# WAYS OF THINKING ABOUT MEDICAL CARE: ALTERNATIVE MODELS AND STRUCTURES AND THEIR POLICY SIGNIFICANCE

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## I. Introduction

I want to start by acknowledging, with thanks, Professor Richard Kaplan for this wonderful invitation to deliver the Ann F. Baum Lecture, which has a history of attracting some of the most distinguished speakers in the academy.[1] I am delighted to bask in their reflected glory and to attain a spot in the pantheon of illustrious speakers. I also want to thank Professor Kaplan for his many courtesies over the years as we worked on the process of getting the Baum Lecture together. I also want to thank Heather Ball, the Director of Events and Alumni Programming; Carolyn Turner, the Assistant Dean for Administration; and Carrie Cay Boric, the Events Coordinator, for their logistical support and their good cheer in making this happen.

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1. This lecture was delivered on March 10, 2021, as part of the Ann F. Baum Lecture on Elder Law at the University of Illinois College of Law. For a sampling of past lecture speakers, *see* Univ. of Ill. Coll. of L., *Ann F. Baum Lecture*, YOUTUBE, https://www.youtube.com/c/UniversityofIllinoisCollegeofLaw1897/search?query=Ann%20baum (last visited Jan. 31, 2022).

My topic is Ways of Thinking about Medical Care: Alternative Models and Structures and their Policy Significance. At the outset, I want to break down the talk into four broad categories. There will be more, but these four categories capture the sum and substance of my presentation. First, I will introduce different ways of thinking about medical care, the different paradigms—the professional and the market paradigms—and how language shapes the perception of the paradigms. Second, I will examine, from a policy perspective, some of the consequences that derive from some of the various assumptions that undergird the professional paradigm, which has been the traditional paradigm in the way we think of medical care. Third, I will introduce an alternative model to the traditional Medicaid model—the Children's Health Insurance Program ("CHIP"). And then finally, Tennessee has been a pioneer in the Medicaid program, introducing economic considerations into medical care decision-making and managing program costs; Tennessee has received approval for a Medicaid demonstration waiver that basically embraces the CHIP model and applies it to Medicaid.[2] That waiver has been challenged in court,[3] a case that is now on pause,[4] as the federal government has reopened a comment period to allow reassessment of that waiver.[5]

2. Letter and Waiver Enclosure from Seema Verma, Adm'r, Dep't of Health & Hum. Servs., HHS, to Stephen Smith, Dir. of TennCare, Tenn. Dep't of Fin. and Admin. (Jan. 8, 2021) [hereinafter Approval Letter], https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-ii-cms-demo-appvl-010821.pdf.

3. Complaint for Declaratory & Injunctive Relief at 1, McCutchen v. Becerra, (D.D.C. Apr. 23, 2021) (No. 1:21-cv-01112-TSC), 2021 WL 1710732 (D.D.C. April 23, 2021) 1710732 [hereinafter TennCare Complaint], https://healthlaw.org/wp-content/uploads/2021/04/Complaint-TennCare.pdf.

4. *Tennessee Medicaid Waiver Approval Lawsuit Put on Pause, Plaintiffs Agree Following New Approval Process*, NAT'L HEALTH L. PROGRAM (Aug. 13, 2021), https://healthlaw.org/news/tennessee-medicaid-waiver-approval-lawsuit-put-on-pause-plaintiffs-agree-following-new-approval-process/.

5. On August 10, 2021, the Centers for Medicare and Medicaid Services opened a new 30-day federal comment period on the special terms and conditions in the approved TennCare III demonstration. The comment period closed on September 9, 2021. *See 1115 TennCare III—Approval STCs*, MEDICAID.GOV, https://1115publiccomments.medicaid.gov/jfe/form/SV_9zWXfvSDSRtLxAy (last visited Jan. 31, 2022).

## II. Two Big-Picture Issues

Before I get to the meat, I want to address some broader, foundational considerations and concerns that I consider to be the two intellectual mega issues of health policy.

The first is whether government has an obligation to assure equality in access to care or whether government has an obligation to assure adequacy of medical care.[6] Another way of thinking about this is whether there should be a unitary system or a pluralistic system.[7] That issue is not the main part of my overall presentation, but I want to mention the issue for completeness, since that has been and continues to be one of the major intellectual issues in health policy over time.[8] The big-picture question is whether we really believe in equality and, if so, whether to "level up" to the level of (metaphorically) Bill Gates and his family. This is expensive, and it is a questionable priority for spending to level everyone up to the Gates level.[9] The other option would be to "level down," prohibiting Bill Gates to spend his own funds to achieve better quality—a coercive approach.[10]

Should we have a unitary or pluralistic system?[11] If one really takes equality seriously, there are only two ways to achieve it; you can either level up or level down. You can level up to Bill Gates' level, which is expensive and of questionable priority, or you can level down. You can prohibit Bill Gates from spending his own funds to achieve better quality or better access; that is highly coercive. Or we can have

6. James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 32–34 (1994) [hereinafter *The Policy Context*].

7. James F. Blumstein, *On Prudence in Health Care Reform*, 4 CORNELL J.L. & PUB. POL'Y 422, 428–31 (1995) [hereinafter *Prudence in Health Care*]; James F. Blumstein & Frank A. Sloan, *Health Care Reform through Medicaid Managed Care: Tennessee (TennCare) As a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 186–89 (2000) [hereinafter *Reform through Medicaid Managed Care*].

8. *See generally* Norman Daniels, *Equity of Access to Health Care: Some Conceptual and Ethical Issues*, 60 MILBANK MEM'L FUND Q., HEALTH & SOC'Y 51 (1982).

9. *See The Policy Context*, *supra* note 6, at 33–38; *Prudence in Health Care*, *supra* note 7, at 428–31.

10. *The Policy Context*, *supra* note 6, at 32–34; *Prudence in Health Care*, *supra* note 7, at 428–31; *Reform through Medicaid Managed Care*, *supra* note 7, at 189–93.

11. A colleague and I have argued "that the goal of equal utilization of medical services is an unrealistic and probably unwarranted policy aspiration." James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order*, 34 VAND. L. REV. 849, 866 (1981) [hereinafter *Dose of Competition*]; *see also* Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & L. 471, 491 (1977) (noting the unreasonableness of demanding absolute equality in medical services distribution).

some hybrid of both. The focus in our country has been on access to an adequate level of services, and the debate has been about how we define what an adequate level of services is.[12] That is, we recognize there can be differences in levels of services.[13] The core policy question is whether those differences can be narrow or great and in what areas and in what scope.[14]

The Affordable Care Act ("ACA") does this by developing a comprehensive mandated set of benefits and uses the term "essential benefits" to suggest that the adequacy level is defined up;[15] but it recognizes, very importantly, and this is key, that there is there an opportunity for supplementation.[16] Without the opportunity for supplementation, then we are in a coercive system of leveling down. Section 1302(b)(5) of the ACA[17] expressly allows for supplementation by health plans beyond the essential health benefits mandated in the ACA.[18] The ACA strategy was to accept the adequacy idea and then to define up the concept of adequacy to narrow the gaps between those who are well situated and those who are not so well situated.[19] In that way, the ACA is consistent with the traditional discussion under an adequacy standard, narrowing gaps in access by robustly defining the scope of "adequacy" by use of a generous vision of adequacy as covering "essential" services on a comprehensive basis.[20] The ACA sophisticatedly left intact the adequacy standard as an intellectual matter, but reduced the levels of inequality by defining "adequacy" as including a comprehensive array of essential services.[21]

The second "megacept" I want to mention is the role of economic considerations in medical decision-making. This is the focus of my presentation.

12. *Reform through Medicaid Managed Care*, *supra* note 7, at 191.
13. *Id.*
14. *Id.* at 191–93.
15. *See* 42 U.S.C.A. § 18022(a).
16. 42 U.S.C.A. § 18022(b)(4)(G).
17. "Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection." 42 U.S.C.A. § 18022(b)(5).
18. *Id.*
19. *See id.*
20. *See Reform through Medicaid Managed Care*, *supra* note 7, at 191.
21. *Cf. Prudence in Health Care*, *supra* note 7, at 430–31 (describing Clinton Administration proposal as adopting the strategy of turning the concept of "core" benefits into "comprehensive" benefits).

## III. The Professional and the Economic Paradigms: The Importance of Language in Shaping Perceptions

When I started in the health policy field decades ago, I remember a doctor on a program saying (to this effect): "It's nice to have someone like you involved in a program who thinks that economics has a role to play in medical decision-making, but you should know that economics has no role to play in medical decision-making." And he literally patted me on the head, saying somewhat paternalistically, "it's nice to have a diversity of viewpoint on this program, but we all know how silly you are."[22] This would not happen today, especially in the world of COVID-19, where we have come to understand what science can teach, what those limits are, and how other considerations such as economics, liberty, and one's taste for risk-taking enter into medical decision-making.[23] Today, there remain differences in perspective, how to balance different perspectives and values, but it is important to remember that history and that heritage. It still appears in rhetorical debates ("just follow the science"), even when experts now recognize that the tradition of denying consideration of non-medical factors in medical decision-making is incomplete.[24] A nuanced, balanced approach is necessary.

22. *See id.* at 423.

23. *See, e.g.*, Clement A. Tisdell, *Economic, Social and Political Issues Raised by the COVID-19 Pandemic*, 68 ECON. ANALYSIS & POL'Y 17, 25 (2020); Jonas Herby, Lars Jonung & Steve H. Hanke, *A Literature Review and Meta-Analysis of the Effects of Lockdowns on COVID-19 Mortality* 41–43 (Johns Hopkins Inst. for Applied Econ., Glob. Health, & Study of Bus. Enter., Working Paper No. 200, 2022) [hereinafter *Effects of Lockdown*], https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf (finding that -despite epidemiological studies predicting success - lockdowns and other compulsory interventions like business closures failed to significantly reduce mortality rates yet increased societal costs by reducing economic activity and enhancing unemployment, and recommending that government authorities explore voluntary behavioral changes).

24. *See* James F. Blumstein, *The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs*, 3 HEALTH MATRIX 1, 8–10 (1993) [hereinafter *Case of Commerce*] (discussing historical objections to the recognition of competition and the role of markets in delivering health care: "It was assumed that there was a correct course of treatment, and that was a professionally determined decision. Science not economic incentives drove medical care diagnosis and treatment decisions."); *see also* James F. Blumstein, Reevaluating the Federal Role in Organ Transplantation Policy: The Relationship Between the Government and the Organ Procurement and Transplantation Network, 35 (June 1989) (unpublished manuscript) (on file at Vanderbilt University School of Law) ("Perhaps the most striking characteristic of the health care industry as it has developed in the last decade has been the recognition that competition and markets have an important role to play in the health policy arena.").

Now I want to talk about different ways of thinking about medical care and the importance of language in shaping perceptions. I like to tell a story about the old Soviet Union when the USSR and the U.S. were involved in a car race—just the two countries. This is how the results were reported in the government-controlled media in the Soviet Union: "We are proud to recognize that there was a car race in which the U.S. and the USSR were involved. The USSR, we are proud to report, finished second and the U.S. finished next to last."[25] Think about that, who won the race?

Language can clarify, but language can mislead, or it can misshape. So, I think language is important. I want to talk here about two language points. One is how do we refer to this area? Do we refer to it as a healthcare delivery "system" or "non-system," for those who object to it, or a healthcare "industry"? Second, I want to draw the distinction in language between "rationing" and "allocating" resources.[26]

A "system" suggests a social services delivery model; in that context, a "non-system" is a pejorative that connotes that there should be an organized system but there is not one.[27] An "industry" suggests an economic sector in which principles of economics have application—principles of supply, demand, the use of incentives, and consideration of trade-offs become the terms of analysis.[28] The non-system terminology has limited applicability in the context of a market.[29] We do not think of a personal computer delivery system or a system of legal services delivery.[30] We think instead of markets for personal computers or legal services, and they are not necessarily organized along social services system lines.[31]

I will now turn to "rationing" versus "allocating" resources. Economists tell us that resources are always allocated to their most efficient

25. Tom Salamone, *The Foot Race Between John F. Kennedy and Nikita Khrushchev*, LINKEDIN (July 14, 2015), https://www.linkedin.com/pulse/foot-race-between-john-f-kennedy-nikita-khrushchev-tom-salamone/.

26. James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1467–68 (1993-1994) [hereinafter *Competing Visions*].

27. *See id.* at 1482.

28. *See* DICTIONARY OF INT'L ECON. TERMS 145 (John Clark ed. 2006) [hereinafter ECON. TERMS] (defining "industry" as "an agglomeration of companies involved in the production of goods); Will Kenton, *Industry*, INVESTOPEDIA (Mar. 31. 2021), https://www.investopedia.com/terms/i/industry.asp.

29. *Competing Visions*, *supra* note 26, at 1482.

30. *See generally id.*

31. *See generally id.*

use in a well-functioning market.[32] Decisions are decentralized to households and firms.[33] Resource allocation decisions are not "made" in a conscious or collective sense in a market. Rather, resource allocation decisions are observed after the fact by national income accountants who tell us how we spent our money last year or last quarter.[34]

The use of the term "ration" in the healthcare arena is employed as a rhetorical tool—a pejorative.[35] Its use submerges a whole host of value judgments.[36] It suggests a certain type of resource-allocation method, a centralized decision by a government or other independent decisionmaker such as a doctor.[37] It also suggests a consciously determined set of criteria that are distinct from typical supply and demand considerations that control in the marketplace.[38] For example, do we ask whether Whole Foods or Kroger rations food or whether the local car dealership rations access to the automobiles on the sales lot? The point is that an array of value judgments is being made when the terminology shifts from "resource allocation" to "rationing," and the use of language blurs those value judgments; that is, the shift in language or terminology tends to obfuscate the special significance of normative concerns for access considerations that characterize public policy debates in the health care arena.[39] Considerations of and debates about egalitarianism and in-kind redistribution are avoided by use of terms like rationing; and concerns about the role of economic factors in the decisionmaking process are swept away once one embraces the rationing terminology.[40] In a market, goods and services are constantly being allocated; use of the rationing terminology pretermits debate about such things as

32. *See* ECON. TERMS, *supra* note 28, at 11 (defining "allocative efficiency" as a principle implying that the allocation of scarce resources is best for the interests of consumers: "a consumer's welfare is at a maximum when market prices equal the minimum real resource cost of supply."); *Economic Efficiency*, INVESTOPEDIA (Feb. 27, 2020), https://www.investopedia.com/terms/e/economic_efficiency.asp.

