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## Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals

Dean M. Harris

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# Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals

Dean M. Harris\*

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\* Clinical Associate Professor, Department of Health Policy and Administration, School of Public Health, University of North Carolina at Chapel Hill.

### I. Introduction

When Congress created the Medicare program in 1965, its purpose was to provide hospital and medical insurance for persons over the age of sixty-five, not to accomplish broader societal goals. The original Medicare statute<sup>1</sup> and its legislative history<sup>2</sup> indicate a congressional intent to provide health insurance coverage for a specific group of people. At that time, Congress viewed the availability of health insurance for the elderly more as a means to avoid dissipating their assets than as a means to eliminate financial barriers to care.<sup>3</sup> Some advocates and some members of Congress envisioned the 1965 legislation as merely the first step in providing more comprehensive benefits and expanding eligibility to persons under the age of sixty-five.<sup>4</sup> However, no persuasive evidence exists that in 1965 Congress intended to use the Medicare program as a mechanism to support the healthcare infrastructure, assist non-beneficiaries, or improve the health status of the broader community.<sup>5</sup> In fact, Congress explicitly provided that the Medicare program should only pay providers for the costs of treating Medicare beneficiaries and not for the costs of treating any other patients.<sup>6</sup>

Despite that limited original purpose, the Medicare program has become a vehicle to accomplish public goals that go beyond covered services and beyond

1. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

2. H.R. REP. NO. 89-213 (1965); S. REP. NO. 89-404 (1965) (*reprinted in* 1965 U.S.C.C.A.N. 1943); CONF. REP. NO. 682 (1965) (*reprinted in* 1965 U.S.C.C.A.N. 1943).

3. THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 96 (2d ed. 2000). Marmor explained:

A program of hospital insurance identifies the aged's problem not as the inaccessibility of health services, but the *financial consequences of using those services* . . . . The hospital benefit was designed, however, not so much to cope with all the health problems of the elderly as to reduce their most onerous financial difficulties.

*Id.* at 12-13.

4. *See id.* at 95-96 (describing expectations for future expansion of eligibility to children, pregnant women, and others).

5. The only possible exception is a very ambiguous statement in the legislative history to the effect that a *part* of the cost of educational activities "should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program." S. REP. NO. 89-404, at 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977; *see also* H.R. REP. NO. 89-213, at 32 (1965) (containing the identical statement); *see infra* notes 203-08 and accompanying text (discussing Congress's failure to clearly address these possibilities).

6. *See infra* notes 185-95 and accompanying text (recounting the congressional mandate against subsidizing those outside of the Medicare program and the Secretary's actions in compliance therewith).

eligible beneficiaries. These broader goals are pursued by: (1) threatening to take funding away from providers who fail to do certain things, such as provide indigent emergency care; (2) giving additional money to providers who actually do certain things, such as provide graduate medical education; (3) regulating certain aspects of the private insurance market, such as prohibiting the sale of supplemental insurance policies that fail to meet federal requirements; and (4) educating enrollees about matters of health and insurance, by distributing written materials and utilizing the internet, for example.

In amendments to the original Medicare statute, Congress directed the Secretary of the United States Department of Health and Human Services (the Secretary) to assist Medicare beneficiaries in purchasing goods and services not covered by the Medicare program. The federal government now regulates—or assists states in regulating—the commercial market for Medicare supplemental insurance,<sup>7</sup> and the Secretary operates a "beneficiary assistance program"<sup>8</sup> to help Medicare beneficiaries with the receipt of services under health insurance programs other than Medicare.<sup>9</sup> Recently, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) relied on this statutory authority in its effort to assist Medicare beneficiaries in purchasing non-covered outpatient prescription drugs by means of a Medicare-endorsed prescription drug card assistance initiative.<sup>10</sup> In addition to helping Medicare beneficiaries obtain non-covered goods and services, Congress has used the Medicare program to assist non-beneficiaries, by using Medicare participation as a "jurisdictional hook" for provider mandates that apply to non-Medicare patients as well as Medicare patients. These mandates include requirements for participating hospitals to provide emergency care without regard to a patient's ability to pay, to advise patients about their rights to refuse treatment and make advance directives, and to participate in other government payment programs.<sup>11</sup> Finally, Congress uses Medicare funds for

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7. 42 U.S.C. § 1395ss (2000). *See infra* notes 33–36 and accompanying text (reporting government efforts to assist beneficiaries with supplemental insurance and other such services).

8. 42 U.S.C. § 1395b-3 (2000). *See infra* notes 33–36 and accompanying text (reporting government efforts to assist beneficiaries with supplemental insurance and other such services).

9. 42 U.S.C. § 395b-3(a) (2000); *see also* Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,620 (Sept. 4, 2002) (codified at 42 C.F.R. pt. 403) ("For several years we have offered Medicare beneficiaries education and assistance in accessing several non-covered benefits that are complimentary to Medicare, Medicaid, and other health insurance programs.")

10. *See* Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 10,262 (proposed Mar. 6, 2002); 67 Fed. Reg. 56,618 (final rule) (codified at 42 C.F.R. pt. 403). *See infra* Part II.B (exploring this initiative in detail). As described below, this issue has been resolved as a practical matter by enactment of the Medicare prescription drug legislation. *See infra* note 81 and accompanying text.

11. *Infra* notes 113–14 and accompanying text.

the benefit of the broader community by paying for public goals such as medical education and indigent care.

The National Academy of Social Insurance (NASI) recognized the importance and complexity of these issues by forming a "Study Panel on Medicare's Larger Social Role," which issued its final report in February 1999.<sup>12</sup> According to the NASI study panel, Medicare's broader social roles are important both politically and socially, but the financing of public goals should be considered as policy issues apart from the ongoing debate about preserving and reforming the Medicare program.<sup>13</sup> Subsequently, two of the contractors for that NASI study panel, Michael Gusmano and Mark Schlesinger, published a more detailed analysis of Medicare's broader social roles, which they described as "collateral functions."<sup>14</sup> Gusmano and Schlesinger considered current and potential uses of the Medicare program from the perspectives of policy analysis and organizational analysis and developed useful criteria to consider the appropriateness of using Medicare to accomplish broader public goals.<sup>15</sup> They concluded that the Medicare program should remain involved in particular collateral functions, but only if these functions are carried out in "a more systematic and cohesive manner."<sup>16</sup>

This Article adds a new dimension to the previous research on Medicare's broader public goals by analyzing the broader uses of Medicare from a legal perspective. Consideration of legal issues can advance our understanding of Medicare in several ways. First, by analyzing each of the specific statutes that granted new authorities and new responsibilities to the Secretary, one can better understand how the role of Medicare has expanded over time. In particular, one can evaluate whether Medicare has been expanded in a calculated and strategic manner to accomplish an identified mission. Alternatively, one can determine whether Medicare has been expanded in a reactive posture to address a series of unrelated concerns. Second, the legal perspective on the broader goals of Medicare will consider statutory mandates that have not been analyzed by some of the writers on social theory and policy analysis.<sup>17</sup> Previous research has addressed each of these

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12. NAT'L ACAD. OF SOC. INS., FINAL REPORT OF THE STUDY PANEL ON MEDICARE'S LARGER SOCIAL ROLE: MEDICARE AND THE AMERICAN SOCIAL CONTRACT (1999) [hereinafter NASI], available at [http://www.nasi.org/usr\\_doc/med\\_report\\_soc\\_contract.pdf](http://www.nasi.org/usr_doc/med_report_soc_contract.pdf).

13. *Id.* at 45.

14. Michael Gusmano & Mark Schlesinger, *The Social Roles of Medicare: Assessing Medicare's Collateral Benefits*, 26 J. HEALTH POL., POL'Y & L. 37 *passim* (2001).

15. *Id.* at 38-40.

16. *Id.* at 40.

17. The NASI study panel considered Medicare's role in subsidizing public goals such as graduate medical education, disproportionate share hospitals, and some research activities, but did not consider beneficiary assistance with non-covered goods and services or provider mandates that apply as well to non-beneficiaries. See NASI, *supra* note 12, at 23-25 (stating

statutory mandates and public goals in depth but in isolation from each other. This Article takes a different approach by considering these broader uses of Medicare in juxtaposition and as part of a coherent whole. By necessity, this effort will require consideration of many different aspects of the Medicare program with greater breadth than depth. Finally, the legal perspective in this Article will provide an additional way to evaluate potential uses of Medicare by analyzing the existing legal authority of the Secretary and by considering which laws, if any, would need to be changed in order to use the Medicare program to accomplish new public goals in the future.

