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THE COURTS AND HEALTH POLICY: STRENGTHS AND LIMITATIONS

by Gerard F. Anderson

Prologue: The executive and Legislative branches of federal and state governments participate visibly in the formation of U.S. health policy. In recent years, however, the health policy debate has expanded to include the nation’s courtrooms. While the courts are no stranger to malpractice lawsuits and cases involving humane treatment of patients in state hospitals, recently questions of broader policy have ended up on courtroom dockets. In this paper, Gerard Anderson examines four policy areas: review of coverage decisions made by public and private payers; analysis of the adequacy of Medicaid payment rates to hospitals and nursing homes; review of hospital mergers in light of antitrust laws; and examination of the tax-exempt status of nonprofit hospitals. Health policy is not the only arena in which courts have assumed an active role; in the past, other social policy issues such as school desegregation, the environment, and prison reform have been debated in and shaped by the nation’s courts. Critics question the appropriateness of deciding issues with such sweeping ramifications in the courtroom, where the focus is on the merits of an individual case and not on the broader implications of decisions rendered. The courts are likely to remain involved, however; in light of this, Anderson offers his suggestions for improving judicial resolution of health policy issues. Anderson has been director of the Center for Hospital Finance and Management at The Johns Hopkins Health Institutions in Baltimore, Maryland, since 1987. He received his doctoral degree in public policy analysis from the University of Pennsylvania. His last published work in Health Affairs drew lessons for the United States from Korea’s health system.
Abstract: In recent years the nation’s courts have expanded their influence in health policy in four areas: reviewing insurers’ coverage decisions, deciding the adequacy of Medicaid payment rates to hospitals and nursing homes, arbitrating hospital mergers, and assessing hospitals’ tax-exempt status. The major problem with developing health policy through the courts is that the courts’ focus will be the concerns of the individuals or groups involved in specific cases, not the broader implications and overall objectives of the health care system. As alternatives to litigation to resolve policy conflicts, scholars have suggested negotiation, binding arbitration, clarification of legislative language, administrative courts, contract revision, and general restructuring of the decision-making process.

The influence of the judiciary in health policy issues is expanding. For several decades the courts were involved in a few specific health policy issues such as medical malpractice or assuring humane treatment of patients in state mental hospitals. Recently, however, the role of the courts has expanded into other areas of health policy. This paper examines the growing role of the courts in four health policy areas: (1) review of coverage decisions made by public and private insurers; (2) analysis of the adequacy of Medicaid payment rates for hospitals and nursing homes; (3) assessment of the advantages and disadvantages of hospital mergers; and (4) development of criteria to assess the charitable mission of tax-exempt hospitals.

There are many reasons for the expanding role of the judiciary in health policy, including the inability of the legislative and executive branches of government to develop explicit policies, the growing share of the nation’s resources devoted to health care, and the increasingly litigious nature of society. As the judiciary’s role expands, it is important to evaluate critically the growing trend of deferring difficult policy choices to the courts. When the courts became involved in social policy issues such as school desegregation, environmental protection, and prison reform, a number of parties expressed concern that the judiciary had certain limitations that could affect policy making.1 This paper explores whether these concerns also apply to health policy.

I begin with an overview of the prior criticisms of the courts’ involvement in social policy issues. I then briefly review how the courts have become involved in the four policy areas outlined above, examine possible limitations of policy making through the courts, and suggest means other than judicial review to resolve these disputes.

General Concerns About Court-Directed Social Policy

With few exceptions, the courts have not sought out cases to become involved in the policy-making process. Instead, they have responded to specific disputes. Nevertheless, the courts have entered some of the major social policy debates of the past few decades, and many scholars
have examined the strengths and limitations of judicial decision making.

Proponents of judicial intervention have suggested a number of advantages of the courts’ becoming involved in social policy issues: the promotion of minority rights, the promotion of more humane conditions in institutions such as prisons and mental hospitals, restrictions on bureaucratic arbitrariness, and, more generally, the promotion of positive social change.\(^2\) Others have been more critical. This paper focuses on critics of the courts’ involvement in policy making, in light of the recent trend toward deferring more health policy choices to the courts.

