Letters

We encourage responses to papers appearing in Health Affairs. Please keep responses brief (two typed pages) and sharply focused. Health Affairs reserves the right to edit all letters for clarity and length.

Health Policy And The Courts: Judicial Or Political Failure?

To the Editor:

Gerard Anderson’s essay, “The Courts and Health Policy: Strengths and Limitations” (Health Affairs, Winter 1992), provides a cogent critique of judge-made health policy. He accurately identifies some of the problems associated with resolving contentious social policy questions in a judicial forum where generalist judges must resolve complex disputes between litigants, often without taking into account the broader social context. He suggests that these problems can be resolved, mostly through legislative or executive action. The difficulty as I see it, however, is not with the diagnosis but with the proposed cure. Does his analysis demonstrate the incapacity of courts or the failure of our political representatives to resolve important health policy questions?

Anderson cites Boren Amendment litigation as an example of poor judicial decision making because generalist judges are becoming involved in the expensive process of second-guessing complex reimbursement questions. The difficulty is, of course, that the courts are merely acting as Congress directed. Congress required states to reimburse providers at rates “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 Supreme Court’s mistake, if there was one, was to take this language seriously by permitting judicial review of a state’s chosen reimbursement mechanism. The evils of the Boren Amendment litigation are as much the product of conflicting legislative objectives and regulatory inaction as they are the result of judicial incapacity.

Judicial analysis of hospital mergers under the antitrust laws presents a similar dilemma. These laws do not provide an explicit exemption for health care. Congress has not amended the acts to provide for such an exemption, and the executive branch has been actively pursuing antitrust cases in health care (even during the Reagan and Bush administrations). It seems misdirected to focus attention on the courts merely because they occasionally reach seemingly irreconcilable results or because they fail to take into consideration social policies that are not expressed in the legislation they are legally bound to interpret and apply.

The disputes over the charitable exemption status for nonprofit hospitals are an inevitable result of the changing health care delivery system. State courts have responded to claims, made largely by state executive branch officials, that the provision of health care is a business rather than an inherently charitable function. It is true that different states are evolving different tests to determine charitable status for hospitals and that different courts within the same state might, temporarily, reach inconsistent results. But these problems are at least as much related to legislative and executive branch actions as to the inherent flaws of the judicial system. In some sense Anderson seems to object to the result rather than to the method; Utah voters, after all, democratically rejected a constitutional amendment that would have returned hospitals’ automatic
charitable exemption.

Insurance coverage for medically necessary or nonexperimental treatments is the only area Anderson cites in which courts have not struggled with either legislative silence or ambiguity. Here it is true that courts have been concerned with protecting sick consumers, not with upholding cost containment strategies with which reasonable, healthy consumers might agree. But courts have traditionally protected consumers from insurance companies’ attempts to deny benefits. The problem is that we depend on the private market to provide cost containment mechanisms that might be more properly controlled through the legislative process.

More than blame shifting is at stake here. Anderson’s provocative analysis of the flaws of the judicial process must not obscure the flaws in the legislative process that are amplified when disputes are shifted from one branch of government to the other. Recent legislative actions do not give one much hope. The Americans with Disabilities Act (ADA), for example, contains seemingly inconsistent provisions regarding the treatment of disabilities in employee benefit plans. Courts in the next few years will be forced to decode the ADA’s benefits and insurance provisions to discover when an employer’s design of its employee benefit plan could constitute discrimination against persons with disabilities; in the end the result may turn on judicial interpretation of the word “subterfuge.”

Anderson himself has noted elsewhere the legislative habit of leaving contentious policy choices unresolved. It therefore is not enough simply to advocate “legislative or regulatory clarification.” Politicians and agency officials must not duck hard policy choices. They must expend political capital to resolve these choices through the democratic process or face the unpalatable alternative of judicial action that Anderson so accurately describes.

