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THE “R” WORD

M. Gregg Bloche and Elizabeth R. Jungman

In American politics, health care rationing is the “R” word. Among people trying to win elections, the “R word” is an epithet invoked to attack the other guy’s medical cost control proposals. Honest talk about the need to withhold beneficial care in order to restrain health spending is as welcome in American public life as are Sally Hemmings’ descendants at a Jefferson family reunion. In 1994, Congressional Republicans rolled out the “R” word to condemn the Clinton Administration health reform plan.¹ A few years later, Democrats returned the favor, deploying the “R” word against Republican efforts to coax Medicare beneficiaries into managed care.²

In the medical marketplace competitors act similarly. Rival health plans do not post billboards on the sides of buses promoting their ability to efficiently withhold beneficial care. Their advertisements and coverage contracts typically promise all “medically necessary” treatment, encouraging subscribers to expect care without compromise. Although market-oriented health policy commentators have urged managed health plans to be explicit in their contracts about the need to set limits on potentially beneficial care, the industry has not done so. Republicans, Democrats, and HMO executives are in agreement about what American health care consumers do not want to hear.

In June 2000, the U.S. Supreme Court broke the political silence about the need to say no. With bracing candor, the Court proclaimed that health care rationing is not only routine in America but, a matter of national policy.³ Writing for a unanimous court in *Pegram v. Herdrich*, Justice David Souter said, “inducement to ration care goes to the very point of any HMO scheme.”⁴ Justice Souter noted that Congress has, since 1973, promoted the formation of HMOs through the HMO Act. . Congress,

1. M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside Rationing*, 284 JAMA 2776 (2000) citing Robert Pear, *Cuts in Medicare are on the table, but peril is seen*, N.Y. TIMES, Aug. 21, 1994, at A4.

2. Bloche & Jacobson, *supra* note 1, at 2776 citing Joan Beck, *Elderly being used as pawns in health-care debate*, CHI. TRIB., Nov. 15, 1998.

3. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

4. *Id.* at 212.

Justice Souter wrote, has thereby endorsed “the profit incentive to ration care.”⁵

Over the next few years, pressure to say no to health care spending will increase greatly. Post-September 11th spending on defense and domestic security, a huge federal tax cut, the recent recession’s effects on employment, and consumer demand translate into less money for public and private medical coverage. Meanwhile, after several years in which health care spending remained almost flat, medical costs are again rising rapidly. Private insurance companies are hiking premiums by double-digit percentages,⁶ and Medicare and Medicaid face similar cost pressures. Medicare is containing costs by limiting provider payments to the point that a growing numbers of doctors are abandoning the program or limiting their participation. This is almost certain to prove politically unsustainable. If and when Medicare payment rates reach levels that jeopardize large numbers of American seniors’ access to care, they will make their voices heard in potent fashion. Medicaid cost increases threaten the solvency of the state governments, crowding out spending on education, public health, and economic development.⁷

Yet political talk about the need to say “no” to beneficial care remains taboo. Prescription drug benefits for seniors and the rights of private health insurance subscribers *vis-a-vis* managed health plans were the principal health care issues in national politics as the 2002 midterm elections approached. Discussion of alternative cost-containment strategies has no place in the current debate or in managed health plans’ marketing efforts.

Political stump speakers promise to take medical decision-making power from HMO bean counters and return it to doctors.⁸ But since the

5. *Id.* at 233.

6. Reed Abelson, *Hard Decisions for Employers as Costs Soar in Health Care*, N. Y. TIMES, Apr. 18, 2002, at C1; *Week in Review: CalPERS to Hike Health Insurance Premiums*, L.A. TIMES, Apr. 21, 2002, at Bus. 2.

7. Robert Pear, *Governors Say States Needs More Federal Help to Deal With Rising Costs of Medicaid*, N.Y. TIMES, Feb. 25, 2002, at A16 (quoting the governor’s policy statement as saying that, “[t]he current fiscal crisis for states, compounded by unsustainable growth in the Medicaid program, is creating a situation in which states are faced with either making massive cuts in programs or being forced to raise taxes significantly.”).