Part I of this Article analyzes how the Medicare program currently assists Medicare beneficiaries to purchase goods and services not covered by Medicare. Part II addresses the use of Medicare as a jurisdictional hook to impose mandates on participating providers for the benefit of non-Medicare beneficiaries as well as beneficiaries. Part III deals with the use of Medicare funds to pay for social goals that benefit the broader community and analyzes judicial views with regard to the nature and purposes of the Medicare program. Finally, Part IV departs from the status quo to explore potential uses of Medicare to accomplish broader public goals in the future.

## *II. Assisting Medicare Beneficiaries to Purchase Goods and Services that Are Not Covered by Medicare*

### *A. Promotion of Supplemental Insurance Coverage and Beneficiary Assistance*

In one of the first sections of the original Medicare legislation, Section 1803 of the Social Security Act, Congress explicitly preserved the right of beneficiaries to purchase other types of health insurance.<sup>18</sup> Rather than merely permitting individuals to purchase additional coverage, the federal government takes a much

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that the reasons for the ancillary duties of Medicare are to be accountable to both enrollees and to taxpayers and as a means to support more general public health and social policy goals identified by Congress). Like the NASI panel, Gusmano and Schlesinger did not address the use of Medicare as a jurisdictional hook for provider mandates that are designed to assist non-Medicare beneficiaries as well as beneficiaries, although they did address some aspects of beneficiary education. See Gusmano & Schlesinger, *supra* note 14, at 42 (discussing steps the Health Care Financing Administration is taking to be a "patient-centered value-based purchaser" by providing beneficiaries with information about benefits, insurance plan options, and treatment options).

18. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1803, 79 Stat. 286, 291 (codified as amended at 42 U.S.C. § 1395b (2000)) ("Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.").

more active role in the market for supplemental insurance known as Medigap. Since 1980, Congress and the Secretary have actively assisted Medicare beneficiaries in purchasing insurance coverage for goods and services not covered by the Medicare program, as well as insurance coverage for Medicare copayments and deductibles. This federal initiative in the private insurance market takes several forms, including providing information and counseling to beneficiaries with regard to supplemental insurance, regulating the private market for Medigap insurance or at least promoting and supervising a system of state regulation, and, in practical effect, using the Medicare program to subsidize the purchase of commercial Medigap insurance.

All health insurance policies have limitations, but Medicare is uniquely burdensome to its beneficiaries in two important respects. First, Medicare does not have an upper limit or "cap" on the beneficiary's obligation for cost-sharing, in contrast to most employee group benefit plans.<sup>19</sup> Second, Medicare generally provides no coverage for outpatient prescription drugs.<sup>20</sup> Under these circumstances, the vast majority of Medicare beneficiaries have obtained some type of additional coverage, although statistics vary depending on the types of additional coverage included in the calculation.<sup>21</sup> Approximately one-fourth of Medicare beneficiaries have Medigap coverage.<sup>22</sup> Of course, Medigap insurance is not a panacea: Premiums may be expensive, benefits are limited, some policies provide no coverage for prescription drugs, and even those that provide prescription drug coverage are subject to significant limitations.<sup>23</sup>

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19. See U.S. GEN. ACCOUNTING OFFICE, GAO-02-533T, MEDIGAP, CURRENT POLICIES CONTAIN COVERAGE GAPS, UNDERMINE COST CONTROL INCENTIVES 7 (2002) [hereinafter MEDIGAP] ("In Medicare, the lack of dollar limits on beneficiaries' cost-sharing obligations—deductibles, coinsurance, and copayments—puts beneficiaries with extensive health care needs at risk for very large expenses for Medicare-covered services."), available at <http://www.gao.gov/index.html>; see also Adam Atherly, *Supplemental Insurance: Medicare's Accidental Stepchild*, 58 MED. CARE RES. & REV. 131, 132–33 (2001) (describing the possibility of large out-of-pocket expenses for Medicare beneficiaries).

20. See MEDIGAP, *supra* note 19, at 2, 7 (stating that prescription drugs are of growing importance in treatment and are rapidly increasing in cost). But see *infra* note 81 (regarding legislation enacted in Nov. 2003).

21. See *id.* at 3–5 (providing charts that demonstrate the variances in different levels of coverage, as well as statistics on what other types of assistance Medicare beneficiaries receive); Atherly, *supra* note 19, at 134–35 (discussing sources of coverage and policy characteristics).

22. MEDIGAP, *supra* note 19, at 5. Aside from those beneficiaries who have Medigap coverage, approximately one-third of Medicare beneficiaries have supplemental coverage through an employer, 14% are enrolled in Medicare+Choice plans that generally provide lower cost sharing and more benefits, and about 17% of the beneficiaries participate in some way in the Medicaid program. *Id.* at 4.

23. MEDIGAP, *supra* note 19, at 8–11. See also U. S. DEP'T OF HEALTH & HUMAN SERVS., CHOOSING A MEDIGAP POLICY: 2003 GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE

In 1980, Congress amended Title XVIII of the Social Security Act to add the new Section 1882 and thereby created a role for the federal government and the Medicare program in the private market for Medigap insurance.<sup>24</sup> The federal statute specified minimum levels of benefits and required each Medigap policy to meet an anticipated loss ratio by returning at least a specified percentage of premiums to the insured in the form of benefits.<sup>25</sup> In addition, the law made abusive marketing of Medigap policies a federal crime.<sup>26</sup> Congress also required the Secretary to develop a program for voluntary certification of Medigap policies, provided that states could choose to regulate the Medigap market if they adopted the same or higher standards.<sup>27</sup>

Allowing states to regulate Medigap insurance is consistent with the usual allocation of authority to regulate the business of insurance under the federal McCarran-Ferguson Act.<sup>28</sup> The current statutory scheme, however, appears to be somewhat unique in two respects. First, it requires an ongoing federal role by the Secretary in reviewing state regulatory programs for Medigap insurance in order to determine whether those state programs continue to meet all of the

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13-15 (2002) [hereinafter CHOOSING A MEDIGAP POLICY] (outlining Medigap and its various options and limitations), available at <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.

24. Act of June 9, 1980, Pub. L. No. 96-265, § 507(a), 94 Stat. 441, 476 (codified as amended at 42 U.S.C. § 1395ss (2000)).

25. U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-87-8, MEDIGAP INSURANCE: LAW HAS INCREASED PROTECTION AGAINST SUBSTANDARD AND OVERPRICED POLICIES 2 (1986) [hereinafter MEDIGAP INSURANCE], available at <http://www.gao.gov/index.html>.

26. *Id.* Congress had held hearings with regard to allegations of abusive sales tactics in the market for supplemental insurance, and received information that was based on anecdotes. Atherly, *supra* note 19, at 138-39. See David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797, 802 n.22 (regarding Congressional reliance on anecdotes in considering proposed legislation).

27. H.R. CONF. REP. NO. 96-944, at 75 (1980), reprinted in 1980 U.S.C.C.A.N. 1392, 1422-24; see also MEDIGAP INSURANCE, *supra* note 25, at 2 ("[I]f a state has adopted laws and/or regulations that are at least as stringent as the [National Association of Insurance Commissioners'] model and the federal loss ratio requirement, policies regulated by the state are deemed to meet the federal requirements."). By 1986, almost all states adopted regulatory programs that met those standards. *Id.* at 3-4.

28. See 15 U.S.C. §§ 1011-1012 (2000) (declaring that the continued regulation and taxation by the several states of the business of insurance is in the public interest); see generally *Humana Inc. v. Forsyth*, 525 U.S. 299 (1999). Subsequently, Congress used the same allocation of federal and state authority in the Newborn's and Mother's Health Protection Act of 1996, by permitting continued state regulation of so-called "drive-through deliveries" if the applicable state law met the standards set forth in the federal statute. Newborn's and Mother's Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified in scattered sections of 29 U.S.C. and 42 U.S.C.).



federal requirements.<sup>29</sup> Second, by enacting the 1980 federal law as part of Title XVIII of the Social Security Act, Congress made federal oversight of private supplemental insurance an integral part of the public Medicare program.

