not stating why or how the mask was stolen, but rather why the mask was missing. That is, the government assumed that the mask was stolen and was illegally imported because the mask went missing from one party in 1973 and then reappeared in a different country with another party in 1998. No allegations were made to suggest who may be involved, how the alleged theft occurred, when the alleged theft occurred, or where the alleged theft or smuggling occurred.\textsuperscript{150} Instead, the government presented a rather bold legal conclusion based not on logical inferences, but rather on an unsupported theory of “the worst case scenario” for the mask’s provenance.

The court in \textit{Mask of Ka-Nefer-Nefer} also took issue with the government’s argument that the mask was brought into the United States contrary to law without stating which established law was violated. After the court dismissed the government’s claim for forfeiture, the government filed a motion to reconsider.\textsuperscript{151} In its memorandum in support of this motion the government argued, “Section 1595a itself prohibits the importation of stolen property into the United States, regardless of whether any other law has been violated in the process of importation.”\textsuperscript{152} Thus, the government wanted to rely only on the language of 19 U.S.C. § 1595a(c). One cannot prove, however, that an object was brought into the United States contrary to law if one does not specify to which law the object’s importation was contrary. A stand-alone interpretation of § 1595a is vague and illogical; the government cannot sufficiently show that an item was brought into the United States contrary to

\begin{itemize}
\item \textsuperscript{148} See \textit{id.} at *2.
\item \textsuperscript{149} \textit{United States v. Mask of Ka-Nefer-Nefer}, 752 F.3d 737, 739 (8th Cir. 2014) (quoting the government’s complaint).
\item \textsuperscript{150} See \textit{Mask of Ka-Nefer-Nefer}, 2012 U.S. Dist. LEXIS 47012, at *9 ("As it now stands, claimant cannot even be sure of the who, what, when or where of the alleged events surrounding the alleged ‘stealing,’ nor can the Museum ascertain if the Government is pursuing seizure of the Mask based on an alleged theft or a unlawful import/export, or both.").
\item \textsuperscript{152} \textit{Mask of Ka-Nefer-Nefer}, 752 F.3d at 741.
\end{itemize}
law if it does not present a law that has been violated. As recognized by the Eighth Circuit, to allow otherwise is not only unreasonable, but also a dangerous enhancement of the government’s forfeiture powers;\textsuperscript{153} the government would be able to seek the forfeiture of any object that appeared to have a dubious past.

V. THE RAMIFICATIONS OF THE FORFEITURE POWERS

As seen in the case studies in Part IV, repercussions have occurred for specific individuals. For example, Sharyl Davis was required to forfeit her Pissarro, and thus suffered a loss that she estimated at $100,000.\textsuperscript{154} In addition, one has seen that the return of art objects and antiquities to countries of origin is a delicate process in which the government, law enforcement, museums, dealers, auction houses, and private individuals must cooperate.\textsuperscript{155} Section 1595a(c) is one way in which the United States government has cooperated with other governments and international law enforcement agencies. Part V will now explore how museums, transactional intermediaries, and purchasers—whether parties to past suits or not—have reacted to the government’s forfeiture powers and its involvement in returning art objects and antiquities.

A. Museums

The museum world is currently confronting a movement in which many countries of origin and individual private owners are seeking the return of art objects and antiquities that were wrongfully taken from them or taken from them under suspicious circumstances. Often times, 19 U.S.C. § 1595a(c) comes into play.\textsuperscript{156} Perhaps two of the greatest fears for museums are that art collections in many American and European museums will begin to be depleted and that the public will be deprived of the opportunity to view these artifacts and objects that provide windows into the past and into different cultures.\textsuperscript{157} Jane C. Waldbaum,

\textsuperscript{153} See id. at 741–42.
\textsuperscript{154} See Taylor, supra note 136.
\textsuperscript{155} Roehrenbeck, supra note 29, at 186.
\textsuperscript{156} Sometimes with archaeological digs, it is not that the excavation was done illegally or without permission. With the earlier excavations of the late nineteenth and early twentieth centuries, no governing guidelines existed as to who owned what was discovered. As a result, antiquities were removed and taken to market or end-collector countries. This was not necessarily a wrongful act at the time, but based on today’s more structured rules for archaeological sites, the items do not belong to the countries in which they currently sit.
\textsuperscript{157} See Jane C. Waldbaum, \textit{From The President: Many Happy Returns}, 59 \textit{Archaeology}, no. 6, Nov.-Dec. 2006,
the honorary president of the Archaeological Institute of America, finds this unlikely to happen. First, most claims are directed towards very specific objects that have been proven as stolen, looted, or subject to some wrongful act. Second, some claimants are now offering museums long-term loans of materials that have equal significance.\footnote{Id.}

