Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program

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I. INTRODUCTION

Since 1980, the federal government, states, and private purchasers of health care services have determined that the amount of resources devoted to purchasing health care services is too great. Consequently, the 1980's have witnessed unprecedented efforts by these purchasers to cut spending for health care services and to adopt payment strategies to purchase health care services more efficiently. For private purchasers, i.e., business, private insurance companies, and Blue Cross and Blue Shield plans, these strategies include chiefly preferred provider organizations[1] and prepaid health plans such as health maintenance organizations.[2] Similarly, states and the federal government have adopted comparable strategies for their public health insurance programs.[3] These strategies limit public expenditures for health care services chiefly through rate regulation.[4]

The underlying theory of nearly all of these public and private strategies is to put the providers of health care services, e.g., hospitals

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[1]A PPO is as an arrangement between selected providers and at least one group purchaser whereby the services of the providers are purchased for a specified group of individuals at a negotiated rate. *See* AM. HOSP. ASS'N, STATE REGULATION OF PREFERRED PROVIDER ORGANIZATIONS: A SURVEY OF STATE STATUTES (1984).

[2]In a prepaid health plan, the consumer or someone on his behalf pays a fixed amount to the provider, and in return, the provider furnishes any volume of covered health care services irrespective of their cost. A health maintenance organization is an example of a prepaid health plan. A prepaid health plan is distinguished from conventional health insurance in that the provider rather than the health insurance company is at risk for the cost of services to beneficiaries over and above the premiums.

[3]The Social Security Act authorizes state Medicaid programs to purchase health care services for certain groups of patients from specified providers on a prepaid basis. 42 U.S.C. § 1396 (1982 & Supp. 1985). To use this strategy, state Medicaid programs must ensure that the providers have a plan to manage the care of individual patients properly. *Id.* § 1396a(a).

[4]In rate regulation schemes, which are directed chiefly at institutional providers, the payer regulates the amount paid for a unit of services, i.e., the price per case as under the Medicare prospective payment system, or even the entire amount the program will pay an institution annually as under revenue caps or budget review strategies.

and physicians, at risk financially for the cost of services that exceed defined norms. This approach involves putting a limit on what the purchaser will pay for services in a given case or group of cases, with the result that if the provider's costs of the care exceed the limit, the provider must absorb the excess costs. The objective of these strategies is the same: to encourage providers to become more conscious of the costs of treating patients and to use less resources and thus incur fewer costs in the treatment of patients.

However, these strategies fundamentally change the nature of the decision-making of health care providers with respect to the medical treatment of individual patients. Simply, providers must consider the cost of the treatment as well as its efficacy. Specifically, providers can no longer adhere to what Dr. Avedis Donabedian has called an absolutist standard of health care quality in which providers specify care based on what they consider best for patients, even if benefits are quite incremental, without regard to costs.[5] Also, the specter of financial liability for excessive services on the part of the provider directly is a troublesome ingredient of the decision making process as it pits the provider's self-interest squarely against the patient's need for an above average amount of health care services in a given instance. This raises the possibility that the quality of medical treatment may be compromised. This possibility, which must be addressed in the design and implementation of any purchasing strategy that places the provider at risk financially, presents a host of important ethical and, in the case of public programs, political issues, some of which will be explored in this Article and this symposium.[6]

This Article delineates the central issues presented when government adopts a strategy to purchase health care services more efficiently and to reduce the resources it devotes to health care. It reviews how the American health care system reached the point where purchasers of health care services have almost uniformly decided to curtail the resources they commit to purchasing health care services and the resulting perception among providers, patients, and the public that hard choices about the allocation of limited resources are now required.

But, the chief objective of this Article is to analyze how the Medicare

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[5]Donabedian, *Quality, Cost, and Clinical Decisions*, 468 ANNALS 196, 200 (1983).

[6]This dilemma and its philosophical implications have been analyzed by several scholars. *See* Cassel, *Doctors and Allocation Decisions: A New Role in the New Medicare,* 10 J. HEALTH POL. POL'Y & L. 549 (1985); Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 L. MED. & HEALTHCARE 245 (1984); Mariner, *Diagnosis Related Groups: Evading Social Responsibility*?, 12 L. MED. & HEALTHCARE 243 (1984); Morriem, *The MD and the DRG*, HASTINGS CENTER REP., June 1985, at 19; Veatch, *DRG's and the Ethical Reallocation of Resources*, HASTINGS CENTER REP., June 1986, at 32.

prospective payment system makes fair decisions about the allocation of hospital services to Medicare beneficiaries. In this reform of the payment methodology for hospital services,[7] Congress endeavored to purchase health care services more efficiently for the nation's elderly and disabled and consequently put hospitals at risk financially for costs of treatment that exceed defined norms. In designing the administrative structure for the prospective payment system, Congress specifically addressed the three critical problems facing public health insurance programs that endeavor to curtail expenditures by putting providers at risk financially: (1) how to make fair decisions at the societal level as to what resources in the control of government should be devoted to the health care of the program's beneficiaries, (2) how to ensure that providers, who are at risk for especially costly services, make fair decisions about what resources should be used to care for beneficiaries, and (3) how to protect adequately beneficiaries' interests in obtaining health care services under the Medicare program.

II. The Central Issues

How much of society's resources should be devoted to health care and how those resources should be distributed among members of society — particularly the more disadvantaged—are fundamental questions of distributive justice beyond the scope of this Article.[8] But these questions are not just abstract philosophical questions of remote importance. They are concrete questions that continually and directly face American health policy. In particular, these questions confront federal and also state policy makers daily as they address the health care needs of their citizens and as they design and implement public health insurance programs. Thus it is useful to explore some of the central issues involved with the general question of how much of society's resources should be devoted to health care and how those resources should be distributed among society's members before reviewing the history of how this nation has endeavored to resolve these issues generally and in the context of the Medicare program.

First and foremost is the issue of whether health care is such an important societal good that it should be accorded special treatment vis-a-vis other societal goods competing for society's resources. Second, who

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[7]Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, § 601(c)(1), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww (Supp. 1985)).

[8]*See, e.g.*, N. Daniels, Just Health Care, 1-74 (1985); Daniels, *Rights to Health Care and Distributive Justice: Programmatic Worries*, 4 J. Med. & Phil. 174 (1979); Fried, *Rights and Health Care - Beyond Equity and Efficiency*, 293 New Eng. J. Med. 241 (1975); Miller & Miller, *Why Saying No to Patients in the United States Is So Hard: Cost Containment, Justice and Provider Economy*, 314 New Eng. J. Med. 1380 (1986).

is making the decisions about the amount and allocation of these health care resources at the societal level and also at the individual level? Third, what consumer interests in health and health care services should be protected while making those choices?

Decisions about the amount and allocation of medical resources are made in two contexts, the societal context and the individual context. The societal context involves decisions about the amount of society's resources that should be allocated to health care services vis-a-vis other unrelated needs, as well as decisions as to what groups these medical resources should be targeted in order to assure preservation or enhancement of the lives of society's members in the aggregate, i.e., "statistical lives."[9] The individual context is fundamentally different; it involves whether and how society's resources should be dedicated to meet the specific health care needs of identifiable individuals.

With respect to whether health is of such value that it should be treated specially, the philosopher Norman Daniels has characterized the key aspects of this issue in developing a philosophical theory of health care:

> In short, a theory of health care needs must come to grips with two widely held judgments: that there is something especially important about health care and that some kinds of health care are more important than others.[10]

Whether it is even philosophically appropriate to give health care special status is a troubling question of distributive justice. But it is fair to say that this society has made a collective judgment that health care has special value and that some measures, e.g., public health insurance programs, over and above market forces should be invoked to ensure that this good is widely distributed. The federal and state governments have concurred in this assumption, albeit with waning enthusiasm in

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[9]*See* Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, 40 L. & CONTEMP. PROBS. 231 (1976) [hereinafter Blumstein, *Constitutional Perspectives*]; Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSRO's*, 70 NW. U.L. REV. 6, 22-23 (1975) [hereinafter Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs*]; *see also* Fried, *The Value of Life*, 82 HARV. L. REV. 1415 (1969).

A "statistical life" is basically a measure representing one unit of human existence, whereas an identifiable life is recognized as a life of a specific human being. Havighurst and Blumstein more aptly articulated the difference between "statistical" and "identifiable" lives in colorful and precise examples of these concepts: an identifiable life is an "intercontinental balloonist lost at sea" whereas statistical lives are those which "predictably will be lost as a result of a societal undertaking such as maintenance of an automobile-based economy or construction of a bridge or tunnel." Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs, supra* at 21-22.

[10]Daniels, *Health-Care Needs and Distributive Justice*, 10 PHIL. & PUB. AFF. 146 (1981); *see also* N. DANIELS, *supra* note 8, at 1-17.

recent years. However, important evidence suggests that the American public does not believe that this nation and its government should limit their financial and ideological commitment to ensuring high quality, accessible health care services for those in need.[11] Nevertheless, the degree to which this nation and its governments should treat health care as special and invoke special measures to assure wide distribution of health care services as well as the nature of these special measures have been the central themes of health policy since 1965.

Daniels' second observation raises the more important inquiry from a practical perspective and perhaps the key ethical dilemma for the American health care system today. Clearly, all health care services are not the same and have varying degrees of worth, especially when compared with other societal needs. This dilemma is perhaps best exemplified by some of the trade-offs that the federal government has made with respect to resources devoted to health care needs of infants. For example, since 1981, the federal government has reduced funding for prenatal health and nutrition programs for millions of mothers and children[12] while at the same time has subsidized costly organ transplants of questionable long term benefit for selected babies through waivers of Medicaid program requirements on a seemingly ad hoc basis.[13] This dilemma raises the second issue involved with making hard choices—who should make these decisions both in the societal and individual contexts.

The decision-makers are a disparate group. In the societal context, the federal and state governments are the primary decision-makers. In the individual context, the decision-makers fall into two categories: those who provide services and those who pay for services. The providers include, chiefly, physicians and hospitals. The payers are insurance companies, Blue Cross and Blue Shield plans, business, and other entities that pay for the health services provided to specified groups of individuals. Payers include individual patients, also an important group given that twenty-eight percent of the nation's personal health care expenditures are made by individuals.[14] Payers also include the federal and state governments in their capacity as administrators of the Medicare, Medicaid, and other public health insurance programs.

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[11]Blendon & Altman, *Public Attitudes About Health-Care Costs: A Lesson in National Schizophrenia*, 311 NEW ENG. J. MED. 613 (1984); *see also* Ferguson & Rogers, *The Myth of America's Turn to the Right*, ATL. MONTHLY, May 1986, at 43.

[12]Mundingher, *Health Services Funding Cuts and the Declining Health of the Poor*, 313 NEW ENG. J. MED. 44 (1985).

[13]*See, e.g.*, Wessell, *Medical Quandary Transplants Increase, and So Do Disputes over Who Pays Bills*, Wall St. J., Apr. 12, 1984, at 1; Friedman & Richards, *Life and Death in a Policy Vacuum*, HOSPITALS, May 16, 1984, at 79; Rust, *Transplant Success Stirs Debate on Coverage*, AM. MED. NEWS, Oct. 21, 1983, at 1.

[14]Levit, Lazenby, Waldo & Davidoff, *1984 National Health Expenditures*, 7 HEALTH CARE FINANCING REV. 1 (1985) [hereinafter *National Health Expenditures, 1984*].

The respective roles of these decision-makers have been the focus of considerable attention in the health policy debate in recent years. The question is whether decisions about the content and allocation of health care resources are best made explicitly on an aggregate level by government as the representative of its citizens, or implicitly and unsystematically on an individual level either through the market and within the context of the provider-patient relationship whenever possible.[15] The liberal position assigns the federal government the predominant role in making decisions on a societal level about what national resources should go to health care services versus competing needs and also, through selection of federally-dominated national health insurance benefits, what health care services should be available to patients at the individual level. The conservative view maintains that health care services should be delivered on a private basis whenever possible and that allocation decisions on the societal level as well as the individual level should be made collectively through the operation of the market with government intervening only as a last resort to correct manifest injustice.

The final issue is what are the interests and, indeed, rights of the individuals who need health care services and are affected by these decisions. Moreover, what kind of protection does a decision-making process afford an individual patient who may be adversely affected by a decision, whether he be one gravely ill individual who is denied expensive, life-prolonging treatment or a member of a group who benefits from a government health service program?

Much ink has been spilled over whether individuals have a right to health care in a moral or legal sense, and if so, what this right means in terms of the responsibility of government, other payers, and providers to furnish health care services.[16] The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research declined to declare that health care is either a legal or moral right, but rather chose to frame its analysis of securing access to health

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[15]The question of who should make these choices, the market or government, has been debated and analyzed extensively in a published dialogue between Professors James Blumstein and Rand Rosenblatt. *See* Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899 (1982); Blumstein, *Rationing Medical Resources: A Constitutional, Legal and Policy Analysis*, 59 TEX. L. REV. 1345 (1981) [hereinafter Blumstein, *Rationing Medical Resources*]; Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401 (1981); Rosenblatt, *Rationing "Normal" Health Care Through Market Mechanisms: A Response to Professor Blumstein*, 60 TEX. L. REV. 919 (1982); *see also* Mehlman, *Rationing Expensive Lifesaving Treatments*, 1985 WIS. L. REV. 239.

[16]*See, e.g.*, K. DAVIS & C. SCHOEN, HEALTH AND THE WAR ON POVERTY: A TEN YEAR APPRAISAL 2-7 (1978); Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55 (1984); Siegler, *A Right to Health Care: Ambiguity, Professional Responsibility, and Patient Liberty*, 4 J. MED. & PHIL. 148 (1979).

"in terms of the special nature of health care and of society's moral obligation to achieve equity, without taking a position on whether the term 'obligation' should be read as entailing a moral right."[17] Indeed, it is hardly useful to talk about the interests of consumers in health care as a right because, as a practical matter, interests are protected and enforceable as rights only when there is an associated remedy accorded by law.

From a legal perspective, it is clear that one does not have an enforceable, legal "right" to health care. The Supreme Court has ruled that the federal Constitution does not recognize any such "right" to medical care.[18] The federal Constitution does protect the entitlement interest of beneficiaries in the federal and state Medicare and Medicaid programs, but only to the extent outlined in the enabling legislation for these programs.[19] However, as with any entitlement program, the nature of the entitlement interest can be limited by subsequent legislative amendment and the nature of the constitutional protection accorded is that of procedural due process.[20]

Certainly, citizens do not have so powerful an interest or right that they can obtain high quality services of any type on demand. However, it is widely held, as a corollary of the tenet that health care is special, that individuals have some interest in obtaining health care services although that interest is subject to legal protection only in the context of an entitlement created by, and then only to the extent authorized by, the government in its design and lawful implementation of the entitlement program. Thus, decision-makers have considerable power in making

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[17]I PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 32 (1983) [hereinafter PRESIDENT'S COMMISSION, SECURING ACCESS TO HEALTH CARE].