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To the Editor:

Gerard Anderson has written an important analysis, new to the legal and policy literature, of the role that judicial decisions play in shaping the financing and institutional structure of health care delivery (Health Affairs, Winter 1992). Past analyses have focused primarily on how courts shape medical practice and medical ethics. I write to suggest an additional dimension to Anderson’s analysis.

It is possible to identify four competing forces that shape health policy: professional norms, rule-based governance, financial incentives, and broader social and historical norms. Each of these ideological paradigms is nicely illustrated by one of Anderson’s four topics. Coverage disputes have been resolved by professional norms of medical necessity. The Boren Amendment concerns Medicaid regulation of hospital and nursing home payment rates. Antitrust challenges to hospital mergers seek to impose a market ideology. And the requirements of tax exemption turn on broad social concepts such as “community benefit” and the historical meaning of charitable.

In contrast, Anderson’s insightful analysis adopts an analytical framework that I refer to as “comparative institutional competence.” Rather than focusing on ideological paradigms, he asks in a more neutral fashion which institution of government and society—the courts, the government, or the markets—should determine the financing and the institutional structure of health care, in each of these four areas. The question I pose is how this institutional choice affects the ideological paradigm, particularly when the courts are chosen. (The answer is obvious if the market is chosen, and fairly predictable if the government is chosen.)

Anderson’s account demonstrates that the answer is not uniform. Because the courts have enforced each of four widely divergent paradigms in each of these areas, they have been shown to be quite catholic in their ideological biases. This does not, however, answer the question of which ide-
ology is correct for each problem and, having so determined, which institution is best suited to implement that paradigm. I sketch some highly cursory opinions of my own.

Several commentators, Anderson and myself included, have argued that the professional paradigm should not control coverage disputes. Anderson suggests market-based contractual revision and more community-based dispute resolution. Others have suggested the regulatory use of practice guidelines. As for Medicaid reimbursement, some courts have overstepped their role of limited oversight of state and administrative agency regulatory processes. Federal law continues to impose a market ideology on hospital construction and ownership; therefore, the judicial role has been appropriate to existing public policy. Finally, the concepts of charity and community benefit (in the context of hospital care) are properly the subject of judicial interpretation of social, historical, and legal sources, even if different courts reach opposing results.

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Health Policy And The Courts:
A New Approach

To the Editor:

Gerard Anderson has made an important contribution to the body of health policy literature with his article concerning the role of the courts in the formulation of health policy in the Winter 1992 issue of Health Affairs. While one might have legitimate quibbles with some of the points he makes in his case studies, the theme of this work is well taken. On the whole, judges are not particularly well equipped (by either experience or expertise) to adjudicate complex matters of health policy.

The larger problem, however, is that neither the legislative nor executive branch is particularly well equipped, either. Whether one likes it or not, sooner or later disputes end up in court. Laws are made and implemented by human beings. Human beings make mistakes. They can also disagree.

It can be argued that a major flaw in Medicare’s resource-based relative value scale (RBRVS) fee schedule is that there is no judicial review of any aspect of the payment methodology. This fact removes an important check from the system. Stated simply, people behave more cautiously and prudently when they know their actions can be held to account in a court of law. This “sentinel effect” is a very important tool to ensure that an element of arbitrariness is not present in a regulatory scheme. Would the Health Care Financing Administration (HCFA), for example, have made the across-the-board cut in the relative value units for 1993 had it known that the possibility even existed that it would have to justify such action before a judge? I doubt it.

The lesson to be learned here, one hopes, is one that will not be lost on the policymakers in the new administration as it attempts to put together a series of reform initiatives to the current health care system. Irrespective of the ultimate shape of that package, one can assume that there will be those who feel aggrieved by the changes that are wrought. A mechanism must be in place to address such problems.

Thus, perhaps the time has come to create a “health court,” which could, over time, develop the expertise required to deal adequately with these extremely vexing and complicated matters. A model already exists with the US. Tax Court, which also deals with a complex (and emotional) subject. The court, at a minimum, could be an arbiter of the coverage and payment disputes arising under existing federal programs.

