

6-24-2014

Re-Neogitiating a Theory of Social Contract for Universal Health Care in America or, Securing the Regulatory State?

George P. Smith II

Richard P. Gallena

Follow this and additional works at: <https://scholarship.law.edu/lawreview>

Recommended Citation

George P. Smith II & Richard P. Gallena, *Re-Neogitiating a Theory of Social Contract for Universal Health Care in America or, Securing the Regulatory State?*, 63 Cath. U. L. Rev. 423 (2014).

Available at: <https://scholarship.law.edu/lawreview/vol63/iss2/8>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Catholic University Law Review by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

Re-Neogitiating a Theory of Social Contract for Universal Health Care in America or, Securing the Regulatory State?

Cover Page Footnote

B.S., J.D., Indiana University; LL.M., Columbia University; LL.D., Indiana University. Professor of Law, The Catholic University of America. I was a Visiting Fellow at the Center for Law, Society, and Culture at Indiana University-Bloomington in July-August, 2012, where I began my research and drafting of this Article. I acknowledge—with gratitude—the gracious hospitality of Professor Lauren K. Robel, Provost and Executive Vice President and former Dean of the Maurer School of Law at the University, as well as Professor Hannah L. Buxbaum, who was the Acting Dean of the Maurer School of Law at the time of my visit. Loyola University Maryland, B.A.; The Catholic University of America, Columbus School of Law, J.D., 2013, magna cum laude. This article was co-authored while he was a third-year law student at The Catholic University of America, Columbus School of Law.

RE-NEGOTIATING A THEORY OF SOCIAL CONTRACT FOR UNIVERSAL HEALTH CARE IN AMERICA OR, SECURING THE REGULATORY STATE?

George P. Smith II⁺
Richard P. Gallena⁺⁺

I. THE AMERICAN SOCIAL CONTRACT	431
A. <i>The PPACA and the Social Contract</i>	433
B. <i>The Constitutional Challenge to the PPACA</i>	434
C. <i>The PPACA and the General Will</i>	437
D. <i>The PPACA and the Lawgiver</i>	437
II. THE STATE OF HEALTH CARE IN AMERICA	439
A. <i>Moral Hazard</i>	440
III. THE FEDERAL GOVERNMENT’S APPROPRIATE ROLE IN HEALTH CARE.....	443
IV. THE INDEPENDENT PAYMENT ADVISORY BOARD: RATIONING THE HEALTH CARE OF AMERICA’S GREATEST GENERATION	446
A. <i>The Benefits and The Burdens of Medicare</i>	446
B. <i>The Goal of Affordable Care</i>	448
C. <i>The Board’s Scope of Authority</i>	449
D. <i>The Structure of the Board</i>	449
E. <i>“Stacking the Deck” in the Board’s Favor</i>	451
F. <i>Patient-Centered Research</i>	452

⁺ B.S., J.D., Indiana University; LL.M., Columbia University; LL.D., Indiana University. Professor of Law, The Catholic University of America. I was a Visiting Fellow at the Center for Law, Society, and Culture at Indiana University-Bloomington in July-August, 2012, where I began my research and drafting of this Article. I acknowledge—with gratitude—the gracious hospitality of Professor Lauren K. Robel, Provost and Executive Vice President and former Dean of the Maurer School of Law at the University, as well as Professor Hannah L. Buxbaum, who was the Acting Dean of the Maurer School of Law at the time of my visit.

⁺⁺ Loyola University Maryland, B.A.; The Catholic University of America, Columbus School of Law, J.D., 2013, magna cum laude. This article was co-authored while he was a third-year law student at The Catholic University of America, Columbus School of Law.

V. THE INEVITABLE CONSEQUENCES OF IPAB REGULATION ON MEDICARE	453
A. <i>Indirect Rationing</i>	454
B. <i>Dire Projections from the Government and Health Care Providers</i>	456
VI. CONCLUSION.....	457

In March 1983, the President’s Commission for the Study of Ethical Problems Medicine and Biomedical and Behavioral Research issued a ground-breaking report entitled *Securing Access to Health Care*.¹ The report called for more responsible health care decision-making not only in the private sector but at all governmental levels, “to ensure that every American has a fair opportunity to benefit from it.”²

The extent to which the Constitution imposes a duty upon the government to protect the health and safety of its citizens has been problematic.³ The conventional position subscribes to the belief that the Constitution is “negative” or “defensive,” and that no positive obligation is imposed on the government to act.⁴ Consequently, according to this conventional position, the only protection granted by the Constitution is to safeguard individual rights from abridgement by the state.⁵ Whereas, the countervailing position recognizes a historical mandate for the states to affirmatively protect the citizenry.⁶

In his State of the Union address on January 11, 1944, President Franklin Delano Roosevelt sought to fortify this minority interpretation of Constitutional powers by enunciating what he termed a “[S]econd Bill of Rights.”⁷ Among the eight rights comprising this new Bill of Rights was a “right to adequate medical care and the opportunity to achieve and enjoy good health.”⁸ President Roosevelt did not believe that this right could be found in, or derived from, the Constitution; instead, he wanted this right—and the seven others—to be recognized as “affirmative rights as fundamental commitments that a democratic

¹ PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAV. RES., *SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES* (1983) [hereinafter *SECURING ACCESS TO HEALTHCARE*], available at http://bioethics.georgetown.edu/pcbe/reports/past_commissions/securing_access.pdf.

2. *Id.* at 1–2.

3. PUBLIC HEALTH LAW AND ETHICS 105 (Lawrence O. Gostin ed., 2d ed. 2010).

4. *Id.*

5. *Id.*

6. *Id.*

7. CASS R. SUNSTEIN, *THE SECOND BILL OF RIGHTS: FDR’S UNFINISHED REVOLUTION AND WHY WE NEED IT MORE THAN EVER* 9–10, 12–13 (2004); IRA KATZNELSON, *FEAR ITSELF: THE NEW DEAL AND THE ORIGINS OF OUR TIME* 195–96 (2013).

8. SUNSTEIN, *supra* note 7, at 13.

government should be making to its citizens.”⁹ Although not enacted in its totality as one bill, various “superstatutes” began to be passed in the 1930’s as part of the New Deal.¹⁰ These “superstatutes” sought to codify Roosevelt’s vision, with the foremost among them being the Social Security Act of 1935.¹¹ Thirty years after the enactment of the Social Security Act of 1935, Congress passed the Social Security Act Amendments of 1965, which established “a hospital insurance program for the aged under the Social Security Act,” better known as Medicare.¹² These amendments embodied President Lyndon B. Johnson’s vision of “a Great Society,” where poverty and racial injustice would be eliminated.¹³ Forty-five years later, Congress enacted the Patient Protection and Affordable Care Act (“PPACA”),¹⁴ which finally realized President Roosevelt’s notion of a universal governmental commitment to provide “adequate medical care” together with “an opportunity to achieve and enjoy good health.”¹⁵

Although the U.S. Supreme Court rarely imposes a direct responsibility on the government to protect individuals and populations,¹⁶ after World War II, there has been an increasing societal emphasis on recognizing society’s moral obligation to ensure that health care benefits are made available to all on an equitable basis.¹⁷ However, the goal of “equality of opportunity” has been thwarted.¹⁸ Even though the United States has regulated health care for more

9. WILLIAM N. ESKRIDGE JR. & JOHN FERREJOHN, *A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION* 46 (2010).

10. *Id.*

11. *Id.* at 46–47; see also MORTON KELLER, *AMERICA’S THREE REGIMES: A NEW POLITICAL HISTORY* 213 (2007) (explaining the greater societal impact of the Social Security Act of 1935).

12. Social Security Act Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286.

13. See JOHN A. ANDREW III, *LYNDON JOHNSON AND THE GREAT SOCIETY* 12–14 (1998) (articulating the elements encompassing President Johnson’s “Great Society”).

14. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) (to be codified as amended in scattered titles of the U.S.C.).

15. See SUNSTEIN, *supra* note 7, at 12–13 (detailing President Roosevelt’s “[S]econd Bill of Rights”). See generally Symposium, *The Federal Leviathan: Is There Any Area of Modern Life to Which Federal Government Power Does Not Extend?*, 37 HARV. J.L. & PUB. POL’Y 5 (2014).

16. PUBLIC HEALTH LAW AND ETHICS, *supra* note 3, at 106.

17. SECURING ACCESS TO HEALTHCARE, *supra* note 1, at 15; see Robert E. Moffitt, *The Economic and Ethical Dimensions of Health Policy*, 18 J. CONTEMP. HEALTH L. & POL’Y 663, 664–65 (2002) (discussing the ramifications of the “World War II era tax policy,” which diminished the ability for employees to make choices regarding health insurance).

18. SECURING ACCESS TO HEALTHCARE, *supra* note 1, at 15.

than one hundred years,¹⁹ “equity of access” has not yet been achieved²⁰ at both the *micro*²¹ and *macro* levels of distribution.²²

At all three levels of governmental decision-making—local, state, and federal—ethical principles are needed to serve as “practical guidance” to shape policy and guide the distribution of health care responses.²³ One of the most complicated and serious ethical problems of contemporary society is the need to find a compromise or point of balance between the near insatiable demand for health care regulation and distribution of this scarce resource.²⁴

The major limitation to both setting and improving public health policy is that, if people are healthier and live longer, this does not necessarily reduce the lifetime expenditures on health care. Most of those expenditures are incurred in the last six months of life, and no matter how long people live, they will eventually enter that terminal phase. However, the longer their healthier lives, the lower their average lifetime health-care expenditures and the greater their productivity, as well as the greater their utility since poor health reduces utility.²⁵

The foundational and, indeed, practical issue is the extent to which government funds should be provided to address specific types of health concerns, as well as when actual care should be commenced and ceased.²⁶

Five standards of justice have been advanced over the course of time in order to safeguard equitable access to health care and thereby come within the ambit of a sustainable level of distributive justice in a just society.²⁷ These standards are based on individual cases—with each standard having its own particular

19. Robert I. Field, *Regulation, Reform and The Creation of Free Market Health Care*, 32 *HAMLIN J. PUB. L. & POL'Y* 301, 301 (2011).

20. SECURING ACCESS TO HEALTHCARE, *supra* note 1, at 31.

21. See, e.g., MARK A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 15 (1993) (discussing the inequity of physician care within the United States); Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, *J. CONTEMP. HEALTH L. & POL'Y*, Spring 1986, at 23, 23 (same).

22. See, e.g., GEORGE P. SMITH, II, *DISTRIBUTIVE JUSTICE AND THE NEW MEDICINE* 17 (2008) [hereinafter *DISTRIBUTIVE JUSTICE*] (addressing the inequality of health care on a macro level); Nan D. Hunter, *Manager Process Due Care: Structures of Accountability in Health Care*, 6 *YALE J. HEALTH POL'Y L. & ETHICS*, Winter 2006, at 93, 97–98 (same). Interestingly, the extent to which a legal claim can be asserted to protect the human right to health, health care, or health protection is problematic. George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 *VAND. J. TRANSNAT'L L.* 1295, 1313–14 (2005) [hereinafter *Human Rights and Bioethics*]; GEORGE P. SMITH, II, *HUMAN RIGHTS AND BIOMEDICINE* 10–11 (2000) (discussing the difficulty of enforcing international human rights claims in domestic courts).

23. SECURING ACCESS TO HEALTHCARE, *supra* note 1, at 3.

24. George P. Smith, II, *Social Justice and Health Care Management: An Elusive Quest*, 9 *HOUS. J. HEALTH L. & POL'Y* 1, 4 (2009).

25. GARY S. BECKER & RICHARD A. POSNER, *UNCOMMON SENSE* 138 (2009).

26. See *id.* at 77.

27. Smith, *supra* note 24, at 6.

template for achievement.²⁸ It is far beyond the scope of this Article to probe the philosophical subtleties of these five standards: distributive, general or social, commutative, modulated, and retributive. Suffice it to observe that distributive justice is an ethical value or norm, which studies the societal obligation owed to all members of society in the *micro* allocation of its health care resources, while general or social justice seeks to shape and thereby chart proper standards of use for individuals in advancing the common good.²⁹ The level of responsibility in clinical medicine set between a physician and his patient is termed commutative justice.³⁰ Modulated justice seeks to preserve equity in distributive justice, general or social justice, and commutative justice.³¹ Assuring compensation to those suffering injustice under commutative, distributive, or general justice is the goal of retributive justice.³²

Central to the analysis of this Article is recognizing the complexity of reaching a fair and equitable level of distributive justice in measuring health care resources to be given or withheld.³³ The ineluctable conclusion to be drawn from any analysis of the issue of the distribution of health care resources is that the ever present quest for attainment of a social balance in policy making or a balance in “the satisfaction of private and public needs,”³⁴ is challenged—indubitably—by the “truce on inequality and the tendency [towards] inflation.”³⁵ Indeed, the whole question of reaching this balance “is lost” altogether as a consequence of this “debate over equality and social equity.”³⁶

Strong cultural, political, and economic forces are always at play in shaping public health policy and setting legal standards for normative conduct.³⁷ As has always been the case in public health, new societal forces, political ideologies, and economic conditions will have the ultimate effect of directing ever-changing

28. See *id.* at 6–9 (describing each standard in detail).

29. DISTRIBUTIVE JUSTICE, *supra* note 22, at 19; Smith, *supra* note 24, at 7; see also JOHN E. ROEMER, THEORIES OF DISTRIBUTIVE JUSTICE (1996); William A. Galston, *The Common Good: Theoretical Content, Practical Utility*, J. AM. ACAD. ARTS & SCI., Spring 2013, at 9, 9 (advancing the notion that the common good “reflects the outcome for bargaining for mutual advantage subject to a fairness test. And it is particularized through a community’s adherence to certain goods as objects of joint endeavor.”).

30. Smith, *supra* note 24, at 7.

31. *Id.*

32. *Id.*

33. *Id.* at 8 (explaining the role of administrative justice in society); see generally George P. Smith, II, *Distributive Justice and Health Care*, 18 J. CONTEMP. HEALTH L. & POL’Y 421, 421–24 (2002) (same).

34. JOHN KENNETH GALBRAITH, THE AFFLUENT SOCIETY 320 (1958).

35. *Id.* at 262.

36. *Id.* at 264; see also *Human Rights and Bioethics*, *supra* note 22, at 1319 (stating that the balancing of “individual claims to health right protections . . . against societal or communal needs . . . means that equity is forsaken for economic stability.”) (footnote omitted).

37. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 514 (2d ed. 2008).

laws and policies in the delivery of health care resources, and impact the elusive balance between the collective good and the protection of recognized individual rights.³⁸

Following President Barack Obama's inauguration in 2009, his bold agenda for national development was lauded as the next logical step in America's advancement of a theory of social contract.³⁹ The critical components of the President's ideal of an American social contract were employment, energy, retirement, and health care policies.⁴⁰ Indeed, the President was described as the "American Rousseau."⁴¹ Economic equality was identified as the root of any viable social contract because "economic inequality is central to a quest for enacting a social contract."⁴²

In 2010, President Obama signed into law America's first universal health care plan.⁴³ In October, 2012, the President himself opined that the PPACA — commonly referred to as Obamacare — would ultimately be seen as "the last piece of our basic social contract."⁴⁴ Whether this legislation is viewed as a noble effort by the federal government to re-negotiate the terms of a contemporary social contract with its citizens, or but another giant step in widening a culture of dependency, rests—in very large measure—upon the particular socio-political philosophy taken.⁴⁵

38. *Id.* at 513–14; Galston, *supra* note 29, at 11.

39. Brian Gilmore, *American Rousseau: Barack Obama and the Social Contract*, 35 T. MARSHALL L. REV. 9, 43 (2009).

40. *Id.*

41. *Id.* at 9.

42. *Id.* at 23.

43. *See infra* Part I.A.

44. Martha T. Moore, *Obama Calls 'Other Guy' an Expletive*, USA TODAY, Oct. 26, 2012, at 4A. Some say that the PPACA not only furthers the rights of people with disabilities, but actually recognizes disabilities as a category of anti-discrimination through "provid[ing] a comprehensive web of legal protections that both outlaw discrimination and promote access." Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 2035 (2013). *See also* Colbert I. King, *Obamacare—A Question of Morality*, WASH. POST, Nov. 29, 2013, http://www.washingtonpost.com/opinions/colbert-king-obamacare-is-a-matter-of-morality/2013/11/29/90379818-57b4-11e3-8304-caf30787c0a9_story.html (concluding that indifference to the needs of others is immoral and applauding Obamacare for responding to the needs of Americans who have no health insurance).

45. *See* Michael Grunwald, *One Nation Subsidized: How Big Government Underwrites Your Life*, TIME, Sept. 17, 2012, at 30 (arguing that Republicans fear the rise of big government under the Obama Administration); *see also* Marshall B. Kapp, *Health Reform and the Affordable Care Act: Not Really Trusting the Consumer*, 42 STETSON L. REV. 9, 33 (2012) (criticizing the PPACA's approach to healthcare that disdains the individual consumer's freedom to improve healthcare quality, access, and affordability, but, instead, codifies the paternalistic notion that "wisdom derives from central planning and intensive regulation" of healthcare resources thereby distorting the very integrity of the social contract); Daniel Henninger, *Let ObamaCare Collapse*, WALL ST. J., Sept. 25, 2013, <http://online.wsj.com/news/articles/SB10001424052702304526204579097443230322758> (discussing the potential impact of the public's growing dissatisfaction with ObamaCare); Charles Krauthammer, *Obama Unbound*, WASH. POST, Jan. 24, 2013, at A19 (lamenting President

Regardless of the socio-political philosophy taken regarding the PPACA and the dimensions of a social contract, there is little dispute over certain facts: presently, there are at least 2,199 federal assistance programs.⁴⁶ There are approximately 49.7 million Americans (or 16.3%) in poverty.⁴⁷ Approximately 15% of Americans use food stamps (now referred to as the Supplemental Nutrition Assistance Program, or SNAP).⁴⁸ Although most Americans pay taxes—either through payroll taxes, gasoline taxes, sales taxes, and state and local taxes—“only half the country pays income taxes.”⁴⁹ Allowable tax deductions for health care expenses cost the U.S. Treasury \$184 billion a year.⁵⁰ Further, in 2011, 65% of federal spending went towards actual “payment for individuals”—which included health care.⁵¹ This 2011 expenditure was a giant leap from expenditure levels in 1955, when the federal government expended only 21% of federal spending on “payments for individuals.”⁵²

Obama’s second term goal of pursuing a “vision of a more just social order where fighting inequality and leveling social differences are the great task of government,” which is achieved by preserving and enhancing entitlements). See generally Symposium, *Implementing Health Reform: Fairness, Accountability & Competition*, 5 ST. LOUIS J. HEALTH L. & POL’Y 1 (2011) (presenting various issues federal and state governments will have to overcome during the PPACA implementation process); Symposium, *The New American Health Care System: Reform, Reformation, or Missed Opportunity?*, 159 U. PA. L. REV. 1577 (2011) (presenting various perspectives on the new health care system); Symposium, *supra* note 15.

46. See *CFDA Statistics: Programs at a Glance*, CATALOG OF FEDERAL DOMESTIC ASSISTANCE, <http://www.cFDA.gov> (last visited Sept. 23, 2013).

47. Hope Yen, *Millions More Americans in Poverty Than Previously Estimated: Census Bureau*, HUFFINGTON POST (Nov. 14, 2012, 7:07PM), http://www.huffingtonpost.com/2012/11/14/american-poverty-2012_n_2130544.html.

48. Diana Furchtgott Roth, *Food Stamps Expand By Leaps*, WASH. EXAMINER (Sept. 18, 2012, 4:05PM), available at <http://washingtonexaminer.com/article/2508364>. The Obama administration recently widened the benefit eligibility under SNAP by exempting states from following the 1996 welfare reform legislation that required participants to either undertake work or prepare for employment. Robert Rector, *How Obama is Gutting Welfare Law*, WASH. POST, Sept. 7, 2012, at A27. In the District of Columbia, D.C. City Councilman David Catania observed that in order to reform welfare, program participants must assume some level of responsibility to leave the welfare program. Alan Blinder, *D.C. Toughens Up Requirements for Welfare Recipients*, WASH. EXAMINER (Jan. 8, 2013, 8:45 PM), available at <http://washingtonexaminer.com/video-d.c.-toughens-up-requirements-for-welfare-recipients/article/2517946> (discussing the D.C. City Council’s attempt to create personal responsibility, by enacting legislation that punished welfare beneficiaries for failing to complete “programs designed to help them improve their lives,” such as job training programs, or suffer up to a three month benefit withholding; the proposed legislation was ultimately modified to a one month benefit withholding).

49. Grunwald, *supra* note 45, at 32.

50. *Id.* at 35.

51. Robert J. Samuelson, *It’s the Welfare State, Stupid*, WASH. POST, Nov. 12, 2012, at A19.

52. *Id.*; see Nicholas Eberstadt, *Are Entitlements Corrupting U.S.? Yes, American Character Is at Stake*, WALL ST. J., Sep. 1, 2012, at C1 (discussing growing disillusionment with entitlements and the mismanaged and expensive state of social programs); Robert J. Samuelson, *The End of Entitlement: Americans’ Lofty Expectations Get a Reality Check*, WASH. POST, April 29, 2013, at A15 (same).

While there is little consensus on how to manage these grave socio-economic issues, the American “political system is sclerotic if not dysfunctional.”⁵³ As debt ceiling posturing began anew in January 2013, President Obama’s administration maintained that the economy would be stimulated by more government spending, which, in effect, would create new jobs and increase productivity levels.⁵⁴ House Republicans, led by the Speaker of the House, John Boehner, asserted that the government spending should be cut by the same amount that the debt ceiling was to be raised.⁵⁵ House Republicans further asserted that if the government failed to reform the so-called “entitlement” programs, the Nation would be seen as adopting “a European-style welfare state.”⁵⁶

For a considerable time, Americans have held to the opinion that “society is falling apart” and that national goals are too broad and complex.⁵⁷ In terms of health care management, Americans themselves are in large measure to “blame” for the present state of affairs—simply because “they lack the information critical to understanding the need for change.”⁵⁸

This Article will illustrate that President Obama’s approach to universal health care is in stark contrast with the fundamental principles of Rousseau’s theory of social contract. The purpose of the social contract theory is not economic equality or an all-providing government state.⁵⁹ Rather, the social contract envisioned by Rousseau, and adopted by the Framers of the American Constitution, is a foundation upon which individuals can succeed.⁶⁰

Part I of this Article discusses the general principles of the social contract and its influence on American democracy. Part II analyzes the current state of health care in the United States using survey data and statistics, and then proceeds to

53. Eugene Robinson, *A Monument to Our Nation at Its Best*, WASH. POST, Jan. 15, 2012, at A19; see Thomas E. Mann & Norman J. Ornstein, *Finding the Common Good in an Era of Dysfunctional Governance*, J. AM. ACAD. ARTS & SCI., Spring 2013 at 15, 15 (concluding that America is facing “a crisis of governability and legitimacy” and—if there are to be changes in serving the common good—“an informed and strategically focused citizenry” must come forward and become engaged). See generally Galston, *supra* note 29.

54. Editorial, *For Obama, Deficits Don’t Matter Any More*, WASH. EXAMINER (Jan. 13, 2013, 5:50PM), available at <http://washingtonexaminer.com/examiner-editorial-for-obama-deficits-dont-matter-any-more/article/2518440#>.

55. *Id.*

56. *Id.*; see Nicholas Eberstadt, Editorial, *Yes, Mr. President, We Are a Nation of Takers*, WALL ST. J., Jan. 25, 2013, at A13 (pointing out that there is an increasing percentage of American workers, “more than twice that of contemporary Greece,” that have withdrawn from the workforce).

57. PHILIP K. HOWARD, *THE DEATH OF COMMON SENSE: HOW LAW IS SUFFOCATING AMERICA* 171, 186 (1994).

58. Bryan R. Lawrence, *Tell Americans the Real Cost of Medicare*, WASH. POST, May 31, 2012, at A15; see Mann & Ornstein, *supra* note 53, at 15.

59. See CHRISTOPHER BERTRAM, *ROUSSEAU AND THE SOCIAL CONTRACT* 203 (2004) (describing the social contract as allowing a “mutual coexistence”).

60. See *id.*; see generally ALFRED COBBAN, *ROUSSEAU AND THE MODERN STATE* 113–50 (1964) (detailing the essential purpose of the Social Contract).

discuss the moral hazard associated with a universal health care plan. Part III proposes the appropriate role of the government in health care as shaped by the social contract. In order to evaluate the government's role within the present context, Part V analyzes the regulatory framework mandated by Congress for administering the new social contract for allocating health care resources. Part IV investigates the Independent Payment Advisory Board's ("IPAB") function and its broad grant of authority. Using current statistics and projections, the economic feasibility of reducing Medicare expenditures — while maintaining a high level quality of care and broad access to services — is explored as a paradigm for achieving distributive justice.⁶¹ Finally, Part V probes the IPAB's expected impact on Medicare, and concludes that the IPAB will ultimately, herald a new age of decreased quality and indirect rationing of basic health care services.

I. THE AMERICAN SOCIAL CONTRACT

The Social Contract is a philosophical approach to political order in which individuals consent to a sovereign power that, in turn, derives its authority from the consent and general will of the populace.⁶² Rousseau proposed that without civil order, individuals exist in the state of nature.⁶³ In the state of nature, individuals are free to do as they wish, but they are exposed to the unbridled greed of others.⁶⁴ In this state, the only limits are an individual's own capabilities.⁶⁵ Rousseau argued that in this basic state, "every force which overcomes another force inherits the right which belonged to the vanquished."⁶⁶ Strength begets obedience, but might does not make right.⁶⁷ Although Rousseau's notion of a state of nature was utopian,⁶⁸ it was also a valid means of expressing "the development of the principle of the autonomy of the will, by means of which [Rousseau] reconciled with liberty."⁶⁹

61. The complications attendant to this aspirational effort for equitable distribution are inextricable from the increasing costs of basic healthcare and of Medicare.

62. JEAN-JACQUES ROUSSEAU, *THE SOCIAL CONTRACT* 136 (Maurice Cranston trans. 1968). There is no actual agreement in the "grand social contract"; rather, "it is meant to produce the same win/win outcomes, just like ordinary contracts, and to do so in settings where huge members of individuals are forced to participate in this joint social venture." RICHARD D. EPSTEIN, *THE CLASSICAL LIBERAL CONSTITUTION: THE UNCERTAIN QUEST FOR LIMITED GOVERNMENT* 20 (2014). Those who deviate, unilaterally, from the contract are seen as menaces, or alternatively, as freeloaders. *Id.*

63. ROUSSEAU, *supra* note 62, at 59–60.

64. *See id.* at 65.

65. *See id.* at 52–53.

66. *Id.* at 53.

67. *Id.*

68. CHRISTOPHER D. WRIGHT, *ROUSSEAU'S THE SOCIAL CONTRACT: A READER'S GUIDE* 14 (2008).

69. COBBAN, *supra* note 60, at 42–43.

In an effort to protect personal property and create a code of civil liberties, humanity forsakes the state of nature. Rousseau argued that humanity reaches “a point where the obstacles to their preservation in a state of nature prove greater than the strength that each man has to preserve himself in that state.”⁷⁰ Humanity exits the state of nature by consenting to a sovereign authority that offers protection and provides a foundation that allows man to prosper.⁷¹ Individuals lose the ability to take by force, but gain “civil liberty and the right of property.”⁷² Thus, according to Rousseau, the goal of the civil society is the protection and preservation of its members.⁷³

Rousseau believed that “[t]he purpose of social contract is to preserve the contracting parties.”⁷⁴ Accordingly, “[h]e who wills the end wills the means also; and these means necessarily involve certain risks, and even contain losses.”⁷⁵ “Fair terms of co-operation” are essential to the integrity of the contract.⁷⁶ Unhappiness and moral degradation occur when unequal relations of dependence result from the subversion of healthy drives “into a more grasping, self-centered set of motives.”⁷⁷

The fundamental principles underlying the social contract serve as the foundation for American democracy. Echoing Rousseau’s belief that man is born free, the Declaration of Independence begins with the words “[w]e hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.”⁷⁸ The Framers wrote “[g]overnments are instituted among Men, deriving their just powers from the consent of the governed.”⁷⁹ The Declaration reflects a belief that the authority of the government is derived from the *consent* of the governed—a central tenet of Rousseau’s social contract.⁸⁰

70. ROUSSEAU, *supra* note 62, at 59.

71. *Id.* at 59–60.

72. *Id.* at 64–65. Rousseau argued that from the social contract, man gains “civil liberty and the legal right of property in what he possesses.” *Id.* at 65.

73. *Id.* at 59–60.