33. *Competing Visions*, *supra* note 26, at 1467–68.

34. ECON. TERMS, *supra* note 28, at 130 (defining "gross domestic product" as "the measure of the value of goods and services produced within a country, normally in one year."); Jason Fernando, *Gross Domestic Product (GDP)*, INVESTOPEDIA (Jan. 28, 2022), https://www.investopedia.com/terms/g/gdp.asp.

35. *Competing Visions*, *supra* note 26, at 1467.

36. *See id.*

37. *Id.*

38. *Id.* at 1467–68.

39. *See id.*

40. *Id.*

economic trade-offs and priorities in the context of resource allocation methods and structuring resource-allocation decisions.[41]

## IV. The Competing Paradigms and Their Analytical Significance

These political or ideological tensions are manifest in different ways of thinking about medical care, about the different models or paradigms—the professional model and the market model. I want to turn to those now.[42]

I do not want to make the case that the competing models or paradigms constitute an either-or proposition. These are broad categories. I think that it is wrong to conceive of these ways of thinking of medical care as either market or professional. Elements of both exist.[43] The policy conversation, honestly engaged, is more about where to place the emphasis, where to draw the line along a continuum.

I like to tell Yogi Berra stories, and he was once asked, "What is more important in baseball, physical ability or mental attitude?"[44] Yogi thought for a moment and then responded, saying, "You know 90% of the game is mental, the other half is physical."[45] Yogi was a great philosopher, albeit not too good at arithmetic. In the healthcare arena, I would say that that 90% of the issue is professional, the other half is economic.

I want, now, to turn to describing the models or paradigms.[46]

### A. The Professional Paradigm

The professional model and its implications and assumptions reflect an approach to perceived market failure in the healthcare arena.[47] It observes the lack of knowledge on the part of consumers—we used to call that ignorance—and the scientific expertise of physicians.[48] The

41. *Id.*
42. *Id.* at 1463–69.
43. *Id.* at 1505.
44. Victor Mather & Katie Rogers, *Behind the Yogi-isms: Those Said and Unsaid*, N.Y. TIMES (Sept. 23, 2015), https://www.nytimes.com/2015/09/24/sports/yogi-berra-yogi-isms-quotes-explored.html.
45. *Id.*
46. *Competing Visions*, *supra* note 26, at 1463–69; James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice Safe Harbors as a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1022–23 (2006) [hereinafter *New Role for QIOs*].
47. *New Role for QIOs*, *supra* note 46, at 1022.
48. *Id.*

professional model substitutes professional control of decision-making for that of consumers, sometimes called substituted decision-making.[49] Substituted decision-making vests enormous authority to determine standards and levels of quality and the volume of services, and ultimately costs, in professional providers.[50] The assumption is that patients are uninformed and cannot really become well informed about medical-care decisions.[51] This is what economists, such as the late Professor Kenneth Arrow, call "the asymmetry of information."[52] Patients are not informed, they are ignorant and they cannot become informed.[53]

Again, if I can be indulged another anecdote, I think about a story of a person on the street being interviewed a few years ago.[54] The reporter asked this fellow, "What is the worst problem today regarding the political process—voter ignorance or voter apathy?"[55] And the person being interviewed said in response: "Well, I don't know and I don't care."[56] And that basically is the assumption of the professional model, or the professional paradigm.[57] As I have said, the substituted decision-making approach that characterizes the professional paradigm has invested enormous authority in professionals to make fundamental decisions regarding medical care.[58]

49. *See Competing Visions, supra* note 26, at 1464 (explaining that "proponents of the professional model embrace a strategy of market substitution, in which the judgment of the physician is substituted for that of the patient.").

50. *Id.* at 1465.

51. *Id.* at 1464.

52. *See generally* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963) [hereinafter *Welfare Economics of Medical Care*].

53. *See Competing Visions*, *supra* note 26, at 1464.

54. Barry Popik, "*What's the difference between ignorance and apathy? I don't know and I don't care,"* THE BIG APPLE (Sept. 3, 2014), https://www.barrypopik.com/index.php/new_york_city/entry/whats_the_difference_between_ignorance_and_apathy.

55. *Id.*

56. *Id.*

57. *Competing Visions*, *supra* note 26, at 1464.

58. *See generally* Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS J. 415 (1990) (criticizing the professional paradigm and arguing that its lasting influence in medical malpractice law, educational and accreditation schemes, hospitals, and payment policies, prevented many of the cost-containment reforms of the 1980s from fully delivering on their promise) [hereinafter *Professional Paradigm*]. *See also Case of Commerce*, *supra* note 24, at 13–14 (1993) (explaining that in contrast to the rest of the health care industry as it has evolved, "the organ transplantation field has been characterized by professional control" and that the risk of professional dominance "is particularly acute when the profession is in a position to exert control over potential competitors who seek to enter the market."). For more on professional dominance in the medical industry

A further assumption of the professional paradigm is that diagnosis and treatment decisions are not influenced by financial incentives.[59] Economists would say that that is a claim that there is no "moral hazard"[60]—that decision-making is not affected by insurance or by subsidization.[61] The lack of moral hazard was once an empirical claim—when that doctor patted me on the head years ago when I started out in this field.[62] Now, it is not so much an empirical claim as a normative claim.[63] Those who object to markets or incentives are typically making a normative claim that consideration of economics in medical decision-making constitutes an inappropriate basis for medical decision-making—a corruption of medical judgment.[64]

The bottom line is that under the professional paradigm, doctors have controlled the field because of their scientific expertise and respect for their scientific expertise and because of their economic leverage; doctors controlled patients, with hospitals being beholden to doctors to fill beds. Market-based competition in such an environment led to increased costs because of competition for doctors' goodwill.[65] This was

historically, *see generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 5 (1982).

59. *See* Kenneth J. Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV. 537, 537 (1968) [hereinafter *Economics of Moral Hazard*].

60. With respect to insurance, the term "moral hazard" refers to the concept that individuals seek and use more medical services when they know that the costs will largely be borne by others, like the insurance company. Economist Kenneth Arrow applied the concept to medical insurance. *See Welfare Economics of Medical Care*, *supra* note 52, at 961; *see also Economics of Moral Hazard*, *supra* note 59, at 538 (explaining that "if individuals are free to spend as they will with the assurance that the insurance company will pay, the resulting resource allocation will certainly not be socially optimal."). For more on "moral hazard" in the context of medical care and state-federal Medicaid programs, *see Reform through Medicaid Managed Care*, *supra* note 7, at 139 n.45.

61. *See Welfare Economics of Medical Care*, *supra* note 52, at 961.

62. *See* James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 IND. HEALTH L. REV. 211, 220 (2007) [hereinafter *Of Doctors and Hospitals*].

63. *See id.*

64. *See Professional Paradigm*, *supra* note 58, at 420 (explaining that much of the paradigm's force comes from "the egalitarian ideal in medicine—the belief that every citizen is entitled to medical care of the same quality and that 'two-tier' medicine is unthinkable"). For a court decision that regards the introduction of economics into medical decision-making as a corruption of medical decision-making, *see Muse v. Charter Hosp. Winston–Salem*, 117 N.C. App. 468, *aff'd*, 342 N.C. 403 (1995).

65. *See* Jack Zwanziger & Glenn A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 316 (1988) (concluding that after California implemented selective

often termed "the medical arms race"[66] where competition led to increased costs because the competition was not for cost containment but to achieve goodwill with physicians.[67]

### B. The Market Paradigm

I now want to turn to the market model and its assumptions and implications.[68]

The market-oriented response to consumer ignorance is market improvement—to improve the functioning of the market through education and the improved flow of information.[69] That includes enhanced disclosure to patients and/or their agents and enhanced patient participation in medical-care decision-making.[70] Increasingly, we are seeing that emerge.[71] The expanded availability and improvement of online tools that support patient awareness and enhance patient decision-making[72] have allowed enhanced patient participation regarding their own medical care.[73]

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contracting in 1983, the nature of hospital competition underwent a structural change and increasingly hospitals competed on a price basis).

66. *See e.g.*, James C. Robinson & Harold S. Luft, *The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care*, 4 J. HEALTH ECON. 333, 353 (1985) [hereinafter *Impact of Hospital Market Structure*] ("[i]t has been argued that increased competition among hospitals for patients will take the form of inflationary increases in the technological intensity of hospital services or a 'medical arms race', rather than the form of price reductions aimed at patients."); James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 JAMA 3241, 3244 (1987) (attributing higher costs to more competitive markets; consistent with the "medical arms race" hypothesis, competition in the hospital sector took the form of cost-increasing acquisition of new technology rather than changes in efficiency).

67. *See generally Impact of Hospital Market Structure*, *supra* note 66, at 353; James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 3–7 (1978).

68. *See Dose of Competition*, *supra* note 11, at 854–67 (examining the market-oriented approach to understanding the health sector); *Reform through Medicaid Managed Care*, *supra* note 7, at 3–7; *Of Doctors and Hospitals*, *supra* note 62, at 220–22. For a discussion of how, in contrast to the larger health policy context, organ transplantation policy and values have resisted the concept of competition and financial incentives, *see generally Case of Commerce, supra* note 24.

69. *Competing Visions, supra* note 26, at 1464.

70. *Id.* at 1474–75.

71. *Id.*; *see, e.g.*, Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS'N J. ETHICS 563, 564 (2012).

72. *See, e.g.*, WEBMD, https://www.webmd.com/ (last visited Jan. 31, 2022); HEALTHLINE, https://www.healthline.com/ (last visited Jan. 31, 2022).

73. The emergence of a patient-centered standard for disclosure of information under the doctrine of informed consent reinforces the role of better informed

Because doctors have had a very different view of a patient's role under the professional paradigm, they have had to develop a label for this expanded patient role in medical decision-making.[74] Lawyers have long seen their professional role as expert advisers, improving and facilitating client-based decision-making—not substituted decision-making.[75] Consumer expectations of physicians' role have changed; more patient involvement in medical decision making is consistent with these changed expectations. The improved flow of information to patients (including a more robust legal expectation of disclosure and, in many jurisdictions, a patient-centered doctrine of informed consent)[76] has enabled a shift to a medical care decision-making model that is more like the traditional legal model of the lawyer's professional role—as that of an expert adviser.[77]

This newer model, in the context of medical care, of informed patients exercising an expanded role in the decision-making process is called "the shared decision-making model."[78] Under "shared decision-making," physicians are not in total control of the system; they share decision-making authority with their patients.[79] The consequence is that under shared decision making payers or consumers have more of

patients in their own medical decision-making. *Competing Visions*, *supra* note 26, at 1475; *see also* Canterbury v. Spence, 464 F.2d 772, 793 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (evaluating a claim for contact without consent under a negligence-based framework); W. M. Moldoff, Annotation, *Malpractice: Physician's Duty to Inform Patient of Nature and Hazards of Disease or Treatment,* 79 A.L.R. 2d 1028 (1961); Michael Justin Myers, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1397 n.5 (1967); Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1969–1970); E. Haavi Morreim, *Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve*, 4 HOUS. J. HEALTH & POL'Y 1, 56 n.266 (2003).

74. *See Case of Commerce*, *supra* note 24, at 1475; *see also* Marjorie Schultz, *From Informed Consent to Patient Choice: A New Protected Interest,* 95 YALE L.J. 219 (1985) [hereinafter *Patient Choice*]. *See generally* Steven A. Wartman, *The Role of the Physician In 21st Century Healthcare*, ASS'N ACAD. HEALTH CTRS. 6 (2017), https://www.aahcdc.org/Portals/41/Series/Nota-Bene/v2n1/Nota-Bene-12-17.pdf.

75. *See Case of Commerce*, *supra* note 24, at 1465.

76. *See Patient Choice*, *supra* note 74, at 227, 227 n.32.

77. *See Case of Commerce*, *supra* note 24, at 1475; *see also* Joseph F. Kasper et al., *Developing Shared Decision-Making Programs to Improve the Quality of Health Care,* 18 QUALITY REV. BULL. 183, 184 (June 1992) [hereinafter *Shared Decision-Making*] (discussing how shared decision-making programs increase patient satisfaction and improve outcomes).

78. *Shared Decision-Making*, *supra* note 77, at 184.

79. *See* James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping With an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 128 (2002) [hereinafter *Legal Liability Regime*].

a role in controlling decisions regarding standards and levels of quality and overall levels (quantity) of service that are provided.[80] The goal of the market model is to develop a system where incentives are proper and private decisionmakers make both self-interested and socially appropriate decisions.[81]

If you remember nothing else about this Article, I hope you remember this donkey riddle story.

Think of a race between the owners of two donkeys. The prize money in the race goes to the owner of the donkey that finishes last. The person running the race blows the whistle, but, as you would expect, neither donkey moves because the goal is to finish last. The person running the race thought of different options—e.g., appealing to the good faith of the parties, threatening prosecution for breaching good faith as that was a term of entering into the race. Nothing worked. Someone who was observing this impasse whispered something in the ear of the person running the race; the whistle blew, and the donkeys raced off at full speed to the finish line. The riddle is, what did that person suggest to solve the problem? The person running the race had the owners switch donkeys. That changes the incentives. Person A is riding Person B's donkey, Person B is riding Person A's donkey. Both Person A and Person B each want their own donkey to finish last; that means both Person A and Person B are going to run the donkeys they are riding to the finish line as fast as they can when each person is riding the other person's donkey, and the prize money goes to the owner of the donkey that finishes last.

That is my vision of how a market works and the advantages of a market model. One does not need heavy regulation. One needs only to set up a structure where the incentives are right, where the players understand those incentives and act in accordance with them. That leads to a socially adapted response. I hope readers remember and get that point of the riddle.

80. *Id.*
81. *Id.*

## V. Some Contributing Factors to the Emergence of the Market Paradigm

I will now identify and discuss some factors that have contributed to the emergence of the market model.