In 1990, Congress made additional changes to the Medigap regulatory scheme in the Omnibus Budget Reconciliation Act (OBRA),<sup>30</sup> including standardization of benefit packages under 10 different policies<sup>31</sup> and a specific period for open enrollment regardless of health status.<sup>32</sup> In addition, Congress required the Secretary to establish "a health insurance advisory service program," which also is referred to as the "beneficiary assistance program."<sup>33</sup> The purpose of this program is to help Medicare beneficiaries "with the receipt of services" through other health insurance programs as well as through Medicare and Medicaid.<sup>34</sup> Congress directed the Secretary to provide

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29. See 42 U.S.C. § 1395ss(b)(2) (2000) ("The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1).").

30. Omnibus Budget Reconciliation Act (OBRA), Pub. L. No. 101-508, §§ 4351-4361, 104 Stat. 1388, 1388-127 to 1388-141 (1990) (codified in scattered sections of 42 U.S.C.).

31. MEDIGAP, *supra* note 19, at 5; see also CHOOSING A MEDIGAP POLICY, *supra* note 23, at 15 (displaying a chart of allowable Medigap plans A through J); Vencor Inc. v. Physicians Mut. Ins. Co., 211 F.3d 1323, 1327 (D.C. Cir. 2000) (describing an amendment of the NAIC Model Regulation to establish ten standardized plans).

32. OBRA § 4357; see also *id.* § 4352 (guaranteeing renewability); Atherly, *supra* note 19, at 139-40 (discussing specific reforms). Subsequently, Congress made further amendments with regard to benefit packages and requirements for guaranteed issue in the Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4031-32, 111 Stat. 251, 359 (1997). See MEDIGAP, *supra* note 19, at 5 (citing changes that the act made to specific benefit plans); Atherly, *supra* note 19, at 142 (listing changes made by the act).

33. OBRA § 4359. Two years earlier, Congress had directed the Secretary to create and distribute a notice of the benefits available under Medicare as well as the types of benefits that are not available under Medicare. Act of July 1, 1988, Pub. L. No. 100-360, § 223(a), 102 Stat. 683, 747 (1988) (codified at 42 U.S.C. § 1395b-2(a) (2000)); see also 42 U.S.C. § 1395ss(e) (2000) (explaining the duty of the Secretary to provide information on supplemental insurance to persons entitled to Medicare benefits "and, to the extent feasible, to individuals about to become so entitled"). That statute is apparently unique and potentially significant in authorizing the Secretary to assist persons who are not yet eligible for Medicare but will be eligible in the future.

34. 42 U.S.C. § 1395b-3(a). The Secretary's authority to assist beneficiaries "with the receipt of services" appears to be broader than the mere authority to provide information and counseling, and arguably would permit the Secretary to act as ombudsman or advocate in helping Medicare beneficiaries to actually *obtain* services from supplemental insurance carriers in cases of benefit denial under Medigap policies. That broad interpretation of the Secretary's authority is also supported by the reference to "information, counseling, and assistance" as three apparently distinct functions in subsection (c) of the statute, which implies that assistance could involve more than simply providing education and advice. 42 U.S.C. § 1395b-3(c). As the Secretary and CMS explained in support of their final rule for the Medicare-endorsed prescription drug card initiative, "[t]he requirement that the beneficiary assistance program

assistance with regard to Medicare, Medicaid and Medicare supplemental policies, and to provide "such other services as the Secretary deems appropriate to increase beneficiary understanding of, and confidence in, the Medicare program and to improve the relationship between beneficiaries and the program."<sup>35</sup> Although somewhat ambiguous, that statutory language may provide significant authority for the Secretary to assist Medicare beneficiaries in ways that go far beyond the receipt of covered benefits under the Medicare program.<sup>36</sup>

The informational and educational aspects of the beneficiary assistance program include activities performed directly by the federal government as well as activities performed by state agencies with federal financial support. Congress authorized the Secretary to make grants to states with approved Medigap regulatory programs in order to provide health insurance information and assistance to Medicare beneficiaries,<sup>37</sup> and authorized appropriations for that purpose from the Medicare trust funds.<sup>38</sup> As its part of the overall educational effort, the federal government provides information with regard to health issues as well as insurance issues. This information is available to the public regardless of eligibility for Medicare.<sup>39</sup>

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provide assistance, in addition to counseling and information, suggests that the Congress contemplated more than the provision of information." Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,621 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403).

35. 42 U.S.C. § 1395b-3(c) (2000).

36. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,621 (Sept. 4, 2002) (arguing that the statutory language grants the Secretary the authority to provide a discount card program). As discussed below, the Secretary and CMS also relied on that provision in adopting their final rule for the Medicare-endorsed prescription drug card initiative. See *infra* notes 96–104 and accompanying text (describing how CMS concluded that it had such authority).

37. OBRA, Pub. L. No. 101-508, § 4360(a), 104 Stat. 1388, 1388-138 (1990) (codified at 42 U.S.C. § 1395B-4(A) (2000)).

38. OBRA § 4360(f) (codified at 42 U.S.C. § 1395b-4(g) (2000)).

39. For example, on its Web site at <http://www.medicare.gov>, CMS provides health information and links to further information. The site is accessible to anyone with Internet access, without the need for any password or beneficiary identification number. In addition to an interactive tool entitled "Medicare Personal Plan Finder," the site includes "Stay Healthy" information and comparisons of quality at some types of healthcare facilities. In addition, CMS operates a National Medicare Education Program (NMEP), which is designed primarily to provide information with regard to beneficiary choices in regard to the Medicare+Choice program. See generally U.S. GEN. ACCOUNTING OFFICE, GAO-01-1071, MEDICARE: PROGRAM DESIGNED TO INFORM BENEFICIARIES AND PROMOTE CHOICE FACES CHALLENGES (2001) (discussing NMEP activities, expenditures, funding sources, and the reactions and challenges to NMEP), available at <http://www.gao.gov/index.html>.

The actual effects of these informational and regulatory activities are difficult to measure, but nevertheless some conclusions can be drawn. First, regulation has improved the operation of the private market for Medigap insurance by reducing fraudulent and abusive marketing practices and by standardizing the products into ten allowable benefit packages. Standardization has made it easier for beneficiaries to compare Medigap policies and select a policy that meets their needs, reduced their search costs, and promoted price competition by Medigap carriers.<sup>40</sup> In these ways, government regulation of the market has been effective in encouraging competition and providing a remedy for market failure.<sup>41</sup> Standardization of benefit packages, however, reduces the ability of consumers to select only those elements of coverage that they desire, and thereby prevents the market from efficiently allocating resources in accordance with consumer preferences.<sup>42</sup>

In addition, by promoting and facilitating the purchase of supplemental coverage, the federal government is increasing the costs of the Medicare program. Studies have clearly shown that supplemental insurance is associated with higher Medicare costs, and there is also persuasive evidence that the availability of supplemental insurance is a cause of higher Medicare costs.<sup>43</sup> According to the GAO, beneficiaries with supplemental insurance cost the Medicare program more than beneficiaries without supplemental insurance.<sup>44</sup> In a comprehensive review of 118 articles and reports on supplemental coverage, Adam Atherly concluded that supplemental insurance causes higher

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40. See Atherly, *supra* note 19, at 140–41 (examining the impact of standardization).

41. See *Cal. Dental Ass'n v. FTC*, 526 U.S. 756, 771–72 (1999) (recognizing that restrictions on advertising might actually enhance competition in a market characterized by information asymmetry); Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management or the Market*, 37 ARIZ. L. REV. 825, 827 (1995) (stating that the market failure of inadequate information and consumers' inability to understand the information justify state regulation of healthcare professionals).

42. See Mark V. Pauly, *The Medicare Mix: Efficient and Inefficient Combinations of Social and Private Health Insurance for U.S. Elderly*, 26 J. HEALTH CARE FIN. 26, 30 (2000) (noting that "by regulation, if one wishes to buy a Medigap policy that covers prescription drugs, one is required to include coverage of some of the Medicare cost sharing"). See generally Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 57–58 (Autumn 2002) (discussing the possibility of consumers making their own individual choices on the trade-off between cost and quality).

