SETTING NATIONAL COVERAGE STANDARDS FOR HEALTH PLANS UNDER HEALTHCARE REFORM

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On March 23, 2010, President Barack Obama signed into law the Patient Protection Affordable Care Act (Affordable Care Act), the most far-reaching healthcare reform legislation since the establishment of the Medicare program in 1965. The Affordable Care Act directs the U.S. Department of Health and Human Services (HHS) to establish a minimum level of health benefits, called the essential health benefits, that must be offered by certain health plans, including all plans participating in the individual and small group health insurance markets. This Article argues that this process for defining the essential health benefits will fail to produce coverage standards that are both fair and serve the public interest, as political considerations will lead politicians to mandate coverage of health benefits desired by the public and special interest groups, regardless of the merits of doing so. To reduce the influence of short-term politics in the development of national coverage standards, the Article recommends two fundamental changes to the process. First, Congress should establish an independent commission that would make recommendations to Congress regarding the essential health benefits. Second, Congress should adopt internal rules of congressional procedure that, in the event that lawmakers modify the commission's recommendations, obligate them to offset the costs of mandating coverage of certain conditions or procedures by excluding other benefits from the essential health benefits. Together, these requirements would make it more difficult for lawmakers to modify the shape of the essential health benefits for political gain, as they would intensify conflict among interest groups and place procedural hurdles in the path of mandated benefits legislation. With significant independence from both Congress and the president, a commission would then have the freedom to engage in a thoughtful, deliberative review of the relevant scientific, economic, and moral factors, with primary consideration given to the overall fairness of the coverage standards rather than their political impact.

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INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (Affordable Care Act),[1] the most far-reaching healthcare reform legislation since the establishment of the Medicare program in 1965. The legislation gives the federal government a prominent role in determining what care private health plans must provide, and what care they will not be required to pay for. Specifically, under the Affordable Care Act, the U.S. Department of Health and Human Services (HHS) will promulgate standards establishing a minimum level of health benefits, called the essential health benefits, following notice and opportunity for public comment.[2] This Article argues that given the political pressures facing policymakers, this process for defining the essential health benefits will fail to produce national coverage

1. Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Some of the statutory provisions of the Affordable Care Act were subsequently amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

2. *Id.* § 1302(b) ("[T]he Secretary shall define the essential health benefits" and in doing so "shall provide notice and an opportunity for public comment."). The term "essential health benefits package" means coverage that not only provides for the essential health benefits defined by the secretary, but also limits cost-sharing for coverage of the essential health benefits in accordance with the parameters specified in the statute. *Id.* § 1302(a). This Article is concerned with the process for defining the scope of the essential health benefits and does not address the cost-sharing limits required under the new law.

standards that are fair and best serve the public interest. To produce benefits better aligned with public values and needs, Congress should enact new legislation adopting an alternative process for defining the essential health benefits. Specifically, this Article recommends two fundamental changes. First, Congress should establish an independent commission that, following expert deliberation relatively unencumbered by political influences, would submit recommendations to Congress as to the essential health benefits.[3] Second, Congress should establish new internal rules of congressional procedure designed to reduce the likelihood that lawmakers will override the commission's expert recommendations by mandating coverage of certain benefits desired by favored special interests and constituencies.[4]

The scope of the essential health benefits will directly or indirectly affect the availability and cost of healthcare for many Americans. All plans that wish to participate in the individual and small group exchanges that the states will establish must offer the minimum essential health benefits.[5] In addition, any employer with fifty or more full-time employees that does not offer its employees a health plan with the minimum essential health benefits will be subject to a tax penalty if one or more of its employees receive federal assistance with their healthcare costs.[6] Individuals not enrolled in a health plan offering the essential health benefits also will be subject to a tax penalty.[7]

Although the Affordable Care Act does not bar the purchase of supplemental insurance to cover care beyond the minimum essential health benefits,[8] many simply would lack the financial means to pay the premiums for

3. As discussed in Part II, *infra*, one of the healthcare reform bills Congress considered—specifically, the bill drafted by the Senate Committee on Health, Education, Labor and Pensions—included an independent commission tasked with recommending the essential health benefits. *See infra* notes 122–128 and accompanying text.

4. Congress has already considered—and enacted—a proposal similar to that recommended in this Article. Specifically, section 3403 of the Affordable Care Act creates an independent Medicare payment advisory board (IPAB) tasked with presenting to Congress proposals to slow the growth in Medicare expenditures and improve the quality of care provided to Medicare beneficiaries. Congress may modify the IPAB's proposals, but any such modifications must be budget-neutral.

5. *See* Affordable Care Act § 1301. Although a state may require that plans participating in its state exchange offer additional benefits, those states that do so must defray the resulting higher costs for individuals qualifying for premiums assistance and reduced cost-sharing. *Id.* § 1311(d)(3)(B)(ii).

6. *Id.* § 1513 (amending the Internal Revenue Code of 1986 to include penalties for employers who fail to offer full-time employees and their dependents minimum essential coverage if at least one such individual enrolls in a qualified health plan and receives a premium tax credit or cost-sharing reduction).

7. *Id.* § 1501 (amending the Internal Revenue Code of 1986 to include penalties for individuals who fail to maintain minimum essential coverage beginning in 2014). The specifics of these penalties were further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1002, 124 Stat. 1032.

8. Affordable Care Act § 1302(b)(5) ("Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits . . . .").

supplemental coverage. In addition, insurers participating in the state exchanges likely would not offer supplemental coverage of certain conditions because of concerns about adverse selection—that is, the concern that only individuals who anticipate needing treatment for these conditions would purchase the supplemental coverage, leaving insurers unable to balance the costs of covering the conditions across a large risk pool that includes healthy individuals.[9] Moreover, in an effort to lower their healthcare costs, some employers may limit their employees' plan options to plans offering only the essential health benefits. Their employees thus would find themselves without coverage for care beyond the minimum standards. Thus, although national coverage standards do not involve the explicit rationing of healthcare, the governmentally determined set of essential health benefits will, for many individuals, establish both a floor and a ceiling for the care they receive.

Such standardized coverage may be necessary to address a broader social problem—skyrocketing healthcare costs. Advances in medical technology and an aging population have led us to the point where funding all potentially beneficial care would preclude spending on all other social goods, including public education, national defense, transportation, and law enforcement.[10] Society thus cannot afford to provide every citizen with access to all medical care that may provide them some health benefit, but instead must decide which health needs will be given priority.[11] In other words, we must ration healthcare. By narrowing the scope of benefits that health plans must cover, national coverage standards would take an important first step toward placing limits on care.

At a basic level, then, government determinations regarding the scope of the essential health benefits involve decisions regarding which patients get "what, when, and how."[12] As with any public policy involving the distribution of society's limited resources, the essential health benefits would reflect a

9. For example, if the essential health benefits exclude treatments for infertility, insurers may be reluctant to offer supplemental coverage for this condition for fear that only those with infertility problems would purchase the supplemental coverage. *See* Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 133 (2009).

10. *See infra* notes 82–87 and accompanying text. *See also* Christopher Newdick, *Accountability for Rationing—Theory Into Practice*, 33 J. LAW, MED. & ETHICS 660, 660 (2005) (noting the "inevitability" of rationing healthcare as demand for care exceeds the supply of resources to provide it); Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 IND. L.J. 1015, 1015 (1997).

11. *See* NORMAN DANIELS & JAMES E. SABIN, SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES? 2 (2002) (commenting that society must place limits on healthcare so that resources are available for meeting other priorities).

12. *See* KEITH SYRETT, LAW, LEGITIMACY AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE 78 (2007) (quoting H. LASSWELL, POLITICS: WHO GETS WHAT, WHEN AND HOW (1936)).

governmental preference for providing benefits to one group of patients over others. These choices take on special significance given the importance of good health to individuals' well-being.[13] We therefore should give careful consideration to two basic issues: (1) the criteria for deciding which medical conditions or services are included in the essential health benefits, and (2) the process for making these determinations.[14]

Much scholarship has been devoted to the first of these issues. The academic literature commonly focuses on three different principles for guiding health rationing decisions: the maximizing principle, the need principle, and the egalitarian principle.[15] The maximizing principle emphasizes the goal of maximizing the health of the population as a whole, with priority given to those treatments that are most cost-effective.[16] For example, under the maximizing principle, priority would be given to preventive dental care over organ transplants if the former were deemed more cost-effective than the latter. The need principle generally would give priority to the sickest patients, such as those facing an immediate threat to life.[17] Under this principle, *in vitro* fertilization (IVF) treatments might be excluded from the essential health benefits on the grounds that IVF treatments do not treat a condition that threatens life or causes pain. Finally, egalitarian principles require that healthcare resources be allocated so as to reduce inequalities in health or, alternatively, so as to equalize individuals' opportunity for lifetime health.[18] For example, patients suffering an illness that some consider largely self-inflicted, such as drug or alcohol addiction, may be given lower priority than other patients on the view that the former had an equal opportunity to good health but chose not to use that opportunity wisely.[19]

The task of establishing the essential health benefits would be fairly straightforward if public officials simply could specify which of these principles should take precedence, with experts then mechanically applying the guiding

13. *See* Howard M. Leichter, *Political Accountability in Health Care Rationing: In Search of a New Jerusalem*, 140 U. PA. L. REV. 1939, 1940–41 (1992) (commenting that the challenge of ensuring that public policies serve the public interest "takes on a rather special significance when the policy involves values that are as cherished as those of good health and access to medical care"); *see also infra* notes 51–54 and accompanying text (discussing the importance of healthcare).

14. *See* Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 698 (1994) ("In searching for an acceptable form of rationing, we are plagued by two basic questions: (1) Who should decide what care is not worth the costs, and (2) What criteria of benefit should be used to make this determination?").

15. *See* Richard Cookson & Paul Dolan, *Principles of Justice in Health Care Rationing*, 26 J. MED. ETHICS 299, 323 (2000) (discussing the different guiding principles discussed in the academic literature).

16. *See* SYRETT, *supra* note 12, at 88–89.

17. *See* Cookson & Dolan, *supra* note 15, at 324.

18. *See id.* at 327.

19. *See id.*

criteria to specific cases. Unfortunately, countries that have attempted to formulate and implement clear decision rules for rationing quickly discovered the difficulty of doing so. For example, in the late 1980s and 1990s, Finland, Norway, and Sweden developed rationing schemes that prioritized the treatment of patients with the most serious conditions.[20] The schemes proved highly controversial, as their emphasis on need principles ignored societal values reflected in the maximizing and egalitarian principles, which most also considered important.[21] Moreover, the specific principles and goals identified by public officials often conflicted with one another, and frequently proved indeterminate when applied to actual cases.[22] After their initial struggles with articulating and applying guiding principles for setting healthcare priorities, the Nordic countries shifted their focus from deciding the relevant priorities directly to establishing a fair *process* for setting the priorities.[23] Other countries, such as New Zealand and the United Kingdom, similarly have shifted their attention to establishing morally acceptable procedures for rationing care.[24] So while the question of what criteria should guide the establishment of national coverage standards is an important one, the lessons of other countries tell us that the more important question is how best to design the *process* by which the essential health benefits will be decided.[25] This issue is the focus of my Article.

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20. *See* DANIELS & SABIN, *supra* note 11, at 153–54.

21. *See id.* at 154–55.

22. *See id.* at 155. *See generally* Hall, *supra* note 14, at 699 (commenting that even if society reaches agreement on the criteria for setting priorities, "their precise definition and application would depend on the broad range of discretion exercised by whomever implemented the criteria"). In this country, the Oregon Medicaid program's attempt to establish systematic priorities parallels the experience of the Nordic countries. When the Oregon Health Services Commission initially ranked priorities based on a single criterion—cost-effectiveness—the resulting list was greeted with widespread condemnation, as the results did not fit with people's intuitions. *See* DANIELS & SABIN, *supra* note 11, at 32. For example, capping teeth was ranked higher than appendectomies and organ transplants. *See id.* at 3; Jan Blustein & Theodore R. Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1561 (1992).

23. *See* DANIELS & SABIN, *supra* note 11, at 156–58.

24. *See id.* at 159–64. *See generally* SYRETT, *supra* note 12, at 93 ("More broadly, policy-makers elsewhere have shifted from earlier attempts to address problems of rationing through the application of technical criteria and have 'turned their attention to ways of strengthening decision-making processes to generate legitimacy for rationing as the limitations of technical approaches have been exposed'" (quoting Chris Ham & Angela Coulter, *Explicit and Implicit Rationing: Taking Responsibility and Avoiding Blame for Health Care Choices*, 6 J. HEALTH SERV. RES. & POL'Y 163, 166 (2001))).

25. *See generally* SYRETT, *supra* note 12, at 101 (arguing for "increase[ed] emphasis on the *process* by which rationing decisions are reached") (emphasis in original); Rudolf Klein, Editorial, *Puzzling out Priorities: Why We Must Acknowledge That Rationing Is a Political Process*, 317 BRIT. MED. J. 959, 959 (1998) (opining that the challenge for healthcare rationing is how to organize and orchestrate the discussion about the principles that should guide rationing and "how best to reconcile conflicting values and competing claims"); Rudolf Klein & Alan Williams, *Setting Priorities: What Is Holding Us Back—Inadequate Information or Inadequate Institutions?*, *in* THE GLOBAL CHALLENGE OF HEALTH CARE RATIONING 15, 20–21 (Angela Coulter & Chris Ham eds., 2000) ("[G]iven conflicting values, the process of setting priorities for

Questions about process ultimately concern how to ensure that those entrusted with governmental powers act in the public interest. As I have argued elsewhere, the public interest is best served by a process that promotes reflective deliberation on the common good.[26] Specifically, the process for setting national coverage standards should facilitate careful analysis of the relevant clinical evidence and ethical arguments, with the final standards supported by adequate scientific, economic, and moral justifications.[27] Decisionmakers also should not exhibit indifference, bias, or favoritism toward any one group of patients or healthcare providers, but instead should show equal regard for the interests of all individuals affected by their decisions.[28] I conclude that the process established by the Affordable Care Act—directing that HHS establish the essential health benefits through notice and an opportunity for public comment—will fail to achieve these objectives. I advocate that this responsibility instead should be vested with an independent commission, and that Congress also should adopt internal rules of congressional procedure designed to deter legislative modification of the commission's essential health benefits.

Part I evaluates whether the process for setting national coverage standards reflected in the Affordable Care Act would promote deliberative, public-regarding decisions. With no real constraints on the president and Congress's ordinary oversight powers over HHS, I conclude that political considerations would lead politicians to push for an essential health benefits package that includes those conditions and treatments demanded by the public or influential special interest groups, regardless of the merits of doing so. The public's moral discomfort with denying medical care to individuals in need, as well as general skepticism about the necessity of doing so in order to control costs, would lead the public to strenuously resist limits on their healthcare. Politicians thus would face tremendous public pressure to mandate that plans cover an ever-expanding list of conditions and therapeutic interventions, no matter what their cost. Special interest groups would similarly lobby lawmakers to advance the interests of the groups' members by requiring that the essential health benefits include certain conditions or services. So although many lawmakers would recognize the need for society to place limits on healthcare, their desire to retain the support of their constituents and special interest groups would lead them

health care must inevitably be a process of debate. . . . Hence, the crucial importance of getting the institutional setting of the debate right . . . .").

26. *See* Jessica Mantel, *Procedural Safeguards for Agency Guidance: A Source of Legitimacy for the Administrative State*, 61 ADMIN. L. REV. 343, 361–65, 372–85 (2009) (arguing for a deliberative theory of democratic legitimacy).

27. *See id.* at 363–64 (discussing the expectation that administrative agencies' analyses be competent, thorough, and rational).

28. *See id.* at 364 (discussing agencies' duty to serve "the polity in its entirety").

to use their oversight powers to either pressure HHS to mandate coverage of certain benefits or override its standards with legislation doing so.

Part II examines an alternative process proposed by the Senate Committee on Health, Education, Labor, and Pensions (HELP). Specifically, in contrast to the health reform legislation Congress ultimately enacted, the Senate HELP Committee's bill would have created a new commission, modeled after the Base Realignment and Closure Commission (BRAC), that would make recommendations on an annual basis regarding the conditions and services to be included in the essential health benefits.[29] An early draft of the bill further proposed to constrain the secretary of HHS's oversight over the commission by limiting her discretion to modify the commission's recommendations.[30] In addition, once accepted by the secretary, the commission's recommended essential health benefits would be submitted to Congress for its review as a "take-it-or-leave-it" proposal, with lawmakers prohibited from amending the commission's recommendations.[31]

By placing obstacles in the path of politicians seeking to influence the shape of the essential health benefits, particularly in the case of the president and other executive branch officials, a commission approach to setting national coverage standards would address many of the shortcomings of simply delegating to HHS the responsibility for defining the essential health benefits. However, I believe that a commission, by itself, would not sufficiently limit counterproductive, politically motivated behavior by lawmakers. Limiting Congress's initial review of a commission's recommended annual coverage standards to an up-or-down vote fails to recognize that Congress would retain its powers to subsequently alter the standards. Unlike base closing decisions, the coverage standards established by a commission would not constitute one-time, irreversible policy decisions, but could be undone by Congress at any time through subsequent legislation mandating coverage of certain benefits (known as mandated benefits legislation). It is likely that Congress would do so frequently in response to the political pressures described in Part I.

Thus, in Part III, I propose additional constraints on the powers of the legislative branch that would make it more difficult for lawmakers to influence or override a commission's recommended coverage standards. Specifically, in addition to creating a commission modeled after the BRAC, I argue that Congress's internal rules of procedure should incorporate an actuarial offset requirement

29. Affordable Health Choices Act, S. 1679, 111th Cong. § 3103(b) (2009).

30. S. Comm. on Health, Educ., Labor, and Pensions, Affordable Health Choices Act § 3103(e) (2009) [hereinafter HELP Unamended Proposal] (on file with the author).

