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Controlling Health Care Costs through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible

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Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible

David Orentlicher*

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I. INTRODUCTION

Assessments of the Patient Protection and Affordable Care Act (Affordable Care Act)¹ echo a common theme: the legislation does much to provide health care coverage for the uninsured, but it does far less to contain health care spending. According to projections by the Congressional Budget Office, the Affordable Care Act will ensure that 94% of Americans are insured by 2019.² On the other hand, the inflation rate for health care costs will change very little. Instead of increasing by 6.8% per year between 2015 and 2019 without the Affordable Care Act, health care costs are expected to increase by 6.7% per year during the same time period under the Act.³

To be sure, the emphasis on increasing access over cutting costs is not unique to the Affordable Care Act. President Lyndon Baines Johnson and Congress employed the same

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

2. Letter from Congressional Budget Office to Nancy Pelosi Speaker of the U.S. House of Representatives (Mar. 20, 2010), *available at* www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf. [hereinafter Congressional Budget Office letter]. This calculation applies to U.S. citizens under the age of 65 (with those 65 or older eligible for Medicare). *Id.*

3. Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2019*, 29 HEALTH AFF. 1933, 1936 (2010).

strategy when they enacted Medicare in 1965,⁴ and Massachusetts followed suit when it passed its health care reform in 2006.⁵ As a political matter, it is much easier to provide new entitlements than to curtail benefits.

The option of kicking the cost problem down the road cannot continue indefinitely, and policy experts have given much thought to options for containing health care spending.⁶ As I will argue in this Article, a key element of leading proposals for cost containment is morally important but socially infeasible. Specifically, scholars regularly—and rightly—recommend a public, transparent process for deciding when health care will not be covered by public or private insurance.⁷ If people will be denied medical tests or treatments that might preserve their life or maintain their health, we ought to ensure that all members of society have a voice in the decision making process.

However, while broad public participation serves important principles of justice, it also breeds intolerable public conflict.⁸ When Americans try to make choices about access to life-preserving medical care, public, transparent processes fail.⁹ Either those using the process never make the difficult choices that are needed, the difficult decisions that are made unravel and are abandoned, or the decision making process itself is discarded.¹⁰ This is the lesson of Medicare funding for dialysis,¹¹ the Oregon Health Plan,¹² managed care,¹³ certificate of need legislation,¹⁴ the effort in 2009 to revise guidelines for breast cancer screening,¹⁵ and the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom. Accordingly, we need to identify alternative strategies for cost-containment that can succeed and that can satisfy, as nearly as possible, the principles of justice. In other words, we need to pay greater attention to social constraints on rationing in deciding which rationing policies to adopt.

4. David Blumenthal & James Morone, *The Lessons of Success—Revisiting the Medicare Story*, 359 NEW ENG. J. MED. 2384, 2385 (2008).

5. Jon Kingsdale, *Implementing Health Care Reform in Massachusetts, Strategic Lessons Learned*, 28 HEALTH AFF. w588, w588 (2009).

6. See generally Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009, at 36 (examining the inordinately high cost of healthcare in McAllen, Texas); Jonathan Oberlander & Joseph White, *Systemwide Cost Control—The Missing Link in Health Care Reform*, 361 NEW ENG. J. MED. 1131 (2009) (explaining the shortcomings in some proposals for controlling healthcare costs); David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996) (exploring the use and misuse of financial incentives in regards to controlling healthcare costs).

7. See *infra* Part IV (discussing the various recommendations for public, transparent processes to contain the high cost of health care).

8. See *infra* text accompanying notes 52–55 (discussing why public transparent processes breed intolerable public conflict).

9. This is not a purely American phenomenon, nor is it a phenomenon limited to health care services. It is a problem with any decisions that have life or death implications, and it is a problem for other societies as well, though often to a lesser extent than in the United States. As discussed, *infra*, text accompanying notes 93–95, the UK also has struggled with its public, transparent process for denying access to expensive medical treatments.

10. See *infra* Part V (describing past failures of public, transparent processes).

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. See *infra* Part V (illustrating the failure of public, transparent processes in a proposed revision of breast cancer screening guidelines in 2009).

II. THE HEALTH CARE COST PROBLEM

Inexorably increasing spending on health care has captured the attention of policy experts and policy makers for decades.¹⁶ Sharply rising health care costs led Congress to promote managed care via the Health Maintenance Organization Act of 1973,¹⁷ and President Jimmy Carter made cost containment the center of his unsuccessful efforts to reform the U.S. health care system in the late 1970s.¹⁸ Managed care appeared to make important inroads into health care cost inflation during the 1990s, when health insurance premiums experienced annual increases as low as 0.8%.¹⁹ Public rejection of managed care's cost-saving strategies, however, was followed by the more typical pattern of substantial premium increases, with double-digit percentage increases by 2001.²⁰

Health care spending now consumes more than 17% of U.S. GDP and is expected to account for more than 19% of GDP by 2019.²¹ As health care costs have risen, so has the number of uninsured Americans. More and more businesses find health care benefits unaffordable, and more and more individuals cannot cover the cost of a health care insurance policy on their own.²² Since 1978, the number of uninsured has more than doubled, and roughly 50 million people now lack health care coverage.²³