Further quelling these fears are the necessary steps that museums have begun to take to avoid forfeiture claims against the art objects and antiquities held within their collections. In the past, many museums would acquire objects with the understanding that any uncertainty in the object’s provenance could lead to potential claims; now museums are focused on making thorough inquiries into provenance prior to acquiring the object.\footnote{See, e.g., Ray Mark Rinaldi, Denver Art Museum Returns Looted Sculpture to Cambodia, DENV. POST (Feb. 29, 2016), http://www.denverpost.com/entertainment/ci_29576291/denver-art-museum-returns-looted-sculpture-cambodia.} Furthermore, museums are even returning those objects that they currently own that have been discovered to be involved in looting, theft, or smuggling.\footnote{Id.}

An example of a museum taking preemptive measures is the policy on acquisitions at the J. Paul Getty Museum (“The Getty”) that was adopted in 2006 by the Board of Trustees of the J. Paul Getty Trust.\footnote{See BD. OF TRS. OF THE J. PAUL GETTY TRUST, POLICY STATEMENT: ACQUISITIONS BY THE J. PAUL GETTY MUSEUM (Oct. 23, 2006) [hereinafter GETTY POLICY STATEMENT], http://www.getty.edu/about/governance/pdfs/acquisitions_policy.pdf.} According to the policy, when an object is acquired, there must be assurance that good title can be transferred, and The Getty has the responsibility of establishing by reasonable efforts that the provenance and legal status of the object is legitimate.\footnote{Id.} The third condition of acquisition is particularly interesting, for it directly addresses 19 U.S.C. § 1595a(c): no object may be acquired that The Getty knows “has been stolen, removed in contravention of treaties and international conventions of which the United States is a signatory, illegally exported from its country of origin or the country where it was last legally owned, or illegally imported into the United States.”\footnote{Id.} By incorporating this condition, The Getty is ensuring that there are no gaps in the historical record and transactions of the object, and that these transactions are not disguised as legitimate purchases designed to obscure an illegal exportation.

Moreover, the condition incorporates both the broader language of

\url{http://archive.archaeology.org/0611/etc/president.html}.\footnote{Id.}

\footnote{Id.}


\footnote{See BD. OF TRS. OF THE J. PAUL GETTY TRUST, POLICY STATEMENT: ACQUISITIONS BY THE J. PAUL GETTY MUSEUM (Oct. 23, 2006) [hereinafter GETTY POLICY STATEMENT], http://www.getty.edu/about/governance/pdfs/acquisitions_policy.pdf.}

\footnote{Id.}

\footnote{Id.}
the conventions and the narrower language of the domestic laws put in place to enact the conventions locally. For example, the United States is a signatory on UNESCO, and thus The Getty will not acquire any object brought into the country in violation of the convention. At the same time, The Getty cannot acquire an object that is in violation of a domestic law such as the NSPA.

Lastly, the Board of Trustees has applied this condition to ensure that The Getty does not acquire any object that left its country of origin illegally. Thus, even if the acquisition is not necessarily in violation of a United States law, The Getty will still not acquire the object. While generally this concept is contemplated by § 1595a(c) and the conventions, the Board of Trustees is still ensuring that this general illegal movement of the object, whether or not within the United States, is sufficient as a wrongful action that prevents The Getty from acquiring the object.

The fourth condition of The Getty’s policy elaborates on the third condition by directly discussing the effect of the UNESCO Convention on the acquisition of antiquities. If the object is an antiquity, The Getty requires documentation that the object was in the United States by November 17, 1970; that the antiquity left its country of origin before November 17, 1970; or that the antiquity was legally exported from its country of origin after November 17, 1970. Using the UNESCO date of November 17, 1970, as the cutoff for establishing provenance for antiquities is not unique to The Getty. The year 1970 has been suggested as the appropriate measure from which provenance must be established for all purchased antiquities, and many museums and similar institutions have adopted it.