[18]*See* Harris v. McRae, 448 U.S. 297 (1980); Mahrer v. Roe, 432 U.S. 464 (1977) (involving state obligations to provide certain benefits under their Medicaid programs). The possible exception is a right of prisoners to necessary medical care on grounds that denial of such care is cruel and unusual punishment proscribed by the eighth amendment. Estelle v. Gamble, 429 U.S. 97 (1976). *See* PRESIDENT'S COMMISSION, SECURING ACCESS TO HEALTH CARE, *supra* note 17, at 33; Blumstein, *Constitutional Perspectives, supra* note 9, at 257-70; Blumstein, *Rationing Medical Resources, supra* note 15, at 1377-81.

It is worth noting that at least one state supreme court has interpreted its state constitution as according a right to certain health care services which the state had to provide. Callahan v. Carey, N.Y.L.J., Dec 11, 1979, at 10, col. 5 (Sup. Ct. N.Y. County 1979); *see also* Malone, *Homelessness in a Modern Urban Setting*, 10 FORDHAM URB. L. J. 749 (1982).

[19]*See, e.g.*, O'Bannan v. Town Court Nursing Center, 447 U.S. 773 (1980); Gray Panthers v. Schweiker, 652 F.2d 146 (D.C. Cir. 1980).

[20]*See* Blumstein, *Rationing Medical Resources, supra* note 15, at 1369-72; *see also* Note, *Due Process in the Allocation of Scarce Lifesaving Medical Resources*, 84 YALE L.J. 1734 (1975).

decisions about the composition and allocation of health care services to individuals.

Finally, it should be noted that there is constant tension between making allocation decisions at the societal level and at the individual level that inevitably confuses decision-makers and that results in considerable irrationality in the distribution of medical resources. This tension exists between the need and effort to allocate scarce medical resources in the societal context and the observance of the strongly-held societal value of assuring preservation of "identifiable" lives in the individual context. This tension has been aptly described:

> Decisions which seem economically necessary and ethically appropriate at the first [macro-prospective] level force choices at the second [micro-immediate] which seem ethically unacceptable (and vice-versa—aggregating up from the micro-immediate level in response to ethical imperatives seems to result in a requirement at the macro-prospective level which is economically unacceptable).[21]

This tension is aggravated when reductions in resources mandate allocation policies that deny services to a specific individual with a life-threatening need. American society values individual life so deeply that it may not be able to tolerate politically or morally the denial of medical care to identifiable individuals in need when government policies and economic realities would curtail such costly health care services at the societal level. Government as representative of its citizens and administrator of public health insurance programs is often confronted with this tension and the hard choices it generates. Congress endeavored to address this tension and the resulting hard choices in its design of the administrative structure for the Medicare prospective payment system for hospitals.

III. Reaching the Point of Hard Choices

A. Some History

In 1965, the Congress of the United States established the Medicare and Medicaid programs to address the problem of restricted access to health care services for the elderly and poor because of the prohibitive cost of many health care services for these disadvantaged groups.[22] This

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[21]Zechauser, *Coverage for Catastrophic Illness*, 21 Pub. Pol'y 149, 163 n.24 (1973) (quoting Carl Stevens); *see* Blumstein, *Constitutional Perspectives*, *supra* note 9, at 254 n.134.

[22]Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I §§ 101-111, 121-122, 79 Stat. 291-360 (codified as amended at 42 U.S.C. §§ 1395, 1396 (1982 & Supp. 1985)); *see also* S. Rep. No. 404, 89th Cong., 1st Sess:, *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943.

congressional action confirmed that modern medicine—with its sophisticated scientific and technological base—had come of age.[23] Never had medicine enjoyed greater prestige. Virtually overnight, penicillin and the Salk vaccine had wiped out diseases that had plagued mankind since recorded history. The discovery of DNA and other startling advances in biomedical research in the early 1950's ushered in a new era promising even greater medical breakthroughs and fostering the public perception that the cure for all illness was within reach.

Surely this phenomenon of modern medicine was truly a "good thing" that should be made available to all Americans. After World War II and in a fashion unprecedented for treatment of a predominantly private activity, Congress committed federal resources to a whole range of health related endeavors. In 1946, Congress established the Hill-Burton program to finance the construction of hospitals and health care facilities, with the requirement that assisted facilities provide a reasonable volume of health care services to the poor and be open to all people in the institution's service area.[24] Congress also established the National Institutes of Health to coordinate the enormous federal expenditure for basic biomedical research.[25] The 1950's and 1960's also saw substantial federal support of academic medical centers for medical and allied health education and biomedical research training.[26] But, the culmination of this federal commitment to ensuring high quality and accessible health care services was establishment of the Medicare and Medicaid programs in 1965.

Medicare, a federal social insurance program administered by the Department of Health and Human Services, provides hospital insurance for hospital and extended care services as well as supplementary medical insurance for physician and associated services to the aged, disabled, and certain individuals with end stage renal disease.[27] Medicaid, a welfare program administered by the states pursuant to federal guidelines, pro-

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[23]*See* P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, 335-78 (1982).

[24]Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291-291o (1982 & Supp. 1985)). *See generally* Blumstein, *Court Action Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227 (1982); Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975); Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243 (1978).

[25]Pub. L. No. 95-622, tit. II, § 241(a)(1), 92 Stat. 3424 (1978) (codified as amended at 42 U.S.C. § 281 *et seq.* (1982 & Supp. 1985)); *see also* Fredrickson, *Health and the Search for Knowledge*, in DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES 159 (J. Knowles ed. 1977).

[26]*See generally* Ebert, *Medical Education in the United States*, in DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES 171 (J. Knowles ed. 1977).

[27]In 1972, Congress added the disabled and individuals with end stage renal disease to those eligible for Medicare. Social Security Amendments of 1972, Pub. L. No. 92-603, tit. II, § 299I, 86 Stat. 1329 (codified as amended at 42 U.S.C. § 1395 (1982 & Supp. 1985)).

vides hospital, physician, and nursing home services to persons eligible for categorical assistance programs under the Social Security Act[28] and who, but for income, otherwise meet the eligibility criteria for these categorical assistance programs.[29] The Medicare program is financed through trust funds comprised chiefly of proceeds from a payroll tax and insurance premiums and, to a minimal extent in the case of the supplementary medical insurance, Congressional appropriations from general revenues; Medicaid is financed out of federal appropriations that match state appropriations for this program.[30] These government health insurance programs now serve over 50 million people.[31] These two programs have had a tremendous impact on the improvement of health status among the elderly and poor, demonstrated by sharp decreases, over thirty percent, in mortality rates for diseases that afflicted the aged and poor disproportionately, e.g., diabetes, heart disease, stroke, and pneumonia, as well as substantial reductions in infant mortality rates.[32] However, at no time did these two programs cover all persons in need and, currently, at least fifteen percent of all Americans have no health insurance coverage.[33]

Medicare and Medicaid represented an enormous expression of confidence in a modern, scientifically-based, health care system. In designing these programs, Congress was guided almost exclusively by concerns and interests of the architects of this new health care system — physicians and hospitals.[34] The hospital industry and the medical profession dictated

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[28]There are two categorical assistance programs under the Social Security Act: Aid to Families with Dependent Children, for poor mothers and children, 42 U.S.C. §§ 601-615 (1982 & Supp. 1985), and Supplemental Security Income Program for the indigent aged, disabled, and blind, *id.* §§ 1381-1394.

[29]*Id.* § 1396a(a)(10)(c); *see also* K. Davis & C. Schoen, *supra* note 16, at 52-56. States must provide Medicaid benefits to those on categorical assistance programs; however, they have the option of adopting a medically needy program. 42 U.S.C. §§ 1396a(a)(10)(c), 1396d(a) (1982 & Supp. 1985). Over half of the states have a medically needy program despite marked cut-backs in federal matching funds for state Medicaid programs.

[30]*See* 42 U.S.C. §§ 1395i, 1395t (1982 & Supp. 1985) (Medicare trust fund provisions); *id.* § 1396b (Medicaid state appropriations provisions).

[31]*National Health Expenditures, 1984*, *supra* note 14.

[32]*What Medicaid and Medicare Did—and Did Not—Achieve,* Hospitals, Aug. 1, 1985, at 41-42 (interview with Karen Davis); *see also* Davis & Reynolds, *The Impact of Medicare and Medicaid on Access to Medical Care*, in The Role of National Health Insurance in the Health Service Sector 391 (R. Rosett ed. 1976).

[33]Mundingher, *supra* note 12, at 44; *see* Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the U.S.*, in 3 President's Commission, Securing Access to Health Care, *supra* note 17, at 55.

[34]*See generally* J. Feder, Medicare: The Politics of Federal Hospital Insurance (1977); T. Marmor, The Politics of Medicare (1973); Cohen, *Reflections on the Enactment of Medicare and Medicaid*, 7 Health Care Fin. Rev. 3 (Supp. 1985).

the benefit packages and payment methodologies for these program and even retained control over who among their ranks would participate in these programs.[35] Further, the Medicare and Medicaid statutes assured that the structure of and key relationships within the health care system would be unaffected by these programs, with such measures as the guarantee of beneficiaries' freedom of choice to select their physicians and other health care providers.[36] Indeed, not interfering with the practice of medicine in any health care institutions was stated as a central policy in the Medicare program in the first section of the Medicare statute:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation or any such institution, agency or person.[37]

Perhaps most important, the Medicare and Medicaid programs gave physicians and hospitals almost complete autonomy in setting the level of payment for services provided to their beneficiaries, chiefly because of considerable political opposition to the programs from providers. According to Wilber Cohen, the Secretary of the Department of Health, Education and Welfare when the Medicare and Medicaid programs were adopted, at the time, "[t]he ideological and political issues were so dominating that they precluded consideration of issues such as reimbursement alternatives and efficiency options."[38]

Initially, both Medicare and Medicaid paid hospitals the costs, as calculated by hospitals, of providing services to beneficiaries with the only prescription that the costs be "reasonable."[39] Medicare paid phy-

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[35]For example, accreditation by the Joint Commission on Accreditation of Hospitals, the private accrediting body appointed by the hospital industry and the medical profession, would be sufficient to demonstrate a hospital's eligibility to participate in the Medicare program. 42 U.S.C. § 1395bb (1982 & Supp. 1985). *See generally* Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. REV. 835 (1983).

[36]*See* 42 U.S.C. §§ 1395a, 1396a(a)(23) (1982 & Supp. 1985).

[37]*Id.* § 1395a.

[38]Cohen, *supra* note 34, at 5.

[39]Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395(f)(b), 1395x(v) (1982 & Supp. 1985)) (Medicare); *id.* at § 121(a) (codified as amended at 42 U.S.C. § 1396(a)(10) (1982 & Supp. 1985)) (Medicaid). Congress suggested that reimbursement methodologies of private insurance companies should guide the Medicare program in development of Medicare's reimbursement methodology:

sicians eighty percent of the reasonable, customary, or prevailing charge for covered services and allowed physicians to bill patients directly for their full charge under the traditional fee-for-services arrangement with patients then receiving payment from Medicare.[40] In contrast, Medicaid has always been stricter in its reimbursement for physicians, requiring them to accept assignment of Medicaid benefits from their patients and allowing states to set payment rates quite low.[41]

The Medicare and Medicaid programs changed the complexion of the American health care system fundamentally by transforming the cost and quality of accessible health care from basically a private matter to a matter of public concern. With Medicare and Medicaid, the federal government and also the states assumed a major responsibility for assuring access to health care services for disadvantaged groups, a significant departure from past policy of viewing the provision of medical care to these groups as primarily a local and voluntary effort. In addition, with these programs, the federal government and also the states assumed responsibility for the problem of what to do about the increasing cost of health care services.

> The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill.

S. REP. No. 404, 89th Code Cong., 1st Sess., *reprinted in* 1965 U.S. CONG. & ADMIN. NEWS 1943, 1976.

Initially, state Medicaid programs had to observe Medicare cost reimbursement principles for paying hospitals. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286. Over time, Congress gave states greater flexibility in structuring Medicaid hospital payment methods and allowed paying hospitals less than Medicare. Social Security Amendments of 1972, Pub. L. No. 92-603, § 232(a), 86 Stat. 1329; Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2171-2178, 195 Stat. 357. Also, in the Omnibus Reconciliation Act of 1981, Congress authorized states to curtail beneficiaries' choice of hospital providers under certain circumstances. *Id.* § 2175.

[40]Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395*l*(a) (1982 & Supp. 1985)). In recent years, physician reimbursement has come under increasing regulation, and now there are greater incentives for physicians to accept assignment of Medicare benefits from their patients as payment in full as well as freezes and other limits on the amount of payment for physicians' services. *See* Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2306, 98 Stat. 494 (codified as amended at 42 U.S.C. § 1395u(b) (Supp. 1985)). *See* American Medical Ass'n v. Heckler, 606 F. Supp. 1422 (S.D. Ind. 1985), in which the American Medical Association and Indiana doctors unsuccessfully challenged this freeze on constitutional and other grounds.

[41]42 U.S.C. § 1396a(45), 1396k (1982 & Supp. 1985). As a result of these restrictive policies and practices, few physicians take Medicaid patients. These patients then must rely chiefly on hospital outpatient clinics and other facilities that cater specifically to the indigent for physicians' services. *See* Mitchell & Cromwell, *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare*, in 3 PRESIDENT'S COMMISSION, SECURING ACCESS TO HEALTH CARE, *supra* note 17, at 105.