The high costs of health care make it unaffordable for too many people. The U.S. also wastes too many dollars on care that is unnecessary or on care whose benefits cannot be justified in terms of its costs.²⁴ At the same time that many people receive insufficient care, others receive too much care.²⁵ Unnecessary or unjustified care has important health consequences in addition to its fiscal consequences. Any medical test or treatment care can cause harm as well as benefit, and many patients realize more harm than good from their health care services.²⁶

16. John K. Iglehart, *The American Health Care System—Managed Care*, 327 NEW ENG. J. MED. 742, 744 (1992).

17. Health Maintenance Organization Act of 1973, Pub. L. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e (2006)).

18. Robert Finbow, *Presidential Leadership or Structural Constraints? The Failure of President Carter's Health Insurance Proposals*, 28 PRESIDENTIAL STUD. Q. 169, 172–73 (1998); *National Health Insurance—A Brief History of Reform Efforts in the U.S.*, KAISER FAM. FOUND. (Mar. 2009), www.kff.org/healthreform/upload/7871.pdf.

19. *Trends in Health Care Costs and Spending*, KAISER FAM. FOUND. (Sept. 2007), www.kff.org/insurance/upload/7692.pdf.

20. *Id.*

21. *National Health Expenditure Projections 2009–2019*, CTRS. FOR MEDICARE AND MEDICAID SERV., (Sept. 2010), www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf.

22. *The Uninsured: A Primer*, KAISER FAM. FOUND., 8–9 (Dec. 2010), http://www.kff.org/uninsured/upload/7451-06_Data_Tables.pdf.

23. Robin A. Cohen et al., *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey*, NAT'L HEALTH STAT. REP., at 5 (July 1, 2009), available at <http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf> (showing that fewer than 25 million Americans lacked health care insurance in 1978); Carmen De Navas-Walt et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2009* U.S. CENSUS BUREAU, at 22 (Sept. 2010) available at <http://www.census.gov/prod/2010pubs/p60-238.pdf> (reporting that 50.7 million Americans were uninsured in 2009).

24. David B. Evans et al., *Comparative Efficiency of National Health Systems*, 323 BMJ 307, 309 (2001).

25. Clark Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 77–82 (2002).

26. Chunliu Zhan & Marlene R. Miller, *Excess Length of Stay, Charges, and Mortality Attributable to*

The inefficiency of the U.S. health care system is reflected in international comparisons of national health care systems. While we spend far more than other countries, we fare poorly in terms of life expectancy, infant mortality, and other indicators of health status.²⁷ In one study, researchers measured both the actual health attainment of a nation and the potential health attainment that could be achieved based on the amount of the nation's health care spending.²⁸ The U.S. ranked below a large number of other countries, including Spain, France, Germany, Austria, Italy, United Kingdom, Denmark, Norway, Japan, China, Australia, Canada, Mexico, Colombia, and Venezuela.²⁹

III. INADEQUATE STEPS TO CONTAIN COSTS IN THE AFFORDABLE CARE ACT

While Obama administration officials promised to "bend the cost curve"³⁰ in their health care reform efforts, it is unlikely that the Affordable Care Act will have a meaningful effect on costs. Indeed, as mentioned, the Congressional Budget Office projects only a minimal reduction of health care cost inflation from the Act.³¹ The Affordable Care Act's most important cost-savings provisions involve reductions in Medicare reimbursement rates. More than \$200 billion will be saved by reducing fees paid to hospitals, nursing homes, and other health care facilities.³² Another \$145 billion will be saved by eliminating excessive payments to private health care plans that serve Medicare recipients under the Medicare Advantage program.³³

For the most part, however, the Act's cost-saving measures do not address the fundamental drivers of health care cost inflation. Our health care system is characterized by too much care at too high prices.³⁴ These excesses in turn reflect a system in which

Medical Injuries During Hospitalization, 290 JAMA 1868, 1871–72 (2003).

27. *Life Expectancy at Birth, Total Population*, OECD (Nov. 25, 2010), www.oecd-ilibrary.org/social-issues-migration-health/life-expectancy-at-birth-total-population_20758480-table8; *Infant Mortality: Deaths per 1,000 Live Births*, OECD (2010), www.oecd-ilibrary.org/social-issues-migration-health/infant-mortality_20758480-table9.

28. Evans et al., *supra* note 24, at 307.

29. *Id.* at 309.

30. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 602 (2010).

31. See Sisko, *supra* note 3 and accompanying text.

32. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3401, 124 Stat. 119, 480 (2010); Memorandum from the Dep't of Health & Human Servs. to Cong. (Apr. 22, 2010), *available at* www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf. The Congressional Budget Office has also calculated estimates for the fiscal impact of the Affordable Care Act. See Congressional Budget Office letter *supra* note 2 (explaining the projections of the Congressional Budget Office). There are differences between the two sets of estimates. Part of the differences reflects the fact that the Centers for Medicare & Medicaid Services estimates look at the impact on total expenditures on health care in the United States, while the Budget Office estimates look at the impact on the federal budget. Mark Campbell, *Making Sense of CMS' Actuarial Report on the Impact of Health Care Reform*, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, NAT'L ASSOC. OF PUB. HOSP. AND HEALTH SYS. (Apr. 28, 2010), <http://www.naph.org/Main-Menu-Category/Newsroom/Safety-Net-Matters-Blog/Making-sense-of-CMS-Actuarial-Report-on-the-Impact-of-Health-Reform.aspx>.