In addition, museums have begun work on a system that could help cleanly resolve any future disputes over ownership. In particular, the Association of Art Museum Directors, an organization of museum directors that supports the contribution of museums to society, formed a thir-
teen-person group known as the Task Force on the Spoliation of Art during the Nazi/World War II Era. The task force’s purpose is to develop guidelines for museums when resolving individual ownership claims arising out of World War II. In addition, the task force has created the Registry of Claims for Nazi-Era Cultural Assets where restituted objects and settlements made since June 4, 1998, are listed. With many forfeiture claims relating to Nazi-looted art, registries like this could significantly curb 19 U.S.C. § 1595a(c) litigation; while the apparent purpose of the list is to provide information on art objects that were subject to restitution, the registry has a secondary purpose of encouraging not only museums, but also dealers, galleries, and individual collectors to be open about the resurfacing of Nazi-looted works, both on a national and international scale. In turn, museums may engage in more negotiations and alternative methods of resolution rather than waiting for litigation.

A major contributor to this shift towards preemptive measures was the decision in United States v. Portrait of Wally. The United States government seizing a work of art that was on loan to MoMA not only shocked the art world, but also brought to the attention of museums, dealers, collectors, policy-makers, and families of victims of art theft that looted art could be recovered. The affair renewed interest in the massive looting by the Nazis and encouraged families to come forward about works that were taken from their descendants and never returned. Moreover, while restitution claims and forfeiture actions had occurred in the past, United States v. Portrait of Wally was not only a
widely publicized case, but also a defining moment for the government in establishing its position in the art world. That is, the decision is significant because it marks the first time that the United States government utilized its forfeiture powers to recover Nazi-looted art.\footnote{Spiegler, supra note 120.} By becoming involved at the request of Bondi’s heirs, the government showed that it would expend national resources to ensure that art objects and antiquities that had been plundered from original owners were returned.\footnote{See id.} Thus, what began as a private title dispute between a museum and a family has become a larger movement to establish that art objects that have been wrongfully taken is a public policy issue that deserves the commitment of the government’s time and resources.

At the same time, the MoMA is actively opposing this stance of the government. The government’s seizure of the Wally suggested to the public that American museums were more concerned with borrowing or collecting art from abroad than with determining who actually owns the art object and returning it.\footnote{See Judith H. Dobrzynski, What Makes the Portrait of Wally Case So Significant?, ART NEWSPAPER (Apr. 24, 2012), http://www.theartnewspaper.com/articles/What-makes-the-Portrait-of-Wally-case-so-significant/26309.} This fight between displaying art and maintaining moral judgment is one that has harmed the reputation of museums; the fight casts a view of institutions as elitists who prioritize self-interest over the ethical issues embedded in claims, and would rather resort to litigation than willingly return works. With policies like that of The Getty, however, museums have begun to rework their reputations with the aim of being viewed as educational institutions that wish only to collect and borrow works with clean pasts that have moved through legitimate channels. While the debate of whether museums are fully supporting restitution claims is still on-going, the diligence being taken by museums in acquisitions and loans is helping to avoid forfeiture claims and long, reputation-harming litigation.\footnote{While one might expect that forfeiture claims also cause business and transactional concerns for museums, and to some extent they do, the steps taken by museums appear to be more about the art, preserving the objects, and the perceived integrity of the institutions.}

**B. Transactional Intermediaries**

Due to their role as transactional intermediaries, sellers of art such as galleries, dealers, and auction houses are repeat market participants. Thus, one can presume that these entities are knowledgeable enough to position themselves, at a minimum, to suspect that an art object or antiq-
uity may have been stolen or subject to some other wrongful act.\footnote{179} While that has not always been the case, over the past ten years, transactional intermediaries have become more scrupulous in determining whether consignors have the right to convey good title, even if no initial suspicion of provenance is present.\footnote{180}

