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Regulating Managed Care Coverage: A New Direction For Health-Planning Agencies*

Thaddeus J. Nodzenski**

If managed care has its anticipated effect of reducing real or perceived excess capacity in the health care delivery system, the current capital-focused orientation of health-planning agencies, which regulate capital expansion in the health care industry, will become anachronistic.¹ Health-planning agencies should anticipate certificate of need (“CON”) applications to drop as managed care penetration and other cost-containing pressures being exerted on health care providers increase.² In states such as California and Minnesota, where managed care market penetration and influence are substantial, the “downsizing” of the medical industrial complex proceeds without the aid of health-planning regulation. For example, in California, where in 1994 approximately forty percent of the population was covered by health maintenance organizations (“HMOs”),³ the inpatient days per thousand population figure in 1996 was 518.8 as com-

* The thoughts, ideas, and positions expressed herein do not represent the policy of the Illinois Hospital & HealthSystems Association and are solely those of the author.

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1. See J. Duncan Moore, Jr., *CON Survival Struggle*, MOD. HEALTHCARE, Aug. 11, 1997, at 32 (Certificate of need (“CON”), the “state regulatory tool, invented in the 1970s to try to rein in galloping health care expenditures, has fallen largely out of favor in this market-driven age. In many states it has withered on the vine; in 13 it has been abolished outright.”). The following states have repealed their CON programs since 1983: Ohio in 1995; South Dakota in 1988; California and Colorado in 1987; Arizona, Kansas, New Mexico, Texas, and Wyoming in 1985; Minnesota and Utah in 1984; and Idaho in 1983. See Thom Wilder, *Ohio Law Highlights Sweeping Changes for State CON Programs*, 4 Health L. Rep. (BNA) 829, 829 (June 1, 1995). Louisiana also never enacted a CON program. See *id.*

2. See Moore, *supra* note 1, at 32 (according to Thomas R. Piper, the Executive Director of Missouri’s CON program, “[o]ne current leading argument is that market-driven managed care, with its emphasis on lower utilization, will supplant the regulatory apparatus. The more you have of one, the less you need of the other.”).

3. See HEALTH CARE STATE RANKINGS 1997 251 (Kathleen O’Leary Morgan & Scott Morgan eds., 5th ed. 1997).

pared with 738.1 days per thousand in Illinois, which had a relatively modest HMO market penetration of only twenty percent that year.⁴ Although capital improvements and changes in services of hospitals and other providers will always play some role in our health care delivery system, the diminishing volume of work for health-planners in these areas raises the question of whether they have a role to play in a managed care world, and if so, what role they should play.

As the health care system changes in response to the efficiency impulses of managed care, health-planners should refocus their expertise and efforts on how managed care and its regulation affect the delivery of health care. These agencies have focused for decades on whether certain proposed capital or service projects were “needed” under various and usually complex formulas and criteria.⁵ The agencies came into being as part of a broader cost-containment agenda in the 1970s. As payors and purchasers of health care pursued their own cost-containing initiatives which led to the birth and growth of managed care options (e.g., HMOs, preferred provider organizations, point of service plans), the growth of health care facilities has slowed, and in some areas hospitals have been forced to close.

The need for health-planning, however, has not gone away. Today, the overarching health care regulatory concern is managed care. The promise of the most aggressive forms of managed care is that wasteful health care costs will be contained by placing providers at financial risk through capitation payments, and that outcomes will be as good as or better than fee-for-service outcomes through greater accountability and standardization of medical care. Managed care’s price competition for provider services is designed, in part, to squeeze out the excess service and capital capacity in the health care system. Whether its cost-cutting efforts cut too deeply has triggered the call for mandated health care coverage.

As a result, we are witnessing the introduction of so-called “patient protection” legislation throughout the United States. Congress has already enacted a prohibition against “drive-through deliveries”⁶ and is now considering similar legislation

4. See HOSPITAL STATISTICS 55, 73 (American Hospital Association ed., 1998).

5. See, e.g., ILL. ADMIN. CODE tit. 77, § 1100 (1991).

6. The term “drive-through deliveries” refers to the practice of discharging new mothers and their babies within twenty-four hours of childbirth. See *Senate Panel Approves Federal Standards for Maternity Coverage*, 5 Health L. Rep. (BNA) 630 (Apr. 25, 1996). At least twenty-six states have enacted mandatory maternity length-

regarding “drive-through mastectomies.”⁷ In 1997, the Illinois legislature considered no fewer than sixteen bills covering nine mandated health care benefits, ranging from minimum lengths of stay to investigational cancer treatment.

The participants in our health care delivery system—payors, patients and providers—have always struggled with the conflicting goals of satisfying individual health objectives and serving some greater common good. The tension between these individual and group interests has engaged our country in a dramatic and intense discussion about how we balance the cost-quality trade-offs in health care. But how should policy makers assess mandated health care proposals? Should the focus be on patients as individuals with idiosyncratic health care needs and desires or as “statistical lives” within a group insurance plan? How can the system reconcile the conflicting goals of individuals as patients, who seek maximum care, and as premium payers, who seek the lowest premium?