**Lack of background.** One concern is that many judges do not have the appropriate educational background or experience to evaluate critically the technical information necessary to resolve complex social policy issues, especially in a courtroom setting, where technical information may be difficult to present.\(^3\) Unlike in the legislative or executive branches, in which policymakers can develop expertise in a specific substantive area over a period of years, judges usually have to be educated on a particular issue at the beginning of each trial. Critics of the judicial process also have noted that much of the information can be filtered by the litigation process and that certain information can be stifled by the adversarial system if one side is able to withhold or successfully prevent the introduction of specific data.\(^4\) In addition, there is concern that courts are more likely to rely on theoretical arguments offered by academic experts than on those offered by practitioners who are more likely to know the limitations of social science theory.\(^5\)

**Decentralized system.** The decentralized nature of the judicial system is a second source of concern, since court autonomy not only hinders the formulation of coordinated policies, it also can lead to inconsistent treatment of similar cases. This can cause confusion in determining what behavior the courts will accept, especially if apparently similar cases have been decided differently by independent courts. A related concern is that the court system is a reactive system, Often the first case involving a particular issue is an atypical case; at a minimum, there is some randomness involving which case is decided first. However, the first case can play a significant role in the overall judicial policy-making process, because of the courts’ reliance on precedent to justify decisions.\(^6\)

**Narrow focus.** A third area of concern is the narrow focus of the courts’ review. Typically, cases are initiated by one party, the scope of the issues under review is controlled by one or both of the litigants, and the decision focuses on the specifics of the particular case.\(^7\) As a result, issues of concern to society generally, but not to specific litigants, may be given less weight. It has been suggested that cases that involve “polycentric” issues are especially difficult for courts to resolve. These disputes
involve multifarious, interrelated issues that could lead to several different but equally valid solutions. One problem is that once the court establishes that a particular litigant has a right, it becomes difficult for the court to make trade-offs. However, many of these “polycentric” cases involve complex social policy issues for which a compromise outcome may be preferable. Since the courts must select winners and losers, it is unlikely that a compromise solution will evolve from a court decision. In addition, once a court has ruled, it becomes more difficult for the legislative and executive branches of government to act, since “winners and losers” already have been established.

It has also been suggested that judges, when confronted with two litigants in a specific case, do not have the responsibility and may not have the ability to determine the long-term consequences of their decisions. Court proceedings focus on retrospective conflict resolution, not on policies for the future. Also, the judicial process may isolate judges from the broader public policy issues, limiting their ability to realize how their decisions will affect or be affected by the broader social milieu. Alternatively, the long-run impact of the decision may not be germane to the specific case. For example, without the requirement that judges or juries consider the budgetary implications of their decisions, the courts do not have to make the same trade-offs that the legislative and executive branches must make in developing social policy.

Unintended consequences. A final concern is that judges do not always have the tools to discover unintended consequences of their decisions and correct the errors. Instead, they must rely on appeals or additional cases that are related to previous decisions to revise earlier decisions. In addition, they do not have access to the traditional “carrots and sticks” favored by economists to influence behavior-taxation, grants, or subsidies. Rulings that require additional government funding, such as school desegregation orders, have been especially difficult for the courts to implement since such rulings can require that additional resources be spent, which could require a tax increase.

Coverage Policy

Here I illustrate how health policy is being influenced by the courts, enumerate the factors the courts appear to consider in reaching their decisions, and consider how the constraints mentioned earlier could affect their policy making. My intention is not to criticize specific rulings or to suggest alternative policies, but instead to discuss the growing role of the judiciary in health policy.