The Medicare and Medicaid programs generated enormous demand for health care services and with this increased demand came sharp and continuing increases in the cost of health care services.[42] The seriousness of the cost problem surfaced shortly after the inauguration of the Medicare and Medicaid programs[43] and has dominated the health policy debate ever since. Of greatest concern were a rate of inflation in health care costs far exceeding that of the general economy, uncontrolled rise in federal and state budgetary expenditures in public health insurance programs to the exclusion of other public commitments, and the fact that health care commanded an ever greater proportion of the nation's resources as well.[44]

The federal government and the states became concerned about escalating costs of the Medicare and Medicaid programs and explored numerous cost containment strategies. Congress authorized waivers of Medicare and Medicaid program requirements to test cost-saving methodologies for paying for hospital services under these programs, and the Department of Health, Education and Welfare inaugurated experiments in several states to test the cost-effectiveness of prospective payment methodologies.[45] Several states adopted programs to regulate rates of hospitals and other health care institutions, and many of these state programs include Blue Cross, other private payers, and even Medicare.[46] Also, in the late 1960's and early 1970's, about one-third of the states

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[42]Gornick, Greenberg, Eggers & Dobson, *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, 7 HEALTH CARE FIN. REV. 13, 35-45 (Supp. 1985).

[43]*Proposed Medicare Reimbursement Formula: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. (1966); STAFF OF SENATE COMM. ON FINANCE, MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES, 91st Cong., 1st Sess. 53, 140-43 (Comm. Print 1970).

[44]Between 1967 and 1983, the rate of increase in hospital costs was 17.2% and did not abate until 1984, the first year of the prospective payment system. Gornick, *supra* note 42, at 35-45. The Medicare program consumed an increasingly large portion of the federal budget during these periods. Further, the health care system commanded a larger portion of the nation's resources. In 1965, the percentage of the gross national product devoted to health care was about 6% and in 1984 that percentage was 10.8%. *National Health Expenditures, 1984*, *supra* note 14, at 1.

[45]Social Security Amendments of 1967, Pub. L. No. 90-248, § 402, 81 Stat. 821; Social Security Amendments of 1972, Pub. L. No. 92-603, § 222(a), 86 Stat. 1329; *see also* DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FINANCING ADMIN., HEALTH CARE FINANCING GRANTS AND CONTRACTS REPORT, THE NATIONAL HOSPITAL RATE-SETTING STUDY: A COMPARATIVE REVIEW OF NINE PROSPECTIVE RATE-SETTING PROGRAMS (1980).

[46]*See* Esposito, Hupfer, Mason & Rogler, *Abstracts of State Legislated Hospital Cost-Containment Programs*, 4 HEALTH CARE FIN. REV. 129 (1982).

As of 1986, ten states have adopted mandatory rate regulation programs involving payers besides Medicaid: New York, New Jersey, Maryland, Massachusetts, Washington, Wisconsin, Connecticut, Maine, and West Virginia. Some states have Medicare waivers to operate all payer systems. States can obtain waivers to set up their own all payer rate

adopted capital expenditure review programs to regulate costly capital investment in health care facilities and services on the theory that excess capital investment was a major cause of the escalation of all health care costs.[47]

In the Social Security Amendments of 1972, Congress adopted several regulatory strategies to address the problem of cost inflation in the Medicare and Medicaid programs. Borrowing from state approaches to rate regulation, Congress authorized HEW to impose a limit on the routine costs that Medicare paid hospitals.[48] These amendments also supported state capital expenditure review programs by authorizing the Medicare program to withhold reimbursement for capital costs for any projects disapproved under a state certificate-of-need program.[49] In addition, these amendments established a professional peer review program to review the utilization of hospital services provided beneficiaries of the Medicare and Medicaid programs.[50] Regarding Medicaid, Congress accorded states greater flexibility to structure and reduce payments to health care institutions for the care of Medicaid beneficiaries.[51]

In 1974, Congress enacted the National Health Planning Resources and Development Act of 1974.[52] This statute required all states to establish health planning and certificate-of-need programs to control capital expenditure by health care facilities and assure rational distribution of health care services. Federally-mandated health planning and certificate-of-need programs represented a comprehensive federal effort to compel states to regulate the distribution of health care services on a local and state-wide level.[53]

Nevertheless, throughout the 1960's and 1970's, the federal government and also the states to varying degrees remained committed to the ideal of a strong government role in ensuring access to health care services for the aged, disabled, and poor through public health insurance programs. Indeed, the federal government under both Republican and

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setting programs and opt out of the Medicare prospective payment system. *See* AM. HOSP. ASS'N, LEGAL DEVELOPMENTS REPORT NO. 1: HOW STATES CAN OPT OUT OF THE FEDERAL MEDICARE DRG SYSTEM: A SUMMARY OF LEGAL ISSUES (1983).

[47]B. LEFKOWITZ, HEALTH PLANNING: LESSONS FOR THE FUTURE 13 (1983).

[48]Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1329 (codified as amended at 42 U.S.C. §1395x(v)(1)(A) (1982 & Supp. 1985)).

[49]*Id.* § 221(a) (codified as amended at 42 U.S.C. § 1320a-1 (1982 & Supp. 1985)).

[50]*Id.* § 249F(b). This program has been terminated and another peer review program established in its place. *See infra* notes 135-42 and accompanying text.

[51]Social Security Amendments of 1972, Pub. L. No. 92-603, § 232(a), 86 Stat. 1329 (codified at 42 U.S.C. § 1396(a) (1982 & Supp. 1985)).

[52]National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified as amended at 42 U.S.C. § 300K (1982 & Supp. 1985)).

[53]This program also established guidelines for the appropriate levels of certain health care services. *See id.* § 3 (codified as amended at 42 U.S.C. § 300k-t (1982)).

Democratic administrations was prepared to expand this commitment and provide health insurance coverage to all Americans through a national health insurance plan.[54] The only barrier to this goal was the serious problem of hospital cost containment and the concomitant fear that national health insurance would be prohibitively expensive.[55]

But also during this period, a consensus developed among federal and state policy makers, scholars, and other observers that the health care system was wasteful in its use of resources and experienced an inordinately high rate of inflation without a corresponding improvement in the health status of the population.[56] This phenomenon was particularly troubling given the other types of government services that could have been provided with the same funds.[57] Three factors were seen as causes for this waste and inflation. First were payment methodologies that paid providers basically the costs they incurred on their charges for providing services.[58] This contained incentives for overutilization of services and the resulting conception and expectation of high quality medical care as being any care that might benefit, regardless of cost.[59] The second factor was increases in costly medical technology.[60] The third factor was the

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[54]*See* HOUSE SUBCOMM. ON HEALTH OF THE COMM. ON WAYS AND MEANS, NATIONAL HEALTH INSURANCE RESOURCE BOOK, 94th Cong., 2d Sess. (1976); K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES (1975); NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER (M. Pauly ed. 1980).

[55]The Carter Administration, to prepare the way for enactment of its National Health Plan, introduced two unsuccessful hospital cost containment bills in Congress. These bills proposed establishing a national rate regulation program for all payers on the theory that this regulation would keep hospital costs under control when the national health insurance program with its increased demand for services was implemented. *See* Wing & Silton, *Constitutional Authority for Extending Federal Control over the Delivery of Health Care,* 57 N.C.L. REV. 1423 (1979).

[56]*See* DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES (J. Knowles ed. 1977); HOSPITAL COST CONTAINMENT: SELECTED NOTES FOR FUTURE POLICY (M. Zubkoff, L. Raskin & R. Hanft eds. 1978).

[57]For example, in 1976, Medicare program analysts estimated that with the $4 billion for new technology for Medicare patients in 1976, the federal government could have brought all aged persons above the poverty line or provided rent to raise two million elderly from substandard to standard housing, brought all the elderly above the lowest accepted food budget, or provided eyeglasses and hearing aids to all in need. *See* Warner, *Effects of Hospital Cost Containment on the Development and Use of Medical Technology*, 56 MILBANK MEMORIAL FUND Q./HEALTH AND SOCIETY 187, 188 (1978).

[58]*See* Biles, Schramm & Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980); Steinwald & Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence*, in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 2736 (M. Olson ed. 1981).

[59]Donabedian, *supra* note 5, at 200; Light, *Is Competition Bad?*, 309 NEW ENG. J. MED. 1315 (1984); *see also* Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs, supra* note 9, at 12-13.

[60]*See* DEP'T OF HEALTH, EDUCATION & WELFARE, MEDICAL TECHNOLOGY: THE CULPRIT BEHIND HEALTH CARE COSTS? (Proceedings on the 1977 Sun Valley Forum on National

structure and financing of most health insurance plans, including public programs.[61] Specifically, health insurance with low or no coinsurance insulated the consumers from any financial consequences of their decision to use health care services, resulting in indiscriminate and wasteful use of services.

Toward the end of the 1970's, recognition of these problems with the American health care system precipitated a loss of confidence in the direction of federal health policy causing many to question the underlying assumptions that had supported federal health policy for over a decade.[62] Specifically challenged was the idea that the federal government should be involved in providing health insurance for all Americans in view of the costly track record of the Medicare and Medicaid programs.[63] Also questioned was whether regulation of capital investment and institutional payment rates were effective in assuring rational distribution of health care services as well as containment of health care costs.[64] It was suggested that the new direction for federal health policy was to promote competition between providers, to reform the structure and financing of public and private health insurance programs to have consumers directly affected by their decisions to use health care services, and to reduce the regulatory control of federal and state governments over providers and health insurers.[65]

B. The Redirection of Federal Health Policy

The election of Ronald Reagan in 1980 marked the turning point in national health policy and the rejection of the liberal health policy

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Health, 1977); L. RUSSELL, *Technology in Hospitals: Medical Advances and Their Diffusion* (1979); *see also* OFFICE OF TECHNOLOGY ASSESSMENT, *Medical Technology Under Proposals to Increase Competition in Health Care* (1982).

[61] *See* P. JOSKOW, CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION 20-31, 36-43 (1981); THE ROLE OF HEALTH INSURANCE IN THE HEALTH SERVICES SECTOR (R. Rosett ed. 1976); Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251 (1973).

[62] *See, e.g.*, I. ILLICH, MEDICAL NEMESIS (1976); Starr, *The Politics of Therapeutic Nihilism*, in WORKING PAPERS FOR A NEW SOCIETY 48 (1976).

[63] *See* NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER, *supra* note 54; *see also* Blumstein & Zukoff, *Public Choices in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL. POL'Y & L. 382 (1979).

[64] C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 25-52 (1982); P. JOSKOW, *supra* note 61, at 169-78.

[65] A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980); *see also Competition and Regulation in Health Care Markets*, 59 MILBANK MEMORIAL FUND Q./HEALTH AND SOCIETY 107 (1981); *A Special Symposium: Market Oriented Approaches to Achieving Health Policy Goals*, 34 VAND. L. REV. 849 (1981).

of the previous fifteen years. Ronald Reagan had a fundamentally conservative conception of government's responsibility toward its citizens and was committed to disengaging the federal government from all aspects of American life and reducing federal taxes dramatically. Thus, instead of expanding the federal role in assuring access to quality health care services to underserved groups, which had clearly been the focus of the Carter Administration's health policy,[66] the Reagan Administration sought to reduce the federal role and commitment to assure quality health care services for Americans in need and to address the problem of cost inflation in public health insurance programs. The Reagan Administration aggressively redirected federal health policy along the lines suggested by the more articulate critics of the liberal health policy such as Alan Enthoven and Clark Havighurst and even enlisted the involvement of these critics in the formulation of a new conservative health policy.

The summer of 1981 was an eventful season for American health policy. The newly-elected and politically powerful Reagan Administration under the technical leadership of the energetic Budget Director David Stockman worked feverishly to develop proposals to dismantle the liberal welfare state and to inaugurate the conservative revolution promised by the election of Ronald Reagan. The specific objective of these proposals was to reduce the amount of the nation's resources commanded by the federal government and to reduce the proportion of federal resources devoted to social programs. The Administration submitted legislative proposals affecting all aspects of American life, which Congress considered in developing the federal budget for fiscal year 1982. With respect to health, the Administration proposed transferring financial and administrative responsibility for nearly all categorical health programs to the states in block grants[67] and to impose a limit on the amount of federal expenditures for the Medicaid program while giving states greater administrative flexibility to achieve savings.[68]

But before adopting these proposals for the federal budget, Congress enacted the Economic Recovery Act of 1981, which contained the Reagan Administration's proposals for sharply reducing federal income taxes, thus reducing the proportion of the nation's resources commanded for government ends.[69] This legislation was to result in an estimated revenue

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[66]DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF THE ASS'T SECRETARY FOR PLANNING & EVALUATION, BACKGROUND PAPERS, VOL. 1 (1980); DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF THE ASS'T SECRETARY FOR PLANNING & EVALUATION, DECISION PAPERS FOR THE SECRETARY, VOL. 2 (1980).

[67]CONG. BUDGET OFFICE, AN ANALYSIS OF PRESIDENT REAGAN'S BUDGET REVISIONS FOR FISCAL YEAR 1982, STAFF WORKING PAPERS, A-53 (1981).

[68]*Id.* at A-56.

[69]Economic Recovery Act of 1981, Pub. L. No. 97-34, 95 Stat. 172.

loss of $37.7 billion for fiscal year 1982[70] despite the fact that the deficit in the federal budget at the time, fiscal year 1981, was $59.6 billion.[71] It should be noted that the actual budget deficit for fiscal year 1982 was $110.6 billion.[72] The Reagan Administration, committed to expanding the nation's defense capability through massive expenditures on national defense, sought to address the budget deficit through draconian decreases in social and health programs and, raising the specter of the increasing deficit, the Administration sought public support to dismantle the American social welfare state.[73]

The major piece of legislation to accomplish this task was the Omnibus Budget Reconciliation Act of 1981,[74] which Congress enacted immediately after the Economic Recovery Act of 1981. In this legislation, Congress adopted many of the health policy proposals and budget reduction strategies of the immensely popular Reagan Administration, including block grants for categorical social and health programs and sharp reduction in funding for regulatory programs such as federally-mandated health planning and certificate of need programs and the peer review organization program for the Medicare and Medicaid programs.[75] The Omnibus Budget Reconciliation Act also reduced federal funding for Medicaid and gave states greater flexibility to structure payment methods and modes of delivering health care services to Medicaid beneficiaries.[76]

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[70]H.R. CONF. REP. No. 215, 97th Cong., 1st Sess. 292, *reprinted in* 1981 U.S. CODE CONG. & ADMIN. NEWS 380.

[71]EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT & BUDGET, FY 1982 BUDGET REVISIONS 11 (1981).

[72]EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT & BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FY 1984 M-11 (1983).

[73]*See generally* D. STOCKMAN, THE TRIUMPH OF POLITICS: WHY THE REAGAN REVOLUTION FAILED (1986); Jacob, *Reaganomics: The Revolution in American Political Economy*, 48 LAW & CONTEMP. PROBS. 7(1985); *see also* Ethridge, *Reagan, Congress, and Health Spending*, 2 HEALTH AFF. 14 (1983); Michaelson, *Reagan Administration Health Legislation: The Emergence of a Hidden Agenda*, 20 HARV. J. ON LEGIS. 575 (1983).