### A. Evidence That Incentives Make a Difference

By now, there is considerable evidence that market-based incentives make a difference in decision-making and outcomes.[82] No longer would doctors pat me on the head or dismiss any person who advocates use of incentives, saying they do not make a difference. The evidence is pretty strong that they do make a difference.[83]

82. *See e.g.*, INCENTIVES & CHOICE IN HEALTH CARE (Frank A. Sloan & Hirschel Kasper eds., MIT Press 2008) (exploring how incentives affect the behavior of patients, physicians, hospitals and other health care providers); Joseph P. Newhouse and Anna D. Sinaiko, *What We Know and Don't Know About the Effects of Cost Sharing on Demand for Medical Care-and So What?*, INCENTIVES & CHOICE IN HEALTH CARE 85-102 (Frank A. Sloan & Hirschel Kasper eds., MIT Press 2008) (examining cost-sharing on patient demand for medical services and finding that generally, the there is less usage for services that require higher cost-sharing payments, like pharmaceuticals); Marc P. Freiman et al., *Provider Response to Medicare's PPS: Reductions in Length of Stay for Psychiatric Patients Treated in Scatter Beds*, 26 INQUIRY 192 (1989) (finding that non-profit hospitals responded to payment incentives by reducing the average length-of-stay by 10% to 20% when Medicare implemented a prospective payment system); UNDERSTANDING NEW LABOUR'S MARKET REFORMS OF THE ENGLISH NHS (Nicholas Mays et al., eds. 2011) (comparing the UK's internal health care market reforms of the 1990s, inspired by Alain Enthoven, with recent reforms by the New Labour government in 2002 that introduced stronger financial incentives for providers based on quality outcomes).

83. *See supra* text accompanying note 82 (discussing incentives). *See also Case of Commerce*, *supra* note 24, at 10–11, 11 n.34 (discussing supply-side responses to incentives in the health care industry such as how the use of Diagnosis Related Groups (DRGs) in Medicare have influenced hospital and physician behavior); Boyd H. Gilman, *Hospital Response to DRG Refinements: The Impact of Multiple Reimbursement Incentives on Inpatient Length of Stay*, 9 HEALTH ECON. 277 (2000) (studying the introduction of procedure-based DRGs for HIV care, which aimed to pay hospitals for additional costs of treating patients needing more intensive care, and finding that average length-of-stay increased for higher-priced DRGs and fell for patients discharged under the lower priced non-procedural DRGs); Leemore S. Dafney, *How Do Hospitals Respond to Price Changes?*, 95 AM. ECON. REV. 1525 (2005) (finding that hospitals–particularly for-profit hospitals—responded to diagnosis-specific payment incentives ("DRGs") by "upcoding" patients to higher-reimbursed codes to increase Medicare reimbursement).

### B. Cost Escalation, Including Cost Containment as an Access Issue

There is the issue of cost escalation. Cost escalation is observed in the professional paradigm because the professional paradigm is linked, as I will explain below, to the development of third-party payment, and the development of third-party payment led to increases in utilization.[84] Increased utilization of services, beyond increases by improving access alone, reinforces the conclusion that the claim undergirding the professional paradigm—that disregarded the impact of and asserted the nonexistence of moral hazard—was not right.[85] The experience is that incentives make a difference[86] and that the blank check associated with Medicare and Medicaid has led to higher costs, and higher costs led to more concerns by payers.[87]

At this point, I want to introduce a graph that helps to understand the economic trade-offs point.

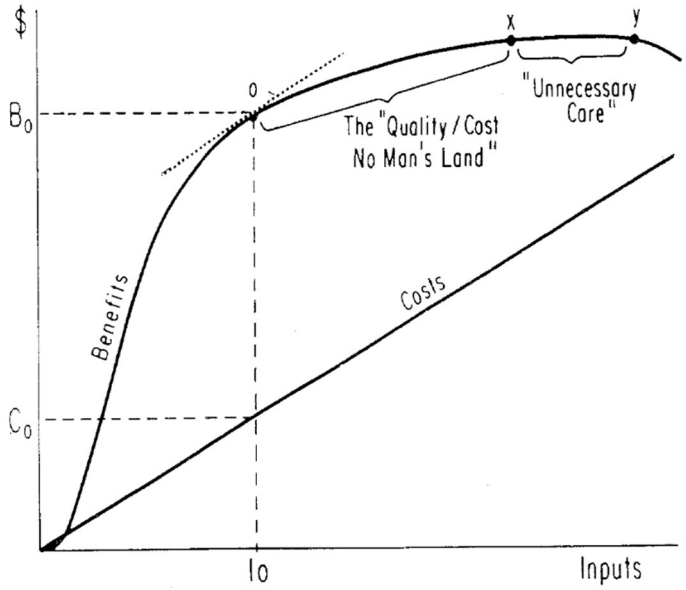
84. *See Competing Visions, supra* note 26, at 1480–82 (discussing the dramatic cost escalation under the Medicare and Medicaid programs and early industry responses in the form of cost-shifting); Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 13–15 (1975–1976) (discussing Medicare and Medicaid cost escalation and arguing that legislation to enact Professional Standards Review Organizations ("PSROs") in 1972 has potential to control costs while maintaining quality). *See also Reform through Medicaid Managed Care*, *supra* note 7, at 144–46 (discussing how states like Tennessee worked to combat cost escalation under Medicaid by leveraging private expenditures).

85. *See also Case of Commerce*, *supra* note 24, at 8–10, 9 n.28 (further explaining that initial rejection of the use of incentives in health care stemmed from ethical and effectiveness concerns, usually couched in rhetorical terms of medical care as a "right[,]" and an ideological commitment to the idea that "unrestricted access to medical care on the basis of medical need was the appropriate normative benchmark.").

86. *See supra* text accompanying notes 82–83 (discussing evidence showing that introducing incentives in health care programs like Medicare impact physician and hospital behavior and costs).

87. *See Competing Visions, supra* note 26, at 1465; James F. Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources,* 60 TEX. L. REV. 899, 900 (1982). *See generally* Jeannie Fuglesten Biniek et al., *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, KAISER FAM. FOUND. (Aug. 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/

Figure 1a: The Optimal Level of Health Care Spending[88]




This Figure was developed by Professor Clark Havighurst and me in a paper we published in the Northwestern Law Review nearly fifty years ago (in 1975).[89] The Figure is still incredibly relevant after all this time; it made a big difference in the reform debates about Tennessee's Medicaid program ("TennCare") about fifteen years ago, which I will discuss infra. Then-Tennessee Governor Phil Bredesen explained to state legislators that the reforms to TennCare that he was introducing were aimed at moving down the curve of costs (from point x towards point o) and making inroads into the quality/cost no man's land.[90] That is, the proposed TennCare reforms addressed low-but-positive value services that were excessively costly in light of their marginal benefits.[91] This courageously represented a form of "cost control"—curtailing

88. Havighurst & Blumstein, *supra* note 84, at 17.

89. *Id.*

90. *See generally Tennessee Governor Explains TennCare Coverage Cuts*, THE COMMONWEALTH FUND [hereinafter *TennCare Coverage Cuts*], https://www.commonwealthfund.org/publications/newsletter-article/tennessee-governor-explains-tenncare-coverage-cuts (last visited Jan. 27, 2022).

91. *See* MARK A. HALL MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS & ECONOMICS OF RATIONING MECHANISMS 67 (1997) (noting that traditionally, insurers did not ask "whether a beneficial result might be obtained more cheaply, let alone whether a marginally increased benefit is simply too expensive to be worth the cost.").

services of high cost and low benefit—as distinct from "waste control," which targets zero-benefit services (to the right of point x on the Figure).[92]

The Figure is heuristic, not empirical. It is designed as a means of conveying a conceptual description, not to show empirical values. On the vertical axis, the Figure shows benefits; on the horizontal axis, the Figure shows costs. There is a cost line that shows the relationship between benefits and costs, and there is a benefits curve that is designed to show that, at relatively low levels of inputs, there is a high level of increase in benefits.[93] Benefits, as depicted on the benefits curve, continue to increase, but the benefits curve flattens out at point x.[94] That (point x) is where benefits are maximized.[95] To the right of point x, between x and y, are traditional notions of unnecessary care, zero-benefit care or "waste."[96]

No one would advocate moving to the right of point x, and political discourse about "waste" control (moving to the left on the Figure from point y to point x) is relatively easy, since no benefits are being lost while costs are being addressed.[97] There is some debate about what works and what does not work—what in the medical arena is often characterized as issues of efficacy[98] and in the economics arena typically characterized as a "production function"[99]—but once analysts agree that some intervention (procedure or service) does not work and provides zero benefit, everyone should and would agree that levels of utilization should not extend beyond point x.[100] "Waste control" is a

92. Havighurst & Blumstein, *supra* note 84, at 17.
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.*
97. *See generally id.*
98. Clinical efficacy is broadly defined as an "indication that [an] intervention produces a desired therapeutic effect on a disease or condition" under ideal conditions. *NIA Glossary of Clinical Research Terms*, NAT'L INST. OF HEALTH, https://www.nia.nih.gov/research/dgcg/nia-glossary-clinical-research-terms (last visited Jan. 31, 2022).
99. D.J. Aigner & S.F. Chu, *On Estimating the Industry Production Function*, 58 AM. ECON. REV. 826, 827–28 (1968) ("a firm's production function . . . expresses the maximum product obtainable by the firm from a given combination of factors during the (assumed) short period of time required to produce this output . . . . [it] sets the highest possible limit on the output which a firm can hope to obtain with a certain combination of factors at the given state of technical knowledge during the production period.").
100. *See generally* Havighurst & Blumstein, *supra* note 84, at 17.

politician's safe space, as costs are reduced, but benefits are not reduced.[101] That is the important distinction between "waste control," where no benefits are lost, and "cost control," where some low-level benefits are left undelivered but at high levels of cost savings.[102]

Point y on the Figure is where benefits turn down, a form of disutility.[103] This is, in medical argot, iatrogenesis[104] where the introduction of medical care is actually harmful, where a practitioner or provider performs an erroneous and harmful procedure.[105] To the right of point y on the Figure, services are contra-indicated, harmful—where, for example, a provider cuts off the wrong limb, or something like that.[106]

Economists tell us that the slope of the cost line reflects incremental or marginal costs.[107] The slope of the benefit curve reflects incremental or marginal benefits.[108] The Figure shows, through the dotted line, the point of tangency, where the slope of the benefit curve (marginal benefits) and the slope of the cost curve (marginal costs) are the same.[109] This is where marginal cost is equal to marginal benefit.[110] The Figure labels that point "o" for "optimality."[111] Economists would tell us that

101. *See id.* at 16.

102. *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 444 (1988) (explaining that the cost control problem is "marginally productive, not unproductive care . . . ." "To repeat a test six times in order to remove a three-in-one million uncertainty is not strictly unnecessary, but it is clearly wasteful."); Havighurst & Blumstein, *supra* note 84, at 32 (explaining that "utilization" and "unnecessary care" often include "care [that] could be rendered effectively and appropriately in a shorter time, in a less sophisticated facility, or on an outpatient basis" . . . . "care falling within these categories is probably neither wholly useless nor affirmatively harmful.").

103. *See generally* Havighurst & Blumstein, *supra* note 84, at 17.

104. "Iatrogensis" refers to the risks and side effects of medical interventions, such as adverse drug reactions. Rafia Farooq Peer & Nadeem Shabir, *Iatrogenesis: A Review on Nature, Extent, and Distribution of Healthcare Hazards*, 7 J. MED. PRIMARY CARE 309, 309 (2018) ("iatrogenic ailments are those where doctors, drugs, diagnostics, hospitals, and other medical institutions act as 'pathogens' or 'sickening agents.'") (endnote omitted).

105. *See id.*

106. *See* Havighurst & Blumstein, *supra* note 84, at 17.

107. *See* ECON. TERMS, *supra* note 28, at 174 (John Clark ed., 2006) ("marginal cost" is "the cost incurred in raising the level of output of by one unit"); *see also* Havighurst & Blumstein, *supra* note 84, at 17.

108. *See* Havighurst & Blumstein, *supra* note 84, at 17.

109. *See id.*

110. *See id.*

111. *See id.*

we should be at point o on the benefits curve, where incremental costs and incremental benefits are the same.[112]

From a policy perspective, what is significant about point o, the point of optimality, is that additional, positive (but low-value) benefits could accrue between point o and point x.[113] On the Figure, this is labeled the quality/cost no man's land.[114] On the Figure, benefits may rise to the right of point o, but those increasing benefits are not worth the cost.[115] Moving from point x on the Figure to point o leaves some benefits not provided for.[116] Traditionally, under the professional paradigm, doctors have advocated that we should provide care up to point x.[117] Advocates for that position often label moving to the left of point x towards point o as rationing care—using the term "rationing" in a very pejorative manner and using language to blur the policy issue—what, if any, low-value, but highly costly services should not be paid for out of a public or private resource pool.[118]

So, it is easy to understand why politicians prefer to talk about "waste control," which is moving from point y to point x and getting rid of "unnecessary" or zero-benefit care; but the tougher and more honest debates are to define where point o is located and where, between point o and point x, we should be as a society (for government plans, such as Medicaid or Medicare) or as a private plan.[119] That is, whereas the move from point y to point x is "waste control," the move

112. *See generally id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.*
117. When objections to cost containment arise, these are sometimes couched in terms of objections to rationing—considering incremental costs in conjunction with and weighed against incremental benefits. Clark Havighurst describes the pejorative use of "rationing care" as "depriving people of beneficial services on the ground that they are too costly." CLARK HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 115 (1995). *See also Case of Commerce*, *supra* note 24, at 9; T. R. Marmor et al., *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003, 1014 (1981) (stating that "cost sharing amounts to a tax or user fee imposed on the sick and is a de facto transfer of wealth from the sick to the healthy"). For more on the concept of rationing beneficial but excessively costly services as part of cost-containment strategies, *see generally* PETER A. UBEL, PRICING LIFE: WHY IT'S TIME FOR HEALTH CARE RATIONING (Glenn McGee & Arthur Caplan eds., MIT Press, 1999). *See also* James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1346 (1981) [hereinafter *Rationing Medical Resources*].
118. Havighurst & Blumstein, *supra* note 84, at 21
119. *See generally id*.

from point x to point o is the more difficult consideration of "cost control."[120] "Cost control" suggests that there are certain procedures or services that, for either a public or private plan, should be left on the table—i.e., not paid for by the common pool of plan resources.[121] This policy discussion requires a conversation in part informed by science but also a conversation that turns on economic trade-offs and one's taste for income redistribution—how much leveling up or leveling down is appropriate and in what circumstances.[122]