31. *Id.* § 3103(g).

modeled after the "pay-as-you-go," or "PAYGO," rules governing legislative proposals for new government spending or tax cuts. The actuarial offset requirement would obligate Congress to offset the costs of mandating coverage of additional medical care with new exclusions from the essential health benefits. This requirement would make it more difficult for lawmakers to modify the shape of the essential health benefits for political gain by intensifying and institutionalizing conflict among interest groups and erecting procedural hurdles in the path of such legislation. These additional constraints would liberate a commission to base its recommendations on a careful review of the relevant scientific, economic, and ethical considerations, rather than on purely political considerations.

Finally, Part IV considers whether insulating a commission from the politically accountable branches would produce national health coverage standards lacking democratic legitimacy. Some may contend that although political considerations would tempt elected officials to support an expansive essential health benefits package, the absence of robust political oversight of the commission poses a greater risk—that the commission will fail to exercise its authority competently and without bias. Although this argument is not without merit, I nevertheless conclude that under my proposal, the president and Congress's residual oversight powers, alongside other procedural safeguards, would adequately protect the public against malfeasance on the part of a commission.

I. THE SETTING OF ESSENTIAL HEALTH BENEFITS BY HHS: PROBLEMS WITH THE STATUS QUO

The Affordable Care Act vests authority for defining the essential health benefits in the secretary of HHS.[32] At a minimum, the essential health benefits must include the following general benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services.[33] HHS, however, may establish additional benefit categories. In addition, HHS may specify which items and services within a benefit category are included in the essential health benefits. For example, HHS may provide that a plan's

32. Affordable Care Act, Pub. L. No. 111-148, § 1302(b), 124 Stat. 163 (2010). The term "essential health benefits package" means coverage that not only provides for the essential health benefits defined by the secretary, but also limits cost-sharing for coverage of the essential health benefits in accordance with the parameters specified in the statute. *See id.* § 1302(a).

33. *Id.* § 1302(b)(1).

prescription drug benefits must include all drugs approved by the FDA for the treatment of HIV/AIDS, but not birth control drugs or drugs prescribed for the treatment of erectile dysfunction or infertility.

The Affordable Care Act specifies several considerations that must guide HHS in defining the essential health benefits. Most importantly, the scope of the essential health benefits must equal "the scope of benefits provided under a typical employer plan."[34] Although the manner in which HHS will implement this requirement remains to be seen, presumably, HHS's inclusion or exclusion of specific conditions, devices, drugs, or services will be guided by whether they are typically covered by current employer plans. In addition, HHS will likely also ensure that the actuarial value of the essential health benefits equals the actuarial value of the benefits offered under a typical employer plan.[35] "Actuarial value" is a measure of the percentage of medical expenses estimated to be paid by a health insurer based on the standard population's expected utilization of medical care.[36] The more expansive the scope of benefits under a plan, the higher its actuarial value; conversely, the less generous the plan's benefits, the lower its actuarial value.[37] Accordingly, the target actuarial value will significantly influence HHS's adoption of additional benefit categories and identification of the items and services included within each benefit category. HHS also must ensure an "appropriate balance" among the benefit categories included in the

34. *Id.* § 1302(b)(2)(A) ("The Secretary shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.").

35. The statutory language "the scope of benefits" is arguably unclear, and could mean either that the essential health benefits include the specific conditions and treatments covered under a typical employer plan, or that the actuarial value of the scope of the essential health benefits equals the actuarial value of the scope of benefits included in a typical employer plan. When read together with the other provisions in section 1302(b), however, it appears that the term refers to the latter. *Id.* § 1302(b)(4)(G)(iv) (describing the requirement that the scope of the essential health benefits package equal the scope of benefits offered under a typical employer plan as an "actuarial limitation[ ]"); *see also id.* § 1302(b)(2)(B) (requiring that the Chief Actuary for the Centers of Medicare & Medicaid Services certify that the scope of the essential health benefits package equals the scope of benefits under a typical employer plan, thereby implying that an analysis of actuarial equivalency is required).

36. *See* CHRIS L. PETERSON, CONG. RESEARCH SERV., SETTING AND VALUING HEALTH INSURANCE BENEFITS 3 (2009).

37. Because the actuarial value of a plan's benefits is based on the percentage of medical expenses the plan expects to pay, a plan's actuarial value is affected not only by the range of benefits covered but also by the cost-sharing for covered benefits. *See id.* In applying the requirement that the *scope* of the essential health benefits package be actuarially equivalent to the *scope* of benefits under a typical employer plan, as distinguished from the actuarial value of the plan's benefits taking into account its cost-sharing structure, the Chief Actuary of the Centers for Medicare & Medicaid Services will likely calculate the actuarial value of the scope of benefits based on an assumption of zero cost-sharing.

essential health benefits;[38] take into account the healthcare needs of "diverse segments of the population," such as women, children, and persons with disabilities;[39] ensure that the essential health benefits do not discriminate against individuals because of their "age, disability, or expected length of life";[40] and consider clinical efficacy and advancements in medicine.[41]

HHS nevertheless retains wide discretion regarding which conditions and medical therapies will be considered essential health benefits. While to some extent the essential health benefits will reflect HHS's careful deliberation of the relevant clinical evidence, cost concerns, and ethical considerations, political factors will also significantly impact the definition of the essential health benefits. In particular, I argue below that the essential health benefits will include certain benefits mandated by a Congress and president seeking to please their constituencies and special interest groups.

As with most legislation delegating policymaking authority to agencies, the Affordable Care Act leaves untouched the ordinary powers that Congress and the president use to influence agencies' regulatory policies. For example, the president could influence the national coverage standards through the appointment of HHS officials sharing his policy priorities and ideology,[42] and the removal of those who do not.[43] Presidents could also use executive directives and prepublication review of agency rules by the Office of Management and Budget (OMB) to pressure HHS to modify the essential health benefits to better reflect the president's preferences.[44] Paramount among Congress's methods for

38. *See* Affordable Care Act § 1302(b)(4)(A) ("[T]he Secretary shall ensure that such essential health benefits reflect an appropriate balance among the categories described in [§ 1302(b)(1)], so that benefits are not unduly weighted toward any category.").

39. *See id.* § 1302(b)(4)(C) ("The Secretary shall . . . take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.").

40. *See id.* § 1302(b)(4)(B) ("The Secretary shall . . . not . . . design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.").

41. *See id.* §§ 1302(b)(4)(G)(ii), (H) (providing that HHS will periodically review and update the essential health benefits package "to account for changes in medical evidence or scientific advancement").

42. *See* David J. Barron, *From Takeover to Merger: Reforming Administrative Law in an Age of Agency Politicization*, 76 GEO. WASH. L. REV. 1095, 1096 (2008) (arguing that presidents have made "novel and aggressive use of their powers of appointment to remake agencies in their own image," with the result that "[a]gencies are now to an unprecedented extent governed by a thick cadre of political appointees . . . chosen either for having close ties to the President or for making strong prior commitments to his regulatory vision").

43. *See* Elena Kagan, *Presidential Administration*, 114 HARV. L. REV. 2245, 2274 (2001). However, the political costs to the president of exercising his removal power at times limit the effectiveness of this tool for controlling agencies. *See id.*

44. *See id.* at 2247–48, 2277–99 (discussing presidential directives and OMB review of agency rules as a means for administrative officials to direct what agencies will (or will not) generate as a regulatory product).

controlling administrative officials is its legislative power, which would allow Congress to undo through overriding legislation (subject to the president's veto) those aspects of HHS's coverage standards that lawmakers find objectionable. Congress could also use its appropriation powers to influence HHS by threatening to punish HHS with less funding if its coverage standards fail to reflect lawmakers' priorities.[45] As HHS would not wish to see its coverage standards overturned by Congress or its budget decreased, HHS would have strong incentives to heed congressional signals as to what the essential health benefits should look like.[46] Both the president and Congress, then, may play an important role in shaping national coverage standards.

Whether the president and Congress would use their oversight powers to influence the shape of the essential health benefits, and the impact of their doing so, would depend on the mix of policy and political forces shaping politicians' behavior.[47] Some politicians may attempt to shape the essential health benefits so as to reflect their notions of what constitutes good policy. For example, politicians primarily motivated by a desire to help those with the misfortune

45. *See* Jack M. Beermann, *Congressional Administration*, 43 SAN DIEGO L. REV. 61, 85 (2006). Congress also frequently enacts appropriation riders prohibiting an agency from expending funds to carry out a specific regulatory activity. *See id*. For example, unhappy with a new regulation that eliminated federal reimbursement under Medicaid for certain school-based administrative activities and transportation, 72 Fed. Reg. 73,635 (Dec. 28, 2007) (to be codified at 42 C.F.R. pts. 431, 433, 440), Congress in 2008 imposed a moratorium precluding the Centers for Medicare and Medicaid Services (CMS) from enforcing the regulation's more stringent provisions. Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 206, 121 Stat. 2492, 2514 (imposing a moratorium until June 30, 2008); Supplemental Appropriations Act of 2008, Pub. L. No. 110-252, § 7001(a)(2)(A), 122 Stat. 2323, 2388 (extending the moratorium until April 1, 2009); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5003(b), 123 Stat. 115, 503 (extending parts of the moratorium until July 1, 2009). Having received a clear message of Congress's disapproval of its regulation, CMS subsequently rescinded the regulation. 74 Fed. Reg. 31183 (June 30, 2009) (to be codified at 42 C.F.R. pts. 431, 433, 440, 441). By including these appropriation riders in large appropriations bills, lawmakers can generally escape a presidential veto, as presidents rarely veto an entire appropriations bill. *See* Beermann, *supra*, at 88.

46. *See* Steven P. Croley, *Public Interested Regulation*, 28 FLA. ST. U. L. REV. 7, 11 (2000). Congress also supervises agencies through various informal means, including congressional committee hearings and informal contacts between members of Congress and agency administrators. These hearings and informal contacts provide members of Congress an opportunity to convey to an agency their views of its performance, including demands that the agency change its policies. Although these communications lack legal effect, they often signal to an agency that if it fails to address Congress's concerns, it may find itself subject to legislation changing the substance of its policies, targeted appropriation riders, or reductions or reallocations of its budget. Consequently, agencies often accept the "suggestions" they receive from committee members and other powerful congressional leaders. Congress therefore can often effectively influence agencies' policies through its informal supervision. *See* Beermann, *supra* note 45, at 121–39 (discussing various informal means by which Congress influences agencies).

47. *Cf*. R. KENT WEAVER, AUTOMATIC GOVERNMENT: THE POLITICS OF INDEXATION 29 (1988) ("In many decisions, politicians are torn between conflicting motives: for example, between perceptions of what is good policy and desire to claim credit for a popular action or avoid blame for an unpopular action.").

of having a potentially deadly or crippling disease may be predisposed to support an expansive definition of the essential health benefits, regardless of the cost. Other politicians, however, may conclude that society simply cannot afford to cover all potentially beneficial medical care, and that the essential health benefits therefore should impose meaningful limits on care. Politicians may also care about whether the mix of conditions and services included in the essential health benefits is fair and reasonable in light of relevant scientific, economic, and ethical considerations.

Politicians do not care only about implementing good policy, however. Usually, they also desire to remain in office. If they wish to win reelection, they must retain the support of their constituents.[48] Voters generally will reelect an incumbent unless given a reason not to.[49] Members of Congress, therefore, take great care to avoid actions that would give their political opponents a popular election issue, especially in an age when an opponent's negative television advertising can quickly undermine an incumbent's popularity.[50] To the extent that the public strongly objects to certain limits on their healthcare, politicians will incur tremendous pressure to "do something" to address the public's concerns. In addition to maintaining or boosting their standing among constituents, incumbents need special interest groups' political resources, including campaign contributions. The continued political support of groups representing healthcare providers, biotechnology businesses, patients, and others in the healthcare industry will be contingent on politicians ensuring that the essential health benefits include coverage of certain conditions or services.

For the reasons discussed below, these political considerations frequently will lead politicians to support efforts to mandate coverage of certain conditions or treatments, as opposing these efforts could adversely impact incumbents' reelection prospects by alienating voters and certain interest groups. At times, then, politicians would put aside any policy misgivings and use their various oversight and legislative powers to pressure HHS to include certain conditions or treatments in the essential health benefits or enact legislation overriding HHS's coverage exclusions. These politically motivated actions will result in coverage standards skewed in favor of the conditions and treatments for which the public or influential special interest groups demand coverage.

48. *See, e.g.*, Croley, *supra* note 46, at 9.
49. *See* R. Kent Weaver, *The Politics of Blame Avoidance*, 6 J. PUB. POL'Y 371, 382–83 (1986).
50. *See id.*

A. Public Pressure to Mandate Coverage of Certain Benefits

Many people believe access to healthcare should be a right and not based on an individual's ability to pay for care.[51] The public's general support for broad access to healthcare arises from the significant consequences of poor health. When effective, healthcare increases individuals' well-being by reducing pain and suffering, thereby increasing net social welfare. What makes healthcare unique, however, is not its direct effect on an individual's welfare, but the impact of ill health or disability on an individual's ability to pursue his or her life goals. As Norman Daniels and James Sabin explain:

> [B]y keeping people close to normal functioning, health care preserves the capabilities individuals need to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life.[52]

In other words, a primary function of healthcare is to restore an individual to normal functioning in order to protect the individual's fair opportunity for meaningful participation in society.[53] Consequently, there is strong public resistance to placing explicit limitations on its availability,[54] well captured in the popular refrain that you cannot put a price on life.

Given the public's general aversion to healthcare rationing, many voters would view a failure by Congress to adopt legislation mandating coverage of certain desired benefits as not only undesirable, but also as immoral.[55] Political incumbents know this, and rightly may fear that failure to mandate coverage for certain health benefits could prove politically costly. These concerns may be particularly acute when affected groups or opposing political candidates successfully employ the media and television advertising to evoke public outcry over lawmakers' inaction on controversial coverage restrictions, as adverse news

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51. *See* DANIELS & SABIN, *supra* note 11, at 14 ("In nearly all societies, people believe that access to health care should be based on need, not on ability to pay."); *see also* SYRETT, *supra* note 12, at 82 (stating that "the principle of fair equality of opportunity" implies "that there should be universal access to care . . . and that healthcare should not be distributed according to ability to pay").

52. DANIELS & SABIN, *supra* note 11, at 15.

53. In their book *Setting Limits Fairly: Can We Learn to Share Medical Resources?*, Norman Daniels and James Sabin distinguish between "fair opportunity" and "equal opportunity." The latter would require that society correct for the effect of "the natural lottery" that not only creates variation in individual's health but also their talents and skills. In their view, society should correct for the impact of disease and disability in order to ensure "normal functioning," but need not enhance otherwise normal but disadvantageous traits. *See id.* at 17–18.

54. *See* Mark A. Hall, *The Problems With Rule-Based Rationing*, 19 J. MED. & PHIL. 315, 325 (1994) (noting "the strong public aversion to making rationing decisions overt").

55. For a discussion of the moral complexity of healthcare rationing, see *supra* note 54 and *infra* notes 56–58 and accompanying text.

coverage or an opponent's negative sound bite can kill a reelection campaign.[56] Public outcry may be particularly strong when individuals feel a psychic connection with the patients denied coverage, such as when the patients are children,[57] or when individuals fear that they may one day need the excluded therapeutic intervention.[58] In these cases, a politician who votes against mandated benefits legislation that would overturn an unpopular exclusion from the essential health benefits could pay a steep political price. Consequently, rather than try to explain a contrary vote to their constituents, politicians seeking to avoid voter backlash may simply vote in favor of popular mandated benefits legislation, even if they have substantial doubts about its merits.[59]

One strategy for avoiding the political repercussions of a nay vote on questionable mandated benefits legislation would be to keep the legislation from coming before Congress for a vote.[60] For example, congressional leaders could prevent a vote on a bill that would mandate coverage of certain benefits by burying the bill in congressional committees. Efforts to prevent mandated benefits legislation from coming to the floor for a vote, however, would often be stymied by the efforts of other lawmakers with strong incentives to force the issue onto the legislative agenda.[61] Some politicians may genuinely believe that legislation mandating that health plans cover a particular benefit constitutes good

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56. *Cf.* Natalie Hanlon, *Military Base Closings: A Study of Government by Commission*, 62 U. COLO. L. REV. 331, 351 (1991) (discussing how television impacts reelection campaigns by generating blame for incumbents).

57. For example, in the mid-1990s the denial of further treatment to a child with leukemia by health authorities in the United Kingdom attracted widespread attention. *See* Chris Ham, *Tragic Choices in Health Care: Lessons From the Child B Case*, *in* THE GLOBAL CHALLENGE OF HEALTH CARE RATIONING, *supra* note 25, at 107, 107–16.

58. For example, interest groups' success in generating support for coverage of an experimental treatment for breast cancer, discussed *infra* notes 93–102 and accompanying text, may partially be attributable to the fact that breast cancer is the most common type of cancer in women.

59. *See* Weaver, *supra* note 49, at 375 (noting that one way in which blame avoidance among politicians manifests itself is when politicians "may vote in favor of legislation about which they have substantial doubts because it would be difficult to explain a contrary vote to their constituents"). One might counter that voters' views are not shaped solely by a desire to punish politicians for real or perceived losses. However, as R. Kent Weaver explains:

> Even if voters' judgments are only partially based on a desire to punish behavior or views of which they disapprove, politicians still have strong incentives to minimize potential blame, because (1) they cannot be certain which issues might be picked up by future opponents and used against them, and (2) only some, not all, voters need to pursue retribution as a voting objective for a politician's office to be in danger.

Id. at 378.

60. *See id.* at 384 ("The best way for policymakers to keep a blame-generating issue from hurting them politically is to keep it off the agenda in the first place.").

61. *See id.* (arguing that legislators cannot always cooperate to keep controversial issues off the agenda in part because "some issues pit the blame-avoiding interests of one group of legislators against the credit-claiming and policy interests of others").

policy. In addition, other politicians may conclude that championing legislation mandating coverage for certain treatments presents an opportunity to build political capital among their constituents and the special interest groups lobbying for the legislation. And some politicians simply may fear the electoral consequences of failing to pass legislation overriding a controversial coverage exclusion. Consequently, in the face of strong incentives to support mandated benefits legislation, attempts to keep such legislation off the legislative agenda will frequently prove futile. The essential health benefits, therefore, will often include those benefits that the public demands, regardless of whether inclusion of these benefits is justified on scientific, economic, or ethical grounds.

