RATIONING JUSTICE

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Medicare has a backlog crisis. When Medicare refuses to cover doctor-recommended healthcare—when it rations—the claimant may seek de novo review before an Administrative Law Judge. But since Medicare started scrutinizing claims more closely in 2008, appeals are being filed four times faster than the ALJs can hear them. The queue today stands at three years, but the Medicare statute requires a decision in 90 days. Something must be done.

The Article diagnoses Medicare’s backlog crisis as a symptom of an underlying problem in the design of the coverage appeal process, to wit, the law provides the same costly and inefficient procedural protections to all appellants, even though most do not benefit from them. We offer many procedural protections (like an individualized hearing) even when they are not cost effective because of the inherent, outcome-independent value of process—the “day in court” ideal—but such protections are wasted when conferred on an appellant for whom process has no inherent value qua process. And that is the case for most Medicare appeals, 90% of which are brought by power wheelchair manufacturers, nursing homes, hospitals, and other providers who usually benefit from the appeals process only when they win.

The Article proposes “procedural justice by default” as a novel solution for this problem. Appeals should be given the full measure of procedural justice by default, but monetarily focused appellants should be incentivized with the promise of a cheaper, faster resolution and aggregation options to opt into a fast track actuarial appeals process that offers zero procedural protection and no hearing. This asymmetrically paternalistic approach would leverage differences between appellants who tend to be motivated by principle and those who tend to be motivated by money—susceptibility to status quo bias and ability to make use of economies of scale—to sift appeals for which process has inherent value from those for which it does not.

The Article concludes by exploring theoretical and substantive implications. First, adjudicatory design theory has previously

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assumed that the inherent value of process is homogeneous across appeals, but the Medicare experience demonstrates that the inherent value of process can be heterogeneous across appeals and that adjudicatory designers can use choice architecture to leverage this heterogeneity when forced by resource constraints to ration procedural justice.

Second, the “justice by default” approach to rationing procedural justice provides a blueprint for making healthcare rationing better in the private sector. The Affordable Care Act mandated a private insurance coverage appeals process, but scholars have criticized that process for failing to correct significant numbers of errors (because the volume of appeals is tiny) and for failing to help patients accept correct rationing decisions (because procedural rights are de minimis). Justice by default makes it possible to increase both effects simultaneously—error correction by incentivizing providers to act as intermediaries and acceptance by expanding procedural rights—with minimal administrative cost.
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## TABLE OF CONTENTS

Introduction .................................................................................................................. 1  

I. Rationing Healthcare in Medicare .......................................................... 5  
   A. Medicare Fee-for-Service Utilization Review ........................................... 5  
   B. Coverage Appeals to Challenge Utilization Review Decisions ............. 8  
   C. Backlog! ........................................................................................................ 10  

II. Rationing Procedural Justice in Medicare ................................................. 11  
   A. Problem: Wasted Procedural Justice ................................................... 11  
      1. Cheaper error correction ............................................................... 11  
      2. The inherent value of access as a roadblock to efficiency .................. 13  
      3. Heterogeneity in the inherent value of access ............................... 15  
         a. Instrumental theories ................................................................. 17  
         b. Mashaw’s dignitary theory: corporate dignity? ................. 19  
         c. Solum’s normative legitimacy theory .................................. 22  
   B. Solution: Rationing Procedural Justice by Default ......................... 23  
      1. Mechanics of justice by default .................................................... 25  
      2. Cost and benefits of justice by default ........................................ 27  
         a. Benefits of justice by default ............................................... 28  
         b. Costs of justice by default ................................................... 30  
   C. Counter Arguments and Concerns ....................................................... 32  
      1. Alternative solutions ..................................................................... 32  
         a. Stop rationing healthcare .................................................... 33  
         b. Precedent ................................................................................... 33  
         c. A la carte justice/ Fee-for-hearing ...................................... 35  
         d. Treat providers differently .................................................. 37  
         e. Pay for more ALJs ................................................................. 40  
      2. Statutory and constitutional considerations ................................. 40  
      3. Justice delayed is justice denied? ................................................. 41  

III. Rationing Justice Beyond Medicare .................................................... 41  
   A. Access Value Heterogeneity and the Design of “Mass Justice” ..... 42  
   B. Accuracy and Acceptance in the Rationing of Healthcare ....... 45  

Conclusion ............................................................................................................... 52
INTRODUCTION

Healthcare is a scarce resource. We do not—and likely could not possibly—commit enough money to healing people to give every person all the care that might possibly heal.¹ So we have to triage by making choices about what healthcare is worthwhile.² Call it “eliminating waste” or “cost effectiveness” or “evidence based medicine,” we have to ration healthcare.³

Doctors and patients are well positioned to decide when healthcare is worthwhile in a particular case, but not well incentivized. As a result, Medicare, like other insurers, itself refuses to pay on a case-by-case basis for some doctor-recommended (and patient-desired) healthcare. The process by which insurers do so is known as utilization review.

¹ See MAXWELL GREGG BLOCHE, THE HIPPOCRATIC MYTH: WHY DOCTORS ARE UNDER PRESSURE TO RATION CARE, PRACTICE POLITICS, AND COMPROMISE THEIR PROMISE TO HEAL (2011) (“Medicine’s therapeutic potential has surpassed our ability to pay for it, but our elected officials are afraid to tell us.”); MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS at 3-4 (1997) (“medical advances” will not “eventually reduce medical spending by making people fundamentally healthier” because “[m]edical needs are inherently limitless”).

² HALL, supra note 1 at 5 (“most policy analysts recognize that rationing in some form is desirable and inevitable . . . [w]e have always rationed health care resources on a massive scale”).

³ In political discourse the word “rationing” is reserved to describe an opponent’s healthcare triage proposals, never one’s own (or current practice). The sensitivity of the word is why Professor Hall self-consciously uses the term “medical spending decisions” rather than “rationing decisions” in his book-length treatment of the subject. Id. (“In order to avoid drawing the fire of those who oppose any use of this term, I will instead lean toward the more neutral terminology of resource allocation or spending decisions.” (emphasis in original)). Persuaded by Professor Bloche that transparency here will improve discourse in the long run, see, I stick with “rationing.” And I use the term in its broadest sense to include any decision to forego healthcare that someone thinks could possibly benefit the patient. Cf. RATIONING HEALTH CARE: HARD CHOICES AND UNAVOIDABLE TRADE-OFFS at 7 (Andre den Extern & Martin Buijsen, eds.) (discussing narrow to broad “notions of health care rationing”). So understood, rationing is already commonplace in our healthcare system. See supra, notes 1 and 2. Note, on this point, that even “wasted” care may be somewhat beneficial—or be thought to have been before it was delivered. See Nicholas Bagley, Bedside Bureaucrats: Why Medicare Reform Hasn’t Worked, 101 GEORGETOWN LAW J. 519 (2013).
At its best utilization review allows Medicare not only to ensure that scarce medical dollars are spent where they are most needed, but also to save patients the risk and physical toll of unnecessary treatments. But utilization review has significant downsides. Reviewers can be biased against coverage, and adverse coverage decisions can be hard for patients and providers to swallow. Try telling a patient who believes she needs a motorized wheelchair, or an experimental chemotherapy drug, or a nurse to care for her at home—and whose doctor agrees—that she cannot have it because a third party reviewer, who she has never met, thinks she and her doctor are wrong.

The tool we use to try to fix the problems posed by rationing through utilization review is a common one in our legal system, namely, adjudicatory process. To combat the threat of bias and encourage acceptance of utilization review decisions, Medicare, like other insurers that engage in utilization review, offers a right to appeal adverse coverage determinations to an independent adjudicator. The idea is that errors will be identified and corrected on appeal, and even when not successful the act of appeal will make the disappointed appellant more comfortable with the outcome. Furthermore, the prevailing view among scholars who study rationing in healthcare and allocation of government “new property” entitlements generally is that to be “just,” a coverage decision must be subject to due process protections. Sounds good, but there is a problem with this solution.

Procedural justice is also a scarce resource. In Medicare and other adjudicatory systems characterized by what Judge Friendly called “mass justice,” there are insufficient resources and stakes, and too many appeals, to give every appellant the full measure of civil justice. Indeed, the Supreme Court has recognized as much in repeatedly upholding Medicare’s administrative exhaustion requirements.

Today, appeals are being filed four times faster than Medicare’s Administrative Law Judges can hear them. The statute says nothing about how to deal with such a problem, so we are now rationing procedural justice in Medicare the way systems for doling out scarce resources tend to ration when they fail to do so consciously, with long lines. An appeal filed today will have to wait three years for a hearing, and four for a decision. If something is not

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done, an appeal filed in 2015 will have to wait until 2020 for a hearing. The statute, for what it is worth, mandates a decision in 90 days.

Something must be done, but no solution to the backlog is in sight. The Office of Medicare Hearings and Appeals (OMHA), the responsible component of the Department of Health and Human Services, has announced an intention to call for proposals, but completion of that process, let alone an actual workable solution, remains far off.

This Article proposes a solution to Medicare’s backlog problem, a way to fix Medicare’s coverage appeals process and, thereby, Medicare fee-for-service utilization review. By default Medicare claimants should be given all the procedural protections that they currently receive, and then some (hearings should be in person, not by videoconference). But claimants should be allowed to opt into a fast-track review process that guarantees neither a hearing, nor an explanation, nor even an individualized determination, but only an expeditious decision. These changes will leverage differences between claimants who stand to benefit most from procedural protections and those for whom process has little or no inherent value—susceptibility to status quo bias, ability to utilize economies of scale, and a desire for fairness—to reduce dramatically the cost of most appeals while preserving expensive procedural protections where they matter. In short, the procedures should be redesigned to better ration procedural justice.

This proposal reflects two insights about adjudicatory design that, in addition to the proposed fix for Medicare’s appeal backlog, compose the Article’s primary contribution. First, however it is understood, the inherent, outcome-independent value of procedural protections varies from claim to claim. So under conditions of process scarcity adjudicatory procedures should be designed to treat claims differently, providing otherwise-inefficient individualized treatment only to those appellants for whose claims process has most inherent value.

Like most adjudicatory processes, healthcare coverage appeals are intended to serve two goals: (1) efficient identification and correction (and thereby prevention) of erroneous decisions, and (2)

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satisfaction of the denied claimants’ demand (some would say right) for an opportunity to be heard. These goals of efficiency and access, procedure scholars know well, are in tension\(^7\); the latter requires costly, individualized hearings even when the former does not. But in Medicare, at least, many appeals do not serve this inherent access value. For example, otherwise inefficient procedural rights granted to a wheelchair manufacturer that appeals thousands of denied claims each year, purely in hopes of a profit, are wasted effort.

The second theoretical insight underlying the Article’s proposed fix to Medicare’s backlog crisis has to do with the method for sorting cases in which an individualized hearing adds value from those in which it does not. Just as procedural rules can be designed to cause claimants to sort among themselves for case quality, for example, by raising the filing fee to cause frivolous claims to weed themselves out by self-selection, rules can be designed to cause claimants to sort themselves based on their likelihood to benefit from an individualized hearing.

Rules may of course cause claimants to sift among themselves actively, say, by charging for the cost of a hearing. But where that approach is insufficient or problematic (the Article explains why that is the case in Medicare), rules may be designed to trigger passive sifting. The Article demonstrates one way this can be done, that is, by allowing claimants to opt out of procedural rights in exchange for the promise of a faster resolution. By making procedural justice the default, such a rule leverages status quo bias—the behavioral tendency to follow the path of inertia, which at least in Medicare disproportionately affects those who benefit most from an individualized hearing—as a claimant sifting mechanism.

Part I offers background on utilization review as a means of cost and quality control in Medicare and discusses the history of Medicare’s growing backlog of appeals. Part II identifies the provision of costly procedural protections to the substantial majority of appellants who do not benefit from those protections as a but-for cause of Medicare’s appeal backlog. It then proposes to fix this problem by re-designing the appeal procedures to cause appellants to sift appeals that benefit from procedural justice from those that do not. The primary sifting mechanism the Part offers is the “justice by default” approach, which plays off of the correlation among Medicare appellants between susceptibility to status quo bias and need for individualized treatment, but the Part also proposes to bolster the sifting effect by making uses of other systematic differences, including ability to make use of economies of scale and repetitive involvement in the process. Rationing procedural justice in this way

\(^7\) E.g. Solum, supra note 6 at 313 (“[i]ndividual participation is costly”).
would allow for the cheap and expeditious resolution of most appeals, without denying full procedural protections for appellants who might benefit from them. Last, Part II addresses counter arguments to and concerns about the justice by default approach in Medicare.

