A Comparison of American and German Cost Containment in Health Care: Tort Liability of U.S. Managed Care Organizations vs. German Health Care Reform Legislation

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I. DIFFERING PHILOSOPHICAL APPROACHES TO ACCESS AND DISTRIBUTION OF HEALTH CARE IN THE UNITED STATES AND GERMANY

United States: Individualism. Individualism and the protection of individual rights have historically been the foundation of the American legal system. Individual rights confer self-respect, dignity, autonomy and protection from undue government interference.[1] Individuals are free to choose, to be left alone and to improve their lot on their own. Life, liberty and property are constitutionally protected values and the foundations of justice. The markets for goods and services, including health care, function according to economic efficiency. The state should play only a minimal role since intervention limits individual liberty and undermines justice.

Everyone is free to privately purchase medical coverage according to means, and health care is left to the market.[2] Because free market principles oppose the principle of need,[3] there is no entitlement to health care provided by the state and funded by the

1. T.L. BEAUCHAMP & J.F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 77 (1997).
2. The application of the principle of economic efficiency to health care led to the development of managed care organizations.
3. *See* BEAUCHAMP & CHILDRESS, *supra* note 1, at 330.

public through the redistribution of income. At its extreme, individualism considers taxation a "coercive and unjust expropriation of fairly acquired individual wealth," and government action is only justified "if it protects the rights or entitlements of citizens to liberty and private property."[4] Enforced rights to social benefits violate individual autonomy, and the needy receive health care based on charity and voluntary beneficence.

But rising expenditures have made health care a scarce resource requiring some rationing decisions, and its provision as charity to the poor has become an unworkable concept. The growing number of uninsured, the increasing inequalities of access to health care, the absence of true health insurance portability and the many exclusionary clauses of health insurance contracts based on actuarial considerations have made the health care crisis a national issue.

Considerations of distributive justice and fairness have become elements of the public debate. Public policy is already based on different principles of distributive justice.[5] Everyone is equally entitled to education, while unemployment benefits, welfare and some health care (through Medicaid) are provided according to material need. A national consensus appears to be developing that rejects many aspects of traditional individualism and advocates a system of universal access and coverage with an entitlement to affordable and adequate medical care for everyone;[6] however, a comprehensive proposal for health care reform has not been put forward.

Germany: Communitarianism. Communitarians define individuals through their social roles. Societal values are derived from community traditions, and cooperation and consensus are essential elements for the creation of a society dedicated to the general welfare. Society is responsible for the individual but the individual also has responsibilities towards society. Normative decisionmaking gives priority to community values and practices and aims to correct socially disruptive outcomes.[7] Society does well only if the individual does well.

Community-derived standards determine what is due to individuals. Principles of justice are considered to be pluralistic, depending on each community's conception of the good.[8] Emanuel proposed a vision of medical ethics shaped by public laws and values,

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4. *Id.* at 337 (quoting R. NOZICK, ANARCHY, STATE AND UTOPIA (1974)).
5. *Id.* at 327.
6. *Id.* at 350.
7. *Id.* at 81 (quoting A. MACINTYRE, AFTER VIRTUE (1984)).
8. *Id.* at 338 (quoting A. MACINTYRE, WHOSE JUSTICE? WHICH RATIONALITY? (1988)).

derived from shared political convictions and conceptions of justice.[9] This approach to communitarianism recognizes pluralistic interpretations of a good society and individual rights.

Solidarity, "both a personal virtue of commitment and a principle of social morality,"[10] is considered by some synonymous with justice. The German health care system is based on the principle of solidarity.[11] Each individual's premium is assessed according to income[12] while access and coverage are universal. The Health Care Reform Act of 1988[13] mandates adequate and appropriate medical treatment for everyone in accordance with the standard of care determined by medical science.

Synthesis. Individual rights can conflict with the interests of the community. A rights-based approach should therefore provide a minimum of enforceable rules for the interaction between the individual and the community;[14] otherwise important societal goods such as health care would be neglected.[15] Individual rights must be balanced with the rights and interests of others and of the community.

According to Feinberg, "human beings [are] part of ongoing communities, defined by reciprocal bonds of obligations, common traditions and institutions. [A]utonomous persons are authentic individuals whose self-determination is as complete as is consistent with the requirement that [they be], of course, members of a community."[16] A more accurate picture of liberalism would then be that social roles and goals stem from tradition, and that "beliefs are adjusted and improved over time through free discussion and collective arrangements." Traditions evolve and integrate "new conceptions fostering community values."[17]

Rawls presents an egalitarian theory of justice. He considers justice to be fairness, "understood as norms of cooperation agreed to

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9. *Id*. at 83 (quoting E. EMANUEL, THE ENDS OF HUMAN LIFE: MEDICAL ETHICS IN A LIBERAL POLICY (1991)).

10. *Id*. at 338.

11. For further discussion, see Part II.B.2 *infra*.

12. The premium is calculated based on gross income up to a statutory income ceiling.

13. *Sozialgesetzbuch—Fünftes Buch, SGB V*. BGBl. S. 2477; Bonn, 20. Dezember 1988 (Social Code ch. 5, Federal Register p. 2477). It was preceded by the Insurance Code of 1914 which was amended and adapted to changing conditions many times over the years. *Reichsversicherungsordnung,* January 1, 1914. Literally: Imperial Insurance Code, passed under William II, before the establishment of the Weimar Republic in 1919.

14. *See* BEAUCHAMP & CHILDRESS, *supra* note 1, at 76.

15. *Id.*

16. *Id*. at 84 (quoting J. Feinberg, *Harm to Self*, *in* 3 THE MORAL LIMITS OF THE CRIMINAL LAW (1986)).

17. *Id*.

by free and equal persons who participate in social activities with mutual respect. Justifying a conception of justice is its congruence with our deeper understanding of ourselves and our aspirations, and our realizations that, given our history and the traditions embedded in our public life, it is the most reasonable doctrine for us."[18]

According to Walzer, no single principle of distributive justice governs all social goods and their distribution, but there is a series of distinct "spheres of justice."[19] Notions of justice are developed internally as community standards evolve. Walzer argues that community traditions in the United States already include the commitment to equal access to health care and that medicine is practiced according to the logic that "care should be proportionate to illness and not to wealth."[20] Daniels extends Rawls' theory by adding that a just health care system would be designed to preserve or restore the "fair equality of opportunity" available to individuals since illness, injury and disability are undeserved misfortunes limiting individuals' ability to benefit from the full range of their opportunities.[21]

Each country must develop and preserve a health care system in accordance with societal values. Germans have a century-old tradition of social programs based on solidarity,[22] and any reform proposals seriously undermining this principle would be rejected by the people. For Americans, it may be more acceptable to support a universal health care system justified by the traditional American virtues of charity, compassion and benevolence.[23] (The concept of "entitlements" is frequently rejected because it implies a legally mandated increased share of social resources.[24]) In such a system, the government would coordinate the means to achieve charitable goals.

As Buchanan observed, the "enforced beneficence" requiring everyone to contribute to a public health care system would be supported even by those Americans who do not believe in the provision of health care based on need and entitlement.[25] The redistribution of income would be acceptable to achieve compassion

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18. *Id.* at 339 (quoting J. Rawls, *Kantian Constructivism in Moral Theory*, J. PHIL. 77 (1980)).

19. *Id.* at 338-39 (quoting M. WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY (1983)).

20. *Id.*

21. *Id.* at 340 (quoting N. DANIELS, JUST HEALTH CARE (1985)).

22. For further discussion, see Part II.B.2 *infra*.

23. *See* BEAUCHAMP & CHILDRESS, *supra* note 1, at 349.

24. *Id.* at 354.

25. *Id.* (quoting A. Buchanan, *Health-Care Delivery and Resource Allocation*, *in* MEDICAL ETHICS (R. Veach ed., 1989)).

as a goal of fundamental importance to American society, and the citizens would be able to identify with such a communitarian notion of a "morally worthy" society.[26]

To some, these ethical and philosophical distinctions may seem merely a matter of semantics. But our attitudes are shaped by the historical, philosophical and legal traditions of our nations. Only a reform based on the underlying values of our societies will achieve a broad social consensus. Currently, Americans agree that the health care system dominated by managed care corporations[27] that leaves many with inadequate or no medical care at all creates hardship and injustice. A universal system, guaranteeing access to adequate coverage for all by combining public and private elements and preserving a measure of individual choice and responsibility, may well be supported by a national consensus that compassion and beneficence are required to remedy the inequities of the present free market approach to the provision of health care.

II. THE AMERICAN AND GERMAN HEALTH CARE SYSTEMS

A. United States: The History and Structure of Managed Care Organizations

1. History

For almost one hundred years, the United States had no national health policy.[28] Beginning in 1798, Congress provided funding for public hospitals for merchant seamen and shortly thereafter, for health care programs for the military and veterans wounded in action. In the 1800s, employers began to offer prepaid health services, the earliest forerunners of "managed care"[29] for immigrants to the United States. Federal income tax legislation was enacted in 1914, giving the federal government access to a reliable source of revenue. The National Institute of Health was established in 1932. After World War II,

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26. *Id.* at 354.

27. The most recent mega-merger was announced on December 10, 1998. Aetna, a "hard-driving health insurer known for tight-fisted relationships with doctors" paid $1 billion for Prudential Health Care, effectively leaving the country with three national health insurance carriers only. *Aetna to Buy Prudential's Health Care Business for $1 Billion*, N.Y. TIMES, Dec. 11, 1998, at C1; *Mixed Reviews, With Doctors Giving Thumbs Down*, N.Y. TIMES, Dec. 11, 1998, at C2.

28. This section is based on P.R. Kearny & C.A. Engh, *History of the American Health Care System: Its Cost Control Programs and Incremental Reforms*, 20 ORTHOPEDICS 236 (Mar. 1997).

29. T. Frakes, *Managed Care—Evolution and Distinguishing Features*, 26 GASTROENTEROLOGY CLINICS OF N. AM. 703 (Dec. 1997).

several federal acts were passed appropriating funds to the states for the construction of health care facilities and the establishment of state health planning agencies.[30] The federal government also subsidized medical schools to alleviate the perceived shortage of physicians, and Medicare and Medicaid were established in 1966 and 1967 respectively as the only federal health care programs.

By 1920, there were more than 7,000 public and private hospitals in the country. After the Depression, the American Hospital Association founded the Blue Cross Commission to oversee the newly developed Blue Cross plans, which were regional not-for-profit group hospital insurance programs financed by community-rated premiums. Hospitals signed contracts with these plans and became plan "providers." Utilization review was developed by Blue Cross as a resource management technique.[31] In 1939, the California Medical Association introduced the first Blue Shield plan, an insurance program intended to cover physicians' services for low-income Americans. In the 1980s, Blue Cross and Blue Shield, now operating under managed care principles, merged into more than seventy different regional organizations, overseen by the Blue Cross/Blue Shield Association.

Private companies began to insure health risks after the Depression by offering indemnity plans. Since World War II, health insurance for most Americans has been provided by employers as a fringe benefit,[32] originally a minor one. The first private organizations such as the Kaiser Permanente Health Plan, that combined insurance with the direct provision of health care (not yet called HMOs) through their own hospitals and physicians, developed in the 1940s. These integrated plans were considered to afford a greater degree of cost-effectiveness than the traditional private fee-for-service indemnity plans. In 1973, President Nixon introduced the Health Maintenance Organization Act, providing start-up grants and loans for new HMOs and mandating benefit guidelines.

But health care costs rose steadily from 5.2% of GDP in 1960 to almost 15% today,[33] and many large employers became concerned about the effect on their profits. As a consequence, HMOs became increasingly popular, enrolling an ever larger share of the insured

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30. *See generally* Kearny & Engh, *supra* note 28.

31. *Id.*

32. R.O. Bischof & D.B. Nash, *Managed Care—Past, Present, and Future*, 80 MEDICAL CLINICS OF N. AM. 225 (Mar. 1996).

33. D.M. Fox, *Managed Care: The Third Reorganization of Health Care*, 46 J. AM. GERIATRICS SOC'Y 314 (Mar. 1998).

population.[34] Today, managed care is a gigantic profit-oriented industry which moved to Wall Street as financiers began to recognize the potential for unlimited returns on their investment.[35] With the primary emphasis on "shareholder value" and preserving or raising profit margins, a decreasing percentage of the premium dollar is spent on what is termed the "medical loss component," namely health care coverage—the reason health insurance was invented in the first place. On the average, the CEOs of managed care corporations earn 62% more than those of other, comparable corporations.[36] When completing mergers and mega-mergers, they receive several hundred million dollars in personal compensation.[37]

An unprecedented degree of consolidation among managed care corporations, triggered by the failure of the Clinton health care reform in 1994, has blurred the original distinctions between traditional indemnity insurance, independent prepaid health plans, integrated insurance and delivery systems, and provider organizations.[38] Thus the term "managed care" has become a "wastebasket expression"[39] for large corporate structures with overall responsibility for the health care of the enrolled population.

2. Current Types of Managed Care Organizations

Managed care organizations can be subdivided into several basic configurations according to their contractual arrangements with participating physicians.[40] One managed care corporation may offer several different types of plans to different employers. Common to all of them, however, is patient access to a limited number of plan physicians (now dubbed "providers"), reduced reimbursement for both providers and patients (now called "subscribers" or "participants"), and the selection of participants according to their actuarial risk. This selection process according to risk, or so-called "cherry-picking", favors the healthier segments of the population at

34. For eighty percent of privately insured Americans managed care has become a fact of life. *Medicare H.M.O.s.*, N.Y. TIMES, Nov. 10, 1998.

35. J.B. Richmond & F. Rashi, *The Health Care Mess*, 273 JAMA 69 (Jan. 1995).

36. *Id.*

37. T. Bodenheimer, *The HMO Backlash—Righteous or Reactionary?*, 335 NEW ENG. J. MED. (Nov. 1996). The CEO of U.S. Healthcare reportedly received $967 million in cash and stocks and a corporate jet after the merger of his company with Aetna.

38. L.M. Behnke, *Managed Care Organizations and Products*, 26 GASTROENTEROLOGY CLINICS OF N. AM. 725 (Dec. 1997).

39. *Id.* at 725.

40. Q.D. Sandifer, *Managing Care*, 19 J. PUB. HEALTH MED. 301 (1997); *see also* Behnke, *supra* note 38.

the expense of publicly supported health care institutions and plans believing in an obligation to serve all.[41]

(a) Closed panel type MCOs. Staff model and group model. Both models function in centralized multi-specialty ambulatory care centers housing physicians' offices, laboratories and diagnostic equipment. The staff model employs mostly salaried physicians while the group model is based on a contract between the managed care company and a multi-specialty group practice which pays the physicians' salaries. The MCO has a considerable degree of control over physicians' behavior, and patients have access only to participating providers. Referrals to outside specialists are not permitted and the primary care staff physicians as gatekeepers refer to inside specialists.

(b) Open panel MCOs: Network model, independent practice associations and direct contract model. For the network model, the MCO contracts with several multi-specialty group practices and/or a larger number of independent physicians. Physicians' fees are generally capitated, which is an incentive to limit treatment.[42] All providers continue to practice in their own offices and treat non-MCO patients on a fee-for-service basis as well. Referrals to outside specialists by the treating primary care physician are permitted at a cost and patients have a choice among network providers.

Independent practice associations (IPAs), which are distinct legal entities, contract with MCOs to meet their service requirements. Physicians practice independently of the MCOs in their own offices but payments are capitated. Physicians negotiate collectively with the managed care companies but can also contract directly with them. With the direct contract model, individual physicians have less bargaining power than a group but more freedom to negotiate individual terms.

(c) Specialty health maintenance organizations. These are the so-called "carve-outs" providing services in specialized sectors such as cancer treatment, mental and dental health. Full-service MCOs often contract these services out to separate entities to simplify their own management structures but retain full control over the provision of care by their subcontractors. For employers, the advantage is greater cost-efficiency for potentially high-risk populations.

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41. *See* Richmond & Rashi, *supra* note 35.

42. S.D. Pearson & J.E. Sabin, *Ethical Guidelines for Physician Compensation Based on Capitation*, 339 NEW ENG. J. MED. (Sept. 1998).

(d) Preferred provider organizations. PPOs are separate entities contracting with a considerable number of individual providers, including hospitals that accept reduced-fee schedules in exchange for access to a larger patient base. These organizations in turn contract with employer benefit plans and health insurance carriers whose members can choose among network providers. Out-of-network access is possible but reimbursement is subject to co-payments. This is the second-fastest growing plan option.[43] An Exclusive Provider Organization (EPO) is mainly a PPO without the out-of-network benefits, even though patients have access to specialists without a primary-care gatekeeper.