74. ROUSSEAU: POLITICAL WRITINGS 35 (Frederick Watkins trans., 1953).

75. *Id.*

76. BERTRAM, *supra* note 59, at 131–32.

77. WRAIGHT, *supra* note 68, at 17.

78. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

79. *Id.*

80. Gilmore, *supra* note 39, at 21–22. For an extensive analysis of the impact of social contract theories on the foundation of American democracy, see GARY ROSEN, AMERICAN COMPACT: JAMES MADISON AND THE PROBLEM OF FOUNDING (Wilson Carey McWilliams & Lance Banning eds., 1999). Interestingly, Pope Benedict XVI’s first social Encyclical Letter, *Caritas in Veritate*, signed June 29, 2009, addressed issues of global development and progress toward advancing and preserving the common good by reflecting on how mortal principles shape economic and social issues. Pope Benedict XVI, *Caritas in Veritate*, VATICAN (June 29, 2009), available at http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate_en.html. Although social contract is not used specifically,

A. *The PPACA and the Social Contract*

It has been argued that an “obvious component of any key social contract between the state and the people” is the provision requiring universal health care through a single-payer system.⁸¹ Further, because “all western industrialized nations in Europe provide universal healthcare,” the fact that a large portion of the U.S. population is without health insurance underscores the failure of the government to meet its responsibility.⁸² However, the comparison to other countries is irrelevant, because it is the consent of the governed that gives legitimacy to laws—not the consent of those governed in other nations.⁸³

President Obama also believes that universal health care is a key component of the social contract. In his book, *The Audacity of Hope*, Obama writes, “[g]iven the amount of money we spend on health care (more per capita than any other nation), we should be able to provide basic coverage to every single American.”⁸⁴ In pursuit of this belief, the President and Congress enacted the Patient Protection and Affordable Care Act (PPACA).⁸⁵ Signed into law on March 23, 2010, the PPACA is an expansive piece of legislation intended to create a universal health care system.⁸⁶ Among many new provisions, the Act requires individuals to purchase health care or face a penalty.⁸⁷ This individual mandate, and several other provisions, have been challenged in federal courts.⁸⁸ From March 26 to March 28, 2012, the Supreme Court heard six hours of oral arguments.⁸⁹

there are direct allusions to this theory in Chapter 3 of the Encyclical where the idea that charity (or giving) fosters justice and a sense of common good among economic actors is advanced. *See generally* CAPITALISM AND SOCIALISM: A THEOLOGICAL INQUIRY (Michael Novak, ed., 1979).

81. Gilmore, *supra* note 39, at 25–26.

82. *Id.* at 25.

83. *See id.* at 21–22 (stating that governments derive their powers from the people).

84. BARACK OBAMA, *THE AUDACITY OF HOPE: THOUGHTS OF RECLAIMING THE AMERICAN DREAM* 184 (2006).

85. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered titles of the U.S.C.).

86. *See id.*

87. HINDA CHAIKIND ET AL., CONG. RESEARCH SERV., R41664, PPACA: A BRIEF OVERVIEW OF THE LAW, IMPLEMENTATION, AND LEGAL CHALLENGES 2 (2011). *See* EPSTEIN, *supra* note 62, at 185–93 (evaluating both conservative attacks on the PPACA and the liberal responses).

88. *Id.* at 5. Attorneys general and governors from 26 states have challenged the individual mandate. *See, e.g.*, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577, 2580 (2012); Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253, 266–67 (4th Cir. 2011) (challenging the individual mandate). *See generally* Jessica Bulman-Pozen, *Partisan Federalism: Examining the Interaction of Party Politics and Federalism*, 127 HARV. L. REV. 1078 (2014).

89. *Patient Protection and Affordable Care Act Cases*, SUPREME COURT OF THE UNITED STATES, <http://www.supremecourt.gov/docket/PPAACA.aspx> (last visited Jan. 25, 2014).

B. *The Constitutional Challenge to the PPACA*

On June 28, 2012, a divided five-to-four Supreme Court decided *National Federation of Independent Business et al. v. Sebelius*—the first constitutional challenge to the PPACA that has reached the Supreme Court.⁹⁰ Twenty-six states, several individuals, and the National Federation of Independent Business challenged the constitutionality of two provisions of the PPACA—the individual mandate that requires individuals to purchase health insurance or pay a tax, and the provision that requires States to expand Medicaid eligibility or lose existing federal funding.⁹¹ The Court only addressed the constitutionality of the PPACA, it did not “consider whether the Act embodies sound policies.”⁹²

Writing for the majority, Chief Justice Roberts first addressed whether the Anti-Injunction Act precluded the lawsuit.⁹³ Under the Act, “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person.”⁹⁴ Thus, if the individual mandate was construed as a tax, plaintiffs would be barred from bringing the suit until the tax was actually levied.⁹⁵ The Court held that the individual mandate was not intended to be a tax, but rather as a penalty.⁹⁶ Therefore, the Court concluded that the plaintiffs were not estopped from bringing suit under the Anti-Injunction Act.⁹⁷

The Court then addressed whether the individual mandate exceeds Congress’s constitutional power under the Commerce Clause and the Necessary and Proper Clause.⁹⁸ Chief Justice Roberts concluded that the Commerce Clause grants Congress the ability to regulate *existing* commercial activities—however, the individual mandate *creates* commercial activity.⁹⁹ Therefore, the Commerce

90. *Sebelius*, 132 S. Ct. at 2608. See generally Stephen M. Feldman, *Chief Justice Robert’s Marbury Moment: The Affordable Care Act Case* (NFIB v. Sebelius), 13 WYO. L. REV. 335 (2013) (commenting on Chief Justice Roberts’ interpretation of the case); Symposium, *Health Care and The Constitution: A Forum on The Supreme Court’s Affordable Care Act Decision*, 81 FORDHAM L. REV. 1697 (2013) (discussing the consequences of the *Sebelius* decision).

91. See *Sebelius*, 132 S. Ct. at 2577, 2584–86, 2601–04. The Court explained that the Medicaid provision “requires state programs to provide Medicaid coverage to adults with incomes up to 133% of the federal poverty level, whereas many States now cover adults with children only if their income is considerably lower, and do not cover childless adults at all.” *Id.* at 2582.

92. *Id.* at 2577.

93. *Id.* at 2582–84.

94. 26 U.S.C. § 7421(a) (2006).

95. *Sebelius*, 132 S. Ct. at 2582–84.

96. *Id.* at 2584.

97. *Id.*

98. *Id.* at 2586, 2593. See U.S. CONST. art. 1, § 8, cl. 3 (stating that under the Commerce Clause Congress shall have the power “to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.”); U.S. CONST. art. 1, § 8, cl. 18. (dictating that Congress shall have the power “[t]o make all Laws which shall be *necessary and proper* for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.”) (emphasis added).

99. *Sebelius*, 132 S. Ct. at 2586–87.

Clause does not grant Congress the authority to create commerce and then regulate it.¹⁰⁰

Likewise, the Court held that the individual mandate cannot be sustained under the Necessary and Proper Clause in the absence of another authority.¹⁰¹ The Court concluded that although the Necessary and Proper Clause is exercised appropriately in support of another constitutionally vested authority, through the individual mandate, Congress created the necessity that it sought to justify.¹⁰² Ultimately, the majority upheld the individual mandate as a legitimate exercise of congressional power under the Taxing Clause.¹⁰³ While the PPACA describes the tax as a penalty, the Court held that it is properly construed as a tax, and thus within Congress' authority.¹⁰⁴

The Court then turned to the ACA's Medicaid expansion provision, which threatens to terminate current federal funds if States fail to comply with the new terms.¹⁰⁵ This provision of the PPACA requires state Medicaid programs to provide coverage to "all individuals under the age of 65 with incomes below 133% of the federal poverty line."¹⁰⁶ Chief Justice Roberts noted that the PPACA changed the nature of the Medicaid program from "a program to care for the neediest among us" into "an element of a comprehensive national plan to provide universal health insurance coverage."¹⁰⁷ While the PPACA provided federal funds to assist states with meeting the expanded eligibility criteria, states that chose not to participate risked losing the federal Medicaid funds that they already received under the existing framework.¹⁰⁸

The States argued that this provision violated the Spending Clause, which provides Congress with the ability to "pay the Debts and provide for the . . . general Welfare of the United States."¹⁰⁹ While Congress can use this power to develop federal and state spending programs, a State must have the ability to voluntarily and knowingly accept the terms of such a program.¹¹⁰

100. *Id.* at 2591; see Robert J. Pushaw, Jr., *ObamaCare and the Original Meaning of the Commerce Clause: Identifying Historical Limits on Congress's Powers*, 2012 U. ILL. L. REV. 1703, 1743–45 (explaining that the Commerce Clause regulates current commercial dealings, not those that may occur in the future).

101. *Sebelius*, 132 S. Ct. at 2593.

102. *Id.* at 2592. See generally Rebecca L. McCullough, *What Is All the Fuss About?: The United States Congress May Impose a Tax (It's Called the "Individual Mandate")*, 22 S. CAL. INTERDISC. L.J. 729 (2013).

103. *Sebelius*, 132 S. Ct. at 2598.

104. *Id.*

105. *Id.* at 2601.

106. *Id.*

107. *Id.* at 2606.

108. *Id.* at 2601, 2603–04.

109. *Id.* at 2601 (quoting U.S. CONST. art. 1, § 8, c. 1).

110. *Id.* at 2601–02 (explaining that "[t]he legitimacy of Congress's exercise of the spending power 'thus rests on whether the State voluntarily and knowingly accepts the terms'" (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981))).

However, Congress exceeds this authority when it withholds other funding to pressure the States to accept a Spending Clause program, because coercing the States in this manner runs counter to this Nation's "system of federalism."¹¹¹ The Chief Justice compared the PPACA's threat to cut noncompliant States' existing funds to "a gun to the head."¹¹² The majority concluded that the Medicaid expansion provision was too coercive and robbed States of the voluntary choice to participate in the program.¹¹³ Thus, the portion of the PPACA that required States to expand Medicaid eligibility or risk losing current funding was held unconstitutional.¹¹⁴

Regardless of the Supreme Court's decision in *Sebelius*, the question remains: should universal health care be a major component of the American social contract? Both the belief that universal health care is an integral component of a contemporary theory of social contract, and the belief that the implementation of the PPACA is necessary to a re-negotiated notion of this contract, inherently contradict the underlying principles of Rousseau's social contract. The purpose of leaving the state of nature and forming a civil society was to relinquish man's "absolute right to anything that tempts him," in exchange for civil liberties and a legal right to property.¹¹⁵ The widespread public opposition,¹¹⁶ and the realities and consequences of implementing universal health care in its current form, reveal the gaping inadequacies of attempting to justify the law based on the American social contract.¹¹⁷

Prior to the Court's decision, Charles Krauthammer opined that if the PPACA was upheld as constitutional, it would be the catalyst for altering the very "nature of the American social contract."¹¹⁸ Further, Krauthammer explained that the direct consequence of the Supreme Court holding the PPACA constitutional would "mean[] the effective end of a government of enumerated powers—i.e., finite, delineated powers beyond which the government may not go, beyond which lies the free realm of the people and their voluntary institutions."¹¹⁹ Additionally, the central government would be one "of unlimited power from which citizen and civil society struggle to carve out and maintain spheres of autonomy."¹²⁰

111. *Id.* at 2602.

112. *Id.* at 2604.

113. *Id.* at 2605.

114. *Id.* at 2666.

115. ROUSSEAU, *supra* note 62, at 65.

116. See *Healthcare System*, GALLUP, <http://www.gallup.com/poll/4708/healthcare-system.aspx?version=print> (last visited Jan. 25, 2014).

117. See *infra* Part V.

118. Charles Krauthammer, *Obamacare: The Reckoning*, WASH. POST, Mar. 23, 2012, at A19.

119. *Id.*

120. *Id.*

C. The PPACA and the General Will

Legitimate laws are those that accurately reflect the general will of the populace, and are implemented by lawmakers that inform the polity.¹²¹ Laws that are not legitimate are not binding on society.¹²² The general will rests on the assumption that the populace is informed and expressing a desire for a general good, rather than an amalgamation of individual desires.¹²³ According to Rousseau, “[t]here is often a great difference between the will of all [what all individuals want] and the general will; the general will studies only the common interest while the will of all studies private interest, and is indeed no more than the sum of individual desires.”¹²⁴ To ask only what government will provide at the expense of others is inconsistent with the very purpose of forsaking the state of nature—civil liberties and the protection of private property.¹²⁵ To allow the majority to take from the minority is a reinstatement of “the strongest is always right.”¹²⁶

The PPACA is supposed to be funded through a variety of measures including decreased Medicare spending and fines levied on non-complying individuals and institutions.¹²⁷ According to the Congressional Research Service, the “PPACA appropriates and transfers from the Medicare trust funds billions of dollars . . . to support many of [its] provisions.”¹²⁸ As implemented, the PPACA embodies a reversion to the state of nature, rather than a legitimate law within the social contract.

D. The PPACA and the Lawgiver

Wise leadership is necessary to accurately guide the general will and translate the voice of the people into legislation. Rousseau posed the hypothetical question: “How can a blind multitude, which often does not know what it wants, because it seldom knows what is good for it, undertake by itself an enterprise as

121. See ROUSSEAU, *supra* note 62, at 81–83 (explaining that “laws stem from the general will”).

122. *See id.* at 53.

123. *Id.* at 72–73, 83.

124. *Id.* at 72.

125. *Id.* at 64–65, 76; *see also* Eberstadt, *supra* note 56 (explaining that “[t]his ‘taker’ mentality can only weaken civil society—even as it places ever-heavier burdens on taxpayers.”).

126. See ROUSSEAU, *supra* note 62, at 52–53.

127. CHAIKIND, *supra* note 87, at 4.

128. *Id.*; *see* Douglas Holtz-Eakin & Michael J. Ramlet, *Health Care Reform is Likely to Widen Federal Budget Deficits, Not Reduce Them*, HEALTH AFFAIRS, June 2010, at 1136, 1137–38. *See also* Philip Klein, *By Discouraging Work, Obamacare is Making U.S. Fiscal Problems Worse*, WASH. EXAMINER (Feb. 6, 2014, 6:02 PM), available at <http://washingtonexaminer.com/by-discouraging-work-obamacare-is-making-u.s.-fiscal-problems-worse/article/2543622> (analyzing a report from the Congressional Budget Office and concluding that these findings confirm the opinion of conservatives that the implementation of Obamacare “discourages work and created more government dependency”).

vast and difficult as a system of legislation?”¹²⁹ The lawgiver, Rousseau argued, should help the polity find “the good path which it is seeking.”¹³⁰ The polity must be “secured against seduction by the desires of individuals; it must be given a sense of situation and season, so as to weigh immediate and tangible advantages against distant and hidden evils.”¹³¹ Thus, the lawgiver must help inform the public of its decisions, and protect the integrity of the general will from the desires of the individual.

It is incumbent upon the legislature to inform the general will and enact legislation that accurately reflects the voice of the people. Congress failed to inform the public of the danger implicit in the health care legislation and allowed the desires of individuals to corrupt the general will. As enacted, the PPACA is over nine hundred pages long.¹³² In response to the new law, some estimate that federal agencies have issued roughly 3,500 pages of PPACA related rules, notices, and corrections.¹³³ During the 2010 Legislative Conference for the National Association of Counties, then-Speaker of the House Nancy Pelosi famously said, “we have to pass the bill so that you can find out what is in it.”¹³⁴ Polls reveal that Americans lack faith in the current leadership.¹³⁵ When given several options and asked who they “trust the most to make sure that all Americans have access to quality healthcare,” 46% of those surveyed “chose ‘none of these’ or ‘don’t know.’”¹³⁶

Finally, the gap between desired reform and the resulting legislation is wide. In response to the question “[h]ow much do you personally worry about the availability and affordability of healthcare,” 60% of those surveyed in March

129. ROUSSEAU, *supra* note 62, at 83.

130. *Id.*

131. *Id.*

132. Tom Giffey, *Is ‘Obamacare’ Really That Long?*, LEADER-TELEGRAM (July 17, 2012, 2:01 PM), http://www.leadertelegram.com/blogs/tom_giffey/article_c9f1fa54-d041-11e1-9d01-0019bb2963f4.html (reporting that the Affordable Care Act, as enacted by Congress, consisted of 906 pages (not between 2,400 and 2,700 pages) in its final version, which is less than the earlier version of the bill consisting of 2,076 pages).