43. See Atherly, *supra* note 19, at 148–53 (analyzing past studies on the effect of supplemental insurance on Medicare spending); MEDIGAP, *supra* note 19, at 12 (explaining that "Medigap's first-dollar coverage reduces financial barriers to health care, but it also diminishes beneficiaries' sensitivity to costs and likely increases beneficiaries' use of services, adding to total Medicare spending") (emphasis added).

44. MEDIGAP, *supra* note 19, at 12.

Medicare spending.<sup>45</sup> Some researchers have argued that the higher Medicare expenditures for beneficiaries with supplemental coverage really are the result of adverse selection, on the theory that those beneficiaries who are more likely to need expensive healthcare services are more likely to purchase supplemental insurance coverage.<sup>46</sup> Other researchers have demonstrated, however, that even when supplemental insurance is obtained on a group basis from an employer with less likelihood of adverse selection, the availability of supplemental insurance is associated with higher Medicare expenditures.<sup>47</sup> There were significantly higher expenditures for beneficiaries with individual Medigap insurance than for beneficiaries with employer group supplemental coverage as a result of adverse selection. In addition, there were significantly higher expenditures for beneficiaries with employer group supplemental coverage than for beneficiaries without any supplemental coverage at all, which resulted at least in part from the moral hazard of having additional insurance.<sup>48</sup> Thus, the availability of supplemental insurance, which the federal government facilitates and promotes, has the effect of increasing the utilization of Medicare services, increasing Medicare costs, and interfering with federal efforts to control the cost of the Medicare program.<sup>49</sup> As Mark Pauly has pointed out, the moral hazard results in the publicly supported Medicare program subsidizing the purchase of commercial Medigap insurance.<sup>50</sup>

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45. See Atherly, *supra* note 19, at 153 ("Supplemental insurance leads to increased Medicare expenditures, although the size of that effect varies from study to study due to variations in data, study methodology, empirical methodology, and legislative changes.") (emphasis added).

46. See *id.* at 150 (citing a study that concluded higher prices were the effect of adverse selection). Atherly also noted that there is adverse selection for individual Medigap policies that provide drug coverage, but favorable selection for those individual Medigap policies that lack drug coverage. *Id.* at 146, 153.

47. See *id.* at 150–51 (describing studies which differentiated claims on the basis of group and individual policies).

48. See *id.* (citing a study finding employer plans had higher costs than individuals with no supplemental insurance due in part to moral hazard). See MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 11–12 (1994) (distinguishing between the phenomena of adverse selection and moral hazard).

49. See Atherly, *supra* note 19, at 151–53 (evaluating the negative effects of the availability of supplemental insurance). Federal efforts to promote supplemental insurance and beneficiary education may also improve the understanding, satisfaction, and health status of beneficiaries, but those effects are difficult to document. See, e.g., *id.* at 152 (noting that the effect of Medigap insurance on health status is not clear).

50. See Pauly, *supra* note 42, at 30 (explaining that "because purchase of private supplemental coverage increases the expected benefit to be claimed from the tax-supported (and community-rated) Medicare plan, there is a cross-subsidy to supplemental coverage").

*B. The Medicare-Endorsed Prescription Drug Card Assistance Initiative*

The lack of coverage for outpatient prescription drugs has been one of the most serious gaps in the Medicare program. This deficiency would be a problem in any health insurance plan, but it is a particular problem for the elderly, who are much more likely to require regular medication for chronic and acute conditions. Three-fourths of all Medicare beneficiaries have some supplemental coverage for a portion of their drug costs, but that coverage may be extremely limited.<sup>51</sup> In addition, millions of beneficiaries have no coverage at all for prescription drugs.<sup>52</sup> These beneficiaries not only have to pay all of their drug costs out of pocket, but also must pay higher prices than insured patients who get the benefit of negotiated discounts.<sup>53</sup>

Policymakers have attempted to solve these problems in a variety of different ways.<sup>54</sup> For several years, Congress debated the addition of a prescription drug benefit to the Medicare program,<sup>55</sup> but progress was delayed by the problem of cost and by philosophical and political disagreements over the appropriate roles of the private sector and the government. Some state governments have expanded their Medicaid programs to provide drug-only Medicaid coverage for certain individuals who would not otherwise qualify for Medicaid<sup>56</sup> or have created a separate, non-Medicaid program of prescription

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51. HEALTH POLICY ALTERNATIVES, INC., KAISER FAMILY FOUND., PRESCRIPTION DRUG DISCOUNT CARDS: CURRENT PROGRAMS AND ISSUES 3 (Feb. 2002) [hereinafter HEALTH POLICY ALTERNATIVES], at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14156> (on file with the Washington and Lee Law Review); see also *supra* notes 20–23 and accompanying text (describing Medicare’s coverage, or lack thereof, for prescription drugs).

52. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,619 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403).

53. See HEALTH POLICY ALTERNATIVES, *supra* note 51, at 3–4 (evaluating the benefits of discount cards); see also Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,619, 56,623 (preamble to final rule) (naming some of the challenges for people without discount cards).

54. See generally MEDICARE PAYMENT ADVISORY COMM’N (MEDPAC), REPORT TO THE CONGRESS: SELECTED MEDICARE ISSUES 3–32 (June 2000) (discussing possible policy solutions to Medicare beneficiaries’ need for drug coverage), available at [http://www.medpac.gov/publications/congressional\\_reports/Jun00%20report.pdf](http://www.medpac.gov/publications/congressional_reports/Jun00%20report.pdf).

55. See, e.g., Prescription Drug Benefit and Cost Containment Act of 2003, S. 7, 108th Cong. (2003) (offering one example of a drug benefit proposal). See also *infra* note 81 (citing legislation finally enacted in Nov. 2003).

56. See, e.g., *Pharm. Research & Mfrs. of Am. v. Thompson*, 251 F.3d 219, 221 (D.C. Cir. 2001) (deciding that the federal government had no authority to approve Vermont’s Medicaid demonstration project, which had attempted to require manufacturers to pay rebates without any use of state Medicaid funds).

drug assistance for residents of the state.<sup>57</sup> In the meantime, pharmaceutical manufacturers have operated drug assistance programs to help individuals purchase their products, and a market has developed for prescription drug discount cards.

Prescription drug discount programs are not a type of insurance.<sup>58</sup> The issuer of the card does not assume an actuarial risk and does not undertake an obligation to pay any of the holder's expenses. Rather, the card entitles the holder to discounts on prescription drugs that the issuer of the card has negotiated with particular manufacturers or pharmacies.<sup>59</sup> Drug card programs may be sponsored by organizations such as AARP or by pharmacy benefit managers (PBMs),<sup>60</sup> as well as by insurance companies, third-party administrators (TPAs), retailers, pharmaceutical manufacturers, and state governments.<sup>61</sup> Cardholders may be required to pay a fee to the sponsor upon enrollment or on a periodic basis.<sup>62</sup> In addition, pharmaceutical manufacturers give rebates to the sponsors of discount card programs to increase the sales of the manufacturers' products.<sup>63</sup> Although discount card programs may be beneficial for consumers, it is extremely difficult and time-consuming for an individual to determine the value of a particular program and choose the card that best meets the individual's needs.<sup>64</sup> These problems can be particularly

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57. See *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 71 (1st Cir. 2001) (determining that a state may encourage or coerce a pharmaceutical manufacturer to participate in a state drug assistance program by threatening to treat the manufacturer's products less favorably under the state's Medicaid program), *aff'd sub nom. Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 123 S. Ct. 1855, 155 L. Ed. 2d 889 (2003)).

58. *But see* HEALTH POLICY ALTERNATIVES, *supra* note 51, at 3 n.4 (noting that California and Washington have attempted to regulate discount drug card programs as insurance companies).

59. See *id.* at 3 (describing the benefits of possessing discount cards).

60. See U.S. GEN. ACCOUNTING OFFICE, GAO-02-280R, PRESCRIPTION DRUGS: PRICES AVAILABLE THROUGH DISCOUNT CARDS AND FROM OTHER SOURCES 3 (2001) (naming sources of discount cards), available at <http://www.gao.gov/index.html>.