Given our history of aggressively attacking illness and infirmity with an open checkbook to pay for seemingly unlimited health care coverage,⁸ the bias of legislators seems to be unsympathetic to the managed care message and approach. Managed care’s standardized, statistical approach to health care is virtually ignored in the current legislative environment because of the political difficulty in denying an individual’s unique need or desire for certain treatment.⁹

This problem is greatly exacerbated when an individual situation, such as a “drive-through delivery,” results in a bad outcome that is publicized across the nation by the news media and repeated enough to turn the matter into a national crisis.¹⁰ While the empirical data on length of stay for newborns and their mothers did not seem to support the legislative response,¹¹

of-stay legislation. See *New Round of ‘Anti-Managed Care’ Bills Await State Action, Blues Survey Finds*, 5 Health Care Pol’y Rep. (BNA) 290 (Feb. 12, 1997).

7. See Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996). The term “drive-through mastectomies” is used to describe the practice of discharging women shortly after having undergone a mastectomy, lumpectomy, or lymph node dissection. See *id.*

8. See LYNN PAYER, *MEDICINE AND CULTURE* 124 (1988).

9. See Terese Hudson, *Quick Fixes?*, HOSP. & HEALTH NETWORKS, Sept. 20, 1995, at 36; Anthony Man, *Drive-Through Deliveries—An Early Skirmish in the Battle Over Managed Health Care*, ILLINOIS ISSUES, May 1996, at 27, 27-28.

10. See Hudson, *supra* note 9, at 36.

11. See Julie A. Gazamararian & Jeffrey P. Koplan, *Length-of-Stay After Delivery: Managed Care Versus Fee-For-Service*, HEALTH AFFAIRS, Winter 1996, at 74; see also

opponents of such legislation could do little to stop it. This "drive-through delivery" example provides a model for illustrating how supporters of mandated health care benefits need to proceed under current conditions to get their mandate enacted. An individual horror story is worth hundreds of empirical studies when it comes to health care issues in legislative bodies.¹² Individual claims will typically triumph over more generalized claims based upon the greater good of the group.

Even when managed care's voice is heard in the current political processes across the country, the message is usually built upon demonizing the opposing side, with little concern for the actual costs and benefits of the proposed mandate.¹³ This environment is not conducive to making sound decisions about health care mandates. Indeed, as of October 1996, all state legislation regulating managed care had been enacted without considering evidence of its impact on the cost and quality of care.¹⁴

Developing a health-planning process to evaluate proposed managed care mandates given the inherent tension between serving the greatest good for the greatest number (utilitarianism), as evidenced by the appeal of managed care, and treating all individuals with equal dignity and respect (egalitarianism), as evidenced by our desire to meet individual health care needs, is the focus of this Article. It begins with a brief description of the utilitarian-egalitarian conflict that plays out in a managed care coverage debate. In developing the factors that ought to be considered in making more informed judgments about such proposals, this Article explores the philosophical tension between the utilitarianism of managed care and the egalitarianism of individual patients making claims for specific health care benefits.¹⁵

Stripped of emotional rhetoric, the managed care coverage debate results in a stalemate between utilitarianism and egalitarianism. Despite efforts by scholars such as Norman Daniels, no one has developed an incontestable and distributively just

George J. Annas, *Women and Children First*, 333 NEW ENG. J. MED. 1647 (1995); Fred J. Helinger, *The Expanding Scope of State Legislation*, 276 JAMA 1065, 1069 (1996); Hudson, *supra* note 9, at 36; Man, *supra* note 9, at 27-28.

12. See Hudson, *supra* note 9, at 36.

13. See GEORGE ANDERS, HEALTH AGAINST WEALTH 218 (1996).

14. See Helinger, *supra* note 11, at 1069.

15. The philosophical positions ascribed to patients and managed care in this Article are artificial in that no one is ever a utilitarian or an egalitarian all of the time. Managed care companies may certainly make individualized exceptions to their general coverage rules, and individual patients may forgo life-sustaining treatment to avoid bankrupting their estates.

scheme for allocating health care. Consequently, we are left trying to accommodate competing, divergent, and, at times, opposing views about such issues. From these philosophical extremes, however, one begins to see what factors merit consideration by policy makers assessing proposed minimum health care benefits. The public policy challenge is to devise a process for rationing managed care services that best allows for these opposing views to be heard and accommodated. If there is an ethical right to health care, it “cannot mean a right to every benefit that health care can provide, but rather only a right to a reasonable package of benefits that can be afforded without great sacrifice by society as a whole.”¹⁶

The second part of this Article describes the mission and function of a health care mandate assessment commission that offers a promising method to assess individual need, technology, the state of the economy, public preferences and expectations, and political realities in the provision of health care. Because the market may fail to allocate health care benefits in a socially desirable way, it is important to have some regulatory check on the abuses, excesses, or failures of the free market system in health care.

Current state health-planning agencies are ideal candidates for assuming the responsibility of monitoring whether the free market for health care coverage sufficiently addresses the allocation of health care resources. A health-planning commission supported by appropriate public input and guided by proper assessment guidelines is likely to offer a more thorough analysis of mandated benefit proposals than is taking place in the present legislative arena. The hope, of course, is that a better-informed legislature, armed with the findings and recommendations of an independent health-planning commission, will be more likely to enact sound health care mandate legislation than the current system yields on a piecemeal basis. Although politics will always play some role in the commission’s assessment of proposed mandates, this approach would help mute or dissipate its impact and give reason and reflection a better chance of guiding legislators.