My favorite example of this type of issue arose years ago in the context of a discussion about national health insurance ("NHI").[123] An article was written about potential coverage under NHI of stool guaiacs—whether NHI should cover a sixth stool guaiac.[124]

A stool guaiac is a test for colon cancer.[125] I will make up these numbers and use them only heuristically. A provider can perform several stool guaiacs; they are all the same price. But each procedure buys less information as each stool guaiac is performed, even though the cost per test remains the same.[126] At some point, as more tests are performed, a diagnostician may get up to 70%, 80%, or 90% certain of a diagnosis, but one never gets to 100% certainty.[127] Gaining more knowledge, and narrowing the range of uncertainty, is asymptotic (never reaching 100% certainty), and each test buys less information at a constant price.[128] The policy question for structuring an NHI program is, "should national health insurance pay for that sixth stool guaiac," which is the same price as the first one, but it only buys information that gets a diagnostician relatively little improvement in reaching a

120. *See generally id*.
121. *Id*. at 65.
122. *Id*. at 62.
123. *See generally* D. Neuhauser & A.M. Lewicki, *National Health Insurance and the Sixth Stool Guaiac*, 2 POL'Y ANALYSIS 175 (1976).
124. *See id*. at 175–76.
125. This is a sequential testing procedure that detects blood in the stool, but a single test is inaccurate because of the high probability of false positives and negatives. As such, in the 1970s before more accurate colon cancer diagnostics were developed, the American Cancer Society recommended a series of six sequential guaiacs. The goal was to use six tests to capture all possible true positive cancer results. *See id.* 176–79.
126. *See id*. at 179.
127. *See id*. at 180.
128. *See id.* at 179 (evaluating guaiac study that assumed that out of every 10,000 patients, there would be 71.942028 detectable colon cancers and concluding that in 1975, the "marginal cost per cancer found by using six guaiacs is $47.1 million.").

diagnosis.[129] That is, assume that the additional (sixth) stool guaiac gets a clinician from, say, 95% certain to 96% certain. Should NHI pay for that sixth stool guaiac? That puts into a concrete decision-making perspective what is really the debate about cost containment and trade-offs from an economic point of view—the kind of issue that policymakers must confront when analyzing scope-of-coverage issues.[130]

As I will reiterate below, a new understanding about the role of consideration of economic trade-offs has emerged from the way that the ACA was, in part, paid for.[131] This has transformed cost containment into an access-to-care issue.[132]

About half of the coverage expansion in the ACA was paid for by proposed reductions in the rate of growth in spending for Medicare.[133] That is, the taste or appetite for cost control was whetted by the recognition that containing costs was no longer an abstraction or a budgetary issue for the budgetary accountants.[134] Cost savings, in the form of reduced rates of projected spending growth rates in Medicare, were a tool for expanding access to care for those who lacked that access.[135] That "either/or" approach to cost containment, rather than the traditional "yes/no"[136] approach placed cost containment into a more favorable context; reduced rates of spending increase could achieve other

129. *See id*. at 177.

130. *See Case of Commerce*, *supra* note 24 (explaining that "much expense in medical care involves careful consideration of the value of buying incremental levels of reduced uncertainty."). For a general discussion of these trade-off issues, *see* Havighurst & Blumstein, *supra* note 84.

131. See discussion *infra*.

132. See discussion *infra*.

133. *See* DOUGLAS W. ELMENDORF, CBO'S ANALYSIS OF THE MAJOR HEALTH CARE LEGISLATION ENACTED IN MARCH 2010 BEFORE THE SUBCOMM. ON HEALTH, COMM. ON ENERGY AND COM., 11 (2011), https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/03-30-healthcarelegislation.pdf (estimating that a number of ACA provisions would reduce federal Medicare outlays by $492 billion over 2010-2019). *See also* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, at 250–68 (2011) (eBook) (describing ACA financing mechanisms that were included in Title IX of the legislation).

134. James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 30 (1994).

135. *Id*.

136. *See Rationing Medical Resources, supra* note 117, at 1350–51 (explaining that "given a certain budget, decisionmakers in the private market face "either/or" rather than "yes/no" choices-selecting one good or service means foregoing another" and that without the ability to recapture or reallocate resources, "decisions are seen not as "either/or" but as "yes/no," and a private decisionmaker will be prone to say "yes" to a given consumption opportunity because he will not gain anything by saying "no" to any outlay of funds.").

important health policy objectives, such as substantial increases in access.[137] That type of trade-off had been an important component of the TennCare "deal," wherein cost savings from universal managed care were re-channeled so as to allow for expanding the scope of coverage of Medicaid.[138]

### C. Clinical Uncertainty

The assumption of the professional paradigm is that we have clinical certainty;[139] but the widespread existence of clinical uncertainty has been persuasively demonstrated, with evidence initially presented by the Dartmouth Atlas pioneered by Jack Weinberg and colleagues at Dartmouth[140] and since replicated.[141] In many areas, this work has undermined the professional paradigm's claims of scientific expertise.[142] The existence and prevalence of clinical uncertainty have suggested a

137. *Id*.

138. *Reform through Medicaid Managed Care*, *supra* note 7, at 202–04, 203 n. 350.

139. For a discussion of the existence of clinical uncertainty and its implications, *see New Role for QIOs, supra* note 46, at 1026–31; *Case of Commerce*, *supra* note 24, at 10 (discussing the existence of clinical uncertainty as evidenced in divergent procedure rates across the country, which "further suggests an appropriate role for incentives.").

140. *See generally* JOHN E. WENNBERG ET AL., THE DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES (Megan McAndrew Cooper ed., 1996) (demonstrating substantial geographic variation in the provision of health care services); John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCI. 1102 (1973).

141. Since its inception, the Dartmouth Atlas research has expanded to also include data on resources and utilization rates at hospitals. For updated data on these issues, *see* Kristen Bronner et al., *The Dartmouth Atlas of Health Care: 2018 Data Update*, DARTMOUTH INST. (2020), https://data.dartmouthatlas.org/downloads/reports/2018_data_report_081821.pdf (finding that between 2011 and 2018, there was a slight decrease in Medicare reimbursements paid to hospitals for inpatient stays, there was "considerable variation across the U.S. with regard to overall Medicare expenditures."). For more Dartmouth Atlas reports on variations in provisions of specific services, *see generally Atlases and Reports*, DARTMOUTH ATLAS PROJECT, https://www.dartmouthatlas.org/atlases-and-reports/#national-atlas-editions (last visited Jan. 31, 2022).

142. This is true, for example, in the area of medical malpractice. *See Legal Liability Regime, supra* note 79, at 136 ("These data call into question the hard scientific basis of much medical practice, and advocates of the strict scientific viewpoint have been critical of this variation."); James F. Blumstein, *Cost Containment and Medical Malpractice, in* HEALTH CARE DELIVERY AND TORT: SYSTEMS ON A COLLISION COURSE? 89 (Elizabeth Rolph ed., 1993) (discussing how to accommodate cost-containment objectives with medical malpractice liability standards). E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE LAW AND THE NEW MEDICAL MARKETPLACE (2001) (considering medical malpractice liability standards in the context of cost-containment objectives).

greater role for consumer choice and a recognition that the role for clinicians mirrors professional roles in other settings—that of expert adviser, not substitute decisionmaker based on scientific determinism.[143]

### D. The Shift in Payment Systems

There has been a shift in payment systems over the years, starting in the 1980s with the development of Diagnosis Related Groups ("DRGs") for hospital payment for Medicare patents[144] and the notion of capitation,[145] that a payer pays a flat amount per member per month.[146] These emphasize risk-taking by providers, along with incentives by providers to curtail low-value expenditures.[147] All suggest that economics have an important role to play.[148] In the ACA, the emphases on value-based payment[149] and bundled payments[150] are examples of that type of shift in payment based upon economic thinking.[151]

143. *See Case of Commerce*, *supra* note 24.

144. *See* Mark McClellan, *Hospital Reimbursement Incentives: An Empirical Analysis*, 6 J. ECON. & MGMT. STRATEGY 91, 92 (1997) (describing the diagnoses related-group associated payments in Medicare: "[a] DRG is an admission-level payment grouping that is associated with a scheduled relative payment weight.").

145. Capitated payments reimburse a physician or provider a fixed, global rate regardless of the services provided. The goal of this type of payment structure is to incentivize providers to enhance quality and contain costs. *See* Samuel H. Zuvekas & Joel W. Cohen, *Fee-For-Service, While Much Maligned, Remains the Dominant Payment Method for Physician Visits*, 35 HEALTH AFFS. 411, 411 (2016).

146. *Id*. at 411.

147. *Id*. at 413.

148. *Id*. at 411.

149. The ACA included several provisions to pay physicians and hospitals for the value—or quality—of care, instead of the quantity of services, under Medicare and Medicaid. Broadly, these provisions are separated into two categories: the first rewards or penalizes providers for certain outcomes such as hospital-acquired infections or readmissions, and the second departs from the traditional payment structure by paying providers on a global scale to hold the accountable care organization to quality and cost outcomes. *See* David Blumenthal & Melinda Abrams, *The Affordable Care Act at 10 Years—Payment and Delivery System Reforms*, 382 NEW ENG. J. MED. 1057, 1057–60 (2020).

150. The core ACA quality-improvement provisions included several bundled payment programs, which give "providers a single, prospective payment for treatment of a surgical or medical condition. Providers retain any savings, may absorb excess costs, and have to meet quality criteria." The ACA-created Center for Medicare and Medicaid Innovation ("CMMI") has also experimented with bundled payments. *See id.* at 1059–60; Chiquita Brooks-LaSure, Elizabeth Fowler Meena, & Seshamani Daniel Tsai, *Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years*, HEALTH AFFS. (Aug. 12, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/.

151. *See* Blumenthal & Abrams, *supra* note 149, at 1057.

### E. Selected Legal Doctrines

Selected legal doctrines have contributed to the emergence of the market model.[152] For example, consumer-oriented informed consent is one illustration of patient empowerment.[153] Under that approach, providers are expected to disclose to patients information that a reasonable patient would want to have, not what a reasonable physician would disclose.[154] The sharing of more information helps to offset consumer ignorance and facilitates patient participation in his or her own medical care decision-making.[155]

I also want to mention antitrust.[156] I have described antitrust as the engine of the market paradigm.[157] Antitrust law applies to trade or commerce,[158] and the Supreme Court has held that the field of medicine,[159] like the practice of law in the Goldfarb case,[160] is trade or commerce subject to the antitrust laws.[161] That suggests that health care is an industry, and that economic considerations and economic factors matter and are important in public policy.[162]

152. *Competing Visions*, *supra* note 26, at 1474.
153. *Id*. at 1474.
154. *Id*. at 1474. For discussion of the role that a patient-centered informed consent inquiry could have in improving the functioning of the health care marketplace, *see Reform through Medicaid Managed Care*, *supra* note 7, at 902–08.
155. *Competing Visions*, *supra* note 26, at 1475.
156. *Id*. at 1483–86.
157. *Id*. at 1493. *See also Professional Paradigm*, *supra* note 58, at 420–21 (noting that in the 1970s the biggest threat to the professional paradigm came from "the antitrust laws, which embodied free-market principles and barred collective action of the kind that the profession was accustomed to use against those who were tempted to depart from its precepts").
158. Sherman Anti-Trust Act, 15 U.S.C. § 1 (West 2004) ("Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.").
159. *See* Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); Summit Health, Ltd. v. Pinhas, 500 U.S. 322 (1991); California Dental Ass'n v. FTC, 526 U.S. 756 (1999).
160. *See generally* Goldfarb v. Virginia State Bar, 497 F.2d 1 (4th Cir. 1974), *rev'd*, 421 U.S. 773 (1975).
161. *See* Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); Summit Health, Ltd. v. Pinhas, 500 U.S. 322 (1991); California Dental Ass'n v. FTC, 526 U.S. 756 (1999).
162. *See, e.g.*, Havighurst & Blumstein, *supra* note 84, at 9.

## VI. Consideration of Economic Trade-offs

I will now address cost issues and consideration of economic trade-offs.

### A. Cost Containment as an Access Issue

Consideration of cost containment and economic trade-offs has often been seen as dismal, something for the nerdy green eye-shades folks and somewhat tracking the notion of economics as the dismal science.[163] But things have changed. Cost containment is now seen as an access issue, a point I made earlier.[164] The ACA is the high-water mark of this new perception—that cost containment should be understood, at least in part, as an access issue.[165]

The proponents of the ACA had a budget that they wanted to live within; they needed to find a way to pay for the expanded access provided for in the ACA.[166] In the legislative process that led to enactment of the ACA, almost 50% of the "pay fors" in the ACA derived from reductions in the rate of increase in payments under Medicare.[167] Expanded Medicaid coverage and other access issues—subsidies and so forth—were paid for not by reductions in actual expenditures, but by reductions in the rate of increase in projected Medicare outlays.[168] That process in the enactment of the ACA of using reductions in projected spending increases to finance broader access established that cost-containment considerations have substantial access-to-care implications.[169]

### B. Ideology and Financial Considerations—The Tragic Muse Case

There is also another point to make about the importance of accepting the reality of and benefits from recognizing considerations of cost in medical decision-making.[170] Failure to recognize the reality of economic incentives can have significant, harmful effects that can be very troubling.[171]

163. *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L.R. 431, 534 (1988).
164. *See supra* text accompanying note 133.
165. *Id*.
166. *Id*.
167. *See id*.
168. *Id.*
169. *Reform through Medicaid Managed Care*, *supra* note 7, at 270.
170. *See generally id.*
171. *Of Doctors and Hospitals*, supra note 62, at 220.