The solution this Article offers has the potential to do more than fix Medicare’s backlog problem. The possibilities of directing procedural justice to those cases for which it has most value, and of leveraging status quo bias to accomplish that goal by offering justice by default, have broader theoretical and substantive implications for adjudicatory design. These are discussed in Part IV. First, a theoretical implication: adjudicatory design scholarship should no longer assume the inherent value of participation is homogenous across claims, or that rules cannot constructively make use of the heterogeneity across claims, especially under conditions of “mass justice.” Second, a substantive implication: the proposed Medicare fix makes adjudicatory process a viable tool for generating accurate and acceptable rationing of healthcare; this model could usefully be applied to make healthcare rationing work better in private insurance as well. Finally, I offer some concluding thoughts.

I. RATIONING HEALTHCARE IN MEDICARE

A. Medicare Fee-for-Service Utilization Review

Healthcare, to state the obvious, can be expensive. Add to that the facts that the demand for healthcare is universal and that most of us do not like the idea of people who cannot afford healthcare having to go without, and you have the makings of an especially tricky “who decides” question. We are unable (or unwilling) to pay for every drug, procedure, or treatment that could possibly help, but our usual tool for doling out scarce resources—the invisible hand of the market—is of limited use, handicapped by our desire to shield people from healthcare costs.

Medicare, like most payers, has long relied on the medical profession to decide when healthcare is worth it. Indeed, the profession’s initial support for the Medicare program was bought with the promise that the program would not interfere with the practice of medicine, which promise is still reflected in the statute.8

8 “Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such
Medicare defers to the medical profession’s rationing choices by excluding any drug, treatment, device, or service that the profession determines it will not endorse, for example, Medicare will usually not pay for mental health treatment for symptoms or using a method not recognized in the DSM.\(^9\) The profession for the most part focuses on the effectiveness of a treatment in deciding whether it is worthwhile, not its cost, but cost considerations often play a role.\(^10\)

In addition, Medicare charges each beneficiary a small copay designed to give her some financial incentive to avoid wasteful healthcare. Many beneficiaries circumvent this incentive effect by purchasing a Medicare supplement plan.

Medicare decided decades ago that doctors and patients alone do not do enough to limit healthcare costs. So Medicare began cautiously deciding for itself in some cases whether doctor-recommended and patient-desired healthcare is really worth it. As to the portions of Medicare governed by the prospective payment system (mostly inpatient hospital care), Medicare attempts to cut back on healthcare by tying hospitals’ compensation for treating Medicare beneficiaries to their ability to cut costs.\(^11\) In the portions of Medicare at issue here, those governed by the fee for service payment system (mostly outpatient care), Medicare does so through utilization review.

In Medicare, as in private insurance, utilization reviewers often deny coverage on the basis of a specific exclusion in Medicare regulations (or the insurance contract). But more often, coverage is denied upon the determination that the desired treatment or service is not “medically necessary.” “Medical necessity” is a term of the art of medicine,\(^12\) on which coverage depends both in private insurance

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\(^10\) See BLOCHE, supra note 1.


(by way of contract) and in Medicare (by way of statute). It means little more than “judged to be worthwhile.”\(^\text{13}\)

In some cases, utilization review in Medicare is prospective, that is, it happens before care is delivered. For example, a beneficiary who wants a motorized wheelchair in many cases must get approval from a Medicare Administrative Contractor (usually an insurance company) before purchasing the device.\(^\text{14}\) For beneficiaries who elect to receive their Medicare coverage through a private insurance company as part of the Medicare Part C program, such prior authorization requirements are more common. The same is true in Medicare Part D, which governs coverage for pharmaceuticals.\(^\text{15}\)

Often, though, Medicare utilization review is retrospective, happening after delivery. Either the beneficiary submits a claim for reimbursement or the provider does so, having taken “assignment” of the claim as a condition of service. A provider that takes assignment of a claim cannot charge the beneficiary if the claim is denied; if a beneficiary’s claim is denied then she usually must bear the cost herself.\(^\text{16}\)

Whether performed prospectively or retrospectively, utilization review affects Medicare beneficiaries’ ability to get healthcare they want. The former does so directly, the latter by influencing the ex ante choices of beneficiaries and especially providers. For example, when Medicare began retrospectively reviewing hospital admissions more closely in 2008, hospitals responded immediately by denying new patients inpatient admission on the margins.\(^\text{17}\) According to some consumer and provider

\(^{13}\) See id.; HALL, supra note 1 at 4 (“As interpreted in practice, ‘medically necessary’ lacks sufficient independent meaning to set a solid limit on how we spend health care resources.”).


\(^{16}\) Pursuant to 42 U.S.C. § 1395pp, the beneficiary is not required to pay if she did not have reason to know coverage would be denied.

\(^{17}\) Zhanlian Feng et al., *Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns about Causes and Consequences*, 31 HEALTH AFF. (MILLWOOD) 1251 (2012).
advocates, Medicare went too far, so hospitals did as well, leading hospital to deny thousands of beneficiaries hospital admission that would have helped them, for fear of a subsequent denial of coverage.\textsuperscript{18}

B. Coverage Appeals to Challenge Utilization Review Decisions

The law mandates that an adverse coverage decision may be appealed (through several steps) to a \textit{de novo} hearing before an Administrative Law Judge. The ALJ’s decision may be appealed to federal district court, but the district court sits in an appellate capacity, giving the ALJ substantial deference, so the ALJ’s decision is for most appeals the last meaningful chance for review.\textsuperscript{19} Indeed, because review of the ALJ’s decision is a question of law, not fact,\textsuperscript{20} the district court can always resolve the case on motions, making the ALJ level the last chance for a live hearing.

The legal right to an individual hearing afforded by the Medicare statute (and implementing regulations) is consistent with the constitutional demand of due process for deprivation of “new” property governments, of which the Medicare statute’s promise of healthcare coverage is one.\textsuperscript{21} Furthermore, health law scholars have argued that the right to an individualized appeal is a pre-requisite to just rationing of healthcare.\textsuperscript{22}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{18} See Bagnall v. Sebelius, 2013 WL 5346659 (D. Conn. 2013); cf. Mary D. Naylor et al., \textit{Unintended Consequences of Steps to Cut Readmissions and Reform Payment May Threaten Care of Vulnerable Older Adults}, 31 \textit{HEALTH AFF.} (MILLWOOD) 1623 (2012).
\item \textsuperscript{19} E.g. Arruejo v. Thompson, (EDNY, 2001) (upholding denial of coverage for anesthesia for UGI endoscopy); Bosko v. Shalala (W.D. PA, 1996) (deferring to administrative determination about Medicare coverage for bone marrow transplant).
\item \textsuperscript{20} Igonia v. Califano, 568 F.2d 1383, 1387 (D.C. Cir. 1977).
\item \textsuperscript{22} Norman Daniels & James E. Sabin, \textit{Setting Limits Fairly: Can We Learn to Share Medical Resources?}, OUP CAT. (2002) (insurers, whether public or private, should do four things in making coverage determinations: (1) ensure decisions are publically available; (2) ensure decisions focus on the health needs of the beneficiaries; (3) offer a right to revise or appeal decisions; and (4) follow a set of rules in meeting first three criteria). On the subject of appeals in particular, Daniels and Sabin make the case for robust internal
\end{itemize}
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As for (more) details about the procedures, the law requires a disappointed beneficiary (or provider on assignment) to be notified of her right to appeal when she is informed of an adverse coverage determination. She must appeal within 60 days, and first exhaust internal administrative appeals before obtaining an ALJ hearing. Once a beneficiary or provider properly requests a hearing, the law requires one be held within 90 days. Otherwise, the claimant may seek de novo reconsideration of the coverage determination in federal court. Pursuant to regulation, hearings are presumptively held by videoconference or telephone; a hearing may be held in one of the four cities that host ALJs if the ALJ determines that “extraordinary circumstances” warrant it.

Finally, some details about the appellants. Eleven percent of appeals are filed directly by beneficiaries challenging a coverage determination, with the remaining 89% filed by either providers or state Medicaid organizations. (State Medicaid agencies often appeal a denial of Medicare coverage for a dual-eligible beneficiary because if Medicare refuses coverage the Medicaid agency must pay.) Providers include hospitals, nursing homes, durable medical equipment manufacturers (like the now-defunct “Scooter Store”), and

and external dispute resolution procedures to minimize the need for external dispute resolution procedures. *Id.*

23 42 C.F.R. § 405.1014.

24 42 C.F.R. § 404.1016.

25 42 C.F.R. § 405.1020(b). *See also “When is a Hearing Not a Hearing,”* (“The Center for Medicare Advocacy has repeatedly attempted to obtain in-person hearings for our clients since the new system was launched, and has repeatedly been denied. In the few cases where in-person hearings were reluctantly granted, they were scheduled at one of the 4 remote sites -- imposing such burdensome and expensive travel requirements that attendance for Medicare beneficiaries is virtually impossible.”), available at [http://www.medicareadvocacy.org/News/Archives/Reform_InPersonHearings.htm# edn2](http://www.medicareadvocacy.org/News/Archives/Reform_InPersonHearings.htm# edn2); Kathleen Scully-Hayes & Daniel A. Cody, *A Practical Guide to Medicare Appeals* (American Bar Association, 2007), available at [http://books.google.com/books?hl=en&lr=&id=2phnAfaZrmIC&oi=fnd&pg=PR13&dq=a+practical+guide+to+medicare+appeals&ots=xD1MvH2vRe&sig=yWUJ_WPU3gUXXKnKAFNhFvo20g](http://books.google.com/books?hl=en&lr=&id=2phnAfaZrmIC&oi=fnd&pg=PR13&dq=a+practical+guide+to+medicare+appeals&ots=xD1MvH2vRe&sig=yWUJ_WPU3gUXXKnKAFNhFvo20g) (“the Rule requires that hearings be conducted by [video teleconference] if such technology is available”). Furthermore, an appellant must waive their right to a decision in 90 days as a condition of requesting an in-person hearing. *Id.* As a result, Medicare currently has a system in which the “faster,” less-protective track is the default.
practitioners. The subject matter of appeals varies widely; disputes reflect disagreements about a patient’s need for a motorized wheelchair, inpatient hospital admission, off-formulary drug, home health or rehabilitation services, particular treatment (like a bone marrow transplant or gender reassignment surgery), and so on.

C. Backlog!

In 2008, in an effort to stem rising Medicare costs, Congress instructed the Secretary of Health and Human Services to step up her cost control efforts. That has led to a dramatic increase in Medicare fraud and abuse enforcement activity. It also led to greater scrutiny on fee-for-service claims and, with it, a swell in coverage denials. Today appeals are being filed four times faster than the administrative process can hear them. Half a million appeals are currently waiting for a hearing (the federal courts process fewer civil cases in a year), and that number grows day by day. These include appeals by beneficiaries (11%), state Medicaid agencies (3%) and providers (85%).

As a result of this backlog, an appeal filed today won’t be heard for three years, and at the rate the backlog is growing an appeal filed next year won’t be heard for five. Appellants have threatened

26 OIG Report, “Improvements,” supra note __.

27 Julie E. Kass & John S. Linehan, Fostering Healthcare Reform through a Bifurcated Model of Fraud and Abuse Regulation, J HEALTH LIFE SCI FEBR. 2 (2012)


29 OMHA Appellant’s Forum, Slides, February 12, 2014.


31 See Dec. 24, 2013 Memorandum to OMHA Medicare Appellants, Department of Health and Human Services, online at __.
legal action, pointing to the statutory mandate of a decision in 90 days. Something has to give.

II. RATIONING PROCEDURAL JUSTICE IN MEDICARE

A. Problem: Wasted Procedural Justice

ALJ hearings are not the most cost-effective way to identify and correct utilization review errors. As elaborated upon in subsection 1, a number of reforms could produce greater error-correction bang for the administrative buck, from statistical sampling to paper hearings.

But, as explained in subsection 2, our reason for offering claimants access to an individualized hearing before an ALJ is not efficiency. We do so because we believe these procedural protections are valuable for their own sake.

That there is a tension between efficiency and access—in Medicare or anywhere—is hardly a novel insight about procedural design. But this is: In many Medicare coverage appeals, there is no such tension, because access has no inherent value (or reduced value). So, as elaborated upon in subsection 3, the procedural protections expended in many Medicare coverage appeals simply go to waste. If we can find a workable way to sort appeals where procedural protections have inherent value from those in which they do not—Part II.B. proposes such a way—we can reduce the cost of processing coverage appeals and solve Medicare’s backlog.

1. Cheaper error correction

32 See Letter from American Hospital Association to Marilyn Tavenner re: Significant Delay in Assignment of Hospital Appeals to Administrative Law judges, January 14, 2014, available online at __.

33 42 U.S.C. § 1395ff; 42 C.F.R. 405.1016. See also Shakhnes ex rel Shakhnes v. Eggleston, 740 F. Supp. 2d 602 (S.D.N.Y. 2010) (ordering New York’s Medicaid program to comply with statutory mandate for processing Medicaid appeals). It is unclear that legal action would be successful. The Medicare statute includes a section with the heading “consequences for failure to meet deadlines” that explains that if an ALJ decision is not reached within 90 days, the claimant may appeal directly to the final step of the administrative appeals process, the Departmental Appeals Board, and then to district court. On one plausible reading of the statute, Congress intended this “consequence[]” to be the exclusive remedy for a failure to meet the 90-day deadline.
Medicare receives more than a billion coverage claims each year.\textsuperscript{34} It denies about five percent of them.\textsuperscript{35}

We currently provide each claimant who disagrees with a denial the option of \textit{de novo} reconsideration of each denied claim, after a hearing before an independent arbiter, an ALJ. If the goal of this system were only the inexpensive identification and correction of errors, then there would be substantial room for improvement.