16. CHARLES J. DOUGHERTY, *BACK TO REFORM* 44-45 (1996).

I. THE MANAGED CARE LANDSCAPE

Before delving more deeply into the utilitarian and egalitarian perspectives regarding the distribution of health care, it is important to highlight what may be overlooked in this debate. What is fundamentally at stake is not just the provision of health care. This conflict is really about how health care is financed. It is a debate about money, what sort of health care it should purchase, and on what terms. The question of how health care is financed has significant ethical implications.

Managed care is primarily a cost-containment strategy that hinges upon the elimination of unnecessary health care. It creates an environment for cost savings in two ways. First, and foremost, managed care places health care providers at financial risk for "over-treating" patients.¹⁷ Managed care's most aggressive cost-containment arrangement with physicians typically involves some sort of capitation payment and withhold or bonus arrangement to induce physicians to be more discriminating consumers of health care resources.¹⁸ A capitated physician, who only gets \$100 per patient per month from an HMO, is loath to spend more than \$100 per month treating a particular patient. Contrary to the traditional fee-for-service model, in which physicians are paid more for doing more, physicians under managed care fare better (financially) by providing less.

The fundamental belief of managed care is that patients will do as well as, if not better than, fee-for-service patients as they receive less care. When faced with medical uncertainty, managed care's default principle is to forgo unproven medical intervention. As long as the efficacy of most medical intervention remains unproved, managed care has ample opportunity to "manage" care by denying it. Sick patients generally take the opposite view: When in doubt, treat.¹⁹ So far, managed care's gamble that patients will do as well as they would do under a fee-for-service system seems to be paying off. Current outcome research, admittedly preliminary and undoubtedly flawed, suggests that managed care may not be placing patients at greater

17. See Marc A. Rodwin, *Conflicts in Managed Care*, 333 NEW ENG. J. MED. 604-07 (1995).

18. Capitated physicians are paid a fixed amount, regardless of the number of patients seen or the amount of services performed. Bonus payments reward physicians who limit referrals to specialists while withhold payments allow a portion of the physicians' salary to be withheld to pay for ancillary services. If residual funds remain, they are returned to the physicians.

19. See PAYER, *supra* note 8, at 124.

risk because of undertreatment.²⁰ The relative absence of medical malpractice cases against managed care organizations for undertreatment also encourages the trend toward cutting down on health care intervention.

It is still too early to tell whether the absence of proven poorer outcomes for managed care patients is due to the validity of the health care minimalist bias or whether managed care has simply attracted a healthier enrollment population that does not need or seek intensive treatments and therapies. The strongest evidence against managed care's "just say no" approach would be outcome data suggesting that managed care has either succeeded at "cream skimming" the healthiest enrollees into its managed care plans or that managed care jeopardizes patient welfare through undertreatment. Ironically, however, organized medicine has historically resisted the very sort of outcome research that it needs to test the assumptions of managed care.²¹

But how far can or should managed care go in cutting out so-called health care "overutilization"? This question leads to the second managed care cost-containment strategy: utilization review. While capitation payments to physicians act as a carrot to encourage efficient health care consumption decisions, utilization review provides the stick.²² Through case managers, managed care companies attempt to oversee health care consumption decisions to make sure that they conform with some sort of utilization standard or protocol that has been adopted by the company. When they do not, punitive measures against the physician may be inflicted (for example, financial penalties, termination from the provider panel).

Health care intervention conceivably falls along a complicated continuum of risks and benefits that could be characterized as follows:

1. Positively harmful care (negligent intervention or malpractice);
2. Wasteful care (when the cost of care significantly outweighs its benefits; futile care);

20. See Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFFAIRS, Sept.-Oct. 1997, at 7; Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance*, HEALTH AFFAIRS, Jan.-Feb. 1997, at 158, 159.

21. See CHARLES M. JACOBS ET AL., MEASURING THE QUALITY OF PATIENT CARE: THE RATIONALE FOR OUTCOME AUDIT (1976).

22. See William S. Andereck, *Balancing the Budget at the Bedside*, HEALTHCARE FORUM J., Sept.-Oct. 1994, at 32, 34.

3. Marginally wasteful care (when the cost of care marginally outweighs its benefits);
4. Break-even care (when the costs and benefits of care are equal);
5. Marginally useful care (when the benefits of care marginally outweigh its costs); and
6. Positively indicated care (when the benefits of care clearly outweigh the costs; e.g., life-saving emergency medical treatment).

Where a particular intervention falls on this continuum for a particular patient may depend upon many factors, such as the patient's condition (including severity of illness and any co-morbidity), the effectiveness of the intervention for this particular patient, the likely outcome for the patient following the intervention, and the cost of the intervention. Even with this information, the cost-benefit calculation cannot take place without an objective or uncontested valuation system that allows a patient, a payor, and a provider to agree on whether benefits outweigh costs. Benefits and costs are not simply matters of dollars and cents. They involve issues such as the quality of life of the patient and the social costs of providing care to some patients at the expense of others.