133. Allison Bell, *PPACA: The Collateral Damage*, LIFEHEALTHPRO (June 2, 2011), <http://www.lifehealthpro.com/2011/06/02/ppaca-the-collateral-damage>. See generally John Harwood, *The Next Big Challenge for Obama’s Health Care Law: Carrying It Out*, N.Y. TIMES, Apr. 30, 2013, at A14 (explaining the many challenges facing the implementation of the PPACA).

134. Marguerite Bowling, *Video of the Week: “We Have to Pass the Bill So You Can Find Out What is in It”*, HERITAGE FOUNDATION (Mar. 10, 2010, 3:30 PM), <http://blog.heritage.org/2010/03/10/video-of-the-week-we-have-to-pass-the-bill-so-you-can-find-out-what-is-in-it/>.

135. See David Ingram, *Poll: Idea of Healthcare Overhaul Gets Wide Support*, REUTERS (Mar. 28, 2012, 6:52 PM), <http://www.reuters.com/article/2012/03/28/us-usa-healthcare-poll-idUSBRE82R1FA20120328> (finding, in a poll consisting of 1953 Americans, that a large percentage of those polled trusted neither Republicans nor Democrats to provide “quality healthcare”).

136. *Id.* The choices were: Obama (14%); Democrats in Congress (9%); Republicans in Congress (7 %); pharmaceutical companies (1%); insurers (6%); and, doctors and other healthcare practitioners (18%). *Id.*

2012 responded that they worry a “great deal.”¹³⁷ However, when asked whether Congress should make changes to the PPACA, a mere 13% replied “keep [it] as is.”¹³⁸ By failing to inform and guide the general will, and by enacting a piece of legislation far removed from the common interest, the legislature failed to uphold its responsibility under Rousseau’s social contract. This disconnect further erodes any argument that the PPACA has a legitimate place within America’s social contract.

II. THE STATE OF HEALTH CARE IN AMERICA

Studies and statistics reveal that health care in America has significant flaws. Currently, annual health care spending in America totals \$2.6 trillion.¹³⁹ This amounts to nearly 18 % of the annual GDP, or roughly \$8,402 per American.¹⁴⁰ The Government Accountability Office estimates at least \$25 trillion is needed to fund Medicare’s future intergenerational obligations.¹⁴¹ While the United States outspends every other country in health care spending,¹⁴² it only ranks twenty-seventh in life expectancy and thirty-first in health care coverage.¹⁴³

Health care costs are also the number one cause of bankruptcy.¹⁴⁴ In 2007, 62% of those filing for personal bankruptcy cited medical costs as the primary reason.¹⁴⁵ This number has risen at a alarming rate: in 1981, a mere 8% of individuals filing for bankruptcy cited medical costs as the primary reason.¹⁴⁶ According to a five-state study, by 2001, the number jumped to 50%.¹⁴⁷ Remarkably, the majority of the respondents had private insurance.¹⁴⁸ Even with insurance, however, individuals paid, on average, an additional \$17,749 in

137. *Healthcare System*, *supra* note 116.

138. *Id.* The other choices were: “minor changes” (29%); “major changes” (24%); “repealed entirely” (32%); and, “no opinion” (3%). *Id.*

139. *See* Ingram, *supra* note 135.

140. *Id.*; *see generally* Steve Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013 at 16 (exploring the problem of high healthcare costs in the United States).

141. Bryan R. Lawrence, *Tell Americans the Real Cost of Medicare*, WASH. POST, May 31, 2012, at A15; *see* Holtz-Eakin & Ramlet, *supra* note 128, at 1138–39 (highlighting overall budget problems with the implementation of healthcare reform and predicting that Medicare will not be able to operate at a reduced budget).

142. Ezekiel J. Emanuel, *Spending More Doesn’t Make Us Healthier*, N.Y. TIMES (Oct. 27, 2011, 12:53 PM), http://opinionator.blogs.nytimes.com/2011/10/27/spending-more-doesn't-make-us-healthier/?_r=0&pagewanted=print.

143. *See* Ingram, *supra* note 135.

144. Catherine Arnst, *Study Links Medical Costs and Personal Bankruptcy*, BLOOMBERG BUSINESSWEEK (June 4, 2009, 8:45 AM), http://www.businessweek.com/print/bwdaily/dnflash/content/jun2009/db2009064_666715.htm (stating that Harvard researchers found the majority of “personal bankruptcies . . . in 2007” were healthcare related).

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

out-of-pocket expenses.¹⁴⁹ The rising costs of health care and its detrimental effect on the economy underscore the need for change, but as observed, the PPACA is not the answer. An emphasis on prevention and personal accountability, rather than legislation, could significantly curb health care related expenses.¹⁵⁰

Recent surveys indicate that Americans are dissatisfied with the current health care system. The percentage of Americans that believe the U.S. health care system “has major problems” has remained high: 52 % of those polled in September, 1994, chose this response, and 57 % chose the same in November 2011.¹⁵¹ Yet, the issue appears to be related to coverage, not quality. In response to a November 2011 Gallup poll, a mere 6 % of those surveyed responded that the health care *coverage* in this country was “excellent.”¹⁵² In contrast, 20 % found the general *quality* of health care to be “excellent,” and 40 % believed the specific health care they received was “excellent.”¹⁵³ While the quality of health care in America is viewed positively, issues regarding coverage and expense still remain.

A. Moral Hazard

A universal health care system with an individual mandate, financed through taxing individuals and syphoning funds from Medicare, can lead to problems associated with moral hazard.¹⁵⁴ Moral hazard is a term that refers to the reduced incentive to prevent loss due to insurance against that loss.¹⁵⁵ Once people are

149. *Id.*

150. *See infra* Section II.A. In order to cut costs, some have turned to crowd fundin’ to raise additional money for healthcare costs. Since 2008, people have raised \$8.8 million in funding using the website GiveForward. Julia Sisler, *Crowdfunding for Medical Expenses*, CANADIAN MED. ASS’N. J., Feb. 7, 2012, at E123, E123-24, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3273528/pdf/184e123.pdf>.

151. *Healthcare System*, *supra* note 116.

152. *Id.* The other choices were: Good (27%); only fair (41%); poor (24%); no opinion (2%). *Id.*

153. *Id.* The other choices were: Good (39%); only fair (29%); poor (11%); no opinion (1%). *Id.*

154. BLACK’S LAW DICTIONARY 786 (9th ed. 2009) (stating that “[t]he risk that an insured will destroy property or allow it to be destroyed ([usually] by burning) in order to collect the insurance proceeds is a moral hazard. Also, an insured’s potential interest, if any, in the burning of the property is sometimes called a moral hazard.”) *Webster’s Dictionary* defines “moral hazard” as “the possibility of loss to an insurance company arising from the character or circumstances of the insured.” MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 756 (10th ed. 1997); *see also* Allard E. Dembe & Leslie I. Boden, *Moral Hazard: A Question of Morality?*, 10 NEW SOLUTIONS: J. ENVT’L & OCCUPATIONAL HEALTH POL’Y 257, 258–72 (2000) (exploring the historical roots of moral hazard as a value-neutral concept or as a pejorative connotation used in describing the propensity of some employees to exercise less caution in the workplace to enhance their opportunities to recover from workplace injuries under worker compensation claims).

155. *See, e.g.*, Cassandra Jones Havard, *African-American Farmers and Fair Lending: Racializing Rural Economic Space*, 12 STAN. L. & POL’Y REV. 333, 339 (2001) (referring to the borrower’s incentives to take risks or not depending on the interest rate of the loan).

protected from the negative consequences of their actions, they engage in riskier behavior.¹⁵⁶ In the context of health care, the term is used to refer to the decreased incentive to engage in healthy practices as a result of universal health care.¹⁵⁷ People who engage in unhealthy behaviors have a decreased incentive to improve their health once they are no longer accountable for the additional expenses that arise from their health problems. Akin to a free-rider problem, in which one person benefits equally from the efforts of others at no cost, those who are healthy will be required to pay for the additional health costs of others.¹⁵⁸ Not only is this an additional burden on the health care system, it disincentivizes healthy habits.¹⁵⁹

Obesity provides a prime example of moral hazard. According to the Centers for Disease Control and Prevention, from 2009–2010, more than one-third of American adults were obese.¹⁶⁰ A recent study conducted at Duke University projected that by 2030, nearly 42% of all Americans will be obese.¹⁶¹ Obesity contributes to heart disease, stroke, diabetes, and many other leading causes of death.¹⁶² As of 2008, obesity-related medical expenses were estimated to be

156. Dembe & Boden, *supra* note 154, at 257.

157. *See id.* at 266.

158. SARAH CONLY, *AGAINST AUTONOMY: JUSTIFYING COERCIVE PATERNALISM* 172-73 (2013).

159. *See* Cass R. Sunstein, *It's For Your Own Good*, N.Y. REV. BOOKS, Mar. 7, 2013, at 8 (challenging John Stuart Mill's principle of autonomy by arguing for extending the boundaries of paternalism in health matters when individual action forces large expenditures of public funds for subsequent care and citing the "individual mandate" in the PPACA as a proper exercise of paternalism); *see, e.g.*, RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 495 (8th ed. 2011) (concluding that market forces "cannot be counted on to optimize the level of obesity in society"). Rather than rely totally on ordinances designed to control obesity by regulating food menus in restaurants and the sale of items in grocery stores, promoting consumer education in healthy living and food consumption may be more important than any direct efforts taken to control obesity by enacting local ordinances. *Id.* at 495-96; Christine Fry, Sara Zimmerman & Manel Kappagoda, *Healthy Reform, Healthy Cities: Using Law and Policy to Reduce Obesity Rates in Underserved Communities*, 40 *FORDHAM URB. L.J.* 1265 (2013); Jeff Stier & Henry I. Miller, *Free Market Offers Real Solutions to Obesity Crisis*, *WASH. EXAMINER* (May 20, 2013, 2:20 PM), available at <http://washingtonexaminer.com/op-ed-free-market-has-real-solutions-to-obesity-crisis/article/2530083>. *But see* John B. Hoke, Note, *Parens Patriae: A Flawed Strategy for State-initiated Obesity Litigation*, 54 *WM. & MARY L. REV.* 1753, 1788 (2013) (arguing that legislation is the solution to America's obesity epidemic); Christine L. Kuss, Comment, *Absolving a Deadly Sin: A Medical and Legal Argument for Including Obesity as a Disability under the Americans with Disability Act*, 12 *J. CONTEMP. HEALTH L. & POL'Y* 563, 603-05 (1996) (arguing that obesity should be considered a disability under the Americans with Disabilities Act and that extensive regulations should be enforced to curtail it).

160. CYNTHIA L. OGDEN, ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., *PREVALENCE OF OBESITY IN THE UNITED STATES, 2009-2010* 1 (2012), available at <http://www.cdc.gov/nchs/data/databriefs/db82.pdf>.

161. Melissa Healy, *No End in Sight to Obesity Epidemic*, *L.A. TIMES*, May 8, 2012, at AA1.

162. *Id.*

\$147 billion.¹⁶³ Over the next twenty years, experts project these expenses to reach \$550 billion.¹⁶⁴ In 2006, obesity-related conditions cost third-party payers an additional \$1,429 for each obese person, compared to a person of normal weight.¹⁶⁵

Even assuming the federal government will bear a small fraction of the additional obesity-related costs as a result of a universal health care system, incurring the costs of an individual's unhealthy behavior provides the government with a legitimate argument to regulate and define what is healthy, and what people can eat. Although obesity can be a result of a genetic disorder, there is no question that personal choice is a large part of the problem.¹⁶⁶ Under a universal health care system, the federal government will be forced to either increase taxes or divert funds from other health care programs like Medicare to pay for the additional costs that could otherwise be prevented.¹⁶⁷ Legislation within Rousseau's social contract should not burden some members in order to confer additional benefits on others.¹⁶⁸ The PPACA confers benefits to some at the expense of others by syphoning funds from Medicare and therefore, reducing benefits for senior citizens in order to pay for avoidable health conditions. Indeed, this inequality has been termed the "flaw of Obamacare," because "it forces some Americans under penalty of law, to carry a larger and larger share of the price of other Americans' health care, through higher premiums and mandates on new taxes."¹⁶⁹

163. Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates*, 28 HEALTH AFFAIRS w822, w822 (2009).

164. Healy, *supra* note 161.

165. Finkelstein, *supra* note 163, at 826.

166. See *Obesity and Genetics*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Jan. 19, 2010), <http://www.cdc.gov/features/obesity/> (noting that, while genes can have an impact on obesity, the rapid rise in obesity cannot be attributed solely to changes in genetics).

167. See CHAIKIND, *supra* note 87, at 4. For example, the PPACA, which expands significantly Medicaid eligibility, is financed by both increasing tax revenue and diverting funds from Medicare. *Id.*

168. See ROUSSEAU, *supra* note 62, at 76; see also Janet L. Dolgin & Katherine R. Dieterich, *Weighing Status: Obesity, Class and Health Reform*, 89 ORE. L. REV. 1113, 1115-16 (2011) (discussing Obamacare's limited response to obesity and to discrimination based on class). See generally Y. Tony Yang & Len M. Nichols, *Obesity and Health System Reform: Private vs. Public Responsibility*, 39 J.L. MED. & ETHICS 380 (2011) (analyzing the PPACA's "new freedoms . . . grant[ed] to employers and health plans to use financial incentives for [employee] participation in wellness programs that emphasize promote good weight control," disease prevention, and maintenance of certain health standards).

169. Editorial, *Obamacare Isn't Reducing Healthcare Costs*, WASH. EXAMINER (Sept. 25, 2012 6:45 PM), available at <http://washingtonexaminer.com/article/2509026>.

See Dave Boyer, *Obamacare's Bold Vision Turns Murky: Health Reform Downsized, Promises Broken*, WASH. TIMES, Nov. 28, 2013, <http://www.washingtontimes.com/news/2013/nov/28/obamacares-bold-vision-turns-murky/?page=all>. The effect of the Supreme Court's construction of the PPACA's penalty for noncompliance as a tax will serve to "severely limit[] the ability of the new health-care regime to cope with its own predictable consequences." George F. Will, *The Time Bomb in Obamacare?*, WASH. POST, Jan. 20, 2013, at A25; see also Daniel P. Kessler,

Universal health care increases moral hazard. The PPACA will give the federal government an even greater role in regulating health and further erode personal choice, autonomy, and individualism. It disincentivizes personal responsibility and healthy choices at the expense of taxpayers and other government programs such as Medicare.