Some would argue that all we as a nation should want from our judges is honesty, a keen intellect, and a sense of fairness. For most matters, I would agree. But, if we have learned anything about health care during the past fifty years, it is that health care is “different” from most things in life. A new approach should be considered.

Larry A. Oday
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The Courts And Health Policy: The Author Responds

To the Editor:

All three responses to my essay make the very important point that it is unfair to criticize the courts when they are simply doing their job of dispute resolution. I agree. The four health policy issues that I discussed are contentious, and in most cases the executive and legislative branches have been reluctant to address them directly, leaving policy making to the courts. My major point is to educate policymakers in the executive and legislative branches about the perils of inaction, not to criticize the courts. Policymakers in the legislative and executive branches must recognize that the policy-making process moves forward regardless of whether they take action.

Mark Hall raises the concept of “comparative institutional competence.” This idea deserves considerably more scrutiny. My paper focuses on the limitations of the courts. Companion pieces also could be written on the limitations of the executive and legislative branches.

Larry Oday argues that the courts provide a necessary check on the excesses of the legislative and executive branches and suggests that policymakers would behave differently if they knew a court was going to review their actions. This argument is based on two assumptions. The first is that decisions of the court will be closer to the desired policy than that promulgated by the legislative or executive branches. Without an independent measure of what is the most desirable policy, it is difficult to assess the merits of this argument. The second assumption is that legislative and executive branch decision making will improve if members know that the courts are watching them. Although this may be true, an equally possible scenario is that the executive and legislative branches will try to second-guess what the courts will find acceptable and not conduct an independent assessment of what is good public policy. Given the limitations of judicial decision making, this may result in a poor policy-making process. In response to his specific concern about the RBRVS, I note that Congress established the Physician Payment Review Commission (PPRC) to provide an independent, objective perspective on Medicare physician payment.

I agree with Oday that a health court, similar to a tax court, would be a good idea. However, I would restrict its jurisdiction to matters of fact and not allow it to develop policy. Perhaps HCFA’s Provider Payment Review Board would be a good model.

My only disagreement with Mary Anne Bobinski is that I do not believe that Congress intended the courts to review the state plans when it passed the Boren Amendment. The committee reports accompanying the legislation clearly give this responsibility to the secretary of health and human services.

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Involving Consumers And Families In Mental Health Policy

To the Editor:

The Health Affairs Fall 1992 issue on mental health policy was in my opinion an important contribution to the field. There was, however, one serious flaw: There were no articles on the significance of the consumer/patient movement and the important role that families currently play in the mental health system. There were indirect references to the role of families and consumers, but no identification of this development and its consequences for policy development and implementation.

Significant policy issues such as forced treatment, the right to self-determination, and the significance of self-help activity all constitute major themes in contemporary mental health policy making. The interest groups made up of consumers and families have politicized the mental health landscape by increasingly making their voices heard in the states and at the national level.

Take, for example, an idea such as “advance directive,” whereby consumers decide what the course of treatment and disposition
will be when their ability to make judgments is compromised by their illness. Similar to the idea of a living will, this policy of engaging the consumer in this critical area of “involuntary” treatment has serious implications for mental health policy. It also acknowledges an important change in the relationship of the individual to the mental health system. This is an issue that policymakers have long neglected.

Serious and meaningful reform has usually come from the grass roots, not the professions. At a recent conference of consumers and commissioners of mental health, a number of issues were identified that included such topics as fiscal consequences of forced treatment; alternatives to involuntary commitment processes; a research agenda based on normative values of a person within his or her culture rather than on the needs of the mental health system; how “quality of life” is measured in terms of consumers’ wants and within their cultural context; research on consumer-run programs and their relation to the rest of the mental health system; an epidemiology of “self-help;” research on what factors assure a successful paradigm shift toward empowerment; research on areas of disagreement and/or tensions between family and consumer views; and an examination of the politics of the mental health system.