Perhaps part of this increased scrupulousness is due to some of the public attention that some of the transactional intermediaries have received. For example, in United States v. 10th Century Cambodian Sandstone Sculpture, Sotheby’s became the focus of a 19 U.S.C. § 1595a(c) forfeiture action.\footnote{181} The tenth century sandstone sculpture was part of a temple in the Koh Ker Preah Vihear Province in Cambodia, but had been removed from the temple when members of organized looting networks plundered the site.\footnote{182} The sculpture was eventually in the possession of a Belgian businessman, whose wife entered into a consignment agreement with Sotheby’s in New York City.\footnote{183} Sotheby’s not only knew that the sculpture had originally been located at the Koh Ker temple, but was also told by an expert in Cambodian art that the Cambodians had clear evidence that the sculpture was stolen from the temple.\footnote{184} While Sotheby’s did send a notice to the Cambodian Minister of Culture, it did not do so from a senior officer, which would have likely caught the attention of a ministry official. Moreover, the notice merely stated that the sculpture would be offered for sale. In addition, the government alleged that Sotheby’s provided inaccurate information on the sculpture’s provenance and omitted information on provenance.\footnote{185}

In its opinion, the District Court for the Southern District of New

\footnote{179}{DeMott, supra note 13, at 613–14.}
\footnote{180}{Id. at 638.}
\footnote{182}{Id. at *4–5.}
\footnote{183}{Id. at *6. The underlying alleged violation in United States v. 10th Century Cambodian Sandstone Sculpture is an example of the type of looting that occurs during political unrest, as discussed in Part II. In this scenario, the temple in Koh Ker was looted during Cambodian political upheaval and civil war.}
\footnote{184}{Id. at *7–8.}
\footnote{185}{Id. at *9–10. The original collector of the statue knew that it had been looted from the temple at Koh Ker. Part of what was omitted from provenance was the original collector’s acquisition of the statue and that Sotheby’s was in contact with him during the time in which the auction house possessed the statue. When the Secretary General of the Cambodian National Commission contacted the director at Sotheby’s, the statue was removed from auction, but Sotheby’s retained possession. Id.}
York was not kind to the widely known auction house. The court found that it was reasonable to infer that Sotheby’s knew that the sculpture was stolen when it entered the United States because the auction house both had an expert in the field who advised that it was stolen and was in contact with the original collector who knew that the sculpture had been looted.\(^{186}\) While the court did not openly disdain the actions of Sotheby’s, its view of the auction house became clear when it addressed the issues of provenance alleged by the government. The court did not even debate the issue as to whether Sotheby’s did or did not inaccurately represent the history of the sculpture. Instead, the court merely stated that when accepting all the facts as true, including Sotheby’s interacting with an expert, one could infer that the auction house knew of the sculpture’s illegal status.\(^{187}\) One can imagine that such an inference does not look good for one of the most well known auction houses for art objects and antiquities.

Of course, Sotheby’s initial reaction to the case was to publicly declare that it did not act unethically. Peter G. Neiman, the attorney representing Sotheby’s, stated, “Any suggestion that Sotheby’s provided information it knew to be inaccurate is demonstrably not true.”\(^{188}\) Moreover, similar to the actions of the MoMA in United States v. Portrait of Wally, Sotheby’s was unwilling to consent to the sculpture’s return when the Cambodian government initially claimed that the statue was illegally removed and should be returned.\(^{189}\) Rather, the auction house waited for litigation. Whether to avoid further litigation or to avoid further tarnishing of its reputation, Sotheby’s eventually agreed to return the statue to the Cambodian government.\(^{190}\)

Interestingly, finding information on Sotheby’s policies about the works it possesses is much more difficult than for museums. Perhaps this is due to the fact that museums are gaining permanent ownership of the works that they are purchasing, whereas auction houses and other transactional intermediaries do not have ownership of the works that

\(^{186}\) Id. at *29.
\(^{190}\) Sotheby’s and the woman who consigned the statue had moved for the claim to be dismissed, and the government had moved to amend the complaint. While the claimant’s motion was denied, the government’s motion was granted. It appears that Sotheby’s agreed to return the statue shortly thereafter.
they offer for sale, but rather act as an agent for the principal consignors. Lucian Simmons, Senior Vice President of Sotheby’s New York, however, has stated, “Sotheby’s longstanding policy [is] not to sell any work of art that is known to have been stolen or where there is credible evidence that our consignor’s title may be compromised by theft or persecution . . . .” Moreover, in furtherance of this policy, Sotheby’s led the Art Loss Register’s Holocaust initiative in 1998; the purpose of the initiative, now additionally supported by other auction houses, is to have Holocaust claims registered on a free database so that auction house catalogues can be verified as containing no stolen or seized objects.