Numerous reforms could provide better error-correction bang for the administrative buck. The most significant savings could be achieved by doing away with individualized determination of appeals altogether. Statistical sampling techniques (what Robert Bone calls “actuarial litigation”) could be used in order to determine the error rate for groups of appealed claims—say, knee brace claims in a given geographic region—with reimbursement in the run of claims based on the rate of success for analogous claims in the sample.\textsuperscript{36} Just as sampling and bellwether trials are used to resolve thousands of claims in federal court and alternative dispute resolution,\textsuperscript{37} such a method could create substantially the same aggregate accuracy, and accompanying incentive effects on utilization reviewers, as individual treatment for a fraction of the cost.

Even without sampling, individual adjudication could be streamlined significantly. The right to a hearing could be done away with except for those cases in which the decisionmaker believes it might be worthwhile. When it comes to Medicare coverage disputes, the usefulness of a hearing for getting decisions “right” (assuming there is one right answer to judgment calls about healthcare) is dubious at best.\textsuperscript{38}


\textsuperscript{38} See Office of Medicare Hearings and Appeals, statements of Deputy Chief Administrative Law Judge C.F. Moore and Administrative Law Judge
Furthermore, appellants currently submit so much additional evidence before the ALJs that, due to the volume of appeals, ALJs are literally running out of space in which to work. Managing this flood of evidence takes significant effort that could be avoided either with a hard cap on evidentiary submissions or a per-page filing fee.

Such methods have been used to achieve aggregate efficiency in resolving claims in other areas of the law. The insurance subrogation system for auto insurers and Medicare’s approach to monitoring its administrative contractors’ reopening decisions are recent examples. Furthermore, mass-disaster relief programs like the 9/11 victims fund have used their own creative approaches to distribute funds efficiently, arguably without sacrificing procedural justice for those who demand it. The barrier to more efficient processing of appeals is not feasibility.

2. The inherent value of access as a roadblock to efficiency

Our commitment to procedural justice, not feasibility, stands in the way of more efficient identification and correction of utilization review errors in Medicare. The inherent, outcome independent value of process—the value of the “day in court”—can be understood in several ways, including its capacity to re-affirm the dignity of the aggrieved, as Mashaw understands it, as a condition of the


The OMHA is working on adopting an electronic filing system, which it hopes will alleviate some of the paper burden.

Palomar Medical Center v. Sebelius, 693 F.3d 1151, 1165 (9th Cir. 2012).


MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE, supra note 6 (discussing “calls for the abandonment of positivist, utilitarian, or instrumentalist perspectives” in favor of “elaboration of dignitary values”); JERRY L. MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS (1983) (rejecting accuracy as criterion for evaluating administrative dispute resolution processes); (“intrinsic”
normative legitimacy of an adjudicatory body, as Solum does, as satisfying a “preference for fairness,” as Shavell and Kaplow understand it, or as the capacity of process to generate acceptance, as I argue elsewhere. But however it is understood, the idea that process is inherently valuable counsels against reforms that trade access for efficiency.

Skeptics doubt that process has inherent value, pointing to, among other things, the lack of consensus about the precise nature of this inherent value and people’s willingness to contract their procedural rights away. But whatever one thinks of the inherent value of access, any solution to Medicare’s backlog problem must give the idea its due. Because the Medicare statute’s promise of healthcare coverage creates a constitutional entitlement, the Due Process Clause of the Fifth Amendment dictates coverage cannot be denied without affording, at least, the right to an individualized hearing. Furthermore, the consensus among scholars of rationing


Solum, supra note 6.

KAPLOW & SHAVELL, supra note 6.


Solum, supra note 6 at 265 n. 213 (collecting sources); KAPLOW & SHAVELL, supra note 6 at 228 n.6 (2002).

that an individual appeal is a necessary component of any rationing program appears to be embedded in the design of the procedures and policymakers’ understanding of the appeal system’s purpose. 49
When, in the 1980s the procedures were made to deny an ALJ hearing for fee-for-service appeals arising in Medicare Part B (governing outpatient care), the resulting outcry led to the right to a hearing now embedded in the statutory text. 50

In addition to concerns about “just” rationing, acceptance is especially important for the operation of Medicare because research shows that beneficiaries’ willingness to make use of a public entitlement program depends to a significant extent on the trust that they put in the operation of the program. 51 Indeed, the Centers for Medicare and Medicaid Services—the agency responsible for administering Medicare—itself has listed generation of acceptance of adverse coverage decisions as a primary purpose of the appeals process, justifying the cost of a related program by reference to the capacity of a “full[] and fair[] system of claims and appeals processing” to “facilitate enrollee acceptance of cost management efforts.” 52

3. Heterogeneity in the inherent value of access

49 See Daniels & Sabin, Setting Limits Fairly, supra note 22; TIMOTHY JOST, HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY: AN INTERNATIONAL COMPARATIVE STUDY (2004); Mark A. Hall & Gerard F. Anderson, Health Insurers’ Assessment of Medical Necessity, UNIV. PA. LAW REV. 1637 (1992)(making case that independent reviewers should be empowered to reconsider coverage decisions on a case-by-case basis, but arguing against relying on courts to perform this function).

50 ELEANOR D. KINNEY, GUIDE TO MEDICARE COVERAGE DECISION-MAKING AND APPEALS 68 (2002) (“By the mid-1980s, there was much concern about the fact that beneficiaries with Part B appeals did not have statutory administrative and judicial review.”).


Medicare, it has been said, is complicated. True enough. Indeed, according to empirical analysis, the provision of the U.S. code governing Medicare is more complicated than any other.\(^{53}\)

But when it comes to adjudicatory design, to weighing the costs and benefits of rules of procedure, Medicare is relatively simple. Unlike the Federal Rules of Civil Procedure, Medicare is bound by no trans-substantivity mandate. It offers Part D sponsors whose contracts are terminated one set of procedures,\(^ {54}\) hospitals who disagree with their prospective payments another,\(^ {55}\) and, relevant here, beneficiaries (or providers on assignment) who disagree with the denial of a request for fee-for-service reimbursement a third set of rules.\(^ {56}\)

The inherent, outcome dependent value of an appeal can depend, according to some views, on its substance. The individual dignity at issue in a personal injury case, for example, might be far greater than that at issue in a property dispute.\(^ {57}\) Even if the outcome of each case is of equal importance, there might be more inherent value to giving the constitutional claimant a “day in court” than in giving the offeree the same right.

Because we need account for only limited substantive variation in designing Medicare fee-for-service appeals, the exercise of assessing the inherent value of process for various sorts of Medicare coverage appeals is much more manageable than would be a similar exercise applied to the Federal Rules. There are still two dimensions that must be accounted for, however. First, there are at least four leading theories of why adjudicatory process might have inherent value in the first place. To avoid taking sides, a full analysis must analyze the extent to which particular cases advance such inherent value as to each theory. (For simplicity, the subsections that follow group these into instrumental and non-instrumental theories.)

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\(^{54}\) 42 C.F.R. 423.500 *et seq.*

\(^{55}\) 42 C.F.R. § 405.1800 *et seq.*

\(^{56}\) 42 C.F.R. § 405.1020 *et seq.*

Second, appeals vary in several ways that could be relevant for assessing the inherent value of process. These are: (1) whether a claim is brought directly by a provider (such as a hospital or a durable medical equipment manufacturer) on assignment or by a beneficiary (ninety percent of appeals are provider-initiated)\(^{58}\), (2) whether the appellant is represented or pro se, (3) whether the appeal is pre-treatment or post-treatment, (4) whether the appellant is motivated to appeal only by money or also by principle that is, the desire to correct a perceived unfairness,\(^ {59}\) and (5) whether the appeal is brought soon after the denial of coverage, or long after.

The subsections that follow analyze the extent to which these variations among types of appeals affect the inherent value created when they are heard. In short, they show significant variation among claims, especially between provider- and beneficiary-directed claims.

Therefore, no matter how the access value is understood, many Medicare appeals—in particular many appeals brought by providers—do little or nothing to advance it. Procedural protections provided solely for process’ sake in such appeals are wasted.

a. Instrumental theories

David Rosenberg, Louis Kaplow, and Steven Shavell model the inherent value of process as its capacity to satisfy a “taste for fairness.”\(^ {60}\) That is, to the extent that a person prefers to be treated

\(^{58}\) Dep’t of Health and Human Servs., Office of the Inspector General, Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals at 8(Nov. 2012) (in FY 2010 beneficiary appeals were 11% of total volume).

\(^{59}\) Individual litigants outside of Medicare report in surveys that their reasons were suing were principled, that “it is not about the money!” See, e.g., Tamara Relis, It’s Not about the Money: A Theory of Misconceptions of Plaintiffs’ Litigation Aims, 68 U Pitt Rev 701 (2006); Those self-descriptions are consistent with empirical observations of claiming behavior. David M. Studdert et al., Negligent Care and Malpractice Claiming Behavior in Utah and Colorado, 38 Med. Care 250 (2000); Fredrick Dunbar & Faten Sabry, The Propensity To Sue: Why Do People Seek Legal Actions?, 42 Bus. Econ. 31 (2007); Herbert M. Kritzer, Propensity to Sue in England and the United States of America: Blaming and Claiming in Tort Cases, J. Law Soc. 400 (1991).

\(^{60}\) Kaplow & Shavell, supra note 6 at 21 (individuals have “taste for a notion of fairness, just as they have a taste for art, nature, or fine wine”); David Rosenberg, Individual Justice and Collectivizing Risk-Based Claims in Mass-Exposure Cases, 71 NYU L. Rev. 210 (1996). See also Michelman, Associational Aims in Procedural Due Process, supra note 42
fairly, an adjudicatory process that is perceived to be fair satisfies that preference, and so creates value in the same way as the consumption of a sandwich, or enjoyment of the ballet. In another paper, I have offered a supplement to Kaplow and Shavell’s theory that (1) notes that process not only satisfies a preference but alters one insofar as, by treating a person in a way she views to be fair, process can lessen a person’s negative emotional reaction to an adverse event; and (2) highlights the fact that this value, like the possibility that someone will suffer an adverse emotional reaction, is probabilistic and uncertain ex ante.61

On either instrumental theory, the inherent value of procedural rights can vary a great deal from case to case. Specifically, if an appellant does not believe she was treated unfairly, but appeals only in hopes of obtaining a monetary benefit, then process has no inherent value; there is instrumental benefit to such an appellant’s appeal only if she wins.

In Medicare, appeals with certain features are more likely to have been brought for purely monetary reasons than other appeals. Providers appeals are of this type, both because providers are better equipped to select appeals that are likely to succeed and because providers, as repeat players, are on net less likely to take a denial in a particular case as a personal affront.62 Indeed, a provider appeal brought by a corporation (with the possible exception of closely held corporations) is certain to have no inherent instrumental value, because directors motivated to appeal by a taste for fairness would violate their duty to their company’s shareholders.63 In FY 2010, one-third of appeals were filed by 96 providers, who filed between 100 and 1,000 appeals each.64 Some of these providers appealed every denial they received.65


62 This consideration does not apply to an appeal brought by an individual physician, rather than a hospital or durable medical equipment company, insofar as an individual physician might view the denial as a professional affront. However, among provider appeals, the vast majority are brought by institutions not individual physicians.

63 The exception would be a closely-held corporation, like Hobby Lobby.

64 OIG Report, “Improvements,” supra note __ at 8.
Moreover, we should not assume that beneficiary appeals are automatically brought for principled reasons. Some beneficiaries may themselves be repeat players who appeal strategically.  

Furthermore, appeals brought long after a denial of coverage are relatively less likely to reflect a principled objection than appeals brought soon after. This is because of hedonic adaptation—the tendency for people’s adverse emotional reactions to diminish over time.  

In addition, a pro se appeal is relatively more likely to be brought for principled rather than monetary reasons. This is so because attorneys may, hoping for monetary benefit, instigate otherwise disinterested appellants to appeal. It is also so because the fact that an appeal is pro se is some indication that the appellant was unable to find representation (although the case may be pro se for other reasons), which is some indication (albeit not a definite signal) that no attorney found the case monetarily viable. That means the appellant is more likely to be motivated by fairness than money.  

Finally, beneficiary-driven appeals are on net more likely to derive value from process qua process than provider-driven appeals because beneficiaries are also patients, which means they are sick (or at least in need of healthcare). Sickness is an “ontological assault” that makes one’s identity especially vulnerable.  

b. Mashaw’s dignitary theory: corporate dignity?