HMOs in the real world, however, do not appear to be bogged down by the obstacles to the identification and maximization of health care efficiency. The HMOs' utilization protocols allow them to make allocation decisions and physicians are encouraged, financially and otherwise, to comply with the protocols and to impose their own bedside rationing. As already mentioned, wherever and however HMOs draw the line on coverage, they seem to be placing their members at no greater health risk. It remains to be seen, however, as managed care competition matures, whether the drive to reduce cost will cause HMOs to offer so little care that patients are at greater health risk than they were under the fee-for-service payment system. If we reach this point, we will also have to decide whether this added health risk is socially acceptable to patients, purchasers, providers, and policy makers.

The two poles of the continuum, clearly harmful and clearly helpful care, do not raise a conflict. No one thinks that our health care financing system should fund care that is negligent or futile. Nor does anyone seek to deny coverage for care where benefits clearly and substantially outweigh costs, such as in the

case of a true medical emergency. The battle line, however, seems to be drawn over whether any care of marginal utility should be provided to a patient if the costs (in the payor's view) outweigh the benefits. Physicians seem to be comfortable with denying care that is either futile or highly unlikely to yield results when the costs to the patient outweigh the benefits to the patient. The physicians may not, however, wish to consider the insurer's costs in this analysis.

The managed care company, by contrast, insists that its costs be considered through the implementation of incentive payments to the physician and utilization protocols. It is not clear where HMOs typically draw the line on when to cut off treatment; however, they may often draw the line well below the patient's cut-off point. The move down the continuum from futile care toward marginally useful care is where the egalitarian-utilitarian conflict plays out. A physician, governed by the patient-centered ethos, will want to provide any care that may be beneficial to the patient, regardless of its social costs. The efficiency-driven HMO, however, may be willing to sacrifice one patient's benefit for the advantage of other enrollees.

II. THE PHILOSOPHICAL EXTREMES

A. *Managed Care's Utilitarianism*

Utilitarians evaluate actions and policies by their potential for maximizing benefits over costs. Utilitarians give moral primacy to ideas such as the common good or the greatest good for the greatest number.²³ Utilitarianism is outcome-oriented, measuring the morality of an act by its empirical results rather than by any theoretical claims.²⁴ Utilitarianism fits in nicely with managed care's medical skepticism, in that care managers tend to avoid providing care that is not recognized as effective. In order for an HMO to authorize certain coverage, the HMO needs to believe that the proposed care is proven or likely to improve the patient's condition significantly.

To the extent that health care can cure disease, alleviate pain and suffering, and prolong life, it is obviously beneficial. Con-

23. See Joseph Fletcher, *Ethics and Health Care Delivery: Computers and Distributive Justice*, in *ETHICS AND HEALTH POLICY* 99, 103 (Robert M. Veatch & Roy Branson eds., 1976); Gene Outka, *Social Justice and Equal Access to Health Care*, in *ETHICS AND HEALTH POLICY* 79, 85 (Robert M. Veatch & Roy Branson eds., 1976).

24. See CHARLES DOUGHERTY, *AMERICAN HEALTH CARE: REALITIES, RIGHTS, AND REFORMS* 35-37 (1998).

versely, the cost of illness, disability, and death has great adverse consequences, not only for the individual, but also for the individual's friends and loved ones and society at large, due in part to the loss of the person's productivity (not to mention the continued payment of health insurance premiums). However, addressing individual instances of health care allocation is not the true focus of managed care's utilitarianism.

Instead, managed care seeks to maximize the largest aggregate utility through the establishment of general rules and policies.²⁵ This concept is known as "rule utilitarianism." The "decent minimum" level of coverage for the rule utilitarian is the minimum cost-effectiveness that any treatment must yield to be included in the benefit package. Individual coverage decisions are governed by the enrollee's contractual promise to abide by the HMO's rule or policy that addresses the requested care, regardless of its utility to the particular patient, in return for paying a lower premium, compared to indemnity coverage. HMO enrollees cannot complain later, when they become sick, that they lack full indemnity coverage. They are entitled to only the type and level of care for which they contracted. Otherwise, the entire system of contracting for health care coverage would become meaningless. Rule utilitarianism strives for maximum benefit in the aggregate over the long run.²⁶ One such rule is the enforceability of contracts.

On the positive side, rule utilitarianism provides a clear policy-making framework for confronting the scarcity of medical resources.²⁷ Costs and benefits of various coverage decisions need to be quantified. The overall impact of the approach must be assessed for the entire covered population. How many "covered lives"²⁸ will be affected? How? For how long? At what cost? For what outcomes? If we provide the care to X, what impact will it have on Y? Managed care deals with health care resource allocation in the context of its covered community. These difficult and potentially emotional issues are diffused by the utilitarian's detached, aggregated, and empirical approach to the problem.²⁹ In addition, by allocating health care resources

25. See *id.* at 37-41.

26. See *id.* at 37.

27. See *id.* at 38.

28. The term "covered lives" refers to the number of patients enrolled in a particular plan.

29. See DOUGHERTY, *supra* note 24, at 38-39.

more efficiently, more people could have increased access to care and, on average, achieve better outcomes and health status.