While the courts have been reviewing the coverage decisions of
public and private insurers since the mid-1960s, the level of judicial activity has picked up in recent years, as insurers have become more aggressive in denying claims for treatments they believe are “medically unnecessary,” “experimental,” or outside the scope of their covered services. Public and private insurers once paid for all services that were ordered by a licensed physician. However, after a spate of cases in the 1960s in which it was generally clear that there was no medical reason for hospitalization, public and private insurers revised their coverage policies by inserting an explicit requirement that services must be “medically necessary” to be reimbursed. As public and private insurers started denying claims based on this criterion, some courts disagreed with the insurer’s interpretation of “medical necessity.”

In reaching their decisions, many judges apparently view their role as the neutral arbitrator between the insurer who does not want to pay for a particular service, the provider who wants to be paid, and the patient who wants to have the insurer pay for a particular service. To render a decision, the judge frequently has been required to educate him or herself about the clinical aspects of a specific medical procedure, in order to decide which set of clinical experts is correct. In such a case, the adversarial nature of the court proceeding may stifle the educational process. In a series of cases involving the definition of “medical necessity,” numerous courts decided in favor of the physician who treated the patient and against the insurer who relied on government reports and scientific studies that challenged the value of a treatment. For example, courts have ordered insurers to pay for laetrile (a substance used to treat cancer) delivered in a Bahamian clinic after the U.S. Food and Drug Administration (FDA) made it illegal to ship laetrile across state lines, and for “immune-augmentative” cancer treatments provided by a Mexican facility in spite of the fact that the treatment has not been approved by the FDA and was generally discredited by the medical community at the time.

In response to these and other rulings, private insurers revised the contractual language in their policies to expressly exclude coverage for “experimental” treatments and to specify that the insurer is the final arbiter for coverage decisions. Yet despite these contract modifications, insurers have continued to lose in court. The most recent litigation over what constitutes “experimental” procedures involves the use of autologous (self-donated) bone marrow transplantation to facilitate use of high-dose chemotherapy for metastatic breast cancer. Many courts have ignored the fact that several institutional review boards and the National Institutes of Health (NIH), having found the evidence regarding this technique to be sufficiently tenuous, have allowed randomized
clinical trials to be conducted. In the most extreme case, a court ordered an insurer to pay for an autologous bone marrow transplant for a person with acquired immunodeficiency syndrome (AIDS), even though the treating physician was the only physician in the country at the time who was using that therapy and the patient had signed a clinical investigation consent form that emphasized the research aspects of the procedure. Many courts have not accepted the technology assessments performed by insurers and have ordered the insurer to pay for the service even though the contracts explicitly denied coverage for “experimental” procedures. Other courts, confronted with apparently similar evidence about the experimental nature of autologous bone marrow transplants, have ruled in favor of the insurer. A careful reading of these cases suggests the courts have not given consistent guidance to insurers with respect to what constitutes “experimental” treatment.

The reasons given by the courts in reaching their judgments demonstrate some of the long-term implications of judicial involvement in health policy issues. For example, some courts were concerned that when the insurer employs retrospective utilization review, the patient already had relied on his or her physician’s advice in undergoing the service and had incurred a bill for the care. When insurers responded to this concern and developed precertification programs, however, other courts became even more concerned. In one ruling the court argued that “mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient’s permanent disability or death.”

These cases demonstrate the courts’ focus on the individual case and not on the societal perspective of promoting cost-effective medical care. For an individual with a serious, potentially life-threatening illness, the provision of any medical services that could provide a benefit, no matter how small or at what cost, may be worthwhile. However, from the perspective of generally healthy individuals who want to purchase an insurance policy, the mandate to do everything possible and ignore the expense may not represent their preferences. There could be a market for policies that exclude specific types of treatments—e.g., treatments where the technology has not been demonstrated to be safe and efficacious. Similarly, when Congress and the administration make a coverage decision for Medicare based upon available clinical data and cost considerations, they supposedly are making the decision in the public’s interest. In the present context, the relevant question is whether a cross-section of generally healthy individuals would be willing
to pay their share of the cost of a particular treatment so that it would be a covered service in the unlikely event that one of them were to need that treatment. Instead, the perspective of many courts is that of the patient with an acute illness who has been denied coverage. This perspective may be discouraging insurers from more aggressively reviewing medical practices, given that it is virtually impossible to demonstrate with certainty that a medical service will have no possible clinical or social benefit to a particular patient. Private insurers typically deny 1 or 2 percent of all claims received, in spite of increased pressure by employers to control costs and published studies suggesting that a significant proportion of medical care is inappropriate.24