Consider in this regard the Muse case.[172] When I teach health law, discussion of Muse is how I start the class. This is the case. Joe Muse had suicidal thoughts and was admitted as an in-patient to a mental health facility, Charter Medical.[173] His inpatient insurance, from his parents' plan, ran out.[174] Charter Medical wanted to discharge Joe; under the traditional tort non-abandonment doctrine, Charter Medical had to find an adequate alternative facility—likely another inpatient facility,[175] such as a public mental health facility that was available. Both an inpatient facility and outpatient care were available options.[176]

Charter Medical released Joe to be treated on an outpatient basis, even though an inpatient facility, a governmental facility, was also available.[177] That choice of outpatient care raises the question, "why did Charter Medical not transfer Joe to an available inpatient public facility but rather release him to treatment as an outpatient?"[178] The answer is that Charter Medical was continuing to deny that economics was relevant.[179] Charter Medical said that Joe was being discharged because he was healthy enough for treatment on an outpatient basis—despite what the court deemed strong evidence that continued in-patient care was indicated[180]—not because his insurance ran out.[181]

The result of the denial that economic factors entered into Charter Medical's decision-making process was Joe went to an outpatient facility, was not adequately supervised, and committed suicide.[182] Charter Medical wanted to maintain that it was following the professional paradigm, making a discharge decision solely on medical criteria.[183] It did not want to own up to the reality that the expiration of Joe's insurance coverage, an economic reality, played a role in the discharge decision, and, under the non-abandonment doctrine, such considerations could

172. *See* Muse v. Charter Hosp., 452 S.E.2d 589, 593 (N.C. 1995).
173. *Id.*
174. *Id.*
175. The court concluded that Joe's medical condition warranted inpatient treatment. *See id.* at 474–75. A physician has a legal and ethical duty not to abandon a patient once the physician has undertaken treatment unless he provides the patient with notice and the opportunity to receive other commensurate medical care. *See infra* notes 69 and 70.
176. *Muse*, 452 S.E.2d at 593.
177. *Id.*
178. *See id.*
179. *See id.*
180. *Id.* at 593.
181. *Id.*
182. *Id.* at 593, 596
183. *Id.* at 594.

play a role so long as an adequate, alternative inpatient treatment facility was available (as was the case).[184]

The Muse case is a tragic example of where the failure to recognize and come to grips truthfully with the economic reality that a hospital cannot afford in the long run to provide, or is not willing to provide, services that are not being paid for.[185] Recognizing that professional relationships are important, that choice is constrained by the non-abandonment principle.[186] Hospitals cannot abandon a patient.[187] It may be that an alternative inpatient facility, such as a public hospital, may not be quite as good as Charter Medical in terms of quality of care; under the non-abandonment doctrine, the issue is not whether (in that case) the government facility was as good as Charter Medical, but whether it would provide an adequate or proper level of oversight and service/treatment.[188] That set of considerations, for Charter Medical, was off the table because it would require forthright recognition that an economic paradigm was in play and, in addition, that some lower level of inpatient quality of care was adequate and acceptable, even if not

184. *Id.* at 589.

185. *Id.*

186. *See* Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 ANNALS INTERNAL MED. 368 (1995) (describing a doctor's duty not to abandon patients as central to medical ethics). In addition, hospitals that are accredited by the Joint Commission Accreditation of Healthcare Organizations ("JCAHO") are deemed to meet Medicare's conditions of participation, making JCAHO standards essentially mandatory for hospitals. *See generally* Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, 57 L. & CONTEMP. PROBS. 15 (1994), https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=4252&context=lcp (discussing history and significance of JCAHO accreditation for hospitals participating in Medicare). JCAHO requires that hospitals meet a variety of standards concerning patient discharge procedures, which can impede hospital discretion in discharge decision-making, such as "hand-off communication" plans when transitioning patients to other settings. *Inadequate Handoff Communication*, 58 SENTINEL EVENT ALERT 1 (2017), https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pdf?db=web&hash=5642D63C1A5017BD214701514DA00139&hash=5642D63C1A5017BD214701514DA00139.

187. *See* Quill & Cassel, *supra* note 186.

188. *See, e.g.*, Lee v. Dewbre, 362 S.W.2d 900, 903 (1962) (reviewing case law and holding that a claim of patient abandonment is only actionable if the patient failed to receive reasonable notice or adequate replacement medical attention); Burnett v. Layman, 181 S.W. 157, 158 (Tenn. 1915) ("It is well settled that a physician who undertakes the treatment of a case may not abandon his patient until in his judgment the facts justify the cessation of attention, unless he give to the patient due notice that he intends to quit the case and affords the patient opportunity to procure other medical attendance.").

exactly equal to the level of service provided by Charter Medical.[189] The result of that ostracism in the Muse case was Joe's suicide, as he was treated on an outpatient basis and left unsupervised.[190]

### C. The Medical Necessity Standard

Next to be discussed in the context of considering economic factors in medical decision making is the issue of medical necessity.[191] Medical necessity has been typically seen as an implementation of the professional model.[192] Traditionally, the concept of medical necessity is the term characteristically used to define the obligation of a health plan, private or governmental, to pay for medical services of a plan beneficiary.[193] The term, customarily, has been based on scientifically-determined criteria like safety and efficacy.[194] Contrary to the findings of clinical uncertainty in the Dartmouth Atlas and elsewhere, which call into question some of the more far-reaching claims of the professional paradigm, the traditional understanding of the concept of medical necessity is that there is a correct (an "indicated") diagnosis or treatment and that there is a scientific basis for that "indicated" diagnosis and/or treatment.[195]

When Tennessee was doing Medicaid (TennCare) reform under Governor Bredesen in 2003–04—I was his outside counsel in that process—Tennessee legislatively defined medical necessity to include an economic dimension;[196] the court overseeing that process upheld that

189. *See* Muse v. Charter Hosp., 452 S.E.2d 589, 594–95 (N.C. 1995).

190. *Id.*

191. *See, e.g.*, *Reform through Medicaid Managed Care*, *supra* note 7, at 205–10; William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance,* 53 DUKE L. REV. 597 (2003) (exploring the concept of medical necessity as it has evolved in the judicial and administrative oversight of managed care).

192. "The term 'medical necessity,' found in most insurance contracts, conforms to the ideology of the professional paradigm," focusing on medical criteria and deemphasizing "traditional economic considerations (such as balancing cost and benefit in consumption decisions)." *Reform through Medicaid Managed Care*, *supra* note 7, at 206. *See also Professional Paradigm*, *supra* note 58, at 425 (discussing the "medical necessity" formulation as embodying the professional paradigm).

193. *See* HAVIGHURST, *supra* note 117, at 115 (noting that "'medical necessity' is ubiquitous as a criterion governing the obligation of the plan to pay for particular services").

194. *Reform through Medicaid Managed Care*, *supra* note 7, at 206, 206 n.365.

195. *Id.*

196. TENN. CODE ANN. §71-5-144(b)(3) (West 2012).

definition.[197] There was no federal definition of medical necessity for Medicaid, so states had considerable discretion in establishing a definition.[198]

This is the operative language legislatively adopted for the TennCare program: to be medically necessary, an item or service must not only be "safe and effective,"[199] the traditional medical efficacy criteria, but in addition; an item or service "must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee."[200]

The TennCare definition of medical necessity does two important things. First, it clearly recognizes that costs are relevant in determining what items or services will be paid for by the common pool of TennCare funds; if something can be done on a less expensive outpatient basis rather than on a more expensive inpatient basis, then TennCare will only pay for the outpatient service.[201] Or if over-the-counter Tums is available, a TennCare patient does not need a prescription for an antacid; the TennCare patient must use the least costly alternative.[202]

197. *See* Grier v. Goetz, 402 F. Supp. 2d 876, 929 (M.D. Tenn. 2005), *order clarified*, 421 F. Supp. 2d 1080 (M.D. Tenn. 2006) ("the State may evaluate all claims for TennCare services in accordance with the definition of medical necessity established by State law. . . and the State may deny any claim for a service that the State has concluded is not medically necessary as that term is defined under state law."). The state had entered into a consent decree regarding TennCare, and the terms of the consent decree incorporated but did not define the meaning of medical necessity. *Id.* at 881–82. The court approved the Tennessee definition as within the state's scope of discretion.

198. Such was not the case with respect to including non-medical, economic criteria, in the definition of medical necessity under Medicare. *See* Hays v. Sebelius, 589 F.3d 1279, 1283 (D.C. Cir. 2009).

199. "To qualify as safe and effective, the type and level of medical item or service must be consistent with the symptoms or diagnosis and treatment of the particular medical condition, and the reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on the enrollee's condition and scientifically supported evidence." TENN. CODE ANN. § 71-5-144(b)(2).

200. TENN. CODE ANN. §71-5-144(b)(3).

201. Deference to TennCare's decision is required. *Id.* ("Where there are less costly alternative courses of diagnosis or treatment, including less costly alternative settings, that are adequate for the medical condition of the enrollee, more costly alternative courses of diagnosis or treatment are not medically necessary."). *See* Wade v. Tennessee Dep't of Fin. & Admin., 487 S.W.3d 123, 136 (Tenn. Ct. App. 2015) (overruling trial court and holding that the patient plaintiff failed to prove that TennCare erred in determining that a 24/7 private duty nurse was not medically necessary because plaintiff could receive adequate care for less cost in a respiratory unit).

202. TENN. CODE ANN. § 71-5-144(b)(3).

Second, the TennCare definition of medical necessity addresses the question/issue of what the standard of effectiveness is.[203] Straightforwardly, the TennCare definition of medical necessity establishes the metric of "adequacy."[204] The question is not what Bill Gates would do for his family or what a putative private plan would cover. A different question determines medical necessity under TennCare: what is "adequate" to address "the medical condition of the enrollee"?[205] Adequacy, not equality, is the yardstick by which to measure the scope of the public obligation to TennCare beneficiaries.[206] It may be, for example, that an aspirin for headache or pain might not be quite as good as some alternative that could be prescribed; but the operative question, which is both normative and empirical, is whether the course of treatment with aspirin is "adequate."[207]

No one during the TennCare reform process was advocating for schlock medicine, and I certainly rejected any such outcome.[208] But TennCare was spending about a hundred million dollars per year at the time (as of fifteen years ago) on antacids.[209] Governor Bredesen said, in effect, "that doesn't seem right, there must be another way."[210] And as somebody whose quality of life has been considerably improved by an over-the-counter antacid Gelusil tablet, Gelusil is pretty inexpensive and it is not prescription.[211] And that is what the reform team had in mind, substituting less costly courses of diagnosis and/or treatment, even if they are marginally less effective, but provided they meet the empirical and normative standard of "adequacy."[212] And, although it is hard to demonstrate causality empirically, one can observe that the rates of expenditure increase under TennCare have been relatively mild over the past fifteen years.[213]

203. TENN. CODE ANN. § 71-5-144(b)(2).
204. TENN. CODE ANN. § 71-5-144(b)(3).
205. *Id.*
206. *Id.*
207. *Id.*
208. *Reform through Medicaid Managed Care, supra* note 7, at 209 n.373.
209. *TennCare Budget—Expenditures and Funding Sources FY2006*, TENN. DIV. OF TENNCARE, https://www.tn.gov/content/dam/tn/tenncare/documents/budgetsfy0607.pdf (last visited Jan. 31, 2022).
210. *See TennCare Coverage Cuts*, *supra* note 90.
211. *What is Gelusil: Uses, Warnings & Interactions*, SINGLECARE, https://www.singlecare.com/prescription/gelusil/what-is# (last visited Jan. 31, 2022).
212. TENN. CODE ANN. § 71-5-144(b)(3).
213. *See FY2022 Budget*, TENN. DIV. OF TENNCARE, at 5, https://www.tn.gov/content/dam/tn/tenncare/documents/FY22RecommendedBudget.pdf (last visited Jan. 31, 2022) (chart showing that TennCare expenditures from 2012 to 2020 were below

## VI. Consequences of the Assumptions of the Professional Paradigm

The next issue to address is: what are the consequences of the assumptions undergirding the professional paradigm that drove Medicare and Medicaid?

### A. The Historical Linkage of Medicare and Medicaid to Income Support Programs

Historically, there has been a linkage between Medicare (for the elderly) and Medicaid (for persons of low income) and income support programs such as Social Security, for the elderly, and Aid to Families with Dependent Families ("AFDC"), now Temporary Assistance for Needy Families ("TANF"), for persons of low income.[214] That linkage created the structure for government support for medical care, and that structure derives from income-support programs like Social Security and AFDC rather than a medically-driven structure.[215]

The linkage between public support for medical care access and income support was explicit in terms of eligibility.[216] Medicaid added a medical care benefit for those on welfare, and Medicare added a medical care benefit for those who on Social Security.[217] A fair inference is that the foundational assumption was that cash assistance and medical assistance were similar in character.[218] Once one defines eligibility, medical care expenses could be realistically projected, with expanded

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the national Medicaid state average); *see also* PHIL BREDESEN, FRESH MEDICINE: HOW TO FIX REFORM AND BUILD A SUSTAINABLE HEALTH CARE SYSTEM 85–108 (2010) (discussing TennCare reforms that aimed to reign in and slow rising costs of the program due to expanding enrollment and high utilization rates).

214. *Reform through Medicaid Managed Care*, *supra* note 7, at 136–37. In 1972, Congress extended Medicare coverage to those who qualified for income support under the disability components of Social Security. *See generally* Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833 (1976) (discussing the Social Security disability program). The AFDC program has now been replaced by the program Temporary Assistance for Needy Families. 42 U.S.C. §§ 601–10, 612, 613, 615–17 (Supp. 1999). *See also* Clark C. Havighurst et al., *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW & CONTEMP. PROBS. 122, 183 (1976) [hereinafter *Strategies in Underwriting*], ("Historically, medical support programs have tended to follow and to be built upon government's income maintenance initiatives.").

215. *See Strategies in Underwriting*, *supra* note 214, at 183, 183 n.274.

216. *Id.*

217. *Id.*

218. *Id.*

funding not affecting overall levels of utilization (other than to expand eligibility and access).[219]

That is, there was an assumption of no moral hazard.[220] The fact that there would be public funding would not affect general levels of utilization for a patient because utilization would be determined under the professional paradigm—based on science, not based upon incentives.[221] The assumption under the professional paradigm was that science would control, economic incentives would play only an insignificant role in terms of overall utilization and styles of practice.[222] Under the professional paradigm, the assumption was that doctors uniformly would agree, and did agree, on diagnosis and treatment decisions for specific conditions.[223]

The Dartmouth Atlas has called that set of assumptions into question for many conditions and procedures.[224] The assumption under the professional paradigm is that there is a single correct answer that is based upon a form of scientific determinism.[225] We have seen that deterministic language come to the fore now in discussions about the pandemic virus—that there is a single correct approach to policy regarding the COVID-19 virus, and it is based upon science and scientific consensus.[226] But a more sophisticated, and accurate, approach realizes and recognizes that science identifies and acknowledges a range of probabilistic judgments not a point on a scale.[227] The relevant science is not mixing two parts hydrogen and one part oxygen to generate water, but determining what risk (not certainty) is associated, for example, with maintaining a certain distance from others or wearing a mask.[228]

219. *See, e.g.*, TENN. CODE ANN. § 71-5-144.