[74]Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357.

[75]*Id.* §§ 1901-1910, 1911, 1921-1922, 1926, 2191-2194 (codified as amended at 42 U.S.C. §§ 201-300 (1982 & Supp. 1985)).

With respect to categorical health services programs of the Public Health Service, the Omnibus Budget Reconciliation Act of 1981 terminated federal programmatic responsibility for nearly all of these programs and placed funding for these programs into block grants to be administered by states. *Id.* §§ 300w to 300w-8. Funding for these block grants was reduced by twenty-five percent in 1981 and has been reduced subsequently. *See* THE REAGAN EXPERIMENT: AN EXAMINATION OF ECONOMIC AND SOCIAL POLICIES UNDER THE REAGAN ADMINISTRATION 280-82 (J. Palmer & I. Sawhill eds. 1982). The Reagan Administration, in its new federalism initiative, proposed even greater transfers of federal responsibility for social programs to states. *See President's Federalism Initiative, Governmental Affairs, United States Senate*, 97th Cong., 2d Sess., Feb. 4, Mar. 11, 16, 18 (1982).

[76]Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2161-2184, 95 Stat. 357 (codified as amended at 42 U.S.C. § 1396 (1982 & Supp. 1985)). *See generally* R.

What the Reagan Administration and Congress accomplished with this first wave of legislation in the summer of 1981 was to reduce the proportion of federal resources devoted to health care at the societal level. Indications are that these decisions have hurt the poor and those without health insurance. About fifteen percent of the population report having no health insurance—a significant barrier to access to health services given the high cost of even minimal medical care.[77] This figure is a twenty-five percent increase since 1977 and is due to several factors such as increased unemployment, an increase in the number of individuals living in poverty, and a tightening of criteria for Medicaid and other public programs that finance health care for the poor.[78] There is also evidence that the health status of mothers and infants and persons with chronic disease, groups likely to be poor and the beneficiaries of public programs, has been significantly compromised since 1980.[79]

After the summer of 1981, the Reagan Administration turned its attention to developing strategies to make Medicare and private insurance programs more efficient purchasers of health care services. The Administration's chief policy initiative and critically important from a rhetorical perspective was to encourage increased competition in the health care system through the reform of health insurance and, particularly, federal financing of private health insurance through the federal income tax exemption for health insurance premiums.[80]

However, the most important of these structural reforms was adoption of the prospective payment system for the Medicare program. Pressed by the need to reduce federal budget expenditures and alleviate the alarming growth of the federal budget deficit, which in fiscal year 1983

Bovbjerg & J. Holahan, Medicaid in the Reagan Era: Federal Policy and State Choices (1982); The Reagan Experiment, *supra* note 75. Congress did not adopt the Reagan Medicaid proposals because of pressure from governors who were concerned about possible increased Medicaid program costs for states. *See* Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 Cath. U.L. Rev. 1 (1983).

[77]*See supra* note 33 and accompanying text.

[78]Mundingher, *supra* note 12, at 45.

[79]*See id.*

[80]*See* H.R. Doc. No. 24, 98th Cong., 1st Sess. (1983); *Proposals to Stimulate Competition in the Financing and Delivery of Health Care, 1981: Hearings Before the Subcomm. on Health of the Comm. on Ways and Means of the House of Representatives*, 97th Cong., 1st Sess. (1981). Congress never enacted the Reagan Administration's competition proposal and this policy initiative, although referred to constantly in the rhetoric of the Administration, never was developed beyond an initial legislative proposal. *See Medicare Reimbursement to Competitive Medical Plans, Hearing Before the Special Comm. on Aging*, 97th Cong., 1st Sess. (1981); Congressional Budget Office, Containing Medicare Care Costs Through Market Forces (1982); Enthoven, *The Competition Strategy: Status and Prospects*, 304 N. Eng. J. Med. 109 (1981); Feder, Holahan, Bovbjerg & Hadley, *The Shift in Social Policy: Health*, in The Reagan Experiment 271 (J. Palmer and I. Sawhill eds. 1982).

was estimated to be $107.2 billion,[81] Congress and the Reagan Administration sought to address the largest component of the federal health budget where reforms were possible and which had been left relatively untouched in the initial budget cutting efforts of 1981: Medicare expenditures for hospital services. In the Tax Equity and Fiscal Responsibility Act of 1982, Congress laid the groundwork for prospective payment by establishing limits on the costs that Medicare would pay hospitals for each patient case and calling on the Department of Health and Human Services to develop a legislative proposal for a prospective payment system by December 1982.[82] Following the Administration's proposal for a prospective payment system based on diagnosis related groupings (DRG's),[83] Congress adopted a prospective payment system the following spring in the Social Security Amendments of 1983.[84]

The legislative initiatives of Congress and the Reagan Administration to purchase health care services more efficiently in the Medicare and Medicaid programs and to encourage private payers to do likewise seem to have been quite successful. In 1984, the rate of inflation in the hospital industry declined dramatically, and Medicare expenditures for hospital services rose only at 9.6% in 1984 compared to 16.7% between 1977 and 1983.[85] This result alone was significant for it defused the problem of hospital costs, which was becoming a serious economic and political problem for this nation. The problem of costs also posed a host of ethical issues of quite another dimension about the allocation of health care services, including whether resources that could be allocated to other social needs, i.e., housing, food, energy, became unavailable because of the need to purchase expensive health care services.[86]

There are indications that structural efficiencies in the delivery of health care services have occurred as well. Hospital admissions for the elderly declined for the first time since 1965, average length of stay continued to decline and data suggest that hospitals were taking care

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[81]EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT & BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 1983 3-23 (1982).

[82]Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 331-36 (codified as amended at 42 U.S.C. § 1395ww(a)-(c) (Supp. 1985)).

[83]SECRETARY OF THE DEP'T OF HEALTH & HUMAN SERVICES, REPORT TO CONGRESS ON HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE (1982) [hereinafter HHS REPORT TO CONGRESS].

[84]Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(c)(1), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww (Supp. 1985)).

[85]PROSPECTIVE PAYMENT ASSESSMENT COMM'N, MEDICARE PROSPECTIVE PAYMENT AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO THE CONGRESS 19-20 (1986) [hereinafter PROPAC REPORT ON THE AMERICAN HEALTH CARE SYSTEM]; *see also National Health Expenditures, 1984*, *supra* note 14.

[86]*See* P. MENTZEL, MEDICAL COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA (1983).

of sicker groups of patients than before.[87] Also, there was greater utilization of outpatient services in 1984 than in previous years.[88] Furthermore, all this has been accomplished while maintaining the financial position of the hospital industry. Indeed, hospitals have, as a whole, done quite well under these new strategies with profits in 1984 increasing 27.6% over 1983.[89]

The redirection of federal health policy since 1981 has precipitated concern among providers, consumers, and other observers as to whether the American health care system can continue to strive for quality and accessible health care for all Americans. Some have wondered whether constraints imposed by new payment methodologies will require the "rationing" of health care services among those in need.[90] Also many are concerned that the quality of health care services will decline because of incentives in these purchasing strategies that encourage providers to curtail the amount of services in the treatment of individual patients.[91] Also, philosophers have questioned the morality of payment systems that place providers in a position of having to balance the cost of resources used to treat patients against their anticipated benefits—particularly when the provider stands to gain personally from saving costs or is at risk for excessive costs.[92]

However, there is no evidence that this nation is now in a position where it must really "ration" health services in any draconian sense. Rather, the federal government as well as the states and private payers have decided only that they must pay less for health services. Further, as the Reagan Administration's tax and budget policies indicate, there are societal resources that could be devoted to health services for those in need. This Administration has simply decided to limit resources available to government to address such needs and look to other quarters for solutions. Thus, federal and state payers have made choices about the allocation of health services at least for vulnerable, poor groups prematurely and frankly unnecessarily.

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[87]PROPAC REPORT ON THE AMERICAN HEALTH CARE SYSTEM, *supra* note 85, at 19-20.

[88]*Id.*

[89]*Id.* at 47-51; *National Health Expenditures, 1984*, *supra* note 14, at 7-8, 23.

[90]*See, e.g.*, Friedman, *Rationing and the Identified Life*, HOSPITALS, May 16, 1984, at 65; Fuchs, *The "Rationing" of Medical Care*, 311 NEW ENG. J. MED. 1572 (1984); Perkins, *The Effects of Health Care Cost Containment on the Poor: An Overview*, 19 CLEARINGHOUSE REV. 831 (1985); Schwartz & Aaron, *Rationing Hospital Care: Lessons from Britain*, 310 NEW ENG. J. MED. 52 (1984).

[91]*See, e.g.*, Leaf, *The Doctor's Dilemma and Society's Too*, 310 NEW ENG. J. MED. 718 (1984); Omenn & Conrad, *Implications of DRG's for Clinicians*, 311 NEW ENG. J. MED. 1314 (1984); Sandrick, *Quality: Will It Make or Break Your Hospital*, HOSPITALS, July 5, 1986, at 54; Schramm, *Can We Solve the Hospital Cost Problem In Our Democracy?*, 311 NEW ENG. J. MED. 729 (1984); Thurow, *Learning to Say No*, 311 NEW ENG. J. MED. 1569 (1984).

[92]*See supra* note 6 and accompanying text.

IV. Making Hard Choices Under the Medicare Prospective Payment System

In the prospective payment system, Congress adopted a payment methodology to purchase hospital services for Medicare beneficiaries more efficiently and to curtail the amount of resources the federal government devoted to medical care for the elderly and disabled. The chief objective of this payment system was to change incentives in hospital financial behavior.[93] No longer would Medicare pay virtually all costs associated with services that hospitals and physicians decided were needed to treat individual Medicare patients. Rather, the Medicare prospective payment system pays a fixed price per case and allows hospitals to keep savings while putting hospitals at risk for costs incurred over and above the price per case.[94]

Congress understood that the prospective payment system would give the executive branch considerable power in deciding the amount of total federal resources to devote to hospital services for Medicare beneficiaries. Congress was frankly concerned that the executive branch, faced with tremendous pressure to curtail the ever increasing federal budget deficit of $107.2 billion[95] and the threatened bankruptcy of the Hospital Insurance Trust Fund,[96] would set payment rates arbitrarily low with little regard to maintaining the quality of services for Medicare beneficiaries.[97]

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[93]With respect to incentives, the House Ways and Means Committee stated, "[The Prospective Payment System] is intended to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost-effective hospital practices." H.R. Rep. No. 25, Part 1, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S. Code Cong. & Admin. News 219, 351.

Similarly, the Administration in its report to Congress on the prospective payment system stated:

> The ultimate objective of PPS is to set a reasonable price for a known product. This provides incentives for hospitals to produce the product more efficiently. When PPS is in place, health care providers will be confronted with strong lasting incentives to restrain costs for the first time in Medicare's history.

Dep't. of Health & Human Services, Hospital Prospective Payment for Medicare: Report to Congress Required by the Tax Equity and Fiscal Responsibility Act of 1982, 101 [hereinafter HHS Report to Congress]; *see also* 20 Years of Medicare and Medicaid, Health Care (Supp. 1985) (comments of J. Alexander McMahon, at 93-94; comments of Congressman Dan Rostenkowski, at 113-14).

[94]*See infra* notes 107-25 and accompanying text.

[95]*See supra* notes 66-92 and accompanying text.

[96]Svahn & Ross, *Social Security Amendments of 1983: Legislative History and Summary of Provisions*, Soc. Security Bull., July 1983, at 3, 40-7.

[97]*See Hospital Prospective Payment System, Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess., Part I, 47-48, 97-98, 134-35, 212 & Part II, 89-90, 162-204, 213 (1983) [hereinafter *Senate Finance Comm. Hearings on the Hospital Prospective Payment System*]; *Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and*

Afterall, Medicare expenditures for hospital services comprised an estimated seven percent of the federal budget for fiscal year 1983,[98] and thus posed an excellent target for budget reductions.

Hospitals were especially concerned about the administrative process by which payment rates would be set. The American Hospital Association (AHA) urged that the Secretary of HHS not have sole responsibility for updating hospital payment rates but that updating rates be done "on a regularly-scheduled basis, with the formula specified in law and calculated by a technical body that is independent of HHS and capable of providing an objective adjustment."[99] The AHA and other groups also objected to proposals eliminating rights to appeal issues with respect to the composition of hospital payment rates.[100]

Congress and beneficiaries were concerned about the incentives in the prospective payment system for hospitals to maximize payment through admitting patients to the hospital unnecessarily and encouraging their physicians to use fewer resources to treat patients.[101] Specifically, they were concerned that the quality and accessibility of hospital care for Medicare beneficiaries, particularly those who were seriously ill and had the greatest need, would be compromised.[102] With respect to quality assurance, the Senate Finance Committee and some interest groups questioned the ability of fiscal intermediaries, i.e., Blue Cross plans and insurance companies with which HHS contracts to administer Medicare coverage and payment determinations,[103] to carry out this key function, and wanted Peer Review Organizations (PRO's), with their mandated physician control, to assume this monitoring responsibility.[104]

Congress disagreed with the Reagan Administration about the appropriate administrative structure for the prospective payment system in

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Means, 98th Cong., 1st Sess. (1983) [hereinafter *House Ways and Means Comm. Hearings on Medicare Hospital Prospective Payment System*].

[98]EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT & BUDGET, BUDGET OF THE UNITED STATES, FY 1984 5-129 (1983).

This figure was derived by dividing estimated Medicare budget outlays for FY 1983 by total federal budget outlays for FY 1983.

[99]*Senate Finance Comm. Hearings on the Hospital Prospective Payment System*, *supra* note 97, Part I, at 128, 135 (statement of J. Alexander McMahon, President, American Hospital Association).

[100]*See id.* at 123-27; *House Ways and Means Comm. Hearings on Medicare Hospital Prospective Payment System*, *supra* note 97, at 19-30.

[101]*See Senate Finance Comm. Hearings on the Hospital Prospective Payment System*, *supra* note 97, Part I, 47-48, 96-98, Part II, 162-204, 213, 293-98; *House Ways and Means Comm. Hearings on Medicare Hospital Prospective Payment System*, *supra* note 97, at 123-29, 139-44.

[102]*Id.*

[103]*See* 42 U.S.C. § 1395h (1982 & Supp. 1985).