8. See e.g. Rep. Dennis Hastert, *Putting Patients First*, BOSTON GLOBE, Aug. 4, 2001, at A15 (asserting that the patients’ bill of rights takes decisions away from HMO accountants and gives them back to doctors); Megan Garvey, *Unlikely Leaders Face Off Over Patients’ Rights*, L.A. TIMES, July 5, 2001, at A14 (reporting

late 1990s, health plan managers have been doing so, to manage costs in "don't ask, don't tell" fashion. Rather than paying bean counters to set limits, health plans are paying doctors to do the bean counting: to ration care at the bedside, often without their patients knowing it. Afraid of possible tort liability and under pressure from health care consumers, who hate HMO bureaucrats, health plans have increasingly delegated utilization management to treating physicians and put these physicians at large financial risk for the cost of care.⁹

The financial and administrative mechanisms involved are complicated. Myriad capitation and profit-sharing schemes, withholding arrangements, and bonuses for frugality reward health care providers for clinical restraint, often without regard for clinical outcomes. Various intervening institutions play crucial roles. Health plans often contract with (and pay) groups of physicians. These groups range from small partnerships of two or more doctors in the same specialty to large, multi-specialty medical groups, comprised of hundreds of physicians. Health plans pay these groups, but money received by each group is then distributed to individual doctors in accordance with the group's distinctive staff payment and utilization management policies. Management, in short, has moved centrifugally from HMO bureaucrats to the doctor's office, raising difficult ethical questions about the dual roles and loyalties involved.

Pegram v. Herdrich involved a challenge to this shift toward reliance on financial rewards to doctors for frugal practice. Dr. Lori Pegram, an internist with an ownership interest in an HMO, waited for more than a week to obtain an abdominal ultrasound for her patient, Cynthia Herdrich, so that the test could be done at one of the HMO's facilities. Herdrich's infected appendix ruptured in the meantime and she developed peritonitis, a life-threatening infection of the abdominal cavity. She survived and sued both Pegram and the HMO over the HMO's financial incentives to physicians to limit care.¹⁰ She alleged that these incentives encouraged Pegram to delay her ultrasound, putting her at increased risk in order to obtain the test more cheaply at a plan-affiliated site.

that Sen. Bill Frist "talked passionately about patients he has seen and the need to have doctors, not managed care bureaucrats, make medical decisions"); Clay Robinson & Lisa Teachey, *Last Stumping Effort Before Primary*, HOUSTON CHRONICLE, March 10, 2002, at A35 (quoting U.S. Representative Ken Bentsen, a candidate for Texas's open Senate seat, as saying that "[m]edical decisions should be made by patients and doctors, not HMO bureaucrats.").

9. JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* (1999).

10. Pegram, *supra* note 3, at 215.

Contrary to what the managed care industry alleged, and some in the media reported, the case involved neither a wholesale attack on managed care nor a bid to outlaw all financial incentives to control costs. Herdrich did not challenge the basic idea of prepaid care, the budgetary constraints it makes inevitable, or utilization management and cost conscious clinical practice. All of these have long been staples of managed care. She merely asked the federal courts to construe an ambiguous federal statute¹¹ to set limits on financial incentives to limit care.¹² But the Supreme Court flatly rejected the proposition that federal law limits financial rewards to physicians for frugality.¹³ The upshot after *Pegram* health plans have *carte blanche* to offer financial incentives to physicians to withhold care, except in so far as state law sets limits.

Many observers of American health policy are concerned by the ethically troublesome role conflict that this legal environment permits, the conflict between physicians' loyalty to individual patients and the pull of monetary incentives (as well as responsibility for stewardship of collective resources).¹⁴ There are anecdotal reports that health plans are moving away from such incentives out of concern of consumers' hostile reaction to them. But if we reject this method of cost control, we need to look for others so long as society demands that limits be set.

In Germany and the U.S., as elsewhere, society is demanding limits. In most industrialized nations, including Germany, overall limits are set on a more-or-less top-down basis, through global budgets that are allocated to regions, health care organizations, and/or other institutions responsible for providing care and managing costs. These institutions vary greatly. Canada, for example, sets overall limits via province-wide health care budgets. Negotiations between provincial health officials and medical care

11. Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1109(a) (1994) ("Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.").

12. Professor Jost discusses the ERISA statute in more detail in his contribution to this issue.

13. *Pegram*, *supra* note 3, at 237 (holding that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA.").

14. Brief of Health Law, Policy and Ethics Scholars in Support of Respondent at 15-16, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (No. 98-1949) (Dec. 20, 1999).

providers determine how these budgets are distributed. The German system of quasi-public, statutory health insurance entities, or "sickness funds," tied to particular occupational groups, functions similarly: "sickness fund" managers do much of the bargaining with providers that provincial health officials do in Canada.

