

3-15-2010

The Independent Medicare Advisory Committee: Death Panel or Smart Governing?

Robert Coleman

Follow this and additional works at: <http://digitalcommons.pepperdine.edu/naalj>

 Part of the [Administrative Law Commons](#), [Health Law Commons](#), [Insurance Law Commons](#), [Jurisprudence Commons](#), [Law and Economics Commons](#), [Law and Society Commons](#), [Legal History, Theory and Process Commons](#), [Legislation Commons](#), [Medical Jurisprudence Commons](#), [Politics Commons](#), [President/Executive Department Commons](#), [Public Law and Legal Theory Commons](#), and the [Social Welfare Law Commons](#)

Recommended Citation

Robert Coleman, *The Independent Medicare Advisory Committee: Death Panel or Smart Governing?*, 30 J. Nat'l Ass'n Admin. L. Judiciary Iss. 1 (2010)

Available at: <http://digitalcommons.pepperdine.edu/naalj/vol30/iss1/7>

This Comment is brought to you for free and open access by the School of Law at Pepperdine Digital Commons. It has been accepted for inclusion in Journal of the National Association of Administrative Law Judiciary by an authorized administrator of Pepperdine Digital Commons. For more information, please contact Kevin.Miller3@pepperdine.edu.

The Independent Medicare Advisory Committee: Death Panel or Smart Governing?

By Robert Coleman*

TABLE OF CONTENTS

I. INTRODUCTION.....	237
II. HISTORY	241
A. <i>What is 'Health care,' What is 'Medicine'?</i>	241
B. <i>A Federal Health Care Policy Prior to World War I: Slippery Slope or Governmental Prerogative?</i>	244
1. Franklin Pierce's Veto of Federal Subsidies for the Mentally Disabled..	244
2. The Progressive Era.....	245
C. <i>Emergence of a National Public Health Policy</i>	246
1. World War I and the Spanish Flu of 1918	246
2. The New Deal Era	247
D. <i>How the Current Employer-Provided Health Care System Developed: Roosevelt, Truman, Wage Controls, and the Internal Revenue Service</i>	248
1. The Beveridge Report and Truman's Health Care Reform	249
2. Wartime Wage Controls and the Tax Deduction for Health Care Benefits	251
E. <i>Johnson & the Great Society</i>	254
F. <i>The Rise and Fall of HMOs</i>	256
1. Nixon Passes the HMO Act of 1973	256
2. Managed Care: The Panacea of Rising Health Care Costs?	257
3. Backlash	259
G. <i>One More Time: Clinton's Stab at Health Care Reform</i>	261
1. Managed Competition	261
III. MEDICARE: HOW THE PROGRAM CURRENTLY CURTAILS COST	264
A. <i>The Medicare Appeals Process</i>	264
1. The Administration of Medicare and the Administrative Procedures Act	264
2. The Appeals Process	267
3. Hays v. Sebelius	268
B. <i>Medicare Payment Advisory Commission</i>	269
IV. THE INDEPENDENT MEDICARE ADVISORY COMMITTEE	270
A. <i>Statutory Provisions of IMAC</i>	270
B. <i>Will The Federal Advisory Committee Act Apply to IMAC?</i>	271
1. Requirements.....	272
2. The Advice or Recommendation Requirement	272
3. Exclusion of Committees Wholly Composed of Federal Employees.....	275

TABLE OF CONTENTS CONT.

C. *IMAC: A "Federal Health Board"* 275

 1. *The Federal Reserve and the Sunshine Act* 278

 2. *Britain's National Institute for Health and Clinical Excellence* 279

D. *Rationing* 281

V. *DIAGNOSIS: IS HEALTH CARE IN AMERICA A FAILURE OR A SUCCESS?* 285

 A. *The Number of Uninsured Citizens* 288

 B. *Cost and Efficiency* 291

 C. *Access to Care* 297

 D. *Quality and Outcomes* 298

VI. *CONCLUSION: HOW WILL IMAC AFFECT AMERICAN HEALTH CARE?* 300

 A. *Instead of IMAC, What Ought to Be Done to Curb Costs?* 300

 B. *Conclusion* 304

I. INTRODUCTION

In 2009, lawmakers presented the American people with a serious dilemma: Is it right that a government “death panel”¹ should be

* Robert Coleman is a second year student at Pepperdine University School of Law. He attended the University of California Berkeley, where he studied History and Philosophy. He owes his achievements to his parents, Ron and Carol Coleman, and dedicates this article to their hard work.

1. Sarah Palin, Governor of Alaska, *Statement on the Current Health Care Debate* (Aug. 7, 2009), http://www.facebook.com/note.php?note_id=113851103434 (“The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care. Such a system is downright evil.”). At the time Governor Palin made this comment on her facebook.com page, critics and journalists condemned her remarks as hyperbolic and incendiary. *See, e.g.*, Jim Rutenberg & Jackie Calmes, *False ‘Death Panel’ Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 13, 2009, available at <http://www.nytimes.com/2009/08/14/health/policy/14panel.html>; Ezra Klein, *Is the Government Going to Euthanize Your Grandmother? An Interview with Sen. Johnny Isakson*, WASH. POST, Aug. 10, 2009, available at http://voices.washingtonpost.com/ezra-klein/2009/08/is_the_government_going_to_eut.html. Several days later, Palin explained that she had been referring to section 1233 of House Resolution 3200 which provides for end of life counseling to Medicare recipients. Sarah Palin, *Concerning the Death Panels* (Aug. 12, 2009), http://www.facebook.com/note.php?note_id=116471698434. Since the bill’s purpose was to reduce Medicare spending, Palin declared that the end of life counseling was intended to reduce costs and therefore ration care by coercing the elderly into accepting end of life treatment. *Id.* Some lawmakers and journalists echoed Palin’s concern. *See, e.g.*, Letter from Ruben Diaz, Chairman of the New York State Senate Aging Committee, to Congressman Henry Waxman re Section 1233 of HR 3200 (July 27, 2009) available at <http://www.nysenate.gov/press-release/letter-congressman-henry-waxman-re-section-1233-hr-3200>; Eugene Robinson, *Behind the Rage, a Cold Reality*, THE WASHINGTON POST, Aug. 11, 2009, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/08/10/AR2009081002455.html>. Section 1233, titled “Advanced Care Planning,” would have provided end of life counseling for Medicare beneficiaries once their health conditions changed or once they entered a nursing home. H.R. 3200, 111th Cong. § 1233 (2009), 2009 Cong. US HR 3200 (Westlaw). That section was ultimately removed from the bill. John Stossel, *Obamacare’s Inevitable Logic*, ABC News, Aug. 18, 2009, <http://abcnews.go.com/2020/Stossel/story?id=8358377>.

charged with the decision of “pull[ing] the plug on grandma,”² or would it be preferable that a “holocaust”³ be perpetuated? Should we ask Americans to “die quickly?”⁴

Indeed, after the health care debate of 2009, no one will ever accuse national lawmakers of soaring with the angels during their recent intellectual discourse. Instead, rhetoric seems to have overshadowed what might have been a fruitful public dialogue on the topic of health care in America. Health care expenditures have spiraled out of control for consumers, employers, and the federal government.⁵ Moreover, the number of uninsured Americans stands

2. Jason Hancock, *Grassley: Government Shouldn't 'Decide when to Pull the Plug on Grandma'*, THE IOWA INDEPENDENT, Aug. 12, 2009, <http://iowaindependent.com/18456/grassley-government-shouldnt-decide-when-to-pull-the-plug-on-grandma>. After Congressman Chuck Grassley declared that section 1233 would “pull the plug on grandma,” President Obama held a nationally televised town-hall meeting where he addressed what he called the “legitimate concern” of rationing care. *ABC News: Obama Debunks Health Bill's 'Death Panels.'* (ABC television broadcast Aug. 13, 2009), available at <http://abcnews.go.com/video/playerIndex?id=8304120>. Obama cited Senator Johnny Isakson, a Republican, who had authored an amendment to the Medicare End of Life Planning Act of 2007, similar to Section 1233; and, Obama asserted that end of life care would be voluntary and non-coercive and that it would merely expand medical options to aging seniors, such as, by extending to seniors information regarding living wills. *See id*; see also Klein, *supra* note 1.

3. Jonathan Allen, *Grayson Likens Health Crisis, Holocaust*, POLITICO, Sep. 30, 2009, <http://www.politico.com/news/stories/0909/27769.html>. Democratic Congressman Alan Grayson accused Republican opponents of the health care reform bill of wanting uninsured Americans to “die quickly,” and later refused to apologize. *Id.* Rather, Congressman Grayson stepped up his indignation, stating on the House floor, “I would like to apologize. . . . to the dead and their families that we haven't voted sooner to end this holocaust in America.” *Id.*

4. *See supra* note 3 and accompanying text.

5. DAVID GRATZER, *THE CURE: HOW CAPITALISM CAN SAVE AMERICAN HEALTH CARE* 104 (2006) (citing projections from the Center for Medicare and Medicaid Services (CMS)). From 1995 to 2000, Medicaid spending increased from \$156 billion to \$207 billion, and from 2000 to 2005, Medicaid spending increased to \$330 billion. *Id.* Dr. Gratzter also cites a 2005 report on Medicare and Social Security Trust Funds, which indicates that Medicare spending will increase from 2.6% of GDP in 2004, to 13.6% by 2079, while creating a staggering unfunded liability (the amount the program will cost beyond what it is expected to take in through payroll taxes) of \$68.3 trillion (or five times the current U.S. Gross Domestic Product (GDP)). *Id.* at 126. Gratzter also discusses the rising out-of-pocket expenses many consumers face; however, Gratzter explains that, as a

as a persistent scandal to many.⁶ To solve these matters, some have advocated a national (federally-managed) health care system that would cover all Americans.⁷ Yet, others have suggested that a national health care system would lead to the rationing of health care.⁸

Economic rationing consists of controlling the distribution of scarce resources and services among a population.⁹ This comment explores whether the health care legislation currently making its way through the United States Congress is establishing an administrative

percentage of total health care spending, out-of-pocket expenses have decreased from 46% in 1962, to 22% in 1982, to 14% in 2002. *Id.* at 32-40. This trend has corresponded to a rising percentage in the expenditures of third-payer insurance coverage and federal subsidies, respectively. *See id.* at 37. Gratzner supports this thesis by citing Nobel Prize winning economist Milton Friedman, who wrote that while the vast majority of goods and services invariably increased slower than the inflation rate throughout the twentieth century, only health care services out-paced inflation, resulting in a real increase in cost. *Id.* at 33-36. For example, in 1946, total U.S. spending on transportation amounted to double the total cost of health care expenditures (4.5% of GDP in 1946), whereas, by the late 1990s, one-and-a-half times as much was spent on health care as on transportation (17% of GDP in 1997). *Id.*

6. *See* TOM DASCHLE, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 3 (2008). Daschle writes that there are 47 million uninsured Americans. *Id.*; *but see infra* notes 325-341.

7. *See, e.g.*, DASCHLE, *supra* note 6, at 144-46. Daschle says that a “pure single-payer system” poses a political hurdle, but does not dismiss the potential virtue of a single-payer system. *Id.* at 144. Moreover, he rejects proposals that individuals should be allowed to purchase their own insurance on an open market, instead recommending a Federal Health Board (FHB) with a public insurance option, like Medicare, provided by the government. *See id.* at 144-46.

8. JOHN C. GOODMAN ET AL., LIVES AT RISK: SINGLE PAYER NATIONAL HEALTH INSURANCE AROUND THE WORLD 2-5 (2004). Goodman argues that government limits high health care expenditures that are increased by high consumer health care demand, by limiting health care supply. *See id.*

9. *Compare* Martin Feldstein, *ObamaCare is All About Rationing*, WALL ST. J., Aug. 18, 2009, available at <http://online.wsj.com/article/SB10001424052970204683204574358233780260914.html> (“The Obama strategy is to reduce health costs by rationing the services that we and future generations of patients will receive.”), *with* David Leonhardt, *Health Care Rationing Rhetoric Overlooks Reality*, N.Y. TIMES, June 17, 2009, available at <http://www.nytimes.com/2009/06/17/business/economy/17leonhardt.html> (“The choice isn’t between rationing and not rationing. It’s between rationing well and rationing badly.”).

body effectively charged with the rationing of health care resources; insofar as it establishes a presidentially appointed Independent Medicare Advisory Committee (IMAC).¹⁰ IMAC would be charged with “making two annual reports dictating updated rates for Medicare providers including physicians, hospitals, skilled nursing facilities, home health, and durable medical equipment.”¹¹ IMAC’s recommendations would be implemented nationally, subject to a Congressional vote.¹² Congress would be granted a thirty-day window to achieve a simple majority for or against the IMAC recommendations.¹³

Critics of health care rationing cite examples of waiting lists and long lines in Canada and elsewhere as proof that government-managed health care leads to rationing.¹⁴ Some proponents of national health care go so far as to advocate rationing as the best way to curtail skyrocketing health care expenditures.¹⁵ Still, for the most part, proponents of national health care (whether consisting of single-payer reform or managed competition reform¹⁶) have suggested that the political rhetoric about health care rationing is just that—rhetoric.¹⁷

Former Alaska Governor Sarah Palin famously accused proponents of the current federal legislation of instituting “death panels” in order to ration health care.¹⁸ Rhetoric aside, advocates of non-governmental, free-market health care reform argue that rationing will be an inseparable component of a national health care system.¹⁹ They submit that rationing finite health care resources is the logical result of government-administered health policy.²⁰ These

10. See *infra* notes 199-208.

11. David Rogers, *W.H. Rollis at Medicare Agency Plan*, Politico, July 15, 2009, <http://dyn.politico.com/printstory.cfm?wid-8155A62B-18FE70B2>. See *infra* notes 199-208.

12. See *infra* notes 199-208.

13. See *infra* notes 199-208.

14. See *infra* notes 396-399.

15. See *infra* notes 286-288.

16. See *infra* notes 153-156.

17. See ABC NEWS, *supra* note 2.

18. See *supra* note 1 and accompanying text.

19. See *infra* notes 299-309.

20. See *infra* notes 299-309.

reformists further assert that free-market health care reform could bring costs down without government intervention and without rationing.²¹

Part II of this comment covers the history of American health care. It lays out the federal government's evolving role in the arena of public health and health care, starting in the mid-nineteenth century and continues up to the present day. Part III examines the existing process by which Medicare spending is controlled. This part focuses on the administrative procedures that control Medicare reimbursements. Part IV examines IMAC. This part discusses IMAC's statutory provisions and the administrative transparency laws IMAC would be bound to follow. The close of this part, draws on three analogies as a gauge for how IMAC will operate: Senator Tom Daschle's Federal Health Board (FHB) proposal; the administrative oversight of the Federal Reserve; and the United Kingdom's National Institute for Health and Clinical Excellence (NICE).

Part V creates a snapshot of the U.S. health care system as it operates today. This part emphasizes cost, quality, and accessibility of health care, with comparisons to international and state-run health care systems. Part VI briefly concludes this comment. Throughout this paper there are a number of words, phrases, and agencies that have been given acronyms to assist in the readability of this paper. For convenience, an index of these acronyms can be found in an appendix following this comment.²²

II. HISTORY

A. What is 'Health care;' What is 'Medicine'?

"Medicine's role," the philosopher Voltaire once quipped, "is to entertain us while Nature takes its course."²³ Today, some two hundred years later, some consider access to health care to be a constitutional and moral right, as still others say neither right exists.²⁴

21. See *infra* notes 442-452.

22. *Infra* note 461.

23. GRATZER, *supra* note 5, at 11.

24. Compare David B. Rikin Jr. & Lee Casey, *Illegal Health Reform*, WASH. POST, Aug. 22, 2009, available at <http://www.washingtonpost.com/wp->

Indeed, nature's course notwithstanding, a lot has changed since the eighteenth century. Most assuredly, little if anything has changed in human physiology since humans first walked the Earth: bones still break and cancer is still deadly. But Dr. David Gratzner, a Canadian psychiatrist and proponent of free-market health care reform, prefers to separate the practice of medicine into pre- and post-twentieth

[dyn/content/article/2009/08/21/AR2009082103033.html](http://online.wsj.com/article/2009/08/21/AR2009082103033.html) (arguing that an individual mandate requiring every American to buy health insurance would be in violation of the Commerce Clause and the Taxing Power of Congress, respectively), and David Rikin Jr. & Lee Casey, *Is Government Health Care Constitutional?*, WALL ST. J., June 22, 2009, available at <http://online.wsj.com/article/SB124562948992235831.html> (arguing that a public option would lead to a single-payer health system, which would impose undue burdens on the right to privacy), with Akhil Amar, *Constitutional Objections to ObamaCare Don't Hold Up*, L.A. TIMES, Jan. 20, 2010, available at <http://www.latimes.com/news/opinion/la-oe-amar20-2010jan20,0,4309186.story> (arguing that the federal government has the authority to regulate commerce, levy taxes and protect human rights). Amar endorses a broad view of national defense, such that curtailing health care spending might reasonably come under the national defense power of Article I. See Amar, *supra* note 24. Amar also suggests that the Fourteenth Amendment extends Congressional authority to protect human rights and that health care "is such a right." *Id.* Further, Amar suggests that an individual mandate is indistinguishable from requiring citizens to purchase automobile insurance. See *id.* To be sure, the auto insurance argument is simply a red herring: state governments require automobile owners to purchase auto insurance as a condition of driving; the individual mandate would be the federal government requiring all citizens to purchase health insurance as a condition of citizenship. See *Illegal Health Reform*, *supra* note 24. Indeed, Rikin and Casey assert that while the Supreme Court has viewed the Commerce Clause as expansive, Congress cannot simply regulate Americans "because they are there." See *id.* The Court has repeatedly affirmed that the Commerce Clause is not likened to the general police power of the state; thus, Congress cannot regulate non-economic activity, which might have a remote economic impact. *Id.* Here, the federal government is attempting to require citizens to buy health insurance for no other reason than that there exists people without health insurance. *Id.* Moreover, the power to tax is limited such that where Congress's exercise of the taxation power has a regulatory effect, Congress must be able to rely on the Commerce Clause in the alternative: where a law enacted pursuant to the taxation power constitutes a mere regulation (of conduct), it does not hold muster. *Id.* Rikin and Casey further assert that the substantive right of privacy could be burdened in the event that a national health care system becomes single-payer. See *Is Government Health Care Constitutional?*, *supra* note 24. To wit, where the government expands its health care role, becoming sole and final decision-maker regarding which medical treatments will be reimbursed under the national health system, government decisions relating to private medical matters will become manifold. *Id.*

century paradigms.²⁵ Gratzner asserts that in the decades leading up to the twentieth century, medical practitioners developed new *treatments* at an increasing rate.²⁶ But in the twentieth century, *cures* to ancient illnesses began to develop.²⁷

At the dawn of the twentieth century, polio was crippling, old age meant painful degeneration and immobility, while schizophrenia meant institutionalization or, worse, a lobotomy.²⁸ Among children, ailments such as measles, whooping cough and leukemia were often death sentences.²⁹ In 1924, President Calvin Coolidge's sixteen-year-old son succumbed to an infected blister he developed playing tennis at the White House.³⁰ The son of the President of the United States died because antibiotics did not exist.

In 1941, a British police officer, Albert Alexander, scratched his face on a rose bush and nearly succumbed to an infection.³¹ Albert's wound became septic, his face was covered with abscesses and he lost his left eye.³² Albert's doctor, Charles Fletcher, decided to administer a new treatment, which would prove to be a medical breakthrough.³³ On February 12th, 1941, Albert became the first human recipient of penicillin.³⁴ His temperature dropped within four days.³⁵

Since the introduction of penicillin, our understanding and expectations of health care have dramatically changed.³⁶ Childhood

25. GRATZER, *supra* note 5, at 11-13. Gratzner writes that prior to the twentieth century, doctors could offer little more than comfort to ailing patients. *Id.* Although the late 1800s witnessed the development of many new medical treatments, this treatment provided comfort rather than cures. *Id.* It was not until the middle of the twentieth century when medical breakthroughs equipped doctors with curative treatments for centuries' old illnesses. *Id.*

26. *Id.*

27. *Id.*

28. *Id.* at 12-13.