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65 Id.  

66 E.g. See Children with diabetes forum, (“Appeal, appeal, appeal. Let me tell you, they killed a whole forest of trees with their denial letters when I had premature triplets in the NICU...they denied routine things for all kinds of crazy reasons. I learned to appeal...early and often.”) Online at http://forums.childrenwithdiabetes.com/showthread.php?70915-Insurance-has-denied-coverage-for-growth-hormone  

67 Hedonic adaptation is the tendency of a person’s dissatisfaction with an adverse event to (in some cases) diminish naturally over time. (“Time heals all wounds.”). Cf. John Bronsteen et al., Hedonic Adaptation and the Settlement of Civil Lawsuits, 108 COLUMBIA LAW REV. 1516 (2008). But see “justice delayed is justice denied.”  

68 See HALL, supra note 1 at 36 (“Illness . . . undermines one’s personal identity by attacking the fundamental unity of mind and body); id. at 36-37 (collecting sources).
Many scholars believe that process has inherent value by virtue of the capacity of participation to affirm the dignity of an individual; Jerry Mashaw’s articulation of this dignitary theory in “Due Process and the Administrative State” is the most well known version of this theory.\(^6^9\) Surprising, in light of this prominence, is the fact that no one has explored whether corporations have “dignity” of the sort that makes procedural rights inherently valuable, notwithstanding that corporate entities are so often claimants.\(^7^0\) So there are no scholarly shoulders on which to stand in exploring whether Medicare appeals vary in their inherent value on Mashaw’s dignitary theory.

A close reading reveals that Mashaw’s dignity-based theory makes the inherent value of process ultimately instrumental, albeit not consequentialist; process has value qua process by virtue of its capacity to “nurture[] or suppress” deontological dignitary values “such as autonomy, self-respect, or equality.”\(^7^1\) So, on Mashaw’s theory, process has zero inherent value if providing it in a case does not further anyone’s “autonomy, self-respect, or equality,” and the degree to which process has inherent value in a case is a function of the degree to which it furthers these dignitary values.\(^7^2\)

So the inherent value of process can vary from appeal to appeal on Mashaw’s theory; the question then becomes which sorts of appeals tend to do more to further dignitary values and which tend to do less. To the extent that “dignity” is a psychological concept, corporate entities have none, and an appeal brought by a corporation can further dignitary values only insofar as the process offered in the case furthers the individual dignity of the corporate employees involved in the appeal. This question sounds much like the one

\(^6^9\) Mashaw, Due Process in the Administrative State, supra note 6.

\(^7^0\) The moral status of corporate entities has been explored in other contexts. E.g. Michael B. Metzger & Dan R. Dalton, Seeing the Elephant: An Organizational Perspective on Corporate Moral Agency, 33 Am. Bus. L.J. 489, 490 (1996).

\(^7^1\) Mashaw, Due Process in the Administrative State, supra note 6 at 162; id. at 164 (“The issue is . . . whether the challenged process sustains or diminishes an appropriate conception of human dignity.”).

\(^7^2\) To be sure, Mashaw sees these as “political” values rather than “psychological” values—he cares about a person’s dignity whether or not they do. Id. at 170-71. But he nonetheless sees their satisfaction as connected to a person’s state of mind, id., and as dependent on the degree to which a particular process furthers them in a particular case. See supra, note __ and accompanying text.
explored above, namely, whether corporate employees’ “taste for
fairness” makes a corporate appeal inherently valuable.73 Nothing
about the focus on “dignity” as opposed to other psychological
phenomena changes the answer; any such value is diluted because the
regulated party is the corporation, not its agent, and in many
corporations the agent would violate her fiduciary duty by putting her
desires before the corporations’. However, in the limited case of a
closely-held corporation that is closely bound up with an individual’s
sense of self, process given to a corporation may have inherent value.
Similarly, financially-motivated appeals are presumably less bound
up in a person’s sense of self, and therefore do less to further the
inherent value of process so understood, than appeals motivated by
principle. So all else being equal, a pro se appeal is likely to derive
greater value from process qua process than one brought by a
represented party.74

To the extent that one believes, as Mashaw maintains at times,
that the “dignity” with which he is concerned is a political concept,
not a psychological phenomena,75 we must look to his (and other
adherents’) understanding of this phenomena, not corporate
psychology, in assessing variation in inherent value. Doing so reveals
that whether “dignity” is a psychological or a political concept is, at
least for present purposes, a distinction without a difference. For
example, the way Mashaw and others talk about “dignity” does not
indicate that they believe corporations have dignity even without
psychology, in fact, quite the opposite. Mashaw, and others who have
written about the dignitary theory of process repeatedly connect it to
humanity, to personhood.76 Indeed, Mashaw analogizes the right to
process to the right to vote.77

73 See supra Part II.A.3.a.

74 See id.

75 Id. at 170-71 (“We are not exploring what processes make people feel
dignified or have self respect.”). But cf. (acknowledging that dignitary
values can be “a question about individual psychology”).

76 MASHAW, BUREAUCRATIC JUSTICE, supra note 42 at 162 (“it seems
reasonable to interpret this concern as a concern for values inherent in or
intrinsic to our common humanity”); id. at 163 B(“it is common place for us
to describe process affronts as somehow related to disrespect for our
individuality, to our not being taken seriously as persons”); id. at 164 (“The
issue is . . . whether the challenged process sustains or diminishes an
appropriate conception of human dignity.”); N. Subrin Stephen & A.
Richard Dykstra, Notice and the Right To Be Heard: The Significance of
Old Friends., 9 HARV CR-CLL REV 449 (1974) (“By asking to hear from
c. Solum’s normative legitimacy theory

On Solum’s view, the inherent value of process comes not only from its capacity to satisfy a desire for fairness but also from its capacity to give decisions normative legitimacy.78 “[A] core right of participation is essential for the [normative] legitimacy of adjudication.”79 By “normative” legitimacy Solum means something more objective than “the legitimacy that is required for the important social goods of voluntary compliance and social stability.”80

For Solum, normative legitimacy is a binary question, not a matter of degree. Either a procedure confers normative legitimacy or it does not. Furthermore, no distinction among sorts of appeals or appellants is evident either explicitly or in the logic of Solum’s normative legitimacy theory. Solum views normative legitimacy as desirable because it creates “content-independent obligations”; it is not apparent that corporations are any less capable of being obliged than individuals. And a claimant’s reason for appealing has no obvious connection to the usefulness of their being able to feel legitimately bound by the outcome. Therefore, from a pure normative legitimacy perspective as understood by Solum, process has the same value across all appeals.

That said, Solum views his normative legitimacy theory as a supplement to, not a replacement for, instrumental, satisfaction-based accounts of the inherent value of process. Therefore, even on Solum’s view the inherent value of process in a case can vary from appeal to appeal as discussed in Part II.B.3, but all the variation happens on the instrumental dimension, not on the normative legitimacy dimension.

litigants and listening to them, the ‘system’ is treating them with a dignity consonant with their self-image as human beings; each is important, and each has some measure of control over his own destiny.”).

77 MASHAW, BUREAUCRATIC JUSTICE, supra note 42 at 163.

78 Solum, supra note 6 at 273 (“What is the value of allowing litigants to participate in civil adjudications that may bind them? . . . [L]itigants may feel more satisfied by adjudication that affords them the opportunity to tell their story in a meaningful way.”).

79 Id. at 274.

80 Id.

81 Solum, supra note 6 at 278.
* * * * *

In sum, as reflected in Table 1 below, the inherent value of procedural justice in the Medicare appeals process is heterogeneous across appeals. The inherent value of participation can be understood in many ways: as satisfaction of a preference or taste for fairness, protection of the individual dignity and autonomy of the appellant, or the grievance-soothing vindication that comes from being “heard.” But except for the normative legitimacy aspect of Solum’s theory, the inherent good that comes from giving an appellant her desired “day in court” does not obtain when a major device manufacturer or hospital group pursues a financially-motivated appeal. On all other understandings a person or entity motivated to appeal in part by fairness may benefit from having her “day in court,” whatever the outcome, but a sophisticated corporate entity that appeals only for money benefits only when it wins. And this is only the most stark of several such variations that depend on whether a claimant is represented, appeals for purely monetary reasons, or is sick.

Table 1: Heterogeneous inherent value of process in Medicare

<table>
<thead>
<tr>
<th>Theory of inherent value of process</th>
<th>Satisfied by choice to waive process rights?</th>
<th>Advanced by appeal motivated purely by money?</th>
<th>Advanced by corporate appeal?</th>
<th>Advanced more by pro se appeal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taste for fairness</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Grievance soothing</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Dignity</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Legitimacy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

B. Solution: Rationing Procedural Justice by Default

82 KAPLOW & SHAVELL, supra note 6.

83 MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE, supra note 6

84 See Lawrence, supra note __. Cf. Richard B. Saphire, Specifying Due Process Values: Toward a More Responsive Approach to Procedural Protection, UNIV. PA. LAW REV. 111 (1978) (“my past experience in representing the poor has repeatedly shown that tenants, consumers, and welfare recipients often regard the way in which they are treated by governmental institutions at least as importantly as the extent to which they achieve their substantive goals”).
As a result of this heterogeneity, at a minimum a substantial majority of the hearings held in the Medicare appeals system are a waste of time and money.\(^8\) The way to fix the backlog is to find a way to provide costly due process rights only for the small fraction of appeals where an individualized hearing has inherent value. If demand for justice is heterogeneous, then the supply of justice should be too.

The most apparent answer is to “sort” appeals, picking and choosing which appeals Medicare should offer procedural protections and which can be handled in a more streamlined process designed to maximize efficiency. Much as judges evaluating Article III standing apply constitutional criteria to sort cases that are deserving of access to federal court from those that are not, ALJs or some other entity could apply a standard to sort those appeals that get a hearing from those that do not. Or a blanket rule could be used to sort appeals without the need for individualized determinations, for example, providers might be forced to bring their appeals through a fast-track process, leaving individualized hearings for the 10% of appeals brought by beneficiaries.

Sorting poses challenges, however, which make it an unattractive fix. First and foremost, sorting would run counter to constitutional due process requirements, depending on the protections offered in the “fast track.”\(^8\) Furthermore, individualized sorting would be intolerably costly and difficult; it is hard to tell whether a suit is motivated only by money or also by a grievance. (“Grievance” here is shorthand for the sort of particularly-negative emotional reaction to an adverse outcome that can make a “fair process” instrumentally valuable.)\(^8\) And a blanket rule that forces provider-driven appeals into a process that providers deem less attractive would incentivize providers to stop taking assignment at all, closing off a practice that arguably benefits Medicare beneficiaries.

\(^8\) Combined, doctor- and patient-driven appeals account for 23% of all appeals, the remaining 7% are brought by hospitals, nursing homes, device manufacturers, state Medicaid agencies, and other corporate entities.

\(^8\) See Schweiker v. McClure, 456 U.S. 188 (1982). The constitutional status of providers’ right to a hearing when they take assignment of a claim is not as straightforward as that of a beneficiary. [Insert expanded discussion of doctrine*].

\(^8\) A grievance can result from a denial that was 100% correct, similarly, an erroneous denial might not produce a grievance. It depends on how the beneficiary reacts to the news; the perceived correctness of the underlying decision is only one determinant of that reaction. See supra, __.
Furthermore, some providers no doubt appeal for justice (and some beneficiaries only for money), so a sorting rule would be both over- and under- inclusive. (These limitations, and others, are elaborated upon below in Part II.C.1.d.)

There is a better solution. Rather than actively sort claims, we can design the rules to “sift” passively among claims by inducing appellants to sort themselves. A rich theoretical literature on adjudicatory design discusses ways that rules can be designed to incentivize appellants to sift themselves for quality, that is, incentivize those with winning claims to sue (or appeal) and those with losing claims to decline to do so.88 Although previously unrecognized, the same principle can be used to sift appeals in which procedural protections have the most value from appeals where such protections are not inherently valuable.

Specifically, Medicare should reform its appeals process to offer justice only by default. That is, all appeals should be defaulted into a procedural route that offers the full panoply of due process protections. But, the rules should offer an opt-in, fast-track process that guarantees no procedural rights—not even the right to an individualized determination—but promises an overall likelihood of success equal to that of the due process track.

Subsection 1 below elaborates upon the mechanics of the justice by default approach, that is, how it would work and why. Subsections 2 then discusses the costs and benefits of such an approach in light of the objectives of the Medicare coverage appeal system.