Some may argue that elected officials' responsiveness to popular opinion regarding national coverage standards should be celebrated, not criticized. After all, are not citizens collectively better judges than political elites of their own needs and how best to advance them? This contention assumes that citizens are fully capable of evaluating their own interests and the relative merits of competing coverage standards.[62] Unfortunately, individuals' limited understanding of the complex moral, scientific, and economic considerations raised by healthcare rationing, as well as individuals' moral discomfort with the issue, raise substantial concerns regarding the public's collective judgment on these questions.

For starters, few people have the time or inclination to undertake the necessary study to become informed on the merits of mandating coverage of specific conditions or medical therapies.[63] Among those willing to do so, few have the technical expertise to fairly evaluate a medical intervention's clinical- and cost-effectiveness. Many voters are also unlikely to appreciate the complex repercussions of coverage mandates beyond their immediate benefits or costs for affected patients. For example, voters may fail to recognize that more expansive essential health benefits would raise health insurance premiums, which in turn may depress real wages and raise the unemployment rate by increasing the cost of employer-financed health insurance. Voters may also fail to appreciate that policymakers may "pay" for the cost of mandated coverage of a particular

62. Elsewhere I have questioned the feasibility of theories of democratic legitimacy that give primacy to popular preferences, also known as "majoritarianism." *See* Mantel, *supra* note 26, at 372–85 (arguing that relative to theories of democratic legitimacy that emphasize political accountability, deliberative theories of democratic legitimacy rest on stronger normative justifications, are more consistent with empirical research on individuals' judgments on legitimacy of political officials and legal authorities, and reflect a more feasible conception of legitimate government).

63. *See* Leichter, *supra* note 13, at 1952 (explaining that one justification for delegating rationing decisions to the political elite is that few people have the time, skills, or inclination to participate in politics).

condition or treatment by excluding other benefits from the essential health benefits in an effort to contain its overall scope. Accordingly, given the highly technical and polycentric nature of rationing decisions, voters' opinions as to the merits of covering a specific condition or medical therapy may be misguided.

Rationing decisions not only raise complex technical issues, but they also involve difficult trade-offs between deeply held values—social utility and efficiency, equality, and individual autonomy. Because healthcare is not the only important social good, governments must determine which health needs should be given priority so that sufficient government resources are available for meeting other needs.[64] Placing restrictions on the essential health benefits therefore serves important utilitarian considerations by lowering health insurance premiums and preserving government funding for other priorities. Setting limits on how much we will spend on healthcare, however, also represents a public acknowledgment that society is unwilling to expend whatever funds are necessary to preserve human life or alleviate suffering.[65] This public declaration that some lives are not worth saving or improving offends society's deeply held belief in the sanctity of life.[66] Moreover, because the allocation of scarce resources necessarily involves treating people differently, doing so offends one of our most basic egalitarian values—that all individuals have an equal right to life and happiness.[67] Finally, in a society like ours, which highly values individual autonomy, limits on coverage may generate intense resentment among patients who believe these limits encroach upon their right to self-determination.

Placing restrictions on the availability of healthcare, therefore, requires that we make trade-offs among our most fundamental values, values we like to think

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64. *See* DANIELS & SABIN, *supra* note 11, at 2 ("However important, health care . . . is not the only important social good. Societies must also provide education, jobs, transportation, energy, defense, research, art and culture, and well-functioning government and political institutions. Society simply cannot meet all medical needs, and certainly not all medical preferences, so it must decide which needs should be given priority and when resources are better spent elsewhere.").

65. *See* Leichter, *supra* note 13, at 1945 (stating that rationing involves "'the specter of government openly renouncing the widely held belief in the sanctity of human life and publicly acknowledging that society is unwilling to expend the funds necessary to preserve human life and health'" (quoting James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1371 (1981))).

66. *See* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 39 (1978) (explaining that when the political process refuses to provide certain groups with medical care, such as the aged who need hemodialysis, "the clear assertion has been made that some lives are not worth saving. To the extent that our lives and institutions depend on the notion that life is beyond price, such a refusal to save lives is horribly costly").

67. *See id.* at 38–39 (observing that a society that views its members as created equal cannot make allocative decisions based on individuals' differences without dissonance); *see also* Kenneth Arrow, *Modes of Choice*, 88 YALE L.J. 436, 437 (1978) (reviewing CALABRESI & BOBBIT, *supra* note 66) ("The incompatibility of notions of an equal right of all to life and the scarcity of resources gives rise to tragic conflict.").

are beyond compromise.[68] Healthcare rationing thus produces profound moral unease for most people. Rather than confront the inevitable tension among these values, however, many simply deny the need to choose among them, convincing themselves that we can have our cake and eat it too. This desire to avoid making the difficult choices raised by rationing is an important factor underlying widespread public skepticism about the need for coverage limits in order to slow the rapid growth in healthcare expenditures.[69]

Compounding the public's skepticism of the need for coverage limits is its mistrust of those who thus far have taken the lead in efforts to reduce patients' consumption of medical care. Health plans ration care by excluding or limiting coverage of certain medical services, such as "experimental" therapies,[70] *in vitro* fertilization, mental health care, organ transplants, and dental care.[71] In addition, managed care organizations employ a range of utilization review procedures designed to discourage care deemed unnecessary or inefficient by the managed care organization.[72] For example, healthcare providers often must secure advance authorization from the managed care organization before rendering costly medical treatment.[73] Many citizens believe, sometimes with good reason, that these efforts are guided by insurers' bottom line rather than fair assessments of the

68. *See* Jules L. Coleman & William L. Holahan, Book Review, 67 CAL. L. REV. 1379, 1380 (1979) (reviewing CALABRESI & BOBBIT, *supra* note 66) (explaining that "[w]hen confronted with tragic choices, . . . the claim that [cherished] principles are equally fundamental and beyond trade-off cannot be sustained. The tragic choice exposes the tension that exists among a society's basic norms and reveals its ordering of them"); SYRETT, *supra* note 12, at 85–86 ("[M]easures which restrict [healthcare's] availability . . . are likely to generate considerable moral unease. The 'tragic choices' thesis builds upon this account by stressing the apparent incommensurability of the moral positions which are exposed when such measures are adopted, and the consequent systemic instability which arises.").

69. *See* ABC News/Washington Post Poll, Q23 (Oct. 9 2003), http://webapps.ropercenter.uconn.edu/cfide/psearch_test/webroot/multquestion_view.cfm?QSTN_ID2=501720&qid=+501720&pid=4&ccd=0&x=85&y=18 (reporting that 79 percent of respondents stated that they oppose the rationing of healthcare in which an increasing number of medical treatments that are currently covered by insurance would no longer be covered because they are too costly, not essential, or have too little chance of success); *see also* Daniel M. Fox, *The Politics of Explicit Rationing*, 19 HEALTH AFF. 279, 280 (2000) (reviewing PETER A. UBEL, PRICING LIFE: WHY IT'S TIME FOR HEALTH CARE RATIONING (2000)) (commenting on "[t]he belief of many Americans that they are entitled to any health care that might help them").

70. An experimental treatment is a therapeutic intervention that the medical community does not generally accept as clinically effective and proven. Often an experimental treatment is new and requires further clinical study. *See* The Free Dictionary by Farlex, http://medical-dictionary.thefreedictionary.com/experimental+treatment (last visited Sept. 16, 2010) (defining experimental treatment).

71. *See* Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1769, 1773–74 (1992).

72. *See* David Villar Patton, *Achieving Managed Care Accountability by Ending the ERISA Preemption Defense*, 59 OHIO ST. L.J. 1423, 1426–28 (1998).

73. *Id.* at 1428.

utility of the desired treatment.[74] This mistrust of insurers' motivations has contributed to public doubts regarding the need to reduce patients' utilization of medical care.[75]

The public has also been misled by politicians about the need for healthcare rationing. Rather than facilitate an honest discussion about whether society can affordably meet all of Americans' demands for healthcare, for decades the public has heard politicians point to various other villains allegedly responsible for our high healthcare costs.[76] For example, many politicians have argued that runaway malpractice litigation costs substantially increase healthcare costs by driving up malpractice premiums and encouraging physicians to practice "defensive medicine."[77] In addition to the alleged problem of high malpractice costs, others have argued that sufficient funding would exist for all our healthcare needs if we just eliminate "unnecessary" or "harmful" care.[78] These assertions mirror popular opinion, with 60 percent of those surveyed in a 2005 poll identifying malpractice lawsuits as a "very important factor" in causing high healthcare costs,[79] and 77 percent of those surveyed in a 2006 poll identifying "fraud and waste in the health care system" as either one of the biggest single factors or a major factor for rising healthcare costs.[80] Not surprisingly, many

74. *See* DANIELS & SABIN, *supra* note 11, at 7, 19–20 (observing that with employers and health plans having played a leading role in setting resource limits in an effort to reduce costs, the American public is likely to conclude that such efforts result from concerns about the bottom line or profits).

75. *See id.* at 40.

76. *See id.* at 9 ("[N]either the U.S. government nor the private sector . . . has been willing to take the heat involved in leading public deliberation about resource limits, the need for setting priorities, and the need for limiting services. Both politicians and corporate managers have a career interest in being seen as giving more, not less, to their constituents, employees, and customers.").

77. *See, e.g.*, Harris Meyer, *GOP Health Fixes Fall Short*, CHI. SUN-TIMES, Sept. 23, 2009, at A31 (noting Republicans' claim that limiting medical malpractice lawsuits will make healthcare more affordable); James Oliphant & Tom Hamburger, *Medical Lawsuit Reform Joins the Mix*, L.A. TIMES, Sept. 10, 2009, at A19 (stating that in "his address to Congress, [President] Obama said that fears of lawsuits ha[ve] driven physicians to practice 'defensive medicine'"). Defensive medicine occurs when a doctor orders tests or procedures not based on determinations of medical need, but in an effort to avoid malpractice lawsuits.

78. *See, e.g.*, Arnold S. Relman, Editorial, *The Trouble With Rationing*, 323 NEW ENG. J. MED. 911, 912 (1990) (arguing that inefficiency in the delivery of healthcare is the source of rising healthcare costs).

79. *See* KAISER FAMILY FOUND./HARVARD SCH. OF PUB. HEALTH SURVEY, HEALTH CARE AGENDA FOR THE NEW CONGRESS 17 (2005), *available at* http://www.kff.org/kaiserpolls/upload/Health-Care-Agenda-for-the-New-Congress-Survey-Toplines.pdf.

80. *See* ABC News/Kaiser/USA Today Health Care Poll, Q20J (Sep. 2006), http://webapps.ropercenter.uconn.edu/cfide/psearch_test/webroot/multquestion_view.cfm?x=64&y=13&QSTN_ID2=1667019&qid=+1667019&pid=4&ccid=4. Thirty-seven percent of respondents identified fraud and waste in the healthcare system as "one of the biggest" single factors in rising healthcare costs, with 40 percent responding it was a "major" factor. Similarly, in an April 2009 survey, 66 percent of respondents said that "too much fraud in the [Medicare] program" is a major reason for Medicare's financial difficulties. Kaiser Health Tracking Poll, Q.26C (Apr. 2009), http://webapps.ropercenter.uconn.edu/cfide/psearch_

Americans reject the need for limits on their healthcare and instead believe that we can solve the problem of rising healthcare costs by adopting benign alternatives to rationing, such as malpractice reform, expanded use of health information technology, or elimination of wasteful procedures.[81]

Voters' cynicism regarding the need to ration healthcare, however, is misguided. While certain proposals for reducing healthcare costs have some merit, most commentators believe that at best their success will prove short-lived because they fail to address the key drivers of rising costs—advances in medical technology and an aging population. By far the largest factor contributing to increasing healthcare costs is advances in medical technology.[82] By increasing the number of health conditions for which there exist potentially beneficial treatments, advances in medical technology have caused significant increases in aggregate utilization of healthcare services.[83] In addition, the cost of these new medical technologies can be quite high, leading to price inflation for healthcare that exceeds the inflation rate for other goods and services.[84] The "graying" of the population also leads to increased demand for healthcare services, as people tend to require more care as they age.[85] Further advances in healthcare and an aging population will only continue to drive up total healthcare spending.[86] Because alternative proposals to reduce costs do little to dampen the escalation of costs attributable to medical advances and an aging population, any initial savings from their implementation would soon be overcome by a return to rapidly rising costs.[87]

So while reliance on public opinion requires that citizens' views about healthcare rationing be at least minimally informed, unfortunately, that is

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81. *See supra* note 69; *see also* Henry J. Aaron, *Health Care Rationing: Inevitable but Impossible?*, 96 GEO. L.J. 539, 547–551 (2008) (discussing the various alternatives to controlling healthcare costs offered by critics of rationing).

82. *See* WELLPOINT INST. OF HEALTH CARE KNOWLEDGE, WHAT'S REALLY DRIVING THE INCREASE IN HEALTH CARE PREMIUMS? 5 (2009) ("[M]edical technology appears to be a major driving force behind the growth in U.S. health care spending.").

83. *See id.* at 6 (stating that new technologies increase healthcare costs by expanding treatment options).

84. *See id.* at 5 ("[N]ewer technologies tend to increase prices because they are generally more expensive than the older technologies they replace.").

85. *See* Aaron, *supra* note 81, at 542 (identifying an increase in the average age of the population as one factor increasing the share of income spent on healthcare); Newdick, *supra* note 10, at 660 (stating that an aging population expands demand for healthcare).

86. *See* Aaron, *supra* note 81, at 542.

87. *See* Blustein & Marmor, *supra* note 22, at 1566 (explaining that medium-term gains from cutting wasteful medical care do nothing to address the rise in costs attributable to the more effective and expensive services to be developed tomorrow). For an in-depth discussion of the limitations of various proposals to lower healthcare costs, see generally Aaron, *supra* note 81.

unlikely to be the case given the complexity of the issue and misguided voter skepticism regarding the need for rationing. Citizens' profound moral unease with rationing healthcare raises additional concerns about their ability to effectively evaluate the merits of including or excluding various benefits from the minimum essential health benefits. While it is not my contention that public opinion on whether to mandate coverage of a certain benefit is always misguided, we cannot presume that simply aggregating citizens' preferences on the issue will produce the "right" or "correct" choice. Consequently, an essential health benefits definition shaped in part by popular opinion may not necessarily be fair or rest on adequate scientific, economic, and moral grounds.

B. Pressure From Narrow Constituencies and Special Interest Groups

Not all exclusions from the essential health benefits would provoke a public backlash. For example, were the essential health benefits to exclude chiropractic services, this exclusion may fail to capture the media's focus or resonate much with the general public. In addition, personal biases may lead some individuals to have little sympathy for the plight of certain patients, such as those with HIV/AIDS. People may also have little objection to excluding from the essential health benefits therapeutic treatments that they do not expect to need themselves, such as ongoing treatment for severe mental disabilities. Yet according to at least one organization, states have enacted over 2,100 laws mandating that health plans provide coverage for specified conditions or the services of certain providers.[88] While in some cases these legislative benefit mandates may reflect broad public pressure or reasoned policy considerations by state lawmakers, in other cases lawmakers may have been motivated largely by narrower political considerations—namely a desire to build political capital with certain constituent and special interest groups.

Politicians motivated to remain in office not only desire to avoid antagonizing voters generally, but also have incentives to advance the interests of certain groups. Getting elected (and reelected) requires campaign contributions and other political resources, which well-organized and well-financed special interest groups are positioned to deliver to politicians who promote policies that

88. *See* VICTORIA CRAIG BUNCE & JO WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES 2009, at 1 (2009). For example, all fifty states and the District of Columbia require health plans to provide coverage for post-mastectomy breast reconstruction. *See id.* at 5, 8–12. Forty-six states require that health plans cover all or some of the services of chiropractors, *see id.* at 18, while forty-five states require coverage of treatments for alcoholism and/or substance abuse. *See id.* at 5.

further the group's interests.[89] Politicians therefore have strong incentives to advance the agendas of special interest groups representing those who would gain economically from the inclusion of certain conditions or treatments in the essential health benefits, such as healthcare providers and pharmaceutical and biotechnology companies.[90] In addition, patients desiring treatments excluded from the essential health benefits, particularly treatments that represent patients' best hope of extending their lives or alleviating their pain and suffering, would be motivated to punish those politicians who ignore their interests by supporting opposing candidates. Not wanting to diminish their reelection prospects, politicians would be tempted to acquiesce to the demands of these groups to mandate coverage of certain benefits, regardless of whether doing so serves the public interest.[91] The history of state legislation mandating coverage of high-dose

89. *See* Croley, *supra* note 46, at 10.

90. At times, insurers and employers' lobbying efforts have counterbalanced the pressure that the public or interested industries (such as providers) placed on state lawmakers to mandate coverage of certain conditions or treatments. Insurers frequently object to state-mandated benefits legislation, as these laws often raise their costs and reduce their profits. Insurers set annual premiums based on the expected cost of paying for the benefits covered under their plan—the more generous the benefits under the plan, the higher the premium charged by the insurer. *See* PETERSON, *supra* note 36, at 3 (noting that the generosity of benefits affects a health plan's premium). Because state-mandated benefit laws require insurers to cover services they otherwise might exclude from their plans, insurers generally charge higher premiums in order to cover their higher expected costs. Higher premiums in turn cause a loss of business for insurers, as some individuals and employers wishing to offer their employees health insurance benefits cannot afford the higher premiums. So although insurers generally pass the costs of mandated benefit laws onto their subscribers in the form of higher premiums, mandated benefits laws nevertheless hurt their profitability by causing some individuals and employers to drop their health insurance coverage. Employers facing higher premiums for their employer-provided health insurance also may object to mandated benefit laws.

Nevertheless, insurers and employers' objections to federal mandated benefits legislation would likely be muted, as the Affordable Care Act imposes a cap on the actuarial value of the essential health benefits. As discussed in Part I, the scope of benefits included in the essential health benefits must equal the scope of benefits covered under "a typical employer plan." Accordingly, any legislation mandating coverage of certain health benefits would necessitate excluding other conditions and services from the essential health benefits in order to ensure that the actuarial value of the essential health benefits does not exceed the applicable threshold. The actuarial value of the essential health benefits, therefore, would remain unchanged, and insurers generally would not need to charge employers and individuals higher premiums. Consequently, insurers and employers would have little reason to oppose efforts to mandate coverage of certain benefits over others.