29. *Id.*

30. GRATZER, *supra* note 5, at 13.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. GRATZER, *supra* note 5, at 13.

36. *Id.* at 16. Gratzner writes that the improved quality of life Americans enjoy well into old age is unique to the modern era. *Id.*

leukemia is survivable in nearly every case.³⁷ Schizophrenia is routinely treated with antipsychotics.³⁸ The first open heart surgery was performed in 1955, and in 1963 the first kidney transplant was performed.³⁹ Strokes can be prevented and hips can be replaced even in old age, while chemotherapy prolongs the life of cancer patients and the first test-tube baby solved infertility.⁴⁰ Yet, in 1787, no one could have claimed that access to such life-saving health care was a moral right to be enshrined in the Constitution: the knowledge and technology for such care did not exist.

B. A Federal Health Care Policy Prior to World War I: Slippery Slope or Governmental Prerogative?

1. Franklin Pierce's Veto of Federal Subsidies for the Mentally Disabled

In 1854, President Franklin Pierce vetoed a bill that would have mandated each of the several states to set up permanent funds to provide social support for the mentally disabled.⁴¹ Pierce surmised that if the federal government took up the task of caring for "all the poor in all the States," such "public philanthropy" would serve as an initial misstep down a slippery slope of federally subsidized welfare.⁴² Pierce declared that the General Welfare Clause is not a

37. *Id.* at 15.

38. *Id.*

39. *Id.* at 14.

40. GRATZER, *supra* note 5, at 14.

41. Franklin Pierce, President of the United States, Veto Message (May 3, 1854), *available at* <http://www.presidency.ucsb.edu/ws/index.php?pid=67850&st=veto&st1=franklin+pierce>. The Senate bill proposed that the Federal government apportion 10 million acres of land to the several states, each of which would sell the lands and invest the proceeds into perpetual funds. *Id.* The interest from the funds was to be "appropriated to the maintenance of the indigent insane within the several States." *Id.*

42. *Id.* ("It can not be questioned that if Congress has power to make provision for the indigent insane. . . . it has the same power to provide for the indigent who are not insane, and thus to transfer to the Federal Government the charge of all the poor in all the States."). Pierce feared that "public philanthropy" on the part of the federal government would lead to limitless Congressional

“substantive general power to provide for the welfare of the United States.”⁴³

2. The Progressive Era

In the five decades after the Pierce administration, the Industrial Revolution drastically changed the American workplace, sparking a new debate about the rights of workers. By the 1910s, the Progressive movement was advocating health care for all citizens.⁴⁴ In 1914, the American Association for Labor Legislation (AALL) drafted a bill, which would have extended medical care to all workers.⁴⁵ The AALL sent the bill to several state legislatures.⁴⁶ Only California and New York took notice, but the bill was soundly defeated in both states.⁴⁷

The legislation met broad opposition from employers, insurance companies, unions, and physicians who feared regulation of their fees.⁴⁸ According to Senator Daschle, opponents of the reform, frightened by the Red Scare, raised the specter of “socialized medicine.”⁴⁹ By 1919, the bill was history.⁵⁰ Still, perhaps as a safeguard against future government intervention, some employers began offering health care coverage as a fringe benefit.⁵¹

legislation enacted for the purpose of providing care for citizens who fall on hard times. *See id.*

43. *Id.* (“It is not a substantive general power to provide for the welfare of the United States, but is a limitation on the grant of power to raise money by taxes, duties, and imposts. If it were otherwise, all the rest of the Constitution, consisting of carefully enumerated and cautiously guarded grants of specific powers, would have been useless, if not delusive.”).

44. DASCHLE, *supra* note 6, at 47-49.

45. *Id.* at 47.

46. *Id.*

47. *Id.* at 48.

48. *Id.* at 48. For instance, Samuel Gompers, founder of the American Federation of Labor (AFL), blasted the legislation as an attack on workers’ liberty. *Id.*

49. DASCHLE, *supra* note 6, at 49.

50. *Id.*

51. *Id.* at 48.

C. Emergence of a National Public Health Policy

1. World War I and the Spanish Flu of 1918

Just as the turbulent First World War was coming to an end, a public health crisis emerged which all but devastated domestic tranquility. The Spanish Flu of 1918 ultimately infected half the world's population and claimed more than 20 million lives worldwide.⁵² The American Red Cross, a nongovernmental charity, responded to the pandemic swiftly.⁵³ As the flu spread, the United States Public Health Service (USPHS) issued a plan of action to a newly organized Red Cross National Committee on Influenza.⁵⁴ The plan required the mobilization of health care practitioners and the allocation of salaries and resources, with the USPHS conducting "all necessary dealings with state and local boards of health concerning the allocation of resources and personnel."⁵⁵

52. See *The Influenza Pandemic of 1918 and the Red Cross Response*, REDCROSS.ORG, <http://www.redcross.org/museum/history/influenza.asp#more>. Some have argued that the unprecedented interaction of so many multinational soldiers during World War I (WWI), with weakened immune systems hastened the transmission of the flu. See BBCNEWS.COM, 1918 Killer Flu Secrets Revealed, Feb. 5, 2004, <http://news.bbc.co.uk/2/hi/health/3455873.stm>.

53. *The Influenza Pandemic of 1918 and the Red Cross Response*, *supra* note 52.

54. *Id.* The USPHS can be traced to a 1798 federal law that provided care for injured merchant marines, and set up marine hospitals. U.S. Public Health Service Commissioned Corps, <http://www.usphs.gov/AboutUs/history.aspx> (follow "About the Commissioned Corps" hyperlink; then follow "History" hyperlink). During the immigration waves of the late nineteenth century, the USPHS expanded its role to include screening immigrants as they arrived. *Id.* In 1878, the National Quarantine Act wrested the power of quarantine from the States, allowing the USPHS to conduct quarantines. *Id.* Today, the USPHS serves multiple agencies such as the Food and Drug Administration (FDA), the Centers for Disease Control (CDC) and the CMS. *Id.* (follow "About the Commissioned Corps" hyperlink; then follow "Agencies" hyperlink).

55. *The Influenza Pandemic of 1918 and the Red Cross Response*, *supra* note 52. The pandemic ended in early 1920, after more than \$2 million had been raised by the Red Cross, and after over a half-million American lives had been lost. *Id.*

2. The New Deal Era

At the beginning of the 1900s, medical services remained fairly cheap and most Americans paid out of pocket for their expenses.⁵⁶ For the indigent, charitable organizations picked up the tab while doctors frequently discounted their poorer patients.⁵⁷ But as the era of curative medicine kicked in, technology, demand, and prices correspondingly increased.⁵⁸ In 1927, a Committee on the Cost of Medical Care (CCMC) formed to address the rising cost of health care.⁵⁹ The committee was especially concerned with the problems of cost and accessibility in rural areas.⁶⁰ As an alternative to practicing medicine independently as most doctors did at the time, the committee recommended that health care professionals form practices to provide rural health services.⁶¹ The practices would be spread throughout rural America and share the costs of facilities, while larger practices with larger facilities would be located in larger cities.⁶² The services they provided would be funded by insurance and tax dollars.⁶³

In 1935, President Franklin Roosevelt employed the assistance of former CCMC member Isidore Falk to draft sections of the Social Security Act, which would have provided subsidies for universal health care insurance.⁶⁴ The American Medical Association (AMA), which had assailed the CCMC report, campaigned against Roosevelt's proposal.⁶⁵ The AMA asserted that the plan would limit patient choice, lead to higher costs, diminish the quality of care and create a "compulsory system of care."⁶⁶ After a rancorous debate,

56. JAN COOMBS, *THE RISE AND FALL OF HMOS: AN AMERICAN HEALTH CARE REVOLUTION* 3-6 (2005).

57. *Id.*

58. *Id.*

59. *Id.* The CCMC was comprised of sixty health care professionals who concluded that America required comprehensive national health coverage. *Id.*

60. *Id.*

61. COOMBS, *supra* note 56, at 3-6.

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. COOMBS, *supra* note 56, at 3-6.

the Social Security Act passed without federal health care subsidies.⁶⁷ Roosevelt was only getting started on health care reform.⁶⁸

D. How the Current Employer-Provided Health Care System Developed: Roosevelt, Truman, Wage Controls, and the Internal Revenue Service

Today, the U.S. health care system consists of a predominantly employer-provided, private insurance system operating alongside a public sector regime, predominantly consisting of Medicare and Medicaid.⁶⁹ Employer-provided, or third-payer, health insurance has its roots in pre-payment health care pools like the BlueCross and BlueShield (BCBS) nonprofit insurance plans.⁷⁰ BlueCross first sprung from a program founded at Baylor University in Dallas, Texas, providing pre-paid hospital insurance to school employees.⁷¹ This system allowed employees to buy into a pool at a monthly or yearly rate in exchange for hospital services, as they required.⁷² BCBS later extended the plan to employee groups throughout Dallas.⁷³ During the early 1900s, many employers began enrolling their employees in prepayment systems.⁷⁴ As early as the 1910s, employers feared that a national health care system would strip businesses of personal autonomy.⁷⁵ A series of World War II (WWII) era political events would cause the number of employer-provided health care plans to swell.

67. *Id.*

68. *See infra* notes 78-79.

69. *See infra* notes 70-99.

70. *See, e.g.,* DASCHLE, *supra* note 6, at 49; BlueCross BlueShield Association, About BCBSA – History of Blue Cross BlueShield, <http://www.bcbs.com/about/history/> (last visited Jan. 23, 2010).

71. BlueCross BlueShield Association, *supra* note 70.

72. *Id.*

73. *Id.*

74. DASCHLE, *supra* note 6, at 48-49, 77.

75. *Id.*

1. The Beveridge Report and Truman's Health Care Reform

On December 1, 1942, British economist Lord William Beveridge issued a report to the House of Commons with solutions to the ubiquitous social evils of poverty, ignorance, and disease in British society.⁷⁶ The report advocated that government become more active in social policy by establishing public health insurance for all citizens, creating the model for the British National Health Service (NHS).⁷⁷ Just one month after the report's publication, President Roosevelt delivered his State of the Union Address, in which he declared that social security must extend from "cradle to grave," and pushed to amend the Social Security Act to include health care.⁷⁸ Some deemed Roosevelt's renewed agenda an "American Beveridge Plan."⁷⁹

76. GRATZER, *supra* note 5, at 29.

77. *Id.* at 29-30. Echoing this call, one Member of Parliament, Lord Douglas Jay, declared that, with respect to nutrition, education and health, Parliament simply knows more about "what is good for people than the people know themselves." *See id.* at 29-30. Gratzner describes Beveridge and Jay as acting out of both "compassion" and "paternalism." *Id.* at 29. Lord Douglas Jay further declared that "[h]ousewives on the whole cannot be trusted to buy all the right things where nutrition and health are concerned," inasmuch as a housewife, "would not trust a child of 4 to select the week's purchases." *Id.* Gratzner is highly critical of Jay's attitude for its paternalistic view of the role of government in addition to its obvious "misogyny." *See id.* Gratzner suggests such an attitude might have been justified in a war-torn England where food was rationed, life expectancy was low and public health was substandard. *Id.* Still, Gratzner emphasizes that this was a very "different world," with the implication being that England has outgrown any possible need it might have had for the British National Health System (NHS). *See id.*

78. *See, e.g., id.* at 30; *Cradle to Grave Pigeonhole*, TIME, Mar. 22, 1943, available at <http://www.time.com/time/magazine/article/0,9171,796080,00.html>; Franklin Roosevelt, President of the United States, State of the Union Address (Jan. 7, 1943), available at <http://www.presidency.ucsb.edu/ws/index.php?pid=16386>. Roosevelt supported a Congressional bill, Wagner-Murray-Dingle, which would have amended the Social Security Act to include health coverage, reviving efforts to institute national health care. GRATZER, *supra* note 5, at 30.

79. *Cradle to Grave Pigeonhole*, *supra* note 78. Some deemed Roosevelt's 721-page social security plan the "American Beveridge Plan" only more vast its scope and more vague in its objectives. *Id.*

Roosevelt died just over a year later, but President Truman pursued national health care with vigor.⁸⁰ The AMA and the U.S. Chamber of Commerce backed a Republican effort to defeat Truman's health care bill.⁸¹ The AMA and the Chamber of Commerce encouraged employers to purchase group insurance.⁸² The AMA called on doctors to advise their patients to purchase private insurance.⁸³ Meanwhile, popular support for national health

80. DASCHLE, *supra* note 6, at 51-55. In a 1945 address to Congress, Truman declared that, "the health of [America] is a national concern [and] that financial barriers. . . shall be removed." *Id.* at 51.

81. *Id.* at 52-54. In Senator Daschle's analysis, the threat of a Communist infiltration allowed government-run health care opponents to raise the specter of creeping socialism. *Id.* Daschle writes that the AMA, national Republicans and the U.S. Chamber of Commerce formed a political coalition to oppose Truman's national health care; and that they intentionally associated Truman's health care reform with the looming communist threat in Europe. *Id.* The implication is that this campaign was intended to arouse the fear of communism among average Americans. *See id.* However, Daschle's criticism of the claim that "socialized medicine" was being instituted is more of a conclusion than an argument: never does he distinguish what "socialized medicine" would actually entail from what Truman, Roosevelt or the progressives were proposing. *Id.* at 60. If "socialized medicine" is a synonym for single-payer health care, in which the government finances all health care, one could find an analogue in Canada. *Id.* Canada's health system bans private insurance and has been described as "a national health insurance with federal contributions, provincial administration and a for-profit but independent delivery of primary care within the context of a government-financed system." GRATZER, *supra* note 5, at 165. Some have suggested that certain reform efforts, including Daschle's own recommendation of a Federal Health Board, would inevitably lead to complete Federal control of the health care industry. *See* Tom Price, Congressman, *The GOP Should Fight Health-Care Rationing*, WALL ST. J., Jan. 7, 2009, available at <http://online.wsj.com/article/SB123128781030459191.html>. Indeed, some have noted that Daschle's own suggestion, which would make employer and business compliance with the Federal Health Board's health policy a condition of health care tax deductions, a "political ruse" which seeks to eliminate private insurance altogether, thus inevitably leading to a single-payer system. *See, e.g., id.*; Michael Barone, *Video Proof: Obama Wants a Single-Payer System*, WASHINGTON EXAMINER, Aug. 9, 2009, <http://www.washingtonexaminer.com/politics/Video-proof-Obama-wants-a-single-payer-system-52699182.html>. In 2003, then-U.S. Senate candidate Obama unequivocally declared support for the idea of a single-payer national health care system and the elimination of employer-provided health care. *See* Barone, *supra* note 81.

82. DASCHLE, *supra* note 6, at 52-54.

83. *Id.*

care plummeted from a 75% approval in 1945 to only 21% in 1949.⁸⁴ In 1946, Republicans regained control of Congress for the first time in fourteen years.⁸⁵

By 1949, Truman's reform effort had fizzled.⁸⁶ As the smoke settled, an employer-provided health care system surfaced.⁸⁷ More businesses began offering health insurance as a fringe benefit.⁸⁸ Unions fell in line with employer coverage as it provided a great benefit to its members.⁸⁹ Senator Daschle asserts that the arrangement made sense insofar as the post-WWII era was marked by an economic boom for the American industrial sector: corporate income was plentiful and foreign competition remained low.⁹⁰

2. Wartime Wage Controls and the Tax Deduction for Health Care Benefits

During WWII, President Roosevelt instituted price and wage controls, declaring that, "where any important article becomes scarce, rationing is the democratic, equitable solution."⁹¹ Wage controls were intended to prevent the inflation of wages as mass amounts of military enlistments led to labor scarcity.⁹² In response, employers extended incentives to their employees in the form of fringe benefits, such as health insurance.⁹³

On October 26, 1943, the Internal Revenue Service (IRS) issued a tax ruling, which allowed employers to bypass Wartime wage controls by giving employees fringe benefits, tax-free.⁹⁴ In 1954, the IRS codified this ruling, allowing employers a tax deduction for the

84. *Id.* at 53.

85. *Id.* 51-55.

86. *Id.*

87. DASCHLE, *supra* note 6, at 54-58.

88. *Id.* In 1950, General Motors extended health insurance to its employees. *Id.* The president of General Motors, Charles Wilson, condemned the idea of nationalized health care as a threat to the free market and individual autonomy. *Id.*

89. *Id.* at 54-58.

90. *Id.*

91. GRATZER, *supra* note 5, at 25.

92. DASCHLE, *supra* note 6, at 50.

93. *E.g., id.*; GRATZER, *supra* note 5, at 25.

94. GRATZER, *supra* note 5, at 25.

health care benefits they provided.⁹⁵ Between 1946 and 1957, union workers covered by employer-provided health care increased from 1 million to 12 million, with an additional 20 million of their family members covered as well.⁹⁶ By 1963, 77% of Americans had hospital insurance.⁹⁷ Although more Americans than ever have become insured this way, critics of the third-payer system include free-market reformists⁹⁸ and national health care advocates alike.⁹⁹

95. *Id.*

96. DASCHLE, *supra* note 6, at 55.

97. *Id.*

98. See GRATZER, *supra* note 5, at 25-27, 31-44. On the free-market side, David Henderson, an economist who served on President Reagan's Council of Economic Advisers, explains that employers became attracted to the third-payer system because it allows them to shift taxable compensation into nontaxable health benefits, thereby incentivizing more lavish health plans for employer and employee. *Id.* at 25-27. To illustrate the incentive, Gratzter cites Henderson's account of a conversation between Henderson and Harvard economist Martin Feldstein, where Feldstein concluded that the typical employee making \$40,000 in the year 2000, with a spouse making \$25,000, would likely fall in the 28% Federal tax bracket. *Id.* Feldstein combined the 28% with 12.4% in social security taxes, 2.9% in Medicare taxes, 5% in state income taxes (3.6% after the Federal allowance for state income taxes is assessed), to arrive at 46.9% in taxes paid, thereby leaving the typical employee with about 53.1% (53¢ on the dollar) of his earnings after taxes. *Id.* Thus, whereas \$1 of compensation becomes about 53¢ after taxes, \$1 of nontaxable health care benefits remains \$1 of health care benefits. *Id.* The employee is better off to take the health care benefits rather than purchase insurance on his or her own, since individuals are not granted the tax deduction: \$1 that could have gone to health insurance becomes only 53¢ toward health insurance. *Id.* Therefore, it is better to offer lavish health benefits than more compensation, because the tax exclusion allows each dollar an employer invests into health insurance to be maximized as each dollar transfers directly from employer to employee without a tax consequence to either party. *Id.* However, free-market reformists assert that this third-payer regime creates the artificial sense for employees that (aside from the co-pay and the deductible) their health care is a "free" benefit; thus, causing the employee with health insurance to consume health care resources in a wasteful and unreasonable fashion, and driving up employer costs to boot. *Id.* at 31-44. By contrast, Gratzter argues that an "insurable event" ought to be one which is (a) unlikely to happen, (b) will come without warning and which (c) is not something the insured person desires. *Id.* at 31. To this end, Gratzter compares health insurance to automobile insurance, asserting that while Americans pay into auto insurance policies which cover large expenses like major accidents which they expect not to occur, with health insurance Americans pay to cover "virtually everything" from minor to major health needs. *Id.* Indeed, the average American family pays \$9,000 per year for health plans with fairly low

deductibles; yet an automobile insurance plan with a low deductible that included major body work as well as oil changes, gas and paintjobs would be considerably more expensive. *Id.* at 31-32. In Gratzner's view, this insurance model directly caused the cost of health care to outpace the rise of inflation, a phenomena not seen in the costs of most other goods and services. *Id.* at 33-35. Gratzner also refutes the argument that the increase in medical science, paired with an increase in research and development, has led to the increase in health care costs. *Id.* at 33-35. Reiterating the comparison to other sectors of the economy, such as the computer and fast-food industries, technological advancements have brought costs down, not up. *Id.* However, one notable area of health care has seen, both, an increase in technological advancement as well as dramatic decreases in cost: cosmetic surgery. *Id.* at 36. Between 1992 and 2002, the instances of cosmetic procedures increased by 400% while real cost has decreased. *Id.* Botox and laser resurfacing are undeniably recent technological innovations, yet their prices are falling. *Id.* And cosmetic procedures are generally paid for out of pocket. *Id.* Out of pocket expenses, however, have decreased from 46% to 14% of total health care spending between 1962 and 2002. *Id.* To illustrate the problem created by low out of pocket expenses, Gratzner analogizes the purchase of food and clothing (basic necessities like health care) to health care, and suggests that if a third party, such as an employer, paid 86¢ on each dollar of a person's grocery bill, that person would have a decreased incentive to shop rationally because the prices would be artificially deflated. *Id.* at 37, 43. In response, the employer and the government (which already provides Medicare and Medicaid) place bureaucratic constraints on usage. *Id.* at 38-40. Moreover, since the tax deduction increases with the tax bracket, higher paid employees experience the fruits of this tax subsidy, while lesser paid employees benefit the least—distinguishing it from most other forms of tax subsidy. *Id.* at 27-28. Consequently, as of 2004, an employee making more than \$100,000 earned an average of \$2,750 in nontaxable health insurance benefits, while an employee making \$40,000-\$49,000 earned an average of \$1,500 per year in tax-free health benefits. *Id.*