1. Mechanics of justice by default

The rules could sift appeals that do not stand to generate inherent value from procedural protections onto an “efficiency” fast track route by taking advantage of three systematic differences between those who tend to bring financially-motivated appeals and those that do not. First and foremost, status quo bias. By now the best-understood behavioral quirk revealed by research in behavioral economics, status quo bias is the tendency of a person to follow the

default path of least resistance even if “opting in” to a different path would be in that person’s financial best interest. Status quo bias is a primary reason that opt-in class actions see low take up rates (while opt-out class actions see tiny opt out rates).89

Pro se patients are systematically more likely to be subject to status quo bias than providers, or attorneys. Evidence of behavioral bias among patients is strong.90 That is not to say that providers are immune to behavioral phenomena. Physicians, for example, have been shown to suffer from optimism bias.91 But on net economically-motivated and sophisticated providers are less likely to be susceptible to behavioral bias than patients, especially those in economic competition with one another (because those with bias will be less successful). And, in any event, physician appeals represent only 13% of provider appeals; most are brought by hospitals, nursing homes, and durable medical equipment manufacturers.92

As a result, defaulting all appellants onto the “justice” route would leverage status quo bias to lead individuals pursuing their own appeals to retain their procedural rights, while leaving the most sophisticated, profit-maximizing providers (and represented parties) with an incentive to shift to the fast track.

Second, those who bring financially-motivated claims tend to be capable of bringing many claims simultaneously, and so from

89 See Matthew JB Lawrence, Courts Should Apply a Relatively More Stringent Pleading Threshold to Class Actions, 81 UNIV. CINCINNATI LAW REV. 1225, 1241-43 (2013) (discussing status quo bias in decision to opt out of a class action).


benefitting from any economies of scale offered by the procedural rules. So, the efficiency route should offer aggregation mechanisms like consolidation or class treatment that would be unavailable on the “justice” route. This would give many financially-motivated entities an incentive (in addition to the promise of a quicker resolution) to opt for the efficiency route, but would not incentivize individual beneficiaries (or doctors who appeal rarely) to do so.

A third (and perhaps most obvious) difference between those who would benefit from a hearing and those who would not is that very fact. To the extent that beneficiaries or providers who would benefit from a hearing realize that fact (and vice versa), the optional nature of the default regime would give an incentive for anyone—even a provider—who might benefit from a hearing to go that route, while incentivizing those who would not benefit from procedural protections to go without. To be sure, the assumption that individual beneficiaries would appreciate the full value of a hearing to them is questionable, but setting the justice route as the default would mitigate this problem.

In addition to incentivizing repeat players and those with a strictly monetary interest in their appeals to opt into the fast track, the rules would also need to ensure that the justice track did not appear to have any relative advantages. Specifically, the rules would need to guarantee appellants that their likelihood of success would not depend on their choice of track. To obtain that end, the fact that a particular appeal was a bellwether—one of the sample cases upon which a large group of cases would turn—could be kept secret from the ALJ hearing the case, to ensure bias would not creep in.

Furthermore, samples of appeals from the fast track and the justice track could be audited and compared, in order to make sure that neither group was obtaining reversal at a higher rate. If the justice track appeals were reversed more often relative to case mix, a random, offsetting proportion of “fast track” appeals might be deemed winners. Any such method of ensuring that the ex ante likelihood of success would be the same in each track from the appellants’ perspective would avoid incentivizing repeat players to stay in the justice track.

2. Cost and benefits of justice by default

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93 See infra Part II.C.1.b.

94 Some non-bellwether appeals might even be pulled from the fast track, without telling either the parties or the ALJ, in order to minimize the likelihood of bias.
This subsection lays out a crude, largely conceptual cost/benefit analysis to show that justice by default is a worthwhile proposal for fixing Medicare’s backlog problem; the section that follows then shows that this proposal would not only be an improvement over the current system of de facto rationing, but would be superior to alternative fixes. Before turning to these costs and benefits, however, a brief overview of the social utility function of Medicare’s appeal system, that is, of the costs and benefits that we should take into account in designing Medicare appeal procedures.

The most obvious benefit of the appeals process comes from its ability to reduce errors. It does so in two ways. Most directly, the appeals process can reduce errors by identifying and correcting individual them. But by doing so the appeals process also has the potential to prevent errors from happening in the first place, because the threat of reversal could incentivize the contractors who make initial coverage determinations to do a better job.

The appeals process also offers whatever benefit comes from the inherent value of procedural justice, or access value. Note that to the extent such value is instrumental—a product of the affect of the procedures on the parties—it is possible that the procedures might produce this value in two ways, as well. First, an appeal could produce this inherent instrumental value by soothing a grievance in an individual case. And second, the appeals process could prevent grievances from forming in the first place, because the availability of a “fair” process could prevent a potential claimant from perceiving a decision to be unfair.95

On the “cost” side of the ledger, the administrative cost of operating the appeal process and processing an appeal, both to the system and to the parties, must be considered. (Indeed, because the budget of the CMS is a constraint on any process, there are limits to the administrative cost we can impose, even when doing so continues to provide worthwhile marginal benefit). So too should the perverse deterrence effect of erroneous decisions on appeal be considered; these might chill appellants from bringing appeals and diminish the positive incentive effect of the appeals process on the contractors who make initial decisions.

A “justice by default” approach has the capacity to enhance all of the benefits of the administrative process without increasing its costs compared to the status quo:

\textit{a. Benefits of justice by default}

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95 See Lawrence, \textit{Mandatory Process}, \textit{supra} note __ Part II.B.2 (discussing grievance-preventing and grievance-soothing functions of dispute resolution process).
The driving benefit of the justice-by-default approach is that it would solve Medicare’s backlog problem by drastically reducing the cost of administering the average appeal. This would enhance the access value by offering those who need them prompt appeals, a significant improvement on the three-year-and-growing backlog currently in place. This solution would also carry several collateral benefits.

First, it would expand access to the appeal mechanism to those who currently are unable to bring appeals, thereby furthering the inherent access value. Procedural protections—individualized creation of a record, a hearing, and so on—are costly not only to those who administer appeals but also to those who bring them. By making it possible to bring an appeal without paying all of these costs, the availability of the fast track would increase the number of appeals that consumer advocates, providers, or for-profit attorneys could bring on behalf of beneficiaries. (“If you build it, they will come.”) Because of the complexity of medical decision-making and stress of sickness, such intermediaries are even more likely to be a necessary prerequisite to access when it comes to Medicare appeals then they are in other adjudicatory contexts.96

Furthermore, by increasing the number of appeals the justice-by-default approach would increase the extent to which the threat of reversal on appeal incentivizes the initial decision-maker to make a correct decision in the first place, thereby increasing the error-preventing effect of the procedures. It is possible to identify this benefit without precisely modeling the decision-making of the initial decisionmaker: whatever reversal “costs” the initial decisionmaker, a greater likelihood means a greater likelihood of reversal and, so, a greater expected cost of error.

Finally, by reducing the number of hearings, the justice-by-default approach would make it possible to re-introduce procedural protections that have been cut in an attempt to streamline the process, further enhancing the access value produced by the adjudicatory process. For example, Medicare offers telephonic hearings by default, allowing a claimant to make the long trek to one of the four ALJ offices nationwide (in Ohio, California, Florida, and Virginia) only upon a showing of extraordinary need. (This is in stark contrast to the social security appeals system, which features 168 hearing offices spread throughout the country and offers an in-person hearing as of right.) Research in procedural justice shows that the ability to

appear in person is an important component of a claimant’s perception of the fairness of an adjudication.\footnote{E. Allan Lind et al., Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments., 59 J. PERS. SOC. PSYCHOL. 952 (1990) (presenting study in which participants labeled outcome as more fair when they had opportunity to speak, even after being told their opinion would have no impact on outcome).} Once the system is re-designed so that it no longer provides acceptance-generating procedural protections to those who do not benefit from them, it will be much less costly to provide any and all such beneficial protections to the subset of appellants who do.

\begin{quote}
\textit{b. Costs of justice by default}
\end{quote}

Justice by default would not be a perfect solution. The primary concern with this solution from a “justice” perspective is the possibility that individuals who would actually benefit from a hearing would mistakenly opt into the efficiency route, perhaps undervaluing the grievance-reducing potential of a hearing due to projection bias.\footnote{See \textit{id.}} This possibility is especially pronounced when dealing with patients.\footnote{See Loewenstein, \textit{Projection Bias in Medical Decision Making}, \textit{ supra} note 90; Halpern & Arnold, \textit{supra} note 90} Such a result would diminish the net “access” benefit of the justice by default approach. And on Mashaw’s non-consequential, dignitary theory of the inherent value of access, such a result would not just decrease the net benefit of the justice by default approach, it would arguably make such an approach impermissible. (This would not be the case for Solum’s theory because the claimant’s consent, even if not in her own interest, would vitiate any legitimacy concerns.)\footnote{See note \textit{__}, infra.}

The possibility that the wrong people would opt out of the “justice” route is indeed theoretically problematic. But experience with status quo bias in other contexts indicates that this concern is empirically unfounded.\footnote{E.g. Theodore Eisenberg & Geoffrey Miller, \textit{Role of Op-Outs and Objectors in Class Action Litigation: Theoretical and Empirical Issues}, \textit{The}, 57 VAND REV 1529 (2004) (reporting trivial opt-out rate).} The rules could be designed to make the default as “sticky” as possible, to make sure ordinary claimants do not opt out. This could be done both by making opt out difficult (we
could require a separate letter, rather than a check box); and by framing the choice to discourage opt out. Furthermore, if this concern is theoretically strong enough then Medicare could first test the “justice by default” approach through a pilot study to make sure that justice indeed sticks.

The primary concern for the “efficiency” of the justice-by-default proposal is that those who would not benefit from a hearing would nonetheless decline to opt into the efficiency route. This possibility is less theoretically problematic; even if a substantial number refused to opt out, the result would be a more efficient system than we currently have. It is also empirically unwarranted; so long as the expected likelihood of success in the efficiency route is the same as it is in the justice route and there is some benefit (from having a claim resolved more quickly, or from aggregation), then financially-motivated repeat players should be trusted to make the profit-maximizing choice.

Furthermore, any residual costs would pale in comparison to the costs of the status quo. We are already rationing procedural justice in Medicare, we are just doing so badly. We have not provided enough funding to give every claimant a prompt hearing, which means we have defaulted into the rationing mechanism that tends to apply when we do not want to ration consciously: first come, first served. When it comes to bread, or medicine, or procedural justice, when we do not ration consciously we often ration with lines. This approach has two major downsides. First, it does not apportion scarce resources to those who most need them, except insofar as the first to file are likely to be the most deserving. While that might (or might not!) be true for bread (hunger does have a tendency to grow) or medicine (health has a tendency to deteriorate),

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103 For example, the choice might be framed as a decision to forego a benefit rather than a decision among two equal routes, perhaps as a choice to “forfeit procedural rights.” Cf. Willis, Why Not Privacy by Default, __ Berk. Tech. L. J. ___ (forthcoming 2014) (discussing situations under which profit-interested parties with power to do so trigger slippery defaults by framing). Also, a hearing date could be identified immediately upon appeal, so as to make the foregone hearing appear even more as a concrete loss to an appellant. Cf: Bertrand et al., supra note 51 (discussing study showing students were more likely to follow through on a medical appointment if given a meeting date in advance rather than simply information about how to make an appointment).
it is not apparently true of the need for procedural justice.\textsuperscript{104} The justice-by-default approach, which takes a consequentialist, “best outcomes” view of rationing,\textsuperscript{105} achieves greater procedural justice “bang” for the adjudicatory buck.

Second, rationing by time means that everyone must wait to obtain a hearing; currently three years or more. Whatever the inherent value of procedural justice, to the extent that there is truth in the notion that “justice delayed is justice denied” (there may not be),\textsuperscript{106} making claimants wait such an extended period could undermine the purpose of providing a hearing in the first place.

In light of these concerns, it is not surprising that Congress has mandated a hearing be offered within 90 days.\textsuperscript{107} Given the current state of the backlog, we should give serious consideration to any proposal that offers the promise of reducing the backlog without substantially diminishing procedural rights; justice by default is such a solution.

C. Counter Arguments and Concerns

1. Alternative solutions

“Justice by default” is not the only theoretical way to deal with Medicare’s backlog problem. We could, for example, devote the funds necessary to increase dramatically the number of ALJs available to hear Medicare appeals, or, as mentioned above, charge a fee for the right to a hearing. This section discusses several

\textsuperscript{104} Cf. I. Glenn Cohen, \textit{Rationing Legal Services}, 5 J. LEG. ANAL. 221, 245-46 (2013) (arguing that first-come-first-served approach is unethical way to ration access to legal services).

\textsuperscript{105} For a survey of rationing approaches, including the “best outcomes” approach, see \textit{Id.} at 244-258.

\textsuperscript{106} Tom R. Tyler, \textit{Citizen Discontent with Legal Procedures: A Social Science Perspective on Civil Procedure Reform}, AM. J. COMP. LAW 871, 884-85 (1997) (reporting results from two studies indicating that litigants’ perceptions of fairness of procedures were not affected by moderate delays). \textit{But see} John H. Knox & David L. Markell, \textit{Evaluating Citizen Petition Procedures: Lessons from an Analysis of the NAFTA Environmental Commission}, 47 TEX INTL LJ 505, 516 (2011) (“It seems obvious that a procedure that does not reach timely results is likely to be considered less effective and attractive than one that does, all else remaining equal.”).