91. Legislators representing relatively "safe districts" may be less concerned with avoiding the loss of political support that comes from supporting legislation that imposes concentrated costs on some of their constituents. *See* Weaver, *supra* note 49, at 380 ("Legislators from relatively safe districts—whether as a result of their own leeway-building efforts, absence of party competition, or some other factor—presumably do not need to be as concerned with avoiding blame as those with only a marginal hold on office."); *see also* Croley, *supra* note 46, at 21 ("Legislators from 'safe' districts, even those who would never jeopardize their reelection prospects, have no strong incentive to satisfy all interest group regulatory demands, since the benefits of doing so would not, for them, be substantial."). However, even legislators from districts lacking two-party competition must be concerned with a primary challenge for their party's nomination. In addition, as interest groups and opposing candidates become increasingly sophisticated in generating blame, a politician's political support among his or her constituents can quickly erode. For example, negative televi-

chemotherapy with autologous bone marrow transplant (HDC/ABMT) illustrates these concerns.

C. Political Pressures at Work: The HDC/ABMT and Screening Mammogram Controversies

Emerging in the late 1980s, HDC/ABMT represented the last hope of recovery for many patients with metastatic or early stage, high-risk breast cancer.[92] However, with no randomly controlled trials supporting its clinical effectiveness, HDC/ABMT was controversial, and insurers balked at covering the expensive procedure.[93] Their coverage denials proved extremely controversial, with the controversy soon capturing the public's attention.

Recognizing that readers would be drawn into the human-interest aspect of the story, the media soon picked up on the HDC/ABMT controversy and played a central role in shaping the public debate about insurers' refusal to cover the procedure. As one commentator described it, the press generally portrayed the HDC/ABMT controversy as stories of "good versus evil":

> A young woman with advanced breast cancer . . . faces almost certain death, unless she braves a harrowing procedure, a fight for her life of Homeric proportions. While the patient played the heroine and victim, the doctor in many stories was cast in the part of a God-like figure who took the patient to the brink of death only to snatch her back with a lifesaving dose of bone marrow. The villain was not only breast cancer itself, but also the greedy insurance companies that refused to pay for the procedure.[94]

The press thereby framed the debate over HDC/ABMT as a patient's right to her choice of medical treatment in the face of unbearable suffering versus "the evil, greedy insurance industry."[95] Few in the media highlighted the procedure's exceedingly high cost or that it had not yet been proven clinically effective.[96] The public outcry generated by the media's coverage of the issue soon spilled over into the political arena.

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sion advertising criticizing an incumbent's voting record can undermine constituents' confidence in the incumbent. *See* Weaver, *supra* note 49, at 382–83. Finally, politicians from safe districts may also face pressure to avoid generating blame for their party in order to boost other party members' reelection prospects. *See id.* at 380.

92. *See* Peter D. Jacobson & Shannon Brownlee, *The Health Insurance Industry and the Media: Why the Insurers Aren't Always Wrong*, 5 HOUS. J. HEALTH L. & POL'Y 235, 237 (2005).

93. *Id.*

94. *Id.* at 248 (footnotes omitted).

95. *Id.* at 253.

96. *See id.* at 246–51 (summarizing media coverage of the HDC/ABMT controversy).

During the 1990s, several states considered whether to mandate that insurers cover HDC/ABMT.[97] Although at the time no study had proven the clinical effectiveness of HDC/ABMT—with subsequent studies confirming that the procedure is no more effective than conventional therapy[98]—discussions of the procedure's cost-effectiveness were largely missing from the legislative debates.[99] Instead, the proposals faced little opposition, as legislators feared that a vote against the proposal would be seen as a vote against the "little guy" in favor of big insurance.[100] Predictably, the vote tallies on measures mandating coverage of HDC/ABMT were extremely lopsided. For example, both houses of the Tennessee legislature passed the bill unanimously.[101] Similarly, the Virginia legislation passed unanimously in the state senate and with only one nay vote in the house.[102]

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97. For a list of all states which proposed or adopted some form of mandated coverage for HDC/ABMT, see U.S. GEN. ACCOUNTING OFFICE, COVERAGE OF AUTOLOGOUS BONE MARROW TRANSPLANTATION FOR BREAST CANCER 11 n.14 (1996). The proposals ranged from those requiring coverage for AMBT as part of "any basic package of health insurance" to those that required only that AMBT coverage be made available—possibly at a higher premium—to patients as a coverage option. *Id.* at 11.

98. *See, e.g.*, Edward A. Stadtmauer et al., *Conventional-Dose Chemotherapy Compared With High-Dose Chemotherapy Plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 NEW ENGL. J. MED. 1069, 1069 (2000); Martin S. Tallman et al., *Conventional Adjuvant Chemotherapy With or Without High-Dose Chemotherapy and Autologous Stem-Cell Transplantation in High-Risk Breast Cancer*, 349 NEW ENGL. J. MED. 17, 22 (2003).

99. *See* Jacobson & Brownlee, *supra* note 92, at 253–54 (describing the "short" debate in the Minnesota legislature over legislation to mandate coverage of HDC/ABMT, and noting that there "was little formal opposition" to the proposal, with the insurance industry "unable to present its side of the story" and the Insurance Commissioner choosing not to take a position on the legislation despite the lack of evidence of the treatment's effectiveness).

100. *See id.* (summarizing comments from interviews with state legislators and other proponents and opponents of legislation mandating coverage of HDC/ABMT).

101. TENN. GEN. ASSEMBLY, BILL INFORMATION FOR SB1523, http://wapp.capitol.tn.gov/apps/Billinfo/default.aspx?BillNumber=SB1523&ga=99 (last visited Sept. 16, 2010) (listing actions on bill and passage by 32–0 in the Senate and 97–0 in the House).

102. VA. GEN. ASSEMBLY, LEGISLATIVE INFORMATION SYSTEMS BILL TRACKING, HB240 ACCIDENT AND SICKNESS INSURANCE; BONE MARROW TRANSPLANTS, SENATE VOTE TOTAL, http://leg1.state.va.us/cgi-bin/legp504.exe?941+vot+SV0564HB0240+HB0240 (last visited Sept. 16, 2010); HOUSE VOTE TOTAL, http://leg1.state.va.us/cgi-bin/legp504.exe?941+vot+HV0327+HB0240 (last visited Sept. 16, 2010). The legislative response to the public outcry over "drive-through deliveries" also demonstrates the political difficulties of opposing mandated benefits legislation. By the mid-1990s, aggressive action on the part of managed care insurers had led to some women and their newborns being discharged from the hospital as early as twenty-four hours after delivery. States and Congress soon began directing their attention to the matter. The legislative discussions framed the issue as greedy HMOs overriding physicians' decisions and putting corporate profits above the health and safety of vulnerable mothers and their newborns. *See* David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 247 (2000). Although many researchers question the necessity of longer hospital stays postpartum, *see, e.g.*, Elaine M. Carty & Christine F. Bradley, *A Randomized, Controlled Evaluation of Early Postpartum Hospital Discharge*, 17 BIRTH ISSUES IN PERINATAL CARE 199 (1990), the emotional appeal of the issue ensured that few legislators would ignore the public's concerns.

The controversy that erupted over a federal task force's recommended changes in guidelines for breast cancer screening further illustrates the potent force political considerations will play in defining the essential health benefits. Issued just prior to the start of the Senate floor debates over healthcare reform legislation, the U.S Preventive Services Task Force (USPSTF) proposed reversing prior clinical guidelines that called for routine screening mammograms in women aged forty to forty-nine years.[103] In addition to recommending against screening mammograms in this age range, the USPSTF recommended only biennial, rather than annual, screening mammograms for women aged fifty to seventy-four years.[104] The USPSTF's recommendations were based on the task force's assessment of the clinical benefits and risks associated with routine screening mammograms.[105] Although cost was not a stated factor in the USPSTF's conclusions, others have questioned whether preexisting guidelines for screening mammograms are justified on cost-benefit grounds, noting that the guidelines issued by the American Cancer Society cost more than $680,000 for every year of life saved.[106]

The USPSTF's recommendations garnered harsh criticism from powerful interest groups, such as the American Cancer Society[107] and the American College of Radiology.[108] For example, the American College of Radiology asserted that the USPSTF's recommendations "amount to rationing" and "make unconscionable decisions about the value of human life."[109] Although some experts spoke out in support of the USPSTF's recommendations,[110] politicians paid little heed to their arguments. With claims that they were "put[ting] women first" and leaving to patients and their doctors the decision of whether

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Currently, all fifty states and Congress have enacted legislation requiring insurers to cover a minimum hospital stay for maternity care. *See* BUNCE & WIESKE, *supra* note 88, at 6.

103. U.S. Preventive Servs. Task Force, *Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement*, 151 ANNALS INTERNAL MED. 716, 716 (2009).

104. *Id.*

105. *See id.* at 717–22.

106. *See* Robert Troug, *Changing Mammography Guidelines and Insights Into Health Care Reform*, THRIVE: CHILD. HOSP. BOSTON'S HEALTH & SCI. BLOG, Dec. 1, 2009, http://childresnshospitalblog.org/changing-mammography-guidelines-and-insights-into-health-care-reform.

107. American Cancer Society, American Cancer Society Responds to Changes to USPSTF Mammography Guidelines (Nov. 16, 2009), http://ww2.cancer.org/docroot/MED/content/MED_2_1x_American_ Cancer_Society_Responds_to_Changes_to_USPSTF_Mammography_Guidelines.asp.

108. American College of Radiology, Detailed ACR Statement on Ill Advised and Dangerous USPSTF Mammography Recommendations, http://www.acr.org/MainMenuCategories/media_room/FeaturedCategories/PressReleases/UPSTFDetails.asp (last visited Sept. 16, 2010).

109. *Id.*

110. *See* Dan Eggen & Rob Stein, *Mammograms and Politics: Task Force Stirs up a Tempest*, WASH. POST, Nov. 18, 2009, at A1 (noting that many patient advocacy groups and breast cancer experts praised the USPSTF's new guidelines).

to obtain screening mammograms,[111] the Senate quickly amended their healthcare reform bill to include a provision guaranteeing coverage of annual mammograms for women age forty and over.[112]

The saga of the HDC/ABMT and mammogram controversies will likely replicate itself as the federal government moves forward with defining the essential health benefits. Rather than assuming a hands-off approach as HHS develops national coverage standards, federal lawmakers will often support efforts to mandate coverage of certain conditions or treatments in response to public or interest group pressure, no matter how misguided, for fear that opposing these efforts would alienate voters.

D. Capping Actuarial Value: An Inadequate Response

Perhaps in recognition that political pressures would encourage policymakers to continuously expand the scope of the essential health benefits, the Affordable Care Act requires that the actuarial value of the essential health benefits equal the actuarial value of the benefits covered under a typical employer plan.[113] Thus, once the actuarial value of the essential health benefits equals the actuarial value of a typical employer plan, the government cannot mandate coverage of additional conditions or therapies without removing from the essential health benefits other conditions or therapies. Consequently, the cap on the essential health benefits' actuarial value prevents policymakers from abandoning the goal of lower healthcare costs in favor of an expansive definition of essential health benefits that serves elected officials' short-term political interests.

Nevertheless, although a cap on the essential health benefits' actuarial value would limit the overall generosity of the essential health benefits, it would have little bearing on the mix of conditions and services included in the essential health benefits. The actuarial limitation will do little to deter politicians from ensuring that the essential health benefits package mandates coverage

111. *See* Press Release, U.S. Senator Barbara A. Mikulski, *Mikulski Puts Women First in Health Care Reform Debate* (Nov. 30, 2009), *available at* http://mikulski.senate.gov/record.cfm?id=320304 (announcing Sen. Mikulski's introduction of an amendment to the Affordable Care Act in order to guarantee women access to preventive healthcare screenings at no cost).

112. *See* Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 130 (2010) (amending Part A of title XXVIII of the Public Health Services Act to include new sections 2713(a)(4) and (5), requiring all group health plans and health insurance issuers offering group or individual health insurance to provide coverage for screening mammograms consistent with the guidelines issued by the Health Resources and Services Administration and the USPTF prior to its new November 2009 recommendations).

113. *Id.* § 1302(b)(2)(A) ("The Secretary shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.").

of those medical items and services that the public or powerful special interest groups desire. To ensure that these mandates do not increase the actuarial value of the essential health benefits beyond the actuarial limit, HHS would be required to exclude other conditions or services that, on the merits, may be deserving of coverage. Moreover, patients represented by groups that are poorly organized or otherwise possess little political power would disproportionately "pay" for the mandates obtained by more powerful groups. Consequently, the resulting national coverage standards will likely be weighted toward those conditions and treatments for which influential special interest groups or the public demand coverage, with the latter susceptible to flawed reasoning and manipulation by interest groups, the media, and politicians themselves.

II. A BETTER BUT INCOMPLETE ALTERNATIVE: GOVERNMENT BY COMMISSION

As discussed above, the establishment of national coverage standards thus poses a collective action problem for politicians who, for political reasons, will not pursue the course of action they believe to be in the public interest—imposing meaningful limits on healthcare based on careful deliberation of the relevant scientific, economic, and ethical considerations. In simply delegating to HHS responsibility for defining the essential health benefits, however, the Affordable Care Act fails to address this dilemma, as political considerations will cause the president and Congress to use their ordinary oversight powers to either pressure HHS to mandate coverage of certain benefits or enact legislation doing so. The Senate HELP committee's healthcare reform bill offered a potential solution to these concerns: government by commission. Unfortunately, the full Senate was denied an opportunity to debate the merits of the Senate HELP committee's approach, as the version of the health reform bill that the democratic leadership sent to the Senate floor failed to incorporate the Senate HELP committee's proposal.[114]

Government by commission entails Congress delegating to a commission responsibility for formulating policy on a specific matter, with the president and Congress having limited authority to modify the commission's recommendations.[115] Under this approach to setting national coverage standards, primary responsibility for proposing the essential health benefits would be vested in a new commission, which the Senate HELP bill named the Medical Advisory Council

114. Compare section 3103 of the Senate HELP Bill, Affordable Health Choices Act, S. 1679, 111th Cong. § 3103 (2009), to section 1302 of the Affordable Care Act, § 1302, 124 Stat. 163 (2010).

115. *See* Hanlon, *supra* note 56, at 331.

(the Council). Modeled after the Base Realignment and Closing Commission, the Council would make recommendations to the secretary of HHS regarding the conditions and services to be included in the essential health benefits,[116] subject to an actuarial value cap similar to that included in the Affordable Care Act.[117] By requiring the secretary to approve or reject the recommendations as a package and limiting the grounds on which she may reject the recommendations,[118] the secretary's influence over the recommendations would be limited. The Council's recommended essential health benefits would be submitted to Congress for its review as a "take-it-or-leave-it" proposal, with lawmakers prohibited from amending the Council's recommendations.[119] Should Congress fail to act on the Council's recommended essential health benefits (or should the president veto any congressional resolution of disapproval), the Council's recommendations would automatically become law within a specified time period after their submission to Congress.[120] In contrast to the process for setting national coverage standards established under the Affordable Care Act, then, a government by commission approach would place certain constraints on the executive and legislative branches' ordinary oversight powers.

Presumably, the Senate HELP proposal sought to curtail politicians' short-term political considerations in order to promote a more deliberative process for establishing national coverage standards. As I discuss below, this approach would take some important steps toward placing obstacles before those politicians, particularly the president and other executive branch officials, who, for purely political reasons, would substitute ill-conceived benefit mandates for the Council's recommended coverage standards. With regard to legislators, however, I ultimately argue that a government by commission approach, by itself, would be insufficient to eliminate incentives to tinker directly with national coverage standards for political gain. Thus, in Part III, I advocate an additional reform that, in

116. HELP Unamended Proposal, *supra* note 30, § 3103(a)(1). The creation of an independent commission to make recommendations to the secretary of HHS regarding the essential health benefits was also part of the HELP bill ultimately approved by the committee. *See* Affordable Health Choices Act, S. 1679, 111th Cong. § 3103(b) (2009) (establishing the National Independent Commission on Essential Health Care Benefits).

117. HELP Unamended Proposal, *supra* note 30, § 3103(h)(2) ("In establishing the essential health care benefits described in paragraph (1)(A), the Council shall ensure that the actuarial gross value of the benefits is equal to the actuarial gross value of the benefits provided under a typical employer plan, as determined by the Secretary."); Affordable Care Act, § 1302(b)(2)(A) ("The Secretary shall ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.").

118. For example, the Senate HELP proposal would have authorized the secretary to request revisions to the Council's recommendations only if she determined that they lacked "scientific and medical validity." HELP Unamended Proposal, *supra* note 30, § 3103(e).

119. *Id.* § 3103(g).

120. *Id.*

conjunction with establishing the Council, would reduce the influence of politically motivated legislators in the year-to-year setting of the essential health benefits.

A. Benefits of Insulation From the Executive

For the reasons discussed above,[121] political considerations may motivate the president (or the political appointees acting on his behalf) to insist on national coverage standards that would minimize public outcry or elevate the narrow interests of one or more groups. A government by commission approach, if structured properly, would place important limitations on the executive branch's influence on the Council's recommendations. First, a government by commission framework typically restricts the president and his political appointees' ability to demand changes to a commission's recommendations so as to better reflect the president's preferences. For example, the Senate HELP bill authorized the secretary of HHS to request revisions to the Council's recommendations only if she determined that they lack "scientific and medical validity."[122] Under this limitation, if the Council proposed to exclude certain self-inflicted conditions from the essential health benefits because it concluded that priority should be given to unavoidable illnesses, the secretary could not reject the Council's proposal simply because she or the president disagreed with its guiding principle (or feared a political backlash from those seeking to mandate coverage of the excluded conditions). Second, a government by commission framework could provide for staggered terms for commission members,[123] which would further promote the Council's independence from the president by ensuring that some members were appointed by other presidents.[124]

Finally, limiting the president's power to remove the Council's members at will would substantially reduce his supervisory authority over the Council. The president's removal power enables him (or his designees) to influence political appointees such as commission members by threatening to remove from office those who do not to conform to the president's wishes.[125] Although the political

121. *See supra* Part I.