33. Affordable Care Act §3201.

34. David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 7 FLA. INT'L U. LAW REVIEW (forthcoming 2011).

the buyers of health care have too little negotiating leverage, the sellers of care have too much leverage, and the providers of care earn their income in terms of the quantity rather than the quality of care they deliver.³⁵ In other countries, for example, a government single payer for health care (the buyer) can bargain more effectively with physicians, hospitals, and pharmaceutical companies than can the many private insurance companies in the United States.³⁶ At the same time, hospital mergers have given sellers of health care in the United States greater leverage than their counterparts in other countries.³⁷ These cost pressures are further aggravated by a fee-for-service reimbursement system that generally rewards physicians and hospitals for providing more care,³⁸ whether or not they provide better care. When it comes to these structural reasons for the high cost of health care in the U.S., the Affordable Care Act is silent or relies on pilot programs that would need much broader implementation in the future to solve the health care cost problem.

IV. PUBLIC, TRANSPARENT PROCESSES TO CONTAIN COSTS

If the Affordable Care Act comes up short in the cost containment effort, which alternatives should be pursued in the future? As this Part discusses, many leading scholars urge the use of an independent, public commission that would assume responsibility for deciding how to ration our limited health care dollars. While a statute can specify in a general way the kinds of health care services that should be covered, it is not possible for legislators to draw precise lines between covered and uncovered services. We want to fund surgery to replace damaged heart valves, but should the surgery be offered to patients with advanced dementia or metastatic cancer? How long and with what quality should a person's life expectancy be to receive a new liver, kidney dialysis, or treatment for prostate cancer? In the view of many scholars, it may not be possible for legislation to provide clear lines between covered and uncovered care, but we can entrust the drawing of lines to a public entity that has the right kinds of decision makers and the appropriate decision making process to make the decisions necessary to ration our health care dollars fairly and wisely.

For example, Yale health policy professor Jennifer Prah Ruger has proposed a model of shared health governance that combines scientific expertise with an open, deliberative process in which consumers, physicians, health care institutions, and public

35. Chris L. Peterson & Rachel Burton, *U.S. Health Care Spending: Comparison with Other OECD Countries*, CONGRESSIONAL RESEARCH SERVICE (Sept. 17, 2007), http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key_workplace&seiredir=1#search=Chris+L.+Peterson+&+Rachel+Burton,+U.S.+Health+Care+Spending:+Comparison+with+Other+OECD+Countries. Higher U.S. health care costs may also reflect the fact that labor costs generally are higher in the U.S. than in other countries and that health care is a labor-intensive industry. Paul H. Rubin & Kaz Miyagiwa, *Why Is Medical Care Expensive in the U.S.* 17 (Mar. 5, 2011) (unpublished manuscript), available at papers.ssrn.com/sol3/papers.cfm?abstract_id=1778305. Still, we can detect inefficiencies in the U.S. health care system by comparing high-cost communities with low-cost communities. Orentlicher, *supra* note 34.

36. Gerard Anderson et al., *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22 HEALTH AFF. 89, 102 (2003).

37. Peterson & Burton, *supra* note 35, at 42.

38. Orentlicher, *supra* note 6, at 158.

officials participate.³⁹ Under the shared governance paradigm, medical evidence and community values together would shape the package of health care services guaranteed to all persons—with people being free to purchase additional services with their own funds.⁴⁰

Similarly, Michigan State philosophy professor Leonard Fleck has proposed an “informed democratic consensus model” to make health care allocation decisions in a public, deliberative process.⁴¹ In Fleck’s model, allocation decisions would be made by local health councils and a national health congress that would be created with lay membership to fashion rationing guidelines on the basis of expert advice and critical moral reflection.⁴²

In his program for reform, former Senator Tom Daschle proposed the creation of a “Federal Health Board” (Board) that would be modeled on the Federal Reserve.⁴³ The Board would be composed of experts in health care and economics and would be appointed by the president for ten-year terms.⁴⁴ In addition to oversight over many other aspects of the health care system’s structure, the Board would “promote ‘high-value’ medical care” by recommending coverage of drugs and procedures that are backed by solid evidence.⁴⁵ The Board would “make its decisions in public meetings, with mandatory reports to Congress.”⁴⁶ The Board’s recommendations would be binding on all federal health programs, and they likely would be influential for private insurance plans, much as Medicare coverage decisions currently influence private insurers.⁴⁷

The Affordable Care Act took an initial step toward a health care allocation commission when it created the Patient-Centered Outcomes Research Institute (Institute).⁴⁸ The Institute will promote “comparative-effectiveness” research—research that compares the benefits and risks of different medical treatments—so physicians will have better data on the value of treatment alternatives when making choices for their patients.⁴⁹ The Institute also will analyze comparative-effectiveness data and issue public reports with its analyses.⁵⁰ While the Institute is prohibited from making coverage recommendations, Medicaid, Medicare, and private insurers may take the Institute’s analyses into account when making their own coverage decisions.⁵¹

The different models I have described differ in the make-up of the decision makers. Daschle and the Patient-Centered Outcomes Research Institute rely on professional experts, Ruger on a broad mix of patients, health care providers and other stakeholders, and Fleck on lay citizens. But all provide for a public, transparent process.