220. *See generally Reform through Medicaid Managed Care*, *supra* note 7, at 207–09; *See* Brief of James F. Blumstein as Amicus Curiae in Support of Petitioners (Medicaid Issue), NFIB v. Sebelius, 132 S. Ct. 2566, at 26 (No. 11-400) [hereinafter Brief of James F. Blumstein, NFIB v. Sebelius] (defining political moral hazard).

221. *Id.*

222. *Id.*

223. *See Case of Commerce*, *supra* note 24.

224. *New Role for QIOs, supra* note 46, at 1027. *See generally* Maxwell Gregg Bloche et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AM. J.L. & MED. 203, 206 (2003) (discussing the impact of variations in care and clinical uncertainty on health disparities).

225. *New Role for QIOs, supra* note 46, at 1023.

226. *See supra notes* 123–29 and accompanying text (discussing sixth stool guaiac); *Effects of Lockdown*, *supra* note 23.

227. *See generally New Role for QIOs, supra* note 46, at 1027–28.

228. *See supra* notes 140–41 and accompanying text (discussing clinical uncertainty and its implications); *New Role for QIOs supra* note 46, at 1026–28. In the context of the COVID-19 pandemic, despite epidemiological studies predicting success,

The word that I always react against is when a doctor will say, "oh such and such a treatment is indicated" in a certain set of circumstances, suggesting that there is only one right way to do things.[229] But that type of thinking asks too much of science, and distorts the role of scientists.[230] Think of the problem as a lawyer might in his or her own professional context, where the lawyer is not a substituted decisionmaker but an expert adviser. Would a lawyer typically say, "an S corporation is indicated in the circumstances." Not the norm; a lawyer would be more likely to say something like this—"there are a lot of different options available; the best one under the circumstances is an S corporation or an LLC based upon all considerations that you, as the client, have asked me to take into account."

A concept of scientific determinism was captured in the traditional concept of medical necessity, and it differs strikingly from the TennCare definition, which takes non-medical considerations into account.[231] That medical necessity definition in TennCare was a breakthrough, recognizing that public policy must be grounded in science, but not wedded to scientific determinism.[232] The relevant science, as illustrated by the Dartmouth Atlas, strongly suggests that a medical care "production function"[233] might well allow for a range of options, with decisions turning on a mix of medical and non-medical factors (such as risk or functionality preferences and trade-offs).[234] Other values enter into a policymaking process; science helps to inform ultimate choices, by patients or overall society, but it is mistake to see, as the professional

recent analyses suggest that mandatory policy interventions restricting movement, like lockdowns, had little impact on reducing mortality rates. *See Effects of Lockdown*, *supra* note 23.

229. *See, e.g.*, James F. Blumstein, *Cost Containment and Medical Malpractice,* in HEALTH CARE DELIVERY AND TORT: SYSTEMS ON A COLLISION COURSE? 76, 94 (Elizabeth Rolph ed., 1993) ("the unitary standard principle is premised on a professional aspiration: that medical protocols are scientifically based and that therefore there is a single appropriate mode of treatment under a given set of circumstances.").

230. *See Legal Liability Regime*, *supra* note 79, at 132.

231. *See supra* notes 199–201 and accompanying text; *Reform through Medicaid Managed Care*, *supra* note 7.

232. *See* Andy Schneider, *Tennessee's New "Medically Necessary" Standard: Uncovering the Insured?*, KAISER FAM. FOUND. (July 2004), https://www.kff.org/wp-content/uploads/2013/01/tennessee-s-new-medically-necessary-standard-uncovering-the-insured-policy-brief.pdf.

233. *See* Bronner et al., *supra* note 141.

234. *Id.*

paradigm does, that medical decisions, in general, are or can be based on a scientific determinism.[235]

In short, the assumption upon which Medicare and Medicaid were predicated was that what doctors would order was based on science and that, for most of medical care, a consensus existed about what treatments are indicated under a given set of circumstances.[236] Expanding coverage under Medicare or Medicaid would not influence the level of utilization or the style of practice, as they were driven by scientifically-determined, consensus-based practices.[237] The type of choices and strategies that characterize a market or other types of professions were not applicable, so the argument went, to the medical care arena.[238]

Within about five or six years after Medicare and Medicaid were enacted in 1965, we saw that the assumptions of the professional paradigm had been faulty. Expenses from Medicare and Medicaid ballooned well beyond projections.[239] Attention then focused on controlling costs.[240]

In 1972, a major piece of legislation, The Professional Standards Review Organization ("PSRO legislation"), was enacted primarily out of concern about costs and escalation of costs.[241] And cost containment has been a focus of much health policy discussion ever since, including with the enactment of the ACA.[242]

### B. Third-party Payment with Minimal Oversight

A second consequence of the assumptions of the professional paradigm is that those assumptions allowed for the development of third-party payment with minimal oversight.[243] The flow of dollars through

235. *See Competing Visions, supra* note 26, at 1479.
236. *See id. at 1479–80.*
237. *Id.*
238. *Id.*
239. *See* Havighurst & Blumstein, *supra* note 84, at 13–15; *Professional Paradigm, supra* note 58, at 415-17; David Blumenthal et al., *Health Care Spending—A Giant Slain or Sleeping?*, 369 NEW ENGLAND J. MED. 2551, 2552 (2013) (explaining that after the enactment of Medicare and Medicaid, the growth in national spending on health care increased dramatically: "[b]etween 1970 and 1993, the real increase in health spending per person exceeded growth in the GDP per capita by 2.7% percentage points annually.").
240. *See* Havighurst & Blumstein, *supra* note 84, at 13–15.
241. *Id.* at 8.
242. *Id.*
243. *See* Havighurst & Blumstein, *supra* note 84, at 11; *Legal Liability Regime*, *supra* note 79, at 126.

Medicare and Medicaid was assumed not to affect styles of practice or levels of utilization—i.e., no moral hazard existed.[244] An open-ended, unconstrained third-party payment system makes sense only if one assumes, consistent with the professional paradigm, that the overall level of utilization and the style of practice would not be affected by levels of financial support.[245]

For Medicaid, the result was a structure of cooperative federalism, that there would be federal matching support and oversight, but that the program was to be administered by the states.[246] But the assumed lack of effect of funding on levels of utilization or styles of practice allowed for the Medicaid program design, which was an open-ended entitlement-based program design—an uncapped expenditure.[247] State expenses were determined by hospitals and doctors and by industry advocates, governed by the traditional medical necessity standard.[248] Once expenses were incurred, it was the obligation of the federal government to match state program expenditures without limitation as long as these expenditures were in the state plan design.[249]

In sum, Medicaid was designed with an open-ended, uncapped structure; that structure could only have been based upon the assumptions of the professional paradigm—that economic incentives do not affect the level of services or the style of practice provided—which turned out to be faulty, with program costs escalating well beyond initial projections.[250]

### C. Methods of Reimbursement—Doctors and Hospitals

Methods of reimbursement in Medicare and Medicaid were similarly reflective of the professional paradigm.[251]

Even the use of the term "reimbursement" is a good example of how we do not like to think of economic factors in the health care context. When a person is compensated for providing a service, that person is paid, not reimbursed. If I get an honorarium or perform a consulting gig, or if I am paid by my university, I am not reimbursed, I am paid;

244. *See* Havighurst & Blumstein, *supra* note 84, at 11.
245. *See Professional Paradigm*, *supra* note 58, at 420.
246. *Reform through Medicaid Managed Care*, *supra* note 7, at 136–49.
247. *Id.* at 137–39.
248. *Id.* at 207.
249. *Id.* at 141.
250. *See generally id.*
251. *See Professional Paradigm*, *supra* note 58, at 420.

but the terminology or language surrounding doctors is different.[252] It seems uncomfortable to think of paying or compensating physicians.[253] They prefer to refer to themselves as being reimbursed.[254] That suggests that physicians (or others in the field) are not making money, that health care is not an economic sector.[255] Use of the term "reimbursement" suggests a payment for an already-incurred out-of-pocket expenditure, not a net earning of income.[256] So, one sees discussions of physician reimbursement, a subtle use of language to distract from the reality that physicians are earning money in an economic endeavor and economic sector, not breaking even by a replacement of already-expended funds.[257]

At its inception, doctors were paid under Medicare on the basis of usual, customary, and reasonable fees.[258] That system allowed doctors to set their own fees.[259] That system has been revised over the years in recognition of the need to acknowledge the significance of costs.[260] Under Medicare, hospitals were initially reimbursed on the basis of cost.[261]

252. *See* Ben Fischer, *Maryland Doctors: We Get Paid, Not 'Reimbursed'* WASH. BIZ J. (June 29, 2012), https://www.bizjournals.com/washington/blog/2012/06/maryland-doctors-we-get-paid-not.html (describing how some doctors in the state of Maryland are pushing back on the term "reimbursement" because it is disingenuous).

253. *See id.*

254. *See id.*

255. *See Competing Visions, supra* note 26, at 1468.

256. *See* Fischer, *supra* note 252.

257. *See Competing Visions*, *supra* note 26, at 1468.

258. Initially, Medicare reimbursed doctors based on the "customary, prevailing, and reasonable charge" ("CPR") system, but was eventually replaced after the system resulted in large increases in payments. In 1992, Medicare began paying doctors based on a physician fee schedule based on relative, average costs of services, called the Resource-Based Relative Value Update Scale ("RBRVS"). Rick Mayes & Soleil Shah, *MACRA and Medicare's Elusive Quest for Fairness and Value with Physician Payment Policy: Speeding Up the Transition to "Big Med"*, 11 ST. LOUIS U.J. HEALTH L. & POL'Y 235, 236–38 (2018); Juliette Cubanksi et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers,* KAISER FAM. FOUND. (Mar. 20, 2021), https://www.kff.org/report-section/a-primer-on-medicare-how-does-medicare-pay-providers-in-traditional-medicare/.

259. *See* Mayes & Shah, *supra* note 258, at 236–38.

260. *See id.* at 242–45 (describing the evolution of Medicare physician payments culminating in the passage of the Medicare Access and CHIP Reauthorization Act ("MACRA") in 2015 that significantly changed how physicians are paid under Medicare by emphasizing value-based payments).

261. Prior to implementation of Medicare's prospective payment system for hospitals based on diagnosis-related groups ("DRGs"), hospitals were reimbursed on a "cost + 2%" basis for services. The additional two percent was intended to capture additional costs incurred such as nursing care etc. *See* Rick Mayes, *The Origins,*

That system was a true form of reimbursement, as hospitals were reimbursed for outlays.[262] That cost-based system has been revised to reflect the economic reality that costs can be driven by economic considerations when those costs are reimbursed without much oversight or limit.[263]

### D. Structural Considerations

And, finally, there are the structural considerations to which I have already alluded. Medicaid is an open-ended, uncapped entitlement.[264] Federal matching is open-ended and automatic for expenditures within a state's Medicaid plan.[265] This has resulted in what I call "the displacement of political accountability."[266] States drive the federal budget so that when states decide how robust their Medicaid program should be, who should be covered beyond those who are mandated to be covered, the federal government is obliged to match those expenditures.[267] So, the states are driving the federal budget. At some points the federal government has said that it is being asked to lay out a lot of money for states. The response has been to impose additional requirements on states, raising the floor for mandated state expenditures.[268] The ACA is an example of that approach, relying on a lock-in effect that makes it very difficult for states to resist[269]—unless the federal government overreaches, as it did in the ACA regarding Medicaid expansion, and deprives the states of any real choice regarding mandated expansion.[270] Under this dynamic, state budgets are being driven by the federal government.[271] The displacement of political accountability stems

*Development, and Passage of Medicare's Revolutionary Prospective Payment System*, 62 J. HIST. MED. & ALLIED SCI. 21, 26–27 (2006).

262. *Id.*

263. *See id.*

264. *See generally* Robin Rudowitz et al., *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (May 7, 2021), https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/.

265. James F. Blumstein, *Enforcing Limits on the Affordable Care Act's Mandated Medicaid Expansion: The Coercion Principle and the Clear Notice Rule*, 2011 CATO SUP. CT. REV. 67, 68 (2011–2012) [hereinafter *Coercion Principle*].

266. *See* Brief of James F. Blumstein, NFIB v. Sebelius, *supra* note 220, at 25–26; *Coercion Principle*, *supra* note 265, at 92–93.

267. *Coercion Principle*, *supra* note 265, at 101.

268. *Reform through Medicaid Managed Care*, *supra* note 7, at 136–49.

269. *See id.*; *Coercion Principle*, *supra* note 265, at 102–05.

270. *See id.*

271. *See id.*

from the states driving the federal budget at the initial state buy-in stage, and then, the federal government driving state budgets once state resistance kicks in and states are politically locked into Medicaid.[272]

## VII. The Children's Health Insurance Program as an Alternative Structural Model

CHIP presents[273] an alternative structural model to the Medicaid program.

That legislation was passed in the 1990s, during the Clinton Administration, on a bipartisan basis. It was sponsored by Senator Kennedy, a Democrat, and Senator Hatch, a Republican.[274] They were political adversaries, but personal friends, and they came together on the CHIP legislation.

CHIP reflects a different model of cooperative federalism than Medicaid. Federal CHIP spending is capped and is based on annual Congressional appropriations through a formula that determines in advance each state's CHIP allocation—not on an uncapped automatic-pilot basis as the federal match is under Medicaid.[275] As a capped entitlement program, CHIP is a more flexible program design than Medicaid.[276] Each state by formula receives an annually appropriated, pre-determined amount with state expenditures generously matched by the federal government for authorized expenditures.[277] States are at risk financially if spending goes beyond the budgeted amount.[278] Federal funding is limited through the appropriations process.[279] And there need not be a programmatic entitlement with respect to program beneficiaries; that program structure is established by each state.[280]

272. *Reform through Medicaid Managed Care*, *supra* note 7, at 136–49.

273. *See The Children's Health Insurance Program*, GEO. UNIV. CNT. CHILD. & FAMS. (Feb. 6, 2017) [hereinafter *The Children's Health Insurance Program*], https://ccf.georgetown.edu/2017/02/06/about-chip/.