99. See DASCHLE, *supra* note 6, at 55-58. National health care advocates bemoan the downfall of "community rating" resultant from the rise of third-payer insurance. See *id.* at 56-57. BlueCross and BlueShield initially used a community rating, in which each person in the pool pays the same premium regardless of age or health status, in order to determine policy prices. *Id.* Community rating essentially requires the young and healthy to subsidize the old and the sick. *Id.* By contrast, commercial insurance companies, which grew in market share under the third-payer regime, had established actuarial tables based on age, risk and sex. *Id.* Commercial insurance companies were thus able to offer cheaper policies to the young and healthy. *Id.* Left with an older and less healthy pool of customers, BlueCross and BlueShield began to raise premiums, ultimately adopting the same actuarial system. *Id.* As a result, the number of uninsured elderly increased. *Id.* Some of the economic brunt of this was softened as unions gained pensions and health benefits for retirees in the late 1950s. *Id.* This gave unions an incentive to advocate a national health care system for the elderly: if the government covered retirees, unions could gain higher wages for current workers. *Id.* at 57-58. Daschle

E. Johnson & the Great Society

By the early 1960s, public support was growing for a federal health care program covering the elderly.¹⁰⁰ As a candidate for President, John F. Kennedy supported passing this program through a “Medicare” bill.¹⁰¹ Kennedy was unable to fulfill this goal prior to his 1963 assassination.¹⁰² Campaigning for President the following year, Lyndon Johnson included a federal health care plan for the elderly as part of his Great Society platform.¹⁰³

After Johnson and his party in the Congress won decisive victories, Johnson moved quickly to pass a Medicare bill.¹⁰⁴ Unions, such as the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), immediately supported Medicare.¹⁰⁵ While the AMA opposed the federal health care plan, the American Hospital Association (AHA) also supported Medicare.¹⁰⁶ By 1965, three bills had made it to the House for consideration: (1) a bill to amend the Social Security Act to provide universal health care for all elderly Americans was supported by Johnson and the unions; (2) “Eldercare,” which would have expanded the 1960 Kerr-Mills Act by helping states pay for the indigent elderly, was supported by the AMA; and (3) “Bettercare,” which would have provided federal

notes that as unions started to gain retirement health benefits for their members, retiree benefits strained employers’ finances, tying up funds that could be spent on wage increase for non-retired union members. *Id.* Unions, such as the AFL-CIO suddenly had an interest in promoting a federally provided national health system for retirees and seniors. *Id.* In the late 1950s, the AFL-CIO drafted a bill and began lobbying the Federal government. *Id.*

100. *Id.* at 57-60. The 1960 Kerr-Mills Act granted states funds to care for the indigent elderly. *Id.* at 59. The program floundered as many states failed to implement it, many of which because could not afford to pay for it. *Id.* Moreover, many doctors and hospitals refused to take part in the program as the reimbursements were low. *Id.*

101. *See, e.g., id.* 59-60; GRATZER, *supra* note 5, at 125.

102. DASCHLE, *supra* note 6, at 59-60.

103. *Id.* at 60-61.

104. *Id.* at 61.

105. *Id.*

106. *Id.* at 60. Hospitals were losing money by providing services to indigent elderly patients and Medicare reimbursements provided a solution. *Id.*

subsidies for the indigent elderly to buy private insurance, was supported by private insurance companies.¹⁰⁷

Congressman Wilbur Mills combined aspects of all three and gained bipartisan support for a three-layered Medicare bill: Part A would cover hospital care, nursing and home care for *all* senior citizens; Part B would be an optional program covering doctor's visits for *all* senior citizens; and Medicaid would cover certain indigent Americans such as seniors, single-parent families, and persons with disabilities.¹⁰⁸ In 1965, President Johnson held the famous signing ceremony for the Medicare bill in Independence, Missouri with former President Harry Truman at his side.¹⁰⁹ There, Johnson granted Truman the first Medicare card.¹¹⁰ Today, Medicare remains a health care system in which the federal government collects and pays all medical fees with tax revenues, providing health

107. DASCHLE, *supra* note 6, at 61.

108. *Id.* at 62; *see also* GRATZER, *supra* note 5, at 124-25 (arguing that Mills' Medicare bill contained structural flaws that have caused the cost of the program to increase beyond expectations). Gratzner argues that Mills was able to gain bipartisan support by drafting a compromise legislation which reflected the circumstances of the time. GRATZER, *supra* note 5, at 124-25. In the early 1960s, health care was cheaper, the population was younger and the elderly population was proportionately less than it is today. *Id.* Free-market reformists argue that Medicare created the same problem prevalent in the private third-payer system. *Id.* That is, by making coverage "free" at the point of consumption (or, in the case of the third-payer system, making deductibles high, with co-pays and out of pocket expenses remaining low) the elderly became "over-insured" and, in the absence of negative disincentives to curtail their usage (such as having to make out-of-pocket payments), the elderly began to over-use health care resources. *Id.* On the other hand, Senator Daschle approvingly reflects that, while Medicare did not initially cover prescription drugs and long-term care, it was the "largest expansion of health-care coverage in American history." DASCHLE, *supra* note 6, at 62. But, Daschle writes that the end result was a compromise program, which did not fully reflect the objectives of President Johnson or the labor unions. *Id.* Daschle also asserts that the hospitals, doctors and insurance companies who had been dragging their feet for decades became immense financial beneficiaries of the new programs. *Id.* at 63-64. Hospitals, BlueCross and the AHA gained a reimbursement formula covering "allowable expenses" plus a 2% bonus with no limit. *Id.* For-profit and nonprofit nursing homes were reimbursed for all costs plus a 7.5% profit. *Id.* Until Medicare, doctors often charged patients whatever they felt the patients could afford. *Id.* But under Medicare Part B, doctors began charging Medicare as much as possible. *Id.*

109. DASCHLE, *supra* note 6, at 62-63.

110. *Id.*

care to eligible citizens over the age of sixty-five.¹¹¹ Medicaid provides healthcare to eligible families with low incomes and is administered by the states with state and federal subsidies.¹¹²

F. The Rise and Fall of HMOs

1. Nixon Passes the HMO Act of 1973

The first Health Maintenance Organization (HMO) was developed in the early 1930s when a physician approached Henry Kaiser, the owner of a Los Angeles construction firm, offering him medical services for each of Kaiser's worker at a cost of five cents per day.¹¹³ Kaiser offered the plan to the public after WWII.¹¹⁴ An HMO is a type of health insurance, which joins doctors and other health care providers into a network to provide services at a flat rate without deductibles.¹¹⁵ HMO patients are limited to the doctors and medical providers within the HMO network.¹¹⁶ HMOs became popular on the West Coast and more than four million were enrolled in HMOs by the time Richard Nixon became President.¹¹⁷

In his first year in office, President Nixon spoke of an imminent "crisis" in the health care system.¹¹⁸ With the costs of health care skyrocketing, Nixon aimed at shifting 90% of the country onto HMOs.¹¹⁹ The HMO Act of 1973 passed in a bipartisan effort, backed by the Whitehouse and the late Senator Edward Kennedy.¹²⁰ The HMO Act of 1973 created a national market for HMOs by removing state-imposed restrictions on HMOs and mandating that employers with more than twenty-five employees offer HMO plans

111. 42 U.S.C. § 1395 (2006).

112. 42 U.S.C. § 1396 (2006).

113. GRATZER, *supra* note 5, at 47.

114. *Id.*

115. DASCHLE, *supra* note 6, at 70.

116. *Id.*

117. GRATZER, *supra* note 5, at 46-47.

118. *Id.* at 45.

119. *Id.* at 46.

120. *Id.* at 47.

alongside traditional indemnity insurance.¹²¹ It also extended federal loans and grants to start up new HMOs.¹²²

2. Managed Care: The Panacea of Rising Health Care Costs?

By the 1990s, HMOs, or managed care, had secured bipartisan political support.¹²³ A consensus view among free-market reformists and single-payer advocates is that access to plentiful health-care resources through third-payer insurance and government subsidies has led to supply-induced demand and the overuse of health care resources—consumers have no incentive to curb their usage because their usage is subsidized.¹²⁴ Enter, managed care.

By the early 1980s, employers who offered health plans with indemnity insurance were feeling the brunt of rising health-care costs.¹²⁵ Both General Motors and Chrysler Corporation were spending more to cover employee health benefits than they were on

121. *Id.*

122. *Id.*

123. GRATZER, *supra* note 5, at 49. With Medicare and Medicaid straining the federal budget, Republican House Speaker Newt Gingrich, among others, praised HMOs as the way to curtail runaway Medicare spending. *Id.* Vermont Governor Howard Dean, who oversaw the institution of a statewide universal health care system in Vermont, also praised HMOs. *Id.* Dean, the former Democratic Party Chairman, is also a medical doctor who once served on an HMO board. *Id.*

124. *See id.* at 48. Stanford economist Alain Enthoven, who would later support President Clinton's health care reform, became a leading academic proponent of HMOs. *Id.* Since the 1970s, Enthoven has been asserting that extending evermore health care expenditures, whether through state and Federal programs or employee benefit plans, causes supply-induced demand and the overuse of health care resources. *Id.* This position is shared by both free market reformists and single-payer health care advocates alike. *See, e.g., id.* at 48-49; DASCHLE, *supra* note 6, at 68-69. In other words, health care consumers will have no incentive to curtail the amount of health care resources they consume because it rarely means a difference in personal cost: deductibles, co-pays and out-of-pocket expenses are low for the average consumer. GRATZER, *supra* note 5, at 48-49. For doctors and hospitals, there is no reason *not* to persuade consumers to over-use or over-spend; Medicare, Medicaid, and employer provided insurance reimburse doctors and hospitals' fees. *Id.*

125. DASCHLE, *supra* note 6, at 68-69.

steel and rubber.¹²⁶ In a nutshell, indemnity insurance allows covered employees to choose their doctors, doctors to choose treatments, and employers to pay insurance companies to pick up the bills.¹²⁷ Between the early 1980s and 1993, health care expenditures soared from 8.9% to 13.6% of U.S. Gross Domestic Product (GDP).¹²⁸

In HMOs, patients can only choose from the doctors within the HMO network, while the HMO approves of financing.¹²⁹ In exchange for keeping costs low, doctors and hospitals, which are inside the HMO network, are guaranteed patients by the HMO.¹³⁰ Patients will pay more should they seek services outside the network.¹³¹ HMOs are paid the same regardless of the health status of its patients; therefore, HMOs have an incentive to keep costs down so that profits go up.¹³²

In 1988, about three-quarters of American workers were covered by indemnity insurance.¹³³ By the late 1990s, indemnity insurance comprised only 14% of the total health insurance market.¹³⁴ HMO enrollment skyrocketed from 4 million in 1969, to 9.1 million in the mid-1980s, to 36.5 million in 1990, and peaked at 79 million in 1998.¹³⁵ The increased size of HMOs led to greater buying power:

126. *Id.* One General Motors executive quipped that BlueCross and BlueShield were bigger suppliers to General Motors than U.S. Steel. *Id.* Famed Chrysler CEO Lee Iacocca experienced the same grief when he took the helm at Chrysler Corporation in 1978: more money was being spent on health care benefits than on steel and rubber! *Id.*

127. *Id.* at 70.

128. *Id.*

129. *Id.*

130. *Id.* In managed care, the HMO firm is a third-party provider, who pays for the services of its patients; however, the HMO will pick the doctors and providers. *Id.* HMOs provide patients to doctors who will keep the HMOs' costs low; if patients want additional services that their doctors in the HMO network will not cover, patients can shop outside the network and pay more. *Id.*

131. DASCHLE, *supra* note 6, at 70

132. *Id.*

133. GRATZER, *supra* note 5, at 49.

134. *Id.*

135. *Id.* at 46, 49; DASCHLE, *supra* note 6, at 71.

HMOs pushed for hospital discounts and rewarded doctors for keeping costs down.¹³⁶

3. Backlash

In a sense, managed care was the panacea to the health care crisis: Costs were contained and health care expenditures did not increase as a percentage of GDP between 1993 and the end of the decade.¹³⁷ Private health care spending was contained at a 2% yearly increase in 1996 (after the “backlash” against managed care, this shot up to 9.6% by 2002).¹³⁸ During the 1990s, hospital spending dropped.¹³⁹ Despite horror stories that surfaced about denials of life-saving care, many have argued that HMOs did not fail for lack of quality.¹⁴⁰ To some extent, free-market reformists and single-payer advocates agree on this point.¹⁴¹

Likewise, both sides would agree that consumers felt that managed care took medical decisions out of the hands of patients and doctors, placing these decisions in the hands of HMO administrators.¹⁴² Patients were kept from seeing specialists and often had to give up their family doctors if they were not part of the HMO network.¹⁴³ Doctors were outraged by HMO cost-cutting practices and sued HMOs to make their decisions more transparent.¹⁴⁴ Free-market reformists further emphasize the changing consumerist attitudes as a catalyst for the HMO backlash.¹⁴⁵

136. GRATZER, *supra* note 5, at 49-50. Gratzner refers the HMO strategy of “selective contracting,” using their buying power to push doctors and hospitals for discounts. *Id.* Doctors were rewarded for not referring patients to specialists. *Id.*

137. *Id.* at 51.

138. *Id.*

139. *Id.* at 52.

140. *Id.* at 53-54. Gratzner asserts that, despite sensational media stories about denials of care and poor quality health services, the quality of care did not generally suffer under HMOs. *Id.*

141. *See, e.g., id.*; DASCHLE, *supra* note 6, at 70-71. Senator Daschle writes that, initially, HMOs worked. DASCHLE, *supra* note 6, at 70-71.

142. *See, e.g., id.*; GRATZER, *supra* note 5, at 55-57.

143. DASCHLE, *supra* note 6, at 70-71.

144. *Id.*

145. GRATZER, *supra* note 5, at 55-57. Gratzner refers to the HMO system, and the structure of health care in America, as paternalistic, contrasting it from other

The growth of the Internet corresponded to the dawn of the Information Age and a boon to health care consumers.¹⁴⁶ Americans are no longer passive recipients of health services; they self-prescribe over the counter drugs, they find answers on WebMD, and they enter their doctors' offices researched and prepared.¹⁴⁷ As effective as HMOs were at containing costs, HMOs restricted choice; employers unilaterally enrolled their employees, and employees were left accepting a health care regime they had not chosen.¹⁴⁸ In Dr. Gratzer's view, "American health care is being reshaped by consumerism—and HMOs ran contrary to that trend."¹⁴⁹

areas of consumer life that are highly individualized. *Id.* at 55. Yet, according to Howard Dean, former Governor of Vermont, "[t]here is no such thing as an informed consumer of health care." *Id.* Gratzner argues that Dean's attitude reflects precisely what brought down the popularity of HMOs. America became increasingly consumer-savvy in the health-care market and was no longer willing to accept health-care decisions being made by disinterested HMO bureaucrats. *See id.*

146. *See* GRATZER, *supra* note 5, at 55-57; *see also* GOODMAN, *supra* note 8, at 180. Goodman writes that prior to 1997, The National Library of Medicine charged users to search its database of medical information and processed about seven million searches per year. GOODMAN, *supra* note 8, at 180. After 1997, it began hosting a free-access website for medical information in 1997 which received 180 million searches per year within the first two years. *Id.* The general public made one-third of these searches. *Id.* Goodman also notes that an FDA decision to let pharmaceutical companies advertise on radio, print and television without lengthy side-effects descriptions also contributed to increase consumer awareness of medical products on the market, removing doctors from their "gatekeeper" position. *Id.* Goodman clarified that drug manufactures still must provide a great deal of information on the packaging and that the FDA strictly limits claims that can be made. *Id.* Still, a concern has been raised that direct-to-consumer advertising also fuels demand for unnecessary drugs. *E.g.*, GRATZER, *supra* note 5, at 56; DASCHLE, *supra* note 6, at 9.

147. *See supra* notes 145-146 and accompanying text.

148. GRATZER, *supra* note 5, at 56. Gratzner argues that Americans did not have a choice about buying into HMOs. *Id.* Gratzner further emphasizes that regardless of health care quality it is the empowerment to make personal health decisions which health care consumers value. *Id.* American consumers, Gratzner argues, rejected the "paternalism" of HMOs. *Id.* at 57.

149. *Id.* at 56. Between 1997 and 1999, enrollment in Aetna insurance grew from 13 million to 21.1 million as it became the dominant HMO provider. *Id.* at 49-50. Today, however, it is again at approximately 13 million enrollees. *Id.*

G. *One More Time: Clinton's Stab at Health Care Reform*

1. Managed Competition

By 1992, three health care reforms were before Congress: (1) a single-payer plan; (2) free market reforms to expand private insurance; and (3) a “play-or-pay” plan.¹⁵⁰ Play-or-pay requires all employers to either purchase health insurance for their employees, or pay taxes so that the federal government can provide the health insurance.¹⁵¹ Campaigning for President, Arkansas Governor Bill Clinton supported play-or-pay.¹⁵² Once in office, Clinton proposed a fourth route called managed competition, in which the federal government regulates the health insurance market in order to avoid price competition among the insurance companies.¹⁵³ The government would manage prices with community rating¹⁵⁴ and create a guaranteed issue (in which all persons are covered regardless of health status).¹⁵⁵ Insurers would not be allowed to set their own prices and would only compete in their ability to provide quality health services while managing their own costs in the process.¹⁵⁶

Like Truman before him, President Clinton’s health care agenda would prove divisive.¹⁵⁷ In 1993, Clinton created an Interagency

150. DASCHLE, *supra* note 6, at 76-77.

151. *Id.*

152. *Id.* at 78-79.

153. *Id.*

154. *See supra* note 99 and accompanying text.