III. THE FEDERAL GOVERNMENT'S APPROPRIATE ROLE IN HEALTH CARE

In crafting public health policy, the federal government should closely follow Rousseau's guidance. Rousseau writes that the general will is "less from the number of voices than from the common interest uniting them."¹⁷⁰ In accordance with this guidance, the federal government should begin by determining the nation's common interest. One way to do this is through a process proposed by Andrew Lister called "zooming out."¹⁷¹ Zooming out is an approach used to analyze an agreement within the social contract by examining the policy along a continuum starting from the proposed agreement.¹⁷² Thus, the starting point for health care is the PPACA. Recent surveys indicate that public support for the PPACA hovers between 40 and 50%.¹⁷³ When public support of some other basic level of health care, such as Medicaid, is "zoomed out" and examined, actual public support is much higher.¹⁷⁴

One pollster commented that surveys confirmed that there is "wide recognition that the system, if not necessarily broken, is breaking."¹⁷⁵ He further opined: "It's just that once you get down to specifics, that coalition of people who want to change the system breaks down."¹⁷⁶ Thus, in addition to educating and leading the public, the legislature should seek to implement a policy somewhere along the continuum that reflects the legitimate general will without "zooming in" to a point that no longer reflects the general will. Legislatures should be aware that the greatest health care-related concern is cost, not availability.¹⁷⁷ When implementing a policy, the government should engage in an open discourse with the populace and seek to educate the public about the risks and long-term consequences of legislation.

ObamaCare's Broken Promises, WALL ST. J., Feb. 1, 2013, at A13 (predicting that non-group insurance subscriber's premiums will rise under ObamaCare).

170. ROUSSEAU, *supra* note 62, at 76.

171. Andrew Lister, *Public Justification and the Limits of State Action*, 9 POL., PHIL. & ECON. 151, 157–58 (2010).

172. *Id.*

173. *See Healthcare System*, *supra* note 116, at 2.

174. *See id.* at 1–2. The poll was conducted between January 14–16, 2011. 7% of those surveyed expressed no opinion. *Id.*

175. Ingram, *supra* note 135 (internal quotation marks omitted).

176. *Id.* (internal quotation marks omitted).

177. *See Healthcare System*, *supra* note 116, at 44–45. 38% responded that cost is the most significant issue, while only 15% identified coverage as the largest problem. *Id.*

Next, when developing policy, the federal government must act within the boundaries of its powers. Rousseau writes that “the sovereign has never any right to impose greater burdens on one subject than on another.”¹⁷⁸ Likewise, the federal government should craft policy that does not impose greater duties on one group than another. One group cannot be taxed more than another in order to finance the program. A policy should not deplete one group’s existing health care resource for the benefit of another group. The PPACA violates this premise by depleting Medicare resources, and thus imposing additional burdens on the elderly.¹⁷⁹

The policy must bind and favor all citizens equally, bearing in mind that these policies must be built on a common interest.¹⁸⁰ This does not mean that the government should select one form of health care that is binding on everyone. Rather, it means that the minimum level of health care, as determined by the general will and without favoring or burdening one group, should be available to all, should they desire it. Under the PPACA, those who wish to “opt out” must pay a fine.¹⁸¹ By the very nature of requiring one party to pay a fine in order to finance a portion of the PPACA, the federal government is burdening one group for the benefit of another group.

Further, states must be given substantial autonomy to determine the needs of its citizens. Rousseau warned repeatedly of the dangers of large governments.¹⁸² Administration “becomes more difficult over great distances [and] [g]overnment becomes more burdensome,” ultimately resulting in waste and inefficiency.¹⁸³ In order to preserve the integrity of a policy and guard against waste and inefficiency, the states – rather than the federal government – must be allowed to determine the needs of its citizens. For example, obesity varies by state.¹⁸⁴ A 2010 study showed that roughly 23% of the Hawaiian population was considered obese, while in Mississippi, 34% of the state was obese.¹⁸⁵ A blanket provision that suits the needs of Mississippi would create waste in Hawaii. Thus, health

178. ROUSSEAU, *supra* note 62, at 77.

179. See CHAIKIND, *supra* note 87, at 4; see also Leonard J. Nelson III, *Rationing Health Care in Britain and the United States*, 7 J. HEALTH & BIOMED. L. 175, 225 (2011) (speculating on the probability of PPACA’s cost containment as an ineffective mechanism for reducing costs over the long run); Kessler, *supra* note 169 (explaining that the largest source of revenue will come from cuts made to Medicare).

180. ROUSSEAU, *supra* note 62 at 69.

181. 26 U.S.C. § 5000A(b)(1) (Supp. V 2012).

182. See ROUSSEAU, *supra* note 62, at 90.

183. *Id.* at 90–91.

184. *Adult Obesity Facts*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 16, 2013), available at <http://www.cdc.gov/obesity/data/adult.html>. While each state is empowered to devise its own lists and guidelines for determining what is necessary health care (e.g., doctor visits, maternity care, prescription drugs, etc.), they must draw from ten broad categories. Sarah Kliff, *A Puzzle for States: What is Necessary Health care?*, WASH. POST, Sept. 22, 2012, at A1.

185. See *Adult Obesity Facts*, *supra* note 184.

care provisions must be controlled by and individually tailored to the needs of each state.

The problems associated with moral hazard should be borne in mind. The government's ultimate goal should be to promote health, but this should not be done at the gross expense of others. Programs should focus on education and prevention, and addressing health problems before they emerge. Rather than only combating the effects of obesity in adults, there should also be initiatives directed at young people that incentivize healthy decisions and lifestyles. Encouraging healthy decisions at a young age would result in a healthier population at a lower cost.¹⁸⁶ By focusing on preventing and detecting health problems in their incipiency, the government can turn the tide on the current health care crisis.

Finally, if there is doubt regarding specific provisions within a piece of legislation—assuming the legislation otherwise complies with Rousseau's guidance—Congress should weigh the gravity of the harm produced against the utility of the provisions to be enacted. The Second Restatement of Torts provides a variety of elements, several of which can be applied with slight modification, to legislative proposals.¹⁸⁷ Regarding the gravity of harm, Congress should consider the extent of the harm involved, the character of the harm, and the social value that society attributes to what is harmed.¹⁸⁸ When determining the utility of the provision, Congress should analyze the social value that society attaches to the goal of the provision, the suitability of the provision to the character of the people, and whether there is a less invasive measure to accomplish the goal.

Rousseau viewed the wise lawgiver as one who “begins not by laying down laws good in themselves, but by finding out whether the people for whom the

186. See JOHNS HOPKINS CNTR. FOR LIVABLE FUTURE, PERSPECTIVES ON CHILDHOOD OBESITY PREVENTION: RECOMMENDATIONS FROM PUBLIC HEALTH RESEARCH AND PRACTICE 9 (2007), available at http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-a-livable-future/research/clf_publications/pub_rep_desc/childhood_obesity.html (explaining the positive benefits of school-based interventions).

187. RESTATEMENT (SECOND) OF TORTS §§ 827–28 (1979). The Restatement provides the following elements when determining the gravity of harm:

- (a) The extent of the harm involved;
- (b) the character of the harm involved
- (c) the social value that the law attaches to the type of use or enjoyment invaded;
- (d) the suitability of the particular use or enjoyment invaded to the character of the locality; and
- (e) the burden on the person harmed of avoiding the harm.

Id. at § 827.

When determining the utility of conduct, the Restatement provides the following elements: “(a) the social value that the law attaches to the primary purpose of the conduct; (b) the suitability of the conduct to the character of the locality; and (c) the impracticability of preventing or avoiding the invasion.” *Id.* at § 828.

188. *Id.* § 827.

laws are intended are able to support them.”¹⁸⁹ After analyzing the factors of both the gravity of the harm and the utility of the provision, the legislature should weigh them against one another. If the utility of the provision outweighs the extent of the harm produced, and the provision is otherwise in accord with the tenets of America’s social contract, it should be enacted.

IV. THE INDEPENDENT PAYMENT ADVISORY BOARD: RATIONING THE HEALTH CARE OF AMERICA’S GREATEST GENERATION

In Book 12 of *The Odyssey*, the goddess, Circes, warned Odysseus that if a man hears the Song of the Sirens, “his wife and children will never welcome him home again.”¹⁹⁰ Odysseus instructed his men to fill their ears with wax and bind him to the mast of the ship, so that when he heard the Sirens and fell into madness, he would be restrained from leaping to his death.¹⁹¹

In an effort to curb Medicare spending, Congress has also bound itself to the mast, restricting its ability to act, and placing the health care of American seniors into the hands of the fifteen individuals who comprise the IPAB. Created by a simple majority in Congress, the Board can only be repealed by a super-majority vote.¹⁹² Shielded from judicial review, the appointed Board wields the power of the elected legislature.¹⁹³ The structure and power of the IPAB undermines the fundamental purpose of the separation of powers within a democracy.¹⁹⁴ This total abdication of responsibility poses a grave and immediate threat to Medicare beneficiaries, and will ultimately result in the indirect rationing of health care at the hands of an inscrutable, unaccountable Board.

A. *The Benefits and The Burdens of Medicare*

Medicare is a government program that provides insurance to Americans who are sixty-five and older.¹⁹⁵ Created in 1965, Medicare represents a commitment

189. ROUSSEAU, *supra* note 62, at 88. See generally Jacob T. Levy, *Federalism, Liberalism, and the Separation of Loyalties*, 101 AM. POL. SCI. REV. 459 (2007) (analyzing the implications of federalism).

190. HOMER, *THE ODYSSEY* 145 (Samuel Butler trans., Orange St. Press Classics 1998), available at <http://www.sparks.eserver.org/books/odyssey.pdf>.

191. *Id.*

192. 42 U.S.C. § 1395kkk(f)(2)(F) (Supp. V 2012) (requiring an affirmative vote of three-fifths of the Senate in order to dissolve the IPAB).

193. *Id.* § 1395kkk(c)(5). See generally Michael H. Cook, *Independent Payment Advisory Board—Part of the Solution for Bending the Cost Curve?*, J. HEALTH & LIFE SCI., Oct. 2010, at 102.

194. DIANE COHEN & MICHAEL F. CANNON, CATO INSTITUTE, *THE INDEPENDENT PAYMENT ADVISORY BOARD: PPACA’S ANTI-CONSTITUTIONAL AND AUTHORITARIAN SUPER-LEGISLATURE* 13–14 (2012), available at <http://www.cato.org/sites/cato.org/files/pubs/pdf/PA700.pdf>.

195. Lori Montgomery, *Good and Bad News for Medicare*, WASH. POST, Dec. 23, 2011, at A1.

between generations that reflects both human and capital investment.¹⁹⁶ Nearly forty-six million seniors currently rely on the program for health care.¹⁹⁷ However, Medicare spending is growing at an alarming rate.¹⁹⁸ From 1985-2009 Medicare spending increased at an annual rate of 8.5%.¹⁹⁹ Since 2002 alone, Medicare spending has grown by 68%²⁰⁰ and now accounts for “nearly 13% of the federal budget.”²⁰¹ In conjunction with Medicaid and Social Security, these three programs amount to roughly 44% of the federal budget.²⁰²

Medicare enrollment is also on the rise. Between 2000 and 2005, enrollment increased 1.3%, and from 2006 to 2010, enrollment increased 2.5%.²⁰³ As more baby boomers become eligible for Medicare, the enrollment figures are expected to continue to swell tremendously.²⁰⁴ One study predicts that the total number of enrollees will double over the next two decades, as roughly 10,000 baby boomers become eligible for Medicare each day.²⁰⁵ However, another study predicts that it will be forty years before enrollment doubles.²⁰⁶ Likewise, individual Medicare beneficiaries are also becoming more expensive. Between

196. GEORGE P. SMITH, II, *LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY* 16 (1996). See generally Andrew H. Smith & John Rother, *Older Americans and the Rationing of Health Care*, 140 U. PA. L. REV. 1847, 1852–55 (1992) (criticizing the “intergenerational justice” argument for rationing healthcare).

197. *Issue Guide: Medicare*, PUBLIC AGENDA, <http://www.publicagendaarchives.org/citizens/issueguides/medicare> (last visited Feb. 10, 2014).

198. See Montgomery, *supra* note 195, at A6.

199. LISA POTETZ ET AL., *MEDICARE SPENDING AND FINANCING: A PRIMER* 1–2 (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7731-03.pdf>

200. Alison Acosta Fraser, *Federal Spending by the Numbers—2012*, HERITAGE FOUNDATION (Oct. 16, 2012), <http://www.heritage.org/research/reports/2012/10/federal-spending-by-the-numbers-2012>. Likewise, Medicaid has grown 38 % since 2002. *Id.*

201. *Issue Guide: Medicare*, *supra* note 199.

202. Fraser, *supra* note 200.

203. JOHN HOLAHAN & STACEY MCMORROW, URBAN INSTITUTE, *MEDICARE, MEDICAID AND THE DEFICIT DEBATE: TIMELY ANALYSIS OF HEALTH POLICY ISSUES* 3 (2012), available at <http://www.urban.org/uploadedPDF/412544-Medicare-Medicaid-and-the-Deficit-Debate.pdf>. Congress established the Medicare Payment Advisory Commission (MedPAC) in 1997 and directed the Commission to report to it each year on the accessibility and the quality of care that beneficiaries are receiving from Medicare providers and to offer suggestions for improvement of the program. *Balanced Budget Act of 1997*, Pub. L. No. 105–33, § 4022, 111 Stat. 251, 350–55 (1997); *About MedPac*, MEDPAC, <http://www.medpac.gov/about.cfm> (last visited Feb. 10, 2014).

204. Montgomery, *supra* note 195, at A1–A6.

205. *Id.* Yet, physicians are beginning to ration services to Medicare recipients at significant rates—with 67.2 % of physician practices giving consideration to limiting new patients and 49.5% considering refusing to take new Medicare patients. Douglas Holtz Eakin, *IPAB and Medicare Costs Are Bad Medicine*, POLITICO (Mar. 22, 2012, 9:201 PM), available at <http://www.politico.com/news/stories/0312/74366.html>.

206. Doug Trapp, *Latest Medicare Projections Renew Alarm on Long-Term Sustainability*, AM. MED. NEWS, April 14, 2008, at 1. See generally Timothy Stoltzfus Jost, *The Independent Medicare Advisory Board*, 11 YALE J. HEALTH POL’Y L. & ETHICS 21 (2011).

1985 and 2008, per enrollee expenditures rose 6.3 % *per year*.²⁰⁷ This rapid growth in spending and enrollment threatens both the Medicare Program and America's economic development.