39. JENNIFER PRAH RUGER, *HEALTH AND SOCIAL JUSTICE* 172–83 (2010).

40. *Id.*

41. Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1617 (1992).

42. *Id.* at 1617–27.

43. TOM DASCHLE, *CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS* 169–72 (2008).

44. *Id.*

45. *Id.*

46. *Id.* at 172.

47. *Id.* at 179.

48. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6301, 124 Stat. 119, 727 (2010).

49. *Id.*

50. *Id.*

51. *Id.*

While public, transparent processes to contain health care costs are well-justified by moral principle, they are difficult to employ when making the kinds of life-and-death decisions that rationing requires.⁵² As Guido Calabresi and Philip Bobbitt observed in *Tragic Choices*, public, transparent processes can provoke intolerable social conflict.⁵³ When Americans have to choose who does and does not have access to health care, some important social values will be served but others may be sacrificed.⁵⁴ If we provide treatment to the patients who can live the longest with care, we often will neglect the patients who have the greatest need for care (since the more advanced a patient's disease, the less amenable it is to treatment). Conversely, if we favor patients with the greatest need, we neglect patients who will live the longest. Because of the inevitable clash of key values, societies often look for ways to disguise their rationing choices; otherwise, public discomfort will bring the rationing process down.⁵⁵

V. PAST FAILURES OF PUBLIC, TRANSPARENT PROCESSES

Public, transparent processes not only are predicted to fail by the *Tragic Choices* analysis, they in fact have generally failed. Important examples include the rationing of kidney dialysis, the Oregon Health Plan, certificate of need legislation, managed care, breast cancer screening guidelines and the UK's National Institute of Health and Clinical Excellence.

When long-term kidney dialysis became available in the 1960s, there were not enough machines to treat everyone with kidney failure, and hospitals created committees to decide which patients would receive dialysis.⁵⁶ Committee members considered the age and medical suitability of patients; they also considered educational background and economic status.⁵⁷ Often, people were chosen because of their perceived social worth rather than on account of more equitable criteria.⁵⁸ As one committee member observed, "I remember voting against a young woman who was a known prostitute. I found I couldn't vote for her, rather than another candidate, a young wife and mother"⁵⁹ Because of the controversy over the decisions, Congress authorized Medicare funding in 1972 for anyone who required dialysis, and the rationing committees were no longer needed.⁶⁰

In the 1990s, Oregon decided to change the way it operated its Medicaid program.⁶¹ Instead of providing broad health care benefits to a limited number of the poor, it would provide basic benefits to all of the poor (defined as anyone with a family income less than

52. GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* 18–28 (1978).

53. *Id.*

54. *Id.*

55. *Id.*

56. Roger W. Evans et al., *Implications for Health Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 JAMA 487, 487 (1981).

57. *Id.*

58. *Id.*

59. RENÉE C. FOX & JUDITH P. SWAZEY, *THE COURAGE TO FAIL: A SOCIAL VIEW OF ORGAN TRANSPLANTS AND DIALYSIS* 246 (1974).

60. Evans et al., *supra* note 56, at 487.

61. Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 501–05 (1995).

the federal poverty level of income).⁶² Government officials toured the state, held town hall meetings and received wide public input.⁶³ They then developed a list of more than 700 pairs of medical conditions and their treatments which they ranked in terms of their benefits and costs.⁶⁴ After receiving public comments, government officials reordered the ranking, and they made additional revisions when the federal government raised concerns about the impact of the ranking on persons with disabilities.⁶⁵ Once the list was finalized and the state legislature decided on the amount of Medicaid funding for the new budget, the state decided how far down the list it could go in providing coverage.⁶⁶ For subsequent budget cycles, state officials updated the list and re-determined how far down the list they could provide coverage.⁶⁷

In a few important ways, the Oregon Health Plan did not meet its goals. First, while the coverage was supposed to provide only a basic benefits package, it provided more generous coverage than typical private insurance plans in Oregon. For example, the Oregon Health Plan provided better coverage for mental health services, treatment of HIV infection, and organ transplantation.⁶⁸ In other words, Oregon did not really cut back on the kinds of health care services it would cover. Instead, it expanded its funding for health care coverage for the poor, through both an increase in the cigarette tax and a larger appropriation from general revenues.⁶⁹ To the extent that Oregon did reduce costs, it did so by increasing its reliance on managed care for patients in the Health Plan.⁷⁰ In addition, Oregon ended up increasing its Medicaid spending faster than other states, and the economic downturn in the early 2000s resulted in a cutback in coverage to the point that Oregon's uninsured population rose back to pre-Health Plan levels within a decade of the Plan's implementation.⁷¹

Certificate-of-need legislation held considerable promise as a rationing strategy, and to an important extent it was designed to avoid the case-by-case rationing judgments that are so difficult to make in a public fashion. As Calabresi and Bobbitt observe, "first-order" rationing decisions, which decide how much of a particular resource will be available, are less exposed and therefore less controversial than "second-order" rationing decisions, which decide how the rationed resource will be allocated among the people who would benefit from access.⁷² Certificate-of-need policies look more like first-order than second-order rationing policies. Under certificate-of-need legislation, hospitals need

62. *Id.* at 502.

63. Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, 10 HEALTH AFF. 7, 20 (1991).

64. Peters, *supra* note 61, at 503.

65. *Id.* at 502-05.

66. Somnath Saha et al., *Giving Teeth to Comparative-Effectiveness Research—The Oregon Experience*, 362 NEW ENG. J. MED. e18(1), e18(2) (2010).

67. *Id.*

68. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 166-67 (1999).

69. *Id.* at 165-66.

70. *Id.*

71. *Id.*; Thomas Bodenheimer, *The Oregon Health Plan—Lessons for the Nation (First of Two Parts)*, 337 NEW ENG. J. MED. 651, 652 (1997); Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFF. w96, w99 (2007).

72. CALABRESI & BOBBITT, *supra* note 52, at 19, 40.

permission from a state agency before they can expand or build a new facility.⁷³ The state agencies are supposed to deny permission when there is no medical need for more hospital beds.⁷⁴ Thus, the state agency makes the first-order determination about the number of hospital beds, but not the second order determination about which patients will have access to the beds. The certificate-of-need approach could automatically ratchet down the provision of expensive medical services simply because physicians would recognize that the availability of hospital beds had diminished. Rather than having committees decide who would have access to hospital care, physicians would adjust their standards for recommending hospitalization, and health care spending would decrease. Thus, for example, people are less likely to be admitted for hospital care in communities with fewer hospital beds per capita. And even with the lower rates of hospitalization, patients are no more likely to die in the communities with fewer beds.⁷⁵

In a health care system like that in the United States, where many communities have surplus hospital beds, certificate-of-need legislation could have a big impact, by reducing unnecessary hospitalizations, and it has in some places for some time.⁷⁶ However, certificate-of-need legislation has not been successful overall.⁷⁷ While a number of reasons underlie the failure of the approach, much of the failure likely reflects the public nature of the process for approving or rejecting applications. If a hospital wants to build a new facility or expand an existing one, residents of the local community can mobilize on behalf of the proposal. Thus, for example, when a community hospital in Irvington, NJ wanted to expand, a court instructed the state agency to consider not only the number of hospital beds in the area, but also the proximity of the beds to local residents, even though the hospital was only 3.5 miles from a university hospital in Newark, NJ.⁷⁸

In other words, a certificate-of-need policy has elements of second-order as well as first-order rationing decisions. When the state agency decides the overall number of beds for the state or region in the state, it makes a first-order rationing decision. When it decides which hospitals will get to operate the beds, it makes a rationing decision that lies between the first-order decision about number of beds and the second-order decision as to who uses the beds. To the extent that the decisions have second-order elements, it becomes more difficult to make them. And even though first-order rationing decisions may be less controversial than second-order decisions, they too can provoke significant controversy. When Congress decides to cut the Medicare budget, for example, it encounters resistance from Medicare beneficiaries.⁷⁹

73. Certificate of need policies also apply to nursing homes and other health care facilities, and they can require permission not only for capital construction but also for acquiring new equipment. MARK HALL ET AL., *HEALTH CARE LAW AND ETHICS*, 1205, 1208 (7th ed. 2007).

74. *Statewide Health Coordinating Council v. Gen. Hosp. of Humana, Inc.*, 660 S.W.2d 906, 908–09 (Ark. 1983).

75. Elliott S. Fisher et al., *Associations Among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors*, 34 *HEALTH SERV. RES.* 1351, 1356 (2000).

76. David Leonhardt, *Health Cuts with Little Effect on Care*, N.Y. TIMES, Dec. 30, 2009, at B1.

77. HALL ET AL., *supra* note 73, at 1208.

78. *Irvington Gen. Hosp. v. Dep't of Health*, 374 A.2d 49, 53 (N.J. Super. Ct. App. Div. 1977).

79. Seniors have consistently been more likely than younger adults to have an unfavorable opinion of the Affordable Care Act, and their opposition likely reflects the fact that much of the expansion in coverage under the Act will be funded by reductions in Medicare reimbursement. *Kaiser Health Tracking Poll*, KAISER FAM. FOUND., 5 (Feb. 2011), www.kff.org/kaiserpolls/upload/8156-F.pdf.

The rise and fall of managed care in the United States also demonstrates the *Tragic Choices* phenomenon. Health maintenance organizations (HMOs) and other managed care plans promised that patients would receive all medically necessary or appropriate care—the same pledge that patients receive from fee-for-service plans. The plans also promised that they would deliver care in a more cost-effective fashion.⁸⁰ However, as patients began to understand that managed care entailed limits on days of hospitalization, restrictions on patient access to physician specialists, and other rationing techniques, public support for managed care dissipated.⁸¹ Managed care plans responded by changing their rules, and they have come to look more like traditional fee-for-service plans.⁸²

A recent example of the failure of public, transparent processes was provided by a proposed revision of breast cancer screening guidelines in 2009. The U.S. Preventive Services Task Force (Task Force) is a panel of independent medical experts that regularly develops recommendations regarding the provision of preventive medical services. The Task Force is appointed by the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services.⁸³ In November 2009, the Task Force concluded that women with a normal risk for breast cancer should receive routine mammograms to screen for cancer beginning at age 50 instead of age 40. An immediate public backlash led the White House and the U.S. Department of Health and Human Services to repudiate the new guidelines within days of their release.⁸⁴