On the negative side, the empirical challenge of quantifying aggregate utility for the entire covered population is itself morally offensive when the coverage rules “de-value” or sacrifice certain lives (for example, the elderly, the chronically ill, and the disabled). General rules that tend to benefit most of the insured most of the time may be untenable for people who seek coverage as individuals in the short run.³⁰ As Gene Outka states, “Once we have witnessed tangible suffering, we cannot just return with ease to public policies aimed at statistical patients.”³¹

Yet the choice of sacrificing one for the many may be a false choice. Joseph Fletcher, a utilitarian, has made the point that the choice is not one of good over evil or benefit over cost.³² Rather, the choice is between saving this one at the expense of many other “ones.”³³ As he states, “The ‘greatest number’ is not an abstraction; it is the sum of real, particular and personal individuals.”³⁴ Thus, the health care allocation dilemma forces choices between competing goods, not choices between good and evil or right and wrong.³⁵ Identifying this dilemma, however, does not solve it. Utilitarianism remains an empty rationalization for anyone who must actually confront and suffer as a result of such choices.

We also lack an agreed-upon calculus for identifying the value of a particular coverage rule.³⁶ Is well-baby care more valuable than well-elder care? What sort of empirical data can even begin to address such a choice? Thus, despite the surface appeal of providing a detached empirical framework for making thoughtful health care allocation decisions, managed care’s utilitarianism fails to meet such expectations. It fails because it is based upon the false premise that such an analysis is objectively possible, and because it serves only to shield us from having to confront the tragic choice of saving one life instead of another.

30. *See id.* at 40.

31. Outka, *supra* note 23, at 96.

32. *See* Fletcher, *supra* note 23, at 107.

33. *See* Howard Brody & Carolyn M. Clancy, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338, 338-39 (1995).

34. Fletcher, *supra* note 23, at 107.

35. *See id.*

36. *See* DOUGHERTY, *supra* note 24, at 39.

B. *The Patient's Egalitarianism*

For the egalitarian, a person's moral dignity is based upon one's incalculable intrinsic worth.³⁷ Because of their intrinsic value, comparing or ranking patients and their medical needs is inappropriate.³⁸ Denying health care because one is weak, poor, old, foolish, or otherwise of less use to some larger community is never merited.³⁹ For egalitarians, the only proper ground for distributing health care is illness.⁴⁰ The physician is interested in achieving substantive egalitarianism in that the physician wishes to provide the amount of health care required to achieve a particular outcome. Rich or poor, all patients with the same disease get the same complete treatment. In making treatment decisions, a purely egalitarian physician does not consider the needs of other patients or the cost of care.⁴¹

Naturally, this approach to the allocation of scarce health care resources is not without flaws. The patient's health care needs and desires do not exist in a vacuum. The payor, relying on the patient's contractual promise to abide by the plan's coverage limits, and the other policyholders and patients are also part of the landscape. The micro-allocation decision at the bedside of a particular patient may have a profound and adverse impact on the rest of the parties that have some interest regarding the allocation of scarce medical resources. Joseph Fletcher argues that the "ancient one-to-one medical ethic is too simple, and it therefore falsifies ethical problems."⁴² In Fletcher's utilitarian view, "sophisticated discussion of the problem of social justice and the delivery of health care is rich with such terms as priorities, relative claims, triage, value judgment, . . . cost-benefit balance, [and] tradeoff . . ."⁴³ In other words, patients who make the egalitarian claim that cost is not a relevant health care consideration are either deluded or deluding.

Even within the physician-patient relationship, the physician's treatment analysis rests to some degree on some sort of utilitarian cost-benefit analysis in selecting and recommending an ap-

37. *See id.* at 52.

38. *See id.* at 53.

39. *See id.* at 53.

40. *See* Bernard Williams, *The Idea of Equality*, in *Justice and Equity* 127 (Bedau H. Engelwood ed. 1971).

41. *See* Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 *AM. J.L. & MED.* 37, 70 (1993).

42. Fletcher, *supra* note 23, at 104.

43. *Id.*

proach to that patient.⁴⁴ Informed consent law generally requires the physician to present the patient with treatment options along with their risks (i.e., costs) and benefits. Even doing nothing is not risk-free or without cost. There is no escaping such an analysis, so why not factor in the cost to the HMO or society? Moreover, the decision to pull out all the stops for one patient is an act that robs not only the managed care entity, but it also robs other patients. Once the scarcity of health care resources is acknowledged, the impact on others in the affected community should not be ignored. Certainly, no one would accept (except perhaps the benefitted patient and the physician) the allocation of an entire HMO's resources on one patient to prevent that patient's death for three months. Yet, by what principle can the egalitarian refuse this patient without relying upon some sort of utilitarian analysis?

Another weakness of egalitarianism rests on our intuitive sense that we are not all equal. Some people may believe that they are more entitled to health care than others. People who engage in a lifetime of high-risk behavior might not have the same moral claim to care as someone who lives conservatively. This strong sense of individuality is denied by egalitarianism. If everyone is intrinsically equal, no one is special. Yet, each of us and our loved ones believe deeply that we are. Egalitarianism flies in the face of some of our most deeply held views about ourselves and others.

III. THE HEALTH-PLANNING MANDATE ASSESSMENT COMMISSION PROPOSAL

One may safely conclude that egalitarianism and utilitarianism are irreconcilable. Nevertheless, decisions about health care mandates persist. The challenge is to devise a process that allows the egalitarian and utilitarian merits of a particular proposed benefit to be debated openly and thoroughly in a more systematic, thoughtful, and empirical way. Until we adopt an approach that systematizes the way legislators address certain questions about mandated health care benefits and protects legislators from the emotional assaults likely to occur under the current system, piecemeal proposals will likely flourish. The ad hoc approach is not conducive to the development of a sound, cohesive health care system.