155. GOODMAN, *supra* note 8, at 202.

156. *Id.*

157. *See, e.g.,* DASCHLE, *supra* note 6, at 79-81; GOODMAN, *supra* note 6, at 201-07. Alain Enthoven became a staunch advocate of managed competition. GOODMAN, *supra* note 6, at 201. Proponents raved that managed competition’s combined doses of community rating and guaranteed issue would finally suppress “unfettered competition” and ensure health care to every American. *See* DASCHLE, *supra* note 6, at 80-81 (quoting a *New York Times* article praising managed care). Daschle, who represented North Dakota in the Senate in the 1990s, writes that he supported managed competition because it appeased Republicans who opposed play-or-pay’s taxation scheme while ultimately laying the groundwork for universal health coverage. *Id.* at 79. Campaigning for president, Bill Clinton proclaimed that managed care would maintain consumer choice, control cost and improve quality, and the federal government would not have to “bankrupt the

Health Care Task Force, chaired by First Lady Hillary Clinton, to develop a comprehensive health care reform bill.¹⁵⁸ The Clintons developed a plan that would have subsidized the unemployed and small businesses to buy health insurance from regional managed

taxpayers to do it.” *Id.* Economist John Goodman, however, criticizes managed competition for its illusory definition of competition. *See* GOODMAN, *supra* note 8, at 201-02. Goodman writes that managed competition would be a market in which the rules of competition are set by the government. *Id.* Insurers would not be allowed to compete on terms such as pricing and risk management; rather, they would only compete in their respective abilities to provide health care services. *Id.* Consumers would be choosing their insurance simply based on which doctors’ networks they would be able to utilize. *Id.* Insurers would not be able to offer more medical services at higher prices and expensive services offered to high-risk customers would become a strain on resources. *Id.* In such a system, the only business incentive left for insurers is to avoid high-risk customers, thereby avoiding high expenses. *Id.* Goodman asserts that where normal competition in pricing exists, incentives are created for sellers to compete for buyers by creating “buyer-pleasing” strategies. *Id.* Thus, insurance companies will normally provide services for high-risk customers. *Id.* However, insurers will discourage expensive, high-risk customers if the incentives that come with competition are taken away. *Id.* Goodman also criticizes community rating. *Id.* at 207. Community rating requires the healthy to pay more than the cost of the services they expect to use and the unhealthy to pay less than the cost of the services they expect to use. *Id.* The idea is that the healthy subsidize the unhealthy, creating a financial equilibrium so that enough funds are contributed to pay for everyone in the community. *Id.* But Goodman asserts that where prices are kept “artificially low” (such as they would be for unhealthy customers), sellers of goods and services will allow those goods and services to degenerate to the point where the cost to the seller equals, dollar-for-dollar, the expected return. *Id.* In a normal market, competition causes consumer prices to equal average cost by the seller. *Id.* at 206. But under community rating when the premium price is constrained to an artificial level, the cost which the insurers input will decrease so that it equals that artificial premium price. *Id.* This would cause the number of high-cost services offered to diminish. *Id.* at 207. Goodman compares the situation to rent control laws, which force landlords to keep rent low, in turn causing the landlords to let the housing quality deteriorate until the landlord’s cost equals rent received. *Id.* Thus, Goodman explains, insurance firms will have a strong interest in over-providing low-cost, superfluous health services which attract healthy customers (inexpensive patients) and under-providing high-cost services which unhealthy customers (expensive patients) may require. *Id.* Health insurance companies might have a profitable incentive to offer health club memberships and cheap vaccinations; but, as Alain Enthoven admits, “[a] good way to avoid cancer patients is to have a poor oncology department.” *Id.* at 203-04. In essence, Goodman submits that community rating causes avoidance of high-cost, unhealthy patients. *Id.*

158. DASCHLE, *supra* note 6, at 84.

competition alliances, with global budget caps on hospitals to contain prices.¹⁵⁹ The plan would have included an employer-mandate to finance the program through taxes.¹⁶⁰ Insurance companies and Republican lawmakers opposed the employer-mandate and community rating.¹⁶¹ Many Democrats splintered from the President's agenda and supported a pure single-payer reform bill.¹⁶² Also, like with Truman, public support nose-dived.¹⁶³

159. *Id.* at 80, 84.

160. *Id.* at 84.

161. *Id.* at 90-97. Daschle chronologically details the events of 1993 and 1994, from the initiation of the task force in the spring of 1993, to President Clinton's address to a joint session of Congress in fall, to the stunning opposition campaign that lasted throughout the spring of 1994. *Id.* He suggests that public support dropped as details of the bill's content became public and opponents lambasted the number of new regulations and administrative councils in the bill. *Id.* at 90. He further asserts that the bill was highly technical and complex, thus allowing opponents to attack the details of the bill. *Id.* at 90-95. However, Daschle also suggests that President Clinton's preoccupation with events in Somalia, which caused him to cancel several health-care speeches, gave opposition "time to mobilize." *Id.* at 89. He further notes that unions were peeved with the president due to his support for the North American Free Trade Agreement. *Id.* 93-94. Finally, in another of what appears to be an alternative reason for the reform effort's ultimate failure, Daschle argues that more liberal members of the President's party decided to support a single payer health care bill, thus splintering support among Democrats. *Id.*

162. *Id.* at 96.

163. *Id.* at 97. From September 1993 to March 1994, opposition to the Clinton reform rose from 18% to 45%. *Id.* In October 1993 alone, supporters outnumbered opponents by 32% at the beginning of the month; but by month's end the gap shrunk to 12%. *Id.* at 89. While Senator Daschle again raises the criticism that opponents played politics with the cry of 'socialized medicine,' Daschle himself is unsettled on the reason the Clinton reform ultimately failed. *See id.* at 90-94. He admits that leaking details of the complex, 1,300 page bill, which created more than ninety new administrative agencies, caused citizens to become mired in the niceties. *Id.* at 90, 94. He laments that while everybody agreed reform was needed, "few groups were willing to tolerate provisions that might harm them, to swallow new regulations, or to sacrifice some profits for the greater good." *Id.* at 99. However, Daschle opposes the explanation that it was the substance of Clinton's reform which killed the reform effort. *Id.* at 109. Daschle writes that because the details of the reform were made public, the bill was targeted by the right who thought the bill was overly generous and by the left who thought it was not generous enough. *Id.* Daschle maintains, however, that while the lengthiness and complexity of the bill made it a target, it was not the substance which caused the bill to fail. *Id.* Moreover, he writes, Republican Governors of Massachusetts

III. MEDICARE: HOW THE PROGRAM CURRENTLY CURTAILS COST

A. The Medicare Appeals Process

1. The Administration of Medicare and the Administrative Procedures Act

The Administrative Procedures Act (APA) requires that persons subject to a federal agency be given notice of all substantive rules promulgated by the agency, and that all interested parties be given an opportunity to respond.¹⁶⁴ An Administrative Law Judge (ALJ) shall be appointed to conduct hearings pursuant to controversies between agencies and persons who are subject to it.¹⁶⁵ The ALJ, however, remains subject to the agency's rules.¹⁶⁶ Under APA, federal courts are compelled to uphold all administrative decisions unless they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."¹⁶⁷ The courts must still defer to an agency's construction of its own regulations.¹⁶⁸

The notice and comment requirement applies to substantive and not interpretative rules.¹⁶⁹ Interpretative rules, "merely explain, but do not add to, the substantive law," while substantive rules "create rights [and] impose obligations."¹⁷⁰ Exemptions to the notice and comment requirement are narrowly construed and reluctantly

and California would both endorse managed care within the next decade. *Id.* at 110. In his analysis, President Clinton waited too long after assuming office to push the reform. *Id.* Clinton assumed office in January 1993, initiated his task force in May and gave his speech to a joint session of Congress in September. *Id.* at 84. Also, by not attaching it to the annual budget, the health care bill was susceptible to filibuster in the Senate. *Id.* at 110. Budget bills are time-limited and filibuster-proof. *Id.* Daschle argues that the issue is so important that the bill ought to be attached to the annual federal budget, despite assertions that this violates Senate protocol. *Id.* at 110, 196-97.

164. See 5 U.S.C. § 554(a) (2006).

165. See *id.* § 556(c) (2006).

166. See *id.*

167. See *id.* § 706 (2006).

168. See *Lyng v. Payne*, 476 U.S. 926, 939 (1986).

169. See *Erringer v. Thompson*, 371 F.3d 625, 630 (9th Cir. 2004).

170. See *Hemp Indust. Ass'n v. DEA*, 333 F.3d 1082, 1087 (9th Cir. 2003).

countenanced.¹⁷¹ The notice and comment requirement is designed to ensure fair treatment of persons affected by the agency's substantive rules and to allow affected persons to participate in the rule-making process.¹⁷²

The federal government provides health care for the poor and elderly under Medicaid and Medicare, respectively. Under Medicare parts A and B, the Centers for Medicare and Medicaid Services (CMS) currently has the legal power to deny reimbursements for items and services that are not "reasonable and necessary for the diagnosis or treatment of illness or injury."¹⁷³ Citizens, however, have a right to appeal all decisions about their Medicare services.¹⁷⁴ The Medicare Act does not define reasonable and necessary. Rather, it is left to the Office of the Secretary of Health and Human Services (the Secretary) to determine whether claimants are entitled to benefits "in accordance with regulations prescribed by him."¹⁷⁵

171. See, e.g., *Environmental Defense Fund, Inc. v. Gorsuch*, 713 F.2d 802, 816 (D.C. Cir. 1983) ("Any claim of exemption from APA rule making requirements will be narrowly construed and only reluctantly countenanced" (quoting *American Federation of Government Emp. v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981))).

172. See, e.g., *Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1103 (4th Cir. 1985) ("the purpose of notice-and-comment procedure [in administrative rule making] is both to allow agency to benefit from the experience and input of the parties who file comments . . . and to see to it that the agency maintains a flexible and open-minded attitude towards its own rules . . ." (quoting *National Tour Brokers Ass'n v. United States*, 591 F.2d 896, 902 (D.C. Cir. 1978))).

173. 42 U.S.C. § 1395y(a)(1)(A) (2006); see also Michael F. Cannon, *Sorry Folks, Sarah Palin Is (Partly) Right*, *Detroit Free Press*, Aug. 19, 2009, available at http://cato.org/pub_display.php?pub_id=10467 (describing the Medicare appeals process). Cannon, director of health policy studies at the Cato Institute, writes that this statutory authority for the CMS to deny coverage based on the reasonable and necessary standard is weak do to political resistance from the medical industry. Cannon, *supra*. Cannon asserts that IMAC is intended to circumvent this political resistance by leaving it to IMAC to reform Medicare by choosing which reimbursements will be covered. *Id.* Unlike the CMS, IMAC would be an independent board of presidential appointees, granted with a much higher degree of autonomy than the CMS. *Id.*

174. Medicare Appeals and Grievances, <http://www.medicare.gov/basics/appeals.asp> (follow "Medicare Appeals" hyperlink; then follow "Appeals and Grievances" hyperlink).

175. 42 U.S.C. § 416 (i)(2)(E)(f).

Medicare is administered by the CMS (formerly known as the Health Care Financing Administration (HCFA)), which contracts with private insurance companies.¹⁷⁶ These Medicare contractors act as financial intermediaries between the CMS and Medicare beneficiaries, and they process all Medicare claims and appeals.¹⁷⁷ The contractors can rely on National Coverage Determinations (NCDs) in their decisions to deny or approve reimbursements for medical services.¹⁷⁸ The Secretary develops NCDs, defining services that are not reasonable and necessary.¹⁷⁹ Medicare contractors can rely on NCDs, but must still uphold the reasonable and necessary standard when denying claims for services that have been yet to be evaluated.¹⁸⁰ For such claims, the contractors can rely on Local Coverage Determinations (LCDs), developed with the guidance of the Secretary.¹⁸¹ Unlike NCDs, LCDs are not substantive laws and are thus not subject to APA.¹⁸²

176. *Erringer*, 371 F.3d at 627.

177. *Id.*

178. Centers for Medicare and Medicaid Services: Medicare Coverage Determination Process, <http://www.cms.hhs.gov/DeterminationProcess/> (follow “Medicare” hyperlink; then follow “Medicare Coverage Determination Process” hyperlink); *see also* http://www.cms.hhs.gov/FACA/02_MEDCAC.asp (follow “Regulations and Guidance” hyperlink; then follow “Federal Advisory Committee Act (FACA)” hyperlink; then follow “Medicare Evidence Development and Coverage Advisory Committee” hyperlink). The Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) provides expert clinical advice to the CMS in its development of NCDs. *Id.* MEDCAC is subject to the Federal Advisory Committee Act (FACA). *Id.*

179. *Erringer*, 371 F.3d at 627.

180. *Id.*

181. *Id.* The Secretary issues frequent guidelines to the contractors on how to develop LCDs. *Id.* LCDs merely interpret the reasonable and necessary language of the Medicare Act. *Id.* at 630. Thus, it is the Medicare Act that creates the substantive law which the LCDs merely interpret. *Id.* LCDs are therefore not subject to the promulgation requirement under the APA because the guidelines creating the LCDs do not carry the force of law. *Id.*; *see also* 5 U.S.C. § 553(b)-(c) (2006). The court noted that the APA’s notice and comment requirement applies to substantive rules passed by the CMS, prior to promulgation. *Erringer*, 371 F.3d at 629.

182. *See supra* note 183 and accompanying text.

2. The Appeals Process

An appeal can be made to the CMS and then to a hearing before a Social Security Administration (SSA) ALJ if the claim exceeds \$100 and is not reviewable unless it exceeds \$1,000.¹⁸³ Under Part B, an appeal can be made to the Medicare contractor, then to a Medicare hearing officer for claims exceeding \$100, and then to an ALJ.¹⁸⁴ Most appeals are granted without reaching an ALJ; about .09% of Part A claims reach an ALJ and 1.25% of Part B claims reach an ALJ.¹⁸⁵

183. 42 U.S.C. § 1395ff (2006).

184. *Id.*

185. *See Erringer*, 371 F.3d at 628; *see also* Hospital Insurance Benefits, SSR 76-26A, 1981 WL 387986 at *4, S.S.A. (1981); *but see* *Wilkins v. Sullivan*, 889 F.2d 135 (7th Cir. 1989). In one hearing before the SSA Appeals Council, the council held that a hospital's efforts to rehabilitate a patient who experienced a sudden onset of aphasia and right-sided hemiplegia were reasonable and necessary thus reimbursable under Medicare. Hospital Insurance Benefits, SSR 76-26A, 1981 WL 387986 at *4, S.S.A. (1981).

Aphasia is a condition in which the patient's language modality is impaired, and hemiplegia is a condition in which half the body is paralyzed. *Id.* at *2. The patient was given a poor prognosis and remained inpatient for a rehabilitation period lasting two months receiving daily speech therapy. *Id.* at *1-3. The patient's progress was slow, but steady. *Id.* at *2-3. In less than two weeks improvements were being made in the patient's speech functions. *Id.* Steady progress also occurred with respect to the patient's mobility which also required intensive physical therapy. *Id.* Upon discharge the patient was able to feed herself, though she still required assistance bathing, dressing and being pushed in her wheelchair. *Id.* at *3. The council reasoned that where a patient requires a "coordinated team approach" for physical rehabilitation, if only in order to achieve a "reasonable level of independence with activities of daily living," such services are reasonable and necessary under Medicare. *Id.* Still, denied Medicare reimbursements are not exactly creatures of mythology, especially where the claims involve "novel surgical procedures that may relieve pain and suffering." *See Wilkins*, 889 F.2d at 141. In *Wilkins v. Sullivan*, an appeal was made against the Secretary for the denial of a bilateral carotid body resection surgery (BCBR). *Id.* at 136. The court denied the appeal, holding that the Secretary's denial was not unreasonable, arbitrary or capricious. *Id.* at 140. The appellant suffered from chronic obstructive pulmonary disease, brought on by emphysema, and underwent a BCBR. *Id.* at 137. A BCBR consists of removing structures that control the diameter of the bronchial tubes from the neck to relieve shortness of breath. *Id.* The Secretary had decided that Medicare would not cover BCBRs. *Id.* The Secretary relied on a HCFA ruling, which held that BCBRs lack medical efficacy. *Id.* The HCFA had been advised by the USPHS and the National Heart, Lung and

3. Hays v. Sebelius

Recently, the D.C. Court of Appeals held that Medicare unequivocally covers “items and services.”¹⁸⁶ In *Hays v. Sebelius*, 589 F.3d 1279 (D.C. Cir. 2009), the court held that reimbursements for items and services are subject only to the reasonable and necessary standard.¹⁸⁷ The Secretary had directed Medicare contractors to apply the “least costly alternative” method for drug reimbursements.¹⁸⁸ In 2008, four Medicare contractors concluded that treating patients with obstructive pulmonary disease (OPD) with a combined dosage of two drugs lacked medical necessity, and began to reimburse for the least expensive of the component drugs.¹⁸⁹ A Medicare beneficiary receiving the combined dose contended that the least costly alternative method was inconsistent with the Secretary’s power to only deny items and services that are not reasonable and necessary.¹⁹⁰ The Secretary responded that Medicare may “partially cover an item or service, declining to reimburse expenses associated with the marginal difference in price between a prescribed item or service and its least costly and medically appropriate alternative.”¹⁹¹ The court rejected the least costly alternative method, and held that the Secretary’s ability to approve or deny coverage items and service

Blood Institute, whose advice was based on the findings of a panel of medical experts, that persons with obstructive pulmonary disease who undergo BCBR are at a heightened risk of hypoventilation (a reduction in the rate and depth of breathing). *Id.* The appellant asserted that the physical relief he experienced after the BCBR was proof that the Secretary’s decision was arbitrary and capricious. *Id.* at 140. The court responded that while pain relief is a significant outcome, the appellant’s emphysema was not cured and possible pain relief should not come at the expense of potential harm. *Id.* The court reasoned that “[i]t is precisely this type of decision—made within the context of an extremely technical and complex field—that courts should leave in the hands of expert administrators.” *Id.*

186. *Hays v. Sebelius*, 589 F.3d 1279, 1282 (D.C. Cir. 2009).

187. *Id.*

188. *Id.* In other words, treatments would be reimbursed only up to the price of their “reasonably feasible and medically appropriate” least costly alternatives. *Id.* at 1280.

189. *Id.* at 1282. DuoNeb provides a combination albuterol sulfate and ipratropium bromide in a single dose. *Id.*

190. *Id.*

191. *Hays v. Sebelius*, 589 F.3d 1279, 1281 (D.C. Cir. 2009).

is purely binary.¹⁹² This decision is already being seen as further affirmation of Medicare's liberal reimbursement regime.¹⁹³

B. Medicare Payment Advisory Commission

In 1997, Congress established the Medicare Payment Advisory Commission (MedPAC), an independent advisory committee that advises the Congress on Medicare related issues.¹⁹⁴ MedPAC issues two annual reports analyzing and making recommendations to improve Medicare payments, services, quality of care and access to care.¹⁹⁵ The Comptroller General appoints seventeen members to three-year terms, with backgrounds in health care, economics and public policy.¹⁹⁶ Two annual reports containing detailed recommendations for cutting Medicare costs are submitted to the Congress.¹⁹⁷ Many, including Peter Orszag, director of the Office of Management and Budget (OMB), Senator Max Baucus (co-author of a Senate version of the current health care bill), Senator Jay Rockefeller, and the late Senator Edward Kennedy have expressed a strong interest in expanding MedPAC's power, by establishing an independent Medicare board charged with curtailing Medicare expenditures.¹⁹⁸

192. *Id.* at 1283.

193. *Id.* In *Hays*, the court rejected the government's application of cost-effectiveness, broadening the scope of what Medicare must cover, and limiting what HHS can deny. *Id.* Senator John Cornyn views the Obama administration's failed attempt to deny reimbursements for items and services as a prelude to IMAC. See Scott Gottlieb & John Cornyn, *Ration With Caution*, AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH, Dec. 3, 2009, <http://www.aei.org/article/101386>. Cornyn cites a recent study by the United States Preventative Services Task Force (USPST), which has declared that women under age fifty do not need to undergo mammograms. *Id.* Cornyn asserts that cost-effectiveness played a major role in USPST's decision and that instituting additional government councils will lead to more denials of treatment based on cost-effectiveness. *Id.*

194. 42 U.S.C. § 1395b-6 (2006); see also MedPAC: Advising the Congress on Medicare Issues, <http://www.medpac.gov> (follow "About MedPAC" hyperlink).

195. *Supra* note 194 and accompanying text.