Treatment of breast cancer provides another illustration of how difficult it is to ration health care publicly. During the late 1980s and 1990s, many physicians thought metastatic breast cancer could be treated with very high doses of chemotherapy followed by “autologous” bone marrow transplantation.⁸⁵ With this therapy, doctors would remove stem cells from the bone marrow of the patient for later use in transplantation and then administer very high doses of chemotherapy to more effectively eliminate the cancer cells.⁸⁶ Ordinarily, doctors cannot use such high doses to treat breast cancer because they also kill the patient’s bone marrow stem cells.⁸⁷ However, since the chemotherapy can be followed by infusing the woman’s previously removed stem cells, the higher doses can be used.⁸⁸ Physicians who provided high dose chemotherapy followed by bone marrow

80. David Orentlicher, *The Rise and Fall of Managed Care: A Predictable “Tragic Choices” Phenomenon*, 47 ST. LOUIS U. L.J. 411, 418–19 (2003).

81. *Id.* at 419.

82. *Id.*

83. U.S. Preventive Services Task Force (USPSTF), AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, www.ahrq.gov/clinic/uspstfix.htm (last visited May 10, 2011).

84. Kevin Sack & Gina Kolata, *Breast Cancer Screening Policy Won’t Change, U.S. Officials Say*, N.Y. TIMES, Nov. 19, 2009, at A1.

85. Edward A. Stadtmauer et al., *Conventional-Dose Chemotherapy Compared with High-Dose Chemotherapy Plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 NEW ENG. J. MED. 1069, 1069 (2000). With autologous transplants, the same person serves as both donor and recipient of the transplant. Hollie Devine et al., *Mobilization of Hematopoietic Stem Cells for Use in Autologous Transplantation*, 144 CLINICAL J. OF ONCOLOGY NURSING 212, 212 (2010).

86. James O. Armitage, *The History of Autologous Hematopoietic Cell Transplantation*, in THOMAS’ HEMATOPOIETIC CELL TRANSPLANTATION: STEM CELL TRANSPLANTATION 8, 8 (Frederick R. Appelbaum et al. eds., 4th ed. 2004).

87. *Id.*

88. *Id.*

transplantation thought they could successfully treat metastatic breast cancer that way.⁸⁹ Many insurance companies initially refused to pay for the treatment, on the ground that their policies excluded coverage for experimental treatments.⁹⁰ Even though the companies were correctly interpreting their policies, the media harshly criticized them, and courts often forced them to provide coverage.⁹¹ Ultimately, studies found that the therapy was not an effective way to treat breast cancer.⁹²

The United Kingdom created its version of an independent health-care allocation agency in 1999 in the form of the National Institute of Health and Clinical Excellence (NICE). For nearly a decade, NICE had authority to decide whether drugs and other treatments were sufficiently cost-effective that the National Health Service would cover them.⁹³ NICE operates much like an administrative agency or independent commission in the United States government, consulting with and inviting comments from patients and other stakeholders. NICE's guidelines are (a) developed by independent panels of experts in health care and economics, (b) finalized by national collaborating centers of representatives from academic medicine, professional associations and patient organizations, and (c) formally approved by the Institute.⁹⁴ But NICE's decisions to exclude coverage for new cancer drugs and other treatments provoked controversy, and in October 2010, the UK government announced its intention to revoke the Institute's authority to make coverage decisions.⁹⁵

Finally, consider the furor over the "death panels" provision in the Affordable Care Act.⁹⁶ According to critics, the provision would have empowered doctors to ration medical care by discontinuing treatment of terminally ill patients and thereby hastening the patients' deaths.⁹⁷ In fact, the provision merely would have authorized reimbursement for the time doctors spent counseling their patients who wanted to write advance directives or otherwise engage in planning about medical decisions at the end of life.⁹⁸ But the public belief that doctors would be rationing life-sustaining medical care was enough to doom adoption of the provision.⁹⁹

89. *Id.* at 11.

90. Michelle Mello & Troyen A. Brennan, *The Controversy Over High-Dose Chemotherapy with Autologous Bone Marrow Transplant For Breast Cancer*, 20 HEALTH AFF. 101, 102 (2001).

91. *See id.* at 101 (discussing how insurers were forced to provide coverage).

92. *Id.* at 101–02; *see generally* Dan T. Vogl & Edward A. Stadtmauer, *High-dose Chemotherapy and Autologous Hematopoietic Stem Cell Transplantation for Metastatic Breast Cancer: A Therapy Whose Time Has Passed*, 37 BONE MARROW TRANSPLANTATION 985 (2006) (concluding that "time of high-dose therapy and autologous stem cell transplant for breast cancer has passed").

93. Robert Steinbrook, *Saying No Isn't NICE*, 359 NEW ENG. J. MED. 1977, 1977 (2008).

94. *Developing NICE Clinical Guidelines*, NAT'L INST. FOR HEALTH AND CLINICAL EXCELLENCE (Feb. 19, 2010), www.nice.org.uk/aboutnice/howwework/developingniceclinicalguidelines/developing_nice_clinical_guidelines.jsp.