44. See Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Ethical Issues in Managed Care*, 273 JAMA 332 (1995).

Some states already have begun to experiment with proposals that seek to avoid the ad hoc approach to regulating access to health care. For example, rather than addressing minimum length-of-stay issues on a procedure-by-procedure or condition-by-condition basis, a proposal adopted in Connecticut provides the following approach:

1. Physicians may ask managed care companies for permission to exceed the plan's recommended length of stay.
2. The plan's medical director must respond to the faxed request within three hours or the extended stay request is deemed to be granted.
3. If the medical director denies the request within the allotted time, the doctor and the hospital are immune from liability for any adverse outcomes associated with the premature discharge.
4. The managed care company bears sole responsibility and liability for adverse outcomes.
5. The physician and patient are entitled to an appeal process before an outside peer review organization to evaluate the denial of the extended length of stay.⁴⁵

This approach allows health plans, patients, and physicians to reach length-of-stay decisions on a case-by-case basis without involving the legislature or a government agency. The added liability exposure to the health plan for the denial of extended stay requests gives patients and physicians additional leverage to get such requests approved.

However, medical malpractice liability may be an empty threat against managed care abuse for at least two reasons. First, the federal Employee Retirement Income Security Act ("ERISA")⁴⁶ may preempt medical malpractice claims for the vast majority of employees receiving their health care coverage from employers with ERISA plans.⁴⁷ Second, to sustain a claim, a patient must suffer a significant injury caused by the denial of an extended stay request. In addition to having a theoretical claim, patients need to incur sufficient harm to make the case

45. See An Act Concerning Managed Care, H.B. 6883, Reg. Sess. (Conn. 1997). Items 3 and 4 were not included in the final enactment. See 1997 Conn. Acts 99 (Reg. Sess.).

46. 29 U.S.C. §§ 1001-1461 (1994).

47. ERISA is a comprehensive federal employee benefits law which contains a broad preemption provision stating that ERISA "shall supercede any and all State laws insofar as they may now or hereafter related to any employee benefit plan." *Id.* § 1144(a).

financially attractive to attorneys. To the extent such denials are not sufficiently harmful to the patient, litigation is unlikely. Issues of causation further chill the zeal of even the most ardent malpractice attorneys. However, the worst aspect of this approach is its reactionary feature. Patients are generally more interested in obtaining adequate care through an extended stay than a medical malpractice claim. Damages are hardly an adequate substitute for a good health care outcome.

Minnesota, on the other hand, is considering a bill that would create a cost-benefit review process for health care mandates.⁴⁸ Under this bill, the state directors of health, commerce, human service, and employee relations would assess proposed health care benefit mandates and their social and financial costs prior to their enactment. Once a mandate is proposed, it would be assessed, and the assessors may recommend that the problem addressed by the mandate be resolved without legislation. Because such assessments would be time consuming, it is likely that a proposal made in one legislative session would not be acted upon until the following session.

This proposal attempts to systematize the way health care mandates are legislated, but this government-run, cost-benefit analysis needs to be structured in a way that helps minimize the possibility of abuse. Accordingly, legislatures in states with a health-planning agency should redirect that agency's energies to the assessment of health care mandates, governed by statutory provisions regarding its mission, membership, and processes.

A. *The Commission's Mission*

One of the global messages from the demise of President Clinton's health care plan and the hope placed upon managed care to strike the proper cost-benefit balance in health care is that this society, for the moment and the foreseeable future, believes that free market forces should address our health-consumption decisions. In the debate over choosing between imperfect market forces and imperfect regulation, the market won. This victory, of course, does not prove that the market approach is absolutely and always superior to a "command and control" regulatory approach, or that markets need not be regulated. Rather, the message from the fall of "Clintoncare" and the rise of managed care is that we are willing to favor a market

48. See Health Care Consumer Protection and Assistance, S.B. 320, 80th Legis. Sess. (Minn. 1997).

approach to distributing health care. Whether the current debate over managed care regulation is evidence that the tide has shifted against market favoritism remains to be seen. For now, however, our collective bias still favors a market approach to health care coverage over government-mandated coverage.

Accordingly, the mission of a health-planning mandate assessment commission should be to presume that the free market provides the best vehicle for resolving the many complex and idiosyncratic tensions and trade-offs between containing health care costs and providing access to care. The primary purpose of commission review is to determine if the market has failed or is likely to fail in providing the coverage that is in the best interest of the insured.⁴⁹ Some of the environmental factors conducive to an insurance market that is responsive to the needs of the insured include the following:

1. That the insured have a strong incentive to move to health plans offering the proposed health care mandate;
2. That health plans in the market are free to offer the proposed benefit; and
3. That new health plans willing to offer the proposed benefit may freely enter the market to meet the demand for this benefit.⁵⁰

In his defense of a free-market focus for the traditional CON health-planning process, Clark Havighurst suggests: "If competitive conditions are truly healthy, with barriers to entry and innovation low, the market could be deemed to reflect consumer preferences well enough to validate the cost-containment mechanisms in place as optimal for consumers' needs."⁵¹

Applying this logic to the current proposal, if the market is sufficiently responsive to consumer concerns, the lack of a proposed mandate being offered by some plans should not justify legislative action. If, however, no plan is likely to offer a mandate that has widespread consumer support, such market failure may warrant a legislated coverage mandate. Thus, as a threshold matter, the commission needs to assess whether there is a market failure that warrants further analysis of the proposed mandate.