61. See HEALTH POLICY ALTERNATIVES, *supra* note 51, at 4 (listing sponsors of discount cards).

62. See *id.* at 3 (charting some discount card enrollment requirements).

63. *Id.* at vii, 4. The authors of the Kaiser report state: "While rebates flow to the card sponsor, there is considerable variation in the degree to which the rebates are passed through to the consumer in the form of lower prices." *Id.* at vii. Card sponsors also may obtain discounts from retail pharmacies. *Id.* at viii. With some understatement, the authors of the Kaiser report note that "[c]onsiderable tension exists between card sponsors and retail pharmacies." *Id.* In addition to extracting discounts on prices and dispensing fees, drug card programs may utilize mail-order prescription services that tend to limit a retail pharmacy's sales of merchandise as well as prescription drugs. *Id.* at viii, 25.

64. See *id.* (describing the challenges consumers face when trying to choose a discount card). Among other impediments to comparing prices, card sponsors might describe their

difficult for those elderly individuals who have multiple prescriptions, physical or psychological infirmities, and limited access to the internet for use in comparison shopping.<sup>65</sup>

The secretary responded to this market failure by developing a plan for the Medicare program to officially endorse drug discount cards that meet the requirements specified by the government. The plan is referred to as the Medicare-Endorsed Prescription Drug Card Assistance Initiative.<sup>66</sup> Under this plan, the government would not add a prescription drug benefit to the Medicare program, and the Secretary has made it clear that this plan is merely an interim measure to provide some assistance to beneficiaries until prescription drug coverage becomes a reality.<sup>67</sup> Although the plan does not require the use of benefit funds,<sup>68</sup> it does expand the role of the Secretary in the private sector and it constitutes a new use of the Medicare program in helping beneficiaries to obtain non-covered goods and services. In fact, it appears to be the first time that the federal government would give the official endorsement of the Medicare program to non-covered goods or services.<sup>69</sup>

The adoption of the Medicare-endorsed drug card plan has followed an extremely tortuous path. The initial plan was published in the Federal Register on July 18, 2001 as a "summary of proposed collections for public comment."<sup>70</sup> At that time, CMS took the position that its implementation of the drug card initiative did not require compliance with the rulemaking formalities of the Administrative Procedure Act (APA).<sup>71</sup> The government's initiative was

respective discounts in very different ways, and might advertise that they offer an average discount from undisclosed list prices. *Id.*

65. *See id.* at ix, 26 (detailing challenges to be addressed in discount card programs).

66. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403).

67. *See, e.g.*, 67 Fed. Reg. at 56,623 ("The administration continues to support modernizing the Medicare program by adding a drug benefit . . . This initiative will provide Medicare beneficiaries with the educational tools and assistance to obtain some relief on drug prices, until a Medicare drug benefit can be enacted.").

68. *Id.* ("This initiative is not a drug benefit, since it does not require the expenditure of benefit dollars.").

69. Sellers of goods and services are prohibited by law from falsely claiming or implying that they have the endorsement of the Medicare program. 42 U.S.C. § 1320b-10(a) (2000). *See infra* note 104 (describing aspects of Medicare that protect beneficiaries). Although not actually an "endorsement," a Medigap policy may be "certified" by the Secretary as meeting the requirements of law. *See* 42 U.S.C. § 1395ss(a)(1) (2000) (explaining the certification procedure); *see also supra* note 27 and accompanying text (discussing state standards for certification).

70. Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 66 Fed. Reg. 37,564 (July 18, 2001).

71. 5 U.S.C. § 553 (2000). *See Amy Goldstein, Judge Blocks Prescription Discount*

challenged by the National Association of Chain Drug Stores and the National Community Pharmacists Association, which filed an action in the Federal District Court for the District of Columbia.<sup>72</sup> In addition to challenging the failure to follow APA rulemaking requirements, the plaintiffs argued that the Secretary had no statutory authority to implement the drug card endorsement program.<sup>73</sup>

On September 11, 2001, the district court issued an order granting plaintiffs' motion for a preliminary injunction and enjoined the Secretary and the Administrator of CMS from implementing the program that had been announced in the Federal Register.<sup>74</sup> According to the district court, plaintiffs had demonstrated a likelihood of success on the merits of their claims on the grounds of both statutory authority and rulemaking procedure.<sup>75</sup> The government filed a motion for a stay of proceedings in the district court on October 10, 2001, while it undertook formal rulemaking on a revised drug card proposal,<sup>76</sup> and the court granted the government's motion for a stay.<sup>77</sup> Then,

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*Plan*, WASH. POST, Sept. 7, 2001, at A1 ("The government argued that HHS was not actually regulating private pharmacy discount programs—but was merely creating a voluntary program for companies and patients."). CMS requested the Office of Management and Budget (OMB) to review and approve on an expedited basis the collection of information, published a notice of its request to OMB in the Federal Register, and invited public comment on the requirements for collection of information. 66 Fed. Reg. 37,564 (July 18, 2001). See also Timothy S. Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 88–96 (1999) (discussing Medicare rulemaking and sub-regulatory issuances such as manual transmittals and policy statements).

72. See Nat'l Ass'n. of Chain Drug Stores v. Thompson, No. 01-1554, 2001 U.S. Dist. LEXIS 14417, at \*2 (D.D.C. Sept. 11, 2001) (granting a preliminary injunction of implementation of the drug card plan).

73. See *id.* at \*1 (stating that the plaintiffs claimed that the defendants were "without legal authority in creating the Medicare Rx Discount Card Program").

74. *Id.* at \*2.

75. *Id.* at \*1 ("The Court found that plaintiffs have a substantial likelihood of success on the merits of their claim that defendants violated the Administrative Procedure Act and acted without legal authority in creating the Medicare Rx Discount Card Program.").

76. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 10,262, 10,262-63 (Mar. 6, 2002) (describing the history of the proposed rule).

77. See Nat'l Ass'n of Chain Drug Stores v. Thompson, No. 01-1554, 2001 U.S. Dist. LEXIS 18411, at \*1 (D.D.C. Nov. 8, 2001) (issuing a memorandum opinion to clarify its order of November 5). As explained in the November 8 opinion, the media incorrectly reported that the court had lifted its preliminary injunction. *Id.* Instead, the court had granted a stay because the government intended to develop a different proposal and comply with formal rulemaking procedures. *Id.* at \*2–3. The court wrote that "[p]laintiffs are free to return to court at any time after such a proposal is submitted." *Id.* at \*3. However, the government objected to that language in the order and related language with regard to the duration of the stay because the wording might have implied a particular time at which the government's new proposal would be subject to judicial review. *Id.* at \*1–2. Therefore, the court issued yet another order of clarification on December 14, 2001, to provide "that the stay will continue until such time as



CMS published a proposed rule with an invitation for public comments on March 6, 2002 and formally withdrew the previous proposal of July 18, 2001.<sup>78</sup> The final rule was published on September 4, 2002, and it became effective on November 4, 2002.<sup>79</sup> However, on January 29, 2003, the district court permanently enjoined the government from implementing its revised proposal.<sup>80</sup> Initially, it was not clear whether the government would pursue an appeal of that final order or merely seek additional authority from Congress, or both, but Congress resolved the issue as a practical matter in November of 2003 as part of the Medicare prescription drug legislation.<sup>81</sup> Moreover, despite the ruling of the district court, it can reasonably be argued that the Secretary did indeed have the authority to implement this proposal without the need for any additional grant of statutory authority.<sup>82</sup>

As described in the final rule, CMS would enter into an endorsement agreement with any sponsor that files an application and meets all of the requirements set forth in the rule.<sup>83</sup> Successful applicants will be allowed to

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defendants' policy is ripe for review." *Nat'l Ass'n of Chain Drug Stores v. Thompson*, No. 01-1554, 2001 U.S. Dist. LEXIS 20806, at \*2 (D.D.C. Dec. 14, 2001).

78. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 10,262, 10,262 (proposed Mar. 6, 2002) ("By publishing this proposed rule, we are formally withdrawing the program described in the Federal Register on July 18, 2001.") (codified at 42 C.F.R. pt. 403).

79. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,623 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403) ("This final rule describes a program that differs in important respects from the Administration's initial proposal from 2001 . . .").