95. Sarah Boseley, *NICE to Lose Powers to Decide on New Drugs*, THE GUARDIAN, Oct. 29, 2010, available at www.guardian.co.uk/politics/2010/oct/29/nice-to-lose-new-drug-power.

96. Jim Rutenberg & Jackie Calmes, *False 'Death Panels' Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 14, 2009, at A1.

97. *Id.*

98. America's Affordable Health Choice Act of 2009, H.R. 3200, 111th Cong. § 1233 (2009) (as introduced).

99. Not only was the provision stripped from the Affordable Care Act, it also failed to be adopted when the U.S. Department of Health and Human Services tried to use the rule-making process to revive the provision.

VI. COST CONTAINMENT THAT CAN WORK

If public, transparent processes face daunting political obstacles, where do we go from here? First, we have to consider the pitfalls of non-transparent processes. As Fleck has observed, hidden, decentralized processes for rationing decisions invite the potential for arbitrary decisions that reflect personal biases.¹⁰⁰ There are important moral and social reasons for transparency and broad public input.

Still, the risk of arbitrary decision making from non-transparent processes may not be too great, and there may be effective ways to protect against the risk. As to the severity of the risk, there is good reason to be concerned. Disparities in access to health care already exist on the basis of race and sex.¹⁰¹ If physicians provide fewer services, we might expect disfavored persons to suffer a disproportionate share of the diminution. On the other hand, a study that looked at this question is reassuring. When a nursing shortage required hospitals in Boston to close intensive care beds and intensive care had to be rationed more strictly, researchers studied the impact of the rationing on patient health.¹⁰² They neither found harm to the average patient, nor evidence that physicians disfavored hopelessly ill patients or older patients.¹⁰³ In addition, safeguards can be employed to discover and correct unfair rationing practices. As indicated by the experience of the VA Health Care system and other model health care systems, good quality health care entails monitoring of physician practices to identify doctors who provide inappropriate care.¹⁰⁴

If we want to choose among non-transparent processes for rationing health care, perhaps the most useful method would be to adopt economic incentives that drive doctors and other providers toward more cost-effective care. By doing so, we can satisfy the need for a workable rationing process and at the same time reduce the need to ration health care. Because fee-for-service reimbursement is a major factor in generating the provision of unnecessary care and pushing health care costs ever higher,¹⁰⁵ eliminating fee-for-service compensation should markedly reduce the cost pressures that make rationing necessary.

What would take the place of fee-for-service reimbursement? Physicians should earn their compensation solely through salary or capitation fees for the patients they serve.¹⁰⁶ Similarly, hospitals should earn their compensation solely through capitation fees.

Robert Pear, *A Reversal for Medicare on Planning for Life's End*, N.Y. TIMES, Jan. 5, 2011, at A15.

100. Fleck, *supra* note 41, at 1616.

101. See generally Alix Weisfeld & Robert L. Perlman, *Disparities and Discrimination in Health Care*, 48 PERSP. IN BIOLOGY & MED. S1 (2005) (examining racial disparities in healthcare).

102. Daniel E. Singer et al., *Rationing Intensive Care—Physician Responses to a Resource Shortage*, 309 NEW ENG. J. MED. 1155, 1158–59 (1983).

103. *Id.*

104. See Jonathan B. Perlin et al., *The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care*, 10 AM. J. MANAGED CARE 828, 831 (2004) (discussing the VA's success in employing "an audit program to assess clinical performance"); David Leonhardt, *Making Health Care Better*, N.Y. TIMES, Nov. 8, 2009, at MM31 (examining efforts to improve healthcare).

105. See *supra* text accompanying note 38.

106. With capitation, physicians would receive a fixed amount of compensation per patient. For example, a physician might assume responsibility for the care of 500 patients and receive \$200 per patient, for total compensation of \$100,000. Orentlicher, *supra* note 6, at 158–59.

Other financial incentives to provide unnecessary care also should be eliminated. For example, when physicians invest in medical laboratories or other health care facilities, they are much more likely to refer patients for services at the facilities.¹⁰⁷ Thus, to the extent that federal law still permits physician investment in health care facilities—as with physician-hospital joint ventures¹⁰⁸—the law should be changed to prohibit such investments.¹⁰⁹ Salaried and capitated physicians can be well-compensated—indeed, primary care physicians should earn more income than they currently receive—but they should not be compensated based on the amount of health care they deliver. To reinforce the incentives for lower-cost, higher-quality care, salaries or capitation fees for physicians and hospitals can be supplemented by bonuses for higher-quality care.

From a *Tragic Choices* perspective, there is an important advantage of salary over capitation when choosing a reimbursement method for physicians. Recall the Calabresi and Bobbitt distinction between first-order and second-order rationing decisions.¹¹⁰ Since the setting of capitation rates entails a determination of how much money to spend on patient care, it clearly represents a first-order rationing decision.¹¹¹ Setting physician salaries also entails a rationing decision—since it constitutes a decision about how much money to allocate for physician care—but it is a less direct form of rationing and therefore less likely to provoke public controversy.¹¹²

As mentioned, eliminating financial incentives for physicians and hospitals to provide unnecessary care will be valuable not only for reducing the need for rationing.¹¹³ It also will serve the important purpose of providing a non-transparent process for the second-order rationing decisions as to how health care resources will be allocated among the patients who might receive care. When physicians and hospitals no longer have incentives to provide more care, they will naturally tend toward providing less care.¹¹⁴ As they reduce their level of care, they automatically will make allocation decisions among different patients, and they will do so in a non-transparent way.