\textsuperscript{107} 42 U.S.C. § 1395ff.
alternative such proposals. While some are potentially viable, none is superior to the justice-by-default approach.

\textit{a. Stop rationing healthcare}

Provider groups—most notably the American Hospital Association—have argued that the solution to the backlog problem is for Medicare to stop scrutinizing (and denying) reimbursement claims in the first place.\footnote{See Jan. 14, 2014 Letter from American Hospital Association to Marilyn Tavenner Re: Significant Delay in Assignment of Hospital Appeals to Administrative Law Judges, online at \url{www.aha.org\%7Fadvocacy-issues\%7Fletter\%2F2014\%2F140114-let-aljdelays.pdf} &ei=Oc3eUsSiLs3ksASO_YGODw&usg=AFQjCNGhkix2j5Bt a68nqWD80Wx2VC6G-w&sig2=B9pEu--Cg29ReqNexUov8Q&bvm=bv.59568121,d.cWc}

That would not fix the appeal process, it would make the appeal process superfluous—few denied claims would mean few appeals, the old status quo.

Medicare needs to scrutinize claims for reimbursement if it is to control costs and ensure that beneficiaries are not needlessly subjected to unnecessary or frivolous treatments. Or at least that is the view memorialized in the Affordable Care Act, which instructed Medicare to continue to scrutinize claims closely, and ordered this scrutiny be expanded to Medicaid.\footnote{Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 § 6411, 124 Stat. 119, 773 (2010).} It would be a pity if Congress’s substantive goal was unattainable due to intractable adjudicatory design issues, but that is not the case. A justice by default approach would solve the backlog while leaving in place Congress’s substantive goal of closer utilization review in Medicare, and is superior to the AHA’s proposal in this sense.

\textit{b. Precedent}

The audit companies that contract with Medicare to scrutinize claims,\footnote{Most Medicare administration is delegated to private contractors, auditing is no exception.} for their part, have argued that the Administrative Law Judges who preside over Medicare coverage appeals are to blame.\footnote{See Press Release, Jan 15, 2014, online at \url{http://properpayments.org/medicare-recovery-audit-contractors-ask-congress-for-changes/}}
Decisions vary too much from judge to judge, the auditors say, making them unpredictable. The auditors are right that the backlog results in part from the fact that ALJ decisions are unpredictable, but wrong to blame the ALJs.

The unpredictability of appeals of healthcare coverage decisions is a function of the inherent uncertainty of medical judgment, not any defect in the way the ALJs do their job. Medicare creates the equivalent of precedents on ‘legal’ issues—whether a particular treatment should be covered in a particular category of cases—insofar as it is possible to do so.112 (Private insurers do the same.113) The disputes that populate the backlog surround “legal” questions where this is not possible, or application of established coverage standards to the facts of a particular patient’s case—judgments about the severity of symptoms, characterization of past history, and so on. As to such questions medicine is “more of an art than a science.”114

Developing drugs and identifying effective treatments are scientific endeavors, to be sure. But treating a patient—applying scientific principles and knowledge to an individual’s specific case history and symptoms—is still an art, a question of professional judgment. Often, it is a question about which reasonable professionals might disagree.115 There is no practical way to “solve” this uncertainty, and so reduce the volume of appeals.

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112 JOST, supra note 49 (discussing National Coverage Determination process); KINNEY, GUIDE TO MEDICARE COVERAGE DECISION-MAKING AND APPEALS, supra note 50.

113 ELEANOR D. KINNEY, GUIDE TO MEDICARE COVERAGE DECISION-MAKING AND APPEALS (2002); RICHARD A. RETTIG, HEALTH CARE IN TRANSITION (1997).

114 See ALAIN C. ENTHOVEN, HEALTH PLAN: THE PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE at 4 (2002) (“In fact, medicine remains more of an art than a science. To be sure, it uses and applies scientific knowledge, and to become a physician, one must have command of a great deal of scientific information. But the application of this knowledge is a matter of judgment.”). See also id. at 5 (“Scientific and balanced analysis of the costs, risks, and benefits of different treatments is still the exception, not the rule.”); HALL, supra note 1 at 84 (“there is fundamental truth in the overused cliché that medicine is more art than science”).

115 See David M. Eddy, Variations in Physician Practice: The Role of Uncertainty, 3 HEALTH AFF. (MILLWOOD) 74 (1984) (“Uncertainty creeps into medical practice through every pore. Whether a physician is defining a disease, making a diagnosis, selecting a procedure, observing outcomes,
c. A la carte justice/ Fee-for-hearing

Part II.A identified a problem, namely, the over-provision of procedural justice to claimants who do not value it enough to make the accompanying delay and cost worthwhile. The “Chicago” solution to this sort of problem would be to make the default procedures as efficient as possible (maximizing efficiency) and then offer additional procedural protections, like an in-person hearing, on an a la carte basis to those willing to pay for them (or otherwise signal value, perhaps simply by opting in). (Along these lines, the HHS Office of Inspector General recommended a filing fee be adopted to reduce the volume of appeals altogether.)

The fundamental difference between an a la carte approach and the “justice by default” approach is the function of choice in each approach. The “Chicago” solution would use choice as a mechanism to evince claimants’ preferences about the inherent value of process, and then provide costly procedural protections only for those claims in which the claimant herself judged them worthwhile.

assessing probabilities, assigning preference, or putting it all together, he is walking on very slippery terrain. It is difficult for nonphysicians, and for many physicians, to appreciate how complex these tasks are, how poorly we understand them, and how easy it is for honest people to come to different conclusions.”. See also id. (discussing sources of uncertainty in medical decisionmaking). For example, “one of the best-studied problems in cancer prevention,” the value of mammography, remains a subject of evolving controversy. Id.

116 Rosenberg proposes an approach like this for mass resolution of class actions. Rosenberg, supra note 60 at 256 n. 110. A mirror image of this approach could also be used, offering claimants the full scope of procedural protections by default and then giving them a discount for choosing to go without. The justice by default approach in fact operates in this way, except it uses inducements keyed to economies of scale and the time-value of money, rather than money, in order to encourage monetizing claimants, but not pro se claimants, to waive their procedural rights. The reason for doing so is paternalistic. As discussed in Part II.B.2 and above, the possibility of behavioral biases (status quo bias and projection bias), as well as inadequate information, in the “market” for process in Medicare give reason for concern that claimants would waive procedural protections even when it is not in their interest to do so.

The justice by default approach is more asymmetrically paternalistic than that; it does not trust all claimants to correctly assess the inherent value of process, to themselves or society. It uses choice primarily as a mechanism to evince systematic differences among claimants that correlate with the value procedural protections would have to them. These differences are, as discussed above: susceptibility to status quo bias, ability to make use of economies of scale, and repeat (versus occasional or one-off) involvement with the appeals process.

By so doing, the justice by default approach rations justice without making the assumption that individuals would correctly weigh the inherent value of procedural protections. This assumption is problematic for a number of reasons that make the a la carte approach similarly problematic.

First, on Mashaw’s and Solum’s views of the inherent value of process, there is a divergence between the inherent value of process to society and its inherent value to an individual. For another example, Solum believes that procedural protections are inherently valuable because they are necessary to preserve the legitimacy of the adjudicatory institution; that legitimacy has value even to those who are not party to a particular appeal.

Second individuals, even if fully informed, may not sufficiently appreciate the inherent value of process to them. As I have written elsewhere, the inherent value of process depends to some extent on its capacity to soothe a negative emotional reaction to an event. Many seniors, when told Medicare will not cover a power scooter, may think nothing of it. Others, however, may feel a stronger emotional reaction, perceiving the decision to be unfair or unjust. Some of the inherent value of process comes from its power to soothe such a person’s grievance, whether they win or lose. But a human tendency to assume we will feel in the future as we do today known in


119 Solum, supra note 6.

120 See Bone, Statistical Adjudication, supra note 34 at 624 for doubts about whether tort plaintiffs, at least, would be fully informed in making such a choice.

121 See Lawrence, Mandatory Process, supra note __.
behavioral economics as “projection bias” could prevent afflicted claimants from anticipating this grievance-soothing function.

Both these reasons to doubt individual choices would truly reflect the inherent value of process—the divergence between the social and individual values of process, and projection bias as a barrier to full appreciation of the individual value of process—would prevent the a la carte approach from maximizing the process “bang” we receive for our administrative buck. Because the justice by default approach does not rely exclusively on individual judgment to sift cases, it is capable of obtaining a better allocation. By actively tailoring choice architecture and the benefits of the fast-track (and justice track) to push cases where process has least inherent value into the fast track while pulling cases where process has most inherent value onto the justice track, the justice by default does a better job of rationing procedural justice than an a la carte approach.

d. Treat providers differently

The possibility of actively sorting cases in which procedure has the most inherent value from those in which it does not by treating provider- and beneficiary-initiated claims differently as a matter of fiat was briefly rejected in introducing the justice-by-default approach above. Here is a more thorough explanation of the relative advantages and disadvantages of mandating that provider-driven appeals be resolved through a fast track and that beneficiary-driven appeals be resolved through the procedural justice track.

First, active sorting would run up against a roadblock that is external to the value created by the coverage appeals process itself. Process can affect primary behavior, and an active sorting rule that forced providers into a fast track might have adverse affects upstream for beneficiaries by changing the way providers offer Medicare services. Specifically, at present many providers—like the scooter store—insulate beneficiaries from the risk of a coverage denial by taking assignment of a claim in exchange for the right to press it. But if providers were fearful that their ability to appeal would be limited by doing so, they might stop accepting assignment (at least at the margins), instead actively representing beneficiaries in beneficiary-directed appeals and leaving the beneficiary to bear the risk of a denial. In short, active sorting could discourage potentially-beneficial assignment choices.\footnote{The acceptance benefits of the assignment approach are obvious: Providers, on the front lines, manage patients’ expectations, guaranteeing that a patient they offer treatment can receive coverage, and shouldering the risk of denial (and any accompanying demoralization cost) themselves. Furthermore, assignment enhances the error correction function of the
Second, on Mashaw’s and Solum’s versions of the inherent value of process, active sorting would be impermissible in ways that choice-based sifting would not. For Mashaw, an originating value that supports the dignity interest that makes process valuable for process’ sake is equality, so he views procedures that give different rights to different claimants to be problematic. Similarly, on Solum’s view, the value of participation also partly reflects the right to equal treatment.

A rule that offers different claimants a different right to participate would violate the equality principle. A sorting approach would be problematic from this perspective both by offering beneficiaries greater procedural protections than providers and by offering providers a right to a faster resolution than beneficiaries. This concern is alleviated with a justice by default approach, however, because claimants are entitled to equal procedural protections; any variation is the product of choice.

procedures by putting the decision to appeal in the hands of entities that are much better positioned to identify erroneous denials and to pursue appeals. (It is not surprising, then, that appeals are much more frequent in Medicare, where assignment is common, than in the private sector, where it is less common.) That said, the value of assignment is assumed for the purposes of this Article; I am exploring the broader question of the optimal assignment of liability for insurance coverage mistakes, in which assignment is a part, in a separate work. See Lawrence, Optimal Assignment of Liability for Insurance Coverage Mistakes, work in progress (on file with author).

123 Mashaw, Due Process in the Administrative State, supra note 6 at 174.

124 Solum, supra note 6 at 277-78; Id. at 287-88 (“If others are afforded a right of participation, but I am arbitrarily denied this right, I have been treated unequally and have a right to complain.”).

125 This is the case notwithstanding the fact that claimants may tend to under-value their procedural rights, that is, they may opt into the “fast track” mistakenly. See supra, note ___ and accompanying text. The alternative view would prove too much; if unequal use of procedural protections were problematic, then the law should not only mandate the process available to claimants but also that they make use of it. Yet no law mandates not only that procedural rights be available to a claimant, but also that the claimant make use of those rights. Indeed, such a rule would conflict with another of the values underlying Mashaw’s dignitary theory, namely, “control over the process of decisionmaking.” Mashaw, Due Process in the Administrative State, supra note 6 at 178. But see Ryan Bubb & Richard H. Pildes, How Behavioral Economics Trims Its Sails and Why, 127 Harv. L. Rev. ___ (2014) (arguing that a default rule is no different than a mandate under conditions of status quo bias).
Third, recall that Solum’s theory of the inherent value of process, unlike others, was binary and applied to all potential appellants equally. As a result, active sorting could violate Solum’s participatory legitimacy requirement if, as might well happen, the “fast track” failed to offer the sorts of procedures Solum views as necessary to serve as a legitimate source of decision authority. While such a result might be justified as a “second best” alternative under conditions of process scarcity in which legitimacy for all is unattainable goal, justice by default is a superior “second best” alternative on Solum’s view. That is because to Solum “it is the option or right” to procedure, not actually use of that procedure, that is a condition for normative legitimacy.\textsuperscript{126} Again, active sorting poses problems that justice by default, which incorporates choice, does now.