[104]*Senate Finance Comm. Hearings on the Hospital Prospective Payment System, supra* note 97, Part II, at 9-90, 162-204, 213.

several respects. The Administration had proposed that the Secretary set the hospital payment rates with input from an outside panel of experts on hospital finance appointed by the Secretary and that fiscal intermediaries monitor hospital admitting and discharge practices and the quality of care accorded Medicare beneficiaries.[105] Further, under the Administration's proposal, providers would have no right to appeal any payment issue—an approach justified as necessary to preserve the integrity of the rate structure under the prospective payment system.[106] But it is fair to say that some of the congressional distrust of the Administration's approach for structuring the prospective payment system came from a perception of this particular Administration's ideological belief that the federal government's role in addressing social problems should be minimal.

A. The Administrative Structure for Making Allocation Decisions Under the Prospective Payment System

Congress decided that decisions by the federal government at the societal level as well as by hospitals and physicians at the individual level about the allocation of medical resources under the Medicare program would be made by setting a price for each Medicare case. Specifically, through the pricing process, the federal government would make the decisions about what federal resources to devote to Medicare hospital services versus other public obligations such as defense and further, about what resources to dedicate to all public obligations versus those that should be left for private purposes. At the individual level, price would also influence how individual hospitals and physicians would decide what resources to use for the care of individual Medicare beneficiaries.

In designing the administrative structure for the prospective payment system, Congress had four chief objectives: (1) ensure that the price was fair compensation for services rendered and thus would not compromise access to hospital services particularly for the more seriously ill; (2) ensure that the process for updating the price would account for new

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[105]*Senate Finance Comm. Hearings on the Hospital Prospective Payment System*, *supra* note 97, Part I, 5-11.

[106]HHS Report to Congress, *supra* note 83, at 41. In this report, HHS stated its position on proscribing hospital appeals altogether:

> Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review. . . . As with any service sold to the Government, the remedy for providers dissatisfied with the rate offered is to convince the purchasing agency that a higher rate is appropriate or, failing that, to refrain from offering services to the Government.

Id.

medical technology, inflation, and other factors that legitimately affect the ability of hospitals to provide care; (3) monitor the quality of hospital services for Medicare beneficiaries under the prospective payment system, and (4) provide a mechanism through which beneficiaries and hospitals could resolve problems with their treatment under the system.[107]

In designing the administrative structure for the prospective payment system, Congress assigned responsibilities to organizations outside the executive branch to participate in decisions about allocation of resources at the societal level as well as at the individual level. Through the use of independent organizations in this unprecedented manner, Congress sought to create a check on the executive branch's control of the prospective payment system and to provide input from the hospital industry, the medical profession, and Medicare beneficiaries on its implementation and operation. This approach to designing an administrative structure for a public insurance program is unique and extraordinary. It provides one model for how a government health insurance program can be structured to enable the government as both payer and representative of the public to make ethical decisions in allocating societal resources to medical care for its beneficiaries and, further, to ensure that providers make fair allocation decisions with respect to individual beneficiaries.

1. The Medicare Rate Structure.—Congress gave HHS primary responsibility for setting and updating hospital payment rates.[108] In determining the rate setting methodology initially, Congress faced four central issues: (1) how would Medicare cases be classified for pricing purposes without jeopardizing the availability of services for seriously ill patients requiring above average amounts of hospital services per hospital stay; (2) what costs would be included in the prices and what costs would be reimbursed separately; (3) how would the rate structure accommodate the various missions, characteristics and geographic locations of different hospitals; and (4) how would the transition from cost reimbursement to the new payment system be accomplished.[109] Congress was also aware that precise data were not available to address these questions adequately and thus flexibility had to be incorporated into the rate setting methodology to address these questions and other unanticipated problems in the future.[110]

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[107]*See generally* H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983); S. Rep. No. 23, 98th Cong., 1st Sess. 111 (1983).

[108]42 U.S.C. § 1395ww(e)(5)(A) (Supp. 1985).

[109]*See Senate Finance Comm. Hearings on the Hospital Prospective Payment System, supra* note 97, at 3-11; *House Ways and Means Comm. Hearings on the Medicare Prospective Payment System, supra* note 97, at 10-13.

[110]H.R. Rep. No. 47, 98th Cong., 1st Sess. 202 (1983).

Under the prospective payment system, the Medicare program pays hospitals a fixed price for each Medicare case based on the diagnosis related grouping (DRG) in which the patient's particular condition falls.[111] The basic concept of the DRG classification system, which is comprised of 470 mutually exclusive DRG's, is that all human disease can be classified according to organ system, length of stay, intensity of resources consumed, morbidity, and sex and that such categories reflect the average cost of providing hospital services to all patients with diseases that fall within the particular category.[112]

The price is determined using a formula by which a figure representing the average price per case for all Medicare cases, called the "standardized amount," is multiplied by the DRG "weight" assigned to the particular patient's case.[113] However, if a particular case greatly exceeds the cost and length of stay ordinarily required for a case in the DRG to which the case would be assigned, Medicare will pay more for that "outlier" case than the DRG price.[114] Some costs are excluded from DRG's, including capital costs of interest and depreciation,[115] as well as the direct costs of medical education.[116]

In a transition period from fiscal year 1983 through fiscal year 1987, the standardized amount is based in part on the actual costs of individual hospitals although in following years, the standardized amount will simply be a national average cost per case for all rural and all urban hospitals.[117]

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[111]42 U.S.C. § 1395ww(d)(1) (Supp. 1985).

[112]This case classification system is based on the *International Classification of Diseases, Ninth Revision, Clinical Modification,* developed by the World Health Organization. *See* Preamble to Interim Final Rule, Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752 (Sept. 2, 1983), at 39,760-61.

[113]42 U.S.C. § 1395ww(d)(1) (Supp. 1985). The DRG weight is a figure representing the proportion of hospital resources that patients in the DRG use on average compared to the average cost of all Medicare cases. *Id.* § 1395ww(d)(4)(B).

[114]*Id.* § 1395ww(d)(5).

[115]*Id.* § 1395ww(a)(4). Congress intended to incorporate capital costs in the DRG prices within a few years after the inception of the prospective payment system. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(d), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww(g)(1) (Supp. 1985)). HHS proposed taking this step for fiscal year 1987 as did the Prospective Payment Assessment Commission. *See* DEP'T OF HEALTH & HUMAN SERVICES, REPORT TO CONGRESS, HOSPITAL CAPITAL EXPENSES: A MEDICARE PAYMENT STRATEGY FOR THE FUTURE (1986); PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES [hereinafter PROPAC REPORT AND RECOMMENDATIONS TO THE SECRETARY, APRIL 1, 1986]. Congress did not take this step for fiscal year 1987 but only imposed limits on reimbursement of hospitals' capital costs for the next few years. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9303, 100 Stat. ____.

[116]42 U.S.C. § 1395ww(a)(2) (Supp. 1985). The prospective payment system also pays an additional allowance to teaching hospitals for higher costs associated with teaching activities. *Id.* § 1395ww(d)(5)(B).

[117]*Id.* §§ 1395ww(b)(3)(A), 1395ww(d)(1).

The standardized amount is updated for inflation and other factors discussed below; "standardized" to remove costs attributable to explainable differences between hospitals, i.e., area wage rates, teaching status, and case mix; and adjusted to reflect payments in outlier cases and the wage level for the area in which the hospital is located.[118]

Congress required HHS to update payments to hospitals annually. This process involves (1) adjusting the standardized amount to reflect inflation, hospital productivity, and new technology, and (2) readjusting the DRG's to reflect changes in resource consumption due to new technology and other factors.[119] In updating the standardized amount, the Secretary must take into account changes in the hospital "market basket" (i.e, the goods and services hospitals purchase to care for Medicare beneficiaries), hospital productivity, technological and scientific advances, quality of health care, and the "long term effectiveness" of the Medicare program as well as recommendations of the Prospective Payment Assessment Commission (ProPAC).[120] The Secretary, also with the advice of ProPAC, must annually adjust the DRG classification and weighting factors "to reflect changes in treatment patterns, technology and other factors which may change the relative use of hospital resources."[121]

There have been serious concerns about the fairness of the prospective payment system's rate setting methodology. First, do the DRG prices, which are based on averages, discriminate against more seriously ill patients who require more resources for their care and cause hospitals to incur costs over and above the DRG price for the patient's diagnosis?[122] Second, does the exclusion of certain costs from the DRG prices compromise the cost saving capability of the pricing system and equity between hospitals by allowing hospitals to push as much of their costs as possible into accounting categories, i.e., capital and medical education, that are reimbursed separately on a cost basis?[123] Third, are hospital payment rates and particularly the DRG prices, which are established according to older data on hospital cost experience, flexible enough to

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[118] *Id.* § 1395ww(d).

[119] *Id.* §§ 1395(d)(3)(A), (d)(2)(D).

[120] *Id.* § 1395ww(e)(2).

[121] *Id.* § 1395ww(d)(4)(C).

[122] *See* Horn, Bulkley, Sharkey, Chambers, Horn & Schramm, *Interhospital Differences in Severity of Illness: Problems for Prospective Payment Based on Diagnosis-Related Groups (DRG's)*, 313 NEW ENG. J. MED. 20 (1985); Horn, Sharkey & Bertram, *Measuring Severity of Illness: Homogeneous Case Mix Groups*, 21 MEDICAL CARE 14 (1983); *see also* AM. HOSP. ASS'N, MEDICARE PROSPECTIVE PRICE BLENDING ON A DRG-SPECIFIC RATE: A POTENTIAL MEANS OF REACHING THE MOST EQUITABLE METHOD OF DETERMINING THE MEDICARE PRICES TO BE PAID TO EACH HOSPITAL (1984).

[123] *See* Verville, *Medicare Rate Setting and Its Problems: A Fixed Price Per Bundled Product*, 6 J. LEGAL MED. 85 (1985).

permit development and diffusion of new and efficacious medical technology.[124] Finally, are hospitals with special missions and characteristics fairly treated under the prospective payment system?[125]

2. Making Decisions at the Societal Level: The Role of The Prospective Payment Assessment Commission.—Congress created ProPAC, a congressional commission, to participate in the process of setting and updating the DRG prices and essentially to evaluate the performance of the executive branch in making allocation decisions at the societal level.[126] Congress conceived of this commission as serving as "a highly knowledgeable independent panel to advise the executive and legislative branches on the Medicare reimbursement system."[127] This commission is composed of seventeen experts in health care delivery, finance, and research appointed by the Director of the congressional Office of Technology Assessment and must be representative of the health care industry with members from national organizations of physicians, hospitals, and health care equipment manufacturers as well as business, labor, and the elderly.[129]

ProPAC has two statutory responsibilities: (1) to recommend to the Secretary of HHS how to update hospital payment rates, and (2) to recommend to the Secretary necessary changes in DRG's, including the advisability of establishing new DRG's, modifying existing DRG's, or changing the relative weights of the DRG's.[129] Congress sees ProPAC's mission as extending beyond these responsibilities, as stated by the House Committee on Appropriations: "[T]he Committee believes that the primary role of the Commission lies in a broader evaluation of the impact of Public Law 98-121 [sic] on the American health care system."[130] To be sure that ProPAC has the requisite information to perform these responsibilities, Congress mandated that ProPAC would have access to all relevant information, data and research within the federal government as well as adequate funding to collect information and conduct its own research.[131]

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[124]Anderson & Steinberg, *To Buy or Not to Buy: Technology Acquisition Under Prospective Payment*, 311 NEW ENG. J. MED. 182 (1984).

[125]*See Senate Finance Comm. Hearings on the Hospital Prospective Payment System, supra* note 97, Part I, 129-46; *House Ways and Means Comm. Hearings on the Medicare Prospective Payment System, supra* note 97, at 36-44.

[126]Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww(e)(2) (Supp. 1985)).

[127]H.R. REP. No. 911, 98th Cong., 2d Sess. 140 (1984).

[128]42 U.S.C. §§ 1395ww(e)(2), (6)(A), (6)(B) (Supp. 1985).

[129]*Id.* § 1395ww(d)(4)(D), (e)(3). *See* PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, APRIL 1, 1985, at 3 (1985) [hereinafter PROPAC REPORT AND RECOMMENDATIONS TO THE SECRETARY, APRIL 1, 1985].

[130]H.R. REP. No. 911, 98th Cong., 2d Sess. 140 (1984).

[131]42 U.S.C. §§ 1395ww(e)(6)(F), (I) (Supp. 1985).

Congress also mandated a formal schedule of public communications between ProPAC and HHS with respect to the annual updating of hospital payment rates. ProPAC must prepare three reports each year: (1) a report to the Secretary on adjustments to the prospective payment system; (2) a report to Congress on the prospective payment system and the American health care system; and (3) a report to Congress on the adjustments adopted by the Secretary in his annual October regulations to govern the prospective payment system for the upcoming fiscal year.[132] The Omnibus Budget Reconciliation Act of 1986 included Congress and providers, beneficiaries, and other interested parties more directly in this dialogue with the requirements that HHS prepare documented recommendations to Congress on updating payment rates by April 1st and publish the proposed rule on payment rates no later than June 1st to allow a 60 day comment period.[133] The Secretary must publish the final rule by September 30th.[134] Through this dialogue, Congress sought to impose accountability on the executive branch in setting the hospital payment rates and to ensure that providers, beneficiaries, and other interested parties have ample opportunity over and above the informal rule making process managed by HHS to become involved in the rate setting process.

3. Making Decisions at the Individual Level: The Role of Peer Review Organizations.—To ensure that hospitals and physicians make good decisions about the allocation of hospital services at the individual level, Congress gave Peer Review Organizations important monitoring and enforcement responsibilities over hospital conduct under the prospective payment system.[135] PRO's are private, physician-controlled organizations designated under the Peer Review Improvement Act of 1982.[136] HHS contracts with PRO's to have PRO's perform certain functions and accomplish specific objectives in return for payment.[137]

For the prospective payment system, Congress has required HHS to contract with PRO's to monitor four areas of hospital behavior to assure that services to Medicare beneficiaries are medically necessary, reasonable and appropriately provided on an inpatient basis: (1) the validity of diagnostic information supplied by hospitals for payment purposes; (2) the completeness, adequacy, and quality of care provided by hospitals

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[132]*Id.* § 1395ww(d)(4)(D), (e)(3). *See* H.R. REP. No. 911, 98th Cong., 1st Sess. 140 (1984).