(e) Point-of-service plans (POS). As a response to consumer dissatisfaction with the limited choices and treatment provided by the above managed care organizations, this model is gaining in importance. With a POS plan, patients may choose out-of-network providers freely who charge on a fee-for-service basis but reimbursement is subject to often considerable deductibles and *co-payments*. This is the most rapidly increasing segment of the health care market.[44]

3. Impact on Providers and Patients

Providers. Clinical decisions, entirely left to the attending physician (or other health and mental health care professionals) in a fee-for-service system, are influenced directly and indirectly by a number of MCO compensation, utilization and "quality assurance" techniques intended to minimize use of resources. Physicians have lost control over medical care quickly—and with surprisingly little resistance.[45] They are replaced by computer operators, often called "case managers," who use MCO information systems based on general data about hypothetical case averages and make treatment decisions for individual patients.

Furthermore, unlike FFS plans, where the actuarial risk is borne by the insurance carrier, all MCOs shift some of that risk to the physicians. Capitation is a prime example — a predetermined amount is paid to individual providers for each patient. Should the patient require care in excess of the prepaid amount, the physician will not be compensated, which is a clear incentive to curtail care. The tension

43. Sandifer, *supra* note 40.
44. *Id.*
45. *See* Richmond & Rashi, *supra* note 35.

between resource allocation and patient care presents an ethical conflict for many physicians.[46]

Patients. Apart from being at the receiving end of MCO cost-containment efforts centered on reducing the utilization of health care resources through denial of care, patients are also subject to strong financial pressures to stay with in-network providers, thus curtailing even further their access to care. Primary care gatekeepers receive incentives for denying referrals to more expensive specialists and are sanctioned if they exceed a preset target.[47] Often, patients see a different physician every time they visit a group practice and thus lose all the benefits of the patient-physician relationship. If precertification for emergency hospitalization is requested, the MCO will channel the patient not to the nearest hospital but to the nearest in-network facility which may be much further away.

Conclusion

Since managed care was developed and promoted exclusively as a model for containing health care costs, has it achieved this purpose? Enrollment in managed care plans rose from 30 million in 1987 to 140 million[48] in 1998. In the early nineties, the growth of national health care expenditures slowed down considerably.[49] Since 1995, premiums have increased at a lower rate than the GDP. But the government already predicts that premiums will rise again, on average 7% to 8% per annum for the next decade.[50]

MCO administration consumes an increasing share of the premium dollar because of the complex in-house management and insurance operations. Hefty investments in corporate information (management and insurance functions), clinical information (case management), and data processing systems are required, further squeezing the funds remaining for actual medical care. Roughly 30% of each premium dollar is spent on administration, marketing and profits.[51] Since every MCO duplicates this elaborate administrative

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46. *See* C.M. Clancy & H. Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA 32 (Jan. 1995).

47. Muller v. Maron, 1995 U.S. Dist. LEXIS 15048, 1995 WL 605483 (E.D. Pa. 1997).

48. *HMO Industry Moves to Allay Patient Worry on Care Quality*, WASH. POST, Dec. 18, 1997, at A2. According to other sources, the number is closer to 70 million.

49. *See* E. Ginzberg, *Managed Care—A Look Back and a Look Ahead*, 336 NEW ENG. J. MED. (Apr. 1997).

50. *Sharp Rise Predicted in Health-Care Spending in Next Decade*, N.Y. TIMES, Sept. 15, 1998, at A21.

51. A.A. Stone, *Psychotherapy and Managed Care: The Iceberg and the Titanic*, HARV. MENTAL HEALTH LETTER (July 1998). The German sickness funds spend 2% to 6% on administration. No marketing expenditures are incurred and premiums, by law, are lowered in case of a surplus.

structure, the aggregate loss to the country from administrative expenditures as percentage of total GDP spent on health care is enormous.

Savings to an MCO can only come from the "medical loss component" of the premium dollar and are achieved through the denial of care. Numerous articles in the press spotlight the often deadly consequences,[52] but they are considered by some as relaying only "anecdotal" evidence[53] of alleged managed care negligence and failure to maintain an appropriate standard of care. These patient "anecdotes," however, are not an isolated phenomenon but betray the consistent efforts of large corporations to maintain their profit margins at the expense of those who are among the most vulnerable members of society—the sick. Numerous lawsuits attest to the horrific consequences for many of those who have no alternative but to surrender their medical care to a managed care corporation.[54]

B. Germany: The History and Structure of the German Statutory Health Care System

1. History

Public health care in Germany has had a long history.[55] In the 12th, 13th and 14th century, hospitals were run by the Christian churches, religious orders and the cities and communities. They cared mostly for the poor. After the Lutheran Reformation, different professional groups such as the miners established their own self-help hospitals. These public and private activities, together with the advances of medical science, led to an increasing role of the state, replacing the attitude that caring for the sick was Christian charity for the poor. In 1794, hospitals were placed under supervision by the Prussian state. Tradesmen's guilds developed for their members "sickness funds,"[56] the earliest type of German health insurance, industrial enterprises established their own health care plans for their workers, and individuals not covered by profession-specific plans became mandatory members of the "local substitute sickness funds"[57]

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52. *Managed Care Comes to Mental Health*, WASH. POST, May 6, 1997, at 12 (Health Section).

53. *Congress Weighs More Regulation on Managed Care as HMO Membership Is Rising*, N.Y. TIMES, Oct. 3, 1997, at A1.

54. For further discussion, see Part III.A.2 *infra*.

55. This section is based on J. ALBER, DAS GESUNDHEITSWESEN DER BUNDESREPUBLIK DEUTSCHLAND [THE HEALTH CARE SYSTEM OF THE FEDERAL REPUBLIC OF GERMANY] (1992).

56. *Krankenkassen.*

57. *Ersatzkassen.*

operated by cities and communities. Sickness fund administration was autonomous.

Physicians originally were a heterogeneous group of practitioners. Beginning in 1725, they were permitted to practice only after passing a state licensing exam. In 1825, detailed examination criteria were enacted for all medical specialties. In 1852, uniform curricula for medical schools were passed and the practice of medicine became a legally recognized profession. On May 31, 1883, the national "Health Insurance Act"[58] was adopted under Chancellor Otto von Bismarck, providing a legal framework for the patchwork of health care traditions. Membership in the six different categories of sickness funds by profession or industry became mandatory for as long as personal income did not exceed a statutory ceiling. Individuals not belonging to any of these professional groups continued to be insured by the local substitute sickness funds. The system was financed through premiums based on the income of individual members who paid two-thirds while their employers contributed the remaining third. On January 1, 1914, the RVO[59] (National Insurance Code) became law, combining all health insurance provisions.

The German national health care traditions were continued with the adoption of the SGB V[60] (Social Code, Chapter Five), the Health Care Reform Act of 1988, also called GRG,[61] on December 12, 1988. The Act codified the first major reform[62] of the national health care system since 1949[63] and replaced the RVO of 1914.[64] On December 21, 1992, it was followed by the second stage of reform, the GSG (Health Care Structure Reform Act).[65] The third stage of health care reform, the NOG I[66] and II[67] (Health Care Code Revision Acts I and

58. Krankenversicherungsgesetz, May 6, 1883.

59. *Reichsversicherungsordnung*, Jan. 1, 1914. Literally: Imperial Insurance Code, passed under William II before the establishment of the Weimar Republic in 1919.

60. *Sozialgesetzbuch—Fünftes Buch, SGB V*. BGBl. S. 2477; Bonn, 20. Dezember 1988 (Social Code, ch. 5, Federal Register p. 2477).

61. *Gesundheitsreformgesetz.*

62. Numerous earlier amendments and cost containment measures were enacted in order to adjust and "fine-tune" the system.

63. With the proclamation of its Constitution, the Federal Republic of Germany was established on May 23, 1949.

64. Some of the RVO provisions were retained by the SGB V, such as maternity benefits.

65. *Gesundheitsstrukturgesetz.* BGBl. S. 2266; Bonn, 21. Dezember 1992 (Health Care Structure Reform Act, Federal Register p. 2266).

66. *1. Neuordnungsgesetz NOG*. BGBl. S. 1518; Bonn, 30. Juni 1997 (Health Care Code Revision Act I, Federal Register p. 1518).

67. *2. Neuordnungsgesetz NOG*. BGBl. S. 1520; Bonn, 30. Juni 1997 (Health Care Code Revision Act II, Federal Register p. 1520).

II) was enacted on July 1, 1997.[68] The fundamental principles and benefits of the German health care system, however, remained unchanged.

2. Basic Principles and Benefits

Basic principles. Solidarity and subsidiarity are the fundamental underlying principles of the statutory German health care system.[69] Solidarity[70] provides for universal access and universal coverage for all Germans. Everyone, regardless of financial means, receives the same benefits.[71] The income-based premiums have an element of redistribution: roughly 50% of members' premiums are spent on their health care, and the rest is redistributed for the care of dependents and the elderly. Subsidiarity,[72] limits state intervention by leaving the health care system administration collectively to the physicians' and sickness funds associations, which are independent legal entities established by public law.

Art. 1 of the SGB V mandates solidarity and individual responsibility:

> The health care system is a community of solidarity and as such preserves or improves the health of its members. Individuals are responsible for their health by practicing a healthy lifestyle and by actively participating in preventive care or in medical treatment. Sickness funds will provide members with the requisite information and benefits.

Art. 3 provides for financing according to the principle of solidarity: "Benefits and other expenditures of the sickness funds are financed by premiums. Both members and employers contribute to the premiums calculated according to the members' income. No premium is assessed for dependents." Art. 4 stipulates subsidiarity: "The sickness funds are independent, self-administered legal entities according to public law. . . . They and their associations will cooperate with each other and with all other bodies of the health care system."

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68. In addition to these three major pieces of legislation, 30 cost control amendments were passed between 1988 and 1997. E. Boxberg, *Mein Recht als Patient* [*My Rights as a Patient*], GESUNDHEITSDIALOGVERLAG GMBH, OBERHACHING (1997).

69. *Gesetzliche Krankenversicherung—GKV.*

70. SGB V, Arts. 1, 3.

71. *Id.* Arts. 2, 11, 12. Private insurance is available in addition to cover some of the exclusions such as single-bed hospital rooms.

72. Subsidiarity as a concept is comparable to the American notion of "federalism." *Id.* Art. 4. Chapters 3-8 provide for the relationship between the sickness funds, all providers and their organizations. The Selbstverwaltungsgesetz (Self-Administration Act) of Feb. 2, 1951, mandates sickness fund autonomy.

Benefits. The German statutory health care system is one of the "most comprehensive health insurance benefits programs in the world."[73] It covers preventive care, family planning, and legal abortions[74]; routine screening examinations[75]; ambulatory, hospital and dental care; physical therapy; psychotherapy (as of January 1, 1999); medication and medical appliances; glasses; fertility treatment; fitness tests and work therapy; home medical care and subsidies for household help while a member is hospitalized;[76] substance abuse and geriatric rehabilitation[77]; home nursing allowances when hospitalization can be avoided[78]; burial allowances;[79] maternity care[80]; maternal benefits[81] ; sick leave benefits[82]; paid parental leave for the care of a sick child.[83] There are no caps on benefits and no life time limits. Art. 11 mandates three particular benefit categories: preventive care (Art. 20-24b), early diagnosis (Art. 25, 26), and treatment of medical conditions (Art. 27-52).

Preventive care and early diagnosis. Sickness funds provide members with regular newsletters informing them of risk factors (such as smoking, poor nutrition) and means of prevention. Preventive care includes individual and group dental preventive procedures and routine screening examinations for cancer, diabetes, cardiac and rhenal conditions, and for childhood developmental disorders. It also includes medical intervention, medication, adjunct procedures, medical equipment, visits to medically supervised sanatoriums for the purpose of preventing adult and childhood illness, and geriatric rehabilitation to eliminate the need for nursing care. Contraception and legal abortions are included under this heading.

Treatment of medical conditions. Art. 27 is one of the key articles of the SGB V and codifies benefits to be provided in the case of illness:

(1) medical treatment and psychotherapy

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73. 1993 German Health Care Reforms [United States General Accounting Office], GAO/HRD-93-103, at 25.

74. SGB V, Art. 24-24b.

75. *Id.* Arts. 25-26.

76. *Id.* Art. 27; *see also* Art. 132.

77. *Id.* Arts. 27, 52.

78. *Id.* Art. 37.

79. *Id.* Arts. 58-59.

80. RVO Art. 196. Some of the provisions of this statute preceding the SGB V were carried over; the reform of 1997 expanded benefits under this article.

81. SGB V, Art. 224.

82. *Id.* Arts. 44-51.

83. *Id.* Art. 45.

(2) dental procedures including major restorative care and prosthetic devices
(3) medication, medical/surgical dressings and supplies; medical equipment, prosthetic devices, glasses, hearing aids
(4) home medical care and household help
(5) hospitalization
(6) medical and adjunct treatment for rehabilitation (including substance abuse), fitness tests and work therapy
(7) psychiatric care and rehabilitation
(8) fertility treatment.

The scope of medical treatment and the applicable standard of care are set out in Art. 28 and Art. 2(1):

> Medical treatment is defined as *all adequate and appropriate procedures performed by a physician as needed for the prevention, early diagnosis and treatment of illness in accordance with the current standard of care.* (emphasis added) Medical treatment includes procedures by providers other than physicians which were ordered by a physician and are performed under her/his responsibility.
>
> The quality and efficacy of the benefits to be provided by the sickness funds must correspond to the *generally recognized medical standard of care and must be in accordance with the progress of medical science.* (emphasis added)

An additional feature of the system consists in the sickness benefits[84] which amount to 80% of the member's gross wages and are payable as of the onset of illness. In most instances, however, collective bargaining agreements apply and employers will cover the remaining 20% for six weeks of continued illness. After that, sickness benefits will be paid for an additional 72 weeks. If the member has not returned to work by then, disability procedures will be initiated.

Longterm Care. Under the SGB V and the preceding health care legislation, long-term medical care and rehabilitative measures for the chronically ill of all age groups have always been covered. For example, family coverage includes children without any age limit whenever they are handicapped physically, mentally or emotionally and thus unable to support themselves.[85] Social-pediatric centers are authorized to provide outpatient treatment for children who, because of the type, severity or duration of their illness cannot be treated by appropriate physicians.[86] The SGB V of 1988 defined "social-pediatric" treatment as medical and non-medical care, especially

84. *Id.* Art.44. *Krankengeld.*
85. *Id.* Art. 10(4).
86. *Id.* Art. 119 (1997).

psychological and rehabilitative, as required to diagnose, prevent or cure an illness or reduce its effect at the earliest possible time.[87] This paragraph was eliminated by the reform of 1997.

As of January 1995, a separate long-term care act[88] introduced additional nursing care benefits so far not provided by the SGB V. This act was mainly designed for better access and coverage for the elderly to either home care or nursing facilities. Eligibility is contingent on differing needs for assistance in daily living activities. Home care can be provided either by family members who are now compensated or by home care enterprises. Eighty percent of all those covered are age 65 and over.[89]

Conclusion

The above summary of benefits indicates that the German health care system is indeed comprehensive. Illness is seen as disruptive of a person's life, and the SGB V aims to alleviate the impact on members as well as their immediate social environment, thus incorporating many items not considered part of health care in the United States. It is particularly noteworthy that the SGB V does not make "benefits" a function of "medical necessity." Together, SGB V, Art. 27 and Art. 28 clearly establish that "adequate and appropriate treatment," or "medical necessity" as defined by the physician, is the benefit. Furthermore, the definition of medical treatment in SGB V, Art. 28, incorporates the current standard of care, subject to scientific medical judgment, Art. 2(1).

Managed care organizations in the United States, however, often use utilization review techniques to claim the absence of "medical necessity" in order to deny "benefits" i.e. treatment,[90] triggering countless malpractice lawsuits against them. To be able to bring any state tort law actions[91] at all against the MCO, plaintiffs have to engage in hairsplitting when differentiating "benefits" from "medical necessity." For successful claims of improper utilization review, medical decisionmaking and benefits must be considered completely separate. "Medical decisionmaking is not part of the 'plan'. It is also

87. *Id.* Art. 119(2) (1988).

88. SGB XI, 1995. *Pflegeversicherung.*

89. U. Schneider, Germany's New Long-Term Care Policy, AM. INST. FOR CONTEMP. GERMAN STUDIES, THE JOHNS HOPKINS UNIVERSITY (1997).

90. For further discussion, see Part III *infra*. Managed care organizations determine standard of care through both corporate clinical guidelines centered around a hypothetical "average" case and utilization management practices, intended to minimize the use of resources. *See also* B.L. Welch, *Don't Be Scapegoated for Managed Care Malpractice*, PSYCHIATRIC TIMES, July 1997.

91. ERISA Sections 502 and 514 often preempt such claims.

not a benefit, a right or entitlement, it is not coverage. Thus, courts should construe making the medical decision . . . as a service to the plan, not part of the plan itself."[92] This casuistry makes any German health care expert's head spin.