In this regard, it is important to remember that physicians and hospitals must always

107. Jean M. Mitchell & Elton Scott, *Evidence on Complex Structures of Physician Joint Ventures*, 9 YALE J. ON REG. 489, 492–93 (1992).

108. 42 U.S.C. § 1395nn(d)(3) (2006).

109. Another incentive for higher-cost, lower-quality care came from the practice of oncologists delivering cancer chemotherapy in their offices and charging substantial premiums over their acquisition costs for the drugs. Alex Berenson, *Incentives Limit Any Savings in Treating Cancer*, N.Y. TIMES, June 12, 2007, available at <http://www.nytimes.com/2007/06/12/business/12cancerpay.html>. Although insurers stopped allowing the substantial premiums, oncologists found other ways to maintain spending on cancer care. *Id.* For example, fee-for-service reimbursement encouraged them to recommend chemotherapy to more patients and also to install imaging machines in their offices to perform expensive diagnostic scans. *Id.*

110. See CALABRESI & BOBBITT, *supra* note 52, at 18–20 (examining first-order and second-order rationing decisions).

111. *Id.*

112. *Id.*

113. See *supra* text accompanying note 105.

114. In fact, physicians decide whether to treat a patient or not and how to treat a patient. It is the physician, for example, who decides whether to admit a patient to a hospital. However, it still is important to remove financial incentives for hospitals to provide more care. Hospital administrators can exert pressures on physicians to admit more or fewer patients (e.g., by giving preferential treatment to physicians who practice in ways that the hospital likes), so it is important to align physician and hospital financial incentives. HALL ET AL., *supra* note 73, at 1113.

make allocation decisions. Whether they are spending 17% of GDP or 12% of GDP on health care, health care professionals have to establish cut-offs for their provision of care. To put it another way, physicians practice under finite time limits and hospitals under finite space limits, so they are always allocating their time and space among the different patients for whom they could provide care.

Of course, with salary and capitation, physicians and hospitals might provide too little care instead of too much care.¹¹⁵ That problem can be addressed by the same monitoring of practices needed to protect against arbitrary decision making. The bonuses for higher-quality care also would counteract the tendency to provide too little care. Liability for medical malpractice should reinforce monitoring and bonuses, as well as deter substandard care. Empirical studies suggest that these safeguards can adequately protect against the risks of too little care. Research on the impact of HMOs and other managed care plans generally has found that those plans provide the same quality of care as traditional, fee-for-service plans.¹¹⁶

The switch to salaries and capitation fees has other implications. Salaries require physicians to be employed by a health care organization, and capitation fees require large patient pools to ensure that physicians and hospitals have enough low-cost patients over which they can spread the expenses of caring for high-cost patients.¹¹⁷ Accordingly, changing physician and hospital reimbursement will encourage physicians and hospitals to participate in accountable care organizations¹¹⁸ or other large health-care networks. While some have raised concerns about the antitrust implications of large health care networks,¹¹⁹ physicians generally provide better care when they practice with colleagues,¹²⁰ and they are in a better position to coordinate care for patients who have multiple medical problems.

VII. CONCLUSION

As health care costs continue to rise, the need for effective cost containment measures will become even greater. From a moral standpoint, policy experts are correct to recommend public, transparent processes for implementing rationing decisions. However, life-and-death decisions do not lend themselves to satisfactory resolution when

115. Orentlicher, *supra* note 6.

116. HALL ET AL., *supra* note 73, at 1030–31. The empirical evidence suggests that poor and chronically ill patients may not fare as well under managed care, so the monitoring of physician practices would be important to protect the needs of those patients. *Id.*

117. Orentlicher, *supra* note 6, at 162–64.

118. Accountable care organizations are entities like the Mayo Clinic or an HMO in which physicians, other health care professionals, and hospitals form provider networks to deliver care in a comprehensive, coordinated fashion. Under the Affordable Care Act, financial incentives will be provided to encourage the formation of accountable care organizations. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 2706, 3022, 124 Stat. 119, 325, 395 (2010); Elliott Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. w219, w220–22 (2009).

119. Barak D. Richman & Kevin A. Schulman, *A Cautious Path Forward on Accountable Care Organizations*, 305 J. AM. MED. ASS'N 602, 602–03 (2011).

120. See, e.g., Jonathan D. Ketcham et al., *Physician Practice Size and Variations in Treatment and Outcomes: Evidence from Medicare Patients with AMI*, 26 HEALTH AFF. 195, 195 (2007) (finding that patients with heart attacks did better when their physicians practiced in a group rather than alone).

pursued openly.

Social constraints push us toward implicit rationing processes. These processes can draw an appropriate balance between moral and social considerations so long as adequate safeguards are employed to detect and correct unfair rationing decisions. By changing reimbursement from fee-for-service to salary and capitation, we not only can have an effective non-transparent process for rationing, we also can reduce the need to ration health care.