B. The Goal of Affordable Care

Reflecting a belief that universal health care is a central tenet in America's social contract, President Obama and Congress enacted the PPACA.²⁰⁸ This expansive piece of legislation increased health care coverage, expanded Medicaid eligibility, implemented new private health insurance market requirements, and created health insurance exchanges for individuals and small businesses.²⁰⁹ The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimated that an additional thirty to thirty-three million Americans would receive health care as a result of the PPACA.²¹⁰ The CBO and the JCT also estimated that the net costs of the insurance and Medicaid provisions would be \$1.1 trillion over the next decade.²¹¹ While PPACA proponents believed that the Act would ultimately reduce the federal deficit and federal health care costs, those eventual savings are far more attenuated than the more concrete and immediate net costs of the PPACA.²¹² To curb rising Medicare costs and offset the new subsidies and Medicaid provisions, the PPACA will syphon funds from Medicare and raise taxes.²¹³

207. JIM HAHN & CHRISTOPHER M. DAVIS, CONG. RESEARCH SERV., R41511, THE INDEPENDENT PAYMENT ADVISORY BOARD 1-2 (2012) [hereinafter IPAB REPORT] (emphasis added).

208. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered titles of the U.S.C.).

209. C. STEPHEN REDHEAD ET AL., CONG. RESEARCH SERV., R41664, ACA: A BRIEF OVERVIEW OF THE LAW, IMPLEMENTATION, AND LEGAL CHALLENGES I (2012).

210. CONG. BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT 3 (2012) [hereinafter CBO MARCH ESTIMATES], available at <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

211. *Id.* at 1.

212. Democrats estimate the total cost to be under \$1 trillion over the next ten years, while Republicans believe the correct number is \$2.3 trillion. Ezra Klein, *Paul Ryan and the True Cost of Healthcare Reform*, WASH. POST (Mar. 1, 2010, 5:26 PM), http://voices.washingtonpost.com/ezraklein/2010/03/paul_ryan_and_the_true_cost_of.html.

213. CBO MARCH ESTIMATES, *supra* note 210, at 2. Initially, the PPACA attempted to expand state Medicaid programs by threatening to withdraw states' federal Medicaid matching funds if they failed to comply with the terms of the expansion. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012). This coercive practice was held to be unconstitutional. *Id.* Thus, if the federal government cannot withdraw funds for failure to comply, the actual cost of expanding Medicaid will likely be much greater than initially projected. *See id.*

C. The Board's Scope of Authority

In order to reduce the per capita growth in Medicare expenses, Congress created the IPAB as part of the PPACA.²¹⁴ The IPAB is composed of fifteen appointed members.²¹⁵ It is a unique creation that simultaneously concentrates legislative authority in an executive organization, while shielding its actions from judicial review.²¹⁶ As a result, the structure and mission of the Board undermines the basic principles of separation of powers²¹⁷ and poses an inevitable threat to current and future Medicare beneficiaries and the overall state of health care in the United States.²¹⁸

The IPAB is empowered to use price control strategies to limit the use of expensive treatments.²¹⁹ Although the IPAB may not engage in direct health care rationing, its reimbursement policies will have the implicit and ultimate effect of rationing treatment. Thus, in the event “the board decides to set payment for state-of-the-art dialysis at below cost, reasoning that the benefits of the procedure aren’t commensurate with the added expense, it isn’t rationing care directly.”²²⁰ Yet, under such a policy patients would be treated with less expensive, but older, treatments.²²¹

D. The Structure of the Board

The Board is comprised of fifteen members appointed by the President, with the advice and consent of the Senate.²²² Upon appointment, each member serves

214. See 42 U.S.C. § 1395kkk(b) (Supp. V 2012).

215. *Id.* § 1395kkk(g)(1)(A)(i).

216. See Cohen & Cannon, *supra* note 194, at 12–13. The idea of a health board that would recommend government coverage decisions based on comparative effectiveness research surfaced some time ago. Various proposals over the years were designed to create a health care governing board that would make coverage and payment decisions based on effectiveness and efficiency. Jost, *supra* note 206, at 21–22. Former U.S. Senator, Tom Daschle, long-championed the expansion of the Federal Health Benefits Program, which would have allowed a Federal Health Board to utilize NIH research on evidence-based drugs and medical procedures to advocate recommendations for efficiencies of scale within government insurance benefits. TOM DASCHLE, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 170–72 (2008).

217. See Cohen & Cannon, *supra* note 194, at 13.

218. *Id.* at 5.

219. Shika Dalmia, *Romney Should Keep Focus on IPAB*, WASH. EXAMINER (Oct. 11, 2012, 3:34 PM), available at <http://washingtonexaminer.com/article/2510511>.

220. *Id.*

221. *Id.*

222. 42 U.S.C. § 1395kkk(g)(1)(A)(i) (Supp. V 2012). The Board will be comprised of “individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields.” *Id.* § 1395kkk(g)(1)(B)(i). In addition to other types of healthcare professionals, the PPACA mandates that the Board will include “representatives of consumers and the elderly.” *Id.* §§ 1395kkk(g)(1)(B)(ii). However, members cannot be concurrently employed while serving on the Board. *Id.* § 1395kkk(g)(1)(D). It is unclear whether “advice and consent of

a six-year term and is limited to two consecutive terms.²²³ The IPAB members are completely isolated from the public and Congress—they can only be removed by the President for neglect of duty or malfeasance in office.²²⁴ This isolation is purportedly to shield Board members from special interest influence, yet unlike other federal employees, Board members are expressly permitted to “accept, use, and dispose of gifts or donations of services or property.”²²⁵ In reality, their isolation prevents the members from being held accountable for their actions by either the public or Congress. While a similar protection exists for Article III judges,²²⁶ it is wholly inappropriate and inapplicable to extend this shield to the Board, given the Board’s mission and the sweeping effect of the Board’s proposals.

Commencing April 30, 2013, the Chief Actuary for the Centers of Medicare & Medicaid Services (CMS) must determine whether the projected Medicare per capita growth rate will exceed the projected Medicare per capita target growth rate for the implementation year.²²⁷ The implementation year on which these projections and targets are based is two years later; therefore, for 2013, the implementation year is 2015.²²⁸ If the projected growth rate exceeds the target growth rate, it triggers the Board’s proposal requirements.²²⁹ Beginning in 2018, the target growth rate will become commensurate with economic growth.²³⁰

It is highly probable that the Board will be required to submit cost reduction proposals every year. The Chief Actuary applied this formula to Medicare growth over the past twenty-five years and determined that, had the IPAB been in existence, the proposal requirement would have been triggered in all but four years.²³¹ In light of this conclusion, with the overwhelming growth in Medicare expenditures over the last two decades and increased enrollment figures, it is inevitable that the Board will be required to reduce the annual growth of Medicare.

the Senate” requires the Senate to approve each member by vote, or whether the President is merely obligated to disclose his appointees to the Senate. *Id.* § 1395kkk(g)(1)(A)(i).

223. *Id.* § 1395kkk(g)(2).

224. *Id.* § 1395kkk(g)(4).

225. *Id.* § 1395kkk(i)(5).

226. U.S. CONST. art. III, § 1.

227. 42 U.S.C. § 1395kkk(b)(1). The Medicare per capita growth rate is the “projected 5-year average (ending with such year) of the growth in Medicare program spending.” *Id.* § 1395kkk(c)(6)(B)(i). For a detailed table that outlines the Board’s obligations by date, *see* IPAB REPORT, *supra* note 207, at App. A.

228. IPAB REPORT, *supra* note 207, at App. A.

229. 42 U.S.C. § 1395kkk(b)(2).

230. *Id.* § 1395kkk(c)(8).

231. IPAB REPORT, *supra* note 207, at 11 (citing Memorandum from Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, Dep’t of Health and Human Servs., Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended 10 (Apr. 22, 2010), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf).

E. “Stacking the Deck” in the Board’s Favor

On January 15 of each “trigger” year, the Board must submit detailed proposals to Congress and the President that will result in a “net reduction in total Medicare program expenditures . . . that are at least equal to the applicable savings target established by the Chief Actuary.”²³² If the Board fails to submit a proposal, the Secretary of Health and Human Services (“Secretary”) will submit a proposal.²³³ These proposals then become law on August 15th and will be implemented by the Secretary.²³⁴

Similar to Odysseus, Congress included a variety of hurdles within the PPACA to restrict its own ability to alter the Board’s proposals. The proposals do not require Congressional approval and will become law, unless Congress enacts legislation that reduces Medicare expenditures by at least the same level as the proposals.²³⁵ In addition to abolishing the need for ratification of the Board’s proposals, the PPACA includes a second hurdle for Congress: any piece of legislation that augments or replaces the Board’s proposals must be approved by both the House and three-fifths of the Senate.²³⁶ Dissolving the Board requires a joint resolution supported by a super-majority vote from both the House and Senate.²³⁷ Finally, once the Board’s proposals become effective, it is shielded from judicial review.²³⁸

The multitude of procedural impediments was clearly intended to restrict Congress’ ability to act or amend the proposals before they become law. As a recent Congressional Research Service Report stated, “[t]he arguable and perhaps intended effect of the procedures in the [PPACA] is to favor the continuation of the IPAB and its recommendations *even in the face of significant opposition* in both chambers of Congress.”²³⁹ The PPACA passed with the support of 50 % of the House and 60 % of the Senate.²⁴⁰ However, any piece of legislation that augments or abolishes the powers delegated to the IPAB under the PPACA requires a super-majority vote.²⁴¹

Allowing a simple majority to enact a law that can only be repealed by a super-majority undermines the very purpose of a representative democracy.

232. *Id.* at 12.

233. 42 U.S.C. § 1395kkk(c)(5).

234. *Id.* § 1395kkk(e)(1).

235. *Id.* § 1395kkk(e)(3); *see also* IPAB REPORT, *supra* note 207, at 17.

236. *Id.* § 1395kkk(d)(3)(D).

237. *Id.* § 1395kkk(f)(2)(F).

238. *Id.* § 1395kkk(e)(5). The provision expressly states: “There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.” *Id.*

239. IPAB REPORT, *supra* note 207, at 23 (emphasis added).

240. *Health Care Bill Passes in House*, CBS NEWS (Mar. 21, 2010, 10:33 PM), available at <http://www.cbsnews.com/stories/2010/03/21/politics/main6321210.shtml>.

241. IPAB REPORT, *supra* note 207, at 22.

Further, giving an unelected Board the powers of the legislature and shielding it from judicial review effectively tears down the barriers that separate the legislative, executive, and judicial branches of government, and puts the lives of elderly Americans in the hands of fifteen people. Unlike other regulatory commission decisions and proposed rules that allow public comment and judicial appeals,²⁴² the IPAB's decisions become law unless either Congress proposes equivalent spending cuts, or both houses (including a Senate super majority of three-fifths) waive the board's determination and the President signs the waiver.²⁴³ The Board's structure and power effectively dissolves the checks and balances that are the hallmarks of American democracy.

F. Patient-Centered Research

Created as a part of the PPACA, The Patient-Centered Outcomes Research Institute ("Institute") is a nonprofit corporation that is neither a government agency nor a federal government establishment.²⁴⁴ It is meant to set comparative effectiveness research priorities and to assess "clinical effectiveness, risks, and benefits of two or more medical treatments, services, and items"²⁴⁵ in order to evaluate the "different characteristics of treatment modalities that may affect research outcomes"²⁴⁶ and be "used in the treatment, management, and diagnosis of, or prevention of illness or injury."²⁴⁷

To accomplish its purpose of assisting the public "in making informed health decisions," the Institute is tasked with a variety of duties including identifying

242. See Michael A. Livermore & Richard L. Revesz, *Regulatory Review, Capture, and Agency Inaction*, 101 GEO. L.J. 1337, 138–39 (2013) (surveying the power of the Office of Information and Regulatory Affairs in reviewing administrative decision making, and cautioning against its abuse and over-exercise of presidential authority in regulating law making conduct); see also ALFRED C. AMAN, JR. & WILLIAM T. MAYTON, *ADMINISTRATIVE LAW* 53–55, 445–47 (2d. ed. 2001) (explaining the right to comment and judicial review). See generally Jeffrey A. Pojanowski, *Reason and Reasonableness in Review of Agency Decisions*, 104 NW. U. L. REV. 799 (2010) (discussing the reasonableness of judicial review of agency decisions).

243. Dalmia, *supra* note 219.

244. 42 U.S.C. § 1320e(b)(1) (Supp. V 2012). See generally James Dabney Miller, *The Patient-Centered Outcomes Research Institute*, J. HEALTH & LIFE SCI., Oct. 2010, at 4.

245. *Id.* § 1320e(a)(2)(A); see also Aaron Klein, *More evidence of 'Death Panels' in ObamaCare: Rationing Concerns Based on Age, Race, Ethnicity*, WND (Jan. 5, 2013, 7:43 PM), <http://www.wnd.com/2013/01/more-evidence-of-death-panels-in-obamacare/>. See generally Robert Coleman, Comment, *The Independent Medicare Advisory Committee: Death Panel or Smart Governing?*, 30 J. NAT'L ASS'N ADMIN. L. JUDICIARY 235 (2010).

Interestingly, at least sixteen health systems in developed countries—including Australia, Canada, Germany, and Great Britain—have comparative effectiveness programs that assist identifying the difference between effective and ineffective care. Paul H. Keckley & Barbara B. Frink, *Comparative Effectiveness: A Strategic Perspective on What It Is and What It May Mean for the United States*, J. HEALTH & LIFE SCI., Oct. 2009, at 53, 56.

246. 17 U.S.C. § 1320e(d)(2)(E).

247. *Id.* U.S.C. § 1320e(a)(2)(B).

research priorities and establishing a research policy agenda.²⁴⁸ Once these priorities are identified, the Institute conducts primary research studies, as well as contracts research studies with public entities, academic institutions, and private sector groups.²⁴⁹ The findings are made available for peer review, and then released to clinicians, patients, and the general public.²⁵⁰ Ultimately, the Institute has the authority to determine and prioritize health care issues in the United States, as well as the financial resources used to fund medical research.²⁵¹ The Institute, because of this power, has been likened to the National Institute for Clinical Excellence (NICE), which is a part of the United Kingdom's National Health Service.²⁵² NICE sets, monitors, and distributes health care resources in the UK. It is criticized for being heavily influenced by cost-effectiveness standards, rather than clinical effectiveness.²⁵³ Given the similarities between NICE and the Institute, the Institute is also at risk for focusing on cutting costs at the expense of clinical effectiveness.

V. THE INEVITABLE CONSEQUENCES OF IPAB REGULATION ON MEDICARE

The IPAB is expressly prohibited from submitting proposals that will “ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”²⁵⁴ Although the PPACA proscribes rationing, it does not define rationing or the types of Board proposals that would violate this directive.²⁵⁵ Even if the Board

248. *Id.* § 1320e(c)–(d)(9). In order to adopt the research priorities identified, there must be a public comment period, and the priorities must be adopted by a majority vote of the Board members. *Id.* § 1320e(d)(9).

249. *Id.* § 1320e(d)(2)(A)(B). Research reports are not permitted to include, *inter alia*, “practice guidelines, coverage recommendations, payment, or policy recommendations.” *Id.* § 1320e(d)(8)(A)(iv).