I hope that in future policy discussions dealing with mental health, the journal will seriously consider engaging directly those persons that represent consumer activity and family interest. I suggest finally that the interests of consumers, ex-patients, and families are not necessarily synonymous. We tend to group them all together and forget that consumers and ex-patients can also be family members. The interests of each, however, can be quite different.

Policy discussions are sterile when they leave out those persons most affected by the policies’ intent.

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Changing Substance Abuse Treatment

To the Editor:

Jeannette Rogowski’s commentary, “Insurance Coverage for Drug Abuse” (Health Affairs, Fall 1992), is pertinent to the current structure of Medicaid and public financing. A 1990 Institute of Medicine report raised three issues that under health care reform might alter this structure: (1) the impact of expanded eligibility for substance abusers on Medicaid or other public financing; (2) whether to expand Medicaid coverage of alcohol, drug abuse, and mental health services and types of providers now limited by or excluded from Medicaid; and (3) whether to integrate the financing of federal substance abuse service block grants into Medicaid.1

Health costs of expanding eligibility to include substance abusers likely will be part of reform estimates. Estimates exist of the costs of expanding Medicaid eligibility to cover the poor uninsured. John Holahan and Sheila Zedlewski estimate that at 100 percent of the federal poverty level for family income, some twenty-seven million persons would be newly eligible at an additional annual cost of $22 billion.2 Jack Rodgers estimates that at 100 percent of the federal poverty level, twenty-five million of the uninsured would become eligible at an added annual cost of $16 billion.3

A majority of the several million persons in need of drug abuse treatment cannot afford to pay for treatment. There are about eighteen million alcoholics, but there are no similar estimates of those who cannot pay. Although the number of substance abusers unable to pay is a fraction of the twenty-five to twenty-seven million who could be covered under expanded Medicaid eligibility, the impact of drug abusers on Medicaid costs may outweigh their proportionately small number. If under national health care reform Medicaid eligibility is expanded without expanded substance abuse coverage, then Medicaid may pay out more in health expenditures than would be the case with expanded substance abuse coverage.

Males ranging in age from the twenties
through the mid-thirties are most likely to use drugs to the point where they need treatment. Under current law, males in these ages are largely excluded from Medicaid coverage, because their incomes and assets are above federal poverty and asset thresholds. If reform makes this group eligible for Medicaid but uncovered for substance abuse treatment, the group may use general health services out of proportion to its size. If, however, this group is treated for substance abuse problems, its general health care costs can be expected to decline in quantity greater than its substance abuse treatment costs. There are well-documented potential program savings in providing substance abuse treatment.

As Rogowski points out, the public system is at capacity and unable to accommodate all of the need for treatment. Two intertwined issues for national health care reform are whether to expand services and provider types covered by Medicaid or other public insurance and whether to integrate the Substance Abuse Treatment and Prevention (SATP) block grants into Medicaid or other public insurance (if any of these programs continue). If public providers and financing are to be phased into Medicaid, significant changes would have to be made in both public block grants and Medicaid. Public-sector treatment facilities would have to change billing practices and upgrade medical record keeping, which some facilities have already done under federal demonstrations. Providers now excluded by Medicaid, such as residential therapeutic communities, might be allowed to participate. Medicaid would have to implement outreach and treatment entry procedures, so that persons with substance abuse problems would not “overuse” general health services. Also, whether the block grants are maintained separately or incorporated into Medicaid, there must be improved financial and administrative integration with nonhealth services block grants.

The ideas presented above suggest some of the issues that national health care reform may address. Rogowski identified current difficulties but not how difficulties can be overcome, the options that are available, and types of trade-offs associated with various options. There is an embryonic body of knowledge on these problems; what is needed is the development of solutions.

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### NOTES

1. The Institute of Medicine report, *Treating Drug Problems* (Washington: National Academy Press, 1990), recommends five “steps” to improve Medicaid coverage of substance abuse treatment services; these might be incorporated into national health care reform. and they could be introduced without such reform (pages 26-27).