3. Structure and Administration

The German statutory health care system can be described as an all-payer,[93] prepaid, not-for-profit system with universal access and coverage. Physicians' compensations consist of a mix of capitation for basic procedures, a nationally negotiated fee schedule based on a relative value scale, fee-for-service charges for specialized procedures, and an indemnity system for some dental procedures. The entire health care system is placed under the authority of the Federal Ministry of Health.

Third-party payers and premiums. Roughly 1100 self-administered sickness funds act as third-party payers. They finance and organize health care for their members within the framework of the SGB V which also regulates the sickness funds' relationships with providers. Sickness fund membership (still largely according to professional group) is mandatory for all Germans up to a certain statutory income ceiling.[94] Premiums are withheld from an individual's paycheck and then paid to the member's sickness fund which also receives the corresponding employer's share. Germans with higher incomes may opt out of the statutory system by purchasing private insurance, but few of them do so because private benefits by law are identical at a minimum to those of the public system. Since most German physicians are licensed to practice within the national health care system, privately insured medical care is provided by the same physician pool. As a consequence, more than 90% of all Germans are covered by the national health care system.

Premiums correspond to a certain percentage[95] (13.5% in 1998) of an individual's gross income up to the statutory ceiling (roughly $42,000 in 1998) and are not based on group membership or actuarial risk. ("Cherry-picking" by sickness funds according to demographics

92. *See* S.C. Pomfret, *Emerging Theories of Liability for Utilization Review under ERISA Health Plans*, 34 TORT AND INS. L.J. 131, 143 (Fall 1998); *see also* Corporate Health Ins. Inc. v. Texas Dep't of Ins., No. H-97-2072, slip op. at 17 (S.D. Tex. Sept. 18, 1998).

93. U. Reinhardt, *West Germany's Health Care and Health Insurance System: Combining Universal Access with Cost Control*. Report prepared for the United States Bipartisan Commission on Comprehensive Health Care, August 30, 1989. Revised June 25, 1990.

94. *Beitragsbemessungsgrenze.*

95. SGB V, Art. 220. Premiums are adjusted up or down annually reflecting the system's deficit or surplus.

and pre-existing illnesses is illegal.[96]) Individuals with higher incomes are not assessed on the amounts exceeding the income ceiling. Employers and employees each pay half of the total premium. Dependents are automatically covered without any additional charge. Since different funds have different actuarial risks, depending on location and member demographics, they are cross-subsidized by other funds for caring for a high proportion of unemployed or retired individuals. Both groups have the same access and coverage as all other members even though their financial contribution to the system is minimal and is reallocated from other entitlement programs (unemployment insurance and social security).

Fund self-administration. A particular feature of the system is the sickness fund self-administration. Historically, these funds developed independently of any government health plan and were self-administered. In 1951, their administrative autonomy was restored by law.[97] Both employers and employees are equally represented on the funds' boards of administration, reflecting their equal financial contribution to the system. In keeping with the principle of subsidiarity, the government refrains from intervention as long as the funds conform to the law and public policy.[98] Some funds such as the substitute funds are managed exclusively by member representatives.

Physicians. Much of the care provided is office-based, including most specialty care. Patients are free to choose their doctors, specialists included. (The health care reform of 1997 does, however, impose limits on "doctor-hopping."[99]) Offices are well-equipped with technology for diagnosis and treatment and often have their own laboratories. For hospitalization, a referral is required. Outpatient surgery is still a rarity, and the recent health care reform acts include incentives to shift surgery from hospitals in order to reduce hospital expenditures, which is the largest percentage cost factor of German health care.

Physicians' compensations are negotiated by region and by specialty between the regional Associations of Public Health Care Physicians[100] run by physicians (once licensed as a national health

96. *Kontrahierungszwang.*

97. *Selbstverwaltungsgesetz* (Self-Administration Act), February 2, 1951.

98. S. Giaimo, *Cost Containment vs. Solidarity in the Welfare State: The Case of German and American Health Care Reform*, AM. INST. FOR CONTEMP. GERMAN STUDIES, JOHNS HOPKINS UNIVERSITY (1998).

99. SGB V, Art.76.

100. *Kassenärztliche Vereinigungen.*

care practitioner, membership is mandatory, unlicensed physicians can join voluntarily) and the Sickness Funds Associations,[101] representing the different categories of sickness funds. Since the adoption of the SGB V of 1988, regional sickness funds associations are free to negotiate a region-specific mix of compensation types with the state physicians' association, such as capitation for basic procedures,[102] a national fee schedule based on a relative value scale,[103] and fee-for-service[104] charges for specialized procedures. (A traditional criticism of these negotiations has been that physicians' associations have wielded too much influence, thus imposing their conditions on the sickness funds and impeding health care cost containment). The premiums collected from employees and employers by the sickness funds are turned over to the regional physicians' associations which process and pay the claims submitted by individual physicians. In this sense, the physicians' associations perform some functions of health insurances and German physicians often harbor for them the antipathy many American physicians feel towards their third-party payers.[105]

The national fee-for-service fee schedule is based on the relative value scale negotiated by a 14-member committee with seven members each representing the National Public Health Care Physicians' Associations[106] and the different National Sickness Funds Associations.[107] The committee is chaired alternately by one physician and one sickness fund representative. The final, and so far hypothetical, arbiter of unresolved conflicts between the two parties is the Federal Ministry of Health which intervenes only if an administrative conflict settlement procedure fails or if it feels that the public welfare is not served by the two parties.

Relative value units (RVU)[108] are assigned to a service or procedure. The actual monetary value of an RVU today "floats" because the RVU conversion factor depends on the amount available under the regional budgets and the total (unpredictable) number of services billed by the physicians. If more physicians bill for more

101. *Spitzenverbände der Krankenkassen.*
102. *Fall-oder Kopfpauschale.*
103. *Einheitlicher Bewertungsmaßstab und Punktwerte.*
104. *Einzelleistungsvergütung.*
105. J.K. Iglehart, *Health Policy Report: Germany's Health Care System, Part II*, 324 NEW ENG. J. MED. 1750 (June 1991).
106. *Kassenärztliche Bundesvereinigungen.*
107. *Spitzenverbände der Krankenkassen.*
108. *Punktwerte.*

services, the monetary value of each RVU drops. As some physicians see it, this amounts to punishment of those who work harder.[109]

Hospitals. Two-thirds of German hospitals are not-for-profit because they are either publicly owned (cities, counties, universities) or run by churches or charitable organizations. Until the recent reform legislation, hospitals were reimbursed on a per diem basis, independent of patient diagnosis and calculated to cover their retrospective operating costs. This has now been replaced by prospective payments and patient management categories. Capital outlays for renovation and new construction are provided by the individual states which also approve hospital budgets.

III. DIFFERENT APPROACHES TO COST CONTAINMENT IN HEALTH CARE

Faced with similar problems—an aging population, increasingly sophisticated and costly medical technology and therapies in both countries, plus high unemployment in Germany—cost containment efforts are under way on both sides of the Atlantic. Today, the United States spends roughly 15% of its GDP on health care, compared to Germany's 8% for national health care plus 2% for private insurance. From 1980 to 1995, overall expenditures in the United States for health care quadrupled, from $250 billion to $1 trillion.[110] German spending increased by a factor of 2.5 from $56 billion in 1980 to $140 in 1996. It was uncontested in both countries that the rate of increase needed to be slowed but, in keeping with the substantially different health care systems, different approaches developed. In the United States, where health care was left to market forces, privately owned managed care corporations with their idiosyncratic cost control techniques centered on the micro-allocation of health care expenditures through the prospective approval or denial of treatment and benefits for individual patients enrolled an increasing share of the workforce. The German response to rising expenditures was the enactment of cost containment legislation focussing on macro-allocation through global and sector-specific budgeting.

109. *Personal communication* with Dr.med. Gisela Groscurth-Galm, Sept. 27, 1998, Bochum, Germany.

110. Ginzberg, *supra* note 49.

A. United States: Managed Care Organizations and Cost Control

1. Cost Control Techniques

Utilization Management. Utilization management, targeted to individual cases and resulting in the micro-allocation of health care, is a major component of all cost containment efforts. It is defined as "a method to increase the cost effectiveness of medical care by optimizing quality and patients' outcomes while reducing the use of resources."[111] As practiced by the managed care industry, it comprises preauthorization of treatment and admission to hospitals, review of treatment plans submitted by providers including medication, concurrent review of treatment and length of hospital stay, and the use of corporate clinical guidelines to determine "medical necessity."

For these purposes, MCOs have created a number of positions such as the "case manager," which are often clerical staff without any medical background. Case managers use computerized corporate clinical guidelines, centered around the statistics and symptoms of an average hypothetical case, enter actual patient data into the system, and then determine the "medical necessity" of individual hospital admissions and the appropriate treatment for a particular patient. Once admission to a hospital has been preauthorized (generally for 23 hours only for an initial evaluation), case managers reauthorize or deny extensions almost on a day-to-day basis. They review treatment concurrently in order to determine the required "level of care" and make phone calls to physicians and nurses to obtain information concerning a patient's diagnosis and course of illness. Case managers' decisions depend entirely on these contacts with providers at the treating facility, remote from the MCO office. Based on this limited access to clinical information and the use of computerized practice standards, corporate in-house staff thus make life or death decisions about treatment and hospitalizations.

Currently, the average length of hospital stay authorized by MCOs is five days for all diagnostic categories. Patients are often discharged from hospitals because a case manager refuses to reauthorize another day or two. "This is the nightmare of utilization review: A stranger in another city, without any clinical experience, calls to tell the treating physician that a patient is to be discharged or that approval for a test deemed necessary is denied."[112]

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111. M.F. Shapiro, *Rethinking Utilization Review*, 333 NEW ENG. J. MED. (1995).

112. K. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J. L. MED. & ETHICS 223, 225 (1995).

Benchmarks are another instrument of company-wide cost control. They are calculated by the MCO based on the utilization information received from individual providers and include length of hospital stay, readmission rates, length of treatment per diagnostic category, number of visits for outpatient treatment, number of appeals of case managers' decisions, and number of treatment denials overturned. Regional and national norms are tabulated and compared with individual providers' monthly, quarterly and annual utilization data. Providers (both hospitals and physicians, or other health care staff such as psychologists) are informed of the benchmarks and made aware when they exceed them.

The annual performance evaluations and remuneration of managerial-level MCO employees depend on their success in maintaining low utilization rates defined by the benchmarks. Regional directors, for example, must ensure that a maximum number of days of hospitalization approved per 1,000 "covered lives" are not exceeded for their region, and their bonuses and raises are contingent on their degree of success.

Quality Assurance. Quality assurance programs are purported to maintain high standards by measuring provider quality of care, outcome, and patient satisfaction. In reality, they are just another means of lowering resource utilization. Only those individuals are selected as potential providers who are willing to deliver care consistent with MCO clinical standards and who agree with the managed care philosophy, or in other words, who are managed-care "friendly." The companies then conclude contracts with their "network providers" stipulating compliance with corporate practices. These include adherence to MCO quality management and utilization review procedures, abiding by corporate clinical standards, willingness to cooperate with MCO case managers, and philosophical agreement with managed care principles. In psychiatry and psychology, for example, the latter means acceptance of a treatment approach "focused on returning the patients to their previous highest level of functioning in the least restricted or intensive environment." This phrase implies restoration to the patient's premorbid condition but translates into a minimum number of outpatient therapy sessions or of days spent at a hospital. As soon as patients hospitalized after a suicide attempt, for example, "contract" not to kill themselves, they are discharged without treatment of their underlying condition. Needless to say, these seriously depressed patients in many instances finally do manage to commit suicide, their depression aggravated by

the traumatic experience of successive revolving-door hospitalizations while undergoing pseudo-therapy.[113]

Many contracts also include "non-disparagement clauses," holding the provider liable for any negative comments made to patients about the MCO, especially when the recommended treatment was denied. "Balance-billing" is often contractually prohibited, preventing providers from billing for any treatment other than what was approved by the MCO. Therefore, there is no incentive to mention other therapy options or additional procedures needed. Both clauses create an ethical dilemma for physicians who would like to prescribe alternative or more expensive treatment. If they appeal the MCO decision, it is entered into their record. If they tell the patient the recommended treatment was denied by the MCO, they violate their contract and make the company "look bad." If they provide the procedures denied by the MCO, they cannot bill for them. If they do nothing, they violate their professional ethics and lower the standard of care.

Contracts between providers and MCOs are renewable regularly through the recredentialing process based on "provider profiling." Utilization data are collected for each provider and include length of treatment per diagnostic category, medical costs, number of appeals of case managers' decisions and number of treatment denials overturned. Providers are also monitored through case and medical records audits and site visits. If the results compare unfavorably with the regional and national norms, providers are "deselected" and the norms keep going down.

Conclusion

Utilization management, "quality assurance" programs and provider profiling are exclusively designed to reduce the use of resources through the micro-allocation of health care for individual patients. Utilization review translates into benefit denial, and "medical necessity has become a convenient euphemism for arbitrary denial of care through clinical sophistry."[114] As one physician observed, "[u]tilization management techniques are marginally effective interventions concerned more with restricting benefits and hassling providers than with developing cost-effective programs." [115]

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113. For further discussion, see Part IV.C.1 *infra*.

114. Welch, *supra* note 90.

115. J.K. Iglehart, *Health Policy Report: The American Health Care System*, 327 NEW ENG. J. MED. 742 (1992) (quoting R.A . Berenson, *A Physician's View of Managed Care*, HEALTH AFFAIRS (MILLWOOD) (1991)).

"Quality assurance" results in incentives or coercion to limit treatment.

Provider profiling is particularly insidious, inducing the treating physician or therapist to silently acquiesce to MCO restrictions while subjecting the unsuspecting patient to the "treatment of choice."[116] The non-disparagement clause and the prohibition of balance-billing are additional means to ensure that patients will never know that treatment decisions are made by the MCO, not the physician or other provider.

2. The Backlash: Malpractice and Agency Lawsuits

(a) ERISA Preemption Analysis: The Impact of Three Recent Supreme Court Cases. The consequence of the above cost containment methods is a generalized tendency to cut corners resulting in a lowered standard of care.[117] Increasingly, patients have been fighting back by suing network providers and managed care organizations not only for denial of benefits but also for malpractice and vicarious and direct tort liability. Many of these cases, however, were either dismissed or limited to benefit recovery because managed care organizations providing health care under employee benefit plans were able to claim that state tort actions against them were preempted by the Employee Income Security Act (ERISA) of 1974.[118]

ERISA was passed to achieve the nationwide uniform regulation of employee benefit and pension plans administered in more than one state. It also extends to plans which provide "medical, surgical, or hospital care or benefits" for plan participants. ERISA thus applies to most managed care organizations in the country. These organizations currently cover over 80% of privately insured Americans.[119] Two ERISA provisions permitted managed care organizations to escape liability: the "general preemption" provision of Section 514(a), preempting any state law which "relates" to an ERISA plan and the "complete preemption" provision of Section 502(a), ERISA's civil enforcement provision, preempting any state law claims for "benefit" recovery.

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116. B.L. Welch, *Managed Care: 'Piano Player' for American Health Care*, PSYCHIATRIC TIMES, June 1998.

117. Christensen, *supra* note 112, at 223-29; J. Fletcher & C. Engelhard, *Ethical Issues in Managed Care*, 122 VA. MED. Q., 162 (1995).

118. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. § 1001 (1994)).

119. *Editorial*, N.Y. TIMES, Oct. 10, 1998, at A26.

Section 514(a). Section 514(a) states that "ERISA shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." Two Supreme Court cases, *Shaw v. Delta Airlines* (1983) and *Pilot Life Ins. Co. v. Dedeaux* (1987), interpreted the intent of Congress to be that the term "to relate" should be read expansively.[120] They defined the term as either "making reference to" or "having a connection with" an ERISA plan. As a consequence, lower courts increasingly found state tort and contract claims against ERISA plans or their administrators preempted as exemplified by the following case.

United Health Care, conducting utilization review under contract with Florence Corcoran's employer-sponsored health plan[121] denied hospitalization during her high-risk pregnancy, contrary to orders by her physician and a second opinion solicited by her employer. Instead, only limited home nursing care was approved. Very near to Mrs. Corcoran's delivery date and while the nurse was not on duty, the fetus went into distress and died. The same physician had hospitalized Mrs. Corcoran during a previous pregnancy, was able to intervene during the 36th week when that fetus went into distress, and saved the baby's life by performing a Cesarean section. The Corcorans characterized their case against United as one of malpractice and specifically alleged wrongful denial by United of the medical care recommended by Mrs. Corcoran's physician, a wrongful decision limiting care to home nursing and a wrongful death action under Article 2315 of the Louisiana Civil Code which grants parents a cause of action for the death of their unborn child. The Court of Appeals, however, upheld the District Court's preemption of the Corcorans' state law claims under Section 514(a) because they "related to" their employer-sponsored health care plan. The Court cited the broad interpretation in *Shaw v. Delta Air Lines* of the term "relate to" as "having a connection with or making reference to" an employee benefit plan and considered *Pilot Life Ins. Co. v. Dedeaux* as a "signal" that the ERISA preemption clause 514(a) was to be construed extremely broadly. "This sweeping preemption of state law is consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans."[122]

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120. Pilot Life Ins. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987); Shaw v. Delta Airlines, 463 U.S. 85, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983).

