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THE ROLE OF THE COURTS IN HEALTH CARE RATIONING: THE GERMAN MODEL

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The most important health policy issue facing the United States today is, in the end, how do we provide universal access to health care for all Americans? This discussion commonly focuses on how we go about extending health insurance coverage to the forty million Americans who currently lack it.[1] This is an appropriate focus, as a large body of research shows a direct correlation between lack of health insurance and lack of access to health care, and indeed between lack of health insurance and lack of health.[2]

The German social health insurance program has for well over a century provided us with a model of how a nation can achieve universal access to health care. The German social insurance system provides Germans with dignified access to health care as a right.[3] It is administered

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1. In 2000, the number of uninsured persons in America dropped to 38.7 million. This number, however, has almost certainly grown with the recent downturn in the economy. *See Access: Uninsured Ranks Dip to 38.7 Million, Census Bureau Says in Annual Estimates*, HEALTH CARE DAILY, (BNA) (Sept. 28, 2001).

2. *See Institute of Medicine, Care Without Coverage: Too Little, Too Late (2002);* John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061 (2000).

3. The German Constitution, Grundgesetz (GG), itself establishes a bounded right to health insurance. The German Constitution states: "The German Republic is a democratic and a social federal state." GG Art. 20 § 1 . Though the Constitution itself does not further elaborate on what it means for Germany to be a "social state," this concept clearly encompasses a commitment to social justice, social equality, and social protection against the viscissitudes of life. *See* DETLEF MERTEN, VERFASSUNGSRECHTLICHE GRUNDLAGEN, HANDBUCH DES SOCIALVERSICHERUNGSRECHTS, KRANKENVERSICHERUNGS-RECHT, 145, 152-154 (Bertram Schulin 2nd ed., 1994). The German social insurance system is statutorily established by the Sozialgesetzbuch (SGB), or the Social Code.

SGB I section 1 sets out the task of the Code as realizing the Constitutional goal of creating a social state:

through nonprofit institutions without excessive state involvement and provides access to modern health care technology without excessively burdensome rationing at an affordable cost.[4]

It is, however, impossible to provide universal access to health care without having systems to ration the availability of that health care. No country can afford to do everything. We ration care increasingly through managed care.[5] However, doing so results in even those with full health insurance coverage sometimes not getting the care they need. The two managed care patient rights bills currently pending in Congress address the concern of how to control this rationing.[6]

Both the House and the Senate bills are lengthy. Both are nearly identical in all respects except for one; the role of the courts in reviewing managed care rationing decisions.[7] This is the key issue in contention, which is keeping these bills from becoming law.

If we look at health care jurisprudence generally in the United States we can find four primary models as to the role of the courts. First, state courts under traditional state insurance law take an active role in reviewing insurer decisions under contract and tort law. Liberally applying common law doctrines like contra preferentem and honoring the reasonable expectations of the insureds, these courts commonly interpret

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> The rights granted under the Social Code shall serve in the realization of the goals of social justice and social security, including social and educational services. To these end it should also:
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> insure an existence compatible with human dignity,
>
> provide equal opportunity for the free development of personality, particularly for young persons,
>
> protect and promote the family,
>
> make it possible to earn a living through a freely chosen occupation, and
>
> assist the prevention or overcoming of particular burdens of life, including assistance with self-help.

SGB V section 38 also recognizes a legal claim to social insurance. Finally, SGB V specifically establishes the German social health insurance system.

4. *See European Observatory on Health Care Systems, Health Care Systems in Transition,* Germany (2000), [hereinafter Observatory], *at* http:// www.euro.who.int/eprise/main/who/progs/obs/hits/toppage (describing the system).

5. *See* Pegram v. Herdrich, 530 U.S. 211, 220-221 (2000).

6. Bipartisan Patient Protection Act of 2001, S. 1052, H.R. 2563, 107th Cong. (2001).

7. *See* S.R. 1052 §§ 302, 303; H.R. 2563 §§ 402 – 404.

insurance contracts against the insurer, thus broadening coverage.[8] Bad faith breach of contract cases, in fact, can result in substantial recoveries for the insured well beyond policy limits.[9]

The second model is that of the federal courts in Employee Retirement Income Security Act (ERISA) cases, and in particular cases from the mid-1980s until the late 1990s. Under broad interpretations of ERISA's preemption provisions, these courts have refused to apply in insurance coverage disputes state contract and tort law, with the expansive rights these bodies of law afforded beneficiaries.[10] Rather, proceeding under Section 502 of ERISA, the federal courts treated insurer decisions very deferentially, essentially proceeding as though they were reviewing the decisions of administrative agencies rather than applying contract law.[11] Under ERISA, insurers have been almost literally been able to get away with murder.