122. HELP Unamended Proposal, *supra* note 30, § 3103(e).

123. For example, the Senate HELP proposal would have provided for three-year staggered terms for Council members. *See id.* § 3103(b)(2).

124. *See* Paul R. Verkuil, *The Purposes and Limits of Independent Agencies*, 1988 DUKE L.J. 257, 260 ("The term . . . of years requirement complements the desire for independence by establishing staggered terms that usually extend beyond a President's four-year term.").

125. *See* Mark Seidenfeld, *A Civic Republican Justification for the Bureaucratic State*, 105 HARV. L. REV. 1511, 1553, 1573 (1992). *See also* Kagan, *supra* note 43, at 2298 (observing that agency officials may accede to a president's preferences "because they respect and fear his removal power"); Nina A. Mendelson, *Agency Burrowing: Entrenching Policies and Personnel Before a New President Arrives*, 78 N.Y.U.

costs of exercising the removal power somewhat limit the effectiveness of this tool, history suggests it nevertheless represents a real source of presidential control over political appointees.[126] In the absence of any limitation on the president's removal power, then, the Council may accede to pressures to shape the essential health benefits so as to further the president's political objectives.[127] Establishing the Council as an independent commission, however, would protect Council members who resist the executive's demands. Thus insulated from the electoral considerations driving the president's agenda, the Council would be free to engage in more expert decisionmaking based on empirical data and reasoned analysis.[128]

B. Benefits (and Limitations) of Insulation From Congress

In addition to insulating the process for defining the essential health benefits from presidential politics, government by commission also has the potential to minimize the impact of legislators' short-term electoral considerations by restructuring the manner in which Congress oversees the process. When effective, government by commission can serve as a precommitment device that binds legislators, "Ulysses-like, to a particular goal or principle and prevent[s them] (and future Congresses) from answering the Siren call of short-term, self-interested politics."[129] For the reasons discussed below, however, the government by commission framework would fail to affect the substantive outcome of the process for defining the essential health benefits. Instead, legislators' political self-interest would continue to play an important role in promoting an essential health benefits definition that reflects the values of more powerful interest groups and public opinion.

L. REV. 557, 581 (2003) (noting that the president "can . . . hold an executive branch agency accountable through the power to replace top management of an agency").

126. *See* Kagan, *supra* note 43, at 2274.

127. *See* Geoffrey P. Miller, *Introduction: The Debate Over Independent Agencies in Light of Empirical Evidence*, 1988 DUKE L.J. 215, 216–17 ("[A]ny substantial limitation on the removal power necessarily reduces the supervisory authority of the person exercising the power."); Verkuil, *supra* note 124, at 260 ("[T]he limitation of removal to designated causes ensures that a President will not be able to discipline an official for purely political reasons, or for no reason at all.").

128. *See* Marshall J. Breger & Gary J. Edles, *Established by Practice: The Theory and Operation of Independent Federal Agencies*, 52 ADMIN. L. REV. 1111, 1131 (2000).

129. Anita S. Krishnakumar, *Representation Reinforcement: A Legislative Solution to a Legislative Process Problem*, 46 HARV. J. ON LEGIS. 1, 16 (2009).

1. A Successful Precedent: The Base Realignment and Closure Commission

The Senate HELP proposal modeled the Council after the Defense Base Realignment and Closure (BRAC) Commission, one of the most successful government commissions.[130] The BRAC was conceived in the period immediately following the Cold War, when members of Congress and the Department of Defense generally agreed that numerous bases were obsolete and should be closed in order to reduce defense spending. Congress, however, was unwilling to vest control over base closures in a Department of Defense that had lied to and withheld information from legislators regarding previous base closure decisions, and had proposed base closings and realignments that were perceived as politically motivated decisions.[131] Instead, members of Congress sought to retain significant control over base closing decisions. Congress, however, was unable to reach consensus about which bases should be closed given the issue's high political stakes.[132] With military bases often providing thousands of jobs, their closure could cause severe economic contraction for a local economy.[133] Individual legislators understandably feared that the loss of a local military base could generate blame and accusations of incompetence from their constituents, and ultimately could end the legislator's congressional career.[134] The closing of military bases, therefore, was "among the most entrenched of pork barrel issues,"[135]

130. Defense Authorization Amendments and Base Closure and Realignment Act, Pub. L. No. 100-526, 102 Stat. 2623 (1988); *see* Hanlon, *supra* note 56, at 334 (describing the BRAC as a successful application of the government by commission approach to governance).

131. *See* Elizabeth Garrett, *The Purposes of Framework Legislation*, 14 J. CONTEMP. LEGAL ISSUES 717, 760 (2005) (discussing legislators' distrust of the Department of Defense's actions regarding base alignment and closures); Kenneth R. Mayer, *Closing Military Bases (Finally): Solving Collective Dilemmas Through Delegation*, 20 LEGIS. STUD. Q. 393, 398–99 (1995) (explaining the Department of Defense's history of politically motivated base closing decisions and Congress's ensuing refusal to grant the Department control over which bases would be closed). For example, in his 1991 fiscal year defense budget request, Defense Secretary Richard Cheney's proposed list of base closures primarily included bases in Democratic districts, with most of the job gains resulting from proposed realignment occurring in Republican districts. *See id.*

132. *See* Krishnakumar, *supra* note 129, at 22 (explaining Congress's collective inability to target specific military bases and installations for closing).

133. *See* Mayer, *supra* note 131, at 396.

134. *See* Hanlon, *supra* note 56, at 334 (stating that legislators face a continuing duty to protect military bases in their home district or state, as adverse decisions may suggest incompetence or lack of interest in their constituents); Mayer, *supra* note 131, at 396 ("The conventional wisdom holds that base closures end congressional careers, and few legislators are willing to sacrifice themselves.").

135. Hanlon, *supra* note 56, at 333.

with debates on the matter characterized by logrolling and other political deals. By the mid-1980s, attempts to close bases had come to a standstill.[136]

Congress's solution to this collective action problem was to establish an independent commission of experts tasked with making recommendations as to which military bases should be closed or consolidated.[137] The original base closure statute departed from the ordinary rules governing presidential and congressional oversight of agency action. First, the base closure rules limited the executive branch's influence by requiring the secretary of Defense to approve or reject the Commission's recommendations in their entirety.[138] Second, once approved by the secretary, the recommendations were presented to Congress in their entirety as a "take-it-or-leave-it" proposal, with members prohibited from amending the BRAC Commission's recommendations.[139] Third, the statute provided for a silent approval mechanism, with the BRAC Commission's recommendations automatically becoming law within forty-five days after their submission to Congress unless Congress affirmatively rejected the recommendations through a joint resolution passed by both houses, subject to the president's veto.[140] Subsequent iterations of the Defense Base Closure and Realignment Act continued this framework, with the exception of subjecting the BRAC Commission's recommendations to the approval of the president, rather than the secretary of Defense.[141]

Overall, the BRAC Commission framework has proven successful. Since 1990, four BRAC Commissions have submitted recommendations to the executive branch and Congress. Although legislators representing the districts or states with a base slated for closure typically lobbied their congressional colleagues to reject the BRAC Commissions' recommendations, their efforts failed all four times.[142] In stark contrast to the paralysis that plagued the base closure process prior to creation of the BRAC Commissions, since 1990, over 125 major military facilities and 225 minor military bases and installations have been slated for closure, with realignment of 145 others.[143] The process thus proved an effective precommitment device that allowed Congress to achieve its

136. *See* Mayer, *supra* note 131, at 394 (commenting that prior to the establishment of the first BRAC Commission, the Department of Defense had given up trying to close any major bases).

137. *See* Defense Authorization Amendments and Base Closure Realignment Act, Pub. L. No. 100-526, 1001 Stat. 2623 (1988).

138. *See id.* § 202(a)(1).

139. *See id.* § 208.

140. *See id.* § 202(b).

141. Defense Closure and Realignment Act of 1990, Pub. L. No. 101-510, § 2903(e), 104 Stat. 1485 (1990).

142. *See* Garrett, *supra* note 131, at 726 (commenting that all four rounds of recommendations by the BRAC Commission that have been sent to Congress survived the process).

143. *See* Krishnakumar, *supra* note 129, at 23.

overall objective—the realignment and closing of unnecessary and obsolete military bases.

2. Benefits of Government by Commission

As the success of the BRAC Commission illustrates, government by commission may serve to entrench certain macro objectives, thereby increasing the likelihood that future policy decisions will be consistent with the desired outcome.[144] First, voting on a commission's recommendations as a package, with amendments disallowed, reduces opportunities for dealmaking that serve individual lawmakers' electoral interests at the expense of the general public. For example, if Congress had retained the right to revise the BRAC Commission's recommendations, the pork barrel politics that had previously stymied efforts to close and realign bases would have returned with full force upon Congress's consideration of the Commission's recommendations.[145] Second, a silent congressional approval mechanism allows Congress to implicitly approve a commission's recommendations without bringing the commission's recommendations to the House and Senate floor for a vote. In the case of base closures, this feature lowered the political risks to members of Congress representing affected districts, as they credibly could claim that they did not take any direct action that adversely affected their constituents or interest group supporters. Finally, passage of a joint resolution rejecting a commission's recommendations typically requires a two-thirds vote, as a president who must accept a commission's recommendations before submitting them to Congress is likely to veto any such resolution. For the opponents of a BRAC Commission's recommendations, this procedural hurdle proved insurmountable, as there was no realistic chance of overturning a BRAC Commission's recommendations with more than one-third of representatives and senators breathing a collective sigh of relief that the bases in their districts or states had been spared. Thus, by changing Congress's internal procedures, government by commission makes it more difficult for legislators collectively to depart from an end objective they generally support.

Incorporating these same features into a proposal to delegate to a commission responsibility for formulating national coverage standards would raise similar barriers to counter legislators' incentives to defect from the collective goal of

144. *See* Garrett, *supra* note 131, at 748 (discussing how framework statutes sometimes seek to entrench certain outcomes).

145. *See* Mayer, *supra* note 131, at 397 ("In the case of base closings, if Congress reserved the right to add or delete bases from the commission's list, the process would represent no improvement over the existing system, which had resulted in deadlock.").

placing fair limits on healthcare. A proposal to ban amendments to the Council's recommendations, for example, would mean that those legislators wishing to alter the Council's proposed coverage standards would be unable to do so. In addition, a silent congressional approval mechanism would lower the political costs of implementing the Council's proposed coverage policies, as it would allow Congress to avoid a direct vote on the Council's recommendations. Finally, government by commission would raise the transactional costs facing legislators opposing the Council's recommendations, who not only must convince their congressional colleagues to bring the recommendations to the floor of both chambers for a vote, but also would have to marshal a 2/3 vote in both houses if a presidential veto appeared likely. These features would make it more likely that Congress would allow the Council's proposed essential health benefits to take effect without modification.

3. Limitations of Government by Commission

Despite these advantages of the government by commission framework, not all commissions have proven successful precommitment devices. Although the government by commission framework increases the likelihood that lawmakers will put aside their short-term electoral interests in favor of their collective policy objectives, it will not completely erase the specter of politically motivated behavior. The controversial history of the Quadrennial Pay Commission illustrates that members of Congress will reject a commission's recommendations when under intense political pressure to do so. Congress established the Quadrennial Pay Commission in order to distance itself from a highly politically charged decision—its own pay raises.[146] Similar to the base closing process, the Quadrennial Pay Commission was designed to deflect blame away from members of Congress by allowing the Commission's recommendations (as modified by the president) to take effect automatically, unless Congress enacted either a joint resolution of disapproval or legislation establishing alternative salaries.[147] Although this process allowed members of Congress to avoid a direct vote on their own pay raises, over the course of two decades Congress repeatedly

146. The Quadrennial Pay Commission was created under the Postal Revenue and Federal Salary Act of 1967. Pub. L. No. 90-206 § 225, 81 Stat. 613, 642; amended by Pub. L. No. 99-190, 99 Stat. 1185 (1985). The commission was required to report to the president recommended salary increases for members of Congress, as well as for the federal judiciary and high level executive branch officials, and the president was then to submit his recommend salary increases to Congress in the next fiscal year's budget. *Id.* § 225(g), 81 Stat. at 644. The commission reported recommendations approximately every four years, from 1969 through 1989. *See* SHARON S. GRESSLE, CONG. RESEARCH SERV., COMMISSION ON EXECUTIVE, LEGISLATIVE, AND JUDICIAL SALARIES: AN HISTORICAL OVERVIEW 1 (1989).

147. *See* Postal Revenue and Federal Salary Act of 1967 § 225(i).

overruled the recommendations in response to public pressure to do so.[148] In 1989, Congress finally abandoned the Quadrennial Pay Commission and instead linked congressional pay raises to the annual cost-of-living adjustment applicable to salaries for civil service federal employees.[149] For the reasons discussed below, similar political incentives would lead Congress either to reject the Council's coverage recommendations as a package or, more likely, to undo those coverage exclusions that prove controversial with subsequent overriding legislation.

The effectiveness of government by commission as a precommitment device depends in part on whether supporting or overriding a commission's recommendations present credit-claiming opportunities for politicians. An important difference between the BRAC and Quadrennial Pay Commissions lies in the degree to which the public supported their respective missions. In the case of the BRAC Commission, the public generally supported efforts to close obsolete and unnecessary military bases.[150] The burgeoning deficit and a defense budget perceived as bloated also added a sense of urgency to the issue.[151] Consequently, legislators who supported the BRAC Commission's recommendations could claim credit with their constituents for supporting a fiscally responsible policy. In contrast, the Quadrennial Pay Commission's recommendations addressed an issue few among the general public viewed as important—raising the salaries of public officials in order to attract high caliber people into public service.[152] In fact, raising congressional pay was counter to concurrent efforts to reduce the deficit by cutting government spending.[153] With constituents overwhelmingly responding negatively, legislators' attempts to claim credit for supporting pay raises intended to recruit talented public servants would have fallen on deaf ears.[154]

As with supporting congressional pay raises, supporting controversial coverage exclusions that a Council might propose would present politicians with few, if any, credit-claiming opportunities. The Council would serve a dual mission—establishing minimum coverage standards to ensure that all plans offer adequate coverage, but also setting limits on that coverage in order to contain costs. While the public may generally support the latter goal of controlling

148. *See* GRESSLE, *supra* note 146, at 39, 47–60 (stating that Congress rejected the recommended salary increases in fiscal years 1973 and 1981); Hanlon, *supra* note 56, at 343 (discussing the rejection of the Quadrennial Pay Commission's fiscal year 1989 recommendations).

149. Ethics Reform Act of 1989, Pub. L. No. 101-194, 103 Stat. 1716.

150. *See* Hanlon, *supra* note 56, at 344 (discussing the political mandate for base closings).

151. *See id.*

152. *See id.* (discussing the lack of public mandate to raise congressional salaries).

153. *See id.*

154. *Cf. id.* at 343 (stating that the negative response of constituents to a congressional pay raise led Congress to reject the recommendations by a vote of 380 to 48 in the House and 94 to 6 in the Senate).

healthcare costs, for the reasons discussed in Part I.A, many would adamantly object to limits on health coverage as the means for doing so. Many of the Council's recommended limits on coverage, therefore, would generate little if any public support. Legislators who support the Council's coverage exclusions thus would get little credit from their constituents for doing something about rapidly rising healthcare costs. Moreover, not only would supporting the Council's proposed coverage exclusions present few credit-claiming opportunities for politicians, but the opposite would be true. Specifically, championing legislation mandating coverage for certain treatments would present an opportunity for politicians to build political capital among their constituents who support the mandate, as well as among those special interest groups who would benefit directly from its passage. With legislators unlikely to gain politically from adopting the Council's more controversial recommendations, many would be tempted to defect from the collective goal of placing meaningful and fair limits on healthcare.

The success of government by commission also depends on whether it allows members of Congress to avoid blame for unpopular policies. The success and failure of the BRAC Commissions and the Quadrennial Pay Commission, respectively, largely can be explained by differences in their effectiveness in deflecting blame away from lawmakers. In the base closing context, the political pain imposed by the BRAC Commissions' recommendations was limited to those districts with bases slated for closure. Consequently, only a few legislators faced pressure to oppose a BRAC Commission's recommendations. With the majority of congressional members free to vote in favor of a BRAC Commission's recommendations without fear of electoral repercussions, members from affected localities could visibly advocate on behalf of their districts even though their efforts were certain to fail.[155] These members thus could credibly "portray themselves as protectors of local interests"[156] and thereby avoid blame for their district's base closure.[157] In contrast to the geographically isolated pain resulting from base closures, congressional pay raises affected all taxpayers.[158] The pay raise issue consequently generated a nationwide backlash against "an irresponsible

155. *See* Mayer, *supra* note 131, at 406 (describing the opportunities afforded members from affected districts to advocate on behalf of their constituents).

156. *Id.*

157. *See id.* at 405 ("Members protected themselves by first, making it difficult for voters to blame their representatives for any local base shut-down (obscuring the causal chain); [and] second, establishing a mechanism that allowed the affected representatives and senators to act as advocates for their constituents, rather than as the bearers of bad news . . . .").

158. *See* Hanlon, *supra* note 56, at 344 (comparing the political impact of base closing and congressional pay raise decisions).

Congress" attempting "to vote raises for themselves."[159] The Quadrennial Pay Commission thereby failed as a mechanism to lower the political risks of congressional pay raises by deflecting blame away from legislators, leading legislators to readily abandon their collective goal of raising congressional salaries.[160]

As with the congressional pay issue, members of Congress may find themselves unable to successfully avoid blame for the more controversial aspects of the Council's recommendations. The Council's recommended coverage exclusions would have the potential to harm constituents in every state and district. As discussed previously, many health plans throughout the country would cover only those conditions and services included in the essential health benefits, with coverage denied for those conditions and services omitted from the federal standards.[161] Consequently, the Council's recommended exclusions would indirectly cause detriment to those patients seeking reimbursement for conditions and therapies excluded from the essential health benefits. Patients throughout the country who are denied coverage of desired treatments may look to Congress to "do something" in their battle against "greedy" health insurers.[162] Healthcare providers, hospitals, drug and medical device manufacturers, and others who lose economically when insurers refuse to pay for care would similarly pressure members of Congress to expand the scope of the essential health benefits.[163] Every legislator, therefore, would face potential political blame for ignoring the pleas of patients and special interest groups seeking mandated benefits legislation.