Fourth, sorting would be undesirable on an instrumental view of the inherent value of process, as well. Some beneficiaries may genuinely (and correctly) prefer the fast track, either because they care little for a hearing and prefer a fast answer, or because a fast, cheap process means cheaper representation and therefore greater access.\textsuperscript{127} Furthermore, some providers may genuinely desire a hearing, a chance to say their peace. To be sure appellants’—and especially beneficiaries’—choices on these matters will not always be consistent with their best interests for reasons discussed above.\textsuperscript{128} That is why the justice by default approach is primarily paternalistic, designed to steer appellants to the track that analysis indicates will serve them best, rather than leave that decision purely to appellants’ free choice. However, I believe it reasonable to assume that allowing claimants to move between tracks will, on net, lead to a distribution that better reflects claimants’ interests than vice versa. Insofar as that assumption is correct, the asymmetrically paternalistic sifting approach—which employs individual choice as a secondary sorting mechanism—is superior to a purely paternalistic mandatory sorting approach.\textsuperscript{129}

\textsuperscript{126} Solum, \textit{supra} note 6 at 275 (“Only an option or right is required because participation may be voluntarily forsworn.”).

\textsuperscript{127} For example, the forum participant whose motto was “appeal, appeal, appeal” would presumably have preferred a simple, fast appeal to a drawn out hearing, as long as likelihood of success was the same in both. \textit{See supra} note ___.

\textsuperscript{128} \textit{See supra}, note ___.

\textsuperscript{129} Camerer et al., \textit{supra} note 118.
e. Pay for more ALJs

Finally, we could pay for enough ALJs to provide a full hearing to every Medicare appeal, whatever the volume. That would fix the backlog, and the “justice delayed” concerns that go with it. But such a solution is unlikely; limits on discretionary funds in the budget would make it very politically difficult to provide a significant enough increase in the budget for Medicare administrative appeals.\textsuperscript{130} Currently, more than four appeals are filed for every one appeal resolved\textsuperscript{131}, therefore we would need to quadruple the appeals budget—at least—to catch up.\textsuperscript{132} That would require an additional appropriation of roughly $400,000,000, just to catch up to today’s demand (note, though, that filing rates are increasing and Medicare will by the end of 2014 have a backlog of more than a million appeals to contend with).\textsuperscript{133} For 2015, aware of the backlog problem, Medicare requested an additional $18,000,000 to process Medicare appeals; that will not come close to solving the problem by itself, even if the request is granted.

Furthermore, increasing the budget for Medicare hearings and appeals would alleviate one symptom of the problem with the appeals process—the backlog—but would not deal with the underlying problem of wasted procedural justice. The “justice by default” approach could achieve the same end at no cost by eliminating waste in the appeals process.

2. Statutory and constitutional considerations

\textsuperscript{130} [Insert further budget discussion from Kamin.*]

\textsuperscript{131} In FY2013, each ALJ processed, on average, 5 appeals per day (a dramatic increase from FY 2009, when the average was 2 per day). See Office of Medicare Hearings and Appeals, Medicare Appellant Forum, online at JERRY L. MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS (1983). That amounted to 1,220 appeals per year and, with 65 ALJs, made the capacity of the appeals process 79,300 appeals per year. Id. In FY 2013, about 350,000 appeals were filed. Id.

\textsuperscript{132} We would need to “at least” quadruple the budget because the current backlog may be deterring some potential appellants from filing appeals, so a shorter timeframe could increase the volume of appeals. It is not apparent that the OMHA has any fixed costs that could be saved in increasing the number of ALJs; the office’s costs are the cost for space and salaries for the ALJs and the administrative office.

\textsuperscript{133} See OMHA Appellant Forum Slides, February 12, 2014.
As for legality, nothing would stop the Secretary of Health and Human Services from adopting the justice by default approach right away. The Medicare statute gives the Secretary broad powers to administer the Medicare program, pursuant to which she could create the fast-track route for handling coverage appeals. Doing so would not run contrary to the statutory instructions for setting up the appeals process, because the fast-track route would be an optional supplement to the justice route, not a replacement. Furthermore, the Due Process Clause would not stand in the way of a justice by default approach, because the Supreme Court has tended to be sanguine about consensual agreements to forego procedural rights made in the course of adjudicating a claim, after a dispute has arisen.\textsuperscript{134} (Pre-dispute agreements can be more problematic.)\textsuperscript{135}

3. Justice delayed is justice denied?

Finally, one might object that the justice by default approach would provide a faster resolution for monetarily-focused appeals than for principled appeals, and that “justice delayed is justice denied.” Three considerations mitigate this objection. First, the justice by default approach is designed to free up administrative resources so that all appeals are resolved more quickly than they would be otherwise. Second, any inequality concern is vitiated by the fact that all appellants would be given the option of pursuing a “fast track” appeal. Third, and finally, research in procedural justice indicates that, counter to the cliché, moderate delays do not substantially affect appellants’ perception of the fairness of a result.\textsuperscript{136}

III. RATIONING JUSTICE BEYOND MEDICARE

The Medicare example teaches two broader lessons; one theoretical for the way we design adjudicatory procedures, and one substantive for the way we make healthcare rationing decisions. First, a theoretical lesson for adjudicatory design. Procedural justice is a scarce resource in many contexts beyond healthcare. Indeed, making the most of limited procedural resources is the defining challenge of many adjudicatory systems, those tasked with doling out what Judge Friendly dubbed “mass justice”—social security, veterans’ benefits,


\textsuperscript{135} See Lawrence, Mandatory Process, supra note __.

\textsuperscript{136} Nourit Zimerman & Tom R. Tyler, Between Access to Counsel and Access to Justice: A Psychological Perspective, 37 FORDHAM URB LJ 473 (2010); Tyler, supra note 106.
workers compensation, and (post-Twombly), perhaps even civil justice in the federal courts.

Traditionally the challenge of mass justice has been met with one of three responses: either limit the procedures available to all appellants, make all appellants wait, or increase funding. But as elaborated upon in Part A, the justice-by-default approach is proof of a concept, namely, that the value society (and individuals) get from procedures can be maximized by consciously rationing procedural justice, pushing those likely to benefit least from procedural rights away from them, and pulling those likely to benefit most in.

Second, the justice by default approach makes viable a promising method—fair hearings—for generating accurate and “just” healthcare rationing decisions. When we ration healthcare it is of course important to get our decisions “right,” but it is also important to minimize the angst—what Michelman speaking in a different context called “demoralization cost” \(^{137}\)—associated with the disappointment of being informed, even correctly, that coverage for a desired treatment has been denied. As elaborated upon in Part A, below, justice by default offers the promise of making healthcare rationing work better—of increasing accuracy and minimizing demoralization cost—even when done by private insurers as well as Medicare.

A. Access Value Heterogeneity and the Design of “Mass Justice”

With limited exception the conventional wisdom in designing adjudicatory institutions—from social security appeals to the federal courts—has been that all claims are equally deserving of the tribunal’s time and attention, that the method by which we dole out access to procedural justice, like our method for resolving cases, should (or must) be blind. \(^{138}\) This view is sometimes assumed

\(^{137}\) Michelman, *Associational Aims in Procedural Due Process*, supra note 42.

\(^{138}\) The primary exception is David Rosenberg’s argument in favor of mandatory class actions to resolve mass tort cases, in which he briefly notes the possibility of variation, and proposes it be addressed by charging claimants a fee for procedural protections. Rosenberg, *supra* note 60 at 256 n. 110. I explain why this solution is problematic *supra* Part II.C.1.c. Also, theorists have occasionally argued that the inherent value of process can vary with the substantive claim at stake—not who brings it and why—but have not attempted to incorporate this possibility into the design of adjudicatory institutions. See Trangsrud, *Joinder Alternatives in Mass Tort Litigation*, *supra* note 57 (arguing that participation has greater inherent value in personal injury cases than in property damage cases); Trangsrud,
explicitly,139 but is apparently so uncontroversial that it is usually assumed implicitly.140 (Theorists have argued that the inherent value of process can vary with the substantive claim at stake—not who brings it and why—but have not applied this insight to adjudicatory design.)141

Mass Trials in Mass Tort Cases, supra note 57 (same); RONALD DWORKIN, PRINCIPLE, POLICY, PROCEDURE 102-03 (1981) (arguing for a stronger participation interest in morally charged cases); MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE, supra note 6 at 208-15 (suggesting special participation right for constitutional cases).

139 In his analysis of rationing legal services Glenn Cohen raises the possibility that the inherent value of participation might depend on the amount at stake in a case or the wealth of the claimant, Cohen, supra note 104 at 289 (recognizing that the inherent value of participation might be greater “for the downtrodden”), but then assumes a homogeneous participation right due to the complexity of the issue. See id. (assuming that inherent value of adjudicating housing claim brought on behalf of 100 individuals would be greater than inherent value of adjudicating four separate eviction actions brought by four separate individuals); id. (modeling inherent value of participation with a “fixed ‘dignitary participation bonus’” assigned equally to each potential claim). Similarly, Robert Bone notes the possibility of variation in inherent procedural value due to the substance of claims, but then assumes a uniform participation value. Bone, Statistical Adjudication, supra note 36 at 630; see also Robert G. Bone, Rethinking the Day in Court Ideal and Nonparty Preclusion, 67 NYUL REV 193 (1992) at 288; Bone, Statistical Adjudication, supra note 36 at 620 (“[E]ach party has an equal claim of right to the process goods being distributed. Consequently, certain utilitarian solutions are ruled out.”); id. at 630 (“I shall assume that the strength of the [participation] right is the same for all cases.’’). See also Glen O. Robinson & Kenneth S. Abraham, Collective Justice in Tort Law, VA. LAW REV. 1481, 1503 (1992) (“if there is a due process right to individualized adjudication, it must be in recognition of an equal right enjoyed by other, similarly situated claimants”).


141 See Trangsrud, Joinder Alternatives in Mass Tort Litigation, supra note 57 (arguing that participation has greater inherent value in personal injury cases than in property damage cases); Trangsrud, Mass Trials in Mass Tort Cases, supra note 57 (same); RONALD DWORKIN, PRINCIPLE, POLICY,
The justice by default solution to Medicare’s backlog problem demonstrates that this assumption is flawed; the inherent value of process can vary from appeal to appeal, and when it does the function of adjudicatory systems can be improved by designing procedures to take account of this variation. Indeed, in the many areas that resource constraints make procedural justice a scarce resource—arenas of what Judge Friendly called “mass justice” like welfare claims and healthcare—we currently ration justice poorly, either by defaulting into a first-come-first served rationing approach that forces all claimants to wait on long lines, or limiting the procedural rights available to all appellants. The approach to solving Medicare’s backlog problem offered in Part II shows that there is a better way.

Specifically, the Medicare experience shows that procedures can be tailored to take advantage of heterogeneity in the inherent value of appeals when two potentially common theoretical conditions are met, namely: (1) there is some tension between the adjudicatory procedures that would be most efficient and those that would best serve the access value and (2) there is heterogeneity in the capability to benefit from access qua access among claimants or claims. For example, in federal court pro se litigants may derive greater benefit from access for access’ sake than, say, corporations in a private dispute, and some adjudicatory procedures may not increase the accuracy of outcomes (in either case).

When these two conditions are met, we should explore whether there is a permissible way to sort out those claims for which process has the least inherent value. In the pro se versus corporate access to civil justice example, it may be possible for the rule to simply hinge access to identity. (Indeed, federal courts take such an approach to pro se claimants, applying to them a lower gate-keeping barrier through a lessened pleading threshold.142) However, in many cases it may be impermissible to treat claimants differently per se, because of constitutional or other considerations, or because one is a believer in Solum’s theory of procedural justice, in which case a justice by default approach can achieve substantially the same result.

This theoretical possibility is especially compelling in adjudicatory systems that administer what Judge Friendly called “mass justice,” that is, systems where appeals are brought at such

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142 Erickson v. Pardus, 551 U.S. 89, 94 (2007) (pleading by pro se litigants “must be held to less stringent standards”).
volume, with so little at stake, that providing every appeal with the full measure of procedural justice is prohibitively costly. 143 Welfare, workers compensation, social security benefits, and healthcare coverage are all such areas; claimants have a strong reason to appeal—they want their entitlement—but society is unwilling or unable to offer every appellant full procedural protections (including not only a full hearing but also a right to counsel).

Friendly suggested that in such areas of “mass justice” the costs of counsel involvement—potential delay, among others—outweighed the benefits, so could justifiably be limited. Friendly was right—of course!—to point out that it is impossible for all claimants in a “mass justice” program to obtain counsel, and that the inclusion of counsel can change the function of a hearing. 144 But his proposed solution, altering procedural rules for all claimants, those represented by counsel and otherwise, paints with too broad a brush. As I have shown, adjudicatory design today has the technology to treat such cases differently, to channel cases onto different procedural tracks; wherever this approach is viable, we should use it.