196. *Id.*

197. *Id.*

198. Letter from Peter Orszag, Director of Office of Management and Budget (OMB), to Nancy Pelosi, Speaker of the House of Representatives (July 17, 2009),

IV. THE INDEPENDENT MEDICARE ADVISORY COMMITTEE

A. Statutory Provisions of IMAC

Section 3403 of House Resolution 3590, titled the “Patient Protection and Affordable Care Act,” would amend title XVIII of the Social Security Act by establishing an Independent Medicare Advisory Board (alternatively referred to as IMAC).¹⁹⁹ This section constitutes more than fifty of the bill’s 2,000-plus pages. IMAC’s purpose would be to “reduce the per capita rate of growth in Medicare spending” by requiring the CMS to project its yearly spending, so the board may form proposals to keep that projection below “target growth rate for that year.”²⁰⁰ IMAC’s yearly proposal would be required to include recommendations resulting in a “net reduction in total Medicare program spending,” but must not include “any recommendation to ration health care, raise revenues or Medicare beneficiary premiums,” or increase Medicare deductibles, or “otherwise restrict benefits or modify eligibility criteria.”²⁰¹ In forming its proposals, IMAC must protect access to necessary and “evidence-based” drugs and treatments.²⁰² The proposals cannot be designed to result in “any increase in the total amount of the net Medicare program spending.”²⁰³ IMAC shall submit a copy of its proposal to MedPAC and to the President, and the President “shall”

available *at*
http://www.whitehouse.gov/omb/assets/legislative_letters/Pelosi_071709.pdf.
Orszag stresses the need for a health care system which, “rewards quality [and] restrains unnecessary costs.” *Id.*

199. H.R. 3590, 111th Cong. § 3403 (2009). IMAC has been given numerous names depending on the person commenting on the latest version of the legislation, including Independent Medicare Advisory “Committee,” “Council,” and “Board” respectively. *E.g.*, Robert Pear, *Obama Proposal to Create Medicare Panel Meets with Resistance*, N.Y. TIMES, Aug. 13, 2009, *available at* <http://www.nytimes.com/2009/08/14/health/policy/14medpac.html> (referring to the new agency as an Independent Medicare Advisory Council).

200. H.R. 3590, 111th Cong. (2009).

201. *Id.*

202. *Id.*

203. *Id.*

submit the proposal to Congress.²⁰⁴ Congress may not consider any bill that fails to satisfy the Medicare cost savings requirements.²⁰⁵

IMAC shall consist of fifteen members appointed by the President by and with the advice and consent of the Senate, with the HHS Secretary, the Administrator of CMS (the Administrator), and the Health Resource and Service Administrator (HRSA) serving as ex officio, non-voting members.²⁰⁶ The members shall be experts from diverse health care and public policy related fields, and, to avoid conflicts of interest, shall not be allowed to engage in any other business, vocation or employment.²⁰⁷ The members shall serve six-year terms, capped at two full consecutive terms.²⁰⁸

B. Will The Federal Advisory Committee Act Apply to IMAC?

By the early 1970s, executive advisory committees numbered in the thousands.²⁰⁹ Some mechanism was needed to account for their expenditures, usefulness, and the type of advice they provided.²¹⁰ In 1972, the Federal Advisory Committee Act (FACA) was enacted to make executive advisory committees transparent.²¹¹

FACA checks the power of various private interests from gaining illicit access to the President.²¹² It requires that no new advisory committee be established unless by presidential authorization or by federal statute.²¹³ It further limits the duration of presidentially established committees to two years.²¹⁴ Moreover, the committees

204. H.R. 3590, 111th Cong. § 3403 (2009).

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. Steven P. Croley & William F. Funk, *The Federal Advisory Committee Act and Good Government*, 14 YALE J. ON REG. 451, 460 (1997). There were more than 3,000 executive advisory committees before FACA was enacted. *Id.*

210. *Id.* at 460-61.

211. *Id.* at 452 (asserting that FACA was meant to keep Congress and the public abreast of the “number, purpose, membership and activities of groups established or utilized to offer advice or recommendations to the President.”).

212. *Id.*

213. *Id.* at 473.

214. Croley, *supra* note 209, at 473.

must be comprised of diverse points of view—they cannot be industry-based committees promoting their own interests.²¹⁵

Committee meetings must be open to the public, and each committee must file timely notice of its meetings in the Federal Register.²¹⁶ Interested citizens are entitled to “attend, appear before, or file statements with any advisory committee.”²¹⁷ The public access and accountability requirements generally restrict the “flexibility and spontaneity” of the committees’ decisions.²¹⁸

1. Requirements

The most litigated aspect of FACA is “whether, when and how” a committee becomes an advisory committee under FACA.²¹⁹ FACA lays out three requirements for all committees falling under its scope: (1) a group containing at least one person not employed by the federal government; (2) established by Congressional statute (or reorganization plan) or established or “utilized” by the President or an agency; and (3) established for the purpose of supplying “advice or recommendations” to the President or one or more agencies of the federal government.²²⁰ Since IMAC would be established by statute, the second prong is met.

2. The Advice or Recommendation Requirement

FACA states that committees must be established or utilized “in the interest of obtaining advice or recommendations for the President or one or more agencies or officers of the Federal Government.”²²¹ First, a committee that does not provide recommendations related to government policy is not an advisory committee under FACA.²²²

215. *Id.* at 464.

216. *Id.*

217. 5 U.S.C. App. II § 10(a)(3) (2006).

218. Croley, *supra* note 209, at 504.

219. *Id.* at 472.

220. *Id.* at 473.

221. 5 U.S.C. App. II § 3(2) (2006).

222. *Judicial Watch, Inc. v. Clinton*, 76 F.3d 1232, 1233 (D.C. Cir. 1996) (holding that a personal trust set up on behalf of the president and his wife for the purpose of settling personal legal expenses was not subject to FACA).

IMAC meets this criterion since its proposals will be related to governmental policy.²²³

Second, utilization of a committee does not extend to the “mere subsequent and optional use of the work product.”²²⁴ The Supreme Court has narrowly interpreted FACA so as to exclude presidential reliance on the advice of his political party or groups that assist the President in carrying out his constitutional obligations.²²⁵ In *Public Citizen v. U.S. Dept. of Justice*,²²⁶ the Supreme Court held that the President’s solicitation of advice on judicial nominees from the American Bar Association (ABA) did not invoke FACA.²²⁷

Third, it has been held that the advice and recommendations must be for the executive branch.²²⁸ IMAC’s purpose is to reduce

223. Letter from Peter Orszag, *supra* note 198.

224. *Sofamor Danek Group, Inc. v. Gaus*, 61 F.3d 929, 933 (D.C. Cir. 1995) (citing *Pub. Citizen v. U.S. Dept. of Justice*, 491 U.S. 440, 459 (1989)). According to Justice Brennan, a straightforward reading of “utilize” would extend even to the President’s own political party, and this was surely not Congress’ intent with FACA. *Pub. Citizen*, 491 U.S. at 453. FACA had been established to cure the ills of wasteful expenditure of public funds and the growing influence of biased proposals by special interests. *Id.* It was not Congress’ intent to “cover every formal and informal consultation between the President or an Executive agency and a group rendering advice.” *Id.* The President’s use of committees or bodies which assist him in carry out constitutional powers specifically designated to the executive, such as the appointment of judges, was not intended to fall under FACA’s scope. *Id.* at 467; *see also* Croley, *infra* note 297, at 469-70 (asserting that the Court was concerned with the separation of power doctrine). In the aftermath of *Public Citizen*, “utilized” is read narrowly so as not to intrude on the separation of powers. Croley, *supra* note 209, at 469-70; *see also* *Sofamor*, 61 F.3d at 933 (citing *Pub. Citizen*, 491 U.S. at 459).

225. *See supra* note 224 and accompanying text.

226. *Pub. Citizen*, 491 U.S. 440.

227. *See id.*

228. *California Forestry Ass’n v. U.S. Forest Serv.*, 102 F.3d 609, 611 (D.C. Cir. 1996) (holding that FACA committees must be establish in the “interest of advising” the executive branch). The Forest Service set up the Sierra Nevada Ecosystem Project (SNEP), which submitted a study on the Sierra Nevada ecosystem to the US Congress. *Id.* at 610. The Forest Service argued that because SNEP’s report was created primarily for the use of the U.S. Congress, FACA did not apply. *Id.* at 612. However, the court rejected this argument since the Forest Service itself had directed funding to SNEP’s research, which the Forest Service intended to use. *Id.* Congress had appropriated nearly two hundred million to the Forest Service for the purpose of “forest research,” and the Forest Service sought Congressional direction on how to proceed. *Id.* at 610. Several Congressmen

Medicare expenditures by requiring the CMS to project its yearly Medicare growth rate, so that IMAC may in turn submit a proposal to reduce the growth rate.²²⁹ The proposal shall be submitted to the President, who “shall immediately” submit that proposal to Congress.²³⁰ The Secretary would be required to implement the proposal unless Congress rejects the proposal within thirty days.²³¹

The lines between committees created to advise the President, committees created to advise Congress,²³² and committees created to advise private groups²³³ are not easily drawn. While the President’s role in implementing the IMAC proposals seems passive (the President “shall” submit the IMAC proposal to Congress for implementation) the proposals will be formed for the express purpose of recommending cost-savings to the Medicare program.²³⁴ Those proposals would be in the interest of an Executive agency, and the agency’s use of the proposal would not be merely optional.²³⁵

responded with letters calling for an ecosystem-wide study of the Sierra Nevada and a report to Congress. *Id.* at 611. Because the study was directed at the Forest Service’s long-term management of the Sierra Nevada ecosystem, the court concluded that SNEP was indeed an advisory committee established “in the interest of” advising the executive branch. *Id.* at 611-12.

229. H.R. 3590, 111th Cong. § 3403 (2009).

230. *Id.*

231. *Id.*

232. *See supra* note 228 and accompanying text.

233. *See Sofamor*, 61 F.3d at 937. In *Sofamor*, the court held that a Low Back Panel (LPB) formed by the Agency for Health Care Policy and Research (AHCPR) was not an advisory committee subject to FACA. *Id.* LBP had been established to develop clinical guidelines on treating lower back pain for the use of health care practitioners. *Id.* at 931-32. However, certain provisions of the enacting statute indicated that lower back conditions were of particular importance to the Medicare program. *Id.* The appellant, a medical device manufacturer, asserted that while LBP had been intended to advise private practitioners, LBP had the dual purpose of advising the Secretary regarding Medicare reimbursement policies. *Id.* at 934. The court was unconvinced, and held that LBP’s guidelines were developed for private health care practitioners and not for the purpose of advising the executive branch. *Id.* The court asserted that although Congress might have intended that HHS would “consult” the guidelines in setting its Medicare reimbursement policy, it does not follow that LBP was established for the purpose of advice or recommendation. *Id.* at 934-35. The “mere subsequent and optional use” by the executive branch of a committee’s work product does not trigger FACA. *Id.* at 933.

234. H.R. 3590, 111th Cong. § 3403 (2009).

235. *See supra* note 224 and accompanying text.

3. Exclusion of Committees Wholly Composed of Federal Employees

FACA defines an advisory committee as excluding “any committee which is composed wholly of full-time officers or employees of the Federal Government.”²³⁶ IMAC shall consist of fifteen Presidential appointees, with the Secretary, the Administrator, and the HRSA serving *ex officio*.²³⁷ “No individual,” IMAC reads, “may serve as an appointed member if that individual engages in any other business, vocation, or employment.”²³⁸ Inferably, IMAC shall be wholly comprised of federal employees, thus, not subject to FACA.

C. IMAC: A “Federal Health Board”

Shortly after President Obama was elected in 2008, former South Dakota Senator Tom Daschle became President Obama’s first choice for HHS Secretary.²³⁹ Daschle advocates the creation of an independent FHB, charged with the power of setting uniform, national health-care policy, analogous to the Federal Reserve’s power to set monetary policy.²⁴⁰ Daschle’s FHB provides great incite into how IMAC would operate.²⁴¹

236. 5 U.S.C. App. II § 3(2)(c)(iii) (2006); *see also* Croley, *supra* note 209, at 492-93. President Clinton’s Health Care Task Force became the target of a FACA lawsuit regarding this requirement. Croley, *supra* note 209, at 492-93. The court remanded the case for the lower court to determine whether “special employees,” a status assigned to forty doctors who had been working on the committee in a temporary capacity and without compensation, were to be considered “full-time employees.” *Id.* However, the court did hold that First Lady Hillary Clinton was in fact a full-time government employee for the purposes of FACA. *Id.*

237. H.R. 3590, 111th Cong. § 3403 (2009).

238. *Id.*

239. Ed Henry and Kristi Keck, *Daschle Withdraws as HHS Nominee*, CNN POLITICS, Feb. 3, 2009, <http://edition.cnn.com/2009/POLITICS/02/03/daschle/>; *see also* Feldstein, *supra* note 9.

240. DASCHLE, *supra* note 6, at xiii-xiv.

241. *Id.*

First, the FHB would work with Medicare to create a public option that would compete with private insurance plans.²⁴² Second, to avoid conflicts of interest, representatives serving on the board would not have outside employment.²⁴³ Third, by making it presidentially appointed, the FHB's decisions would be insulated from politics.²⁴⁴ Fourth, the FHB would provide only those drugs and treatments backed by "solid evidence."²⁴⁵ To this end, the FHB would rank treatments by their "health and cost impacts."²⁴⁶ Fifth, the FHB would reward doctors for curbing costs by awarding bonuses for patient outcomes.²⁴⁷ It would curb costs by expending

242. *Id.* at 146. In its current state, the federal bill has no public option. Many public option advocates have suggested that a public option will come to pass eventually, regardless of the current bill. See Stephanie Condon, *Dems Commit to Health Bill, Some Push For Public Option*, CBS NEWS, Jan. 27, 2010, <http://www.cbsnews.com/blogs/2010/01/27/politics/politicalhotsheet/entry6148164.shtml>; but see Michael O. Leavitt and Jeffrey H. Anderson, *The President's Trojan Horse*, THE WASHINGTON TIMES, June 23, 2009, available at <http://www.washingtontimes.com/news/2009/jun/23/the-presidents-trojan-horse/> (arguing that a public option would be an incremental step toward single payer health care). Some have argued that instituting a public option would force private insurances out of the market, while giving employers the incentive to drop their insurance plans and let the federal government take over the responsibility, entirely. Leavitt, *supra* note 242.

243. See DASCHLE, *supra* note 6, at 170. Daschle stresses that the board members should be free from professional conflicts of interest. *Id.*

244. See *id.* at xiii, 169, 200-01. Congress and the President would "relinquish some of their health-policy decisions to it." *Id.* at xiii. Daschle argues that, while the amount of power delegated to the FHB would rightfully raise concern, the FHB shall be transparent and accountable to elected leaders. *Id.* at 200-01. Still, by insulating it from political pressures, the FHB would have the flexibility to make tough decisions. *Id.* at 169.

245. DASCHLE, *supra* note 6, at 171-72. IMAC language limits itself to protecting "evidence-based" items and services. See H.R. 3590, 111th Cong. § 3403 (2009).

246. DASCHLE, *supra* note 6, at 172. Daschle criticizes the current system in which doctors employ high-tech treatments, "when the patient would be better off with . . . low-tech alternative[s]—or no care at all." *Id.* Daschle praises Britain's NICE cost-effectiveness test for drug approvals. *Id.* at 172.

247. *Id.* at 174-76. Daschle emphasizes that the FHB should curb artificial consumer demand for expensive drugs and treatments, currently induced by direct-to-consumer pharmaceutical advertising. *Id.* at 9-11, 174-75. Drug companies advertise new drugs, which do not improve on "older, cheaper alternatives." *Id.* at

more on procedures that are medically recommended and less for procedures that are deemed discretionary.²⁴⁸ Sixth, Daschle calls for the “rationalizing” of health care infrastructure, by creating a national guide to direct health care resources efficiently.²⁴⁹ Seventh, Senator Daschle envisions strong enforcement power for the FHB.²⁵⁰ Unlike a traditional regulatory agency, the FHB’s recommendations would bind all federal programs (such as Medicare) causing private insurance programs to follow suit.²⁵¹ Private insurance companies would find it difficult to set their own rules when competing with the federal program.²⁵² Daschle further recommends that Congress could limit the business tax deduction for health insurance to programs that follow the rules set by the FHB.²⁵³

Two crucial examples are raised throughout Senator Daschle’s analysis, which further elucidate how IMAC would operate.²⁵⁴ Firstly, Daschle analogizes the FHB to the Federal Reserve System in terms of its political insulation and authority regarding monetary policy.²⁵⁵ Secondly, Daschle raises Britain’s NICE as a working example of an independent health policy board which sets a national health care agenda regarding which drugs and treatments shall be covered by the national health program.²⁵⁶

174. The FHB could do this by approving evidence-based treatments, considerate of cost-effectiveness. *See id.* at 172-75.

248. *Id.* at 175-76. Daschle cites a nonprofit Minneapolis health plan, which paid doctors bonuses if their diabetic patients met blood sugar and cholesterol quotas. *Id.* A 12% increase in patients meeting the quota occurred between 1996 and 2003. *Id.*

249. *Id.* at 178 (“We have too many imaging machines in some areas and too few emergency rooms in others.”).

250. *Id.* at 179.

251. DASCHLE, *supra* note 6, at 179.

252. *Id.*

253. *Id.*

254. *Id.* at 127-37.

255. *Id.* at 129-37.

256. DASCHLE, *supra* note 6, at 127-29.

1. The Federal Reserve and the Sunshine Act

The Federal Reserve Act was passed in 1913, in order to “incorporate under Federal control. . . all national banks.”²⁵⁷ The Federal Reserve, or the Fed, is headed by a presidentially appointed Board of Governors, which oversees twelve privately owned banks.²⁵⁸ Additionally, there are numerous member banks throughout the country comprising some 40% of all federally insured banks.²⁵⁹

FACA expressly exempts the Federal Reserve from its scope.²⁶⁰ However, APA requires notice and comment with regard to the Fed’s substantive rulemaking.²⁶¹ Additionally, the Fed is subject to the Sunshine Act, enacted in 1976 to create openness in federal agency proceedings.²⁶² The Sunshine Act, a sibling to FACA, provides that “every portion of every meeting of an agency shall be open to public observation.”²⁶³ The Sunshine Act requires advance notice to the public of agency meetings.²⁶⁴

257. See 12 U.S.C. § 221 (2006); see also *U.S. v Davenport*, 266 F. 425, 432 (W.D. Tex. 1920).

258. 12 U.S.C. § 221 (2006).

259. DASCHLE, *supra* note 6, at 130.

260. 5 U.S.C. App. II § 4(b)(1)-(2) (2006) (“Nothing in this Act shall be construed to apply to any advisory committee established or utilized by . . . the Federal Reserve System.”).

261. 5 U.S.C. § 554(a) (2006).

262. 5 U.S.C. § 552(b) (2006); see also *The Federal Reserve Board, Government in the Sunshine: A Guide to Meetings of the Board of Governors of the Federal Reserve System*, <http://www.federalreserve.gov/boarddocs/meetings/sunshine> (last visited Mar. 31, 2010)..

263. 5 U.S.C. § 552(b) (2006); see also *Croley*, *supra* note 209, at 453.

264. 5 U.S.C. § 552(b) (2006). Agency meetings shall be conducted openly (to the public) and, “notice of the time, place, and subject matter of a meeting, whether the meeting is open or closed, any change in one of the preceding, and the name and phone number of the official designated by the agency to respond to requests for information about the meeting” shall be placed in the Federal Register. *Id.* The meeting must be announced one week in advanced, unless the agency members vote by majority that the agency’s business requires a quicker determination, in which case, the meeting’s time and place shall be announced at the “earliest practicable time.” *Id.*

Senator Daschle considers the Federal Reserve to be a transparent body which sets monetary policy founded on evidence-based analysis and free from political rancor.²⁶⁵ The Federal Reserve remains the offspring of the Congress, and Congress can dismantle the Federal Reserve, discharge a member of the Board of Governors, or overturn a decision at any point.²⁶⁶ Nevertheless, Congress has never exploited these powers.²⁶⁷

2. Britain's National Institute for Health and Clinical Excellence

Senator Daschle states, approvingly, that NICE uses “cost-effectiveness information” to determine drug coverage.²⁶⁸ Daschle stresses that the FHB must, like NICE, consider which treatments are “clinically valuable and cost effective,” in order to curb spending.²⁶⁹ While Daschle would not use a “hard-and-fast” cost-effective strategy, he suggests that the U.S. must, “[n]evertheless. . . . look at medical care in a different way.”²⁷⁰

NICE was established for the purpose of promoting clinical excellence and the “effective use of” health care resources.²⁷¹ NICE is responsible for providing guidelines as to which drugs and treatments shall be covered under the NHS.²⁷² Its cost-effective strategies are implemented to weigh economic considerations like cost against the medical benefits or effectiveness of the treatment.²⁷³ In doing so, NICE relies on an independent committee of medical experts and economists who review clinical evidence.²⁷⁴

One mechanism relied on by NICE is the Quality Adjusted Life Year (QALY), which measures the cost of gaining a particular unit of

265. See DASCHLE, *supra* note 6, at 133.

266. *Id.*

267. *Id.*

268. *Id.* at 172-75.