250. *Id.* § 1320e(d)(7)–(8).

251. *See* Nelson, *supra* note 179, at 215.

252. *See id.* at 178, 210. The official website for NICE is: <http://www.nice.org.uk>.

253. Nelson, *supra* note 179, at 210–11. Under efforts taken by England's current Prime Minister, David Cameron, in 2010, the powers of NICE to disapprove drugs based on cost-effectiveness has been weakened substantially and returned to clinical physicians, thus signaling a retreat from public rationing and a return to implicit rationing. *Id.* at 211–12; *see* JONATHAN HERRING, *MEDICAL LAW AND ETHICS* 7278 (4th ed. 2012); JONATHAN HERRING, *CARING AND THE LAW* 17680 (2013) [hereinafter *CARING AND THE LAW*].

254. 42 U.S.C. § 1395kkk(c)(2)(A)(ii) (Supp. V 2012). *But see* Jacqueline Fox, *The Hidden Role of Cost: Medical Decisions, Transparency and Public Trust*, 79 U. CINN. L. REV. 1, 4–5, 15–17 (2010) (arguing Medicare practices “stealth rationing” by utilizing National Coverage Determination which allows it to refuse to cover use of expensive new technologies).

255. Scott W. Atlas, *IPAB: President Obama's NICE Way to Ration Care to Seniors*, FORBES (Oct. 21, 2012, 10:53 AM), <http://www.forbes.com/sites/scottatlas/2012/10/21/ipab-president-obamas-nice-way-to-ration-care-to-seniors/>. *See generally* BEATRIX HOFFMAN, *HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930* (2012); Cook, *supra* note 193.

banned certain basic procedures for individuals based solely on age—a clear example of rationing²⁵⁶—the judicial shield surrounding Board proposals would severely curtail any remedy. Assuming for the purposes of this Article that the Board will not directly ration health care, indirect rationing is the only means by which the Board can curb Medicare growth to the extent required.

A. Indirect Rationing

As baby boomers begin to retire at unprecedented rates, the number of Medicare enrollees will increase tremendously in the immediate future.²⁵⁷ Likewise, current enrollees are living longer as a result of medical advancements, and thus incurring increased health care costs.²⁵⁸ Despite this certain increased demand for services, the Chief Actuary expects the IPAB to ultimately *cut* net Medicare expenditures by 11% by 2019.²⁵⁹ In order to accomplish this goal in the face of increased coverage demand, the Board will need to drastically cut Medicare expenditures to continue to provide coverage to Medicare beneficiaries. The main tool that will be used to cut Medicare expenditures is the Board's authority to reduce provider payment rates.²⁶⁰ Indeed, of the \$575 billion in net Medicare savings that the PPACA is expected to facilitate over the next decade, \$233 billion is expected to come from provider payment freezes and reductions.²⁶¹ The inevitability of payment cuts is illustrated by the following paradigm:

Suppose that in Year 1, 10,000 Medicare patients require chemotherapy treatment at a market cost of \$10,000 per patient. The total cost to Medicare would be \$100 million. Given the rapid increase in enrollment figures, by Year 3 there are projected to be 11,000

256. See Smith, *supra* note 33, at 427–28; see also Sally Pipes, Op-Ed., *For Cancer Treatments, A Rationing Trap*, WASH. EXAMINER (Jan. 9, 2013, 2:00 PM), available at <http://washingtonexaminer.com/article/2518040> (discussing the efforts to curb use of an expensive drug, Zaltrap, costing \$11,000 in favor of using a more cost-effective cancer drug, Avastin, costing \$5,000).

257. See *supra* notes 203–207 and accompanying text. See also Montgomery, *supra* note 195, at A1, A6 (stating that “[a]n average of 10,000 baby boomers will turn 65 every day for the next 20 years”).

258. Avik Roy, *Saving Medicare From Itself*, NAT'L AFFAIRS, Summer 2011, at 35, 33–45. When Medicare was enacted, the average life expectancy was 70.2 years; however, by 2010 the average life expectancy had increased to 78.4 years. *Id.* Thus, the average coverage period per individual has grown 158%. *Id.* at 45.

259. *The Fiscal Consequences of the Health Care Law: Hearing Before the H. Comm. On the Budget*, 112 Cong. 13 (2011) (statement of Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services) [hereinafter *Foster Testimony*]. The GAO Journal reported flagrant abuse and overspending by Medicare of hundreds of millions of dollars for reimbursement of hospitals and clinics for drugs to treat patients using dialysis. Peter Whoriskey, *Medicare Eyes Payments for Dialysis Drugs*, WASH. POST, Jan. 31, 2013, at A12. Sadly, until new rates for reimbursement are established in 2014, these overpayments will continue. *Id.*

260. 42 U.S.C. § 1395kkk(c)(2)(A)(iv) (Supp. V 2012).

261. See *Foster Testimony*, *supra* note 259, at 5.

patients that require the same treatment for a total cost of \$110 million. Thus, the projected growth rate is 10%. The Chief Actuary determined that the target growth rate for Year 3 is 3%. The Board would then be required to cut \$7 million to meet the target growth rate. In order to meet this rate, the Board must either: (A) reduce the amount of patients undergoing chemotherapy by denying the procedure to 7,000 patients; or (B) reduce the price paid to providers from \$10,000 to \$9,363.64 for each patient that receives treatment.

Choice A amounts to direct rationing, while Choice B will erode the quality of care provided to Medicare patients and ultimately lead to indirect rationing. This conclusion is shared by the Obama Administration's former Administrator of Medicare and Medicaid, Donald Berwick, who said "[t]he decision is not whether or not we will ration care—the decision is whether we will ration with our eyes open."²⁶²

Based on this paradigm, an argument could be made that a small difference in payment per procedure between Medicare patients and market cost will not cause providers to discontinue servicing Medicare patients. Properly viewed, however, the aggregate impact of these payment cuts is astounding. The Chief Actuary estimates that between 2010-2019 reduced payment levels will "save" \$233 billion.²⁶³ In reality, this figure represents the amount of money that providers will *lose* if they choose Medicare patients over the insured. \$233 billion is a compelling economic incentive for providers to leave the Medicare program — right when enrollment is expected to explode.

The incentive to discontinue service to Medicare patients is compounded by the influx of patients that will qualify for private insurance under the PPACA. By 2019, the PPACA will provide private insurance to an additional sixteen million people. These costs are subsidized by funds diverted from Medicare.²⁶⁴ The discrepancy between Medicare rates and market costs paid by private insurer rates will grow as Medicare and private insurance enrollment increases.²⁶⁵ Once the rate discrepancy reaches a certain point, physicians and hospitals will cease to provide services to current and future Medicare patients.²⁶⁶ Ultimately, Medicare beneficiaries will not enjoy the same degree of access to health care services. Those providers that do remain under the Medicare program will be forced to reduce their costs per procedure for Medicare patients, and thus, Medicare patients will receive a lower quality of care than patients that receive subsidized private insurance.²⁶⁷

262. Atlas, *supra* note 255 (internal quotation marks omitted).

263. See Foster Testimony, *supra* note 259, at 12.

264. Memorandum from Richard S. Foster, *supra* note 231, at 4; see also *supra* note 210 and accompanying text.

265. See Foster Testimony, *supra* note 259, at 12; Roy, *supra* note 258, at 47–48.

266. See Atlas, *supra* note 255.

267. See Roy, *supra* note 258, at 36. Likewise, roughly 42 % of U.S. physicians are over the age of fifty-five. Sandra G. Boodman, *Aging Doctors Face Greater Scrutiny*, KAISER HEALTH

B. Dire Projections from the Government and Health Care Providers

Both the federal government and private health care associations recognize the IPAB's potential implications for Medicare providers and patients.²⁶⁸ In his memorandum on the financial impact of the PPACA, Chief Actuary, Richard S. Foster, wrote: "[P]roviders for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries)."²⁶⁹ Foster reiterated this concern in his testimony before the House Committee on the Budget.²⁷⁰ The Office of the Actuary at CMS estimates that roughly 15 % of Part A providers will become unprofitable over the next ten years.²⁷¹ Finally, the Medicare Board of Trustees has also cautioned that "[u]nless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries."²⁷²

Health care providers fear that the payment cuts will not only harm current patients, but also impact the long-term quality of Medicare.²⁷³ The Chair of the American Medical Association ("AMA") Board of Trustees, Edward L. Langston, M.D., wrote that "[t]rying to save Medicare money by slashing physician payments will ruin the physician foundation of Medicare for current and future generations of seniors."²⁷⁴ The AMA is currently calling for the repeal of the IPAB because it "puts important health care payment and policy decisions in the hands of an independent body that has far too little accountability."²⁷⁵ As evidenced by the grave concern within the medical community, the IPAB's structure and authority must be reconsidered and its potential ramifications must be explored further.

Senator John Cornyn sought to repeal the IPAB through legislation that he introduced in the 112th Congress in 2011, entitled the "Health Care Bureaucrats

NEWS (Dec. 10, 2012), <http://www.kaiserhealthnews.org/stories/2012/december/11/aging-doctors-face-greater-scrutiny.aspx>. As these doctors begin to retire and new doctors seek to avoid Medicare patients, access will likely be further restricted. Roy, *supra* note 258, at 44.

268. See Memorandum from Richard S. Foster, *supra* note 231, at 9–10.

269. *Id.* at 10.

270. Foster Testimony, *supra* note 259, at 14.

271. Memorandum from Richard S. Foster, *supra* note 231, at 10.

272. 2010 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 2 (Aug. 5, 2010), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf>.

273. See Phil Roe, *Pound the Medicare Board Before It Hammers the Elderly*, WASH. TIMES, Apr. 30, 2013, at B1 (discussing how the PPACA and Medicare cuts will change patient care).

274. Trapp, *supra* note 206, at 1 (internal quotation marks omitted).

275. Letter from James L. Madara to The Honorable Joe Pitts, Chairman, Committee on Energy and Commerce, Subcommittee on Health (Feb. 27, 2012), available at <http://www.ama-assn.org/resources/doc/washington/hr452-support-letter-27feb2012.pdf>.

Elimination Act.”²⁷⁶ However, the Bill was never reported out of Committee for a vote.²⁷⁷

On December 20, 2012, the U.S. District Court in Arizona dismissed the Fourth, Fifth, and Ninth Amendment challenges to the constitutionality of the PPACA and—particularly—to the IPAB’s unfettered ability to dictate the extent to which physicians can charge fees for medical care, the manner in which insurance companies pay for it, and which patients can have access to new cutting edge technologies.²⁷⁸ In light of the U.S. Supreme Court’s decision in *Sebelius*,²⁷⁹ the issues raised were found, essentially, to be moot.²⁸⁰ Nevertheless, an appeal was made to the U.S. Court of Appeals for the 9th Circuit.²⁸¹

VI. CONCLUSION

The effort to re-negotiate the American notion of a social contract to include universal health care and to structure a template for achieving social justice through the distribution of health care resources are noble goals. However, rather than imposing a federal standard that restricts state autonomy in managing health resources, the better position is to allow the states—through co-operative federalism—to serve as laboratories to “try novel social and economic experiments.”²⁸²

276. S. 668, 112th Cong. (2011); see Roe, *supra* note 273 (detailing the efforts of Congressman Roe to repeal the PPACA and his specific efforts to introduce legislation to repeal the IPAB through passage of The Protecting Seniors’ Access to Medicine Act, H.R. 351, which has 160 co-sponsors and has been referred to the House Energy and Commerce Committee). In the last session of Congress, the House passed identical legislation by a vote of 223-184, but the bill was never considered by the Senate. Art Kelly, *HR 351, To Repeal the Rationing Board in Obamacare*, 60 SECOND ACTIVIST (Jan. 29, 2013), <http://www.60secondactivist.com/content/hr-351-repeal-rationing-board-obamacare>. But see PAUL N. VAN DE WATER, CENTER ON BUDGET & POLICY PRIORITIES, INDEPENDENT PAYMENT ADVISORY BOARD WILL HELP REDUCE HEALTH COSTS: REPEALING IPAB WOULD BE UNWISE 5–6 (2012), available at <http://www.cbpp.org/files/3-15-12health.pdf> (observing that if the IPAB was repealed, Congress would likely shift more costs to beneficiaries by increasing Medicare premiums and raising the age of Medicare eligibility).

277. *Health Care Bureaucrats Elimination Act (2011; 112th Congress S. 668)*, GOVTRAC.US, <https://www.govtrack.us/congress/bills/112/s668#overview> (last visited Oct. 31, 2013).

278. See *Coons v. Geithner*, No. CV-10-1714-PHX-GMS, 2012 WL 6674394, at *1, *5 (D. Ariz. Dec. 20, 2012); *supra* Part IV.C (discussing the IPAB’s role and impact on patient care).

279. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

280. *Coons*, 2012 WL 6674393, at *1, *3.

281. Appellants’ Brief at 1, *Coons*, 2012 WL 6674394, *appeal docketed*, No. 13-15324 (9th Cir. Feb. 19, 2013). The fight to strike down portions of the PPACA in the courts is still alive in courts, and, further, the idea of Congress repealing the PPACA is alive as well. See Christopher Conover, Op-Ed. *Obamacare: Not Too Late to Take Back This Lemon*, WASH. EXAMINER, Mar. 29, 2013, at 30 (observing that a congressional repeal of the PPACA is a viable option, because the Medicare Catastrophic Coverage Act was repealed some sixteen months after its 1988 enactment).

282. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

As laboratories for public policy experimentation in governance, the states should be allowed to undertake their work through mediating structures, thereby enhancing “the pluralism that mediating structures make possible.”²⁸³ It is key to define mediating structures as “institutions standing between the individual in his private life and the large institutions of public life,”²⁸⁴ and to recognize that they are the primary agents of social welfare. This allows the mediating structures to underscore and validate their own inherent responsibility for health care,²⁸⁵ and encourages decentralized medical delivery systems, instead of expanding the bureaucratic powers of a leviathan, which destroys or compromises state autonomy.²⁸⁶

When deciding whether a law is legitimate, it is necessary to determine whether the law reflects the general will of an informed polity and treats all members equally. The PPACA is not a provision within America’s social contract, but rather a return to “might makes right”²⁸⁷ or “command-and-control”²⁸⁸ with the potential for disastrous consequences. Rousseau’s social contract is not an express mandate for government growth, nor is it a tool for economic equality. The social contract, as envisioned by Rousseau and adopted by the United States, is a pact between the people and the government that guarantees a right to property and civil liberties. It is a foundation that allows individuals to succeed.

The fears of unfettered regulatory bureaucracies going “rogue” were raised by Justice Anton Scalia’s dissent in *Mistretta v. United States* in 1989.²⁸⁹ There he opined—and even predicted—that unless the prohibition on delegation of legislative power was enforced by the judiciary, Congress would be emboldened to create:

‘expert’ bodies, insulated from the political process, to which Congress will delegate various portions of its lawmaking responsibility. How tempting to create an expert Medical Commission

283. PETER L. BERGER & RICHARD JOHN NEUHAUS, TO EMPOWER PEOPLE: FROM STATE TO CIVIL SOCIETY 207 (Michael Novak ed., 2d ed. 1996). See Bulman-Pozen, *supra* note 88, at 1124 (observing how states act as “[l]aboratories of [p]artisan [p]olitics”).