121. Corcoran v. United Health Care, 965 F.2d 1321, 1992 U.S. App. LEXIS 14621 (5th Cir. 1992).

122. *Pilot Life*, 481 U.S. at 45-46.

The court also rejected the Corcorans' claims for damages for emotional injuries (aggravation of a depressive condition, loss of consortium, loss of the love, affection and society of their unborn child) under Section 502(a), arguing that the statutory term "other appropriate equitable relief" does not provide for recovery under the state trust and contract law principles which, as the Corcorans urged, should guide the court's interpretation of this section. The court concluded:

> The result ERISA compels us to reach means that the Corcorans *have no remedy, state or federal, for what may have been a serious mistake*. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. *With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking.* Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgment) need not be factored into utilization review companies' cost of doing business, *bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs*. ERISA plans, in turn, will have one less incentive to seek out the companies which can deliver both high quality services and reasonable prices.[123]

In spite of these qualms, the court felt that its ruling was "faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcoran's position with a remedy under ERISA."[124] On December 14, 1992, the Supreme Court denied certiorari.

Other courts, further interpreting the terms "having a connection or making reference to" employer-sponsored health care plans reasoned that (a) state tort laws had an economic impact on these plans and were preempted because ERISA was intended to ensure the plans' financial viability, and (b) Congressional intent of ensuring the uniform administration of multi-state plans would be defeated by granting plan participants relief under differing state tort laws. For patients who were negligently treated by plan physicians and hospitals this meant the absence of any tort law recourse for their damages and the dismissal of the case. As a consequence, MCOs, interfering with or mandating treatment decisions, were free to benefit from this regulatory vacuum which created a lawless era and permitted them to escape liability for inadequate standards of care.

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123. Corcoran, *supra* note 121, at 1338 (emphasis added).
124. *Id.*

In 1995, however, the Supreme Court, narrowed the scope of the term "to relate" in a landmark case, *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers*.[125] As Justice Souter put it, "We have to recognize that our prior attempts to construe the phrase 'relate to' does not give us much help."[126] The Supreme Court ruled that New York's inpatient rate-setting system was not preempted by ERISA because it only had an indirect economic impact on ERISA plans and did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself."[127] Justice Souter added that the term "relate to" should be interpreted in a limiting sense because of the justified assumption that Congress did not intend to preempt state laws in fields of traditional areas of state regulation.[128] The Court then stated specifically, "If ERISA were concerned with any state action such as medical care quality standards, we would scarcely see the end of ERISA's preemptive reach, and the words 'relate to' would limit nothing."[129] As a consequence, ERISA preemption should apply only to the types of state law which address the purpose of the federal law: (1) laws which mandate benefit structures or their administration, (2) laws which bind employers to particular choices or preclude uniform administrative structures, and (3) alternative enforcement mechanisms to obtain benefits. Many courts followed the analysis in *Travelers* and held that vicarious liability actions against MCOs for provider negligence are not preempted by Section 514(a) since they neither mandate benefit structures nor preclude uniform plan administration.

In 1997, two additional Supreme Court cases, *California Division of Labor Standards Enforcement v. Dillingham Construction Inc.* and *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, further narrowed the meaning of the term "relate to."[130] The Court ruled in *Dillingham* that the test is whether a particular state law applies equally to ERISA entities and non-ERISA entities, i.e. whether it is a law of general applicability or one affecting ERISA plans only. It concluded that California's Prevailing Wage Statute, a law of general applicability, was not preempted, and thus it was

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125. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Corp., 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995).

126. *Id.* at 655.

127. *Id.* at 659.

128. *Id.* at 654.

129. *Travelers*, 514 U.S. at 645 (slip op., at 14-15).

130. California Div. of Labor Standards Enforcement v. Dillingham Constr. Inc., 519 U.S. 316, 117 S. Ct. 832, 136 L. Ed. 2d 791 (1997); De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997).

allowed to regulate the payments to be made by the ERISA plan to its beneficiaries, effectively limiting the options available to the plan. State malpractice, tort liability, wrongful death, and survival statutes apply independently of any ERISA plan; therefore, actions based on them are not preempted. As Justice Scalia phrased it in his concurring opinion, "Applying the "relate to" provision according to its terms was a project doomed for failure, since, as many a curbstone philosopher has observed, everything is related to everything else." In *De Buono*, the plaintiffs objected to a New York state tax on gross receipts for patient services at diagnostic and treatment centers because the state law "related" to their Fund under Section 514(a) and was therefore preempted as applied to hospitals run by ERISA plans. The Court disagreed and concluded that the applicable state statute:

> . . . clearly operates in a *field that has traditionally been occupied by the States: The regulation of health and safety matters*. . . . It is one of a *myriad of state laws of general applicability* that impose some burdens on the administration of ERISA plans but nevertheless do not relate to them within the statute's meaning.[131]

Section 502(a). The purpose of Section 502(a), ERISA's civil enforcement provision, is to permit civil action by plan participants to recover benefits due, to enforce rights, or to clarify the right to future benefits under their ERISA plan while at the same time limiting the remedies available. Any tort action in connection with benefit denial is preempted as an alternative enforcement mechanism and subject to removal to federal court. The plaintiff is then left with benefit recovery as the only remedy.

In 1995, two circuit court decisions, *Dukes v. U.S. Healthcare* and *Rice v. Panchal*,[132] addressed the issue of whether state tort claims based on vicarious liability were within the scope of Section 502(a). *Dukes* focused on vicarious liability claims as potential actions to "recover benefits due." In *Rice*, the court analyzed whether a suit claiming vicarious liability was an action "to enforce rights under the terms of the plan." Both courts agreed that the claims were not preempted by Section 502(a) and thus not removable to federal court. No benefit recovery was at issue since the claims arose from challenges to the quality rather than the quantity of the medical care received. The *Dukes* court concluded that "patients enjoy the right to

131. *De Buono*, 117 S. Ct. at 1749 (emphasis added).

132. Dukes v. United States Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).

be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan."[133] Furthermore, as the Supreme Court had done in *Travelers,* the court emphasized legislative intent. It pointed out that Congress had wanted to ensure that benefits would be available to members when needed and therefore provided a remedy in Section 502(a) in case a plan did not keep its promises.

> [Nothing] in the legislative history of ERISA suggests that Congress viewed § 502(a) as creating a remedy for a participant injured by medical malpractice. . . . *Quality control of* [*health care*] *benefits is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such*.[134]

Increasingly, courts have followed the *Dukes* analysis and ruled that tort liability actions against MCOs based on negligent treatment by plan providers relate to the quality not quantity of care or negligent plan administration. Therefore they are medical malpractice suits and do not fall under the scope of Section 502(a).

Claims arising from negligent utilization review, however, were interpreted differently in *Dukes* and *Jass v. Prudential Health Care Plan (1997)*.[135] Both courts ruled that the claims against a utilization review organization for negligent denial of treatment were preempted by Section 502(a) because they arose from "benefit denial" and were claims to recover benefits due. In *Jass*, however, the vicarious liability claim against the MCO, based on the attending physician's failure to treat, was not found preempted by Section 502(a), but rather by Section 514(a). The court concluded that here the physician's failure to treat was indistinguishable from the utilization review nurse's benefit denial but added, consistent with *Dukes*, that a physician's malpractice, if established, would not sufficiently "relate to" a plan and would therefore not be preempted because malpractice claims can be resolved without "reference to" it.

(b) Pennsylvania Case Law. As the Supreme Court in *Travelers, Dillingham* and *De Buono* had helped to clarify and limit the meaning of the term "relate to" in Section 514(a), the Court of Appeals of the Third Circuit in *Dukes* laid the foundation for clarification of the meaning of the term "benefits" in Section 502(a). A number of decisions in the Eastern District of Pennsylvania followed the *Dukes* analysis and made this district the most advanced

133. *Dukes*, 57 F.3d at 358.
134. *Id.* at 357.
135. Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1997).

in the nation, giving injured patients or their survivors the right to sue managed care companies for malpractice and agency in cases of negligent medical care by network physicians and other providers. In each of the following cases, the courts simply refused to accept the MCOs' argument that anything and everything provided or denied under a plan is a "benefit" and remanded the cases to the trial courts. Successful removal by the MCOs of the plaintiffs' state law causes of action to federal court and possible preemption under ERISA Sections 514 and 502 signifies minimal recovery or no recovery at all. Only before the trial courts do the plaintiffs have the opportunity to obtain sizeable jury verdicts against the managed care corporations or, at a minimum, satisfactory settlements.

In February 1998, in *Hoose v. United States Healthcare*,[136] the district court of the Eastern District of Pennsylvania refused to preempt under Section 502(a) direct liability claims against a managed care company for failure to exercise reasonable care in the selection, oversight and supervision of medical personnel; vicarious liability claims under ostensible and agency theories for the negligence of doctors, therapists and nurses; negligence claims against physicians and nurses; claims for loss of consortium and negligent infliction of emotional distress; and a claim against an MCO case manager for negligent monitoring of the patient's post-operative condition. The court stated, "It is clear that this case is nothing more than a medical malpractice action and indistinguishable from the recent *Dukes* decision. . . . The plaintiffs solely complain about the inadequate medical treatment received. There is no allegation of a refus[al] to treat or improper care because of [the managed care company's] refusal to pay."[137] The managed care company had claimed that its refusal to transfer the plaintiff to a rehabilitation hospital after a leg amputation and the discharge to his home instead, leading to a second amputation, was a denial of benefits, and that all of plaintiffs' claims therefore were preempted by Section 502(a).

In May 1998, the same court held in *Miller v. Riddle*[138] that the managed care company's decision to prematurely and inappropriately discharge the plaintiff to her home instead of to a skilled nursing facility was not preempted as a benefit denial by 502(a), as the defendant had claimed. Following the negligent treatment of her hypertension, the plaintiff had suffered a major cerebrovascular

136. Hoose v. United States Healthcare, 1998 U.S. Dist. LEXIS 1369 (E.D. Pa. 1998).
137. *Id.* at 10.
138. Miller v. Riddle Mem'l Hosp., 1998 U.S. Dist. LEXIS 7752 (E.D. Pa. 1998).

accident with longterm, debilitating consequences. The court found that the complaint was "replete with allegations that the quality of medical care received was inadequate."[139] Citing *Hoose* and *Dukes*, the court concluded that this was a suit "attacking the quality of benefits provided, not the quantity of benefits received"[140] and granted plaintiff's motion to remand. The court ruled that none of the remaining claims including direct liability for the negligent selection, retention and supervision of the treating physicians, vicarious liability based on ostensible and actual agency and malpractice were preempted.

The court in *Hoyt v. Edge*[141] decided that the complaint, which alleged medical malpractice and held the managed care company vicariously liable for the negligence of its agents, directly liable for negligent referral to incompetent physicians for a second opinion and for failing to "properly supervise, manage or control Hoyt's case," was outside of the scope of Section 502(a). The court concluded that it was bound by the *Dukes* ruling and specifically quoted the above passage from *Dukes* pointing to congressional intent not to regulate the quality of health care benefits. The plaintiff had undergone unnecessary urological surgery and two unnecessary brain surgeries leading to permanent brain damage.

The court in *Muller v. Maron*,[142] in addition to permitting claims of direct and vicarious liability against the managed care company, also did not preempt counts of fraud and misrepresentation. The plaintiff claimed that the MCO did not disclose financial arrangements with its doctors concerning compensation for not making referrals and penalizing them for too many referrals. The plaintiff's decedent had consulted the physicians complaining of severe chest pain but was not referred to a specialist. The court refused to accept defendant's argument that these two charges were preempted under Section 502(a) because they concerned the recovery of benefits and the clarification of rights under the plan. It also rejected preemption of the non-disclosure charge under 502(c) which requires plan administrators to provide information to plan participants. The court went on to quote *Dukes* and differentiated between "utilization review and precertification procedures" and "arranging for medical care." The latter is not preempted by Section 502(a) while the two former are.

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139. *Id.* at 15.
140. *Id.* at 10.
141. Hoyt v. Edge, 1997 U.S. Dist. LEXIS 8846 (E.D. Pa. 1997).
142. Muller v. Maron, 1995 U.S. Dist. LEXIS 15048, 1995 WL 605483 (E.D. Pa. 1997).

In *Kampmeier v. Sacred Heart Hospital*,[143] the court ruled that counts of direct and vicarious liability against the MCO were not preempted because the failure to perform an ultrasound was not denial of benefits, as the defendant had claimed, but arose from the MCO's faulty policy in "arranging for medical treatment" in a timely fashion. Because of the delayed ultrasound, the plaintiff's baby suffered severe injuries during delivery.

In *Whelan v. Keystone*,[144] the court did not preempt claims of direct liability against the MCO based on breach of contract, breach of warranty, negligence, wrongful death and survival actions, loss of consortium and a claim for punitive damages. The court reasoned that all counts "attack the quality of the care and benefits received," not the "withholding of benefits due" or the "enforcement and clarification of rights under the plan." While six months pregnant and suffering from negligently treated diabetes, the plaintiff's wife went into yet another insulin shock, this time while driving, crashed into a tree and was killed.

The court refused in *Howard v. Sasson*[145] to preempt negligence claims against both physicians and the MCO for failure to properly diagnose and treat a newborn's condition of vascular malformations in his legs, leading to his death. The court once again pointed to the MCO's role in "arranging for medical treatment."

Conclusion

As shown by the above cases, *Dukes* was instrumental in clarifying the meaning of the term "benefit" under Section 502(a). Only those claims seeking redress for benefits denied through utilization review and precertification or for the enforcement or clarification of administrative rights are preempted. In those instances, Section 502(a) serves as the civil enforcement provision it was intended to be by Congress. But when managed care has interfered with medical treatment, patients or their survivors can resort to all the means offered by state law to hold the negligent parties responsible and to seek damages. As the *Howard* Court put it, "*Dukes* cannot be evaded by artful pleading." Adding this to the effect of the Supreme Court's more restrictive interpretation of the term "relate to" of Section 514(a) in its rulings in *Travelers*, *Dillingham* and *De Buono*, which effectively limited the preemption

143. Kampmeier v. Sacred Heart Hosp., 1996 U.S. Dist. LEXIS 5739, 1996 WL 220979 (E.D. Pa. 1996).

144. Whelan v. Keystone Health Plan East, 1995 U.S. Dist. LEXIS 9417, 1995 WL 394153 (E.D. Pa. 1995).

145. Howard v. Sasson, 1995 U.S. Dist. LEXIS 14373, 1995 WL 581960 (E.D. Pa. 1995).

of state tort claims for malpractice against managed care organizations, we can conclude that ERISA's shield protecting the managed care industry has weakened.[146]

B. Germany: Cost Control Through Health Care Reform Legislation (1988, 1992 and 1997)

1. Necessity for Reform

Under the statutory health care system, for decades patients[147] chose their family practitioners and specialists without any concerns about access to health care. Every year, each covered family received a book of four vouchers (one for each quarter and to be submitted to the treating physician of choice) entitling everyone to complete health care coverage. Physicians made all treatment decisions and billed the third-party payers directly on a fee-for-service basis. Hospitals received per diems per patient day irrespective of diagnosis and calculated to cover their operating costs. There was no wait for any type of treatment including hospitalization, surgery and the use of major medical equipment. Once children had reached the appropriate age, they were routinely vaccinated by family physicians and received booster vaccinations during immunization campaigns in schools (against poliomyelitis, for example). Patients never saw an invoice[148] and were unconcerned about the effect of illness on family finances. German physicians, according to an international comparison by the OECD,[149] ranked second behind American physicians in terms of income and access to patients (American coefficient: 12.4; German coefficient: 11.6; mean coefficient for 21 industrialized nations: 5.5).

By the late eighties, however, annual health care expenditures were growing twice as fast as the sickness funds' revenues, mainly due to an aging population and increasingly sophisticated medical technology and treatment. As a consequence, the SGB V[150] (Social Code, Chapter Five) of 1988 was adopted, followed by the GSG[151] in 1992, both mandating new cost containment measures including

146. K.A. Jordan, *Tort Liability for Managed Care: The Weakening of ERISA's Protective Shield*, 25 J. L. MED. & ETHICS 160 (1997).

147. The terms "plan participants," "subscribers," or "members" are rarely used in German. Everyone is covered for life by the same system so everyone is a "patient."

148. ALBER, *supra* note 55, at 53; K. STRAUB, GESETZLICHE KRANKENVERSICHERUNG SGB V [THE STATUTORY HEALTH CARE SYSTEM] 1 (1997).

149. *See* ALBER, *supra* note 55, at 105 (quoting OECD (1990)).