In the United States, limits are set in much more fragmented fashion.¹⁵ As consumers, Americans contribute to the setting of limits in the private health insurance market every time they purchase goods or services. If I purchase a Ford instead of a Chevrolet and price is a factor, then I am part of the process of setting limits on autoworkers' health care, since I am putting market pressure on Ford and General Motors to constrain their employee compensation, including health benefits. There are numerous players in this process: consumers, employers who design compensation packages to compete for workers, employees who make choices among employers (and health plans) in part based on their marginal preferences for salary versus health benefits, and public policymakers who define market actors' tax and regulatory environments. The American system of employer-provided medical coverage is a vector sum of the choices this fragmented process generates. For Americans unhappy with this system's limit-setting behavior, the "enemy" in the largest sense is us every time we go to market.

Physicians in clinical practice in the U.S., Germany, and elsewhere rarely take explicit account of medical costs. Indeed, most physicians view the weighing of medical benefits against financial costs as unethical, whether done by treating physicians or by drafters of clinical practice protocols. Moreover, forthright balancing of costs and benefits is beset by countless uncertainties, arising from insufficiency of scientific data about the efficacy of clinical alternatives and lack of general agreement about how to value clinical benefits in dollar terms.¹⁶

Yet clinical practice norms incorporate implicit cost-benefit trade-offs.¹⁷ Medical practice tends to put a premium on the value of life in rough proportion to the immediacy of the threat to life. Medical practice norms call for huge expenditures in the medical intensive care unit to buy days or weeks of possible life. But when screening tests and prevention-oriented services are at issue and clinical risk is remote, clinical practice norms

15. Public sector systems, such as Medicaid and Medicare, are not incorporated into this argument.

16. M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. (forthcoming Jan. 2003).

17. HENRY J. AARON & WILLIAM B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE*, 79-88, 134-135(1984).

place lower implicit values on life. The law that governs clinical resource allocation obscures this inconsistency. The opaque standard of medical necessity, which governs medical insurance coverage in the private sector by contract and in public programs by statute or regulation, permits the making of inconsistent trade-offs without conscious reflection or deliberation.

Legal opacity of this sort permits the making of painful, life-sacrificing choices without widespread awareness of what is being sacrificed. There is, perhaps, something to be said for collective self-deception in service of social peace. But as pressures for cost control mount, so does the strain on this method of society-wide self-deception. The popular backlash against managed care over the past several years may well signal the breakdown of this self-deception. In the long run, we will need to speak about the unspeakable, if social support for cost containment that costs lives is to be built and sustained. This means free-ranging discussion about how lives and health status are to be valued and about how uncertainty about treatment efficacy is to be counted in health care's cost-benefit calculus. It means open discussion about permissible and impermissible links between personal wealth and access to costly care.¹⁸

It also means conversation about the extent to which medical care's inconsistent valuations of life are ethically desirable or even ethically tolerable. Does medicine's propensity to place higher valuations on years (or days or weeks) of life saved at moments of life-or-death extremes than in the design of health screening and promotion programs reflect something inherent in human psychology – a cognitive bias toward rescue over prevention? If so, should we treat this inclination as a truth of human nature that should be incorporated into clinical and social ethics? Or, should we treat this inclination as a cognitive error to be corrected via public policymaking that demands consistent valuations of life across all clinical contexts? Must any society that defers to popular choice, via markets and politics, accept people's willingness to pay much more to save a life year in the intensive care unit than in the outpatient clinic, when doctors prescribe drugs for hypertension? Or is there something special about medicine's caring role—its promise to keep faith with people in dire need—something so special that its disparately low population-wide health status payoff is ethically permissible? More broadly, should valuation of life be equalized for all health-related public spending, on education,

18. In economics language, to what degree, if at all, is health care a “merit good” that is, a good that society believes should be distributed in a more egalitarian fashion than would be the case based on private purchasing power, alone.

environmental protection, occupational safety, economic development, and other social programs. We know from abundant empirical evidence that the health status of populations correlated more closely with socio-economic class, education, and environmental determinants than with health care spending. Does this knowledge support a large-scale resource shift from medical care to social programs that achieve a higher health payoff and, perhaps, greater social justice? Or is there something special about medicine's caring role, its promise to keep faith with people in dire need. Something so special that its disparately low population-wide health status payoff is ethically permissible?

These questions hardly exhaust the range of issues that merit focus in candid public discussion about limit-setting in the health sphere. But they are a start. Sooner or later the cost of our technology will compel us to transcend the taboo of the "R word." When this happens, we can hope that the ensuing, painful discussion about how to set limits will push us toward deeper reflection about the values at stake—and toward policies that more faithfully express our moral inclinations.