284. BERGER & NEUHAUS, *supra* note 283 at 158.

285. *Id.* at 162–63. Private sector charities may be included within the notion of mediating structures—especially because they are more efficient in securing assistance to those in need and “encouraging self-sufficiency and self-reliance.” JOHN C. GOODMAN ET AL., NAT’L CTR. FOR POLICY ANALYSIS, WHY NOT ABOLISH THE WELFARE STATE?, Executive Summary (1994), available at <http://www.ncpa.org/pdfs/st187.pdf>.

286. BERGER & NEUHAUS, *supra* note 283, at 199–200.

287. G. Edward White, *The Evolution of Reasoned Elaboration: Jurisprudential Criticism and Social Change*, 59 VA. L. REV. 279, 283 (1973) (stating that “might makes right” is the manifestation of a totalitarian government).

288. Grace-Marie Turner, *Repeal Obamacare’s Payment Panel Now*, WASH. EXAMINER (Mar. 21, 2012, 4:00 PM), available at <http://washingtonexaminer.com/repeal-obamacares-payment-panel-now/article/392811>.

289. *Mistretta v. United States*, 488 U.S. 361, 415 (1989) (Scalia, J., dissenting).

(mostly M.D.'s, with perhaps a few Ph.D.'s in moral philosophy) to dispose of such thorny, 'no-win' political issues as the withholding of life-support systems in federally funded hospitals The only government power the Commission possesses is the power to make law; and it is not the Congress.²⁹⁰

Justice Scalia's predictions materialized two decades later—for this is now the very character of the IPAB.

Justice Scalia's concerns over the expansion of the vast regulatory network and agenda of federal regulatory agencies, together with a near total abnegation of the notion of co-operative federalism through the states acting in partnership with the federal government, are both valid and—indeed—problematic. Two sets of facts confirm this present state of affairs. First, from 2001 to 2006, Congress enacted twenty-seven statutes, which not only pre-empted state health, safety, and environmental regulations as well as other social policies, but also effectively prohibited state regulation in its entirety.²⁹¹

Second, a recent study by the Competitive Enterprise Institute found that federal administrative agencies finalized forty-seven more rules and regulations than laws enacted in 2011.²⁹² Further, the Institute found that while Congress legislated eighty-one new laws in 2011, the duly approved administrative agencies promulgated 3,807 regulations; or, in other words, "47 times more new rules than laws."²⁹³ Previously in 2010, Congress enacted 217 new laws—this, compared with 3,573 rules.²⁹⁴ This statistical record decisively shows that regulatory bodies issued sixteen times more rules than Congress enacted laws.²⁹⁵ The end result of these findings by the Enterprise Institute is that congressional power and responsibility has been delegated—improperly—to a fourth branch of government: the regulatory branch.²⁹⁶

290. *Id.* at 422.

291. PUBLIC HEALTH LAW AND ETHICS, *supra* note 3, at 82.

292. Paul Bedard, *Out of Control: 47 New Regs for Every New Law*, WASH. EXAMINER (Jan. 30, 2013, 9:35 AM), available at <http://washingtonexaminer.com/article/2519994>.

293. *See id.*

294. *Id.*

295. *Id.* See Ron Arnold, *Watchdogging Obama's Regulatory State*, WASH. EXAMINER, Feb. 5, 2014, available at <http://washingtonexaminer.com/watchdogging-obamas-regulatory-state/article/2543540>.

296. See Thomas J. Donohue, *The Fourth Branch of Government*, WEEKLY STANDARD, Feb. 11, 2013, at 29 (examining the systemic consequences of over regulation resulting in the passage of "economically significant" rules costing \$100 million or more—with 127 such rules being passed in 2003 and some 224 rules being promulgated in 2012, and reporting on a GAO study showing that 35 % of these rules were issued without public comment period). It has been estimated that American businesses and families will expend approximately 189 million hours annually in order to comply with Obamacare's regulatory requirements. Paul Bedard, *Obamacare Red Tape Burden Surges to 189 Million Hours a Year-And It Hasn't Even Started*, WASH. EXAMINER (May. 7, 2013, 4:20 PM), available at <http://washingtonexaminer.com/obama-care-red-tape-burden-surges-to-189-million-hours-a-year-and-it-hasn-t-even-started/article/252903>. The House Ways and Means, Education and The Workforce, and the Energy and Commerce Committees have an

In 1989, Charles Murray stated both a fundamental truth and a caveat in trying to manage social policy—and in this case, health care—when he acknowledged, social problems in a democratic society tend to produce net harm in dealing with the most difficult programs. They will inherently tend to have enough of an inducement to produce bad behavior and not enough of a solution to stimulate good behavior; and the more difficult the problem, the more likely it is that this relationship will prevail. The lesson is not that we can do no good at all, but that we must pick our shots.²⁹⁷

Although there is no objective metric available to determine the adequate level of care, conceptually, it can be evaluated by patterns of access and overall efforts to improve equity. Reasonable individuals disagree invariably over what particular patterns and policies satisfy the standards of adequacy.²⁹⁸ The level of health care resources available determines the level of health care distributed.²⁹⁹ These resource allocations must reflect, accordingly, the cost and benefits of such care.³⁰⁰

As “self-interested choosers,” the behavior of individuals and the direction of policy is shaped—if not directed—by incentives.³⁰¹ Thus, when either benefits or costs change, incentives must also change, and ideally, these incentives should be guided by rational choice.³⁰² The response to changes in incentives becomes central to determining public policy on any given issue.³⁰³

Inasmuch as the federal government primarily underwrites the health care program for senior citizens, little incentives exist for seniors to either curb patterns of consumption or seek better prices.³⁰⁴ Rather than incentivize savings, Congress has historically sought to restrict spending by limiting rates of reimbursement for physician-providers.³⁰⁵ Because of the political power of

online site to track compliance burdens of implementing the PPACA. *ObamaCare Burden Tracker*, COMM. ON WAYS & MEANS, EDUC. & THE WORKFORCE & COMM. ON ENERGY & COMMERCE, http://waysandmeans.house.gov/uploadedfiles/aca_burden_tracker_.pdf (last visited Feb. 18, 2014). See generally George P. Smith, II, *An Obscure Object of Desire: Minimizing the Information Reporting Burden*, 31 ADMIN. L. REV. 115 (1979).

297. CHARLES MURRAY, *LOSING GROUND: AMERICAN SOCIAL POLICY, 1950–1980* 218 (1984).

298. *SECURING ACCESS TO HEALTHCARE*, *supra* note 1, at 35.

299. *Id.* at 36.

300. *Id.* at 36–47.

301. See BECKER & POSNER, *supra* note 25, at 4, 15 (commenting that economic growth and changes in economic growth have led families around the world to have fewer and fewer children, because of investments in female education and employment opportunities); see also Tom G. Palmer, *Poverty, Morality, and Liberty*, in *AFTER THE WELFARE STATE* 109, 123–25 (Tom G. Palmer ed., 2012) (discussing the proposition that “[i]nstitutions create incentive and incentives shape behavior”).

302. See BECKER & POSNER, *supra* note 25, at 15; Palmer, *supra* note 301, at 123–25.

303. See BECKER & POSNER, *supra* note 25, at 15; Palmer, *supra* note 301, at 123–25.

304. Dalmia, *supra* note 219.

305. *Id.*

provider groups, whenever automatic cuts have been proposed, Congress has always stopped or delayed the cuts.³⁰⁶

This time, however, 90 % of the country's physicians appear to be "completely uninformed" about the effect of Obamacare on the practice of medicine.³⁰⁷ Yet, there is a pervasive fear of a mass exodus among physicians and a growing resistance among health care providers to the government's underpayment for medical costs.³⁰⁸ Rather than wait for the full impact of Obamacare, a number of physicians are already taking early retirement, selling their practices, or converting to fee-for-service, and thereby limiting their exposure to Medicare, Medicaid, and private insurance.³⁰⁹

It is anticipated that because Medicaid is cheaper, more and more individuals who qualify will drop their private insurance coverage for the full Medicaid program.³¹⁰ Because reimbursements for Medicaid are lower and more problematic to realize, providers will simply limit the number of Medicaid patients they accept.³¹¹ This will ultimately cause the cost of medical care to rise, while access to Medicaid services will fall.³¹²

While the federal government and the Obamacare health program are obviously central players in the present struggle for more effective allocations of finite health care resources, Americans themselves are in large measure to "blame" for the present state of uncertainty. Quite simply, Americans "lack the information critical to understanding the need for change;" and, they lack the will power to cure conspicuous consumption.³¹³

Any solution—if, indeed, there is a single solution or policy to curtailing or even breaking a culture of dependency and a widening network of social

306. *Id.*

307. Valerie Richardson, *Vital Signs, The Realities of Obamacare: Doctors Feel Ill Winds, Blowing as They Look Closely at 'Obamacare,'* WASH. TIMES, Feb. 8, 2013, at A1.

308. *Id.* There is also a discussion as to whether physicians will soon become obsolete—this, as a consequence of new robotic medical technologies born from IBM's super computer, "Watson," being tested and utilized presently in the Sloan-Kettering Cancer Center in New York City. Jonathan Cohn, *The Robot Will See You Now,* ATLANTIC MONTHLY, Mar. 3, 2012, at 59.

309. Richardson, *supra* note 307.

310. *Id.*; see Brian Hughes, *President Obama's Health Care Plan Faces Doubt Among the Young and the Restless,* WASH. EXAMINER (Feb. 19, 2013, 6:45 PM), available at <http://washingtonexaminer.com/president-obamas-health-care-plan-faces-doubts-among-the-young-and-the-restless/article/2521863> (predicting that the perceived inequity between senior citizens receiving lower health insurance premiums under Obamacare than younger, healthier members of society, who will be required to assume a greater share of health care delivery costs in order to compensate for the discount of older retirees, will be fatal to a sustained level of success for PPACA); see also *supra* notes 24–29, 167–169, and accompanying text (discussing issues of social and intergenerational justice).

311. See Richardson, *supra* note 307.

312. *Id.*

313. Lawrence, *supra* note 141. See generally MICHAEL F. CANNON, 50 VETOES: HOW STATES CAN STOP THE OBAMA HEALTH CARE LAW (2013), available at http://object.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper_1.pdf.

benefits—is to balance federal responsibility with the need for both state autonomy and individual responsibility. If co-operative federalism is to be effective in health care, it must be viewed economically as “a scheme of decentralized governance, designed to optimize the provision of government services.”³¹⁴ There are finite limits—both economic and social—to government action. Accordingly, for every fundamental right asserted, there is a co-ordinate responsibility that the asserted right be exercised reasonably, effectively, and within the boundaries of cost–benefit analysis.³¹⁵

The search for social balance in an affluent society is but a search for “the satisfaction of private and public needs;”³¹⁶ and, the search for this balance is “lost [invariably] in the debate over equality and social equity.”³¹⁷ Fairness is not strictly pertinent to economic analysis—because, economic analysis seeks to “determin[e] which allocation of scarce resources maximizes wealth” and is efficient.³¹⁸

In testing the limits of reasonable conduct, establishing a point of balance in lawmaking, and formulating administrative policy, the Restatement of Torts presents not only a template or framework for principled decision making at the *macro* level (e.g., congressional), it also should be utilized at the *micro* level by regulatory agencies—for individual policy making functions.³¹⁹ Put simply, regulatory decisions and policies should be guided by a cost–benefit analysis that seeks to measure the effectiveness of a decision by comparing the social benefits of proposed rules or policies with their economic costs.³²⁰

The Medicare program that so many in the nation rely upon is currently traveling along a course destined for disaster. Rather than intervening, Congress chose to tie itself to the mast and relinquish its responsibility to an appointed board with inscrutable authority. Determining how to control Medicare costs should properly be left to elected officials that can be held accountable by the very populace their decisions affect.

314. BECKER & POSNER, *supra* note 25, at 220; see CARING AND THE LAW, *supra* note 253, at 88. See generally Yuval Levin & Ramesh Ponnuru, *Repeal, Replace, Still*, NAT'L REV. (Mar. 20, 2013, 12:00 AM), available at <https://www.nationalreview.com/nrd/343540> (arguing that Obamacare's primary flaw is that it ignores fundamental economics and attempts to force consumers to purchase a product that they would not ordinarily buy).

315. See generally RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* chs. 1–2 (8th ed. 2011) (discussing the nature of economic reasoning, the economic approach to the law, and the impact on social theory).

316. GALBRAITH, *supra* note 34, at 320.

317. *Id.* at 264.

318. DAVID W. BARNES & LYNN A. STOUT, *THE ECONOMICS OF PROPERTY RIGHTS AND NUISANCE LAW* 17 (1992).

319. See RESTATEMENT (SECOND) OF TORTS §§ 827–28 (1979).

320. See *id.*

The allocation of limited resources should be dictated by the informed and compassionate relationship between the patient and physician.³²¹ The choices that flow from this relationship, based on mutual trust, must be free from any coercive influence.³²² At its best, the IPAB will poison this hallowed relationship between patients and physicians. At its worst, the IPAB will enact irreversible legislation that will reduce the quality and access to health care under Medicare, jeopardize the lives of this nation's greatest generation, and mortally wound the American health care system.

321. See Smith, *supra* note 24, at 4–5; see also Pellegrino, *supra* note 21, at 23. See generally SMITH, *supra* note 22, at 18 (commenting, among other things, that delivering medical care in a “marketplace” should emphasize both typical incentives—“entrepreneurship, efficiency and profit maximization”—as well as—“customer satisfaction and ability to pay”).

322. See Clayton Christensen et al., *The Coming Failure of ‘Accountable Care’*, WALL ST. J., Feb. 19, 2013, at A15 (suggesting a central flaw in the PPACA is a fatal assumption that physicians will adopt new, transformative behavioral approaches to the practice of medicine, which will not only reduce the actual expenses of medical services—by utilizing evidence-based protocols in order to assess optimal treatments—but, as cost conscious gatekeepers, adapt some facets of care “to lower-cost sites of service,” e.g., ambulatory clinics rather than hospitals); see also Scott Gottlieb, *The Doctor Won’t See You Now. He’s Clocked Out*, WALL ST. J., Mar. 15, 2013, at A13 (observing that because of Obamacare, the practice of medicine will become so expensive that physicians are expected to close their private offices to become salaried hospital employees). See generally Thomas A. Firey, *Is IPAB A Paper Tiger?*, REGULATION, Winter 2013–2014, at 46 (predicting that, as a result of political pressure from the President and Congress, IPAB will be largely ineffective and will lead to waste); but see Jacqueline Fox, *Death Panels: A Defense of the Independent Payment Advisory Board*, 66 ADMIN. L. REV. 131 (2014).