150. *Sozialgesetzbuch—Fünftes Buch, SGB V*. BGBl. S. 2477; Bonn, 20. Dezember 1988 (Social Code, ch. 5, Federal Register, p. 2477).

151. *Gesundheitsstrukturgesetz*. BGBl. S. 2266; Bonn, 21. Dezember 1992 (Health Care Structure Reform Act, Federal Register, p. 2266).

spending caps. As of 1990, the Federal Government had been making roughly $80 billion in annual transfer payments to the five new states (Germany was unified on October 3, 1990) and the unemployment rate approached 10%.[152] Because these two factors continued to burden the national budget (by 1998, more than $625 billion had been transferred to the new states[153] and the unemployment rate had grown to almost 12.5%), the NOG I[154] and II[155] (Health Care Code Revision Acts I and II), the third stage of healthcare reform, were enacted on July 1, 1997.[156]

Health care expenditures. Overall spending on health care grew from DM 25.2 billion in 1970 to DM 159.8 billion in 1991[157] to DM 234 billion in 1994 (in 1995, the sickness fund deficit was DM 7.5 billion[158]) and to DM 265 billion in 1997.[159] This represented an increase from 3.5% of GDP in 1965 to between 8% (national health care system alone) and 10% (including those Germans having chosen private insurance) today (United States 15%). The average sickness fund premium rose from 6.4% in 1960 to 11.8% in 1985 and to 13.4% in 1992.[160] It remains at 13.5% today.[161] This rate had always been a politically charged issue, its adjustments—up or down—closely observed by the public. It became even more political in the early nineties because a "solidarity surcharge" (or less euphemistically, a tax increase) for rebuilding the five new states was introduced, further lowering disposable income.

Preservation and enhancement of equity. Apart from the rising health care expenditures, the government also wanted to remedy some of the inequities in the system. By law, the individual sickness funds were insuring different segments of the population which impacted on their actuarial risk and led to premiums ranging from 8% to 14%. The

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152. Unemployed individuals and their dependents continue to receive the same mandatory health care benefits as the rest of the nation.

153. R. Cohen, *Germany's New Face: Age 22, at Threshold of Change*, N.Y. TIMES, Oct. 25, 1998, at A6.

154. *See 1. Neuordnungsgesetz NOG*., *supra* note 66.

155. *See 2. Neuordnungsgesetz NOG*., *supra* note 67.

156. In addition to these three major pieces of legislation, 30 cost control amendments were passed between 1988 and 1997. *See* Boxberg, *supra* note 68.

157. *Amtliche Begründung zum Gesundheitsstrukturgesetz* (Legislative Intent, Health Care Structure Reform Act). BT 12/3608, Federal Parliament, Bonn, 1992.

158. *Amtliche Begründung zum 2. GKV-Neuordnungsgesetz* (Legislative Intent, Health Care Code Revision Act II). BT 13/6087, Federal Parliament, Bonn, 1997.

159. *Eigenverantwortung contra Solidarität (Individual Responsibility vs. Solidarity*), SÜDDEUTSCHE ZEITUNG, May 20, 1998, at 702.

160. Giaimo, *supra* note 98.

161. *Seehofer räumt neues Defizit der Kassen ein* [*Minister of Health Admits New Sickness Fund Deficit*], SÜDDEUTSCHE ZEITUNG, Sept. 4, 1998.

General Local Funds,[162] having to accept all those not covered by any of the other funds, had the highest actuarial risk and hence the most expensive premiums. The government wanted to remove this inequity from the system by equalizing the premiums.[163]

Raising individual responsibility. Furthermore, there was concern that patients were insufficiently aware of the considerable value of health care. Since patients for decades had never seen an invoice for medical procedures, the government formulated an intent to introduce cost transparency into the system.[164] This was accomplished in part by adding indemnity elements to the traditional prepaid system,[165] by facilitating patient access to information (such as premiums charged by different funds and discretionary benefits offered), and a switch between sickness funds at short notice.[166] Furthermore, by raising and adding co-payments, the hope was to create a more responsible approach to the consumption of the scarce and onerous resource of health care.

2. Reform Measures

Numerous relatively minor cost-containment adjustments have been made to the health care system since its inception by relying on a system of macro-allocation of health care funds through legislative measures. Beginning in the mid-seventies, some cost-sharing for patients was introduced in the form of small co-payments for medication and dental procedures. Spending increases in some sectors were linked to increases in sickness fund revenues (which depended on the rise in wages and salaries).

When the National Health Care Conference (see p. 68 below) was established in 1977, global spending targets for physicians were set for the first time as guidelines for the negotiations between the regional sickness fund associations and the physicians' associations. Even though these guidelines were voluntary and lacked enforcement mechanisms, real spending was reduced by 17% between 1977 and 1987.[167] No caps were passed for hospitals.

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162. *Allgemeine Ortskrankenkassen.*

163. *Amtliche Begründung zum Gesundheitsstrukturgesetz* (Legislative Intent, Health Care Structure Reform Act). BT 12/3608, Federal Parliament, Bonn, 1992, at II(3).

164. *Id.*

165. SGB V, Art. 63 (1997).

166. *Id.* Art. 191 (1997).

167. J.L. Shakles, *1993 German Health Care Reforms: Initiatives Tighten Cost Control: Testimony Before the Committee on Finance of the United States Senate* [GAO/T-HRD-94-2] (Oct. 13, 1993).

Recent Reforms. All three recent reform acts introduced new cost control measures for providers and patients as well as structural reforms to enhance the efficiency of the system.

(a) Providers

A variety of provider spending targets, many of them voluntary, were codified in 1988. In 1992, because of government dissatisfaction with the results of the voluntary approach, non-negotiable budgets for all sectors of the health care system (hospitals, ambulatory care physicians, dentists, pharmaceuticals) were enacted as a temporary emergency measure for three years.

Physicians. The GRG of 1988 had left in place the voluntary spending targets for physicians' fees as negotiated between the sickness funds and the physicians' associations. This did not help to stabilize premiums, however, and in 1992, a non-negotiable global sector budget was introduced.[168] Annual increases from 1993 to 1995 were strictly limited to sickness fund revenue increases. Since the number of physicians continued to rise more quickly than the caps, physicians' incomes either stagnated or were actually reduced.

Physicians exceeding their expected billing by 15% or more (before: 30%; as of 1997: 10%) were audited and those found to be in excess by 25% or more were fined unless they could justify the overruns.[169] Currently, roughly 10% of all office-based practices are audited and 2% of those are found to be in violation. The sector budget was eliminated in 1997 and replaced by caps for individual practices (taking into consideration specialty, patient demographics and region) negotiated by the physicians' associations and the sickness funds.[170]

Dentists. The GSG of 1992 included a three-year mandatory budget for dental care. Any annual increases were to be linked to sickness revenue increases. The reimbursement rates for dentures and orthodontic treatments were reduced by 10%, payments for dental technicians by 5%.[171] Certain prosthetic devices not considered medically necessary were no longer covered, and treatments exceeding the average volumes for practices were to be reimbursed only at reduced rates.[172] Dentists, by the way, had the highest income of all providers, and spending on dental care in Germany exceeded

168. SGB V, Art. 85 (1992).
169. *Id.* Art. 296; *see also* GAO, 1993, *supra* note 73, at 10.
170. SGB V, Arts. 85-87.
171. *Id.* Art. 85(2b).
172. *Id.* Art. 85(4c, d, e).

that of other comparable countries,[173] owing in part to the emphasis on prosthetic replacements over restorative or preventive measures.

Pharmaceuticals. The most radical cost control measure enacted in 1988 was the reference price system for pharmaceuticals.[174] By 1988, the German expenditures for prescription medicine per patient exceeded those in the United States despite much higher overall American health care costs.[175] Both per capita consumption and prices charged for medication surpassed those of many other industrialized nations. A total of 65,000 different drugs were on the market due to the German predilection for "combination drugs," i.e. medication with a mixture of several different active ingredients.

The reference price system divided covered pharmaceuticals into three groups (drugs with identical active ingredients; pharmacologically-therapeutically comparable active ingredients; therapeutically comparable effects), set the prices reimbursed by the sickness funds, and thus de facto introduced co-payments for the remaining amount. (Patented innovative drugs were exempted.) As a consequence, manufacturers adjusted their prices closer to the level of reimbursement or the cost of generics. The increased substitution by generics further reduced the expected expenditure growth rate in this sector.

In addition, the GSG of 1992 set a global budget for medication to be prescribed by physicians based on the actual expenditures incurred in 1991. Any overruns were to be covered through reduced physicians' fees and lower drug prices to be charged by the pharmaceutical industry.[176] In addition, the GSG mandated additional spending cuts through tightening the reference price system. Gradually, 70% to 75% of all prescription drugs were to be subject to reference prices, and a 5% price reduction for the remaining pharmaceuticals and a 2% cut for non-prescription medicine were passed for 1993 and 1994. During the following two years, drug prices were frozen. Reference prices continue to be in force today.[177] Needless to say, the pharmaceutical manufacturers, both German and American companies with major stakes in the most lucrative drug market in Europe, ferociously fought the reference price system from its inception.

Hospitals. Before 1992, hospitals were paid a per diem rate for each patient day, irrespective of diagnosis and calculated

173. *See* GAO, 1993, *supra* note 73.
174. SGB V, Art. 35 (1988).
175. *See* GAO, 1993, *supra* note 73, at 12.
176. SGB V, Art. 84(1).
177. *Id.* Art. 35 (1997).

retrospectively to cover operating costs. This system was found to discourage efficiency and to encourage over-utilization. Hospital budgets, based on prospective utilization, were introduced and reimbursement (beginning in 1995) was based on 160 clinical procedures and 40 conditions, the so-called patient management categories,[178] similar to the DRGs (diagnosis-related groups) used by Medicare. The NOG II of 1997 also required of each patient an annual contribution of $12 for 1997 to 1999 to cover the modernization and renovation of hospitals.

(*b) Patients*

Co-payments. Until 1988, co-payments had been practically inexistent. Minor exceptions were the fee for each prescription filled by a pharmacy, rising from $0.60 in 1967 to $1.50 by 1988, and the $3 co-payment per day of hospitalization up to a maximum of two weeks, introduced in 1982.[179] The GRG of 1988 raised the latter to $7 per day, and its current level is $10.[180] Beginning in 1988, co-payments for medication were staggered according to package size and now range from $5 to $7.50[181]; co-payments for medical/surgical dressings and supplies (20%),[182] for alcohol, drug and geriatric rehabilitation (identical to the hospital co-pays),[183] and for physical therapy, massage therapy etc. (15%)[184] were introduced.

Reduced benefits. Some benefits were curtailed such as entitlement to medical spa visits[185] (currently only three weeks every fourth year, formerly four weeks every three years); the partial reimbursement of frames for glasses was reduced and then dropped by the NOG in 1997 (it was maintained for the lenses themselves); some medications of questionable effectiveness were no longer covered, and the reimbursement of transportation costs (ambulance, taxi) was reduced. The deepest cuts were made to dental benefits. Co-payments now reach 60% of all dental care, and the reimbursement of crowns and dental prostheses for everyone born after 1978 was completely eliminated.[186]

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178. This system was developed by Wanda Young of the Pittsburgh Research Institute, the research institute of Blue Cross of Western Pennsylvania. *German Health Reforms*, United States General Accounting Office, GAO/HEHS-95-27, Dec. 1994, at 19-20.

179. *See* ALBER, *supra* note 55, at 53.

180. SGB V, Art. 39.

181. *Id.* Art. 31.

182. *Id.* Art. 33.

183. *Id.* Art. 40.

184. *Id.* Art. 32.

185. *Id.* Art. 40.

186. *Id.* Art. 30.

Improved Prevention. The reforms expanded preventive care and early diagnostic procedures for children (routine screening up to age 10 for conditions potentially retarding physical and mental development[187]) and adults (for cardiac and rhenal conditions, diabetes and cancer[188]). Dental prophylaxis for all was enhanced as well.[189]

Choice of Indemnity or Prepaid System. Since 1997, patients for the first time were able to choose either system[190] as well as a deductible and a correspondingly lower premium.[191] Mandatory indemnity payments and the concept of reimbursing only the "usual and customary" fee for a number of dental procedures[192] were introduced.

Exemptions. To offset some of the added burden on patients, the GRG of 1988 and the GSG of 1992 made provisions for "hardship" cases,[193] which were expanded by the NOG in 1997. Partial or complete exemption from co-pays will be granted if total medical expenditures exceed 2% (formerly 4%) of gross income. For the chronically ill who have paid the maximum 2% for one year, the rate drops to 1%.

(c) Structural Reforms

Limiting the number of physicians. The number of physicians had risen continually through the 1980s, leading to what was considered an oversupply of physicians and inflating health care expenditures due to an increasing volume of procedures billed despite zero population growth. The GRG of 1988 provided for specific regional limitations for new practices according to specialty. Regional requirements were determined jointly by state agencies and the associations representing physicians and sickness funds. This approach remains in force today.[194]

Competition among sickness funds. To make patients more cost-conscious, an element of competition among the sickness funds was introduced in 1992. Historically, 50% of all patients were required to join specific funds depending on their profession which created actuarial risk imbalances and premium differentials between sickness funds. As of January 1, 1996, all membership restrictions were

187. *Id.* Art. 26.
188. *Id.* Art. 25.
189. *Id.* Arts. 21, 22.
190. *Id.* Art. 13.
191. *Id.* Art. 51.
192. *Id.* Arts. 29, 30.
193. *Id.* Arts. 61, 62.
194. *Id.* Arts. 99, 101-104.

lifted.[195] Theoretically, sickness funds were now free to compete with each other by offering more competitive premiums and optional benefits.[196] Initially, open enrollment was available only once a year, but since 1997, patients now are entitled to switch funds as soon as premiums are raised.[197]

The effectiveness of competition, however, was limited from the beginning by the rate equalization scheme in force as of 1994. For reasons of equity, the government wanted to level the premium differential, and risk adjustment payments were made to those sickness funds which incurred higher than average expenditures because of patient demographics.

Raising sickness fund cost awareness. A mandatory linkage between medication co-payment and premium increases[198] was intended to prevent funds from raising premiums rather than risk losing their members.

Strengthening the funds' bargaining position. Another important element was to strengthen the bargaining position of the sickness funds during their negotiations with the physicians. A traditional critique of the system had been that the physicians' associations wielded too much bargaining power and oftentimes imposed their conditions on the funds. The GRG of 1988, with the intent of leveling the playing field between the two parties, mandated that premium stability be one of the goals of the fee negotiations between physicians and sickness funds.[199] In addition, the sickness funds were given increased "policing powers" over physicians' and hospitals' cost effectiveness,[200] as well as the responsibility to negotiate prescribing guidelines with the physicians to ensure that the sector budget for prescription pharmaceuticals would not be exceeded.

Lowering the barriers between outpatient and inpatient care. Traditionally, the ambulatory and hospital sectors had been kept separate. Hospital physicians, for example, were not permitted to see outpatients which led to prolonged hospital stays for what would have been pre-admission testing and aftercare. The GSG of 1992 allowed

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195. *Id.* Arts. 173-175.

196. Some of the funds did so quite aggressively by holding belly dancing and cooking classes which, not surprisingly, displeased legislators. As one commentator observed, "Legislative amendments limited optional benefits to the point of robbing them of all their interest." STRAUB, *supra* note 148, appendix, at 7.

197. SGB V, Art. 175.

198. *Id.* Art. 221.

199. The physicians' refusal to contribute to this goal was said to have been one of the prime motivators of the non-negotiable budgets passed in 1992.

200. SGB V, Arts. 106, 296, 297; 113.

hospitals to open ambulatory surgery departments, and hospital physicians could now see their inpatients before and after hospitalization to reduce hospital utilization rates.

Conclusion

These legislative reform efforts have successfully limited the growth of health care costs.[201] Between 1972 and 1982, expenditures rose by 32% (U.S.: 36%) as percentage of GDP but only by 1% (U.S.: 36%) between 1982 and 1992 .[202] Between 1992 and 1994, growth rates fell in all sectors and spending per member dropped by 1%.[203] Overall expenditures have been stable at roughly 8% of GDP since 1982, supporting the conclusion that there is no health care cost explosion in Germany.[204] From 1985 to 1998, premiums have risen only slightly (1985: 11.8%; 1993: 13.4%; 1998: 13.5%[205]). All other industrialized nations with statutory health care systems have also been able to stabilize their total health expenditures at levels below 10% of GDP.[206]

None of the above reforms have changed the fundamental character of the German health care system which continues to provide universal access[207] and coverage. Comprehensive treatment as judged necessary by the physicians is still provided and the standard of care, by law, continues to be based on the progress of medical science. Immediate access to all treatments and medical facilities has not been impaired.