**Medicaid Payment Policy**

Courts have been asked to decide both policy-related procedural and technical issues to resolve recent litigation involving the adequacy of Medicaid’s hospital and nursing home payment rates. Congress passed legislation encouraging Medicaid programs to stop using Medicare cost-based reimbursement principles to pay nursing homes (in 1980) and hospitals (in 1981) and to start developing alternative payment systems.25 The legislation, commonly known as the Boren Amendment, requires the Medicaid program to set rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities” (42 U.S.C. 1396A[a][13][A]). The statute also requires the secretary of health and human services (HHS) to review the state’s finding that the rates are adequate.

States responded quickly to the flexibility of the Boren Amendment; by 1991 forty-seven states had instituted some form of prospective payment for Medicaid reimbursement to hospitals.26 Litigation over the meaning of the terms of the amendment and adequacy of payment rates started almost as soon as the states instituted prospective payment systems that gave some providers less than their full allowable costs.27 As of July 1991 Medicaid programs in twelve states had been sued over the adequacy of hospital payment rates, and more suits were contemplated.28 Nursing homes have been involved in similar amounts of litigation.

One procedural issue the courts were asked to resolve is, Who are the intended beneficiaries of the Medicaid program and the Boren Amendment-Medicaid recipients or providers? In Wilder v. Virginia Hospital Association, the Commonwealth of Virginia argued that Medicaid recipients, not hospitals, were the intended beneficiaries of the Medicaid program and that it was necessary to demonstrate that Medicaid patients were actually harmed by an inadequate payment rate through reduced
access or lower-quality care. A majority of the U.S. Supreme Court disagreed, ruling that “there can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment.”

The Wilder v. Virginia Hospital Association decision resolved a second procedural issue: how much discretion to afford a government agency in determining the adequacy of payment rates. The Commonwealth of Virginia argued that the Boren Amendment gives states flexibility to adopt any rate the state finds reasonable and adequate and is accepted by the HHS secretary. The majority of the Supreme Court rejected this argument, finding that while the states have considerable discretion, there is still a role for the courts in reviewing the adequacy of the payment rates. In their dissent, four of the justices argued that the scope of judicial review should be narrow. Writing for the minority, Chief Justice William Rehnquist noted that “providers . . . will inevitably seek the substitution of a rate system preferred by the provider for a rate system chosen by the State.”29 If the court decides in favor of the provider, then states will be required “to adopt reimbursement rate systems different from those Congress expressly required them to adopt.” Later in his dissent, Justice Rehnquist argued that a major issue is whether the states can be trusted to determine if the rates meet the amendment’s requirements and whether the secretary’s review of a state’s payment rates has any meaning without judicial oversight.

Although early decisions were in favor of the states as the courts deferred to the state agencies, increasingly hospitals have begun to prevail.30 One of the primary reasons for the change was a U.S. Appeals Court ruling, which created a standard that subsequent judges have used to determine if the payment rates are adequate. In AMISUB (PSL), Inc. v. State of Colorado Department of Social Services, the court was not satisfied with Colorado’s assurances that the rates were adequate and mandated that the “Medicaid agency, at a minimum,[is] to make ‘findings’ which identify and determine (1) efficiently and economically operated facilities; (2) the costs that must be incurred by such hospitals; and (3) payment rates which are reasonable and adequate to meet the reasonable costs of the State’s efficiently and economically operated hospitals.”31 In effect, the court imposed criteria that states must meet in order to be accepted by the courts, even if findings that the rates are adequate have been made by the states and accepted by the HHS secretary. In a number of nursing home decisions, the courts have focused more on whether the state met the requirements established in AMISUB and less on whether the rates are adequate.