Finally, those who believe that modeling the Council after the BRAC Commission would effectively check lawmakers' short-term political considerations fail to recognize an important distinction between setting national coverage standards and base closings—lawmakers' willingness to revisit the Council or BRAC Commission's recommendations. Although the Council's recommendations, like the BRAC Commissions', would be subject to an up-or-down vote without amendment, nothing automatically forecloses Congress from subsequently reversing one or more of either commission's recommendations. In the base closing context, however, Congress is unlikely to do so. As noted above, lawmakers who do not represent districts with bases that the BRAC Commission slates for closure would have little interest in revisiting the Commission's recommendations once approved. Moreover, once the BRAC

159. *Id.* at 344.

160. *See id.* at 343 (noting that Congress repeatedly rejected the recommendations of the Quadrennial Pay Commission).

161. *See supra* notes 5–9 and accompanying text.

162. *See supra* Part I.A.

163. *See supra* Part I.B.

Commission's recommended base closings take effect, reopening a previously closed base may not be feasible. In practice, then, the BRAC Commission's base closing recommendations generally constitute one-time, irreversible policy decisions.

In contrast to the base closing context, lawmakers would have strong political incentives to revisit the individual coverage standards established by the Council, with few practical barriers to doing so. Whereas overriding a recommendation of the BRAC Commission to close a particular base would provide no electoral benefit to most lawmakers, mandating coverage of a particular health benefit could provide political dividends to most, if not all, lawmakers, particularly if the benefit's exclusion from the essential health benefits proved controversial. Moreover, the requirement that Congress consider the Council's recommendations as a package would not foreclose Congress from enacting legislation constraining the Council's discretion with respect to future recommendations. For example, if the Council excluded IVF treatments from the essential health benefits, members of Congress could simply enact legislation mandating their inclusion for future plan years if doing so would provide lawmakers with a popular legislative achievement to show voters or their special interest group supporters. Lawmakers could also duck responsibility for the adverse consequences of any mandate by delegating to the Council the dirty work of identifying alternative conditions or treatments for exclusion in order to ensure that the essential health benefits do not exceed the maximum actuarial value. Consequently, in the face of intense pressure from the public and special interest groups to mandate coverage of certain conditions or services, lawmakers most likely would do so.

For these reasons, the government by commission framework would ultimately prove an ineffective precommitment device. Because lawmakers would retain the authority to alter the Council's coverage standards, they would likely face the same collective action problems that motivated adoption of the government by commission framework in the first place, with their collective dilemma merely shifted to a later stage in the policymaking process. Creating an independent commission to establish national coverage standards, then, would be insufficient by itself to lessen the influence of political considerations on the shape of the essential health benefits.

III. RESOLVING THE COLLECTIVE ACTION PROBLEM OF COVERAGE MANDATES: AN ACTUARIAL OFFSET REQUIREMENT

This Part proposes an additional solution for countering lawmakers' incentives to shape the essential health benefits so as to advance their political objectives—a procedural rule that would require that any mandated benefits legislation be budget-neutral (or lower healthcare costs). Specifically, my proposal would allow lawmakers to mandate that health plans cover certain benefits; however, rather than leaving it to the Council to offset any benefits mandate by excluding other conditions or services from the essential health benefits, my proposal would require that lawmakers *themselves* do so.

The collective action concerns motivating the Senate HELP proposal to insulate the Council from political influence parallel the collective action problems that plague the federal budgeting process. Lawmakers seeking to elevate their reelection prospects often favor enacting or expanding popular federal programs or lowering taxes in order to gain credit with their constituents.[164] Rather than raising funds to pay for these programs or tax cuts, however, lawmakers instead often pay for these programs or tax cuts through deficit spending, thereby spreading the burden of financing current government programs to future taxpayers.[165] This dynamic leads to higher levels of deficit spending than many legislators consider optimal, and yet collectively they "cannot withstand the temptation, no matter what their other values and no matter what their partisan affiliation."[166]

To overcome this collective dilemma, Congress has turned to various devices designed to restructure its decisionmaking process, including "pay-as-you-go" budgetary rules (PAYGO). PAYGO rules require that any new tax legislation or direct spending[167] enacted by Congress be revenue-neutral; that is, the legislation cannot cause the federal government to lose more money than it

164. *See* Elizabeth Garrett, *Framework Legislation and Federalism*, 83 NOTRE DAME L. REV. 1495, 1514 (2008).

165. *See id.* at 1514.

166. *Id*. *See also* Cheryl D. Block, *Pathologies at the Intersection of the Budget and Tax Legislative Processes*, 43 B.C. L. REV. 863, 879 (2002) ("Given the natural inclination of lawmakers to want to provide programs to constituents, it might be easy for legislators to ignore their previous decisions on macrobudgetary objectives when the time comes to consider microbudgetary considerations on individual programs.").

167. Under current law, PAYGO rules do not apply to discretionary spending or to changes in indirect spending and revenue levels resulting from changes in the economy, demographic trends, and other factors. *See* ROBERT KEITH, PAY-AS-YOU-GO PROCEDURES FOR BUDGET ENFORCEMENT 1 (2007). Nor do they apply to proposed legislation that would impose costs on private entities, individuals, or other third parties, but would not raise federal spending or reduce federal revenues. *See id*.

gains.[168] The zero-sum nature of the offset requirement thereby discourages the enactment of legislation expected to increase the federal deficit.[169] To facilitate compliance with the PAYGO rules, the Congressional Budget Office develops a cost estimate, or "score," for any new tax legislation or direct spending.[170] Although the PAYGO rules have not achieved their underlying objectives in all cases, observers believe that the PAYGO rules have resulted in reduced levels of new federal spending.[171]

I believe a congressional rule requiring lawmakers to consider the impact of mandated benefits legislation would similarly affect the dynamics and substantive output of the process for establishing national coverage standards. Specifically, this Article proposes that Congress adopt a rule of procedure requiring lawmakers to ensure that the net effect of any legislative modification to the essential health benefits either be actuarially neutral or lower costs, with the actuarial value of the essential health benefits for a plan year either remaining unchanged or decreasing.[172] In other words, should lawmakers mandate that the essential health benefits include certain conditions or medical services, they must also offset any such mandate by excluding conditions or services that would otherwise be included in the essential health benefits. This rule would apply to both proposed amendments to the Council's recommended essential health benefits

168. *See id.*; Elizabeth Garrett, *Harnessing Politics: The Dynamics of Offset Requirements in the Tax Legislative Process*, 65 U. CHI. L. REV. 501, 510 (1998). The PAYGO rules were originally codified in the Budget Enforcement Act of 1990, title XIII, Pub. L. No. 101-508, 104 Stat. 1388–573 (1994) (codified as amended at 2 U.S.C. § 902 (2006)). The statutory PAYGO provisions expired in 2002. However, each chamber of Congress has incorporated the PAYGO rules into their internal rules of procedure. Section 201 of the FY 2008 Budget Resolution, S. Con. Res. 21, 110th Cong. (2008); Rules of the House of Representatives, § 1068e (2009).

169. *See* Garrett, *supra* note 168, at 514.

170. *See* Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, 88 Stat. 297.

171. *See* Rudolph G. Penner, *Can Congress Use Budget Rules to Improve Tax Policy?*, TAX NOTES, Oct. 23, 2006, at 377 (noting that the PAYGO rules worked "extremely well" until a budget surplus emerged in 1998).

172. Scholars critical of the PAYGO rules often bemoan Congress's use of timing and accounting gimmicks to ensure that proposed legislation complies with PAYGO's requirements. For example, lawmakers may provide for a delay in the imposition of the legislation's costs to future years outside the relevant budget window, in which case the costs need not be offset with an increase in revenue. *See* Block, *supra* note 166, at 864. Congress also uses cash-flow, rather than present-value accounting, which allows Congress not to take into account future costs until actually incurred, rather than assessing the present value of anticipated future costs. *See id.* at 864–65. These gimmicks would be less available to Congress under my proposal. Because mandated benefits legislation may not increase the actuarial value of the essential health benefits for *a plan year*, the mandated benefit and offsetting benefit exclusion would apply simultaneously. In other words, Congress could not offset the costs of mandating coverage of a particular benefit for the current or forthcoming plan year by excluding other benefits from future plan years, as this would increase the actuarial value of the essential health benefits for the current or forthcoming plan year.

and standalone mandated benefits legislation. My proposal thus would build on the actuarial value requirement included in both the Affordable Care Act and the Senate HELP bill, but rather than allow lawmakers to delegate to HHS or the Council the difficult task of figuring out how to offset the costs of mandated benefits legislation, my proposal would require lawmakers themselves to do so. In addition, any standalone mandated benefits legislation that would apply to future plan years would be subject to a sunset provision providing for the automatic cessation of the legislation after a specified time period unless reauthorized by Congress. A sunset provision thus would require lawmakers to reconsider the merits of mandating or excluding from coverage certain benefits in light of changing clinical evidence and treatment costs. Any extension or renewal of mandated benefits legislation would be subject to the actuarial requirement proposed above, with the law's impact on the essential health benefits continuing to be either actuarially neutral or lowering the actuarial value of the essential health benefits. I refer to this legislative framework as an actuarial offset rule.

In obligating legislators to consider the costs associated with new or renewed coverage mandates, an actuarial offset rule would make it more difficult for Congress to amend the Council's proposed coverage standards or enact or extend mandated benefits legislation designed to advance their short-term political interests. Specifically, an actuarial offset rule would change the political dynamics and cost of mandated benefits legislation by (1) promoting informed deliberations that take full account of a mandate's costs; (2) weakening the influence of special interest groups; and (3) raising the transaction costs of modifying the Council's recommendations by placing a procedural hurdle in the path of those advocating mandated benefit legislation or amendment to the Council's recommendations.

A. Promoting More Informed Deliberations

An actuarial offset rule would encourage more informed deliberations regarding the costs and benefits of a legislative proposal to mandate coverage of certain conditions or medical services. Many lawmakers may share the public's fiscal illusion that mandating coverage of certain benefits will have little impact on overall healthcare costs. Alternatively, they may underestimate the cost of a particular mandate. If lawmakers are allowed simply to delegate responsibility for actuarial considerations to the Council, they may never develop a full sense of the cost of a mandated benefit or amendment to the Council's recommendations. An actuarial offset requirement would remedy this situation both by producing information for lawmakers about the costs of a specific coverage

mandate, and by obligating lawmakers to consider these costs. With heightened awareness of the trade-offs inherent in any coverage mandate, lawmakers might be forced to engage in more informed deliberations over proposals to mandate specified benefits or amend the Council's recommendations.[173]

B. Reducing the Influence of Special Interests

While additional information on the policy impact of a proposed coverage mandate may encourage more informed decisionmaking on the part of some lawmakers, for those lawmakers primarily concerned with the political ramifications of their actions, this information may do little to diminish their support for a mandate favored by their constituents or special interest groups. Nevertheless, an actuarial offset rule would counter lawmakers' electoral incentives to support mandated benefits legislation or an amendment to the Council's recommendations by increasing the political transaction costs for enacting such legislation or amendment.

Similar to the PAYGO rules, an actuarial offset requirement would weaken pressures on lawmakers to promote coverage mandates favored by special interest groups by changing the dynamics of special interest politics. As Elizabeth Garrett explains, PAYGO rules check interest group pressure for tax subsidies or spending programs in several ways. First, PAYGO rules raise the cost of obtaining these benefits. PAYGO rules allow lawmakers to turn down requests for new tax subsidies or spending programs unless the requesting interest group identifies an offsetting tax increase or spending cut.[174] Special interest groups therefore must invest time and effort in identifying promising offsets so that their request is revenue-neutral.[175] An actuarial offset requirement would similarly require those advocating legislation or an amendment that would mandate coverage of a particular benefit to identify offsetting exclusions from the essential health benefits. In addition, the requirement that any standalone mandated benefits legislation include a sunset provision would raise the costs of

173. *Cf.* Garrett, *supra* note 164, at 1513 ("The hope is that [under the Unfunded Mandates Reform Act (UMRA)] better informed lawmakers will not pass as many laws that burden states and localities with unfunded mandates; the argument is that legislators are well-intentioned but through ignorance pass laws that they would prefer not to.").

174. *See* Krishnakumar, *supra* note 129, at 15 n.60 (explaining that PAYGO rules serve to check interest group pressures on members of Congress).

175. *See* Garrett, *supra* note 168, at 517 (explaining that advocates of new or expanded spending "must invest resources in identifying a promising offset").

obtaining mandated benefits legislation, as those desiring a mandate would have to lobby not only for its initial enactment, but also for its repeated extension.[176]

Second, the PAYGO rules intensify and institutionalize conflict among interest groups by requiring those seeking new federal spending or tax subsidies to target existing spending valued by other groups. Often these latter groups fight vigorously to protect their existing benefits, with their efforts counterbalancing the lobbying by groups seeking new benefits.[177] Lawmakers thus are often less than receptive to requests for new spending or tax cuts. To the extent that groups advocating for mandated coverage of certain health benefits target as offsets conditions or services valued by other groups, their efforts likewise would generate opposition from other groups.[178] The actuarial offset rules may similarly dampen lawmakers' support for new benefit mandates or extension of existing mandates, as they may fear the political repercussions from those who value the proposed offsets.

A group seeking mandated coverage of a desired condition or service could potentially avoid vigorous opposition from those defending the targeted offset if they target benefits considered weak prey.[179] While certain conditions and services included in the essential health benefits would be fiercely defended by well-organized and wealthy groups, the groups defending others may be disorganized or otherwise lack political influence. In the latter case, lawmakers may pay little if any political price for excluding these benefits from the essential

176. *See* Rebecca M. Keysar, *The Sun Also Rises: The Political Economy of Sunset Provisions in the Tax Code*, 40 GA. L. REV. 335, 365–66 (2006) (discussing the costs for interest groups that must continue to engage in lobbying for extension of legislation subject to sunset provisions).

177. *See* Garrett, *supra* note 168, at 519–25 (discussing the opposition generated by proposed offsets under the PAYGO rules).

178. In his review of CMS's process for determining coverage policies for new medical technologies under Medicare, Timothy Jost observes that although the process is open to everyone, not once during the studied timeframe did anyone appear before CMS to oppose coverage of a new technology. *See* Timothy Stoltzfus Jost, *The Medicare Coverage Determination Process in the United States*, *in* HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY 230 (Timothy Stoltzfus Jost ed., 2005). One might argue that a similar pattern will play out under my proposed actuarial offset rule, with only the voices of those supporting mandated coverage of a benefit echoing through the halls of Congress. However, this argument overlooks a fundamental distinction between the Medicare coverage process and the actuarial offset rule. In the Medicare context, the decision to cover a new technology represents an *expansion* of Medicare coverage, so that groups concerned about protecting current Medicare benefits have no reason to oppose decisions to cover new technologies under Medicare. In contrast, the cap on the actuarial value of the essential health benefits means the government cannot mandate coverage of additional conditions or therapies without eliminating coverage of other conditions or therapies, so any campaign to include a new benefit likely will generate opposition from groups seeking to protect currently included benefits that may be targeted as offsets.

179. *See* Garrett, *supra* note 168, at 519 (noting that under the PAYGO rules, groups may be able to avoid vigorous opposition to their attempts to obtain new federal spending or tax cuts by choosing as an offset a program or subsidy "that benefits the relatively needy, rather than an expenditure that benefits organized and wealthy economic interests").

health benefits, with any political costs outweighed by the political benefits of mandating coverage of a condition or service desired by more powerful groups. The resulting essential health benefits thus may tilt in favor of those conditions and services backed by the politically influential, rather than reflecting a fair and balanced consideration of all patients' interests. However, there are several reasons to believe that in the battle to influence the shape of the essential health benefits, the scenario of powerful groups dominating over those with less influence would prove the exception, not the rule.

First, powerful special interest groups would still face significant political obstacles when seeking new mandated benefits. For starters, it may be difficult for special interest groups to discern whether targeting a particular condition or medical service would produce strong or weak opposition.[180] Second, if the group identifies an offset that is unlikely to generate much resistance, other groups seeking a benefit mandate may seize on the targeted offset to pay for their own mandate requests.[181] Finally, groups defending the status quo have important advantages over those seeking new mandated benefits legislation, as it is easier to block legislation than promote its enactment.[182] Proposed legislation typically must be reported out of the various congressional committees with jurisdiction over the legislation's subject matter, be placed on the House and Senate calendar, survive any filibuster in the Senate, and be passed by both the House and Senate[183] before the president signs it. In the event of a presidential veto, the bill must receive the vote of two-thirds of the members of each chamber.[184] Accordingly, groups defending benefits targeted as offsets for new mandated benefits would only need to prevail at one of these stages in order to protect their interests, whereas proponents of new mandated benefits must successfully navigate each stage of the legislative process.[185] These political realities thus would neutralize many of the advantages powerful groups possess over weaker groups, making it more difficult for the former to obtain new benefit mandates at the expense of the latter.

180. *See id.* at 521 ("[I]t can be difficult to discover which and how many interest groups are concerned about a particular benefit, so an offset proposal may provoke unexpectedly strong opposition.").

181. *See id.* at 524 ("[E]ven if a group finds a weakly defended target to use as an offset [under PAYGO rules], it has no enforceable property rights in its discovery. It must be prepared to defend the offset against other predators who might seek to use it to pay for their own new benefits.").

182. *See id.* at 522 (noting that even if a new federal program "is supported by an established group or coalition, it is generally easier to oppose legislative change than to enact it").

183. CONG. QUARTERLY, HOW CONGRESS WORKS 163 (3d ed. 1998).

184. *Id.*

185. *See* Garrett, *supra* note 168, at 522–23 (discussing the advantages to those seeking to block new legislation relative to those promoting legislative change).