[133]Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9302(e)(3), 100 Stat. ____ (amending 42 U.S.C. § 1395ww(e)(3) (1982 & Supp. 1985)).

[134]42 U.S.C. § 1395ww(d)(4)(D) (Supp. 1985).

[135]42 U.S.C. § 1395cc(a)(1) (1982 & Supp. 1985).

[136]Peer Review Improvement Act of 1982, tit. I, subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 141 *et seq.*, 96 Stat. 324 (codified as amended at 42 U.S.C. § 1320c-2(b)(3)(A) (Supp. 1985)).

[137]42 U.S.C. §§ 1320c-2, 1320c-3(a) (Supp. 1985).

to Medicare beneficiaries; (3) the appropriateness of hospital admissions and discharges; and (4) the appropriateness of care in "outlier" cases in which additional Medicare payment was made.[138] As a condition of payment, all hospitals must have a contract with the designated PRO authorizing the PRO to conduct these review activities.[139]

PRO's have considerable power to force hospital compliance with HHS admission and other quality standards. They may deny payment to hospitals where abusive practices are found and, in some instances, report such practices to HHS for additional enforcement action.[140] In the Consolidated Budget Reconciliation Act of 1985, this punitive authority was expanded to permit PRO's to deny payment for specific cases in which the PRO finds that substandard care was provided to a Medicare beneficiary.[141] In addition, PRO's handle appeals of beneficiaries and hospitals regarding coverage of and, in some instances, payment for hospital services under the prospective payment system.[142]

The basic responsibility of PRO's is to see that the hospital services that the Medicare program purchases for individual beneficiaries are appropriate, necessary, and provided in the most cost effective manner. PRO's are also the means by which beneficiaries as well as hospitals can challenge Medicare coverage and payment decisions that they find unfair. Implicit in these responsibilities are two critical functions from an ethical perspective. The first function is to oversee how hospitals and physicians allocate health care resources among individual Medicare beneficiaries who need these services and specifically whether these services were of sufficient amount and quality. The second function, as explained below, is to provide a mechanism whereby individual beneficiaries can register complaints when they believe that hospitals, physicians, or the Medicare program have not allocated resources fairly in their individual cases.

4. Protecting Individual Interests: Opportunity for Appeal.—The procedures available for administrative and judicial review under the Social Security Act are a chief means for individual beneficiaries and also hospitals to raise specific objections about their treatment under the prospective payment system and to contest decisions about the allocation of Medicare services that affect them directly. Where allocation decisions affect the quality of services, tort law also offers some protection to individual beneficiaries vis-a-vis providers. The ability of hospitals and

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[138]*Id.* § 1395cc(a)(1)(F).

[139]*Id.*

[140]*Id.* §§ 1320c-3(a)(2), 1320c-5(b)(1).

[141]Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, tit. IX, § 9403, 100 Stat. 82, 200 (amending 42 U.S.C. § 1320c-3(a)(2) (1982 & Supp. 1985)).

[142]*See infra* notes 143-50 and accompanying text.

beneficiaries to challenge the composition of DRG's is specifically precluded by statute,[143] thus effectively inhibiting the ability of individual beneficiaries and hospitals to challenge effectively the allocation of resources to Medicare hospital services at the societal level.

Beneficiaries have a right to administrative and judicial review of disputes over coverage of and payment for hospital services under the Medicare program. If a beneficiary is denied coverage and payment for any inpatient hospital service, including admission or continued stay in the hospital, the beneficiary may appeal the decision to the PRO and seek reconsideration of the PRO decision by HHS.[144] If the amount involved exceeds $200, the beneficiary can obtain a hearing before an administrative law judge in the Social Security Administration and, for claims exceeding $2000, judicial review in federal district court.[145]

As noted, individual beneficiaries have the right to challenge substandard care under the common law tort system and this ability, according to some observers, provides an effective protection against substandard or insufficient care in a rationing context.[146] In this regard, a recent California decision, *Wickline v. State*,[147] in which the court recognized that a payer could be liable for negligence in cases where a provider's decision to terminate treatment was predicated on the payer's policy of limiting payment for the treatment, is important. This case suggests tort law could provide greater protection in the future by imposing liability directly on payment programs that force hospitals to deliver services more efficiently and limit needed services in specific cases as well as some protection to providers forced to make treatment decisions because of cost considerations.

Hospitals have more limited rights of appeal under the prospective payment system. Congress prohibited providers from challenging the DRG prices through administrative appeal or judicial review. Specifically, a hospital may obtain administrative or judicial review of any payment decision except the establishment of DRG's, the methodology for classifying patient discharges into DRG's, or the appropriate weighting factor

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[143]*See infra* notes 149-50 and accompanying text.

[144]42 U.S.C. § 1320c-4 (Supp. 1985); 42 C.F.R. §§ 473.16, .40 (1986).

[145]42 U.S.C. § 1320c-4 (1982 & Supp. 1985); 42 C.F.R. §§ 473.16, .40 (1986).

[146]Blumstein, *Rationing Medical Resources*, *supra* note 15, at 1392-99; *see also* Schuck, *Malpractice Liability and the Rationing of Care*, 59 TEX. L. REV. 1421 (1981). *But see* Rosenblatt, *Rationing "Normal" Health Care*, 59 TEX. L. REV. 1401, 1411-19 (1981). This article challenges Professor Blumstein's thesis that medical malpractice serves as an adequate check to the unfair rationing of resources on an individual basis.

[147]183 Cal. App. 3d 661, 228 Cal. Rptr. 661 (1986), *rev. granted*, slip op. (Cal. Nov. 20, 1986). *See* Comment, *Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of* Wickline v. State, 34 BUFFALO L. REV. 1011 (1985).

for DRG's.[148] Congress, like the Reagan Administration which advocated even more restrictive appellate rights for hospitals,[149] expressly precluded such review out of concern that it would jeopardize the integrity of the rate structure under the prospective payment system.[150]

B. Performance of the Model

It is still early to assess fully the efficacy of this administrative model in making decisions about the allocation of limited Medicare resources either on a societal level or an individual level. However, at this point, the fourth year of the prospective payment system, some observations about the model and its ability to meet its important resource allocation responsibilities are possible and appropriate. In assessing the performance of this model, it must be appreciated that many hospitals have done quite well under the system[151] and serious scarcities requiring difficult allocation decisions have not occurred.

To date, four issues have emerged that suggest how this administrative model is working in allocating resources for hospital services. First is the annual process of updating hospital payment rates.[152] Second is the question of whether the prospective payment system should accord special financial treatment to hospitals that serve a disproportionate number of low income and Medicare patients.[153] Third is the implementation of the peer review program and the specific problems of developing an adequate mechanism for monitoring the quality of care that hospitals provide Medicare beneficiaries.[154] Finally there is the question of how this administrative structure dealt with reported problems that Medicare beneficiaries were discharged from hospitals in a sicker condition, against their will, and with little recourse to contest such discharge decisions.[155]

1. Updating the DRG prices.—As discussed above, the federal government makes decisions at the societal level about the allocation of federal resources to hospital services for Medicare beneficiaries by setting the price that the Medicare program will pay for each Medicare case. It is clear from performance to date that the executive branch has taken

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[148]42 U.S.C. §§ 1395oo(g)(2), 1395ww(d)(7) (1982 & Supp. 1985).

[149]*See supra* note 106.

[150]H.R. REP. No. 25, PT. 1, 98th Cong., 1st Sess. 142-3 (1983); H.R. REP. No. 47, 98th Cong., 1st Sess. 202 (1983).

[151]*See* DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, FINANCIAL IMPACT OF THE PROSPECTIVE PAYMENT SYSTEM ON MEDICARE PARTICIPATING HOSPITALS - 1984 (1984); PROPAC REPORT ON THE AMERICAN HEALTH CARE SYSTEM, *supra* note 85, at 47, 52-53; *National Health Expenditures, 1984*, *supra* note 14, at 23.

[152]*See infra* notes 156-75 and accompanying text.

[153]*See infra* notes 176-97 and accompanying text.

[154]*See infra* notes 198-208 and accompanying text.

[155]*See infra* notes 209-16 and accompanying text.

a strict view of the federal resources that will be allocated to this purpose. This position has generated conflict with hospitals and also with Congress. HHS has not adopted ProPAC recommendations on various methodologies for updating hospital payment rates and has always developed lower rates than it would using formulas suggested by ProPAC.[156] In recent years, Congress, relying on ProPAC's analysis, has legislatively supplanted HHS rules on updating hospital payment rates in order to establish more generous payment rates.[157]

In its first recommendations for fiscal year 1986 payment rates, ProPAC conservatively confined its recommendations to updating hospital payment rates and changing one DRG which had permitted hospitals to make enormous profits.[158] HHS adopted another method for updating payment rates, which resulted in a lower payment rate for fiscal year 1986, and changed several DRG's.[159] In its fiscal year 1987 recommendations, ProPAC was more activist. Besides recommendations on updating payment rates, ProPAC proposed that the Secretary include capital costs in the DRG prices beginning in fiscal year 1987 and that HHS adjust certain DRG's to reflect new treatment modalities and their use of labor resources.[160] ProPAC also addressed issues outside its strict statutory mandate and made recommendations for improved appeals procedures for beneficiaries and improved quality of care review by PRO's.[161] Again, HHS disregarded ProPAC's recommendations on hospital payment rates and adopted formulas and assumptions for fiscal year 1987 that resulted in lower payment rates than suggested by ProPAC.[162] HHS also proposed folding capital costs into the DRG prices but in a manner different and less expensively than ProPAC had proposed.[163]

The Administration's action on updating hospital payment rates for fiscal years 1986 and 1987 has been controversial. In commenting on the fiscal year 1987 rates, hospitals charged that HHS was motivated chiefly by its desire to cut Medicare budgetary expenditures rather than setting a fair price for hospital services. Specifically, according to an AHA spokesman:

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[156]*See infra* notes 165-67 and accompanying text.

[157]*See infra* notes 172-75 and accompanying text.

[158]ProPAC Report and Recommendations to the Secretary, April 1, 1985, *supra* note 129, at 8, 33-35, 41-42.

[159]Preamble to Proposed Rule, 50 Fed. Reg. 24,366. (1985); Interim Final Rule, 51 Fed. Reg. 16,772 (1986).

[160]ProPAC Report and Recommendations to the Secretary, April 1, 1986, *supra* note 115, at 32-33.

[161]*See infra* notes 209-30 and accompanying text.

[162]51 Fed. Reg. 16,772 (1986).

[163]51 Fed. Reg. 19,970, 19,983-85 (1986).

> In our response to the FFY 1986 proposed rule on PPS, AHA commented that "the Health Care Financing Administration (HCFA) has an obligation to the public to do more in the Notice than provide a statement of those beliefs that form the basis for the rule; HCFA must provide evidence which validates their beliefs." For a second year, the notice of proposed rates fails to document the appropriateness and validity of the update factor and other changes. Absent detailed evidence, AHA must assume that the primary motivating factor in the development of each component of the rate calculation is budget reduction. We can only conclude that HCFA is not truly interested in the adequacy of the rates that are promulgated, the equity of payments to hospitals or the administration of the Medicare program in a manner that reflects its responsibilities to Medicare beneficiaries and providers. If these issues had been considered in the development of the PPS rates for FY 1987, the update factor and other modifications identified by HCFA would be better documented by quantitative and qualitative evidence of the adjustments and their appropriate levels.[164]

ProPAC has also voiced complaints about HHS' conduct in updating hospital payment rates. In its comments to the proposed rule on payment rates for fiscal year 1987, ProPAC observed that its approach and that of HHS in updating hospital payment rates were "diverging in significant ways" and this divergence appeared to be based on a "difference in philosophy between the Commission and the Department."[165] ProPAC explained this difference in philosophy as based on ProPAC's belief that the prospective payment system "should be a flexible and evolutionary system responsive to changing health technology and practice patterns and to the distributional impacts of payments within the system" and that adjustments in the system are "critical to maintaining an environment which fosters innovation and scientific advancement."[166] HHS, in relying on averaging methodologies and ignoring adjustments in the payment system to reflect special circumstances and new developments in medical technology and their impact on specific DRG's, did not advance these

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[164]Letter from Jack Owen, Executive Vice President of the American Hospital Association, to William Roper, M.D., Administrator of the Health Care Financing Administration (July 3, 1986) (comments on Proposed PPS Rules for FFY 1987).

[165]Letter from Stuart H. Altman, Ph.D., Chairman of the Prospective Payment Assessment Commission, to William L. Roper, M.D., Administrator of the Health Care Financing Administration (July 2, 1986) (comments of the Prospective Payment Assessment Commission on the Notice of Proposed Rulemaking of June 3, 1986, Concerning Fiscal Year 1987 Changes in the Inpatient Hospital Prospective Payment System).

[166]*Id.*

objectives. ProPAC commented further on HHS' response to ProPAC's recommendations:

> ProPAC was established by the Congress to provide independent advice and oversight on a new, untried prospective payment system. From the beginning, we have strived to make our decision-making analytically based, with careful consideration to a wide range of options on every topic which we review. We do not believe that the Secretary's response to our recommendations always gives full consideration to the detail and extent of the problems we have identified. We also do not believe that the response exhibits the flexibility which we believe is necessary to update and maintain the system. In order to encourage the confidence of beneficiaries, providers, suppliers, and taxpayers, we hope that the Secretary will reconsider the details of our analysis in developing the final fiscal year 1987 PPS regulations.[167]

Finally, there was even debate within the Administration about the fairness of the updated payment rates, i.e., 0.5%, that the Administration had proposed in June 1986.[168] In August 1986, the new physician Secretary of HHS, Dr. Otis Bowen, took the position that if the fiscal year 1987 hospital payment rates were not updated at least 1.5%, then the quality of hospital care for Medicare beneficiaries would be jeopardized.[169] Eventually, the Office of Management and Budget prevailed in the internicine debate, and the final rule updated fiscal year 1987 payment rates 0.5%.[170]

In the context of setting the federal budget, Congress has taken an extraordinarily active role in updating hospital payment rates and thus in making allocation decisions as to how much federal resources should be devoted to hospital care for Medicare beneficiaries. Initially, Congress took a restrictive perspective as to the amount of resources to devote to this purpose and in the Deficit Reduction Act of 1984 tightened the formula for updating hospital payment rates to account for inflation.[171]

But since 1984, Congress has taken a more expansive perspective, at least when compared with the executive branch. Congress has not approved of the Administration's positions on how to adjust hospital payment rates and has supplanted HHS rules for updating hospital payment rates with legislation for fiscal years 1986 and 1987. Specifically,

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[167] *Id.*

[168] 51 Fed. Reg. 19,970 (1986).