80. See *Nat'l Ass'n of Chain Drug Stores v. Thompson*, 241 F. Supp. 2d 29, 30 (D.D.C. 2003) (permanently enjoining the implementation of the proposal that was published in the Federal Register on September 4, 2002). The wording of the court's order is very sparse. According to the media, however, Judge Friedman "said it was 'mind-boggling' for the administration to suggest that existing laws provided legal authority for a program with such big effects on beneficiaries and pharmacies." Robert Pear & Elisabeth Bumiller, *Doubts Are Emerging as Bush Pushes His Medicare Plan*, N.Y. TIMES, Jan. 30, 2003, at A18.

81. See Neely Tucker, *Judge Rejects Bush's Drug Discount Plan*, WASH. POST, Jan. 30, 2003, at A7 ("Medicare administrator Tom Scully said the administration would still seek to implement the idea, through congressional authorization or a further appeal."). The litigation was stayed pending possible action by Congress. Then, on November 25, 2003, Congress enacted Medicare legislation that includes statutory authorization for the Secretary to establish a prescription drug discount card program. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 (codified in scattered sections of 42 U.S.C.).

82. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,621 (arguing that the Secretary has such statutory authority).

83. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 42 C.F.R. § 403.804(d) (2002); see also Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,625 (explaining the conditions of endorsement). The final rule makes some changes from the initial proposal of July 18, 2001, such as limiting endorsements to those card

describe and market their discount drug card programs as "Medicare-endorsed."<sup>84</sup> To be eligible for an endorsement, the sponsor must agree to enroll all Medicare beneficiaries who wish to enroll in its drug card program with an enrollment fee of not more than \$25, and only Medicare beneficiaries may enroll in the sponsor's program.<sup>85</sup> Sponsors also must meet requirements with regard to their experience, structure, discounts or rebates, access, customer service, and privacy standards.<sup>86</sup> Finally, applicants for endorsement must agree to participate in—and contribute financial support to—a private administrative consortium with other sponsors of Medicare-endorsed card programs to disseminate comparative information, monitor the information distributed by each sponsor, prevent duplicate enrollment of beneficiaries, ensure legal compliance, and establish a plan to protect the security of health information.<sup>87</sup>

In the preamble to its final rule, CMS emphasizes that it does not spend benefit money on prescription drugs, does not require manufacturers or pharmacies to provide any discounts, and does not impose requirements on any organization.<sup>88</sup> CMS describes its initiative as merely establishing the requirements that it will use in endorsing those discount cards in the private sector, that would be most valuable for Medicare beneficiaries.<sup>89</sup> CMS's

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programs that can obtain discounts and pass on a significant portion of those discounts to the consumers. *Id.* at 56,623. The final rule is based on the same concept as the informal 2001 proposal, however, in that the Medicare program will officially endorse prescription drug discount cards that are issued by sponsors in the private sector.

84. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,625.

85. 42 C.F.R. § 403.806(c) (2002). In addition, a sponsor may not enroll a Medicare beneficiary who is already a member of another Medicare-endorsed drug card program because beneficiaries may participate in only one endorsed program at a time. *Id.* § 403.811. The purpose of limiting each beneficiary to one endorsed drug card program at a time is to enable the sponsor of each card program to obtain the best possible price concessions or rebates from pharmaceutical manufacturers. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,625–26 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403) (listing aspects of the initiative).

86. 42 C.F.R. § 403.806 (2002).

87. *Id.* §§ 403.806(b)(6), 403.810. For example, the administrative consortium will publish or facilitate publication of price information to help beneficiaries determine which of the endorsed drug card programs would best meet their needs and will monitor the accuracy of the representations made by each of the sponsors. *Id.* § 403.810(a)(2)–(3).

88. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,621.

89. *Id.* ("[T]his initiative does not impose requirement [sic] on any entities—it merely creates conditions that we will use to endorse card programs that we consider to be appropriate for beneficiaries.").

characterization of its role as mere passive endorsement of private sector services, however, is incomplete and somewhat misleading. Rather than merely identifying and publicizing the best programs in an existing market for drug discount cards, CMS essentially is creating a new market for drug discount card programs limited to Medicare beneficiaries.<sup>90</sup> At the very least, CMS is shaping the market and the sellers in that market, just as the Medicare program has shaped the structure and operation of healthcare providers by establishing conditions of participation for each type of facility.<sup>91</sup> As a practical matter, CMS is offering to enter into a non-exclusive endorsement agreement with any sponsor that is willing to structure its operations to meet the agency's conditions.<sup>92</sup> Moreover, CMS will play an active role in establishing the private administrative consortium that will provide a self-regulatory structure for the market that CMS is creating.<sup>93</sup>

CMS characterizes its endorsement program as merely a passive educational activity because it is relying on the Secretary's authority to educate and assist Medicare beneficiaries for statutory authority for the program.<sup>94</sup> As described above,<sup>95</sup> Congress authorized the Secretary in Section 4359 of OBRA to establish a health insurance advisory service, also known as the beneficiary assistance program. CMS takes the position that its drug card initiative

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90. According to a report published by the Kaiser Family Foundation in February 2002, none of the existing drug discount programs that were surveyed could have met the requirements set forth in the government's proposal. See HEALTH POLICY ALTERNATIVES, *supra* note 51, at 2 ("It is important to emphasize, however, that the programs that exist today are different than the discount card programs that are envisioned under the Bush Administration's proposal."). For example, most of the private sector card programs were open to anyone regardless of age, and two programs, including the program sponsored by the American Association of Retired Persons, were limited to persons over fifty years old. *Id.* at 9. In contrast, the final rule requires sponsors to limit their drug discount card programs to Medicare beneficiaries. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 42 C.F.R. § 403.806(c)(2) (2002).

91. See, e.g., 42 U.S.C. § 1395bbb (2000) (outlining conditions of participation for home health agencies).

92. See 42 C.F.R. § 403.806 (2002) (setting forth endorsement requirements).

93. See *id.* § 403.810(b) ("In order to facilitate the formation of the administrative consortium and ensure that all functions are performed in a timely manner, CMS may assist in the start-up of the administrative consortium and perform any of the functions in this section for a transitional period of time."). Although CMS emphasizes that it is not using benefit funds, the agency will inevitably use administrative funds or at least staff time and resources to perform those activities for the consortium during the period of transition.

94. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,620 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403) (citing Section 4359 of OBRA as authority for the Secretary's action).

95. See *supra* notes 33–36 and accompanying text (reporting government efforts to assist beneficiaries with supplemental insurance and other such services).

constitutes a beneficiary assistance program within the meaning of that statute and makes several arguments that the statutory language of Section 4359 provides authority for the initiative.<sup>96</sup> As CMS points out, Section 4359 directs the Secretary to assist Medicare beneficiaries with the "receipt of services"<sup>97</sup> under Medicare. By helping beneficiaries obtain prescription drugs not covered by Medicare that their physicians routinely prescribe, CMS asserts that this initiative will enable beneficiaries to more efficiently utilize physician services that the Medicare program covers.<sup>98</sup> In addition, Section 4359 authorizes the Secretary to provide "information, counseling, and assistance,"<sup>99</sup> and CMS argues that this statutory language contemplates that assistance will go beyond merely providing information and advice.<sup>100</sup> The statute also authorizes the Secretary to provide "such other services as the Secretary deems appropriate" to promote beneficiary confidence in the Medicare program and improve its relationship with its beneficiaries.<sup>101</sup> According to CMS, this initiative will demonstrate to beneficiaries that the Medicare program understands their concerns about the cost of prescription drugs and is trying to help as much as possible.<sup>102</sup> CMS also relies on the Secretary's general rulemaking authority<sup>103</sup>

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96. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,620–21. CMS reiterated that it "believe[d] that this initiative meets the definition of a beneficiary assistance program." *Id.* at 56,620.

97. OBRA, Pub. L. No. 101-508, § 4359, 104 Stat. 1388, 1388-137 to 1388-138 (1990) (codified at 42 U.S.C. § 1395b-3(a) (2000)).

98. Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,620, 56,622. CMS cited several studies indicating that some Medicare beneficiaries were unable to fill the prescriptions ordered by their physicians or failed to take the full doses recommended by their physicians. *Id.* "[T]here is also evidence supporting our conclusion that access to prescription drugs is an integral part of the health care services delivered by the Medicare program, and that improving access to prescription drugs directly influences the effectiveness of Medicare-covered services." *Id.* at 56,622.