But what impact on the provision of health care did the reforms have? As a consequence of the budget caps and new forms of compensation, physicians have cut back some treatment, especially in areas of capitation. Government macro-allocation measures thus have resulted in at least some micro-allocation of medical care for individual patients, similar to the effect of MCO utilization procedures in the United States. Contrary to the micro-allocation decisions made by managed care organizations under the guise of

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201. United States General Accounting Office, *German Health Reforms*, GAO/HEHS-95-27, Dec. 1994, at 1, 6.

202. *See* Giaimo, *supra* note 98 (quoting *The Reform of Health Care Systems*, OECD 37 (1997)).

203. *See* GAO, 1994, *supra* note 201, at 3.

204. K. Schuler, Secretary, Health Care Committee of the Federal Parliament, *Personal Communication*, Oct. 1, 1998, Bonn, Germany.

205. *Seehofer räumt neues Defizit der Kassen ein* [*Minister of Health Admits New Sickness Fund Deficit*], SÜDDEUTSCHE ZEITUNG, Sept. 4, 1998.

206. U.E. Reinhardt, *Managed Competition in Health Care Reform: Just another American Dream, or the Perfect Solution?*, 22 J. L. MED. & ETHICS 106 (Summer 1994).

207. By 1994, access to appropriate care was not impaired. *See* GAO, 1994, *supra* note 201, at 7.

"medical necessity," however, all medical decisions in Germany are still left to the treating physicians. Those physicians who refuse to lower their traditional standard of care often end up providing 25% of their office-based capitated procedures for free.[208] This is akin to U.S. hospitals unwilling to discharge seriously ill patients once additional care has been denied by the MCO and payment is cut off. In both countries, there is concern that the current approach to cost-control will have an increasingly detrimental effect on the overall quality of health care.[209]

IV. A COMPARATIVE LAW APPROACH TO HEALTH CARE COST CONTAINMENT IN THE UNITED STATES AND GERMANY

A. New Directions in Comparative Law Methodology

Is comparative law experiencing an identity crisis?[210] Apparently, this debate centered on the purpose and methodology of comparative law is as old as the discipline itself. The first comparative law associations were founded in Germany, France and England in the late nineteenth century[211] but in 1995, a professor at Harvard Law School was still heard to remark, "You comparativists just do whatever the hell you feel like, isn't that right?"[212]

However, there seems to be a consensus that "parallel exposition," the mere descriptive juxtaposition of different national approaches to the regulation or resolution of specific legal problems without any further analysis, has outlived its usefulness[213] (if it ever had any to begin with). The descriptive element remains important but must be followed by a second step: understanding "the meaning of a foreign law, its history, and the way in which it operates as a 'living law.'"[214] Only then can the comparative methodology of

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208. Dr.med. Gisela Groscurth-Galm, *personal communication*, Sept. 27, 1998, Bochum, Germany.

209. *See* C.-M. Stegers, *Der medizinische Standard im Arzthaftungsrecht* [*The Medical Standard of Care and Physician Liability*], *in* CAPPING HEALTH CARE—WHAT WILL HAPPEN TO THE MEDICAL STANDARD OF CARE? 103 (1997); Iglehart, *supra* note 115, at 742.

210. M.S. Glendon, *General Report, Symposium: Individualism and Communitarianism in Contemporary Legal Systems: Tensions and Accommodations*, 1993 BYU L. REV. 385 (1993).

211. *Id.* at 385.

212. D.H. Foote, *The Role of Comparative Law: Inaugural Lecture for the Dan Fenno Henderson Professorship in East Asian Legal Studies*, 73 WASH. L. REV. 25 (1998).

213. *Id.* at 29.

214. J. Zekoll, *Kant and Comparative Law—Some Reflections on a Reform Effort*, 70 TUL. L. REV. 2719 (1996).

searching for the common core and functional equivalents of different normative systems be applied successfully.[215]

The current consensus also extends to the recognition that, in the era of globalization and the need for basic international regulatory mechanisms,[216] comparative law has an increasingly important practical contribution to make. But what it can teach us about other nations' legal systems may actually be less significant than what we can learn about our own legal system[217] and the increased "critical self-awareness"[218] we may develop as a consequence.

According to Glendon,[219] it has become indispensable to develop an interdisciplinary approach to comparative law in order to understand the origin and impact of law on our ever more complex and fragmented industrialized societies (where public and private institutions and programs have assumed some of the roles traditionally associated with the extended family, such as caring for the sick). Laws come out of the social, economic and political context of a particular society, and their impact can only be grasped fully when linking sociology, economics, political science, anthropology, feminist jurisprudence[220] and their methods with those of comparative law. Only then can this venerable discipline assume a practical role[221] in improving particular aspects of our societies.

Accordingly, numerous publications have suggested new avenues for comparative legal research. William Ewald, in his efforts to "rethink the foundations of comparative law," proposed to combine legal philosophy with comparative law in order to create "comparative jurisprudence."[222] He argued that understanding foreign law is contingent on studying its intellectual foundations and underlying philosophical principles and that such study must include the works of a nation's great jurists and those of the philosophers who

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215. *Id.* at 2725.

216. Examples: International Labor Organization, World Trade Organization, Bank for International Reconstruction and Development, International Monetary Fund, Bank for International Settlements.

217. *See* Foote, *supra* note 212, at 28.

218. P.G. Carozza, *Continuity and Rupture in 'New Approaches to Comparative Law'*, 1997 UTAH L. REV. 657.

219. Glendon, *supra* note 210, at 418.

220. *See* Foote, *supra* note 212, at 28; Zekoll, *supra* note 214, at 2735; Carozza, *supra* note 218, at 658 (questioning whether some of the "new approaches" deserve this label since comparative law for quite some time has been moving towards "wide-ranging inquiries on questions of law and society").

221. *See* Foote, *supra* note 212, at 28.

222. W. Ewald, *Comparative Jurisprudence (I): What Was It Like to Try a Rat?* 143 UNIV. PENN. L. REV. 1889 (1995) (143).

influenced them. Quoting as an example the origins of German legal thought, he points to the impact of Kant's categorical imperative on the development of a state based on the rule of law.[223] Gierke,[224] however, objected to the social injustice brought forth by such an individualistic and economically liberal system and proposed the theory of a "socially responsible state"[225] emphasizing the group over the individual, thus earning the label "economic communitarian."[226] Gierke's writings were published at the time when the German Reich under Bismarck adopted the first national "Health Insurance Act," mandating health insurance for workers.[227] Gierke's concept of a socially responsible state based on the rule of law continued to be a major influence on German government and today is reflected in Article 20 of the Constitution[228] which (for further discussion see *infra* Part IV.A.1) has a direct impact on the current provision of health care.

Ewald concludes his philosophical excursion into "comparative jurisprudence" by observing that comparative law must promote understanding among lawyers from different nations. To this end, knowledge of the black-letter rules is of importance, certainly, but must be accompanied by a comprehension of the underlying philosophy. He then paraphrases Horace: "Metaphysicam expellas furcam, tamen usque recurret—You can drive away philosophy with a pitchfork, but it always comes back."[229]

In his response, Zekoll[230] does not dispute the influence of philosophy on law but decries Ewald's rejection of contemporary comparative methodology and his failure to develop a new approach based on "comparative jurisprudence." Zekoll points to the harmonization of national legislation within the European Union as attesting to the success and strong position of comparative law in Europe. The main vehicles for harmonization are the directives issued by the E.U. Commission in Brussels, drawing on different national legal ideas after careful comparative research of the laws of

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223. *Rechtsstaat.*

224. *See* Ewald, *supra* note 222 (quoting O. VON GIERKE, DAS DEUTSCHE GENOSSENSCHAFTSRECHT [THE GERMAN LAW OF ASSOCIATIONS] (1881)).

225. *Sozialstaat*. English translation by R.G. Livingston in P.R. Range & R.G. Livingston, *The German Welfare Model That Still Is*, WASH. POST, Aug. 11, 1997, at C2.

226. *See* Ewald, *supra* note 222, at 2056.

227. *Krankenversicherungsgesetz*, May 6, 1883.

228. "The Federal Republic of Germany is a democratic and socially responsible federal state." Art. 20, Grundgesetz (Constitution of the Federal Republic of Germany), May 23, 1949.

229. *See* Ewald, *supra* note 222, at 2149 (quoting Horace, *Epistles 316*).

230. Zekoll, *supra* note 214.

all countries concerned.[231] Understanding the origins of the different legal systems' differences and similarities is of prime importance.

1. Practical Applications of the New Comparative Law Methodology

According to Kakouris, the judgments rendered by the European Court of Justice are excellent examples of the successful practical application of a new and greatly expanded comparative law methodology.[232] Not only the Justices' knowledge of the law itself is essential but also of the reasons for its introduction or of its particular form. Therefore, an important element of this comparative approach is an initial understanding by the jurist of the "set of socio-politico-economic relations which make up the subject matter" before the different national legal regimes are compared.

The comparative step is based on the "teleological interpretation" of the applicable laws of the member nations and takes into consideration the beliefs and common values of the peoples of the European Union. If no such legislation exists or if national legislation is inconsistent or contradictory, the Court draws directly on these beliefs and values for its ruling since it and E.U. law in general must reflect them. Whenever there is national legislation, the Court often adopts the rule representing the highest common denominator, but it is not bound to always do so. Finding such a denominator, however, may be difficult at times because of the great diversity of national legislation, requiring the interpretation of laws already in force which may be vague or incomplete.[233] Therefore, an opinion may very well involve a creative interpretive element, but it must be in keeping with the ultimate goal of European integration.

While all peoples of the E.U. member nations share the same fundamental attitudes towards human existence, there are national and regional variations which the Court must respect by practicing a multi-cultural approach. In each of its decisions, it must be guided by

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231. *Id.* at 2731.

232. C.N. Kakouris, *Use of the Comparative Method by the Court of Justice of the European Communities*, 6 PACE INT'L L. REV. 267 (1994). Most actions brought before the Court concern the judicial review of E.U. regulations which were adopted as national legislation by the respective legislatures. The Court's rulings therefore become E.U. case law.

233. *Id.* at 269 n.5. In such an instance, the Court will resort to unwritten law already in force. "Regarding the existence of unwritten law, we cannot fail to refer to the *Antigone* by Sophocles, verses 456 and 457, referring to the 'unwritten and immutable laws of the Gods . . . not only today or yesterday but eternally, . . . living laws and no one knows when they appeared.'"

the "teloz," the resultant vector of these variations[234] and "act as though it were the consciousness (sic) of Europe."[235] The Court must also express its respect for cultural differences by examining beforehand the political and sociological consequences a particular ruling would have. When adding this to the justices' differing backgrounds in legal training and knowledge, depending on their nationality, it becomes readily apparent that the European Court of Justice represents comparative law in action.

The influence of local culture and attitudes on laws has real and practical implications. A comparative law study by Echols,[236] identifying how culture and legal attitudes impact food safety regulations is of considerable value, especially since food exports have been a frequent bone of contention between the United States and the European Union. European public opinion has vehemently opposed as "unsafe" food produced with genetically altered ingredients or pasteurized by ionizing radiation, while American regulators have not had any difficulty with public acceptance of these fairly recent technological developments. Also, American regulations tend to focus on the final product while European regulations target the production process. As a result, American regulations permit scientifically based innovative food production processes and assume that the safety of foods based on new plant varieties does not differ from other foods. In the E.U., on the other hand, the adoption of regulations permitting the use of new procedures is a tedious and lengthy process[237] because of strong and even violent public opposition.[238] European bans on imports of genetically altered American soy protein, for example, which smack of protectionism, may thus at least in part be truly motivated by the "social factor" the European Commission considers to be an integral element of food regulation. American regulation, on the other hand, is mostly based on scientific considerations readily accepted by the American public. This study is an excellent application of the expanded concept of

234. *Id*. at 278.

235. *Id*. at 274. The author presumably means "conscience."

236. M.E. Echols, *Food Safety Regulation in the European Union and the United States: Different Cultures, Different Laws*, 4 COLUM. J. EUR. L. 525 (1998).

237. By December 31, 2002, the E.U. Commission will issue a very limited 'positive list' of foods approved for pasteurization by irradiation.

238. For years, numerous field experiments in Germany with genetically altered plants or organisms were systematically destroyed by groups fearful of the deleterious consequences for human life and the natural environment. When Germany recently lifted its ban on many biotech procedures, all major German pharmaceutical companies had already built manufacturing facilities in the United States.

comparative law, describing not only the different regulatory approaches themselves but examining the external influences on the origins of laws and their potential social consequences.

An examination of American and European theories of regulation and their application to the competing factors of accountability and expertise by Egan and Wolf[239] suggested that the American approach of increased public participation in the regulatory process and administrative transparency may be a valid model to help reduce some of the "democratic deficit" often ascribed to the E.U. regulatory procedures by European public opinion. Clearly, comparative law is able to propose innovative approaches to similar problems encountered in different regulatory systems.

Conclusion

Comparative law has transcended the traditional merely descriptive "parallel exposition" of systems of law. Today, it traces the origins of laws, explains the influences on their particular forms and anticipates their potential impact. Comparative law has thus changed in step with our broadening social, economic and political environment. The seemingly unending debate as to its purpose and methodology may just be proof that comparative law is fulfilling its true mission: To understand and predict change, to adapt to it, and eventually to become an instrument of change itself.[240]

B. Some Aspects of Individualism and Communitarianism in the Contemporary Legal Systems of the United States and Germany

No doubt, historically different conceptions of the individual have had an influence on culture and law. The American "myth of the self-reliant, lonely, proud individual"[241] has produced legal norms

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239. M. Egan & D. Wolf, *Regulation and Comitology: The E.U. Committee System in Regulatory Perspective*, 4 COLUM. J. EUR. L. 499 (1998).

240. One could envisage applying an approximation of the experimental paradigm to comparative law ("the influence of x on y"). The independent variable x would be a new or amended law, y would be the dependent variable to be examined, i.e. the particular field targeted by the legislation. Here, x could be the different health care reform measures enacted in Germany over time. Y would then be operationalized as the impact of the new laws on patients, providers and the standard of care. The results could be compared to the changes in American health care, triggered by the growing market share of managed care and the developing case law, impacting also on patients, providers and the standard of care. Of course such a study could never really be called "empirical" because of the absence of a true experimental protocol and the inapplicability of inferential statistics. But the differences in outcome observed between the two national cost control approaches could be explained at least in part by identifying some of the specific differences between the two systems. Actually, some of the German cost containment measures did have readily quantifiable results and the potential effects of similar measures on U.S. health care could be discussed.

241. *See* Glendon, *supra* note 210.

emphasizing the autonomous, self-determining individual. The German inclination to define the individual also through relationships with others resulted in the early development of the concept of the "socially responsible state" by the "economic communitarians"[242] of the nineteenth century. This made possible the early acceptance of mandatory health insurance for workers while the greater American emphasis on the individual still creates reluctance to the adoption of such national programs.

Historically, American society has emphasized "the ideals of individual initiative, classlessness and opportunity."[243] The Due Process Clause of the Fourteenth Amendment to the Constitution, which could be read as providing the right to certain minimum rights of treatment, has not been interpreted in such a fashion. In *Collins v. Harker Heights*,[244] the Supreme Court ruled that the Due Process Clause does not guarantee "certain minimal levels of safety and security [or otherwise] impose an affirmative obligation on the state to ensure that [life, liberty or property] do not come to harm through other means."[245] It is merely intended to "prevent government 'from abusing [its] power, or employing it as an instrument of oppression.'"[246] As a consequence, substantive due process does not recognize a fundamental right to health care.

The current Art. 1(1) of the German Constitution of 1949 states that human dignity is inviolable; Art. 2(2) guarantees the inviolability of life and the individual's physical inviolability[247]; and Art. 20(1) declares the Federal Republic to be a socially responsible state. During the first year of its existence, the Federal Constitutional Court, interpreting Art. 2(2), refused to recognize the non-textual fundamental right of an individual to receive from the state the necessary material minimum.[248] In 1954, however, the Federal Administrative Court ruled that Art. 1(1) together with Art. 20(1) require the state to help all those in need and inferred a constitutional

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242. *See* Ewald, *supra* note 222 (quoting GIERKE, *supra* note 224).

243. *See id.* (quoting D.C. Bok, *Reflections on the Distinctive Character of American Labor Laws*, 84 HARV. L. REV. 1394 (1971).

244. Collins v. Harker Heights, 503 U.S. 115; 112 S. Ct. 1061 (1992); *see also* R.C. Hartley, *The Supreme Court's 1991-1992 Labor and Employment Law Term*, 8 LABOR LAW. (1992).

245. Collins, 503 U.S. at 126 (citing DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189, 196 (1989)).

246. *Id*. at 126 (citing *DeShaney*, 489 U.S. at 195).