274. Robert Pear, *Hatch Joins Kennedy to Back a Health Program*, N.Y. TIMES (Mar. 14, 1997), https://www.nytimes.com/1997/03/14/us/hatch-joins-kennedy-to-back-a-health-program.html.

275. *The Children's Health Insurance Program*, *supra* note 273.

276. *See id.*

277. *See id.*

278. *See id.* (explaining that CHIP funds are capped based on state-specific allotments, which can result in state funding shortfalls).

279. *See id.*; *A Brief Guide to the Federal Budget and Appropriations Process*¸ AM. COUNCIL ON EDUC., https://www.acenet.edu/Policy-Advocacy/Pages/Budget-Appropriations/Brief-Guide-to-Budget-Appropriations.aspx (last visited Jan. 30, 2022).

280. *See Children's Health Insurance Program*, *supra* note 273.

To the extent that, through state choice, CHIP creates an entitlement, it is a capped entitlement.[281] The federal obligation is subject to the annual appropriations process.[282] Federal funding is not on automatic pilot, unlike Medicaid, where the federal government must match state funding within the state's approved plan.[283] Federal funding levels are determined in advance through the political process.[284] The overall level of federal funding is a matter of annual appropriations, and the level of federal appropriations is capped at that politically pre-determined amount.[285]

Unlike Medicaid, where federal appropriations are obliged to follow the expenditures under a state's plan, under CHIP the pre-determined level of appropriations drives the level of federal expenditures.[286] It is a clear recognition of the economic dimensions of medical care because a budget is set ex ante, with states expected to live within a pre-determined budget.[287] States are at risk financially if there is excess spending, as the federal commitment does not automatically follow from state levels of expenditure; federal spending levels are set at the front end of a fiscal year.[288] And CHIP subjects medical expenditures to the political appropriations process.[289] Federal CHIP spending is not on uncapped automatic pilot.[290]

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281. *Id.*

282. *See generally id.*; *Financing*, MEDICAID.GOV, https://www.medicaid.gov/chip/financing/index.html (last visited Jan. 30, 2022).

283. *Children's Health Insurance Program*, *supra* note 273; *see also* Phillip Oliff & Rebecca Thiess, *Children's Health Insurance Program Funding and Structure Vary Significantly by State,* PEW TRUSTS (Oct. 6, 2017), https://www.pewtrusts.org/en/research-and-analysis/articles/2017/10/05/childrens-health-insurance-program-funding-and-structure-vary-significantly-by-state; Rudowitz, *supra* note 264.

284. *See generally A Brief Guide to the Federal Budget and Appropriations Process*, AM. COUNCIL ON EDUC., https://www.acenet.edu/Policy-Advocacy/Pages/Budget-Appropriations/Brief-Guide-to-Budget-Appropriations.aspx (last visited Jan. 30, 2022); Oliff & Thiess, *supra* note 283.

285. *Children's Health Insurance Program*, *supra* note 273.

286. *Id.*

287. *Id.*

288. *See id.*; *A Brief Guide to the Federal Budget and Appropriations Process*, AM. COUNCIL ON EDUC., https://www.acenet.edu/Policy-Advocacy/Pages/Budget-Appropriations/Brief-Guide-to-Budget-Appropriations.aspx (last visited Jan. 30, 2022); Oliff & Thiess, *supra* note 283.

289. *Financing*, MEDICAID.GOV, https://www.medicaid.gov/chip/financing/index.html (last visited Jan. 30, 2022); *see generally A Brief Guide to the Federal Budget and Appropriations Process*, AM. COUNCIL ON EDUC., https://www.acenet.edu/Policy-Advocacy/Pages/Budget-Appropriations/Brief-Guide-to-Budget-Appropriations.aspx (last visited Jan. 30, 2022); Oliff & Thiess, *supra* note 283.

290. *Children's Health Insurance Program*, *supra* note 273.

This program structure builds on Medicaid's mandated managed care option, which Tennessee pioneered.[291] For its TennCare program in 1994, Tennessee had to obtain a waiver to allow it to place all beneficiaries in managed care,[292] but the experiment was deemed to be so successful that within three years mandatory managed care became available to any state without a waiver for its Medicaid program.[293] Under managed care, TennCare plans have to manage within a budget and are expected to deliver on quality and constrain costs.[294] As I have previously discussed, I like to draw an analogy to the economic dimensions of the ACA in which nearly 50% of the financing for additional access under expanded Medicaid was paid for by reductions in the projected rate of spending in Medicare.[295]

## VIII. The Access Problems Resulting from the ACA's Expanded Medicaid

I now want to turn to the access problems that resulted from the ACA's expansion of Medicaid.

In 2012, in the Supreme Court decision NFIB v. Sebelius,[296] states were allowed to opt in to expanded Medicaid without facing a penalty to pre-existing Medicaid funding.[297] Under the ACA, states really did not have a choice about expansion, and the ACA was structured to make non-expansion politically painful and economically undoable as a practical matter.[298] Non-expanding states faced the loss of all pre-existing federal Medicaid funding.[299]

In NFIB, the Supreme Court held the Medicaid expansion component of the ACA unconstitutional.[300] The states have to be able to opt in

291. *See CHIP Managed Care*, MEDICAID.GOV, https://www.medicaid.gov/chip/chip-managed-care/index.html (last visited Jan. 30, 2022); *Reform through Medicaid Managed Care*, *supra* note 7, at 123.
292. *Reform through Medicaid Managed Care*, *supra* note 7, at 169–74.
293. *Reform through Medicaid Managed Care*, *supra* note 7, at 173, 173 nn.191–92.
294. *Id.* at 136.
295. *See supra* text accompanying note 133.
296. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 575 (2012).
297. *Id.* at 580, 588.
298. *See Coercion Principle, supra* note 265, at 69–70; James F. Blumstein, NFIB v. Sebelius *and Enforceable Limits on Federal Leveraging: The Contract Paradigm, The Clear Notice Rule, and The Coercion Principle*, 6 J. HEALTH & LIFE SCI. L. 123, 133–43 (Feb. 2013) [hereinafter *NFIB v. Sebelius*]; *Sebelius*, 567 U.S. at 579–80.
299. *Sebelius*, 567 U.S. at 582.
300. *Id.* at 588, 687.

or not without putting at risk pre-existing Medicaid.[301] And for such a major and unforeseeable change to Medicaid, states must be provided with notice when they sign up for the program, not after the fact when they have become locked in to the program.[302] States must be able to choose, in a realistic manner, whether or not to expand Medicaid coverage under the ACA, without facing the loss of pre-existing Medicaid funding.[303]

As of September 2021, twelve states have opted not to expand Medicaid.[304] As a result of this opt-in process, which stems from the NFIB decision, persons with incomes between 100% and 400% of poverty qualify for subsidy on the ACA-based exchanges that were set in place by the ACA.[305] But some persons with incomes below 100% of poverty do not qualify for ACA subsidies on the exchanges and some persons with incomes below 100% of poverty are not eligible for traditional Medicaid under their non-expanded state Medicaid programs.[306] As a result, there are uncovered persons who have too little income to qualify for the ACA subsidies on the exchanges and too much income

301. *Id.* at 584–86; *see Coercion Principle, supra* note 265, at 98–99.

302. *Sebelius*, 567 U.S. at 584–86; Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17, 24 (1981); *Coercion Principle, supra* note 265, at 94–99; Brief of James F. Blumstein, NFIB v. Sebelius, *supra* note 220, at 20 (noting that, under *Pennhurst*, "the very 'legitimacy' of federal spending-power programs turns on states' authority to decide whether to participate or not.").

303. *Sebelius*, 567 U.S. at 585.

304. As of January 2022, Wyoming, Texas, South Dakota, Wisconsin, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Kansas and Florida have chosen not to expand Medicaid. For updated tracking of state decisions to expand, *see Status of State Action on the Medicaid Expansion Decisions Interactive Map*, KAISER FAM. FOUND. (Jan. 18, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

305. The COVID pandemic relief legislation—the American Rescue Plan—temporarily allows individuals above 400% of the federal poverty level to qualify for subsidies after they pay up to 8.5 percent of their income on premiums in 2021 and 2022. But it but did not provide relief to those with incomes below 100% of poverty who did not qualify for Medicaid in non-expanding states. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021); Jason Levitus & Daniel Meuse, *The American Rescue Plan's Premium Tax Credit Expansion - State Policy Considerations*, BROOKINGS INST. (Apr. 19, 2021), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/04/19/what-does-the-american-rescue-plans-premium-tax-credit-expansion-and-the-uncertainty-around-it-mean-for-state-health-policy/.

306. *See* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

to qualify for Medicaid in some states, including Tennessee, that have not expanded Medicaid under the ACA. This is a "coverage gap."[307]

Some of the non-expanding states are quite large in population, such as Texas and Florida, so the coverage gap affects a substantial population, leaving many people uncovered.[308] Non-expanding states have been unwilling to take on the financial obligations and programmatic constraints of Medicaid; as a result, non-expanding states do not benefit from funding under the ACA, resulting in considerable vulnerable populations without medical insurance coverage and no support from federal funding, which is available only for states that expand Medicaid.[309]

The terms of Medicaid expansion under the ACA are very attractive.[310] There is a 90% federal match for newly eligible persons.[311] That high level of match was designed to lure states into the program,[312] and thirty-eight of the fifty states have been enticed into the program.[313] They have voluntarily done this, but twelve have not, including some large ones like Texas and Florida.[314]

The non-expanding states have been concerned about the uncertainty associated with their expansion; do they retain flexibility to curtail Medicaid expansion once they opt it?[315] That is, what happens once

307. *See id.*
308. *See id.*
309. *See id.*
310. *See id.*; Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 584, 587 (2012).
311. *See id.*
312. The American Rescue Plan includes provisions to encourage the remaining states to expand. In addition to getting a 90 percent federal match for newly eligible individuals, beginning in fiscal year 2022, states would get an additional 5 percent on top of their Medicaid expenditures for two years if they expand pursuant to the ACA. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4, § 3105 (2021); Leighton Ku & Erin Brantley, *The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan*, COMMONWEALTH FUND (May 20, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp.
313. Ku & Brantley, *supra* note 312; *see Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Jan. 18, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
314. *See Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Jan. 18, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/; Garfield et al., *supra* note 306.
315. *See* Brian Blase et al., *Why states should not expand Medicaid*, GALEN INST. (Oct. 6, 2020), https://thefga.org/wp-content/uploads/2020/10/Reasons-Not-to-Expand-Medicaid.pdf; Sara Rosenbaum, *Why Medicaid Expansion States Are Unlikely to Eliminate Coverage if Congress Enacts a New Pathway for Residents in Coverage Gap*, COMMONWEALTH FUND (July 20, 2021), https://www.commonwealthfund.org/blog/

they opt in? Would Medicaid guidelines constrain states from withdrawing from only a portion of Medicaid once a state has agreed to participate by opting in to the new expansion available under the ACA (an expansion that seemed mandatory before the decision in NFIB allowed states not to expand without jeopardizing pre-existing Medicaid funding)?[316] And as I have been told by legislators in Tennessee and others, 10% of a big number is still a big number.[317] I like to explain to students that I could get a 90% discount on the Hope Diamond, but could still not afford to buy it; my wife should not hold her breath until she would receive the Hope Diamond, even if I were offered it at a 90% discount. Again, 10% of a big number is still a big number.

## IX. Tennessee's Medicaid Waiver Proposals—Old and New

I want to conclude with a brief discussion of Tennessee's new proposed Medicaid waiver, which was approved in modified form in January 2021, but, in response to litigation, is on hold with new comments having been invited.[318]

The original waiver in 1994[319] provided for mandatory managed care for Tennessee Medicaid enrollees.[320] The goal was to incur savings

2021/why-medicaid-expansion-states-are-unlikely-eliminate-coverage-if-congress-enacts-new# (explaining that states that *have* opted for expansion are unlikely to roll it back including because the federal process to eliminate Medicaid eligibility is lengthy and onerous); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 581 (2012).

316. *See Sebelius*, 567 U.S. at 581 (stating "the financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head.") (noting the Medicaid statute requires that states comply with all federal requirements of the program or they risk losing all Medicaid funding); 42 U.S.C. § 1396c (West) (Since the NFIB decision, states technically can eliminate Medicaid expansion once they have chosen to opt-in, but policy analysts argue that this is unlikely.). *See* Rosenbaum, *supra* note 315.

317. *See* Rosenbaum, *supra* note 315; Blase et al., *supra* note 315.

318. *See* Approval Letter, *supra* note 2; TennCare Complaint, *supra* note 3; *Tennessee Medicaid Waiver Approval Lawsuit Put on Pause, Plaintiffs Agree Following New Approval Process*, *supra* note 5; *1115 TennCare III - Approval STCs*, *supra* note 5 (showing that on January 8, 2021, the Centers for Medicare and Medicaid Services ("CMS") approved Tennessee's application to amend the TennCare program under Section 1115 of the Social Security Act. The National Health Law Program, the Tennessee Justice Center ("TJC"), and King & Spalding LLP filed the suit on behalf of thirteen Tennessee Medicaid beneficiaries to challenge the Administration's approval. After CMS opened a new 30-day federal public comment period on special terms and conditions in the waiver (from August 10 through September 9), the U.S. District Court for the District of Columbia ordered the case to be held in abeyance).

319. *Reform through Medicaid Managed Care*, *supra* note 7, at 129.

320. *Id.* at 123, 171–72.

by moving from an unmanaged care situation to managed care.[321] The idea was to take 20–25% of costs out of the system once Tennessee moved to managed care; but once the state transformed Medicaid to mandatory managed care, the rate of expenditure increase went up pretty much the way it did before.[322] The adoption and implementation of managed care drives costs out of the system and lowers the baseline rate of spending; but the level of increases then starts back up at about the same rate.[323] It took about five years or so for Tennessee to transform to a managed care system.[324] For over twenty years, states have been allowed to adopt mandatory managed care for their Medicaid programs without the need for a waiver, so that strategy is now universally available.[325]

In Tennessee, cost consciousness through mandatory managed care was viewed as an access opportunity and was supported by patient advocates on that basis.[326] Cost savings were recycled into the

321. *Id.* at 130, 169.