269. *Id.* at 172.

270. DASCHLE, *supra* note 6, at 172.

271. National Institute for Clinical Excellence (Establishment and Constitution) Amendment Order, 2005, S.I. 2005/497, art. 3 (U.K.).

272. See, e.g., DASCHLE, *supra* note 6, at 127-28; GRATZER, *supra* note 5, at 181-82.

273. See *supra* note 272 and accompanying text.

274. *Id.*

utility through the use of the technology which can be applied across a range of treatments.²⁷⁵ For instance, moderate mobility impairment is rated at 0.85 times “perfect health,” thus, a patient living ten years of moderately impaired mobility is equated to a person living in perfect health for eight and a half years.²⁷⁶ In establishing the cost-effectiveness of national health dollars to be expended, the system requires QALYs to be maximized.²⁷⁷ Thus, for example, NHS generally shall not spend more than \$22,000 for treatments that extend a life for less than six months.²⁷⁸

The QALY formula is manifestly utilitarian and has scandalized critics who feel that NICE is not so *nice*.²⁷⁹ Numerous, media

275. See, e.g., *Eisai Ltd. v. Nat’l Inst. for Health & Clinical Excellence*, 2007 WL 2186995, at ¶ 18 (Q.B.).

276. Govind Persad, Alan Wertheimer & Ezekiel J. Emanuel, *Principles for Allocation of Scarce Medical Interventions*, 373 THE LANCET 423, 427-29 (2009), available at <http://www.thelancet.com/journals/lancet/issue/current?tab=past>.

277. *Id.*

278. See *Obama’s Senior Moment*, WSJ.COM, (Aug. 14, 2009), <http://online.wsj.com/article/SB10001424052970203863204574344900152168372.html>; see also *Eisai Ltd.*, *supra* note 275 at ¶ 19.

279. See e.g., *Obama’s Senior Moment*, *supra* note 278; *GPs Admit to Rationing Care*, BBCNEWS.COM, Jan. 20, 1999, <http://news.bbc.co.uk/2/hi/health/258558.stm>; Kevn Devlin, *Patients ‘Demand Refunds for Expensive Cancer Drugs’ on the NHS*, TELEGRAPH, Oct. 27, 2008, <http://www.telegraph.co.uk/news/uknews/3269533/Patients-demand-refunds-for-expensive-cancer-drugs--on-the-NHS.html>; Nigel Hawkes, *Secret NHS Plan to Ration Patient Care*, TIMESONLINE, Apr. 7, 2006, <http://www.timesonline.co.uk/tol/news/uk/health/article702894.ece>; Kevin Devlin, *Ruling ‘Denies Treatment to 100,000 Alzheimer’s Patients’*, TELEGRAPH, Apr. 15, 2008, <http://www.telegraph.co.uk/news/uknews/1895656/Ruling-denies-treatment-to-100000-Alzheimers-patients.html>; Lewis Carter, *Cancer Specialists Blame NICE Over Drug Rationing*, TELEGRAPH, Aug. 24, 2008, <http://www.telegraph.co.uk/news/uknews/2613653/Cancer-specialists-blame-Nice-over-drug-rationing.html>; *Kidney Cancer Patients Denied Life-Saving Drugs by NHS Rationing Body NICE*, MAILONLINE, Apr. 29, 2009, <http://www.dailymail.co.uk/health/article-1174592/Kidney-cancer-patients-denied-life-saving-drugs-NHS-rationing-body-NICE.html>; Kevin Devlin, *Sentenced to Death by NHS*, TELEGRAPH, Sept. 2, 2009, <http://www.telegraph.co.uk/health/healthnews/6127514/Sentenced-to-death-on-the-NHS.html>. In 2008, it was reported that NICE had denied 100,000 Alzheimer’s patients certain medications as it had been determined that £2.50 per day was too expensive for patients whose condition had not deteriorated. Devlin, *Ruling ‘Denies Treatment to 100,000 Alzheimer’s Patients’* *supra* note 279. Another story

exposés in the British press have attacked QALYs and other NICE rationing polices.²⁸⁰ American critics of the QALY system include Dr. Ezekiel Emmanuel, a bioethicist from Harvard Medical School and Special Advisor for Health Policy to Peter Orszag of the OMB.²⁸¹ Emmanuel has stressed that QALYs, in their attempt to curb costs, ignore fair distribution of health care resources and does not encompass the moral goals of prioritizing the medically needy, treating individuals equally and saving the most lives.²⁸² Dr. Emmanuel has, however, advocated for “comparative effectiveness” of treatments.²⁸³

D. Rationing

Dr. Emmanuel has come under controversy for his views on euthanasia.²⁸⁴ Although opposed to legalizing euthanasia, he once

reported that NICE guidelines aimed to help medical practitioners deal with dying patients by removing fluids and drugs and placing the patients on continuous sedation until they pass. Devlin, *Sentenced to Death by NHS*, *supra* note 279. Between 2007 and 2008, continuous sedation accounted for 16.5% of deaths in Britain (double the proportion for Belgium and Netherlands). *Id.* While NICE instituted the program to ease suffering in the patients’ final hours, critics have argued that sedation can mask possible signs of the patients’ improvement. *Id.* NICE also denied approval for a kidney cancer drug, which would cost £24,000 per patient, per year. *Kidney Cancer Patients Denied Life-Saving Drugs by NHS Rationing Body NICE*, *supra* note 279.

280. See *supra* note 279 and accompanying text.

281. Emanuel, *supra* note 276, at 427-29. Emanuel has also advocated eliminating employer-provided health care and replacing it with health care vouchers funded by a national value added tax, which would phase out Medicare and Medicaid. Ezekiel J. Emanuel & Victor R. Fuchs, *Getting Covered: Choose a Plan Everyone Can Agree With*, BOSTON REVIEW, Nov.-Dec. 2005, <http://www.bostonreview.net/BR30.6/emanuelfuchs.php>. Still, Emanuel does not support a single-payer health care system. Emanuel, *supra* note 281. Indeed, Emanuel admits that a single-payer system would be inefficient and would lead to rationing. *Id.*

282. Emanuel, *supra* note 276, at 428.

283. See Betsy McCaughey, *Obama’s Health Rationer-in-Chief*, WALL ST. J., Aug. 27, 2009, <http://online.wsj.com/article/SB10001424052970203706604574374463280098676.html>.

284. See Robert Pear, *A Hard-Charging Doctor on Obama’s Team*, N.Y. TIMES, Apr. 17, 2009, at A14, available at

evaluated the cost-effectiveness that physician-assisted suicide might have on health care expenditures.²⁸⁵ Presidential advisor Robert Reich has also indicated his attraction to rationing health care.²⁸⁶ In 2007, addressing students at the University of California Berkeley, Reich quipped that he would advise a candidate for the presidency, advocating for health care reform, to be honest and explain to Americans that “if you’re very old, we’re not going to give you all that technology and all those drugs for the last couple of years of your life to keep you maybe going for another couple of months. It’s too expensive . . . so we’re going to let you die.”²⁸⁷ Reich went on, advocating that an ideal health care reform would:

[U]se the bargaining leverage of the federal government in terms of Medicare, Medicaid— we already have a lot of bargaining leverage—to force drug companies and insurance companies and medical suppliers to reduce their costs. What that means, [is] less innovation and that means less new products and less new drugs on the market which means [young Americans] are probably not going to live much longer than [their] parents.²⁸⁸

Reich and Emmanuel do not represent mere anecdotes. To wit, the enforcement powers of Daschle’s FHB would be derived from the

http://www.nytimes.com/2009/04/18/us/politics/18zeke.html?_r=1. Emanuel was a vocal opponent of legalizing euthanasia. *Id.* Yet, Emanuel has been an oft-cited authority on the potential cost-savings of legalizing euthanasia. Ezekiel J. Emanuel & Margaret P. Battin, *What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide*, 339 NEW ENG. J. MED. 169, 169-72 (1998), available at <http://content.nejm.org/cgi/content/full/339/3/167>. Emanuel concluded that the potential cost-savings of legalizing physician-assisted suicide are lower than many proponents have suggested. *Id.*

285. *See supra* note 284 and accompanying text.

286. *Obama’s Transition Economic Advisory Board*, N.Y. TIMES, Nov. 7, 2008, <http://www.nytimes.com/2008/11/08/us/politics/08advisors.html>. The former Labor Secretary served on an elite Transition Economic Advisory Board for President Obama. *Id.*

287. *Id.*

288. *Id.*

FHB's bargaining power.²⁸⁹ Daschle argues that the federal government must "exert tremendous leverage" in choosing the drugs and treatments it will reimburse, steering providers to those which are, "the most clinically valuable and cost-effective, and dissuade them from wasting time and money on those that are neither."²⁹⁰

Daschle says he opposes a strict cost-effectiveness regime like NICE.²⁹¹ However, some have argued that Daschle's FHB proposal is patently designed to ration health care resources.²⁹² Some argue that any expansion of federal financing of health care would require rationing mechanisms in order to rein in costs.²⁹³ IMAC is intended to reduce the growth rate of Medicare.²⁹⁴ The FHB, applying a NICE-style cost-effectiveness strategy, would need to weigh the cost of a given treatment against the treatment's overall economic benefit (how much Medicare will save).²⁹⁵

Although the *Hays* court prevented it from doing so, the CMS has already attempted to apply a "least costly alternative" method for evaluating reimbursements.²⁹⁶ The CMS is powerless to refuse judicial review of the reasonable and necessary standard, whereas IMAC will not be subject to the reasonable and necessary standard. IMAC will not simply approve or deny reimbursements, but it will evaluate medical evidence with deference to cost-effectiveness in order to reduce the growth rate of Medicare expenditures.²⁹⁷

Nevertheless, the bill states that rationing measures cannot be utilized.²⁹⁸ But economist John Goodman contends that rationing is a

289. DASCHLE, *supra* note 6, at 179.

290. *Id.* at 158.

291. *Id.* at 172.

292. See, e.g., Feldstein, *supra* note 9; Sally C. Pipes, *Obama Will Ration Your Health Care*, WALL ST. J., Dec. 30, 2008, at A11, available at <http://online.wsj.com/article/SB123060332638041525.html>.

293. See, e.g., Jim Angle, *Medicare's Popularity Defies Need to Cut Spending*, FOXNEWS.COM, Feb. 3, 2010, <http://www.foxnews.com/politics/2010/02/03/medicares-popularity-defies-need-cut-spending/>. The current bill seeks to cut about \$500 billion from Medicare. *Id.*

294. H.R. 3590, 111th Cong. § 3403 (2009).

295. See DASCHLE, *supra* note 6, at 171-74.

296. *Hays v. Sebelius*, 589 F.3d 1279 (D.C. Cir. 2009).

297. H.R. 3590, 111th Cong. § 3403 (2009).

298. *Id.*

necessary outcome of government provided health care.²⁹⁹ If health care was “free” at the point of delivery, people would want to obtain every health care service possible “so long as it [has] *any* value to them.”³⁰⁰ Unconstrained, consumers would have the incentive to utilize every service the health care system provides up to the point that the costs outweigh the value returned.³⁰¹ If the cost of services are artificially decreased or subsidized entirely by a third party (such as by an employer or the federal government), there is theoretically no rational limit to the amount of services each patient would consume.³⁰²

Managed care experienced this problem, and, in response, HMOs curbed consumer demand.³⁰³ In case-by-case reviews, HMOs utilized cost-effective strategies to determine that a patient might not need a MRI, for example.³⁰⁴ Goodman argues that in national health care systems where the government is the sole provider of services, obstacles must be placed between consumers and the services they are seeking in order to curb costs.³⁰⁵

However, single-payer health care systems do not curb demand (as HMOs do), but, instead, they curb supply.³⁰⁶ Goodman writes that in Canada the government does not need to micromanage the decisions of doctors as HMOs do.³⁰⁷ Rather, by limiting the number of MRI machines in a given region, patients are placed in waiting lines and precluded from over-burdening and overcharging the system.³⁰⁸ Canada has one-third the amount of MRI units per capita, compared to the U.S., and ranks last in terms of access to advanced medical technology out of twenty-nine Organization for Economic Cooperation and Development (OECD) nations.³⁰⁹

299. See GOODMAN, *supra* note 8, at 2-5.

300. *Id.* at 2 (emphasis added).

301. *Id.*

302. *Id.* at 2-3.

303. *Id.*

304. GOODMAN, *supra* note 8, at 2-3.

305. *Id.*

306. *Id.*

307. *Id.*

308. *Id.*

309. GOODMAN, *supra* note 8, at 63.

The current health care bill would do little to alter the basic structure of Medicare or the CMS appeals process. Medicare beneficiaries would enjoy the same right of appeal treatment denials as they do now.³¹⁰ However, IMAC shall be in the position of research and testing drugs and treatments, and its recommendations shall be instituted by Congressional implementation. The reasonable and necessary standard for Medicare reimbursements would remain in place, but IMAC's proposals would not be subject to it.³¹¹ IMAC does not circumvent the reasonable and necessary standard; rather, it preempts the standard by limiting the drugs and medical treatments that the national health plan will be able to provide.³¹²

V. DIAGNOSIS: IS HEALTH CARE IN AMERICA A FAILURE OR A SUCCESS?

This section examines the failings and achievements of the U.S. health care system. Often, comparisons will be drawn between the U.S. system and single-payer systems. The health care bills submitted to Congress in 2009 were not single-payer reforms, nor, as of February 2010, a public option,³¹³ which has been deemed by

310. *See generally*, H.R. 3590, 111th Cong. (2009). The bill section does not purport to alter the Medicare appeals process; it focuses instead on the new powers of IMAC.

311. *Id.*

312. *Id.* Whether a drug or treatment is covered under the new health care plan will be determined by IMAC; whether those drugs and treatments are reasonable and necessary under Medicare would be determined after IMAC's recommendations are put in place (IMAC proposals will be submitted for consideration for the annual federal budget). *See supra* notes 199-208.

313. *See* Gregory Mankiw, *The Pitfalls of the Public Option*, N.Y. TIMES, Jan. 27, 2009, at BU5, available at <http://www.nytimes.com/2009/06/28/business/economy/28view.html> (asserting that the AMA opposes a public option.). Harvard economist Gregory Mankiw defines a public option as, simply put, a federal, tax-subsidized health plan. *See id.* Critical of the idea, Mankiw asserts, for example, that we do not have, "government-run grocery stores or government-run gas stations to ensure that Americans can buy food and fuel at reasonable prices." *Id.* Mankiw is not an objective observer of this issue (arguably, few, if any, objective observers exist); however, Mankiw correctly identifies the basic structure of the public option: the federal government collects taxes (like the Medicare payroll tax) and buys health services for beneficiaries of the plan (like the Medicare program). *See id.* Free-

some as mechanism that will effectively lead to a single-payer system,³¹⁴ was in the current House version of the bill, but not the Senate version.³¹⁵ Although it would seem simplistic to place all

market reformists declare that a public option would cause employers to dump their employees into the public plan and individuals to flood the cheap public plan, ultimately squeezing most private providers out of the market, leaving the public plan as the “only game in town.” *See, e.g., id.* At this point, the U.S. would essentially have a single-payer health care system. *See, e.g., id.; see also, infra* note 314.

314. *See, e.g., The Public Option Two Step*, WALL ST. J, July 10, 2009, available at <http://online.wsj.com/article/SB124709618142215031.html>; but see DASCHLE, *supra* note 6, at 146. Daschle advocates a public option. DASCHLE, *supra* note 6, at 146. Some have suggested a public option is merely a mechanism to force private insurers out of business, leaving the federal government as the sole insurer of health services. *See, e.g., The Public Option Two Step*, WALL ST. J, July 10, 2009, available at <http://online.wsj.com/article/SB124709618142215031.html>. Eventually, the system would control costs by forcing medical providers to accept lower reimbursements. *See id.* This would lead to supply restrictions. *See id.*

315. On November 7th, 2009, the House passed its version of the health care bill (inclusive of IMAC and a public option) by a narrow 220-215 margin. Carl Hulse and Robert Pear, *Sweeping Health Care Plan Passes House*, N.Y. TIMES, Nov. 7, 2009, at A1, available at <http://www.nytimes.com/2009/11/08/health/policy/08health.html>. Thirty-nine Democrats voted with 176 Republican House members, who opposed the bill (only one Republican voted for the bill). *Id.* A last minute amendment to prohibit funds for the public option from being used to provide abortions made passage possible: pro-life Democrats remained obstinate, and the amendment passed by a decisive 240-194 margin. *Id.* The bill was revised in the Senate, which had come up with a bill exclusive of the public option. Huma Khan, *Health Care Bill Passes Senate, Faces New Hurdles in 2010*, ABC NEWS, Dec. 24, 2010, <http://abcnews.go.com/GMA/HealthCare/president-obama-hails-senate-health-care-bill-republicans/story?id=9410912>. That bill passed the Senate on December 24th, 2009 by a 60-39 margin. *Id.* Because of the amendments, the bill then had to be resent to the House for approval. *Id.* At that point, sixty senators caucused with the Democrats (fifty-eight Democrats and two Independents). David M. Herszenhorn and Robert Pear, *Health Bill Passes Key Test in the Senate*, N.Y. TIMES, Dec. 21, 2009, <http://www.nytimes.com/2009/12/21/us/21vote.html>. Republican lawmakers had been warning that they would vote in bloc to defeat the health care bill; but with only forty votes this would have been fruitless: in the Senate, a filibuster is the parliamentary act which halts debate on legislation; however, when a bill's proponents have at least sixty votes, they can vote in bloc to stop debate, break a filibuster and send the bill to a vote by simple-majority. *See id.* Thus, opposition must have at least forty-one votes to stall debate and effectively block legislation. *Id.* However, to complicate matters further, Massachusetts scheduled a special election in January to fill the Senate seat of the

health care reform proposals into two distinct schools, by doing so, one can examine two broad types of reform—a government program to expand and reduce cost versus private sector incentives to expand access and reduce cost.³¹⁶

Daschle and others who advocate government-managed health care have not rejected single-payer health care system as a viable reform option.³¹⁷ Indeed, Daschle writes that the highest ranked systems in the world are single-payer.³¹⁸ He also declares, rather equivocally, that a “pure single-payer system is politically problematic in the United States, at least right now.”³¹⁹ It cannot be refuted that the current reform effort’s leading advocates support single-payer health care and incremental moves towards its implementation.³²⁰

late Edward Kennedy. See Charles Krauthammer, *What Scott Brown’s Win Means for the Democrats*, WASH. POST, Jan. 22, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/01/21/AR2010012103500.html>. Although the state has been known as a Democratic stronghold for decades (with registered Democrats outnumbering Republicans three-to-one, President Obama won the state swimmingly in 2008), Republican candidate Scott Brown took the seat by a decisive 52% to 47% margin. *Brown Scores Upset Victory Over Coakley in Massachusetts Senate Race*, FOX NEWS, Jan. 19, 2010, <http://www.foxnews.com/politics/2010/01/19/polls-close-competitive-massachusetts-senate-race/>. Brown campaigned throughout the state as the 41st vote. See *id.* As of late February, the House bill remains a lame duck in the Senate, where forty-one Republicans and several Democrats will not pass the bill. Shailagh Murray & Michael D. Shear, *Republicans ‘Ready to Participate’ in Obama’s Health Care Summit*, WASH. POST, Feb. 21, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/21/AR2010022101506.html?hpid=topnews>. In March, President Obama will hold a health care summit to engage members of both parties to develop a compromise bill; the fate of the IMAC proposal is unknown, while the demise of the public option (at least in this Congress) appears foregone. See *id.*

316. See GOODMAN, *supra* note 8, at 217.

317. See DASCHLE, *supra* note 6, at 143-44. Daschle writes that he supported President Clinton’s managed competition reform because it would eventually lead to universal coverage. See *id.* at 78. On single-payer health care, Daschle only states that it would be “politically problematic. . .at least right now.” *Id.* at 144.