Lastly, in 1997, Sotheby’s began what Simmons calls “a due diligence program” that targets potential World War II provenance issues among the works that it is asked to sell or appraise. By investigating the title and history of the object, Sotheby’s is minimizing the risk of any adverse title claims and future litigation. If an object that was previously sold at auction later becomes subject to a claim, Sotheby’s general response is to forward a letter from the claimants or their attorneys to the consignor and/or buyer from the past sale.

The justification given for Sotheby’s policy and the subsequent programs is not one of moral responsibility, but rather one of blatant commercial gain. That is, Simmons states, that to sell items with potentially troublesome provenance has the potential to damage the reputation of Sotheby’s and to expose the company and its clients to liability. Moreover, selling troublesome items is not in the best interest of the company’s shareholders. Thus, the policy encourages careful research and in turn minimizes the possibility of future forfeiture litigation, but the underlying reasoning appears to be quite different from what has been observed with museums; while museums are concerned with reputation and their roles as cultural institutions, auction houses are concerned with reputation and their commercial presence. Perhaps this is

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191 Lucian Simmons, Senior Vice President, Sotheby’s N.Y., Presentation at Holocaust Era Assets Conference (June 28, 2009) (transcript available at http://www.holocausteraassets.eu/en/working-groups/looted-art/).
192 Id.
193 See id.
194 Id.
195 Simmons, supra note 191. See the transcript of Simmons’s speech for some essential elements of the program.
196 See id.
197 Sotheby’s forwards the letter rather than have the client send it directly because of Sotheby’s client confidentiality policy. Id.
198 Id.
due to the differing nature of these entities. Museums are often non-profit entities with the purpose of providing cultural and educational spaces for the larger public. In contrast, auction houses are for-profit entities that primarily focus on generating revenue by efficiently completing business transactions. Often times, these transactions involve a substantial amount of money.  

On the other hand, the difference in reasoning may extend beyond the basic purposes of the entities and into their distinguished roles as end-collectors and transactional intermediaries. As end-collectors, the museums are obtaining permanent possession of these art objects and antiquities with the motivation of preserving them as representations of human culture and artistic ingenuity. Presumably, this is done with altruistic intention. As transactional intermediaries, art dealers, auction houses, and galleries are essentially gatekeepers; as the entities that are constantly participating in the art market, they are in the best position to use their expertise and knowledge of current art practices to discover problems with provenance and thus halt an object’s movement in the art market. Whatever the reasoning for these justifications, auction houses and other transactional intermediaries and sellers are taking the necessary steps to avoid the effects of forfeiture claims. Thus, while 19 U.S.C. § 1595a(c) may lead to poor reputations for transactional intermediaries, it is also encouraging sellers to be more precautionary in their transactions rather than waiting for future litigation to occur.

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199 Sotheby’s highest total art sale for a single auction is $442.1 million, with one item alone, an Alberto Giacometti sculpture, selling for $101 million. Elizabeth Blair, Sotheby’s Had Record Auction With Works by Giacometti, Van Gogh, NPR (last updated Nov. 6, 2014), http://www.npr.org/2014/11/05/361820796/sothebys-has-record-auction-with-works-by-giacometti-van-gogh. The highest price ever paid for an artwork at auction occurred at Christie’s, with Francis Bacon’s Three Studies of Lucian Freud selling for $142.4 million. See Carol Vogel, Buyer of $142.4 Million Bacon Triptych Identified as Elaine Wynn, N.Y. TIMES (Jan. 15, 2014), http://www.nytimes.com/2014/01/16/arts/design/buyer-of-142-4-million-bacon-painting-identified-as-elaine-wynn.html. In 2015, Paul Gauguin’s “Nafea Faa Ipoipo” fetched the highest price ever paid for a single work, $300 million. Although the buyer has not been identified, it is speculated that the work was purchased by the nation of Qatar for its state-financed museums. The two dealers with knowledge of the sale have declined to be named as of yet. See Scott Neuman, Gauguin Painting Reportedly Fetches Record $300 Million, NPR (Feb. 7, 2015), http://www.npr.org/blogs/thetwoweek/2015/02/07/384519464/gauguin-painting-reportedly-fetches-record-300-million; Scott Reyburn & Doreen Carvajal, Gauguin Painting Is Said to Fetch $300 Million, N.Y. TIMES (Feb. 5, 2015), http://www.nytimes.com/2015/02/06/arts/design/gauguin-painting-is-said-to-fetch-nearly-300-million.html.