In Wilder, the Supreme Court also discussed the technical competence of the judiciary to decide complex rate-setting issues. Justice
William Brennan, writing for the majority, believed that it is obvious when a state has set unreasonable rates: “Although some knowledge of the hospital industry might be required to evaluate a state’s findings with respect to the reasonableness of its rates, such an inquiry is well within the competence of the judiciary.”\(^3\) As anyone familiar with the difficulty of setting hospital and nursing home payment rates can attest, these can be extremely controversial issues and not easily resolved in the highly adversarial atmosphere of the courtroom. It is not surprising that when “the courts have scrutinized components of Medicaid payment methodologies in detail . . . [t]heir final verdicts have been inconsistent.”\(^3\) Reviews of recent Boren Amendment cases illustrate the complexity of the policy issues that the courts must decide to determine if the rates are adequate.\(^4\) Some of the specific policy issues that have been litigated include (1) whether the need to balance a state’s budget can be a factor in determining payment rates; (2) what is an appropriate rate of increase in the payment rate and what criteria need to be considered in establishing the update factor; (3) what factors can be used to form hospital peer groups and how many peer groups are appropriate; (4) whether Congress meant average or marginal costs when it required states to pay the costs that must be incurred; (5) what percentage of hospitals are economically and efficiently operated in a state; and (6) whether the level of payment for capital, clinical education, or disproportionate share is a policy decision that the state can make.

Boren Amendment litigation has significant implications for Medicaid programs and providers. Both sides are affected by the cost of litigation (which can be several million dollars) as well as by restrictions placed on the policy-making process during litigation, when direct communication between the two parties is constrained. When states have lost cases, they have been ordered to alter their payment formulae and to make substantially higher payments to providers. In Pennsylvania, for example, the court ordered hospital payment rates increased by 14.5 percent, and in Washington State, by 9 percent.\(^3\) Given the budgetary situation in most states, court decisions in favor of high payment rates have forced governors and state legislatures to make difficult trade-offs between eligibility and coverage reductions in Medicaid, reductions in other government programs, and new taxes.

### Hospital Mergers

In 1975 the U.S. Supreme Court decided that learned professions were not exempt from antitrust law. Since that decision the Federal Trade Commission and the Department of Justice have investigated the
anticompetitive actions of physicians, hospitals, and other health care providers, including review of mergers of nonprofit hospitals. At the same time many health planning agencies have continued to promote hospital consolidation as a policy to achieve economies of scale and to prevent the diffusion of expensive technologies into more hospitals.

Two different federal courts recently examined mergers of nonprofit hospitals and reached contradictory decisions in two cases with essentially the same facts at roughly the same time period. In these two cases the Department of Justice challenged the mergers of nonprofit hospitals in Rockford, Illinois, and Roanoke, Virginia. According to information developed by the Department of Justice, each merger would create a single institution that would own 73 percent of the licensed acute care beds in the Roanoke Valley and 72 percent in Rockford. Following lengthy litigation, the courts permitted the Roanoke hospitals to merge but denied the Rockford merger.

Several economic and policy issues were raised during the proceedings. These included (1) how to measure the hospital product as one service or a cluster of services; (2) how to define the geographic dimensions of a hospital market area; (3) how to measure hospital capacity (potential measurement units include beds, discharges, patient days, patient days weighted by source of payment, and hospital revenue); (4) how to determine the effect of hospital mergers and market concentration on hospital prices; and (5) how to evaluate the economies of scale and scope from consolidating clinical and administrative functions.

In court reviews of hospital mergers, the technical issues usually have overshadowed the basic policy issue of whether hospital mergers should be encouraged or prevented and the more fundamental debate over whether competition or regulation is the appropriate public policy. Health planners have generally encouraged hospital mergers to eliminate duplicative services and to generate economies of scale and scope. Antitrust activities, on the other hand, are more concerned with the effect of market concentration on prices. In the absence of consensus in the executive and legislative branches on this issue, courts have become the arbiter of this debate through their review of hospital mergers.