318. *Id.* at 143-44.

319. *Id.* at 144.

320. See e.g., *id.*; *Obama Touts Single-Payer System for Health Care*, WSJ.COM, Aug. 19, 2008, <http://blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system/tab/article/>.

A. The Number of Uninsured Citizens

There are approximately 300 million people living in the United States.³²¹ It has been said that the number of uninsured Americans continues to increase.³²² Between 1991 and 2003, the percentage of Americans without health insurance ranged from 14.1% (1991) to 16.3% (1998), remaining at or near the 15% mark throughout the last decade.³²³ The logical inference is that the number of uninsured is increasing no faster than the U.S. population is increasing.

First, it has been said that approximately forty five million lack health insurance.³²⁴ Second, the number of uninsured Americans fluctuates around the forty five million mark, depending on the source, due to the fact that the Census Bureau updates this number yearly.³²⁵ According to the Census Bureau, 20% are non-citizens.³²⁶

321. U.S. Census Bureau Home Page, <http://www.census.gov> (last visited Mar. 31, 2010).

322. See Milt Freudenheim, *Record Level of Americans Not Insured on Health*, N.Y. TIMES, Aug. 7, 2004, <http://www.nytimes.com/2004/08/27/business/27health.html?pagewanted=1> (stating that the number of uninsured Americans grew from 43.6 million to 45 million between 2002 and 2004); but see Steven Reinberg, *Number of Uninsured Americans Drops: More Children Now Covered by Government-Sponsored Programs*, *Census Bureau Reports*, U.S. NEWS & WORLD REPORT, Aug. 26, 2008, <http://www.usnews.com/health/managing-your-healthcare/insurance/articles/2008/08/26/number-of-uninsured-americans-drops.html> (stating that the number of uninsured Americans dropped from 47 million to 45.7 million between 2006 and 2007).

323. GRATZER, *supra* note 5, at 84; see also John Lott, *As Obama Pushes National Health Care, Most Americans Already Happy With Coverage*, FOX NEWS, June 24, 2009, <http://www.foxnews.com/politics/2009/06/24/obama-pushes-national-health-care-americans-happy-coverage/> (citing a Census Bureau report affirming the proposition). About 13.4% of Americans are currently uninsured. LOTT, *supra* note 323. This figure is in contrast to the 15.6% 2003 Census Bureau estimate. GRATZER, *supra* note 5, at 84. In coming to its estimates, the Census Bureau surveys about 50,000 households per year. GRATZER, *supra* note 5, at 84-85.

324. *E.g.*, DASCHLE, *supra* note 6, at 3.

325. See GRATZER, *supra* note 5, at 84-86.

326. *Id.* Gratzner writes that the issues facing immigration in America are distinct from the issue of health care. *Id.* The fact that immigrants are uninsured cannot reasonably be cited as an example of a gross lack of access to U.S. health care. See *id.*

Therefore, approximately thirty six million American citizens are uninsured.³²⁷ This comment takes no position on whether a national health plan ought to cover non-citizens, but can it be said that America's health care system has failed insofar as it has failed to insure non-citizens?³²⁸

Third, while the actual number of uninsured Americans is somewhat constant from year to year, the actual individuals who are uninsured are rapidly shifting.³²⁹ This is due to the fact that America has a predominantly employer-provided health care system.³³⁰ Often, when people become unemployed, they lose their insurance.³³¹ The Congressional Budget Office (CBO) states that 74.7% of the current uninsured will become insured within one year, 84% within two years, and 97.5% will have insurance within three years.³³² Since the U.S. has an employer-provided insurance model, the number of uninsured is moot unless long-term unemployment figures are viewed in conjunction. For instance, in 1998 the U.S. economy was strong, while the percentage of uninsured peaked at a record 16.3% of the population, yet the median duration of unemployment was only seven weeks.³³³

Fourth, the composition of the uninsured is increasingly middle-class, while the indigent are gaining insurance through government

327. *See id.*

328. *See id.*; *see also* Carl Bialik, *The Unhealthy Accounting of Uninsured Americans*, WALL ST. J., June 24, 2009, at A12, *available at* <http://online.wsj.com/article/SB124579852347944191.html> (arguing that the current legislation does not purport to cover any of the 6 million undocumented immigrants, and that it is therefore misleading to suggest that "45.7 million" persons shall gain health insurance under the current proposal).

329. *See* GRATZER, *supra* note 5, at 85. In 2003, the Congressional Budget Office (CBO) showed that between 56.8 and 59 million were uninsured at some point during the previous year, while between 39 and 42.6 million were uninsured at any point in time, whereas between 21 and 31 million were uninsured for the entire year. *Id.* Indeed, every five months, the total pool of uninsured Americans has a 50% turnover in composition. *See id.*

330. *Id.* at 86.

331. *Id.*

332. *Id.*; GOODMAN, *supra* note 8, at 35.

333. *See* GRATZER, *supra* note 5, at 84-86. "The executive who leaves his corner office," Gratzner writes, shall "join the ranks of the uninsured," becoming part of the crude number of uninsured Americans that often goes unexplained by politicians. *Id.* at 86.

assistance.³³⁴ Eighteen million uninsured have annual household incomes exceeding \$50,000, and half of these individuals have incomes over \$80,000 per year.³³⁵ The inference is that a lack of insurance is not necessarily indicative of a lack of access to insurance.³³⁶

Last, many have cited the Institute of Medicine's estimate that 18,000 die each year due to lack of health insurance.³³⁷ This figure is based on numerous small studies that suggest uninsured indigents experience poor clinical outcomes.³³⁸ Taken together, the studies are

334. *E.g., id.* at 87; GOODMAN, *supra* note 8, at 35; *but see* DASCHLE, *supra* note 6, at 21. Daschle asserts that since the mid 1970s, the percentage of Americans with employer provided coverage has dropped from 70% to 60%. DASCHLE, *supra* note 6, at 21. He reasons that this is due in part to a 140% increase in the cost of health care for businesses over the past decade. *Id.* at 17. However, he also asserts that 18 of the 47 million uninsured have family incomes exceeding \$50,000 per year. *Id.* at 4. More than half of these 18 million have family incomes of over \$80,000 per year. GOODMAN, *supra* note 8, at 35. The Census Bureau reported that between 1993 and 2003, the number of uninsured increased by 130% in households earning over \$75,000 per year, but declined by 14% in households earning less than \$25,000 per year. GRATZER, *supra* note 5, at 88. One study surveyed a group of uninsured Californians at twice the poverty level (a group larger than persons making over \$50,000 per year), with one-third making less than \$30,000 per year and 10% making over \$75,000 per year. *Id.* The study found that 40% were homeowners, 60% reported being in excellent health, and the group spent an average of \$200 per year on health services. *Id.* But Daschle would argue that between 2000 and 2007, the cost of the average health premium increased by 98% while the average salary increased by only 23%, nationwide. DASCHLE, *supra* note 6, at 5. Moreover, medical bills are a leading cause of bankruptcy. *Id.*; *Medical Debt Huge Bankruptcy Culprit*, CBS NEWS, June 5, 2009, <http://www.cbsnews.com/stories/2009/06/05/earlyshow/health/main5064981.shtml>. Of all bankruptcy cases filed, 75% reported having some type of medical insurance, and 62% of all bankruptcies are somewhat attributable to sickness. *Id.* Finally, it has been asserted that one-third of the 47 million qualify for government aid through Medicaid and State Children's Health Insurance Programs (SCHIP), but have simply not enrolled. GOODMAN, *supra* note 8, at 35. Moreover, Federal law requires emergency rooms to provide care to whoever seeks care, regardless of financial circumstances or ability to pay. *Id.*

335. *See supra* note 334 and accompanying text.

336. *Id.*

337. *See* DASCHLE, *supra* note 6, at 24.

338. GRATZER, *supra* note 5, at 90.

inconsistent and unclear in their findings.³³⁹ Indeed, one study showed that the survival rate for women with breast cancer was lower among women with Medicaid than among women without insurance.³⁴⁰ The logical conclusion of this study is rather odd: *having* Medicaid would lead to more deaths than *lacking* insurance would.³⁴¹

B. Cost and Efficiency

The U.S. spends more on health care per person and as a percent of GDP than any other nation.³⁴² In total, more than \$1.6 trillion is spent on U.S. health care per year.³⁴³ Four major issues address why U.S. expenditures are high and how government-managed health care has affected expenditures elsewhere.

First, what has caused cost to increase faster than inflation?³⁴⁴ Simply put, a person receiving services at zero-cost has an incentive to use as many of those services as have *any* value to the person.³⁴⁵ With government services, taxes are collected and services are distributed with the revenue; little or no upfront cost is charged for individual usage of the services.³⁴⁶ Theoretically, citizens in a single-payer system could spend the entire GDP on health services.³⁴⁷

Employer provided health care experiences the same problem because employers provide low-deductible, low-premium insurance policies, requiring employees to pay relatively low out-of-pocket

339. *See id.*

340. *Id.*

341. *See id.*

342. GOODMAN, *supra* note 8, at 6.

343. *Id.* at 6, 77. The U.S. is a wealthy nation and wealthier nations generally spend larger portions of GDP in health care than poorer nations. *Id.*

344. GRATZER, *supra* note 5, at 32-40. According to the late Nobel Prize winning economist, Milton Friedman, health care costs are an anomaly compared with other sectors of the economy insofar as technological advancements in health care have been accompanied by rising costs of services. *Id.* It was Friedman's view that this has been a result of federal regulation in the health care sector, coupled with its collateral effect of employer-provided care, encouraged by the federal tax code. *See id.*

345. *See* GOODMAN, *supra* note 8, at 4-6.

346. *See id.*

347. *See id.*

costs.³⁴⁸ For the health care system as a whole, which includes employer-provided and government benefits, patients pay approximately 18¢ on each health care dollar spent nationally.³⁴⁹ Therefore, Americans have an incentive to consume health services until the services received equal eighteen cents on the dollar.³⁵⁰ This leads to high usage, high waste, and high costs.³⁵¹ Generally, there are two ways to prevent this from happening: by limiting demand or by limiting supply (rationing).³⁵²

Second, the U.S. already controls cost as well as many single-payer nations do.³⁵³ One exception is Canada, which saved costs during the 1990s by closing hospitals, cutting block grants to its provinces, and limiting its use of new technologies.³⁵⁴ In other words, Canada, like the U.K., must ration care.³⁵⁵

348. *See id.*

349. *See id.*

350. *See* GOODMAN, *supra* note 8, at 4-6.

351. *See id.* Goodman argues that nothing is wrong with spending an increasing amount on health care so long as Americans are receiving the value of their money in return. *See id.* If a person's income increases as he ages, he will place a higher value on health services and will want to direct more of his income to health care. *See id.* However, the value of services cannot be assessed when the prices are removed or artificially lowered. *See id.* For the employer, it cannot be determined how much in wages a person is willing to trade for health benefits. *See id.* Employees do not pay the actual costs of their health services and simply consume resources without consideration of the cost: the employee only has to pay a low monthly premium commiserate with a low deductible; the employer picks up the bill from the insurance company and receives the federal tax deduction. *Id.*

In sum, while health care costs are rising, it is impossible to know whether, and where, the costs are rising too much if it cannot be determined what the true value of services and treatments are. *See id.* This, Goodman writes, is the effect of suppressing normal market functions by removing health care decisions from the individual. *See id.*

352. *See id.*

353. *See id.* at 77. Between 1960 and 1998, the per capita increase in spending on health care ranged between 2.5% and 2.7% in the U.S., U.K., Australia, New Zealand, Germany and the Netherlands. *Id.* Goodman writes that this is surprising given that we have more access to technology and less rationing. *See id.* Japan experienced a 3.5% increase, while Canada experienced a .8% increase. *Id.*

354. *Id.* at 80.

355. *See* GOODMAN, *supra* note 8, at 80.

Further still, official Canadian health care costs do not tell the whole story: Canada lags far behind in spending on medical research and development (a field where the U.S. leads), and, unlike private insurance companies in the U.S., administrative costs are subsumed in the Canadian government's total budget.³⁵⁶ Indeed, single-payer advocates often cite the fact that administrative costs are low for Medicare and Medicaid.³⁵⁷ However, like Canada, the U.S. government can also hide its administrative costs.³⁵⁸ And, like

356. *See id.* at 80-81. Several other factors unlock the mystery of why U.S. spending on health care appears out of control when compared to Canadian spending. *See id.* First, Canada is able to hide its administrative costs insofar as health facilities and equipment are subsumed into the government's total budget, whereas in the U.S., the cost of building new hospitals, for instance, is included when people refer to total health care expenditures. *See id.* Second, the U.S. is the global leader in medical research and development, whereas Canada lags far behind in medical innovation. *See id.* Third, the U.S., with a population outmatching Canada by more than ten-to-one, is burdened with a slightly older population as well as higher AIDS, obesity, teen-pregnancy and military injury rates than Canada. *See id.*

357. *See, e.g.,* DASCHLE, *supra* note 6, at 146.

358. *See* GOODMAN, *supra* note 8, at 105-09; *but see* DASCHLE, *supra* note 6, at 146. Some have argued the administrative overhead, marketing budgets and profits of private insurance can be eliminated by instituting a government program. *See, e.g.,* DASCHLE, *supra* note 6, at 9-12, 146. Many have cited the astonishingly low 2% cost of Medicare's overhead when compared to 9.5% for private insurance and 11.9% for HMOs, respectively. *See* GOODMAN, *supra* note 8, at 105-06 (*citing* the Congressional Research Service). Goodman argues that one-way Medicare keeps costs low is by shifting costs to patients and doctors: for example, a physician spends an average of six minutes on each Medicare claim, while his staff spends an additional hour processing the claim; yet, these labor costs are not calculated in Medicare's overhead. *See* GOODMAN, *supra* note 8, at 105-06. Goodman asserts that if the federal government wanted, it could also eliminate the same administrative costs associated with automobiles by eliminating private auto manufactures and designing a uniform model. *See id.* at 106-07. Theoretically, this would reduce overhead, and consumers could pay taxes in exchange for a new car every so often. *See id.* Needless to say, consumers would object to such a scheme. *See id.* One study concluded that Medicare spends an average of 27% of its total spending on overhead, compared with about 16% overhead for private insurance. *See id.* at 108-09. Finally, Goodman writes, by granting employers tax deductions for health insurance, but not individuals who would buy their insurance directly, the federal government has encouraged third-party provided insurance, which leads to over-insurance and wasteful consumer behavior. *See id.* at 110.

Canada, official costs do not tell the whole story of Medicare.³⁵⁹ About three-quarters of a million Medicare beneficiaries pay \$5,000 in out-of-pocket expenses per year, while two-thirds of all beneficiaries must obtain supplemental health insurance policies to cover services Medicare will not cover.³⁶⁰ Also, because Medicare does not cover as many drugs as private programs, Medicare covers significantly more health services that might be otherwise unnecessary had the drugs been prescribed in the first place.³⁶¹

Third, Daschle, Gratzler, and Goodman all agree that drug companies often advertise “new” drugs that are no better than generics or older brands.³⁶² All agree that drug companies lobby and advertise aggressively, wining and dining doctors to convince them of the latest drug or treatment.³⁶³ Some have asserted that drug re-importation or price controls would solve the cost problem.³⁶⁴ However, if the U.S. re-imported from Canada, for instance, where price controls are in place, all this would do is import Canadian price controls!³⁶⁵ Moreover, if drug companies cannot make a profit, they cannot innovate new technology.³⁶⁶

Gratzler argues that there are three reasons drug costs are high.³⁶⁷ One, consumers do not pay directly for drugs.³⁶⁸ For example, the innovative drug Prilosec was highly successful, but once its patent expired, AstraZeneca, a cheaper but similar product, was released and ate away at Prilosec’s market share.³⁶⁹ Prilosec came out with

359. *See id.* at 107-09. Most Medicare beneficiaries require supplemental private insurance because Medicare cannot cover their needs. *See id.* These beneficiaries pay 30% more on health care than beneficiaries who do not purchase supplemental insurance. *Id.*

360. *Id.* at 107.

361. *Id.*

362. *See id.* at 167-75; DASCHLE, *supra* note 6, at 9-12; GRATZER, *supra* note 5, at 145-48.

363. *See, e.g.,* GRATZER, *supra* note 5, at 145.

364. *See, e.g., id.* at 142-44. Gratzler writes that support for re-importation is broad, coming from academics and both political parties. *Id.*

365. *See id.*

366. *See id.*

367. *Id.*

368. *Id.*

369. GRATZER, *supra* note 5, at 145-46.

Nexium, which was basically a mirror image of the same drug.³⁷⁰ However, since most Americans pay small co-pays for their drugs, few consumers noticed.³⁷¹ Two, the FDA approval can take up to fifteen years and cost over \$1 billion to get a single drug approved.³⁷² Add the cost of advertising and it is no wonder that pharmaceutical companies attempt to regain such vast revenue before their patent expires.³⁷³ Three, tort suits are commonplace in the U.S., and recoveries can be large.³⁷⁴

The fourth major issue to be considered respecting high health expenditures is the fragmented U.S. health care market.³⁷⁵ States have varying regulatory regimes; each state requires that insurance companies provide specific services.³⁷⁶ Between 1965 and 2004, the number of medical benefits that states required by law increased from 7 to 1,823.³⁷⁷ The result has been a wide variation among health prices in each state.³⁷⁸ For example, an unemployed individual can purchase a policy for a family of four at a cost of \$170 per month in Kansas City, Missouri, but a similar policy would cost more than \$750 per month in Boston, Massachusetts.³⁷⁹

To further complicate matters, several states have experimented with public programs to cover state residents. In Vermont, a form of managed care was tested, and community rating and guaranteed issue

370. *Id.*

371. *Id.*

372. *Id.* at 142-44, 152.

373. *Id.* at 150-55. Gratzer asserts that the FDA can reduce some of this burden on pharmaceutical companies by contracting out its data analysis and being more liberal about approving drugs and treatments that have already passed European Union standards. *See id.* at 153-55.

374. *Id.* at 142-44. Gratzer submits that the FDA should grant more legal protection to drug companies from tort suits, on the condition that the companies invest in more post-approval drug testing. *Id.* at 159.

375. *See infra* note 376 and accompanying text.

376. GRATZER, *supra* note 5, at 95. Maine, for instance, requires pastoral counseling. *Id.* Gratzer argues that this is a direct result of the politicization of health care, which allows lobbyists in each state to force various interests into health care policies. *See id.*

377. *Id.* at 93-96.

378. *Id.*

379. *Id.*

were imposed on all insurance companies.³⁸⁰ Young and healthy residents saw premium increases that caused them to drop their insurance policies, and thirty-one of Vermont's thirty-three insurance companies ultimately left the state.³⁸¹ The amount of uninsured residents rose from 9.5% to 14%.³⁸² The state expanded the program, but premium prices in Vermont are now among the highest, nationally.³⁸³ New Jersey also uses guaranteed issue, and it costs more to purchase one of the state's cheapest health care policies than it does to lease a Ferrari.³⁸⁴ In the six years after guaranteed issue was introduced, that policy price shot up six-fold.³⁸⁵

In Tennessee, the state government chose to expand the federally subsidized Medicaid program in the mid-1990s.³⁸⁶ The federal government matches more than half of the state subsidies for Medicaid.³⁸⁷ Today, nearly a quarter of Tennessee's residents are enrolled, and costs have increased from \$2.5 billion to \$8 billion between 1995 and 2004.³⁸⁸ To make matters worse, Medicaid fraud has been rampant.³⁸⁹ An audit showed that TennCare was covering 14,000 beneficiaries who turned out to be dead, and another 16,500 persons who were living out-of-state.³⁹⁰ Tennessee is not the only state that has seized the opportunity to expand Medicaid in order to gain more federal subsidies.³⁹¹ As Gratzner writes, "creative accounting" is the rule, not the exception for state governments seeking Medicaid subsidies.³⁹²

380. *Id.* at 92-93.