200 Ritchie, supra note 72, at 353–54.

201 DeMott, supra note 13, at 623.
C. Good-Faith Purchasers

One might assume that the risk of forfeiture being allocated to the buyer of a work of art, whether one is a good-faith purchaser or not, would be enough to encourage private individuals to be wary of purchasing art objects or antiquities with suspect provenance or that are coming from a potentially unreliable transactional intermediary. The Federal Bureau of Investigation’s Special Agent Brusokas of the Art Crime Team encourages a private buyer to be diligent and wary.\(^{202}\) He advises that a buyer get a complete provenance rather than just relying on a certificate of authenticity as a way of confirming that the work’s history is legitimate.\(^{203}\) Second, he recommends that a buyer carefully research the dealer from whom he is buying.\(^{204}\) One recommended question to ask is whether the dealer “sell[s] only online or if [he] ha[s] a gallery.”\(^{205}\) Third, Special Agent Brusokas suggests that any collector who possesses pieces that did not have a full provenance check to go back to the gallery from which he purchased the work and ask for provenance.\(^{206}\) Special Agent Brusokas then leaves the potential buyer with one final piece of advice: “When you’re trying to find that one treasure from someone’s garage, that’s when you’re more likely to let your guard down.”\(^{207}\)

Judah Best, a Washington, D.C. lawyer and the Commissioner of the Smithsonian American Museum of Art, is a collector who takes this advice seriously. When it comes to purchasing American art, Best ensures that the work has established provenance, even if doing so entails insisting that the dealers do the research.\(^{208}\) Moreover, once the work is in Best’s possession, he ensures that he is protecting the art, including lending any pieces in an orderly fashion to ensure that it is returned safe-

\(^{202}\) Fine Art Forgeries: Global Counterfeiting Scams Uncovered, FBI (Mar. 21, 2008), http://www.fbi.gov/news/stories/2008/march/artscam_032108. The FBI Art Crime Team was established in 2004. It is composed of sixteen special agents who focus their efforts on addressing art and cultural property crimes. Its investigations are not contained to the United States, but rather extend worldwide. Thus far, the Art Crime Team has recovered more than $150 million in more than 2,650 items. For a non-exhaustive list of what has been recovered, see Art Theft: Art Crime Team, FBI, http://www.fbi.gov/about-us/investigate/vc_majorthefts/arttheft/art-crime-team (last visited Mar. 1, 2016).

\(^{203}\) See Fine Art Forgeries, supra note 202.

\(^{204}\) Id.

\(^{205}\) Id.

\(^{206}\) Id.

\(^{207}\) See Fine Art Forgeries, supra note 202.

\(^{208}\) Interestingly, Best states that dealers complain about the cost of research to confirm that paintings are not stolen. Best takes the view that the cost of research is already hidden in the price of the work. Judah Best, Trepidations of a Private Art Collector, in ART AND CRIME: EXPLORING THE DARK SIDE OF THE ART WORLD 111–12 (Noah Charney ed., 2009).
ly.\textsuperscript{209}

Best is what one would call a good-faith purchaser—he is an individual “who buys something for value without notice of another’s claim to the property and without actual or constructive notice of any defects in or infirmities, claims, or equities against the seller’s title.”\textsuperscript{210}

He not only purchases his art that presents no notice of defects in the object’s provenance, but also takes affirmative steps to further prevent future forfeiture and litigation. Taking such steps, however, will not guarantee that the art object or antiquity has a clear and full provenance; the good-faith purchaser may still encounter future forfeiture claims.

Perhaps one of the biggest concerns with this imperfect nature of researching provenance is that good-faith purchasers will be discouraged from purchasing works that do not have a perfectly documented history from the time the work was created or discovered until the time that it reached the potential buyer. This would halt the private buyer category to the art market, making it more difficult for auction houses and other transactional intermediaries of art to successfully complete transactions.