247. Grundgesetz (Constitution of the Federal Republic of Germany) Artikel 1(1), Artikel 2(1), Artikel 20(1).

248. BVerfGE 1, 97, at 104 (Ruling of the Federal Constitutional Court) (1949).

right to the material minimum needed for a dignified life.[249] This was later recognized by the Federal Constitutional Court as well[250] and interpreted to include the right to a minimum of health care.[251]

The differences between the United States and Germany, however, are merely in degree. As Glendon observed, both countries are liberal democracies and can be considered liberal welfare states[252] but with a somewhat different emphasis on the protection of either individual liberties or the individual by the community. This is reflected in specific aspects of their legal systems such as in family, labor and health care law. As liberal welfare states, both nations face the same problems. Communities have weakened and liberated individuals have become more vulnerable as a consequence. Few in either country dispute that there is a collective responsibility for individual risks such as illness, unemployment and retirement, and that individuals have rights which transcend political and civil rights to include social rights such as education and health care.[253] Both states are called upon to find the optimal balance between private and public solutions in order to take care of the needs of their citizens. How they resolve this issue is a function of their culture and systems of law.

Many Americans have concluded that an excess of individualism may actually threaten the individual,[254] and that "modern liberalism, with its limited conception of community, ends up undermining the social conditions necessary to sustain its noble project of enhancing individual status and personal liberty."[255] The German system, on the other hand, has become an intricate bureaucracy with laws and regulations limiting its citizens' liberty in many areas of life[256] and regulating individual behavior without consulting those concerned first. In such a system, individual initiative and responsibility are stifled.

Both countries face the issue of finding a workable welfare state model where individuals have the responsibility and freedom to be in

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249. BVerwGE 1, 159 at 161 (Ruling of the Federal Administrative Court), 1954.

250. BVerfGE 40, 121 (133); 45, 187 (228). (Rulings of the Federal Constitutional Court).

251. SEEWALD, GESUNDHEIT ALS GRUNDRECHT [THE FUNDAMENTAL RIGHT TO HEALTH CARE] (1982).

252. Glendon, *supra* note 210, at 397, 405, 407.

253. *Id*. at 399.

254. *Id*. at 412.

255. T.C. Kohler, *Individualism and Communitarianism at Work*, 1993 BYL L. REV. 727.

256. Women are now permitted to keep their last name without having to add that of their husbands (required by law for many years, creating the 'hyphenated woman'). If the couple, however, are unable to agree on the last name of their children, the city registrar will decide for them. Imagine such a rule in the United States. . . .

charge of their own lives, to reach out to others in need, and to obtain help themselves when necessary.[257] Because of our fragmented societies, we are dependent on at least some bureaucratic "value-generating institutions [which] are not necessarily organized on liberal principles. Successful political modernization thus requires the preservation of something premodern within its framework of rights and constitutional arrangements."[258] One such institution is a reliable system of health care accessible to all.

In Germany, the effects on the individual of the top-down bureaucratic system of administrative regulation of health care are mitigated by subsidiarity, resulting in the affirmation of the historical principle of sickness fund self-administration and the establishment of the National Health Care Conference.[259] In the United States, federalism has been the traditional approach to "giving bureaucracy a more human face"[260] and could be the foundation for the administration of a universal public health care system.

C. Resulting Approaches to Health Care in the United States and Germany

Different attitudes towards the individual have generated different systems of regulation. Comparing regulation in the United States and Sweden, Kelman[261] observed: "Out of the Swedish [political] tradition grows the notion that people ought to defer to the wishes of those in authority. Out of the American liberal tradition grows the notion that it is legitimate for people to define and pursue their own goals, independent of what the state thinks is best for them. . . . The traditional problem of European states with established rulers has been to tame those rulers and let the people breathe; that of America with its liberal tradition has been to tame the unruly so that other people can breathe." Kelman concludes that the American approach leads to a system of enforcement while the Swedish system is cooperation-oriented. As a result, the United States has strong agencies regulating industry by enforcing acts of Congress and by issuing regulations of their own—taming the "unruly" forces of the

257. *See* Glendon, *supra* note 210.

258. *Id.* (quoting F. FUKUYAMA, THE END OF HISTORY AND THE LAST MAN 334 (1992)).

259. *Die Konzertierte Aktion im Gesundheitswesen*. For further discussion, see Part IV.C.2 *infra*. Subsidiarity is also a cherished principle of E.U. regulation.

260. *See* Glendon, *supra* note 210, at 418.

261. S. Kelman, *Enforcement of Occupational Health and Safety Regulations: A Comparison of Swedish and American Practices*, *in* ENFORCING REGULATION (K. Hawkins & J. Thomas eds., 1984).

market. But in unregulated areas such as health care and in the absence of national legislation, the enforcement of individual rights works from the bottom up. Individuals must take it upon themselves to defend their right to appropriate and adequate medical treatment against the micro-allocation of health care funds by managed care organizations.

Like Sweden, the Federal Republic, on the other hand, has practiced a cooperation-based model because Germany's "powerful ethic of communitarianism fosters consensus."[262] Such national consensus leads to a top-down comprehensive system of administrative law protecting, and possibly overprotecting, individuals through legislation. Health care costs are contained on a national level through legislation resulting in the macro-allocation of funds through global and sector-specific budgets.

1. United States: Enforcement

(a) Reliance on the individual and the courts. Absent a fundamental right to health care and national legislation, patients or their survivors have increasingly resorted to legal action to enforce their rights against the managed care industry. Large jury awards or sizeable settlements, feared by the managed care organizations, set limits to their continuous efforts to lower the standard of care even further through minimizing expenditures for medical treatment. The courts thus play a decisive role in defining the access to and the distribution of health care.

But what causes an individual to sue a managed care company? Who are the plaintiffs? What are their motives? Mental health care, always a step child of the health insurance industry,[263] experienced a sea change[264] for the worse when subjected to the cost-cutting rigors of managed care. The managed care industry, "responding to the needs of their primary client, corporate America, has been particularly ruthless in restricting psychiatric hospitalization and long-term psychotherapy."[265] Two tragic cases exemplify the battle for the right of the individual to proper treatment.

Thirteen-year old Stephen Lurie[266] had a drug problem and a juvenile record. He was on medication, supervised by a psychiatrist, and saw a social worker for weekly sessions. His therapists advised

262. Range & Livingston, *supra* note 225, at C2.
263. Stone, *supra* note 51.
264. WASH. POST, *supra* note 52, at 12.
265. Stone, *supra* note 51.
266. *See* WASH. POST, *supra* note 52.

Suzanne Lurie, the boy's mother, that his increasing problems most likely were due to the combination of adolescence, drug addiction and serious depression, triggered by his father's sudden death. They, along with a magistrate who did not feel that Stephen belonged in a juvenile detention center, recommended residential treatment to prevent him from deteriorating. Suzanne Lurie's insurance, a managed mental health company, approved 48 hours in a hospital and then had Stephen discharged because he "was not a danger to himself or others." Barely three weeks later Stephen was dead. Once again he had stolen his mother's car (he had been arrested several times previously for this offense), had picked up some of his friends and gone joy-riding. Realizing that the police were going to stop him, he let his friends out of the car and began a high-speed race with the police. At 80 miles per hour, he hit a tree and was killed instantly, a few days after his fourteenth birthday. Ms. Lurie, who filed charges against the managed care company and the hospital, said, "We were trying every which way to get him inpatient treatment, but the company was like a brick wall that I could not get around, over or through."

Fifteen-year old Gregory Mizell[267] was hospitalized for attempted suicide at a facility under contract with his family's managed care company. The treating psychiatrist, claiming that Gregory no longer was a danger to himself or others, released him after two days. Shortly before his discharge, the boy was seen lying on the floor crying and banging his head. Ten days later, he attacked Lynn Mizell, his mother, and was readmitted to the same hospital. Psychological testing indicated that he was at a high risk for suicide. The next morning, the same attending psychiatrist wanted to release him but his mother refused to take him home. Gregory was discharged within a few days, shortly after still having been on suicide watch.

This was the beginning of a two-year odyssey for Lynn Mizell who fought the managed care company like a tiger to have her son diagnosed and treated properly. In spite of a lifetime maximum of $500,000 coverage for mental health treatment, the managed care company kept denying the "medical necessity" of appropriate treatment and Gregory's care eventually was paid for by the state through Medicaid. Seven months after the *Washington Post* article recounting the Mizell's struggle was published, Gregory was dead—he had finally succeeded in killing himself.

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267. *Id.*

Plaintiffs often are parents of deceased children and are engaging in unimaginable trench warfare when daring to take on the managed care company which denied their dead child the needed care. They will now hear that their child was really untreatable, a curious clinical phenomenon,[268] considering that the managed care company did not find any "medical necessity" for residential or inpatient care. They will also discover that they were "rotten parents" and as such responsible for their child's death, relieving the managed care company of any liability. Without these grieving parents' courage, there would not be a public backlash against the abuses of an out-of-control health insurance system.

(b) Determining the standard of care. The managed care industry, responsive mainly to Wall Street,[269] has had free reign to impose its economically driven definition of standard of care. Paying lip service to quality care, MCOs require physicians to deliver only minimum treatment to fill their own pocketbooks with billions of dollars annually.[270]

But faced with a public outcry, legislators have not stood by idly. In 1996, one thousand pieces of legislation regulating managed care in some fashion were submitted to state legislatures, and 56 laws were enacted in 35 states.[271] Today, 46 states and the District of Columbia mandate at least some MCO benefits and prohibit practices considered particularly detrimental to the provision of health care.[272] Emergency care must be covered when a "prudent lay person" would consider such treatment necessary (23 states); women may see gynecologists and obstetricians without referral by a primary care "gatekeeper" (36 states); continuity of care must be provided when pregnant women or seriously ill individuals were treated by a physician later dropped from the network (17 states); visits to out-of-network physicians (point-of-service) will be reimbursed (16 states); "gag" (non-disparagement) clauses are prohibited (46 states); financial incentives for physicians denying treatment are illegal (20 states); grievance and appeal procedures must be available (all states).[273] Many states also ban "drive-through" deliveries and

268. Welch, *supra* note 90.
269. R. Kuttner, *Toward Universal Coverage*, WASH. POST, July 14, 1998.
270. A.B. Ackerman, *Doctors, Not Providers*, WASH. POST, July 8, 1997, at A15.
271. Bodenheimer, *supra* note 37.
272. *Health Policy Report: Must Good HMOs Go Bad?* 338 NEW ENG. J. MED. (Nov. 1996).
273. *States Take Lead in Health Legislation*, N.Y. TIMES, Sept. 14, 1998, at A10.

mandate that new mothers must remain hospitalized for at least 48 hours.

On July 24, 1998, the House of Representatives adopted a comprehensive Republican-sponsored act protecting patients rights and defeated a more extensive Democratic bill. On October 9, a Democratic bill regulating MCOs did not pass the Senate. The Republicans had drafted a similar measure but the parties were unable to reach a compromise, mainly disagreeing about managed care liability. Both Democratic bills would have enabled patients to sue MCOs more easily, while the Republican acts provided for administrative appeal procedures, shielding managed care from potentially onerous malpractice claims.

All legislative efforts, however, state or federal, are merely piecemeal measures providing patients with access to isolated minimum benefits and protecting them from some of the most destructive managed care practices. Without comprehensive national legislation guaranteeing an adequate standard of care for all, bills for almost every medical procedure and managed care practice would be required, which is an impossible undertaking. With every new piece of legislation, the managed care industry would employ a maximum of resources to contravene its purpose.

2. Germany: Consensus Model

(a) The Health Care Consensus. In 1977, a National Health Care Conference was created by law[274] for the purpose of achieving a consensus on health care management issues in order to avoid the necessity of government intervention. Its roughly 70 members represent the sickness funds, private health insurance, physicians, dentists, pharmacists, hospitals, the pharmaceutical industry, unions, employers' associations, the individual states, and the Federal Ministry of Health. The committee meets twice a year and submits recommendations for physicians' compensations, the global budgets for ambulatory and hospital care, reference prices for pharmaceuticals, and makes general cost containment and structural

274. SGB V, Art. 141. Die konzertierte Aktion im Gesundheitswesen (literally: Concerted Action Committee on Health Care). Its historical precedent was the earlier economic "Konzertierte Aktion," convened for the first time in 1967 and bringing together government, employers' associations, unions, the Independent Committee of Economic Advisers ("die fünf Weisen") and the Central Bank. Its purpose was to achieve the consensus necessary to implement the "Economic Stability Act of 1967," providing for anticyclical measures intended to ensure full employment, steady economic growth, low inflation and a healthy balance of trade. This consensus lasted until 1977 and guaranteed the much valued "social peace" and the success of the "social market economy."

reform proposals. The Conference proposals are nonbinding but have a significant impact on the regional negotiations between physicians and sickness funds.

(b) Determining the Standard of Care. Statutory health insurance as a "value-generating institution"[275] mandates an appropriate standard of care. "The quality and efficacy of the benefits to be provided by the sickness funds must correspond to the *generally recognized medical standard of care and must be in accordance with the progress of medical science*."[276] "Sickness funds and providers must insure reliable patient care according to need and the generally recognized medical standard of care. Patients must receive *adequate, appropriate and cost-effective* care, not exceeding what is required." "Sickness funds and providers must insure humane medical treatment through appropriate procedures."[277] (emphasis added)

The SGB V thus stipulates that medical science objectively determine the standard of care. It also requires cost-effectiveness but entitles patients to "adequate, appropriate treatment according to need" and cost thus is no justification for the denial of proper medical care.[278] "In this sense, medical treatment normatively is not a scarce resource: The patient is entitled to care in accordance with the applicable standard of care."[279]

But the recent innovations in physicians' compensation, which include capitated payments for some though not for all procedures, are now confronting German physicians too with allocation decisions. Depending on practice location, patient demographics and specialty, German physicians, like their American colleagues, must decide whether to curtail treatment and thus lower the standard of care or whether to provide some of the capitated procedures for free.[280] General practitioners who have less opportunity than orthopedists, for example, to implement procedures billable under the indemnity

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275. *See* FUKUYAMA, *supra* note 258.

276. SGB V, Art. 2(1).

277. *Id.* Art. 70(1) and (2).

278. I. Ebsen, *Ressourcenknappheit im Gesundheitswesen—verfassungsrechtliche Implikationen* [*Scarce Health Care Resources—Constitutional Implications*], *in* ARBEITSGEMEINSCHAFT RECHTSANWÄLTE IM MEDIZINRECHT E.V. (HRSG.), DIE BUDGETIERUNG DES GESUNDHEITSWESENS—WO BLEIBT DER MEDIZINISCHE STANDARD? [CAPPING HEALTH CARE—WHAT WILL HAPPEN TO THE MEDICAL STANDARD OF CARE?] (German Medical Law Ass'n eds., 1997) [hereinafter CAPPING HEALTH CARE].

279. *Id.* at 110.

280. The sickness funds monitor billing practices and audit physicians who exceed the budgeted amounts. No sanctions apply in cases of justified additional expenditures for the treatment of serious illnesses.

system, often end up doing so.[281] Furthermore, the SGB V entitles members to preventive care[282] but physicians now feel the need for compromise in order to provide the more urgent treatment of illness and pain.[283]

Conclusion

The American bottom-up system places an undue burden on the individual: patients must sue managed care companies to defend their contractual right to the delivery of health care. Only the most horrific cases are brought before the courts: a patient dies or is seriously injured before the emotional and financial investment into a tort liability lawsuit seems bearable. Countless other instances of managed care malpractice never reach the courts, and the true extent of human suffering remains largely unknown.

In the German top-down system, on the other hand, individuals are presumed to be protected by a highly complex health care law. Patients are neither represented in the negotiations of the National Health Care Conference nor the decisionmaking process on the regional level when sickness funds' and physicians' associations determine the financial details of the provision of medical care.[284] The patients' associations (which do exist) did not weigh in even during the numerous recent public debates on health care reform legislation.[285]

At least some protests were registered by the press when the first major reform act, the GRG of 1988, was adopted. One article reproached the Federal Minister for Health with kowtowing to the pharmaceutical industry: "Pharmaceutical manufacturers won't have to pay a single penny. But the patients do not have lobbyists. Such is the disease of our health care system."[286] Another article complained that the act was negotiated exclusively among politicians and those who had business interests at stake, i.e. the physicians and pharmacists, while the patients were doled out bite-sized pieces of information and were never allowed enough time before the adoption

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281. Dr.med. Gisela Groscurth-Galm, *personal communication,* September 27, 1998, Bochum, Germany.

282. SGB V, Art. 11.

283. H. von der Hardt, *Das Dilemma des Arztes unter dem Budget* [*The Physician's Dilemma in a Capitated System*], *in* CAPPING HEALTH CARE, *supra* note 278.

284. Interestingly, the omission of patient input seems to have escaped all German authors reviewed for this paper.

285. K. Schuler, Secretary, Health Care Committee of the Federal Parliament. *Personal communication,* October 1,1998, Bonn, Germany.