99. OBRA § 4359.

100. *See* Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. 56,618, 56,621 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403) ("The requirement that the beneficiary assistance program provide assistance, in addition to information and counseling, suggests that the Congress contemplated more than the provision of information."); *supra* notes 35–36 and accompanying text (discussing the Secretary's role in aiding beneficiaries).

101. *See* 42 U.S.C. § 1395b-3(c) (2000) (describing the general role of the Secretary in the Medicare program).

102. *See* Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,622 (acknowledging survey data indicating a lack of confidence in the respondents' ability to pay for prescription drugs once they become eligible for Medicare and explaining how the initiative should alleviate some of these prescription drug costs).

103. *See id.* at 56,621 (discussing the general rulemaking authority given to the Secretary, including the authority to "publish such rules and regulations as may be necessary to the efficient administrations of the functions with which he is charged"); *see also* 42 U.S.C.

and argues that the Secretary is entitled to deference in interpreting the ambiguous provisions of Section 4359.<sup>104</sup>

Despite the somewhat misleading characterization of the initiative as a passive educational activity, the appellate courts would have been likely to uphold the authority of CMS to adopt the program as a permissible type of beneficiary assistance, even without any additional grant of statutory authority. The agency's arguments with regard to the language of Section 4359 are reasonable. Therefore, despite the ruling of the district court, appellate courts would have been likely to give deference to the agency's interpretation of the statute.<sup>105</sup> Although it is unlikely that Congress explicitly contemplated endorsements by the Medicare program, the drug card program is consistent

§ 1395hh(1) (2000) ("The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter."); 42 U.S.C. § 1302(a) (2000) ("The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.").

104. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,620 (noting that the statute's language is broad, particularly Section 4395(c)'s grant of authority to provide services that will increase confidence in the Medicare program as the Secretary deems appropriate). CMS cited the decision of a federal district court that, although subsequently vacated on other grounds, found Section 4359 to be ambiguous and, therefore, gave deference to the Secretary's interpretation. See *Tex. Gray Panthers v. Thompson*, 139 F. Supp. 2d 66, 76 (D.D.C. 2001) (finding the statute's key terms—"information, counseling, and assistance"—to be ambiguous and therefore deferring to the Secretary's reasonable interpretation of the statute), *vacated and remanded on other grounds*, 2002 U.S. App. LEXIS 11467 (D.C. Cir. May 12, 2002), *reh'g denied*, 2002 U.S. App. LEXIS 12056 (D.C. Cir. June 13, 2002).

In addition, CMS argues that further support exists for its drug card endorsement program in the federal statute that prohibits giving a false impression that an item is endorsed by the Medicare program. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,621-23 (citing Section 1140 of the Social Security Act, codified at 42 U.S.C. § 1320b-10(a)(1) (2000), which prohibits any person from, among other things, using the word Medicare "in a manner which such person knows or should know would convey . . . the false impression that such item is approved, endorsed, or authorized by the . . . Department of Health and Human Services"). In the preamble to its final rule, CMS argued that this statute, in conjunction with the other cited statutes, lends further support to its claim of statutory authority for its endorsement program by implying that Congress contemplated that some claims of endorsement would not be false. See Medicare-Endorsed Prescription Drug Card Assistance Initiative, 67 Fed. Reg. at 56,621-23 (stating that "Congress understood that in some cases use of the word Medicare by private parties and organizations will be approved by the Secretary"). However, that is not a strong argument. The statute is equally susceptible to the interpretation that Medicare would never give its endorsement to products or services in the private sector.

105. See Jost, *supra* note 71, at 51-56 (discussing the deference that courts give to interpretations of the Secretary in Medicare cases); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417 (1993) ("[W]here the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction.").

with the underlying intent of Congress that the Secretary assist beneficiaries in ways that do not require the expenditure of benefit funds or create any new entitlement. For all of these reasons, the appellate courts would have been likely to find that CMS had the authority to implement the drug card endorsement program.<sup>106</sup>

As a matter of public policy, this broader use of the Medicare program to assist beneficiaries in obtaining non-covered goods and services, when considered in isolation, is fairly innocuous and potentially beneficial. A potential problem exists, however, with justifying additional functions for Medicare by characterizing them as beneficiary assistance programs. It is difficult—if not impossible—to develop a workable rule to determine which additional functions would be authorized and appropriate for the Medicare program and which activities, if any, would go too far.

### *III. Assisting All Patients by Using Medicare Participation as a Jurisdictional Hook for Provider Mandates*

Section 1866 of the Social Security Act, which was part of the original 1965 legislation,<sup>107</sup> sets forth the terms to which providers must agree in order to qualify to participate in the Medicare program and to be eligible to receive Medicare payments.<sup>108</sup> Unlike the conditions of participation, which are detailed standards for the organization and operation of specific types of facilities,<sup>109</sup> the requirements for provider agreements in Section 1866 apply

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106. CMS also points out that it made some changes to the initiative that originally was announced. *See Medicare-Endorsed Prescription Drug Card Assistance Initiative*, 67 Fed. Reg. 56,618, 56,623 (Sept. 4, 2002) (to be codified at 42 C.F.R. pt. 403) (explaining how the final rule differs from the initial proposal, including the discount programs the final rule endorses, additional reporting requirements, and the card programs that are endorsed, among other distinctions). However, Congress did not change the basic concept of the endorsement program. Therefore, it is unlikely that the changes, in and of themselves, would lead to a different outcome on the issue of statutory authority.

107. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1866, 79 Stat. 286, 327–29 (current version at 42 U.S.C. § 1395cc (2000)).

108. *See* 42 U.S.C. § 1395cc (2000) (outlining conditions which providers must agree to prior to Medicare participation).

109. *See, e.g.*, 42 U.S.C. § 1395bbb (2000) (enumerating conditions of participation for home health agencies); 42 C.F.R. pt. 482 (2002) (detailing conditions of participation for hospitals). The conditions of participation may also be used to accomplish goals that go beyond providing covered services to eligible beneficiaries. For example, apart from Section 1866, Congress has limited participation in Medicare and Medicaid to those hospitals that adopt written protocols to identify potential organ donors and provide notice of potential donors to their local organ procurement agency. *See* 42 U.S.C. § 1320b-8(a)(1)(A) (2000) (explaining organ procurement requirements for program participation). Pursuant to that statute, the

regardless of the category of facility.<sup>110</sup> In the original 1965 version of the statute, the requirements for provider agreements in Section 1866 merely limited the types of charges that providers were permitted to make to Medicare beneficiaries.<sup>111</sup> After 1965, however, Congress frequently amended Section 1866 to include many types of affirmative obligations to which providers are now required to agree.<sup>112</sup>

Current requirements for providers include obligations to participate in government payment programs other than Medicare,<sup>113</sup> to provide emergency care to non-Medicare beneficiaries as well as to beneficiaries, and to advise Medicare patients and non-Medicare patients about their rights under state law

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Secretary has adopted a specific condition of participation for hospitals with regard to organ procurement. *See* 42 C.F.R. § 482.45 (2002) (announcing organ procurement and transportation responsibilities for Medicare and Medicaid participants).

110. *See* 42 U.S.C. § 1395cc(a)(1) (2000) (applying the statute to "[a]ny provider of services" with the exception of certain funds established by physicians at teaching hospitals).

111. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 1866, 79 Stat. 286, 327-29 (current version at 42 U.S.C. § 1395cc (2000)) (setting out the restrictions with which providers would have to comply to participate in Medicare).

112. *See, e.g.*, Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, §§ 9121(a), 9122(a), 100 Stat. 82, 164, 167 (1986) (codified at 42 U.S.C. § 1395cc (2000)) (expanding obligations related to the examination and treatment of emergency medical conditions and requiring the use of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) payment systems for provider participation); *see also* 42 C.F.R. § 489.20 (2002) (listing basic commitments of provider agreements).