322. According to one report, after implementation of TennCare, state Medicaid spending growth dropped from 17.4 percent a year to about 10.8 percent a year. *See* Christopher J. Conover & Hester H. Davies, *The Role of TennCare in Health Policy for Low-Income People in Tennessee*, URBAN INST. 16 (2000), https://www.urban.org/sites/default/files/publication/62071/309341-The-Role-of-TennCare-in-Health-Policy-for-Low-Income-People-in-Tennessee.PDF (explaining that "[b]etween 1988 and 1993, Tennessee's Medicaid expenditures (excluding DSH payments) grew 17.4 percent annually, whereas between 1994 (the start of TennCare) and 1996—in spite of the large expansion of coverage under TennCare—the state's Medicaid growth had dropped to 10.8 percent per year."). However, beginning in 2000, TennCare expenditures began to grow at about 12 percent a year, and in 2005, TennCare spent more than its approved budget, prompting the state to tighten eligibility to slow enrollment. *See TennCare Annual Report 2005-2005,* BUREAU OF TENNCARE at 11–15 (2006), https://www.tn.gov/content/dam/tn/tenncare/documents/annual05.pdf (reporting that from fiscal year (FY) 2000 through FY2005, TennCare expenditures had a "compound annual growth rate of 12.1 percent" largely due to unanticipated high medical and pharmacy utilization rates).

323. *See generally* David Cutler & Louise Sheiner, *Managed Care and the Growth of Medical Expenditures,* NAT'L BUREAU OF ECON. RSCH., (NBER Working Paper Series, Cambridge, Mass.) (Aug. 1997) 2–3, https://www.nber.org/system/files/working_papers/w6140/w6140.pdf (finding that growth in medical spending grows slower in states with higher enrollment in managed care plans).

324. *See* Cyril F. Chang & Stephanie C. Steinberg, *TennCare Timeline: Major Events and Milestones from 1992 to 2016*, METHODIST LE BONHEUR CTR. FOR HEALTHCARE ECON. (Sept. 2016), https://www.memphis.edu/mlche/pdfs/tenncare/tenncare_bulleted_timeline.pdf.

325. *Reform through Medicaid Managed Care*, *supra* note 7, at 173, 173 nn.191–93; *see* Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. H, § 4701(a), tit. XIX, § 1932(a)(1)(A)(i), 111 Stat. 251, 489 (1997) (codified as amended at 42 U.S.C. § 1396u-2 (1998)); *Reform through Medicaid Managed Care*, *supra* note 7, at 173, 173 nn.191–93.

326. *Reform through Medicaid Managed Care*, *supra* note 7, at 200–02.

health care arena and used to expand access to care for persons not covered by the state's Medicaid program.[327] As previously discussed, that approach was later replicated in the ACA, where nearly 50% of the expanded access is funded by reduced rates of increase in Medicare expenditures.[328]

So what was the political "deal" underlying the original waiver in Tennessee?[329] All the cost savings, all 100% of the cost savings from Medicaid managed care, went into expanding coverage for the uninsured.[330] That "deal" secured the support for the original TennCare waiver by Medicaid patient advocates who endorsed TennCare.[331] Cost savings were accepted as part of the expansion and were understood to be part of funding expanded access beyond the scope of then-eligible Medicaid beneficiaries.[332]

The original waiver was modified by the Bredesen administration.[333] Among other provisions, the state adopted a new standard of medical necessity that includes cost considerations.[334] There was also a necessary, but nevertheless painful reduction in the coverage of non-Medicaid eligible beneficiaries, a non-preferred option driven by unsuccessful hard-ball tactics of patient advocates who managed to close off other available options.[335]

This background is important to understand subsequent developments in Tennessee; the past experience in cutting off non-Medicaid beneficiaries who had been added with the onset of the original TennCare waiver left Tennessee legislators unwilling to face another cut-off, or, fiscally, an uncertain future if reductions in coverage from ACA expansion were disallowed.[336] Tennessee is a non-expanding state with a significant coverage gap.[337] The legislature did not agree to

327. *Id.* at 201.
328. *See supra* note 133 and accompanying text.
329. *See Reform through Medicaid Managed Care*, *supra* note 7, at 200–02.
330. *Id.* at 264.
331. *Id.* at 200–02.
332. *Id.*
333. *See* Chang & Steinberg, *supra* note 324.
334. For a discussion of the new medical necessity standard, *see supra* Section VI. C.
335. *See* Chang & Steinberg, *supra* note 324, at 16.
336. *See generally* Draft, Amendment 42, TennCare II Demonstration, TENN. DIV. OF TENNCARE at 2–3 (Sept. 2020) [hereinafter Draft Amendment], available at https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42.pdf (draft proposal explaining the need for a block grant style program to manage growing costs within TennCare).
337. *Id.* at 264.

accept Medicaid expansion.[338] Basically, the legislature was worried about getting locked into participation in expanded Medicaid not knowing what they were buying into and getting no satisfactory assurances that they would be able to change their mind and opt out of expanded Medicaid if they thought it became too expensive.[339] As a result, some people in Tennessee, as in other non-expanding states, had too much income to qualify for Medicaid and too little income to qualify for the subsidies on the ACA-based exchanges—the "coverage gap."[340]

Tennessee has managed its Medicaid costs based upon its waivers and based upon its medical necessity standard; but under the Medicaid matching formula, the state has not received matching funds because it is spending less in terms of program growth than it could.[341] If a state spends less, it does not qualify for matching funds on that that amount of unspent money.[342] The state is leaving money on the table.[343] Without expanding Medicaid, and facing the programmatic constraints of Medicaid, a state cannot obtain funds from the ACA pool of money available to states that expand Medicaid.[344] The result is that federally-supported inroads into the coverage gap are unavailable to a non-expanding state.[345]

As an alternative, Tennessee sought a new waiver to allow it to benefit from these forgone ACA Medicaid-expansion funds.[346] Tennessee proposed a block grant.[347] The strategy was for the state to take on financial risk but to share in the cost savings with the federal government.[348] Tennessee was advocating a 50/50 split, and some of the shared savings would be used by the state to increase health insurance

338. *Id.*
339. *Id.*
340. *Id.*
341. *Id.*
342. *Id.*
343. *Id.*
344. *Id.*
345. *Id.*
346. Draft Amendment, *supra* note 336; Approval Letter, *supra* note 2 (approved waiver amendment enclosed); *Tennessee Medicaid Block Grant Waiver Amendment Approved by Federal Government*, TENN. DIV. OF TENNCARE (Jan. 08, 2021), https://www.tn.gov/tenncare/news/2021/1/8/tennessee-medicaid-block-grant-waiver-amendment-approved-by-federal-government.html.
347. *Tennessee Medicaid Block Grant Waiver Amendment Approved by Federal Government*, TENN. DIV. OF TENNCARE (Jan. 08, 2021), https://www.tn.gov/tenncare/news/2021/1/8/tennessee-medicaid-block-grant-waiver-amendment-approved-by-federal-government.html.
348. Draft Amendment, *supra* note 336, at 10.

coverage for those in the coverage gap.[349] But unlike in the original waiver, the state declined to commit to use 100% of shared savings for expanded health insurance coverage.[350] It wanted to retain flexibility to use some of the shared savings for other spending priorities.[351] That was a change from the political "deal" that allowed the initial waiver to secure support from patient advocates, and patient advocates have vigorously opposed the most recent waiver proposal—the block grant.[352]

The block grant proposal was submitted to the Trump administration in November 2019, and it was approved in modified form fourteen months later in January 2021.[353]

What is the approved waiver?[354] Instead of approving the proposed block grant, the federal government approved what it calls an "aggregate cap financing approach."[355] That limits federal matching beyond an aggregate, specified spending cap.[356] Under Medicaid, there is an open-ended federal spending obligation to match qualifying state Medicaid expenditures.[357] There is no cap; federal matching funding is open-ended and driven by qualifying state Medicaid expenditures.[358] Under the "aggregate cap financing approach," there is a cap based on recent state costs and enrollment for the covered populations.[359] The

349. *Id.*
350. *Id.* at 22.
351. *Id.* at 10, 12–16.
352. The Tennessee Justice Center, an advocacy organization for low-income families, opposed the waiver, claiming the block grant mechanism would reduce benefits for vulnerable individuals, and—with the National Health Law Program – filed suit against the federal government for approving the proposal. *See* Press Release, Tenn. Just. Ctr., Medicaid Restructure Threatens Care for Low-Income Tennesseans (Apr. 22, 2021), available at https://www.tnjustice.org/press-release-complaint-filed-to-stop-harmful-medicaid-block-grant/ [hereinafter Press Release]; *see also* Hannah Katch, *Providers, Patients, Advocates Oppose Tennessee's Medicaid Block Grant*, CTR. BUDGET & POL'Y PRIORITIES (Jan. 15, 2020), https://www.cbpp.org/blog/providers-patients-advocates-oppose-tennessees-medicaid-block-grant (describing opposition from national advocacy groups).
353. Approval Letter, *supra* note 2 (including approved waiver amendment enclosed).
354. *Id.* at 1.
355. *See* Approval Letter, *supra* note 2; Press Release, Ctrs. Medicare & Medicaid Servs., CMS Approves Innovative Tennessee Aggregate Cap Demonstration to Prioritize Accountability for Value and Outcomes (Jan. 08, 2021), https://www.cms.gov/newsroom/press-releases/cms-approves-innovative-tennessee-aggregate-cap-demonstration-prioritize-accountability-value-and.
356. *See* Approval Letter, *supra* note 2, at 4 (describing financing structure and budget neutrality structure imposed by the aggregate cap).
357. *Id.*
358. *Id.*
359. *Id.*

cap allows for adjustments for cost and population, but importantly, the state is at risk financially if expenditures exceed the aggregate cap.[360]

The state legislature accepted the federal concept and gave its approval to the revised waiver.[361] It was willing to take this financial risk, allowing for shared benefits from the revised waiver.[362] The legislature was not willing to take the risk of opting into Medicaid.[363] Under the revised waiver, the state gets the benefit of management flexibility and administration.[364] It also gets flexibility in administering pharmaceutical benefits; for example, the state can use a closed drug formulary, excluding new drugs from the formulary so long as at least one drug per therapeutic class is available.[365] If the state saves money from projections through prudent management, Tennessee shares in the savings in the range of 45–55% of savings accruing to the state.[366] Importantly, the shared savings are available to expand coverage.[367] This was an attempt at a partial restoration of the original TennCare political deal, wherein 100% of the savings from managed care went to expanded access.[368]

Where does this place the recent TennCare waiver? It is not characterized as a block grant; it is described as an aggregate cap on spending and financing.[370] This approach is really a borrowing and adoption of the CHIP model, not perfectly, but largely a transplantation of the CHIP model to Medicaid.[371] There is a fixed maximum budget.[372] The state takes on financial risk, the federal government's matching obligation is capped, it shares cost savings with the state.[373] Tennessee takes on some financial risk, but it secures program management flexibility (as under CHIP) and can benefit from its history of prudent

360. *Id.*
361. *See General Assembly Starts 2021 Legislative Session with Passage of Historic Medicaid Block Grant Waiver Amendment to Improve Health Care in Tennessee*, TENN. SENATE REPUBLICAN CAUCUS (Jan. 15, 2021) [hereinafter *Block Grant Waiver Passage*], https://www.tngopsenate.com/?p=3246.
362. *Id.*
363. *Id.*
364. *Id.*
365. Approval Letter, *supra* note 2, at 6.
366. *See* TennCare Complaint, *supra* note 3, at 24.
367. *See* Draft Amendment, *supra* note 336, at 6.
368. *Id*.
370. Approval Letter, *supra* note 2, at 6.
371. *See generally* Oliff & Thiess, *supra* note 283.
372. *Id.*
373. *See* Brief of James F. Blumstein, NFIB v. Sebelius, *supra* note 220, at 150 n.81.

management of program costs.[374] Politically, the original program "deal" is partially reinstated, but patient advocates have not accepted the assurance that access objectives will be paid for to some extent.[375] That other state priorities can stake out claims to some of the shared savings seems to have been a deal breaker from the perspective of patient advocates.[376] Under the original TennCare waiver, 100% of cost savings went to access expansion.[377] The new waiver provides for some spending to reduce the coverage gap, but patient advocates are apparently unwilling to accept less than the original "deal"—100% of program savings being recycled to achieving access-to-care objectives.[378]

Patient advocates have sued to block the new waiver.[379] CMS has agreed to re-open the record for comments,[380] and the case has been paused to allow for new comments.[381] One can only surmise that CMS, under the Biden Administration, is reconsidering the decision to approve the waiver; and if it does, one can anticipate a challenge by the state to any substantial changes in the approved program.[382]

In conclusion, the new TennCare waiver, as approved in January 2021, expressly takes costs into consideration.[383] It recognizes that costs enter into medical decision-making.[384] It recognizes that shared savings can result in improvements to access.[385] It reflects a decision by Tennessee to take some financial risk, but not the risk of expanding Medicaid with the programmatic constraints that stem from Medicaid.[386] It makes use of an alternative model of cooperative federalism reflected in CHIP, adapting it to Medicaid more broadly.[387] It shows that managing program costs can pay dividends in terms of expanding access, as in the

374. *See 2021 Block Grant Waiver Passage*, *supra* note 361.
375. *The Policy Context*, *supra* note 6, at 196.
376. *Id.*
377. *See generally* Approval Letter, *supra* note 2.
378. *See generally id.*; *see also Tennessee's Medicaid Block Grant Waiver*, TENN. JUST. CTR. (last visited Jan. 31, 2022), https://www.tnjustice.org/blockgrant/ (describing opposition to TennCare waiver: "[t]he block grant creates incentives to cut TennCare and use the resulting "savings" for other parts of the state budget.").
379. *See* TennCare Complaint, *supra* note 3.
380. *Id.*
381. *See supra* note 4 and accompanying text.
382. Chiquita Brooks-LaSure et al., *supra* note 150.
383. *See generally* Draft Amendment, *supra* note 336.
384. *Id.*
385. *Id.*
386. *Id.*
387. *Id.*

ACA more generally.[388] And although not measured or perhaps not even measurable, the definition of medical necessity in TennCare plays an important role in the state's managing costs and expanding access to coverage through the new waiver.[389]

We should all stay tuned, as the Biden Administration reviews the situation, and the challenge remains on hold, but potentially to be resurrected if the Biden Administration disappoints the position of the challengers to the approved waiver. And if the Biden Administration disappoints Tennessee, one could also anticipate litigation to challenge any changes to the approved waiver that the state deems unacceptable.

388. *Id.*
389. *Id.*