49. See generally, CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 257 (1982).

50. See *id.*; see also DOUGHERTY, *supra* note 16, at 151.

51. HAVIGHURST, *supra* note 49, at 300.

In addition to studying whether competitive market conditions are suspect or inferior, the commission needs to consider the following factors in its deliberations.

1. Societal Factors:

1. The extent to which the proposed mandate is needed by the affected community;
2. Current availability and utilization of the proposed coverage within the affected community;
3. The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the affected community;
4. The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit;
5. All relevant findings bearing on the social impact of the absence of the proposed benefit;
6. The extent to which similar mandated benefits in other states have affected the quality, cost and availability of the proposed service mandate.

2. Financial Factors:

1. The extent to which the proposed benefit would increase or decrease the cost treatment or service;
2. The extent to which similar mandated benefits in other states have affected charges and payments for services;
3. The impact of the proposed benefit on the administrative expenses of health care insurers;
4. The impact of the proposed benefit on the cost of benefits to purchasers;
5. The impact of the proposed benefit on the total cost of health care within the state;
6. The extent to which employers already provide the benefit to their employees, and the cost and benefit of that provision;
7. The impact of the proposed mandate, if enacted, on other benefits typically provided by insurers.

3. Medical Factors:

1. The extent to which the proposed benefit would increase the appropriate use of a treatment or service;
2. The extent to which outcome research suggests that the mandate improves health care quality or reduces health care costs;
3. The extent to which the health care delivery system can supply the benefit throughout the community.

Obviously, these factors are not exhaustive of all that a particular state may wish to explore to reach sound policy decisions regarding health care mandates. These factors are merely suggestions for limiting the debate to a more rational consideration of the issue. Hysteria, of course, cannot always be eliminated, but at least an approach that is structured to look at empirical data regarding a proposed mandate should help inform the judgment of the commission members and perhaps offset some of the emotional heat with empirical light.

B. The Commission's Membership

The commission's membership should have sufficient representation from payors, such as the business community; providers, including hospitals, physicians, insurers, and HMAS; and consumer advocates. The members of the commission must represent a broad cross-section of the community, possess expertise, and maintain varying perspectives so that the commission has the ability to speak authoritatively on these issues. Commission membership will be one of the keys to obtaining a well-rounded, thoughtful perspective on a proposed health care mandate.

C. The Commission's Jurisdiction

Not all legislative proposals regulating managed care practices should be referred to this commission. The commission's main contribution to the legislative process is its expert and thorough analysis of the cost-benefit effects of a proposed health care coverage mandate. The combination of medical, financial, and social consequences that may flow from such proposals are so complex and highly charged that commission review would be beneficial to a legislator's consideration of the proposal. By contrast, bills involving such matters as enrollee grievance procedures, gag clauses, managed care malpractice liability, and provider due process rights, while complex in their own way,

raise neither the medical complexity nor the emotion that attends a mandated coverage proposal. The commission's special expertise in the area of health care economics would not significantly improve a legislator's ability to assess the merits of non-mandate managed care reform proposals. Thus, the commission's jurisdiction should be limited to bills that only seek to define the minimum benefit coverage package of managed care plans.

D. The Commission's Process

Under this proposal, supporters of health care mandates should be required to justify the proposed mandates with whatever arguments, claims, and data are available. In other words, the burden of proof regarding the mandate will rest with its proponent. The difficulty with this approach is that certain mandate proponents may not have the time or the data to satisfy all of the criteria in any given case, so that as a practical matter, their proposals would be barred. Also, for some proposals, no data are available (for example, cost-benefit analysis of length-of-stays for mastectomies), and added time might not allow proponents to generate or find such data. In other cases, hard data may suggest that the proposal is unnecessary (for example, maternity length-of-stay mandates), but the issue is so politically sensitive that it still may be recommended by the commission. In light of all of these complex and unpredictable contingencies that present themselves with respect to proposed health care mandates, the assessment criteria that define the commission's mission should serve as mandate assessment guidelines, not prerequisites. In this way, the mandate proponents and the commissioners could consult the guidelines on a case-by-case basis and apply each guideline to the extent it is feasible to do so. Although lack of supporting evidence under each of the assessment guidelines should not automatically disqualify a proposal, a proponent failing to support a proposal with evidence under all of the guidelines should be required to explain such failure to the commission.

Although this process will likely raise the cost of advocating for a particular mandate, and thus may reduce the number of proposals being offered or recommended, it provides a level of deliberation that is currently missing. To offset some of the inherent bias against recommending mandates, procedural rules should be established for the commission so that a mandate pro-

ponent need only make a prima facie or credible showing to convince a simple majority of the commissioners that the proposal has merit. Once the commission makes this finding, the burden of persuasion would shift to the mandate's opponents to convince a super-majority, for instance, two-thirds of the commissioners, that the proposal lacks merit. These burden-shifting and majority vote requirements could be employed to offset the inherent obstacles within this process to support proposed health care mandates.