[169] AM HOSP. ASS'N, WASHINGTON MEMO, (Memo #616, Aug. 29, 1986).

[170] 51 Fed. Reg. 31,498 (1986).

[171] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2310(a), 98 Stat. 1075 (codified as amended at 42 U.S.C. § 1395ww(b)(3)(B) (Supp. 1985)).

Congress refused to uphold a freeze on hospital payment rates that HHS proposed for fiscal year 1986.[172] Also, in the Balanced Budget Budget and Emergency Deficit Control Act of 1985 (Graham-Rudman-Hollings), Congress mandated that hospital payments could only be reduced from fiscal year 1986 payment rates by one percent for the remainder of the fiscal year and by two percent in following years to assure that the Medicare program was not the target of excessive budget cutting.[173] Also, in the Omnibus Budget Reconciliation Act of 1986, Congress increased hospital payment rates by 1.15% for fiscal year 1987 compared to the 0.5% proposed by HHS.[174] The House Ways and Means Committee expressed considerable displeasure with HHS' performance in updating rates and the consequent need for Congress to step in and change rates legislatively, stating:

> The Committee has given, in the past, a significant amount of discretion to the Secretary of Health and Human Services in developing the annual update factor for hospital payments under the [M]edicare program. The statutory language requires that hospital payments reflect the amounts necessary for the efficient delivery of medically appropriate and necessary care of high quality.
>
> The Committee has, however, for the last two years overridden the Administration's recommended update factor. The Committee finds itself in the same situation once again this year as it finds the Secretary's recommended FY 1987 update factor unacceptable. The Committee concludes that the Administration, in developing the update factor for fiscal year 1987 used factors other than those originally anticipated in the legislation.[175]

It is clear that under the current administrative model, the executive branch has considerable authority to determine the proportion of federal resources that will be attributed to hospital care of Medicare beneficiaries. It is also clear that ProPAC's role and the mandated dialogue between

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[172]*See* Emergency Extension Act of 1985, Pub. L. No. 99-107, § 5(c), 99 Stat. 480, *amended by* Pub. L. No. 99-201, § 34, 99 Stat. 1184 (1985); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9101, 100 Stat. 82 (codified as amended at 42 U.S.C. §§ 1395ww(b)(3)(B), (d)(3)(A) (Supp. 1985)).

This legislation abrogated the freeze on fiscal year 1986 payment rates HHS promulgated in its Final Rule of 1986 Rates, 50 Fed. Reg. 35,646 (1985), and substituted a freeze on payment rates at levels Congress determined.

[173]Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, § 3256(d)(1), 99 Stat. 1087.

[174]Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9303(a), 100 Stat. ____ (amending 42 U.S.C. § 1395ww (1982 & Supp. 1985)).

[175]H.R. Rep. No. 727, 99th Cong., 2d Sess. 427 (1986).

HHS and ProPAC have not functioned as intended to force HHS to state the rationale for its decisions about payment rates in a detailed manner and justify those that are contrary to the outside commission of experts. Indeed, this process has had little effect on influencing how HHS actually updates the DRG prices. This situation has precipitated a more interventionist role by Congress in the rate setting process and has changed the role of ProPAC. ProPAC has provided Congress with the information that it needs to substitute its own judgments for those of the executive branch in this complex, highly technical area, through the political process. This administrative model thus exemplifies a process by which the legislative branch can obtain the requisite technical information to make informed judgments that are generally left to administrative agencies and their technical expertise.

2. Treatment of Disproportionate Share Hospitals.—In the prospective payment system, Congress authorized the Secretary to make exceptions and adjustment for "public and other hospitals that served a significant disproportionate number" of low income and Medicare patients.[176] In authorizing this adjustment, Congress was concerned that such hospitals may serve patients that are "more severely ill than average and the DRG payment system would not adequately take into account such factors."[177] In refining the payment methodology for the prospective payment system initially, HHS refused to adopt an adjustment for such hospitals because "current data do not show that such an adjustment is warranted," and HHS has consistently maintained this position ever since.[178]

HHS' refusal to create an adjustment for so-called disproportionate share hospitals generated considerable litigation by public and other hospitals that serve primarily low income patients seeking a judicial mandate that HHS create an exception for disproportionate share hospitals.[179] In *Redbud Hospital District v. Heckler*,[180] the United States

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[176]42 U.S.C. § 1395ww(d)(5)(c)(i) (Supp. 1985).

[177]H.R. REP. No. 25 Part I, 98th Cong., 1st Sess. 192-3 (1983); *see also* S. REP. No. 23, 98th Cong., 1st Sess. (1983); H.R. REP. No. 47, 98th Cong., 1st Sess. (1983).

[178]Preamble to Final Rule, 49 Fed. Reg. 234, 276 (1984).

[179]*See, e.g.*, Samaritan Health Center v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,862 (D.D.C. Aug. 28, 1985); Sunshine Health Sys., Inc. v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,858 (C.D. Cal. July 22, 1985); Redbud Hosp. Dist. v. Heckler, [1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. July 30, 1984), *modified*, [1985 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,669 (N.D. Cal. June 14, 1985), *application for stay of preliminary injunction granted*, 106 S. Ct. 1 (1985) (Rehnquist, J. sitting as Circuit Judge).

[180][1984-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,085 (N.D. Cal. 1984), *modified*, [1985 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,669 (N.D. Cal. June 14, 1985), *application for stay of preliminary injunction granted*, 106 S. Ct. 1 (1985) (Rehnquist, J., sitting as Circuit Judge).

District Court for the Northern District of California ruled that the Secretary of HHS had abused her discretion in not addressing the special needs of disproportionate share hospitals and ordered HHS to promulgate regulations or written policies that would "take into account the special needs" of disproportionate share hospitals.[181] HHS did issue regulations authorizing a very narrowly drawn exception applicable for very few hospitals[182] when the *Redbud* district court ordered their promulgation by July 1, 1985.[183] HHS rescinded these regulations when Justice Rehnquist, sitting as circuit judge, stayed the court's order.[184]

Concerns about treatment of disproportionate share hospitals under the prospective payment system were raised in other arenas as well. Congress became concerned about HHS' refusal to address adequately the special needs of disproportionate share hospitals.[185] In the Deficit Reduction Act of 1984, Congress provided that before December 31, 1984, the Secretary "shall" develop and publish a definition of disproportionate share hospitals, identify those which meet the definition, and notify the Senate Finance Committee and House Ways and Means Committee accordingly.[186]

HHS did not meet this deadline and, through its inaction, behaved in a fashion that suggested that it did not plan to comply with this congressional directive. Consequently, in *Samaritan Health Center v. Heckler*,[187] the United States District Court for the District of Columbia ordered the Secretary to comply with section 2315(h) of the Deficit Reduction Act of 1984 by December 31, 1985. However, the *Samaritan Health Center* court concluded that the Secretary did have discretion as to whether or not to create an adjustment for disproportionate share hospitals.[188]

In its report to the Secretary on the fiscal year 1986 hospital payment rates, ProPAC recommended that the Secretary develop a methodology for adjusting payment rates for hospitals that serve a disproportionate share of Medicare and low income patients that Congress authorized in the Social Security Amendments of 1983.[189] ProPAC justified this rec-

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[181]*Id.* at 9884.

[182]50 Fed. Reg. 27,208 (July 1, 1985).

[183][1985 Transfer Binder] Medicare & Medicaid Guide (CCH), at ¶ 34,669.

[184]106 S. Ct. 1 (1985). *See* 50 Fed. Reg. 30,944 (July 31, 1985).

[185]*See Administration's Fiscal Year 1985 Budget Proposals: Hearings Before the Senate Comm. on Finance*, 98th Cong., 2d Sess. (1984).

[186]Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), 98 Stat. 1075 (codified as amended at 42 U.S.C. § 1395ww(b)(3)(B) (Supp. 1985)).

[187][1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,862 (D.D.C. Aug. 29, 1985).

[188]*Id*; *accord* Sunshine Health Sys. v. Heckler, [1986-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 34,858 (C.D. Cal. July 22, 1985).

[189]ProPAC Report and Recommendations to the Secretary, April 1, 1985, *supra* note 129, at 37.

ommendation with analysis of data indicating that public and other hospitals serving the poor and Medicare patients incurred greater costs in the treatment of these patients.[190] However, in its payment rates for fiscal year 1986, HHS refused to create an adjustment to reflect higher costs for disproportionate share hospitals, relying on its consistent position that HHS data did not justify such an exception.[191]

In December 1985, HHS published a definition of disproportionate share hospitals that provided that eligible hospitals must serve 39.55% low income patients and 91.01% Medicare patients.[192] According to this definition, only 108 hospitals fit under the definition, and large public hospitals that one would expect Congress intended to assist with the disproportionate share provisions were not included.[193]

ProPAC clearly was not convinced that this definition was adequate and, in its recommendations for fiscal year 1987 payment rates, ProPAC reiterated its recommendation that the Secretary implement an adjustment for disproportionate share hospitals.[194] In the proposed rule, HHS responded to ProPAC's recommendations by stating that it had complied with the Deficit Reduction Act of 1984.[195] Nor was Congress convinced that HHS had complied with its requirements that hospitals serving these special patients be treated specially and therefore fairly under the prospective payment system. In the Consolidated Budget Reconciliation Act of 1985, Congress redefined disproportionate share hospitals more generously to include more hospitals, including those urban public hospitals that one would expect would care for large proportions of indigent patients on public health insurance programs.[196] In the Omnibus Budget Reconciliation Act of 1986, Congress further refined the methodology for paying disproportionate share hospitals to provide additional assistance to those in rural areas.[197]

HHS' treatment of the disproportionate share hospital issue indicates that the executive branch has narrowly viewed the needs of hospitals serving underserved groups and restricted the allocation of Medicare resources to those hospitals. Further, it is clear that ProPAC disagrees with HHS' allocation decisions but is relatively powerless, except by

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[190]*Id.* at 37-38.

[191]50 Fed. Reg. 24,393 (1985).

[192]50 Fed. Reg. 53,398 (1985).

[193]For a list of disproportionate share hospitals, see [1986-1] Medicare & Medicaid Guide (CCH) ¶ 35,102.

[194]ProPAC Report and Recommendations to the Secretary, April 1, 1986, *supra* note 115, at 37.

[195]51 Fed. Reg. 19,970, 19,996 (1986).

[196]Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, §105, 100 Stat. 82 (amending 42 U.S.C. § 1395ww(d)(5) (Supp. 1985)).

[197]Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9306, 100 Stat. ____ (amending 42 U.S.C. § 1395ww(d)(5)(F) (Supp. 1985)).

virtue of is analytical authority, to get HHS to change its position. The key player in this allocation decision, as clearly conceived by the courts, is Congress. Congress has stepped in several times to address the problems of hospitals serving a poor clientele with special and expensive needs, indicating that the ultimate means of resolving allocation problems under the prospective payment system has been essentially political.

3. Implementation of the PRO Program.—Reviews of PRO performance in monitoring hospital behavior and quality of care under the prospective payment system are mixed. By statute, hospitals had to have a contract with a PRO by October 1984, although this date was extended to November 1984 because of HHS' delays in entering contracts with PRO's in all states and in issuing the requisite regulations for the selection and designation of PRO's and other administrative matters, a matter of grave concern to Congress.[198] By November 1984, HHS entered contracts with fifty-four PRO's for all states and territories.[199] Many PRO's were slow getting started and the performance of some PRO's was so deficient that HHS terminated their participation in the program.[200]

The chief complaint of PRO's, Congress, hospitals and beneficiaries about HHS's administration of the program in its first two years was that the contracts required PRO's to focus excessively on cost containment goals to the detriment of quality of care goals, with concentration chiefly on reducing unnecessary hospital admissions.[201] For the first PRO contracts, HHS delineated five quality objectives: (1) reduce unnecessary hospital readmissions resulting from substandard care; (2) assure provision of medical services which, if not performed, have a significant potential for causing complications; (3) reduce "avoidable deaths;" (4) reduce unnecessary surgery and invasive procedures; and (5) reduce postoperative and other complications.[202]

In the first year of the prospective payment program, concerns were raised that these objectives did not permit PRO's to determine whether

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[198]Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2347(c), 98 Stat. 494 (amending 42 U.S.C. § 1302c-2(b)(2) (Supp. 1985)). HCFA did not promulgate final regulations to govern PRO activities until April 1985. 50 Fed. Reg. 15,312 (1985).

[199]Dans, Weiner & Otter, *Peer Review Organizations—Promises and Pitfalls*, 313 NEW ENG. J. MED. 1131 (1985).

[200]*See* PROSPECTIVE PAYMENT ASSESSMENT COMM'N, TECHNICAL APPENDIXES TO THE REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, APRIL 1, 1986, App. C at 158 [hereinafter TECHNICAL APPENDIXES TO THE PROPAC REPORT AND RECOMMENDATION TO THE SECRETARY, APRIL 1, 1986].

[201]AM. ASS'N OF PEER REVIEW ASS'NS, PRO'S: THE FUTURE AGENDA (1985); *see also* Dans, Weiner & Otter, *supra* note 200; Gosfield, *Hospital Utilization Control by PROs: A Guide Through the Maze*, HEALTH SPAN, Feb. 1984, at 3.

[202]Request for Proposal (RFP No. HCFA-84-015, Feb. 29, 1984), 48 Fed. Reg. 39,160 (1983). For each of these general objectives, PRO's must select one procedure to monitor and state numerical goals for each objective.

hospitals were providing high quality services under the prospective payment system.[203] At the same time, the General Accounting Office released preliminary data that Medicare beneficiaries were being released "quicker and sicker" and often with inadequate arrangements for post-hospital care.[204] The House Select Committee on Aging held hearings which confirmed these findings.[205]

The staff of the Senate Special Committee on Aging conducted an investigation of PRO monitoring activities and found serious deficiencies.[206] The committee staff recommended that the Secretary emphasize quality assurance in the new PRO contracts and specifically that PRO's be given power to deny payment for substandard care and that PRO's review what happens to patients after discharge from the hospital.[207] In September 1985, the Senate Special Committee on Aging held hearings on the impact of the prospective payment system on the quality of care for Medicare beneficiaries revealing significant beneficiary and provider dissatisfaction with quality of care and the failure of PRO's to detect these quality problems.[208]

In 1986, ProPAC became increasingly concerned about assuring the quality of care under the prospective payment system and ascertaining ways to determine whether quality of care was affected by the new payment rates. ProPAC was disturbed about the problem of hospitals discharging patients prematurely and without adequate arrangements for post-hospital care and about the inability of PRO's to monitor this problem sufficiently under their current contracts with HCFA.[209] ProPAC recommended that PRO quality of care review look at what happens to patients after discharge from the hospital and also at the quality of outpatient surgery provided Medicare beneficiaries. HHS was responsive to these proposals.[210]

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[203] *Quality of Care Under Medicare's Prospective Payment System: Hearings Before the Senate Special Comm. on Aging*, 99th Cong., 1st Sess. (1985) [hereinafter *Senate Special Comm. on Aging Hearings on Quality of Care*]. Government Accounting Office, *Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report* (PEMD-85-8, Feb. 21, 1985); TECHNICAL APPENDIXES TO THE PROPAC REPORT AND RECOMMENDATIONS TO THE SECRETARY, APRIL 1, 1986, *supra* note 201, at 149-50.