In addition, for moral reasons, lawmakers may resist efforts to target as offsets those benefits valued by those who are less well organized or financed. Many politicians would likely share the public's moral qualms with denying certain individuals desired healthcare, as no one wants to say no to those with the misfortune of having a potentially deadly or crippling disease.[186] An actuarial offset requirement, however, would force lawmakers to affirmatively choose to place coverage limits on care that certain patients desire. Moreover, because the impetus for imposing these limits is to free up healthcare resources for other patients, lawmakers would in effect be making the painful choice to give preference to one group of patients over another. For many, if not most, lawmakers, the prospect of making these allocative decisions would produce profound moral unease. So even if the political calculus favored granting the request of powerful groups to mandate coverage of a condition or service at the expense of less powerful groups, lawmakers may be reluctant to do so for moral reasons.[187]

C. Creating Procedural Hurdles to Mandated Benefits Legislation

An actuarial offset requirement would also counter lawmakers' incentive to enact mandated benefits legislation or amend the Council's recommendations for purely political reasons by erecting a procedural hurdle in the path of such legislation or amendment. Like the PAYGO rules, an actuarial offset requirement would be enforced through points of order, a procedural objection a lawmaker raises on the House or Senate floor when proposed legislation or a proposed amendment to the Council's recommended essential health benefits would violate the actuarial offset rule. If a lawmaker raises a point of order against legislation or an amendment that would mandate coverage of certain benefits without providing an adequate offset, the offending provisions or amendment would be struck. Although a point of order may often be waived by a majority vote in the relevant chamber,[188] sometimes a waiver requires a supermajority vote, such as the vote of three-fifths of a chamber's members.[189] A point of order enforcement mechanism thus would allow a limited number of

186. *See* Martha R. Gold, *Tea, Biscuits, and Health Care Prioritizing*, 24 HEALTH AFF. 234, 237 (2005) ("No one present wants to say no to someone with the misfortune of having a devastating but costly disease.").

187. *Cf.* SYRETT, *supra* note 12, at 116 (noting the public's reluctance to become involved in healthcare rationing due to "an unwillingness to be seen to be denying care to those enduring pain and suffering").

188. Although the House PAYGO rules do not specify a point-of-order waiver requirement, they may be waived by a special rule reported by the House Rules Committee. *See* KEITH, *supra* note 167, at 6.

189. For example, waiver of a point of order raised under the Senate's PAYGO rules requires a three-fifths vote. Section 201 of the FY 2008 Budget Resolution, S. Con. Res. 210, 100th Cong. (2008).

lawmakers to block an amendment to the Council's recommendations or mandated benefit legislation when inconsistent with the actuarial offset requirement.

A potential problem with the actuarial offset requirement is that the rule can be ignored if political self-interest causes a sufficient number of lawmakers to waive its application to a particular bill or amendment.[190] In practice, then, the actuarial offset requirement may fail as an effective precommitment device because the political incentives that would motivate lawmakers to pass mandated benefits legislation or amend the Council's recommendations may also cause them to waive any point of order raised against such legislation or amendment. In other words, lawmakers may simply vote to ignore the actuarial offset requirement, thereby allowing them to vote for mandated benefits legislation or modifications to the Council's recommendations when it serves their short-term political interests, while leaving it to the Council to determine how best to offset the costs of the mandated benefits. While at times lawmakers may indeed vote to ignore the actuarial offset requirement, there is reason to believe that at other times they would not do so.

As discussed above,[191] some politicians who oppose legislation that would mandate coverage of certain conditions on policy grounds may seek to avoid a vote on the legislation by keeping it off the legislative agenda. Others, however, would have strong incentives to push for a full House and Senate vote on mandated benefits legislation. Under the ordinary legislative process, once congressional leaders agree to a request and bring the legislation to the floor for a vote, those opposing the legislation on policy grounds will likely have lost the battle, as most lawmakers would jump on the bandwagon rather than risk antagonizing constituents or special interest groups by openly voting against the legislation.[192] For similar reasons, lawmakers may be reluctant to oppose amendments to the Council's recommendations that would mandate coverage of certain benefits. The point of order mechanism, however, provides lawmakers who oppose the mandated benefits legislation or amendment an opportunity to preclude consideration of the legislation on the House or Senate floor.

Unlike the final vote on proposed legislation or an amendment, procedural votes on whether to waive or sustain a point of order raised against a bill or

190. *Cf.* Block, *supra* note 166, at 881 ("Despite the bite of the numerous budget point-of-order rules, their potency is diminished to the extent that the rules can be waived.").

191. *See supra* Part I.A.

192. *See* Weaver, *supra* note 49, at 388 (explaining that lawmakers who oppose a bill on policy grounds will reverse course and support the bill when it becomes clear that the bill will come to the floor for a vote).

amendment often go little noticed by constituents.[193] Moreover, most constituents would not understand the significance of an obscure procedural vote, and thus would not equate a vote to sustain a point of order with an affirmative vote against a bill or amendment. A lawmaker opposing on policy grounds mandated benefits legislation or an amendment to the Council's recommendations, therefore, may feel free to sustain a point of order raised against the legislation or amendment without fear of alienating his or her constituents.[194]

Although most citizens would not appreciate the significance of procedural votes on whether to waive or sustain points of order raised under the actuarial offset rule, sophisticated interest groups likely would recognize their importance. Lawmakers, therefore, may vote to waive a point of order raised against such legislation or amendment in order to avoid alienating those groups supporting the benefits mandate. Nevertheless, not all members of Congress would be beholden to those groups. Because congressional committees and subcommittees wield significant power over legislation,[195] special interest groups, particularly industry-sponsored PACs, typically target their campaign contributions and other political assistance to members of those committees with jurisdiction over issues concerning the groups.[196] For example, during the 2003–04 and 2005–06 campaign cycles, over half of the health sector's campaign contributions to House members were made to either House leadership or members serving on the House committees with jurisdiction over healthcare.[197]

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193. *See* Garrett, *supra* note 164, at 1523 (commenting that "the meaning of procedural votes is often relatively opaque to constituents").

194. *See* Weaver, *supra* note 49, at 388 (noting the phenomenon of "seemingly unimportant procedural votes that are in fact more important than final votes on passage," and thus "may be closely fought").

195. *See* J.R. DeShazo & Jody Freeman, *The Congressional Competition to Control Delegated Power*, 81 TEX. L. REV. 1443, 1489 (2003) ("[Congressional] committees enjoy considerable power both in the adoption and implementation of legislation."); Catherine Fisk & Erwin Chemerinsky, *The Filibuster*, 49 STAN. L. REV. 181, 217 (1997) ("Committees and subcommittees have significant power in both the House and the Senate."). The power of congressional committees stems from their gate-keeping authority over legislation. Specifically, committees generally determine what legislation reaches the House or Senate floor for a vote. In addition, congressional committee members play a major role in shaping the legislation Congress enacts, as the House and Senate usually pass the legislation approved by a committee without amendment. In addition, the conference committee responsible for reconciling the bills approved by the two chambers typically includes delegates from the congressional committees that originally drafted the bills. *See id.* at 217–18; DeShazo & Freeman, *supra*, at 1489.

196. *See* J. Skelly Wright, *Money and the Pollution of Politics: Is the First Amendment an Obstacle to Political Equality?*, 82 COLUM. L. REV. 609, 616 (1982) ("The political generosity of the PAC's is directed to legislators who are in a position to help, especially members of committees with jurisdiction over legislation affecting the sponsors.").

197. *See* Center for Responsive Politics, Health: Money to Congress, http://www.opensecrets.org/industries/summary.php?ind=H&recipdetail=A&sortorder=U&cycle=2004 (last visited Sept. 17, 2010). The three House committees with jurisdiction over health matters are Ways & Means, Energy &

Consequently, groups advocating for legislation mandating that the essential health benefits include certain benefits likely would have little sway with many lawmakers, and thus may prove unable to persuade these lawmakers to waive a point of order raised against such legislation.

The point of order mechanism thereby empowers individual members who can command enough votes to sustain a point of order objection raised against mandated benefits legislation or an amendment to the Council's recommendations that fails to meet the actuarial offset requirement. To the extent that waiver of a point of order requires a supermajority vote, opponents of mandated benefits legislation or an amendment need only comprise a determined minority in either the House or Senate.[198] Although not insurmountable, the point of order mechanism would thereby make it more difficult for lawmakers to mandate coverage of certain benefits without specifying an offset, particularly if waiver of a point of order requires a supermajority vote.

Finally, the point of order mechanism may affect the drafting of mandated benefits legislation. As noted previously, prior to its being placed on the House and Senate calendar, proposed legislation generally must be approved by the various congressional committees with jurisdiction over the legislation's subject matter.[199] Committees that harbor doubts as to whether they have enough votes to waive a point of order raised against their proposed legislation have strong incentives to draft their bills so as to avoid the potential objection.[200] For example, the Government Accountability Office (GAO) has observed that the Unfunded Mandates Reform Act of 1995 (UMRA) has changed the way congressional committees markup prospective legislation that includes a mandate on state, local, and tribal governments. Because the committees may view a point of order raised against their proposed legislation under the UMRA as an unattractive possibility, they take care not to include in their bills a mandate that may trigger an objection on the House or Senate floor.[201] The point of order mechanism may similarly deter congressional committees from sending to the

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Commerce, and Education and Labor. Members serving on these committees comprised approximately one-third of all House members during the 2003–04 and 2005–06 election cycles.

198. Although in the Senate opponents of mandated benefits legislation could use the threat of a filibuster to block consideration of these bills, the filibuster threat is more costly than the more obscure point of order procedure, which requires little or no debate and forces an immediate ruling and vote when raised. *See* Garrett, *supra* note 164, at 1515.

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

200. *See* Garrett, *supra* note 164, at 1519 ("[T]he effect of the point of order may well be felt before the bill reaches the floor, as legislation is changed by drafters and committees to avoid triggering a point of order when they are not confident they have the votes on the floor to waive the objection.").

201. *See* U.S. GEN. ACCOUNTING OFFICE, UNFUNDED MANDATES: ANALYSIS OF REFORM ACT COVERAGE 19 (2004), *available at* http:// www.gao.gov/new.items/d04637.pdf.

House or Senate floor mandated benefits legislation that fails to comply with the actuarial offset rule.

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In sum, my proposal would discourage national coverage standards designed in part to advance politicians' short-term political interests rather than ensuring fair and reasonable limits on healthcare. While my proposal would not completely erase self-interested politics from influencing the shape of the essential health benefits, it would afford the Council greater independence from the president and Congress than simply establishing a commission modeled after the BRAC. A Council insulated from the political branches would have greater liberty to base its coverage recommendations on purposeful deliberation about the common good. Specifically, if left to its own devices, the Council could give more careful consideration to the relevant empirical evidence on clinical efficacy and cost-effectiveness, show sensitivity to the concerns of all individuals impacted by its decisions, correct for fallacies or biases in public opinion, and exercise moral powers of persuasion in evaluating the various policy options.

IV. MAINTAINING POLITICAL ACCOUNTABILITY

In Parts I, II, and III, I argued that because political self-interest will lead politicians to favor broader essential health benefits than is optimal, with the mix of conditions and services included in the essential health benefits reflecting political considerations, national coverage standards should be set by a commission largely insulated from the political branches. Specifically, I concluded that the Council should be established as an independent commission, with its members protected against removal at will by the president and secretary, and argued in favor of various legislative procedures designed to constrain Congress's ability to override or otherwise influence the Council's coverage standards. Although critics of my proposal may agree that political considerations will tempt elected officials to support more and more coverage mandates, many of which may be misguided, they nevertheless may argue that the absence of robust political oversight of the Council poses a greater risk—that the Council's members will become "policy knight-errants."[202] For example, rather than engage in a deliberative, public-regarding decisionmaking process, a highly independent Council may show favoritism towards or bias against certain patients or medical

202. Verkuil, *supra* note 124, at 265.

therapies,[203] or may adopt policies based on criteria inconsistent with community values.[204] Critics, therefore, may assert that, on balance, subjecting the Council to close supervision by the politically accountable branches is necessary in order to check against such behaviors, as electoral considerations will motivate the president and members of Congress to ensure that the Council uses its authority wisely and for the public interest.[205]

Although not without merit, the argument for greater supervision of the Council by the politically accountable branches overlooks that my proposal reserves for the president and Congress certain powers that would allow them real, albeit limited, influence over the Council. In addition, the need to reach consensus, the availability of opportunities for public input, and the backstop of judicial review would guard against abuse by constraining the manner in which the Council makes its decisions. While an exhaustive discussion of all the potential safeguards shaping the Council's deliberations is beyond the scope of this Article, below I briefly highlight some of the possibilities.

A. Maintaining Direct Presidential and Congressional Oversight

My proposal would impose various constraints on the president and Congress's ability to exercise oversight over the Council. Nevertheless, both the president and Congress would retain important residual powers that would allow them to guard against gross abuses of power or deviations from public values on the part of the Council. Primary among these safeguards is Congress's residual legislative power. Although the actuarial offset rule proposed in Part III would discourage congressional interference with the Council's substantive coverage

203. For example, a Council member may favor therapies that treat diseases suffered by a family member. Similarly, members of the Council who are physicians may favor therapies in their own specialties. *Cf.* Leichter, *supra* note 13, at 1961 (stating that the physician-members of an Oregon Medicaid task force charged with prioritizing 1600 medical interventions placed a low value on preventive health services, such as dental check-ups and nutritional supplements); THE GLOBAL CHALLENGE OF HEALTH CARE RATIONING, *supra* note 25 (raising questions about whether health service professionals are good proxies for the views of the general public, or whether they may have special interests of their own that might bias their rationing judgments).

204. *Cf.* CELIA DAVIES ET AL., OPENING THE BOX: EVALUATING THE CITIZENS COUNCIL OF NICE 67 (2005) (stating that a report of the Citizens Council advising the UK's National Institute for Health and Clinical Excellence (NICE), a group of citizens who provide public input on the Institute's process, presented views contrary to those of NICE's executive committee on whether self-induced illnesses should be a criterion for refusal to treat patients and whether younger patients should be privileged over older ones).

205. *See* Mantel, *supra* note 26, at 360 ("Political accountability—requiring public officials to stand periodically for election—ensures that public officials honor majority preferences because voters can turn out of office those who fail to do so."); *see also* Mendelson, *supra* note 125, at 578–79 (stating that the democratic character of an institution may be inferred if its membership is selected by the electorate, as those who fail to enact appropriate policies may not be reelected).

standards, Congress would nevertheless retain the authority to narrow the Council's discretion. For example, if the Council limits coverage of treatments for medical conditions associated with certain lifestyle choices, such as smoking, Congress could pass legislation prohibiting the Council from basing its decisions on these criteria if it considered it morally unacceptable to do so. Similarly, the Council might find its recommendations subject to a joint resolution of disapproval if they lacked impartiality or offended society's ethics. Finally, if the Council regularly ignored congressional input as to the substance of its recommended coverage standards, Congress might repeal its framework rules in order to strengthen its oversight over the Council's decisionmaking. Consequently, the Council would have strong incentives to consider the views of members of Congress in forming its recommendations, as a Council unresponsive to congressional cues might see its authority curtailed or even abolished.[206] These residual legislative powers thus would serve as a source of real restraint over the Council's activities.[207]

The president (or his delegate, the secretary) could also influence the Council's policies through his appointment and removal powers. Although staggered terms and the protection of Council members from removal at will would moderate this influence, the president or secretary could nevertheless affect the substantive values shaping the Council's decisionmaking through the appointment of members who share the president's philosophy.[208] Typically,

206. Professor Koh makes a parallel observation with respect to the relationship between the executive and legislative branches and the fast-tracking of trade agreements. Specifically, he argues that despite the shift of power from the legislative branch to the executive branch following the fast-tracking of trade agreements, presidents typically consult with members of Congress when negotiating trade agreements because they need to gain subsequent congressional approval (or avoid subsequent disapproval). *See* Harold Hongju Koh, *The Fast Track and United States Trade Policy*, 18 BROOK. J. INT'L L. 143, 146 (1992).

207. Professor Ramirez similarly argues that the power of the political branches to abolish the Federal Reserve Board serves as a real source of restraint over the Board's activities. *See* Steven A. Ramirez, *The End of Corporate Governance Law: Optimizing Regulatory Structures for a Race to the Top*, 24 YALE J. ON REG. 313, 351 (2007).

208. *Cf.* Barron, *supra* note 42, at 1096 (observing that recent presidential administrations have increased their influence over agency decisionmaking by infusing agencies with a cadre of political appointments sharing the president's ideology and regulatory vision); Aulana L. Peters, *Independent Agencies: Government's Scourge or Salvation?*, 1988 DUKE L.J. 286, 287–88 (discussing the president's influence over the Securities and Exchange Commission (SEC) through his power of appointment). The ability of a presidential administration to influence the Council's deliberations through the appointment of Council members is tempered somewhat by the fact that Council members are appointed to staggered terms, with at least some members appointed by other administrations. Nevertheless, the appointment of at least some of the Council's members ensures that individuals sharing the presidents' values and priorities have a seat at the table. The Senate similarly could influence the Council by refusing to confirm the nomination of individuals whose values or impartiality are questioned. *See* Peters, *supra*, at 288; *cf.* Richard E. Wiley, *"Political" Influence at the FCC*, 1988 DUKE L.J. 280, 282 (noting that

the president (or his delegate) also has the power to appoint, as well as remove at will, a commission's chairperson among its members. The chairperson of an independent commission has primary responsibility for its management, and thus plays a crucial role in setting a commission's agenda and overall orientation.[209] Were Congress to grant the president or the secretary the power to appoint the Council's chairperson, this would provide an additional means through which the president or secretary could shape the Council's policies,[210] as the threat of removing from office a chairperson whose priorities differ from the president thereby allows the president or secretary to exert some control over the Council's agenda.[211] Finally, the secretary's ability to remove for cause any Council member who was derelict in his or her duties would provide an important means of addressing any malfeasance by Council members.