Charitable Obligations Of Nonprofit Hospitals

From 1913, when the first federal income tax statutes exempted charitable organizations, through a series of regulatory clarifications in the 1950s and 1960s, culminating with the 1969 “community benefit standard,” it was relatively easy for nonprofit hospitals to maintain their tax-exempt status. The community benefit standard, promulgated by
the Internal Revenue Service (IRS), provided federal tax exemption for organizations “operated for religious, charitable, scientific, testing for public safety, or educational purposes.” Because the standard did not expressly mention hospitals, it was presumed that hospitals qualify under the term charitable. Federal judicial oversight was restricted when the U.S. Supreme Court decided in 1976 that there could be no federal judicial review of this standard in response to a suit brought by members of the Eastern Kentucky Welfare Rights Organization, who claimed that they were denied care by a tax-exempt hospital and therefore that the hospital was not meeting its charitable obligation. In recent years Congress has conducted hearings on the 1969 IRS ruling to determine if the criteria for tax-exempt hospitals need to be more explicit.

State and local courts have been the primary actors in debates over the charitable obligation of tax-exempt hospitals. Recently, state and local governments have questioned whether the level of the societal contributions made by nonprofit hospitals fulfills their charitable obligations and have attempted to levy state and local taxes on them. In dispute are over $4 billion in state and local tax benefits that nonprofit hospitals received. There are a number of reasons why the state and local governments have questioned the tax exemption of nonprofit hospitals. These include the growing financial problems of state and local governments, concern over the increasing number of uninsured persons and the uneven distribution of uncompensated care provided by hospitals, the burst of “profitability” in the nonprofit hospital sector immediately following implementation of Medicare’s prospective payment system (PPS), and the diversification activities of many nonprofit hospitals, which place them in direct competition with for-profit entities. The issue has duly ended up in state and local courts.

In 1985 the Utah Supreme Court was the first court to attempt to establish a set of explicit criteria that nonprofit hospitals must meet to maintain their tax-exempt status. Since then there has been litigation in over twenty states. In general, the court decisions have followed one of two different policy directions. In Vermont, for example, a court ruled that to retain their tax-exempt status, hospitals must maintain an open door to all, regardless of ability to pay. In Utah, on the other hand, the tests were more comprehensive and the requirements much more explicit. The Utah test includes Vermont’s requirement plus requirements that include a mandatory comparison of the value of the property tax exemption with the value of the charitable services provided. The courts in Pennsylvania have been inconsistent: Some courts have imposed a version of the Vermont criteria, while others have imposed a version of the Utah standard. Hospitals in Pennsylvania and elsewhere do not
know which judicial standard will apply to them.

A key technical issue is the definition and measurement of charitable services. Definitions of charitable services generally include charity care; however, the inclusion of bad debt, payment less than costs for Medicaid patients, unsponsored research, unsponsored clinical education, the provision of health- and nonhealth-related services to the community, and many other factors is more debatable. Because the hospital and policy communities have not reached consensus on which of these services are indeed charitable services, the courts are being forced to decide this issue in rendering a decision.

An issue that has received comparatively little attention in the discussion is that the long-run response of hospitals to any charity care requirement is unknown. Nonprofit hospitals could increase their level of charitable services to maintain their tax-exempt status, could remain nonprofit but not tax exempt, or could become for-profit. As a result, the overall level of charity care could increase, decrease, or remain the same in response to these rulings. Even more difficult to anticipate is the long-run impact on the overall system of hospital care, which is now based primarily on locally governed, community-based institutions.

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**Role Of The Courts**

It is not surprising that many of the concerns expressed about court-directed social policy are also applicable to health policy. For example, as noted earlier, judges have needed to develop considerable technical expertise to render judgments in health policy issues (such as the appropriateness of specific medical procedures and specifics about hospitals and nursing home payment formulae). To render these verdicts, they have needed to define hospital market areas, assess the impact of competition on health care prices, and define charitable services.