In fact, many present-day rules of adjudicatory procedure may have sifting as a previously-unrecognized benefits. For instance, many federal courts schedule appellants automatically to attend mediation, requiring parties to opt out if they believe mediation would be unhelpful. More research is of course needed, but this practice may be justifiable as an example of justice by default.

B. Accuracy and Acceptance in the Rationing of Healthcare

By making the healthcare coverage appeal process better, justice by default holds the promise of making rationing better, not only in Medicare but throughout our healthcare system. We ration healthcare in three ways: We can make rationing decisions explicitly,

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143 Friendly, supra note 4 at 1289 (“problems concerning counsel and confrontation inevitably bring up the question whether we would not do better to abandon the adversary system in certain areas of mass justice . . . in favor of one in which an examiner—of administrative law judge if you will—with no connection with the agency would have the responsibility for developing all the pertinent facts and making a just decision.”).

144 Id. at 1288 (“Under our adversary system the role of counsel is not to make sure the truth is ascertained but to advance his client's cause by any ethical means. Within the limits of professional propriety, causing delay and sowing confusion not only are his right but may be his duty.”).
by telling the patient she cannot have healthcare she wants. Or we can make rationing decisions implicitly, embedding cost considerations in practice protocols, professional training, or doctors’ incentives, and thereby incorporating them into doctors’ recommendations about what care a patient should want, or we can induce patients to ration their own care, by making them pay some of the cost of healthcare.

Implicit, bedside rationing has obvious benefits. Acceptance by the patient comes easily with implicit rationing, thanks to the patient’s and her family’s trust for the doctor. Furthermore, rationing done by doctors is cheaper to administer; no third party need be informed about or involved in the treatment decision. So does incentivizing patients to forego care; a patient is less likely to complain of the decision to go without care when it is her own.

Inevitably, though, we ration healthcare explicitly. There are limits to our willingness and ability to make patients pay for their own healthcare. And when we impose rationing, we often do so explicitly. This might be because we believe we should, for moral reasons (Gregg Bloche argues that implicit rationing violates the doctor’s Hippocratic oath), or instrumental ones. Or because

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145 RATIONING HEALTH CARE: HARD CHOICES AND UNAVOIDABLE TRADE-OFFS at 7 (Andre den Extern & Martin Buijsen, eds.) (rationing may be “explicit or not”).


147 On the traditional trust relationship between doctor and patient, see Mark A. Hall, Law, Medicine, and Trust, 55 Stan. L. Rev. 463, 477 (2002) (trust is “defining aspect” of doctor/patient relationship).

148 Christopher Robertson, The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game, 98 CORNELL LAW REV. 921, 942 (2013) (“cost sharing is impractical when costs are high in proportion to patient wealth”).

149 BLOCHE, supra note 1; see also David Orentlicher, Matters of Life and Death, MAK. MORAL THEORY WORK MED. at 6 (2001) (arguing that physicians should make rationing decisions explicitly); see generally RATIONING HEALTH CARE: HARD CHOICES AND UNAVOIDABLE TRADE-OFFS at 8-9 (Andre den Extern & Martin Buijsen, eds.) (discussing dispute about whether to ration explicitly) Len Doyal, The Rationing Debate: Rationing within the NHS Should Be Explicit: The Case for, 314 BMJ 1114
implicit rationing can cause significant distress, to patients and in public, when it comes to light. Or because we have no choice but to ration explicitly, because our efforts at controlling the way physicians practice medicine fail (a situation Nicholas Bagley argues is endemic in Medicare). Indeed, private insurers use utilization review, especially prospective (pre-treatment) utilization review, to limit coverage much more vigorously than does Medicare.

When we do ration explicitly, experience shows, we should be prepared for the fact that healthcare rationing choices—correct or otherwise—can be hard for patients to accept. “Disappointed individuals who have been denied access to treatment seem increasingly unwilling to accept such decisions without question.”

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151 Thomas H. Gallagher et al., *Patients' Attitudes toward Cost Control Bonuses for Managed Care Physicians*, 20 HEALTH AFF. (MILLWOOD) 186 (2001).

152 See Bagley, supra note 3.

153 In 2013, beneficiaries were told that their insurer would not pay for doctor-recommended care—in other words, that their insurer disagreed with their doctor about the medical necessity of a treatment—millions of times. This is not surprising, because “[m]ost insurance companies and MCOs rely on prospective and concurrent [utilization review] to determine if care is necessary, as well as what level of care is appropriate. Utilization review has become an accepted and essential part of cost containment.” GEORGE D. POZGAR, LEGAL ESSENTIALS OF HEALTH CARE ADMINISTRATION 303 (2009). See also David M. Eddy 1996) (“Physicians are slowly being stripped of their decisionmaking power.”). William M. Sage, *The Lawyerization of Medicine*, 26 J. HEALTH POLIT. POLICY LAW 1179 (2001) (“third-party payment led to third-party control.”).

The efforts of the families of Sarah Murnaghan (a little girl who was denied a lung transplant due to her age) and Alexis Shapiro (a little girl who was denied bariatric surgery), are notable examples that happened to make headlines. But equally passionate outcries by patients who feel they were the subject of unfair rationing choices populate the internet.

Michelman’s concept of “demoralization cost” is an apt description of the inherent cost of even correct explicit rationing that comes from the difficulty of acceptance. Writing of property takings—arguably a less personally sensitive context than healthcare—Michelman pointed out that even correct government action can impose real cost for disappointed subjects/recipients, whose dissatisfaction may not only hurt them but hurt their productivity, and that a sound regulatory system must take this cost into account.

The demoralization cost of correct healthcare rationing decisions is hardly the only worry for explicit rationing, however. Especially when utilization review is conducted by private insurers—who take no Hippocratic oath—we must be concerned decisions will be biased to deny coverage when it should be granted (according to whatever rationing metric we employ).

Health Insurance, GLOB. CHALL. HEALTH CARE RATIONING 89 (2000)) (emphasis in original).


156 See, e.g. Migraine Forum ("Does anyone have any solid advice other than appealing a second time? . . . I have cried buckets of tears over this") available at http://forums.healthcentral.com/discussion/migraine/forums/a/tpc/f/78210901/m/87510233.


158 Id.
A good appeals process can help to mitigate both problems by generating acceptance and accuracy. Appeals can generate acceptance either by making initial decisions appear fair or by giving an aggrieved patient a second chance at fairness, depending on the design of the procedures. And appeals generate accuracy both when incorrect decisions are appealed (and reversed) and when incorrect decisions are deterred for fear of reversal.

Three challenges evident in the Medicare example are pervasive in healthcare and stand in the way of effective appeals, however. First, patients are uninformed, sick, and vulnerable, so without the help of an intermediary it is difficult for a patient to understand, let alone use, her appeal right. Second, providers have...

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159 Norman Daniels & James E. Sabin, Last Chance Therapies and Managed Care Pluralism, Fair Procedures, and Legitimacy, 28 Hastings Cent. Rep. 27, 33-34 (1998) ("when the patients’ concerns about insurer trustworthiness and potential conflict of interest were addressed in advance by the option of going outside of Kaiser for independent consultation, patients and families were much readier to enter into a reflective dialogue with their Kaiser physicians about what treatment approach really made sense for them").

160 "Research indicates that procedural values not only influence individuals’ evaluations of the fairness of any specific process, but that greater perceived fairness also enhances []voluntary acceptance of decisions . . . ." Zimerman & Tyler, supra note 136 ("[T]hat people care about procedural values no less than they care about outcomes, and that procedural values play a significant role in people’s evaluations of, and satisfaction with, procedures in which they have participated—is now widely supported by a large body of empirical studies.").

161 See Lawrence, Mandatory Process, supra note __ at Park II.B.1 (discussing error reduction effect of process).

162 "Patients, particularly those who appeal (via the internal and external processes), are often vulnerable and medically fragile.” Sept. 21, 2010 Comment of American Medical Association on Interim Final Rules for . . . Internal Claims and Appeals and External Review Processes, at 2. “Even with the support and assistance of their physician(s), the processes for challenging an insurer determination are daunting and require physical, financial, and emotional reserves.” Id. See also Brian Elbel & Mark Schlesinger, Responsive Consumerism: Empowerment in Markets for Health Plans, 87 Milbank Q. 633 (2009) ("[t]he vast majority of consumers do not formally voice their complaints or exit health plans, even in response to problems with significant consequences"). Anecdotes from online forums indicate that patients do not understand the likelihood of success on appeal, even when informed of their appeal right. See Lymphoma Forum ("I’m not sure even if my oncologist put the order in that they would do it, based on
a financial interest in claims, so if they are involved in appeals the volume will be high, including many appeals brought by providers whose patients may or may not have a real interest in the appeal. And third, the irreducible uncertainty of medical judgment makes appeal outcomes inevitably unpredictable, further increasing volume.\footnote{163}

The ACA mandated an appeals process to govern healthcare coverage appeals in the private sector,\footnote{164} but it is of questionable usefulness because it does not account for these challenges. (The ACA’s process mandate makes somewhat uniform an appeal right that was already mandated for insured plans in many states thanks to the Supreme Court’s holding in \textit{Rush Prudential HMO v. Moran}.\footnote{165} As Katherine Vukadin has pointed out, appeal rates are tiny (less than .5\% of denied claims), even while success rates on appeal are high (close to 50\%).\footnote{166} Combined with a low cost of reversal, these facts make it doubtful that appeals have any incentive effect on insurers. (Studies of equivalent state mandates throughout the 1990s and 2000s also took a dim view of their effectiveness.\footnote{167})

\textit{this letter. They are very clear when they say that they don't feel that this therapy is medically appropriate for me at this time.”}, online at http://forums.lymphoma.com/archive/index.php/t-51149.html.

\footnote{163} See supra note __ and accompanying text.

\footnote{164} Pub. L. No. 111-148, § 2719, 124 Stat. 119, 137 (2010) ((mandating that private health insurers offer beneficiaries a number of protections, including the requirement that private insurers offer beneficiaries the right to independent, external review of decisions denying coverage, at the insurer’s, i.e., the beneficiary’s, expense).

\footnote{165} 536 U.S. 355 (2002).


\footnote{167} Nan D. Hunter, \textit{Managed Process, Due Care: Structures of Accountability in Health Care}, 6 YALE J HEALTH POL ETHICS 93 (2006); Sage, \textit{Managed Care’s Crimea, supra} note 12, Aaron Seth Kesselheim,
Furthermore, appellants are never entitled to a hearing, in person or otherwise, and there is no formal mechanism for providers to facilitate or press beneficiary appeals. Indeed, providers are not even informed of their patients’ appeal rights (and, anecdotally, providers are themselves often unaware that beneficiaries have appeal rights at all). These facts make it doubtful that appeals in the private sector do much to facilitate acceptance of rationing decisions.168 (An anecdote that is consistent with this point is the public outcry that erupted when Alexis Shapiro was denied coverage for bariatric surgery. With the help of the Today show her family crowdsourced $87,000 to pay for the surgery, all before she appealed the denial. Her appeal was granted, the decision reversed, and her family plans to donate the funds to children’s charities.169)

While a full analysis of the design of the private health insurance coverage appeal system is beyond the scope of this Article, the Medicare experience offers a suggestive blueprint for a more effective coverage appeals process, and so better rationing, in private health insurance. Providers should be incentivized to act as intermediaries for patients,170 or take assignment of appeal rights, in

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168 See Sage, Managed Care’s Crimea, supra note 12 at 626 (“No feature of current programs seems designed to further therapeutic trust or patient participation. . . . [P]aper review of submitted materials is the norm.”).

169 Morbidly obese girl with rare condition will receive gastric bypass surgery after Tricare reverses earlier denial, supra note 155.

170 Currently notice is communicated directly to the patient, not the physician, so that many primary care physicians are actually unaware of their patients’ appeal rights. A rule giving a beneficiary’s primary care
order to increase the volume of claims and insulate beneficiaries from denials. This would increase the accuracy benefit of the appeals process. Simultaneously, appeal rights should be expanded to include a hearing, at least by telephone, to improve the capacity of appeals to generate acceptance.171 Both changes could be made without creating an intractable administrative burden by adopting a two-track process along the lines of the justice by default approach.

CONCLUSION

In adjudication as in healthcare, a dollar spent on a person unnecessarily is a dollar taken from someone who could have used it. Perhaps desperately. Yet in Medicare, we’re wasting so much of our adjudication budget providing procedural justice for all, even though it only benefits some, that we cannot afford to give anyone a prompt hearing.

As the Article has shown, we can construct better adjudicatory processes by tailoring the provision of procedural justice to need. And by doing so with choice architecture rather than a mandatory intervention, we can secure the benefits of tailoring while avoiding the pitfalls.

The result is an improved regulatory tool, better able to help us work through the hard choices that scarcity forces us to make. In healthcare and beyond, we could sure use it.

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171 Zimerman & Tyler, supra note 136.