E. In Defense of the Proposal

This proposal has merit for at least four reasons. First, by re-directing its capital-focused expertise to service mandates, the commission can investigate and debate the alleged abusive managed care practice of underserving enrollees in a forum designed to look at the health care system as a whole.

Second, the addition of commission review into the legislative process also will allow emotions surrounding the event—precipitating the “there ought to be a law” sentiment of the public, media, and politicians—to dissipate. Public and media attention to issues in general is short-lived, but mandate legislation virtually lasts forever. By subjecting proposed mandates to a more reasoned and, therefore, time-consuming process, their need can be assessed without the glare and heat of a single, tragic event supposedly signaling a major crisis in the health care delivery system. As Guido Calabresi and Philip Bobbit recognized twenty years ago in their classic book, *Tragic Choices*, the passage of time

permits the description of the actors involved in abstract terms and thereby encourages the perception of the tragic choice in theoretical terms; and it allows criticism of past decisions without indicting the present decision making. The scholarly commentary on tragic choices amply documents the vast difference it makes to society whether lives are confronted as statistical or real.⁵²

In short, slowing down the process allows reason to overtake emotion.

Third, this added review in the mandate-enactment process will give the corrective measures of the marketplace a chance to address and eliminate the problem without the need for legislation. Although many states have enacted “drive-through” legis-

52. GUIDO CALABRESI & PHILIP BOBBIT, *TRAGIC CHOICES* 68 (1978).

lation, health plans easily could have gained a marketing advantage by distinguishing themselves from plans that failed to provide a sufficient length-of-stay for newborns and their mothers. If the public viewed such coverage as a sign of a better health plan, the plans providing inadequate coverage would lose market share. Health-planners would be required to assess whether the market has or will adequately address a particular coverage dispute before recommending more drastic legislative action.

Lastly, the commission's decisions are not final; they are only studied recommendations, possibly with dissenting views, to the legislators that created the commission. Legislators are free to accept or reject the views of the commission regarding a proposed benefit mandate if and when it comes to a vote. The commission does not eliminate political accountability. It simply affords all of the effected parties time to thoroughly assess a proposed health care coverage mandate and to determine if the immediate appeal of the proposal is exaggerated. If the case for the proposal is compelling after this process is completed, legislators can be more confident that their vote in favor of the proposal is right.

Although the commission will not yield a perfectly well-balanced or ideal minimum health care benefits package, it offers advantages that our current legislative process lacks. No humanly created entity will be entirely free of political or philosophical bias. Nor will it be free of errors in judgment or perception regarding the claims made before it. The public policy challenge, however, is not to choose between perfect competition and perfect regulation. The challenge is to create sufficient tension between imperfect competition and imperfect regulation so that the excesses of either force do not always control how health care is provided. This approach does not guarantee that poorly designed mandates will be prohibited or that good ones will become law. However, it would be a vast improvement over the ad hoc approach most states and Congress have adopted for defining a minimum health care benefits package.

F. Why Health-Planning Agencies?

State health-planning agencies have been struggling with issues such as the need for health care facilities, equipment, and

services since the 1970s.⁵³ The complex need analysis under which health-planning agencies determine whether there is a “need” for facilities, equipment, or services demonstrates these agencies ability to determine the “need” for a proposed health care mandate.⁵⁴ Health-planning agencies have extensive experience and expertise in assessing the needs of the health care delivery system, as evidenced by their comprehensive substantive regulatory provisions, governing everything from the need for more magnetic resonance imaging equipment to non-hospital based ambulatory surgery.⁵⁵ The breadth and depth of the analysis undertaken by these agencies makes them perhaps the only state agency capable of providing the sort of needs analysis that health care mandate proposals deserve.

Thirty-seven states still have health-planning agencies. As managed care cost-containment pressures diminish the role of health-planning with respect to capital and service intensity on the provider side, these agencies can move naturally to a needs assessment of health care coverage proposals on the payor side.

IV. CONCLUSION

As patients, we expect our physician to be devoted entirely to our well-being, even at the expense of others. As insureds, we expect our HMO to provide the most health care at the lowest premium. This Article illustrates that neither the egalitarian nor the utilitarian perspective takes us where we want to go as patients and premium payors. We are as schizophrenic as our health care system. Given our pluralistic attitudes about managed care coverage questions, health-planners should favor a free-market allocation of managed care services subject to a market-failure analysis. Under this approach, legislators could assess proposed health care mandates outside of the politically charged, emotionally draining debate that currently takes place. It imposes a more analytical health-planning approach. It requires mandate proponents to appear before an independent health-planning mandate assessment commission and overcome the presumption against legislating health care benefits by offering arguments based upon data, health policy, individual rights,

53. See, e.g., Illinois Health Facilities Planning Act, 20 ILL. COMP. STAT. 3960/1-19 (West 1996) (codifying Pub. Act 78-1156, effective Aug. 27, 1974).

54. See, e.g., ILL. ADMIN. CODE tit. 77, § 1100 (1991).

55. See *id.*

moral philosophy, economics, or whatever compelling reasons they may have for proposing a particular mandate.

The ability to debate mandated health care benefits through traditional legislative processes is deficient, and a new approach should be adopted. Addressing these issues in the context of a widely representative health-planning commission applying a defined set of factors in its deliberations would introduce more reason and reflection into the way we mandate minimum health care benefits within our health care system.