The structure of the judicial system has made it difficult for the courts to provide consistent guidance about what constitutes acceptable behavior. As I have outlined above, individual courts have rendered contradictory decisions in all four policy areas. This has made it difficult for providers, patients, and payers to anticipate the courts’ rulings in particular cases or to determine what behavior the courts find acceptable.

Coverage decisions are focused on the situation of the individual patient, not on the overall objective of paying for appropriate, cost-effective, or cost-beneficial medical care. Medicaid payment issues have focused on the needs of the specific providers and not on the opportunity costs associated with alternative uses of these dollars by the Medicaid program. Merger decisions have only started to review the broader
issue of whether we should be promoting or discouraging hospital merg-
ers with the goal of providing more cost-effective care. Cases involving
the responsibilities of tax-exempt hospitals have focused neither on the
behavioral response of hospitals to an explicit charity standard nor on
the implications of having fewer nonprofit community-based hospitals.

Before discussing alternative means of resolving disputes, I note that
courts retain the ability to overcome some of these limitations. Judges
can address their technical deficiencies by asking questions during hear-
ings, appointing special masters, and reviewing amicus briefs. They can
monitor and affect responses to their orders through structural injunc-
tions, supplemental decrees, special masters, and lay committees. In
addition, the courts can rely on reasoning and not polls, majority votes,
rule of expediency, or claims of right when they reach their decision.

Alternatives To Court-Directed Policy

Students of conflict resolution have proposed several alternatives to
litigation for policy resolution. These include negotiation, binding
arbitration, legislative clarification, administrative courts, contract revi-
sion, and, more generally, a restructuring of the decision-making pro-
cess. It is not surprising that the selection of the specific alternatives to
resolve a particular dispute will depend on the specific policy issue.

Contract revision and restructuring of the decision-making process
could help to resolve coverage disputes. One proposal is for public and
private insurers to state explicitly what treatments they wish to cover,
develop standards to determine under what circumstances other treat-
ments would be covered, establish one or more entities to make prospective
and case-specific judgments about whether the standards are being
met, and include a provision that mandates that the process is binding
on all parties. This would remove some of the ambiguity in the current
coverage process, and more specificity would constrain the scope of the
court’s inquiry.

Reducing litigation over the appropriate Medicaid payment rate to
hospitals will probably require legislative or regulatory clarification of
the language in the Boren Amendment or possibly a complete revision
of the legislation. One possibility is for the executive branch to be more
specific in its regulations; an alternative is for Congress to revisit this
issue and examine several policy issues that are beyond the traditional
purview of the courts. For example, Congress may explore the option of
mandating an all-payer system or a single-rate system for all public
programs. Alternatively, Congress may consider whether actual costs
should be a standard for determining appropriate payment rates.
Policies regarding hospital mergers and the charitable responsibilities of tax-exempt hospitals may also require legislative or executive branch action. More research and policy discussion regarding the benefits and liabilities of hospital mergers is probably necessary; however, executive and legislative action may be required in the near future if the uncertainty about what constitutes acceptable behavior is to be resolved. There is already congressional activity on reviewing the tax-exempt status of nonprofit hospitals. This legislation, if passed, would provide an explicit standard for determining tax exemption and could establish a standard that states and local municipalities could use.

Conclusion

Because of the difficulty in making decisions about certain health policy issues, resolution of many of these issues has become the responsibility of the courts. This paper has described some of the inadequacies of this solution and has suggested that it may be necessary to consider other means to resolve these policy issues over the long term. In some circumstances, it is important for executive and legislative branches of government to act quickly, since allowing the courts to establish health policy will make it more difficult to intervene afterwards, as the court already will have established winners and losers. In addition, as Archibald Cox has stated, “excessive reliance on the courts instead of self government through democratic process may deaden a people’s sense of moral and political responsibility for their own future.”

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NOTES


8. Fuller, “The Forms and Limits of Adjudication.”


11. Fuller, “The Forms and Limits of Adjudication.”


15. Ibid.

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27. Ibid.; and Anderson and Hall, “The Adequacy of Hospital Reimbursement.”


33. ProPAC, *Medicaid Hospital Payment*.  

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