[204] Government Accounting Office, *supra* note 203.

[205] *See Quality of Care Under Medicare's Prospective Payment System: Hearings Before the House Select Comm. on Aging and the Task Force on the Rural Elderly*, 99th Cong., 1st Sess. (1985) [hereinafter *House Select Comm. on Aging Hearings on Quality of Care*].

[206] STAFF OF SENATE COMM. ON AGING, IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES (1985).

[207] *Id.* at 3.

[208] *Senate Special Comm. on Aging Hearings on Quality of Care*, *supra* note 203.

[209] *Id. See* TECHNICAL APPENDIXES TO THE PROPAC REPORT AND RECOMMENDATIONS TO THE SECRETARY, APRIL 1, 1986, *supra* note 201, App. C at 159.

[210] PROPAC REPORT AND RECOMMENDATIONS TO THE SECRETARY, APRIL 1, 1986, *supra*

As a result of these concerns, the Secretary and Congress instituted substantial changes in the quality of care review procedures for PRO's. In the new PRO contracts issued in January 1986, HCFA changed the procedures and objectives of the quality of care reviews substantially. Specifically, HCFA focused PRO review on reduction of adverse outcomes in five areas: (1) adequacy of discharge planning; (2) deaths; (3) nosocomial infections; (4) unscheduled returns to surgery for the same condition as the previous surgery or to correct post-operative problems; and (5) trauma suffered in the hospital.[211] Also, in the Consolidated Omnibus Budget Reconciliation Act of 1985, Congress gave PRO's the authority to deny payment for substandard care identified through criteria developed by HCFA.[212] Congress also imposed additional responsibilities on PRO's to review outpatient and other surgery procedures.[213]

Congress continued to be concerned about the quality of care under the Medicare prospective payment system and the role of PRO's in assuring quality of care. In the Omnibus Budget Reconciliation Act of 1986, Congress assigned important new responsibilities to PRO's. Specifically, Congress required that PRO's devote a greater proportion of their time and resources to reviewing quality of hospital services to Medicare beneficiaries and that quality of care reviews include what happens to patients after discharge from the hospital.[214] In addition, Congress required PRO's to review so-called early readmission cases to determine if previous inpatient hospital services and post-hospital services met professionally recognized standards of health care.[215] Congress has also required PRO's to have consumer representation on their boards.[216]

Whether PRO quality of care review will be improved with the reforms instituted in the new PRO contracts or the recent legislation is uncertain. Furthermore, the hospital industry has successfully challenged

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note 115. HCFA explained PRO responsibilities with respect to monitoring quality of care aspects of inpatient medical review. 51 Fed. Reg. 19,970, 19,998 (1986). This review would include criteria to detect premature discharges and review of discharge planning to determine if the availability of needed post-discharge care was considered. Regarding outpatient surgery, HCFA reported that it was in the process of developing a list of procedures for which PRO review was required, including review for outpatient procedures in light of new requirements for PRO review of surgery in the Consolidated Omnibus Budget Reconciliation Act of 1985. *Id.* at 19,998-99.

[211]The Health Care Financing Administration submitted a separate Request for Proposal to each state PRO.

[212]Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, tit. IX, § 9403, 100 Stat. 82 (amending 42 U.S.C. § 1320c-3(a)(2) (1982 & Supp. 1985)).

[213]*Id.* § 9401.

[214]Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9353(a), 100 Stat. ____ (amending 42 U.S.C. § 1320c-3(a)(4) (1982 & Supp. 1985)).

[215]*Id.* § 9352 (amending 42 U.S.C. § 1320c-2 (1982 & Supp. 1985)).

[216]*Id.* § 9353(b) (amending 42 U.S.C. § 1320c-1 (1982 & Supp. 1985)).

the process HHS used to implement the PRO program. In *American Hospital Association v. Bowen*,[217] the United States District Court for the District of Columbia ruled that HHS had improperly implemented the PRO program through program directives rather than rules properly promulgated under the the informal rule-making procedures of section 553 of the Administrative Procedure Act[218] and consequently were invalid.[219] This decision, now on appeal before the United States Court of Appeals for the District of Columbia Circuit, has generated considerable uncertainty for the PRO program, the full implications of which have yet to be determined.

Given the slow start up of the PRO program and the controversy over what PRO's are to accomplish in their reviews, it is still unclear how effective PRO's have been in assuring the adequacy of allocation of Medicare resources among Medicare beneficiaries on an individual basis. However, excessive emphasis on cost containment objectives has inhibited PRO's from monitoring thoroughly the allocation of medical resources on a individual basis.[220] Congress has demonstrated strong support and confidence in the peer review concept as a means of monitoring resource allocation and has acted aggressively on several occasions to strengthen the role of PRO's to be sure that they can function more effectively.

4. Preventing Premature Discharge from Hospitals.—The most important ethical issue regarding allocation of hospital services under the prospective payment system to emerge to date has been the premature discharge of Medicare beneficiaries from hospitals. This issue surfaced in congressional hearings and investigations in 1985 which reported problems with hospitals discharging Medicare patients against their will, early, and inappropriately with the explanation to the beneficiary that the number of covered days for the patient's illness had "run out."[221] Beneficiaries did not appeal such decisions because they were unaware of appeal procedures and, until recently, were financially liable for the continued stay.[222] This problem generated considerable publicity partic-

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[217]640 F. Supp. 453 (D.D.C. 1986); *see* Duffy, *PRO-Court Grants Secretary's Motion for Stay*, HEALTH LAW VIGIL, Oct. 10, 1986, at 4.

[218]5 U.S.C. § 553 (1982 & Supp. 1985).

[219]640 F. Supp. at 463.

[220]See Veatch, *supra* note 6, for a discussion of the ethical implications for peer review when charged with cost containment goals.

[221]*See Senate Special Comm. on Aging Hearings on Quality of Care*, *supra* note 203; *House Select Comm. on Aging Hearings on Quality of Care*, *supra* note 205; Government Accounting Office, *supra* note 203.

[222]Wilson, *How to Appeal Medicare Coverage Denials Under the DRG System*, 20 CLEARINGHOUSE REV. 434 (1986).

ularly when the elderly reporter, Sarah McClendon, opened a January 1986 presidential press conference with an unexpected question to President Reagan about this problem.[223]

Congress, ProPAC, and HHS took immediate steps to address this problem. ProPAC urged the Secretary to require hospitals to give beneficiaries immediate notice of appeal rights upon admission and to improve the information available to beneficiaries about their rights under the prospective payment system.[224] ProPAC also conducted a study which suggested that this problem was not widespread.[225] Working with consumer groups, HHS developed a notice to be given to all Medicare patients upon admission to the hospital, that would clearly explain the patient's rights to appeal any decision by the hospital, the patient's physician, or the PRO about the patient's admission or continued stay.[226]

It is not at all clear that this problem has been resolved or that it is not widespread. Both the American Medical Association and the American Society of Internal Medicine have conducted surveys of their membership. These surveys report that many patients are discharged sooner and often without adequate post-hospital placement, thus compromising the quality of medicare care for Medicare beneficiaries.[227] Consumers are also concerned about the PRO's ability to handle appeals regarding inappropriate discharge in a fair and expeditious manner.[228]

In the Omnibus Budget Reconciliation Act of 1986, Congress affirmatively addressed this problem. Specifically, it required PRO's to review all cases in which a hospital determines that a beneficiary no longer needs hospital care and the attending physician does not agree with the decision.[229] Further, Congress has required that beneficiaries have the opportunity for immediate appeal to the PRO of any discharge decision and suspended the beneficiary's financial liability for continued care during the appellate period, a critical factor in assuring that these appeal rights of appeal are meaningful.[230]

The premature discharge of Medicare beneficiaries often against their

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[223]Rovner, *Medicare: The Cost of Cost-Cutting*, Washington Post Health, Jan. 15, 1985, at 9.

[224]ProPAC Report and Recommendations to the Secretary, April 1, 1986, *supra* note 115, at 43-44.

[225]Technical Appendixes to the ProPAC Report and Recommendations to the Secretary, April 1, 1986, *supra* note 200, at 147-55.

[226]51 Fed. Reg. 19,970, 19,998 (1986).

[227]Am. Medical Ass'n, Report of the American Medical Association Board of Trustees: AMA's DRG Monitoring Project and the Prospective Payment System (1986); Am. Soc'y of Internal Medicine, The Impact of DRG's on Patient Care: A Survey by the American Society of Internal Medicine, March 1984 - October 1985 (1986).

[228]Wilson, *supra* note 222.

[229]Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9351(a), 100 Stat. ____ (amending 42 U.S.C. § 1320c-3 (1982 & Supp. 1985)).

[230]*Id.*

will and without adequate provision for post-hospital care confirms the concern that payment reforms for public or private health insurance programs designed to encourage providers to limit resources in the treatment of patients can have untoward effects. It also emphasizes the need to have an accessible process in place which allows individual beneficiaries to appeal allocation decisions that they believe are unfair.

C. Some Conclusions

The report card on the performance of this administrative model of the Medicare prospective payment system in making hard choices about the amount and allocation of medical resources is incomplete. In making decisions at the societal level, three key actors have played dominant and conflicting roles which have tested this model considerably: the executive branch, Congress, and ProPAC. The executive branch has consistently taken an extraordinarily strict position on the amount of federal resources to allocate to hospital care for Medicare beneficiaries. This strictness is amply demonstrated in the executive branch's conduct in updating hospital payment rates since the first year of the prospective payment system, as well as in its treatment of hospitals that serve a disproportionate number of low income and Medicare patients. Furthermore, the other key players, Congress and ProPAC, have not agreed with the executive branch's positions on these issues.

ProPAC has demonstrated professional expertise in its analytic work on updating the hospital payment rates and modifying the DRG's as well as in its response to issues such as ensuring quality of care, treatment of disproportionate share hospitals, and the premature discharge of beneficiaries from hospitals. ProPAC's role and function as well as the excellence of its analysis have enabled Congress to participate substantively in the rate setting process and thus to exercise greater political control over the rate setting process. In fact, this interchange with Congress has been the most important characteristic of ProPAC's role under the prospective payment system. The fact that the executive branch is not compelled to follow ProPAC's technical recommendations has proven relatively immaterial given the more generous disposition of Congress regarding decisions on allocating federal resources to the hospital care of Medicare beneficiaries. It is worth pondering, however, whether this model for making allocative decisions would operate effectively to ensure that ethical decisions are made, if Congress and ProPAC took the same strict position on rate setting issues as the executive branch. This question is especially important in view of the fact that the model has expressly limited hospitals' access to the courts to contest unfairness of some aspects of Medicare payment rates.[231]

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[231] *See supra* notes 148-50 and accompanying text.

There still remain questions about the performance of PRO's in monitoring quality of care under the prospective payment system and ensuring that proper allocation decisions are made at the individual level. Admittedly, the PRO program, which involves over 50 PRO's and nearly 5,800 hospitals,[232] is administratively complex and thus full implementation of the program will take time. But problems extend beyond mere start-up complications and are generated in large part by HHS' stewardship of the program. HHS controls the PRO monitoring process directly through its contracts and sets the agenda for the PRO reviews. Clearly, HHS has not focused PRO reviews on monitoring quality of care but rather on cost containment.

The problem of premature discharge of beneficiaries from hospitals and associated complaints suggest that many beneficiaries perceive that the federal government, through the prospective payment system, and hospitals and physicians operating under the system have made some unfair decisions about the allocation of Medicare resources among Medicare beneficiaries. This finding is curious since hospitals have done well financially under the prospective payment system.[233] It may be that some hospitals, as decision makers in the allocation of medical resources under their control, are making unnecessarily hard choices with respect to those beneficiaries in the unethical fashion anticipated by some observers. It may also be that elderly beneficiaries, accustomed to the patterns of utilization under more generous payment methodologies, perceive that needed medical services are being denied when in fact they are being provided in a different and more cost-effective manner.[234]

The remarkable characteristic of this administrative model is its dependence on political intervention, chiefly through congressional action, to ensure that allocation decisions at the societal level and even the individual level are made fairly among the Medicare program and its beneficiaries. At the societal level, the independent ProPAC has no legal authority over setting hospital payment rates but serves chiefly to enhance Congress' ability to control the rate setting process politically. At the individual level, PRO's have more legal authority over hospitals and physicians in their care of Medicare beneficiaries. However, it has taken continual congressional oversight, legislation and prodding to get these organizations in a position to discharge their responsibilities as contemplated. Finally, the actual evidence of poor treatment of some patients under the prospective payment system emphasizes the need to have a strong and effective appeals process to protect the interests of individual beneficiaries in allocation decisions for Medicare resources.

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[232]Am. Hosp. Ass'n, Hospital Statistics, 1986 Edition, at xvii (1986).

[233]*See supra* note 151 and accompanying text.

[234]Technical Appendixes to the ProPAC Report and Recommendations to the Secretary, April 1, 1986, *supra* note 200, App. C, at 147.

Nevertheless, the Medicare prospective payment system has not really had to make truly hard choices about allocation of medical resources among its beneficiaries or providers. But the day may come, possibly when the federal budget deficit seriously and immediately threatens the national economy, when the federal government will be forced to make hard choices about the amount and allocation of medical resources in the Medicare program. Only such a challenge will reveal whether the administrative structure for the prospective payment system, designed expressly to assure quality and accessible health care services for Medicare beneficiaries, is equal to the task of making hard choices and resolving ethical dilemmas about the allocation of scarce medical resources at the societal and individual levels.