Moreover, current owners of art objects and antiquities may be reluctant to relinquish control of the items to consignors or museums; that is, the owners may not be willing to sell the object or to donate it due to a fear that the object may become subject to a forfeiture claim. With respect to consignors such as the auction houses, such a fear could slow down business, and thus further halt the art market. Perhaps more importantly, however, is that this fear of forfeiture could lead to museums losing one of their biggest contributors. Often times, it is private individuals who are leaving their prolific art collections to institutions so that the collection may be well preserved and benefit the general public. Thus, if museums lose private individuals as contributors to their collections, not only will the museums suffer in being unable to expand their permanent collections, but also the public will suffer in not having access to the works. For those who champion art as a form of culture and history over art as a collectible item, this is perhaps the worst effect of the forfeiture powers; works are being hidden from the public.

Unfortunately, very little data exists as to how the forfeiture powers pursuant to 19 U.S.C. § 1595a are affecting good-faith purchasers. Thus, much of what is discussed in this section is speculative at best. Unlike museums and sellers, private individuals are not under the constant scrutiny of the public, and thus do not take as many concrete, purposeful

\textsuperscript{209} Id.

\textsuperscript{210} Good-Faith Purchaser, BLACK’S LAW DICTIONARY (10th ed. 2014).
steps in preserving the integrity of their collections. One can hope, however, that while § 1595a(c) may lead to works being taken from private individuals, it will also begin to increase the number of private buyers taking the same precautionary steps as Judah Best when it comes to purchasing new art objects and antiquities. While forfeiture actions against works of art may never become a rarity, private individuals can contribute to a decrease in these actions by following the advice of the FBI Art Crime Team and Best, and becoming meticulous in his or her research before any purchase.

VI. Conclusion

In conclusion, 19 U.S.C. § 1595a(c) is a powerful tool by which the United States government may seek forfeiture of art objects and antiquities with illegitimate provenance. On the one hand, this power is beneficial, for it encourages individuals and entities to come forward about stolen, smuggled, or unlawfully obtained objects because they will have the assurance that the government will assist them. Moreover, the statute and its use by the government discourage individuals and entities from attempting to move such objects through the art market. Often times it is this continuous movement through the art market that keeps an art object or antiquity from being discovered and returned to its rightful owner. In some cases, this discouragement of moving unlawfully obtained objects has encouraged the implementation of policies such as that of The Getty that are meant to be precautionary measures to ensure that art objects and antiquities are unlikely to lead to future litigation. Additionally, purchasers are becoming more aware of the importance of provenance and the need to research not only the item being purchased, but also the individual from whom he is purchasing.

Yet, through the United States government’s attempts to expand its forfeiture powers through 19 U.S.C. § 1595a(c), the statute has begun to have adverse effects. Due to their responses to the potential forfeiture of works in their collections, museums have earned a poor reputation with the public that they now must work to repair. That is, they have become viewed as elitist institutions with no moral scruples and now must reinvent themselves as cultural entities that wish to both display their collections in order to educate the masses and to ensure that the objects they display have been obtained lawfully. The reputation of transactional intermediaries such as Sotheby’s has undergone similar scrutiny. In addition, the expansion of the forfeiture powers may begin to frighten private individuals who buy and collect art, leading to less works moving
through the art market, and less works eventually ending up in institutions where they can become accessible to the public.

In turn, the use of 19 U.S.C. § 1595a(c) sits on a very fine line between the United States government promoting sound public policy, and the government’s overreaching in its role as an outlet through which one may seek assistance. While adverse effects can be identified in the government’s use of the statute, the best course of action for those involved in the art market is to cooperate with the government and with those for whom it is seeking forfeiture. Forfeiting an art object or antiquity without compensation is not the ideal course of action for those in possession of the works, but the forfeiture power has led to many beneficial developments in the art world. As long as those within the art world continue to investigate the history of art objects and antiquities, and the courts continue to keep the United States government at bay in its attempts to expand its forfeiture powers, the art world will increasingly become a market in which original owners are able to seek relief and in which current owners are able to purchase and move art objects and antiquities without the fear of the work being taken from them without compensation.