286. *13 Milliarden gespart—für die Patienten wird alles anders* [*Thirteen Billion to be Saved—For the Patients, Almost Everything Will Change*], ABENDZEITUNG, MUNICH, Nov. 11, 1988, at 2.

of the act to become familiar with its content.[287] But patients' attitudes are slowly changing, as indicated, for example, by the overwhelming public response to the sickness funds' efforts to inform members of the reform of 1988[288] and the increasing number of law suits filed with the courts.[289] Called upon to make greater individual efforts than ever before, German patients are no longer satisfied with a paternalistic system presumed to know what is best for them.

V. CONVERGENCE IN AMERICAN AND GERMAN HEALTH CARE LAW

Convergence in legal systems and regulatory approaches has been observed by many authors and in many different fields.[290] In health care as well, comparative law can analyze the origins of and the influences on the different systems of law, their development and impact on all citizens. Comparatists can point out the strengths and weaknesses of each system and suggest experimentation with some of the principles proven of value in the other country. This may mean less governmental health care regulation for Germany, and more for the United States.

As all industrialized nations are compelled to, according to Glendon,[291] both countries are already experimenting with new divisions of labor between public and private structures, requiring some adjustment of their citizens' traditional attitudes based on individualism and communitarianism. Both governments, through their recent legislative activities, have proven their awareness that elements of both are needed.[292] Currently, in the United States the

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287. *Reformaufklärung häppchenweise* [*Bite-Sized Information on Reform*], SÜDDEUTSCHE ZEITUNG, MUNICH, Mar. 29, 1989, at 4.

288. One of the large sickness funds organized seminars to inform its patients of the reforms. The program had to be canceled, however, because 100,000 participants registered and "literally flooded" the local offices. *Krankenkassen planen Informationsaktionen* [*Sickness Funds Information Campaigns*], SÜDDEUTSCHE ZEITUNG, Dec. 31/Jan. 1, 1989.

289. For further discussion, see Part V.B *infra*.

290. A.T. Von Mehren, *Some Reflections on Codification and Case Law in the Twenty-First Century*, 31 U.C. DAVIS L. REV. 659 (1998); M. Shapiro, Symposium, *The Globalization of Law, Politics, and Markets: Implications for Domestic Law Reform*, 1 IND. J. OF GLOBAL LEGAL STUDIES 37 (1993); J. Zekoll, *The Louisiana Private-Law System: The Best of Both Worlds*, 10 TUL. EUR. & CIV. L.F. 1 (1995); J.J. Norton, *The Ongoing Process of International Bank Regulatory and Supervisory Convergence: A New Regulatory-Market 'Partnership,'* 16 ANNUAL REV. OF BANKING L. 227 (1997); P.L. Lindseth, *Comparing Administrative States: Susan Rose-Ackerman and the Limits of Public Law in Germany and the United States*, 2 COLUM. J. EUR. L. 589 (1996); J.J. Friedberg, *The Convergence of Law in an Era of Political Integration: The Wood Pulp Case and the Alcoa Effects Doctrine*, 52 UNIV. PITTS. L. REV. 289 (1991).

291. *See* Glendon, *supra* note 210, at 418.

292. If an article in the *New York Times Magazine* is any indication at all, American conservatism among the intellectual elite may be undergoing radical changes and libertarians may be on the defensive. Might this "new conservatism" provide the necessary boost for resolving the

trend in health care is towards more legislative control; in Germany, the trend is towards more judicial interpretation of the SGB V and hence case law. In addition, recent legislative German efforts at health care reform have also included the introduction of market elements.

A. United States: The Need for More Comprehensive Health Care Legislation

The current piecemeal legislative efforts by the states and Congress, prohibiting only the most blatantly abusive practices of benefit denial and utilization management by the MCOs, are deemed inadequate[293] and increasingly calls are made for a universal system of health care.[294] Legislation creating a more communitarian foundation for a comprehensive and coherent system[295] combining access to health care with financing, cost-effectiveness and equity, is needed. Already in 1991, an entire edition of the Journal of the American Medical Association was dedicated to health care reform. Thirteen of fifteen articles authored by physicians advocated universal access and coverage, many of them also stressing the necessity of covering the tens of millions of uninsured Americans.[296] Grumbach[297] proposed a model for a comprehensive, single-payer plan containing many elements of the German system. Based on national legislation and the principle of federalism, such a plan would be administered by the states which would receive federal compensation according to their populations' differing actuarial risks. Patients would preserve their right to choose providers, and physicians could elect to be salaried or to practice privately on a fee-for-service basis. Global expenditure targets or caps would replace "intrusive patient-by-patient utilization review and bureaucratic interference in clinical decisionmaking."[298]

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health care crisis? "Galvanizing the right-wing intelligentsia at century's end is a different kind of conservatism altogether: much less liberal, far less economic and only nominally skeptical of government power. It is inherently pessimistic—a return to older, conservative themes of cultural decline, moralism and the need for greater social control. As much European as American in its forebears, this conservatism is not afraid of the state or its power to set a moral tone or coerce a moral order. A mix of big government conservatism and old-fashioned puritanism, this new orthodoxy was waiting to explode on the political scene when Monica Lewinsky lighted the fuse." A. Sullivan, *Going Down Screaming*, N.Y. TIMES, Oct. 11, 1998, at 48.

293. *See* Kuttner, *supra* note 269.

294. *See id.*; Richmond & Rashi, *supra* note 35.

295. BEAUCHAMP & CHILDRESS, *supra* note 1.

296. 265 JAMA (1991), Vol. 19.

297. K. Grumbach et al., *Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal*, 265 JAMA (1991), Vol. 19, at 2549.

298. *Id.* at 2553.

The single insurer could be part of a government agency or overseen by a commission elected by the public or appointed by provider and consumer representatives. Savings would be considerable because simplified administrative procedures such as billing a single payer and the abolition of case micromanagement, lower expenditures for insurance overhead, and the elimination of the profit element would make a much larger share of the premium dollar available for health care and thus offset some of the additional financing requirements.

According to Kirkman-Liff,[299] the German concept of solidarity would ensure access to health care for all segments of the population and encourage constructive negotiations between insurers and providers. Davis[300] proposed universal health insurance based in part on the strengths of the current Medicare system, i.e. its low ratio of administrative expenditures to benefits and its efficient payment methods for hospitals and individual providers. Todd[301] focused in particular on health care coverage for uninsured Americans and deplored that health care reform was not yet on the national agenda.

Today, however, the public and legislators are well aware of the current health care crisis, triggered by managed care abuses and the inefficiency of the current corporate approach to cost containment. A universal access-universal coverage system, similar to the models described above and combined with the option of private insurance, would eliminate the current four-tier system (the uninsured; recipients of government-sponsored coverage such Medicaid and Medicare; individuals covered by managed care; and those who can afford private insurance) and replace it with a more equitable two-tier system.

B. Germany: The Introduction of Market Elements and the Increasing Importance of Case Law

A number of market elements have already been integrated into the German statutory health care system. Competition among insurance carriers (the sickness funds), patients' choice between a prepaid or an indemnity system, lower premiums in exchange for a deductible, co-payments—these are approaches well-known to

299. B.K. Kirkman-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany: An Alternative Path to Universal Coverage*, 265 JAMA (1991), Vol. 19, at 2496.

300. K. Davis, *Expanding Medicare and Employer Plans to Achieve Universal Health Insurance*, 265 JAMA (1991), Vol. 19, at 2525.

301. J.S. Todd, *Health Access America—Strengthening the US Health Care System*, 265 JAMA (1991), Vol. 19, at 2503; *see also infra* note 320.

Americans. The Social-Democratic government, inaugurated on October 27, 1998, is in fundamental agreement with its predecessor on the continued necessity of market-oriented reforms. During the election campaign, the Social Democrats had already proposed additional reform efforts.[302] Sickness funds would be able to contract directly with physicians and physician networks for the purchase of specific benefits as an alternative to the collective negotiations; referrals to specialists by primary care physicians would be required; expenditures and physicians' compensations would continue to be limited to increases in sickness fund revenue, and a global budget would replace the current caps by sector; a "positive list" limiting the reimbursement of prescription medicine to those drugs with proven effectiveness would be adopted; and the panoply of benefits would be reexamined in the light of "medical necessity."

Immediately after its inauguration on October 27, the government announced proposed amendments to the SGB V.[303] Effective January 1, 1999, some of the most unpopular recent reforms were to be reversed: the $12 annual tax for the renovation of hospitals, the indemnity payments for some dental procedures, and the linkage between premium increases and higher co-payments. In addition, the government wanted to lower the co-payments for medication and reintroduce coverage for dental prosthetics for all those born after 1978. Legal proceedings against physicians who had refused to pay their penalties for exceeding the treatment budgets and prescribing guidelines were to be initiated.

But protests were swift and vehement,[304] with physicians fearing a "race to the bottom"[305] and hospitals fearing for their survival.[306] The Minister of Health, a member of the Green Party, after initially

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302. *Wahlprogramm der SPD, Kapitel Vier* (Campaign Platform of the Social Democratic Party, Chapter Four), Bonn, 1998. *Die Quadratur des Kreises* [*Squaring the Circle*], SÜDDEUTSCHE ZEITUNG, Sept. 22, 1998, at 10.

303. *SPD sucht für Kassen neue Geldquellen* [*Social-Democrats Looking for New Sources of Sickness Fund Financing*], SÜDDEUTSCHE ZEITUNG, Oct. 28, 1998, at 26; *Von Notopfer bis Zahnersatz* [*From Hospital Tax to Dental Prosthetics*], SÜDDEUTSCHE ZEITUNG, Nov. 11, 1998, at 2.

304. *Schüsse ohne Knalleffekt; Gesundheitsministerin Fischer trifft mit ihren Sparplänen auf gut vorbereitete Lobbyisten* [*Shots Without a Bang—Minister of Health Opposed by a Well-Prepared Lobby*] SÜDDEUTSCHE ZEITUNG, Nov. 11, 1998, at 2.

305. *Krankenkassen-Finanzierung nicht ändern* [*Do Not Change Sickness Fund Financing*], SÜDDEUTSCHE ZEITUNG, Sept. 21, 1998, at 24; *Das ist die Freiheit des Gefängnisinnenhofes* [*As Free as in a Prison Yard*], Interview with the Chairman of the Federal Association of Physicians, SÜDDEUTSCHE ZEITUNG, Sept. 23, 1998, at 26.

306. *Kliniken kritisieren konsequente Budgetpolitik* [*Hospitals Criticize Stringent Budgeting Plans*], SÜDDEUTSCHE ZEITUNG, Nov.9, 1998, at 23.

defending the reform projects,[307] beat a hasty retreat.[308] Planned budget cuts for the pharmaceutical industry will be reduced by half, the maximum prices for prescription medicine will not to be lowered, medication co-pay reductions will be delayed, hospitals will continue to receive renovation subsidies and budget plans for physicians and dentists will be modified. Other reform measures such as primary physician "gatekeeping" will be postponed at least until January 1, 2000, when a new "Structural Reform Act" will be adopted. This lively and dynamic public debate indicates that German health care reform is a work in progress, that the major actors of the health care system wield considerable influence—and that, once again, no one asked the patients.

The "subjects" of statutory health insurance, however, have begun to fight back, as witnessed by the increasing number of actions for benefits and malpractice lawsuits filed with the social[309] and civil courts, rising from 6,000 complaints in 1987 to 30,000 today.[310] The Federal Court of Justice[311] just lowered the causation standard for medical malpractice in cases of "fundamental error" or "gross negligence".[312] With three separate rulings, the same court also strengthened patients' rights by insisting on the importance of informed consent.[313] Two health care cases were even brought before the European Court of Justice which ruled that Germans treated abroad were entitled to reimbursement by the sickness funds.[314]

VI. CONCLUSION

Paradoxically, the greater the accomplishments of modern medical science, the greater the need for health care. The United

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307. *Die Suche nach der anderen Art Fortschritt* [*Searching for a Different Kind of Progress*], SÜDDEUTSCHE ZEITUNG, Nov. 24, 1998, at 9.

308. *Andrea Fischer korrigiert Gesundheitsreform* [*Minister of Health Modifies Health Care Reform*], SÜDDEUTSCHE ZEITUNG, Dec. 1, 1998, at 6.

309. *Sozialgerichte*. The social courts have jurisdiction over the health care system.

310. *Grenzenloses Mißtrauen* [*Unlimited Distrust*], SÜDDEUTSCHE ZEITUNG, May 20/21, 1998, at G6.

311. *Bundesgerichtshof.* The highest court in Germany with both civil and criminal jurisdiction, including medical malpractice.

312. Rulings of the Bundesgerichtshof (Federal Court of Justice): BGH, VI ZR 239/97. *Quoted in*: "Patienten können dem Arzt leichter Fehler nachweisen (Malpractice Easier to Prove)." Süddeutsche Zeitung, November 12, 1998, at 5.

313. Rulings of the Bundesgerichtshof (Federal Court of Justice): BGH, June 14, 1994, VI ZR 178/93; BGH, June 14, 1994, VIZR 260/93; BGH, February 17, 1998, VI ZR 42/97.

314. The Federal Minister of Health responded by protesting that the German health care system should not be subject to the same standards as goods traded freely within the European Union. *Gesundheit ist kein Waschpulver* [*Health Care is not a Laundry Detergent*], SÜDDEUTSCHE ZEITUNG, May 5, 1998, at 701.

States and Germany face the same problems. The differences are merely a matter of emphasis and degree, and both systems can learn from each other. An ethical vision[315] is called for in both countries to guide the inevitable choices to be made for the allocation of finite resources while preserving and enhancing equity and quality in both systems of health care. For Americans, equity will mean coverage for the 41 million uninsured[316] and access to a decent minimum for all citizens.[317] To this end, an element of redistribution of income to those of lesser means is needed; this is accomplished in Germany by premiums assessed according to patients' income, not their actuarial risk. Equity in the German system will mean limiting health care spending without disadvantaging one group of health care participants over another. Quality in both systems requires a judicious balance between the allocation of limited financial resources and an acceptable standard of care, making fair and efficient use of increasingly sophisticated and expensive medical technology.

Physicians are assigned an important role in this process. In both countries, there has been a shift away from "advocacy to allocation."[318] In the United States, managed care has imposed rationing of treatment on physicians for years and has defined standard of care according to purely economic principles. In Germany, recent reform legislation has confronted physicians with allocation decisions as well. But both American and German practitioners must be able to contribute their expertise when standards are set on a political level. In Germany, physicians already wield considerable political influence through their representative organizations.[319] In the United States, managed care has robbed physicians of most of their influence. Therefore, a new structure is needed so that they too can assist policymakers when formulating legal norms for health care.[320]

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315. J.E. Sabin, *Managed Behavioral Health Care: Is There a Basis for Optimism?*, HARV. MENTAL HEALTH LETTER 15(2), Aug. 1998.

316. *After 1994 Defeat, Clinton Pushes More Modest Health Care Plan*, WASH. POST, July 24, 1998, at A1.

317. Richmond & Rashi, *supra* note 35.

318. Iglehart, *supra* note 115.

319. Their current concern is to lose some of this influence when more negotiating power will be given to the sickness funds through the option of individual contracts with providers. *Ärzte: Pläne der neuen Regierung unakzeptabel* [*Physicians: Plans of the New Government Unacceptable*], SÜDDEUTSCHE ZEITUNG, Nov. 4, 1998, at 5.

320. *Council Report: Ethical Issues in Managed Care*, 273 JAMA (Jan. 1995); Iglehart, *supra* note 105 (quoting Dr. James S. Todd, then executive vice-president of the AMA: "One of the main strengths of the German system is the presence of formalized medical input. . . . Such formal roles for medicine in the decisionmaking process in this country are badly needed,

Patients are called upon to contribute as well. Germans must understand that more individual responsibility for their care does not mean the end of solidarity but guarantees financing to be available when needed. Americans must continue to be responsible consumers of health care even in a universal system. Individual responsibility implies self-determination and freedom from bureaucratic intervention. In both countries, towering bureaucracies currently limit individual choices: in the United States, patients are at the mercy of managed care decisions, and in Germany, the paternalistic statutory system has given them a voice. For them, a new relationship between solidarity and individual responsibility is required.[321] Regulation protecting American patients from unbridled market forces will liberate them from arbitrary managed care interference with medical treatment. Fewer administrative strictures in Germany will enhance patients' individual rights and eventually make them more active participants in the normative process.

But laws also express and protect the basic beliefs and values of a society. "Regulation is the exercise of collective power to cure market failures and to protect the public from the effects of monopoly behavior, destructive competition and the abuse of private economic power."[322] In the United States, regulation must protect the public by limiting the market forces in health care. In Germany, it must give the patients more collective power to protect themselves.

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particularly in areas such as reimbursement, appropriateness of fees, and the review of the quality and appropriateness of services.").

321. *Eigenverantwortung contra Solidarität* [*Individual Responsiblity vs. Solidarity*, SÜDDEUTSCHE ZEITUNG, May 20, 1998, at 702.

322. Egan & Wolf, *supra* note 239.