B. Promoting Democratic Values Through Consensus Decisionmaking

An important characteristic of the Council would be its organization as a board, rather than as an agency headed by a single decisionmaker. Because setting limits on healthcare would bring into conflict deeply held values, the process for doing so should involve debate among competing viewpoints.[212] For this reason, the decisionmaking process should not be dominated by one particular interest or perspective, but should allow for a range of viewpoints. Placing authority for developing coverage standards in a board, rather than a single decisionmaker, would allow for such diversity. Specifically, Congress could require that the Council's members consist of individuals with varying expertise, including health professionals, economists, businesspersons, and patient advocates. This diversity in the Council's membership would help ensure that the Council takes into account a range of policy and moral perspectives.[213] Moreover, because the Council's decisions would require the approval of a majority of its members, the need to build consensus among a pluralist group

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congressional strategies for overseeing the Federal Communications Commission (FCC) include the Senate's power of advice and consent over the appointment of the FCC's commissioners).

209. *Cf.* Peters, *supra* note 208, at 288.

210. *Cf. id.* (discussing the special importance of the president's power to appoint the chairperson of the SEC).

211. *See* Kagan, *supra* note 43, at 2274 (discussing how the power to remove administrative officials allows the president to exert some influence over agencies). The potential political costs of exercising this removal power, however, somewhat limit the effectiveness of this tool. *See id.*

212. *See* SYRETT, *supra* note 12, at 101 ("Given conflicting values, the process of setting priorities for healthcare must inevitably be a process of debate.").

213. *See* Breger & Edles, *supra* note 128, at 1198 ("Placing decisional responsibility with a group ensures that the group take into account diverse policy perspectives . . . .").

would require compromise among competing perspectives.[214] The Council's policies thus would tend toward more moderate positions reflective of public values.

The commission structure would also guard against capture of the Council's policymaking process by special interest groups. The theory of agency capture posits that rather than serve the public interest, the Council would cater to the demands of special interests, particularly if its members hold positions in the private sector.[215] The commission structure, however, would make capture of the Council more difficult, as a group seeking favorable treatment would need to unduly influence a majority of the Council's members, rather than a single decisionmaker. Moreover, if the Council's membership was sufficiently large and included individuals representing a wide range of perspectives, a special interest group may find few Council members partial to the group's interests. For example, a special interest group representing chiropractors may have little success in capturing the sympathies of physicians, health insurance executives, or labor representatives serving on the Council. The Council's group decisionmaking process thus would help protect against favoritism toward or bias against certain groups, particularly if its membership is large and diverse, as the lack of impartiality on the part of any one Council member would likely be checked by the others.[216]

C. Enhancing the Council's Reasoning Through Public Input and Transparency

As with diversity in the Council's membership, opportunities for public input would also encourage the Council to consider competing perspectives, thereby enhancing the quality of the Council's decisionmaking process. Specifically, public input would illuminate for the Council the full range of interests

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214. *See id.* (commenting that decisionmaking by independent agencies requires "consensus-building through compromise"); *see also* Verkuil, *supra* note 124, at 261 ("Collegial decisionmaking . . . is meant to be consensual, reflective and pluralistic.").

215. *See* Edna Earle Vass Johnson, *Agency "Capture": The "Revolving Door" Between Regulated Industries and Their Regulating Agencies*, 18 U. RICH. L. REV. 95, 95–96 (1983).

216. *See* Wiley, *supra* note 208, at 284–85 (commenting that collegial decisionmaking helps minimize the potential for improper political pressure and considerations). Critics may contend that the commission decisionmaking process is inefficient and often indecisive. Although consensus decisionmaking may be slower than single (or executive) decisionmaking, this decrease in efficiency would be outweighed by the need to ensure fair, deliberative decisionmaking in light of the Council's insulation from the politically accountable branches. Moreover, unlike other independent agencies that are granted broad regulatory authority, the narrow scope of the Council's mission may minimize the need for quick, decisive action. Finally, commissions that have difficulty reaching consensus typically deal with highly partisan issues. *See, e.g.*, Hanlon, *supra* note 56, at 344–45 (discussing the failure of the National Economic Commission (NEC) to reach consensus on how to address the government's chronic deficit spending).

among those potentially affected by its proposed coverage standards.[217] In addition, public feedback on the ethical, economic, and clinical criteria guiding the Council's deliberations would also promote higher-quality decisionmaking by providing interested parties the opportunity to challenge the basis for the Council's criteria or policies.[218] Finally, the Council would benefit from relevant information provided by interested parties, such as information on the clinical- and cost-effectiveness of various treatments or the anticipated effects of various coverage standards.[219] Public input thus would advance the Council's competence by promoting more accurate and rational decisionmaking.

One approach for obtaining public input would be for the Council to solicit comments on its draft recommendations.[220] Although typically administrative processes that allow for public comment on proposed agency policies are open to all, in practice "the playing field is anything but level," as not all individuals are represented by the interest groups that submit the vast majority of public comments, and not all interest groups have equal resources or influence.[221] Consequently, any public comments submitted in response to the Council's

217. *See* Mantel, *supra* note 26, at 392.

218. *Cf. id.* (noting that an opportunity to comment on draft agency guidance would provide the public the opportunity to challenge the legal and policy bases for the guidance before its adoption); Michael Asimow, *Public Participation in the Adoption of Interpretive Rules and Policy Statements*, 75 MICH. L. REV. 520, 574 (1977) (discussing the effect that public participation can have in shaping rules).

219. *See* Jim Rossi, *Participation Run Amok: The Costs of Mass Participation for Deliberative Agency Decisionmaking*, 92 NW. U. L. REV. 173, 185–86 (1997) (commenting that participation allows agencies to learn about the anticipated effects of their actions and get better information).

220. A possible model for allowing for public input would be the notice-and-comment rulemaking requirements set forth in the Administrative Procedure Act (APA). 5 U.S.C. §§ 500–96 (2006). The APA's notice-and-comment process consists of three steps: First, the agency issues a notice of proposed rulemaking that either sets forth the terms or substance of the rule under consideration or describes the subjects and issues involved. *Id.* § 553(b). Second, the agency solicits, receives, and reviews public comments on the proposed rule. *Id.* § 553(c). Third, the agency issues the final rule, which must include a statement of basis and purpose that adequately articulates the legal authority and policy reasons for the agency's rule. *Id.* The APA's notice-and-comment rulemaking process, however, is often lengthy and expensive. In reviewing an agency's final rule, courts apply the "hard look" doctrine, under which

> a reviewing court [is] obliged to examine carefully the administrative record and the agency's explanation, to determine whether the agency applied the correct analytical methodology, applied the right criteria, considered the relevant factors, chose from among the available range of regulatory options, relied upon appropriate policies, and pointed to adequate support in the record for material empirical conclusions.

Thomas O. McGarity, *Some Thoughts on "Deossifying" the Rulemaking Process*, 41 DUKE L.J. 1385, 1410 (1992). The courts' greater scrutiny of agencies' reasoning had the practical effect of causing agencies to draft statements of basis and purpose that are "comprehensive and encyclopedic," *see* Richard J. Pierce, Jr., *Waiting for* Vermont Yankee *III, IV, and V? A Response to Beermann and Lawson*, 75 GEO. WASH. L. REV. 902, 908 (2007), responding in detail to public comments "no matter how ridiculous they may appear to agency staff." McGarity, *supra*, at 1412. This process may prove particularly problematic when developing national coverage standards given the Council's need for flexibility to quickly address changes in clinical knowledge and practices.

221. *See* Leichter, *supra* note 13, at 1954–55.

proposed coverage standards would likely not reflect the full diversity of public views, but instead would be dominated by groups with a vested interest in the Council's policies, such as clinicians, industry groups, researchers, and associations representing select patient groups.[222]

To address similar concerns, some countries have turned to citizen advisory councils comprised of individuals considered representative of the population as a whole. The purpose of these citizen advisory councils is to ensure that a country's rationing decisionmaking process is informed by the public's social values. Toward that end, the citizen advisory councils provide advice to government decisionmakers on issues pertaining to rationing. For example, in the United Kingdom, the Citizens' Council—a group of thirty citizens who deliberate twice a year—provides specific recommendations to the National Institute for Health and Clinical Excellence (NICE) on what values NICE should take into account when making decisions about clinical need.[223] The Council could similarly receive input from a citizens' advisory group in order to better understand the public's views of important ethical considerations.

Requiring that the Council make transparent the rationale for its choices would also enhance the legitimacy of its recommended coverage standards. First, exposing the Council's reasoning to public scrutiny would facilitate Congress's oversight of the Council's deliberations.[224] For example, transparency as to the ethical criteria guiding the Council's decisionmaking process would highlight for Congress and the general public any conflict between the Council's guidelines and community values.[225] If Congress discovers perceived deficiencies in the Council's deliberations, as noted above, Congress could pass legislation altering the scope of the Council's discretion. In addition, if scrutiny of the Council's deliberations reveals that certain perspectives are not represented among its members or that its deliberations are dominated by one particular interest,

222. Timothy Jost has observed that those who appeared before CMS hearings concerning whether to cover a new technology under Medicare represented manufacturers, specialty societies, professionals who offered the service, and patient groups. *See* Jost, *supra* note 178, at 228.

223. *See* SYRETT, *supra* note 12, at 118 (discussing the Citizens' Council); Newdick, *supra* note 10, at 667 (same); *see also* DANIELS & SABIN, *supra* note 11, at 156–57 (noting that health planning in countries that ration should be "organized in such a way as to ensure the possibility for common citizens to participate in the decision-making process").

224. *See* SYRETT, *supra* note 12, at 62–63 (stating that transparency as to the ethical and scientific criteria that are the basis for allocating choices enables the public to hold decisionmakers accountable through political mechanisms).

225. *See* DANIELS & SABIN, *supra* note 11, at 156–57 ("Such openness [as to the reasons for a particular healthcare priority scheme] is crucial to ensuring that individual decisions can be subjected to criticism and possibly changed on the basis of the public debate.").

Congress could change the representational makeup of the Council's membership.[226]

Second, a transparency requirement would enhance the quality, consistency, and fairness of the Council's deliberations. Transparency would encourage careful reflection by the Council, as it must be able to defend the reasonableness of the ethical and scientific criteria that guide its decisionmaking. In addition, a Council that must publicly explain its choices is more likely to take care that its analysis is thorough and accurate, and that its final recommendations flow logically from the application of the relevant ethical and scientific criteria to its factfinding.[227] Council members would also need to demonstrate how their choices serve the public interest.[228] In addition, transparency would promote predictability and guard against indifference or hostility toward the concerns of certain patients, as it obligates the Council to apply its guiding principles uniformly (or justify any departure from past practices).[229] Similarly, public scrutiny of the agency's reasoning "may minimize the potential for powerful interest groups to capture the [Council's] decisionmaking process."[230]

In sum, public input and transparency in the Council's reasoning would encourage the Council to exercise its authority in a careful, deliberative manner, without bias or favoritism toward any one group, and in a way that is consistent with community values. These requirements thus would make it more likely that the Council's recommended coverage standards would promote the public interest.

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226. *See* CALABRESI & BOBBITT, *supra* note 66, at 67 (commenting that examination of a group's reasoning provides information regarding whether the group's membership represents those that need representation); SYRETT, *supra* note 12, at 101 (commenting on the importance of "getting the institutional setting of the debate [on rationing] right" in order to ensure "that the debate will not be dominated by one particular interest").

227. *See* SYRETT, *supra* note 12, at 61–62 ("The articulation of reasons . . . not only assists the development of standards and principles, but encourages more care and deliberation on the purposes of actions by decision-makers" (quoting DIANE LONGLEY, PUBLIC LAW AND HEALTH SERVICE ACCOUNTABILITY 7–8 (1993))); Mantel, *supra* note 26, at 392 (explaining that a requirement that agencies provide a statement setting forth the basis for their guidance policies promotes careful deliberation, as agencies "must demonstrate a rational connection between the agency's factual conclusions and its policy").

228. *See* Mantel, *supra* note 26, at 392 (noting that a requirement that agencies provide a statement of reasons necessitates that agencies demonstrate how their "policy choices serve the relevant statutory or regulatory objectives").

229. *See* DANIELS & SABIN, *supra* note 11, at 47–48 (explaining that transparency ensures fairness and consistency in decisionmaking by creating a "case-law" that would govern future decisions); SYRETT, *supra* note 12, at 62–63 (arguing that transparency promotes consistency in decisionmaking).

230. *See* Mantel, *supra* note 26, at 392–93.

D. Preserving Accountability Through Judicial Review

Agencies typically must answer not only to the executive and legislative branches but also to the courts. In addition to holding agencies faithful to the language of their governing statutes, courts also ensure their compliance with any applicable procedural requirements, such as those required by the Administrative Procedures Act (APA).[231] For example, judicial review ensures that agencies subject to the APA allow for public input on, and provide a reasoned explanation for, their substantive rules.[232] Under the APA, courts may also set aside any agency action deemed arbitrary or capricious.[233] Accordingly, subjecting the Council's actions to judicial review under the APA or similar standards would provide an important mechanism for ensuring that its decisionmaking process is deliberative, competent, and public-regarding.

The prospect of judicial review necessitates that an agency's explanatory statement in support of its policies be defensible. Specifically, the courts have interpreted the APA's arbitrary and capricious standard as requiring that an agency examine the relevant data, consider all important aspects of an issue, and offer a rational explanation for its decision in light of the information considered and facts found.[234] Were Congress to subject the Council to the APA's arbitrary and capricious standard, the Council thus would have incentives to "exercise due care in its factfinding; make rational policy choices consistent with the" relevant ethical and scientific criteria; take into account community values; "and substantiate its policies with a public-regarding rationale."[235] Judicial review of both the procedural and substantive aspects of the Council's decisionmaking thus would offer some protection against imprudent coverage standards.

Judicial review would also guard against favoritism or capture of the Council's decisionmaking process by powerful special interest groups.[236] As others have noted, the prospect of judicial review makes regulatory rent-seeking

231. 5 U.S.C. §§ 500–96 (2006).

232. *Id.* §§ 553(b)–(c).

233. *Id.* § 706(2)(A).

234. *See* Motor Vehicle Mfr. Ass'n v. State Farm Mutual Auto Ins. Co., 463 U.S. 29 (1983) (requiring that courts examine the administrative record and the agency's explanation carefully to determine whether the agency applied the correct analytical methodology and criteria and carefully considered the relevant factors, and whether there was adequate support in the record for the agency's empirical conclusions).

235. *See* Mantel, *supra* note 26, at 400; McGarity, *supra* note 220, at 1444 ("[A] reasoned explanation ensures that the range of agency action is bound by those options that are supportable by facts in the record, reasonable assumptions, and sound policy considerations . . . ."); *see also* Henry J. Friendly, *"Some Kind of Hearing"*, 123 U. PA. L. REV. 1267, 1292 (1975) (observing that the requirement that the agency provide a statement of reasons "is a powerful preventive of wrong decisions" and is "almost essential if there is to be judicial review").

236. *See* Rossi, *supra* note 219, at 182, 213.

more difficult by promoting evenhandedness on the part of the agency.[237] For example, in judging the merits of a claim that the Council favored certain patients at the expense of others, the court could scrutinize whether the Council gave due consideration to all relevant facts or arguments, and applied its decisionmaking criteria consistently and in a nonarbitrary manner.[238] Although the courts would show considerable deference to the Council's judgment, judicial review would nevertheless make it difficult for the Council "to ignore the relevant consequences of its decisions, to change course abruptly in response to political pressures for example, where the underlying facts do not so warrant, or to under-value certain interests in order to advance others."[239] Judicial review thus would inhibit the Council from showing bias toward certain patients or therapies, or otherwise advancing narrow, private interests over the common good.[240]

CONCLUSION

In establishing the process for adoption of national coverage standards for health plans, we should be mindful that political considerations will tempt politicians to mandate coverage of health benefits desired by the public and special interest groups, regardless of the merits of doing so. Unfortunately, the process established by the Affordable Care Act—simply delegating to HHS responsibility for defining the minimum essential health benefits—fails to address these concerns. Nor would the Senate HELP Committee's proposal to create an expert commission modeled after the Base Realignment and Closing Commission do much to reduce the influence of short-term political

237. *See* Croley, *supra* note 46, at 23–24, 51 (explaining that judicial review makes it difficult for agencies to cater to certain special interest groups at the expense of others).

238. *See id.* at 23 ("[J]udicial review . . . makes it difficult for agencies to cater to the regulatory preferences of one group without due consideration of facts or arguments that may support the regulatory preferences of an opposing group.").

239. *Id.* at 51.

240. However, requiring the Council to articulate the reasons for its recommendations would not guarantee that the true basis for the recommendations would reflect some sufficiently public purpose, and not a nonpublic purpose. For example, when there exists two or more explanations for a policy, one legitimate and one impermissible, "it will be difficult for anyone, including the actor, to be clear about what 'really' generated it, and it is simple human nature to want to believe that the more laudable purpose played a (the) significant role." JOHN HART ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW 128 (1980). Similarly, the prospect of pubic scrutiny does not ensure that the Council will fairly consider the concerns of all affected parties. *Cf.* Evelyn R. Sinaiko, *Due Process Rights of Participation in Administrative Rulemaking*, 63 CAL. L. REV. 886, 916 (1975) (noting that the submission of written comments to an agency on its proposed rule does not ensure that the agency will consider all viewpoints of those potentially affected by the rule). Nevertheless, requiring the Council to issue an explanatory statement with its recommendations provides some protection for the public interest by ensuring that, at a minimum, the Council articulates a legitimate explanation for its actions.

considerations in the development of national coverage standards. Although a government-by-commission framework has the potential to limit efforts by the president and other executive branch officials to alter the essential health benefits for political reasons, it would not succeed in limiting congressional attempts to do so. This Article argues that in addition to establishing an independent commission, Congress should adopt internal rules of procedure that would obligate lawmakers to offset the costs of mandating coverage of additional medical care with new exclusions from the essential health benefits. This requirement would make it more difficult for lawmakers to modify the shape of the essential health benefits for political gain because it would intensify and institutionalize conflict among interest groups and raise procedural hurdles in the path of mandated health benefits legislation. With significant independence from both Congress and the president, the commission would have the freedom to engage in a thoughtful, deliberative review of the relevant scientific, economic, and moral factors, with primary consideration given to the overall fairness of the coverage standards rather than their political impact.