381. *Id.*

382. *See* GRATZER, *supra* note 5, at 92-93.

383. *Id.*

384. *See id.* at 94.

385. *Id.*

386. *Id.* at 104-06.

387. *Id.*

388. *See* GRATZER, *supra* note 5, at 104-06.

389. *Id.*

390. *Id.*

391. *Id.*

392. *Id.*

C. Access to Care

It has been said that access to health care is a human right.³⁹³ But, what good is that right if health services are strictly limited while no one has standing to sue the government for an abridgment of the right?³⁹⁴ Goodman argues that Canadians have no “right to an MRI,” for example.³⁹⁵ In England, one million people are waiting to be admitted to hospitals, while more than 800,000 Canadians are in waiting lines for some form of treatment.³⁹⁶ In Norway, 270,000, or more than 5% of the population, are in a waiting line for medical treatment.³⁹⁷ In 2003, Canadians waited an average of 8.3 weeks between referral and consultation with a specialist, and an additional 9.5 weeks before being treated or undergoing surgery.³⁹⁸ More than 40,000 British citizens had been waiting more than a year by the end of 2001 for surgeries such as hip and knee replacements.³⁹⁹

Senator Daschle has remarked that minorities experience a disproportionate lack of access to U.S. health care.⁴⁰⁰ For instance, he acknowledges that African-American life expectancy and infant mortality rates are exceptionally higher than among other races.⁴⁰¹

393. See, e.g., GOODMAN, *supra* note 8, at 17 (citing the U.S. Physicians’ Working Group for Single-Payer National Health Insurance); see also *supra* note 24 and accompanying text.

394. See GOODMAN, *supra* note 8, at 17.

395. *Id.*

396. *Id.* at 18.

397. *Id.*

398. *Id.* at 19. Numbers are often skewed to represent shorter waits than are actually occurring in these countries. See *id.* For instance, a Canadian may require a visit to a general practitioner, then a specialist, and possibly a recommended treatment or surgery. See *id.* The Canadian health system might report each wait period in the process separately, even though the point from which a medical issue arises to the final treatment could last months or years. See *id.* The problem with lengthy waits for medical care is obvious: patients’ health often diminishes or becomes simply untreatable as they wait. See *id.* at 21. In England, 25% of cardiac patients die while waiting in line. Although a degree of rationing already exists in the U.S., especially in the Medicare program, only 5% of U.S. patients wait more than four months for surgery. See *id.* at 21-23. In England, 36% wait at least four months for surgery. *Id.* at 23.

399. See GOODMAN, *supra* note 8, at 19.

400. See DASCHLE, *supra* note 6, at 34.

401. *Id.*

While minorities are more likely to be uninsured and poorer than non-minorities, single-payer systems tend to have the same issues.⁴⁰²

Moreover, single-payer systems disproportionately discriminate against the poor and elderly and rural citizens by trimming expenditures for those groups.⁴⁰³ For instance, in England the NHS has cut costs by reducing the amount of geriatric beds by 50% over the last twenty years.⁴⁰⁴ In New Zealand, patients over seventy-five are simply not accepted to receive dialysis; there are no private dialysis facilities in the country.⁴⁰⁵ The U.S., of course, has a Medicare program for the elderly. IMAC's key purpose would be to find ways to reduce Medicare expenditures.⁴⁰⁶

D. Quality and Outcomes

According to the World Health Organization (WHO), the U.S. health care system ranks at 37th out of 191 WHO nations, just above Slovenia and just below Costa Rica.⁴⁰⁷ Numerous single-payer systems, including Canada, England, and Sweden rank higher.⁴⁰⁸ However, the factors used in assessing the quality of health systems are highly tenuous. One factor is overall health, which relies on infant mortality rates and life expectancy.⁴⁰⁹ Another factor is health system responsiveness, based on patient and expert surveys.⁴¹⁰

402. See GOODMAN, *supra* note 8, at 153-55.

403. See *id.* at 147-65. In England and Canada, rural areas receive disproportionately less care than urban and wealthy regions. See *id.* at 27. This is because there is greater political incentive to direct resources to populous and wealthy regions. See *id.* While access to health care is a problem for the poor in every country, in the U.S. it is strictly due to financial constraints; in Canada and England, it is because the government has chosen which regions will get the most services. See *id.*

404. *Id.* at 148. Approximately three times as many British citizens above the age of seventy-five die of pneumonia each year, compared with U.S. citizens of the same age. See *id.*

405. *Id.* at 148-49. There is literally no recourse for a person with kidney failure above the age of seventy-five. See *id.*

406. See H.R. 3590, 111th Cong. § 3403 (2009).

407. GOODMAN, *supra* note 8, at 67-68.

408. See *id.*

409. *Id.*

410. See *id.*

Indeed, this is the only factor that takes patient opinion into account, and the U.S. ranks first in this category.⁴¹¹ Still, even this factor says little about health quality in terms of health outcomes.⁴¹²

Taken alone, lifespan says *nothing* about a nation's health care system.⁴¹³ One can imagine a physically inactive, obese, accident-prone, disease-ridden, homicidal, suicidal group of people with access to the best health care possible, or a well-fed, active, and healthy population with no health care access. Aside from the quality of one's health care system, things that affect lifespan include: lifestyle, environment, education, genetics, income, and other social factors.⁴¹⁴ With 300 million people, the U.S. is arguably the most ethnically and socially diverse nation. Japan has the longest lifespan; this stands to reason why Japanese Americans also have the longest lifespan *among* all other Americans.⁴¹⁵ European Americans live about as long as Western Europeans.⁴¹⁶ However, the U.S. tops out the list of OECD nations with respect to persons over the age of forty-five reporting good health.⁴¹⁷

The U.S. also leads in infant mortality among developed nations with about 7 deaths per 1,000 live births.⁴¹⁸ But not every country measures infant mortality the same way.⁴¹⁹ Switzerland, which has a rate of 4.8 deaths per 1,000 live births, does not include infants of less than thirty centimeters.⁴²⁰ This excludes many low-birth-weight infants, a grave problem that African Americans are hit by disproportionately.⁴²¹ African Americans have an infant mortality rate of 13.7 per 1,000 live births, while Mexican American and American infants of European descent have about the same rate of about 6 per 1,000 live births.⁴²² Yet, Mexican American infants are

411. *See id.*

412. *See id.* at 67-68.

413. *See* GOODMAN, *supra* note 8, at 51.

414. *Id.* at 51.

415. *Id.*

416. *Id.*

417. *Id.* at 49.

418. *Id.* at 51-53.

419. *See* GOODMAN, *supra* note 8, at 53.

420. *Id.*

421. *Id.*

422. *Id.* at 53-54.

twice as likely to be born outside of hospitals as white infants.⁴²³ Many have concluded that parental diet as well as drug use, lifestyle, marital status, and genetics play heavy roles in determining infant mortality.⁴²⁴ Indeed, African Americans deliver low-birth-weight infants at twice the rate of European Americans, *even when controlling* for income, age, and education.⁴²⁵ As with lifespan, the mortality rate of American infants of European descent is about equal to the rates of Western-European infants.⁴²⁶

Arguably, one of the best proxies for determining the quality of a nation's health care system is cancer survival.⁴²⁷ The proportion of people dying from breast cancer and prostate cancer is lower in the U.S. than in New Zealand, Australia, Germany, France, Canada and England.⁴²⁸ In the U.S., 70% of prostate cancer cases are caught early, compared with 58% in England.⁴²⁹ The survival rate for first stage breast cancer is 97% in the U.S., compared with 78% in England.⁴³⁰ Colorectal cancer patients have a 90% survival rate in the U.S., compared with 80% in Germany and 70% in England.⁴³¹ Overall, five-year survival rate for cancer is 66% among American men, compared with 45% of British men.⁴³²

VI. CONCLUSION: HOW WILL IMAC AFFECT AMERICAN HEALTH CARE?

A. Instead of IMAC, What Ought to Be Done to Curb Costs?

In single-payer systems, waits are long, specialists and treatments are rationed and restricted, all of which leads to poor outlooks for the elderly, the indigent and the sick.⁴³³ These are not problems faced by

423. GRATZER, *supra* note 5, at 174-75.

424. *See, e.g.*, GOODMAN, *supra* note 8, at 53-54.

425. *Id.*

426. *Id.*

427. *See, e.g., id.* at 55-56.

428. *See id.* at 55.

429. GRATZER, *supra* note 5, at 175-76.

430. *Id.* at 175.

431. *Id.*

432. *Id.* at xix.

433. *See* GOODMAN, *supra* note 8, at 115-16.

the majority of people who are young and healthy; as Dr. Gratzner quips, single-payer medicine is “the best health care in the world (unless you’re sick).”⁴³⁴ In any case, single-payer health care has proved unpopular as a way of reforming the American health care system.⁴³⁵ Still, some Americans look to the federal government for a solution to the problems in the health care system.⁴³⁶ What options are left?

First, Medicare and Medicaid must be reformed.⁴³⁷ While many have asserted that costly social programs like Medicare and Social Security, for that matter, should be pre-funded with all funds secured in a trust, Gratzner contends that this would be impractical.⁴³⁸ Instead, Gratzner argues that the U.S. must increase the current age of Medicare, as Congress has done with Social Security, to compensate for the rise in average lifespan since the program started.⁴³⁹ Then, the government should establish private savings accounts, setting

434. GRATZER, *supra* note 5, at 164.

435. See, e.g., *id.* 177-79; *Health Care Reform*, RASMUSSEN REPORTS, Jan. 22, 2010,

http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/september_2009/health_care_reform. Truman, Johnson, Clinton and Obama each initiated health care reform in their first year in office. See DASCHLE, *supra* note 6, at 51, 60-61, 85. Most health care reform efforts typically began with strong support for the proposed reform. See, e.g., *id.* at 53, 89. Today, about one-third of Americans support a complete overhaul of the health care system, with 41% of the uninsured concurring. GOODMAN, *supra* note 8, at 77. Seventy-nine percent of Americans feel that covering all Americans is important even if it means raising taxes, while 79% oppose the notion of rationing health care. *Id.* at 177-79. Although a 2003 Washington Post-ABC poll found that 62% of Americans supported a universal health care system, 40% of the respondents who had supported it changed their minds when told it meant that their choice of doctor would be limited. *Id.* at 179. The current health care bill was first presented to Congress in the summer of 2009, and by the end of January, 2010, 61% of voters wanted the plan dropped. *Health Care Reform*, *supra* note 435. Moreover, 42% of Americans favored the bill, while 58% opposed the plan (18% overall strongly favored it, while 50% overall strongly opposed the plan). *Id.* Of seniors, 62% opposed the bill. *Id.* An astonishing 78% believed the plan would cost more than projected. *Id.*

436. See *supra* note 435.

437. See *supra* note 435.

438. See GRATZER, *supra* note 5, at 191-92 (asserting that this exact system has been tried with Social Security and has only served to create larger deficits.).

439. *Id.* at 192.

aside the payroll tax that currently funds Medicare and investing the funds in stocks and bonds.⁴⁴⁰

Second, eliminate the employer-provided third-payer insurance system that emerged through WWII-era wage controls.⁴⁴¹ To this end, the federal government should eliminate the tax deduction for businesses, thereby eliminating the incentive for employers to provide insurance.⁴⁴² As Milton Freidman bluntly put it, “[t]here is no more reason for medical care expenses to be tax deductible than for food, clothing and housing expenses to be tax deductible.”⁴⁴³ Indeed, the personal exemption that the tax code provides all taxpayers should be sufficient.⁴⁴⁴ Then, people would purchase their own health insurance, and the incentive to overuse health resources would be eliminated.⁴⁴⁵ People would buy plans with higher deductibles and pay more out of pocket.⁴⁴⁶ Moreover, people would retain their health insurance even when changing jobs, causing the annual number of the uninsured to shrink dramatically.⁴⁴⁷ This can be accomplished through individual health savings accounts.⁴⁴⁸

440. *Id.* at 191-92.

441. *See supra* notes 91-99 and accompanying text.

442. GRATZER, *supra* note 5, at 186-87.

443. *Id.* at 186.

444. *Id.* at 187-88.

445. *Id.*

446. *Id.*

447. *Id.* at 187-88

448. GRATZER, *supra* note 5, at 62; GOODMAN, *supra* note 8, at 5. Essentially, individuals would pay premiums into personal accounts that would accrue funds overtime. GOODMAN, *supra* note 8, at 5. Patients would use their accounts to shop for medical services, and the medical providers would not be “agents” of third parties (such as HMOs, insurance companies, or the federal government). *See id.* Rather, medical providers would be free agents competing for patients with quality services at the lowest prices; and patients would be self-motivating free market actors as well, shopping for the best deals with their money. *See id.* Moreover, these accounts, like home and auto insurance, would carry high deductible insurance policies, allowing patients to use their private accounts for cheaper, less urgent, and minor medical issues. *See id.* Major surgeries and cancer care would be covered by the high insurance deductible. *See id.* In 1996, Congress passed the Health Insurance Portability Act (HIPAA), which created medical savings accounts that expired in 2001. *Id.* at 111. More than 750,000 were allowed, but only 70,000 enrolled due to heavy restrictions on the plan. *Id.* However, the Medicare Modernization Act of 2003 created health savings

Eventually, the proliferation of such accounts would end the need for a Medicare program for the elderly entirely, as all Americans would have private health accounts to provide health care in retirement.

Third, to bring down the cost of insurance, the federal and state governments could free up restrictive insurance industry regulations, opening the floodgate for numerous providers to compete with the best services at the lowest prices: charities, unions, and even religious organizations might begin offering insurance plans.⁴⁴⁹ Fourth, low-income and high-risk individuals should be provided a safety net. Returning to point number three, Gratzer argues that the federal government can rely on the Commerce Clause to open up a national market, rather than allowing states to impose conflicting regulations: opening a single national market of competing medical providers would, by itself, cause prices to drop.⁴⁵⁰ However, Gratzter further discusses the need to reform Medicaid, creating a program that works for those that are uninsurable.⁴⁵¹ To this end, the federal government should scarp the current system and extend block grants to each state.⁴⁵²

accounts, which are currently available to all non-elderly Americans. *Id.* Under these plans, unused funds roll over and accumulate as regular retirement accounts. *Id.* Moreover, while low deductible insurance policies carry high premiums, high deductible policies carry considerably lower premiums. GRATZER, *supra* note 5, at 62-64. Goodman further stresses the need for automatic renewal, so that, once in an insurance pool, a member's premium shall not be raised based on the emergence of a health issue. *See* GOODMAN, *supra* note 8, at 236-38. Rather, once in the pool, a member will be secure and all members' premiums would be raised (or lowered) upon the annual renewal; this way, no one could be penalized for having future and potential health issues. *See id.* This would only leave a problem for initial entry, which would be difficult for persons with preexisting medical problems. Nevertheless, these individuals shall be secured by a strengthened Medicaid program and a freer, cheaper health care market. *See infra* note 452 and accompanying text.

449. GRATZER, *supra* note 5, at 187.

450. *See id.* at 188.

451. *See id.* at 110-16.

452. *See id.* Currently the system is regulated and largely funded by the federal government while the states administer the program. *Id.* Instead, the federal government could get out of the system entirely, extending block grants to the state, rather than matching state funds (creating an incentive for state-level waste of federal funds.). *Id.*

B. Conclusion

IMAC's proposals will not be subject to the strict limits of FACA.⁴⁵³ However, APA's notice and comment requirement, coupled with the Sunshine Act's open meetings requirement, will keep IMAC generally transparent.⁴⁵⁴ Given the relative openness under which the Federal Reserve operates, pursuant to APA and Sunshine, one could expect IMAC's proposals to be in full public view.⁴⁵⁵ Nevertheless, this transparency is arguably more theoretical than actual. The Federal Reserve is seemingly transparent, but most Americans remain generally unaware of the Federal Reserve's activities and the economic power it wields.⁴⁵⁶ To this end, some might fear that the analogy Daschle creates between IMAC and the Federal Reserve is apropos. In fact, many would argue that the Federal Reserve is not a model of successful monetary policy or administrative transparency.⁴⁵⁷

This comment takes no position on whether IMAC's approval of evidence-based medical treatments with deference to cost will be a successful model with respect to reducing total costs and increasing efficiency in American health care. Instead, this comment asked whether a national health care program would lead to health care rationing; the conclusion of this comment is that treatments will need to be excluded, supply will have to be limited, and the costs of finite resources will have to be spread among beneficiaries if the federal government's health care burden is increased.

453. *See supra* notes 236-238.

454. *See supra* notes 164-172.

455. *See supra* notes 164-172, 257-267.

456. *See infra* note 457.

457. *See, e.g.*, Judson Berger, *Mr. Sunshine? Ron Paul Wins Support to Audit Fed Reserve*, FOX NEWS, June 30, 2009, <http://www.foxnews.com/politics/2009/06/30/mr-sunshine-ron-paul-wins-support-audit-fed-reserve/>. Recent economic situations, including the housing market bubble and the major bank failures, have caused many to question the Federal Reserve's level of contribution as well as the power it wields over economic affairs. *See id.* Congress has passed legislation to audit the Federal Reserve in an effort to increase transparency and investigate the Federal Reserve's responsibility for the economic situation. *See id.*

Although IMAC is not a death panel⁴⁵⁸ per se, and although the language of the bill expressly forbids rationing in its current form, how can it be that Medicare costs will decrease, as individual expenditures decrease, while revenues are not increased, while health care resources remain plentifully accessible nationwide? If IMAC would be limited to approving evidence-based treatments that do not increase Medicare spending, how can it be said that IMAC will not engage in rationing? The consensus among national health care advocates is that there are finite health care resources that require efficient and effective federal distribution.⁴⁵⁹ Is this not the definition of rationing?

Free-market reformists suggest that heavy regulation, coupled with artificial competition and artificially low out-of-pocket expenses, have unnecessarily driven cost and usage of health care resources up.⁴⁶⁰ If they are correct, is it even true that health care resources are finite? Indeed, might free market reforms reduce federal expenditures, drive health care costs down, and expand health care access without rationing care?

458. See *supra* note 1 and accompanying text.

459. See, e.g., Emanuel, *supra* note 281.

460. *Id.*

Index of Commonly Used Acronyms⁴⁶¹

(ALJ) -	Administrative Law Judge
(APA) -	Administrative Procedures Act
(the Administrator) -	Administrator of CMS
(AALL) -	American Association for Labor Legislation
(ABA) -	American Bar Association
(AFL-CIO) -	American Federation of Labor and Congress of Industrial Organizations
(AHA) -	American Hospital Association
(AMA) -	American Medical Association
(BCBS) -	BlueCross and BlueShield
(CDC) -	Centers for Disease Control
(CMMS) -	Centers for Medicare and Medicaid Services
(CCMC) -	Committee on the Cost of Medical Care
(CBO) -	Congressional Budget Office
(HHS) -	Department of Health and Human Services
(FACA) -	Federal Advisory Committee Act
(FHB) -	Federal Health Board
(FDA) -	Food and Drug Administration
(GDP) -	Gross Domestic Product
(HCFA) -	Health Care Financing Administration
(HMO) or (Managed Care) -	Health Maintenance Organization
(HRSA) -	Health Resource and Service Administrator
(IMAB) -	Independent Medicare Advisory Board
(IMAC) -	Independent Medicare Advisory Committee
(IRS) -	Internal Revenue Service
(LCD) -	Local Coverage Determinations
(MEDCAC) -	Medicare Evidence Development and Coverage Advisory Committee
(MedPAC) -	Medicare Payment Advisory Commission
(NCD) -	National Coverage Determinations
(NHS) -	(U.K.) National Health System
(NICE) -	(U.K.) National Institute for Health and Clinical Excellence
(OPD) -	Obstructive Pulmonary Disease

461. *Supra* note 22.

- (OMB) - Office of Management and Budget
(the Secretary) or (HHS Secretary) - Office of the Secretary of Health and Human Services
- (OECD) - Organization for Economic Cooperation and Development
- (QALY) - Quality Adjusted Life Year
- (SSA) - Social Security Administration
- (USPHS) - United States Public Health Service
- (WPO) - World Health Organization