The role of the courts in the Medicare and Medicaid programs present other models. Courts reviewing Medicare decisions have been almost as deferential as ERISA courts.[12] The Supreme Court in Medicare cases has rigidly enforced exhaustion requirements, deflecting most disputes from the courts back to the agency.[13] When Medicare disputes finally reach the federal courts, moreover, the courts have behaved reticently, deferring to agency interpretations of statutes under a broad reading of the *Chevron* doctrine and to agency interpretation of regulations under the *Thomas Jefferson University* case.[14] Recently, Courts have taken a more active role in the Medicaid program.[15] However, the 1997 Balanced Budget Act

8. *See* BARRY R. FURROW ET AL. HEALTH LAW HORNBOOK § 9 - 2 (2d. ed. 2000); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1648-49 (1992).

9. Furrow et al., *supra* note 9, § 9 - 3.

10. *See*, e.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Corcoran v. United HealthCare, Inc. 965 F.2d 1321 (5th Cir. 1992).

11. *See* Furrow et al., *supra* note 9, § 8-6.

12. *See* Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 45-65 (1999).

13. *Id.* at 46-49. The most recent of its exhaustion cases is Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000).

14. *See* Thomas Jefferson Univ. v. Shalala, 512 U.S. 504 (1994); Jost, *supra* note 13, at 49-55.

15. See Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INT'L & COMP. L. REV. 639, 696-702 (1998).

limited the role of the courts[16] and recent decisions have threatened to remove, from the federal courts, the power to play any role in the Medicaid program.[17] In any event, the indigence of Medicaid recipients impedes accessibility to the courts.

Finally, the Senate's patient bill of rights creates yet another role for the courts; reviewing rationing decisions of private managed care organizations applying a liability model rather than an administrative review or contract model. Under this bill, courts could hold health plans liable in tort, both for negligent claims adjudication decisions and negligent medical decisions.[18]

By contrast, the German social courts are fully integrated into the social insurance system. They operate as an external appeals board; reviewing the decisions of the administrative organs of the social insurance system. There are sixty-nine local social courts, located throughout Germany.[19] Social court decisions are reviewed by appellate courts at the Land level, and ultimately by the federal social court in Kassel.[20] The federal social court has final jurisdiction to decide social law issues, subject to review by the German Constitutional Court of Constitutional Issues.

A social court is comprised of a panel of three judges, one professional judge and two lay judges who represent the interests of the classes of litigants who appear before the court.[21] At Land and Bundessozialgericht (BSG) levels, the panels consist of five judges, three of whom are professional and two lay.[22] This lay representation in the courts reflects the corporatist nature of the German social insurance system.[23] In a dispute between an insured and an insurance fund, for example, judges may represent insureds, employers, or insurance companies.[24] Insureds and

16. It did so by repealing the Boren Amendment, which had provided a basis for much Medicaid hospital and nursing home rate litigation in the 1970s, 1980s, and 1990s. *See* Furrow et al., *supra* note 9, § 12 – 9.

17. *See* Westside Mothers v. Haveman, 113 F. Supp. 2d 549 (E.D. Mich. 2001), rev'd 289 F.3d 812 (6th Cir. 2002).

18. Bipartisan Patient Protection Act of 2001, S.R. 1052, H.R. 2563, 107th Cong. § 302(a), (d) (2001).

19. *See* Das Bundessozialgericht, *at* http://www.bundessozialgericht.de/funktionbsg.htm.

20. *Id.*

21. *Id.*

22. *Id.*

23. *See* Observatory, *supra* note 5, at 25-27.

24. *See* § 12 SGG.

health care providers have access to the courts without cost,[25] and can represent themselves if they choose not to hire a lawyer, except in the BSG.[26] They can also choose to be represented by advocates from unions or other advocacy groups,[27] hence, proceedings are informal by American standards.

It is my impression, having attended social court hearings at all levels and having read many of the federal court's decisions, that judges have a balanced and sensitive approach to the parties and interests that appear before them. They have traditionally been very protective, for example, of doctors engaged in utilization review disputes with insurers.[28] Though they have become increasingly deferential to insurers in coverage disputes, they have traditionally been protective of insureds when nontraditional therapies sought seemed to offer some promise in desperate situations.[29] They have been particularly open to the constitutional claims of providers and insureds in health care disputes.[30] They present an explicitly administrative, rather than a contract or tort, approach to review of insurer decisions. In addition, they offer an independent forum for review, and a more extensive review than has often been available in American courts reviewing ERISA cases or public benefit program decisions.

If we are going to achieve universal access to health care, or even maintain the level of access we currently have, we need to find responsible approaches to rationing health care. Rationing decisions cannot, however, be left to the unreviewable discretion of payers. There must be some recourse when wrong and harmful decisions are made. We seem to be turning to a liability model of review, in part because alternative models have failed us. A liability model, however, is problematic if it ends up imposing excessive costs on our health insurance system, thereby depriving even more Americans of health insurance.[31] We should instead look elsewhere for better models. The German social courts present us with a plausible alternative.

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25. § 183 SGG.

26. Das Bundessozialgericht, *supra* note 20.

27. *Id.*

28. *See* Jost, *supra* note 16, at 669-677.

29. *Id.* at 663-669.

30. *Id.* at 667.

31. *See generally* U.S. GAO, *Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals is Uncertain* (GAO/HEHS-98-203R, 1998).