113. *See* 42 U.S.C. § 1395cc(a)(1)(J-L)(2000) (requiring Medicare-participating hospitals to also participate in the CHAMPUS and CHAMPVA programs and to admit military veterans authorized by the Department of Veterans Affairs (VA) and accept compensation from the VA as payment in full). In COBRA of 1985, Pub. L. No. 99-272, § 9122, 100 Stat. 82, 167 (1986), Congress added a new subparagraph (J) to Section 1866 to require Medicare-participating hospitals to participate in the CHAMPUS and CHAMPVA programs, which mandated that those hospitals accept payments from these programs as payment in full for covered services, except for deductibles and cost-sharing. *See* Participation in CHAMPUS and CHAMPVA, 59 Fed. Reg. 32,086, 32,087 (June 22, 1994) (to be codified at 42 C.F.R. pts. 405, 489, 1003) (discussing statutory requirement for Medicare hospitals of participation in CHAMPUS and CHAMPVA programs); *see also* 42 C.F.R. § 489.25 (2002) (requiring hospitals that participate in Medicare to also participate in the CHAMPUS and CHAMPVA programs for inpatient services). The Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, Pub. L. No. 99-576, § 233, 100 Stat. 3248, 3265, requires hospitals participating in the Medicare program to accept payment for treatment of authorized veterans under the VA's payment methodology. *See* Participation in CHAMPUS and CHAMPVA, 59 Fed. Reg. at 32,087-88 (noting that participants must provide care for eligible veterans and then receive payment for these services under the applicable VA payment system). *See also* 42 C.F.R. § 489.26 (2002) (requiring hospitals that participate in Medicare to admit any VA authorized veteran and to follow the VA payment procedures for these patients). Interestingly, Section 1866 of the Social Security Act does not require Medicare-participating hospitals to also participate in the federally-supported Medicaid program.

to refuse treatment and make advance directives.<sup>114</sup> The requirements to provide emergency care and advise patients about advance directives are described in detail below.

#### A. *The Emergency Medical Treatment and Active Labor Act (EMTALA)*

In the Consolidated Omnibus Reconciliation Act of 1985,<sup>115</sup> Congress amended the requirements for provider agreements in Section 1866 of the Social Security Act<sup>116</sup> and added a new Section 1867, which is known as EMTALA or the COBRA Anti-Dumping Law.<sup>117</sup> The statute requires every

114. These requirements are distinguishable from the requirement that Medicare providers comply with civil rights and anti-discrimination laws because those laws are applicable to providers independently of Section 1866, without any need for providers to agree to be bound by those laws. Instead, civil rights and anti-discrimination laws apply to all recipients of "federal financial assistance," which courts and the Secretary have interpreted to include facilities participating in Medicare. See, e.g., *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1047 (5th Cir. 1984) (surveying cases that found federal discrimination statutes protective of Medicare hospitals and agreeing with this conclusion). Although the Secretary requires Medicare providers to formally agree to comply with civil rights and anti-discrimination laws, 42 C.F.R. § 489.10(b) (2002), those requirements are not included in Section 1866. Moreover, those laws apply independently of the Social Security Act. A requirement to agree to comply with laws that are applicable already is redundant and unnecessary. In contrast, the obligations to which providers are required to agree under Section 1866 are only binding on providers as a result of the Medicare statute and their agreement to comply.

115. COBRA of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67 (1986).

116. *Id.* § 9121(a), 100 Stat. at 164 (codified at 42 U.S.C. § 1395cc(a)(1)(I) (2000)); see also 42 C.F.R. § 489.20(m), (q), (r) (2002) (requiring a provider to report to CMS anytime it receives a patient in an unstable condition from another hospital in violation of the provider agreement, to post signs describing each patient's rights regarding emergency treatment, to post signs indicating whether the hospital is a Medicare provider, to maintain medical records for patients who come to the emergency department, and to keep a list of physicians who are on call for duty in emergency situations).

117. 42 U.S.C. § 1395dd (2000). See also 42 C.F.R. § 489.24 (2002) (describing new provider obligations). See generally David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998) (analyzing the original case for EMTALA and speculating about the statute's future in the current health care marketplace); Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173 (1989) (describing problems generally associated with patient-dumping and issues that are likely to arise under the antidumping statute); Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOUS. L. REV. 113 (1996) (discussing the dramatic effects of EMTALA on malpractice law); Erik J. Olson, Note, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449 (1994) (examining the antidumping laws of COBRA and various states and concluding that they have been insufficient in curtailing treatment and financing problems in emergency rooms); Lynn Healey Scaduto, Comment, *The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries*, 46 UCLA L. REV. 943



hospital that participates in the Medicare program<sup>118</sup> and has an emergency department to provide emergency services without regard to a patient's ability to pay.<sup>119</sup> Specifically, the hospital must provide "an appropriate medical screening examination"<sup>120</sup> to determine if the patient has "an emergency medical condition."<sup>121</sup> If the hospital concludes that the patient indeed does have a medical emergency, then the hospital must provide additional

(1999) (reviewing the legislative history of EMTALA and arguing for a narrowing of the class of patients to whom it should be applied).

118. See 42 U.S.C. § 1395dd(e)(2) (2002) (defining the term "participating hospital" as a "hospital that has entered into a provider agreement under section 1866").

119. See *Burditt v. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366, 1368 (5th Cir. 1991) (explaining that execution of the Medicare provider agreement makes EMTALA applicable); McClurg, *supra* note 117, at 199–201, 232 (discussing procedures that a Medicare provider must undertake for all emergency patients and the penalties that accompany a failure to provide emergency treatment). Required emergency services may not be delayed "in order to inquire about the individual's method of payment or insurance status." 42 U.S.C. § 1395dd(h) (2000). Thus, EMTALA does not prohibit hospitals from charging patients after the hospital provides emergency services, although a large percentage of those bills are likely to be uncollectible.

EMTALA applies when a person "comes to the emergency department." *Id.* § 1395dd(a). Obviously, this phrase needs to be interpreted in a flexible manner, in order to protect a person who walks in the wrong door of the hospital. The government has had difficulty, however, developing a reasonable and understandable set of rules to determine where and when EMTALA obligations are applicable. See, e.g., *Changes to the Hospital Inpatient Prospective Payment Systems*, 67 Fed. Reg. 31,404, 31,472–77 (proposed May 9, 2002) (announcing proposed amendments to EMTALA regulations with regard to off-campus facilities). In addition, there is a dispute as to whether EMTALA obligations apply to inpatients already admitted to the hospital. See *id.* at 31,475–76, 31,507 (discussing proposed 42 C.F.R. § 489.24(d)(2)).

120. 42 U.S.C. § 1395dd(a) (2000). The term "appropriate medical screening examination" is not defined in the statute, but the purpose of the examination is set forth in the statute as determining whether the patient has a medical emergency. *Id.* In addition, the screening examination must be "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." *Id.*

In contrast to the community practice standard of malpractice law, the screening examination must comply with the hospital's own uniform procedure for patients with the same condition. See *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879–80 (4th Cir. 1992) ("[EMTALA] establishes a standard which will of necessity be individualized for each hospital, since hospital emergency departments have varying capabilities."). However, a split exists among the circuits as to whether a plaintiff in a private civil action under EMTALA is only required to prove that the patient received a disparate screening examination or, alternatively, is also required to prove a bad motive for a hospital's failure to provide its standard screening. *Id.* at 880 n.8. In *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 253 & n.1 (1999), the Supreme Court did not resolve that precise issue with regard to screening under subsection (a), but the Court did note that most appellate courts do not require proof of bad motive for the disparate screening.

121. 42 U.S.C. § 1395dd(a) (2000). The term "emergency medical condition" is defined in § 1395dd(e)(1) and includes specific applications for women in labor. *Id.* § 1395dd(e)(1).

examination and treatment to stabilize the condition of the patient or, alternatively, transfer the patient to another hospital in accordance with the strict conditions set forth in the statute.<sup>122</sup> If a hospital fails to comply with these requirements, the government may assess civil monetary penalties and even terminate the hospital's Medicare provider agreement.<sup>123</sup> In addition, the statute creates a private civil action for any person who is injured as a result of a hospital's violation of the law.<sup>124</sup>

The statute is not limited to Medicare beneficiaries, but rather applies to all patients "whether or not eligible for benefits under this [title]."<sup>125</sup> In fact, the statute was not enacted to assist persons who are eligible for Medicare. Congress had expressed its concern about patients who were denied emergency care because they lacked medical insurance.<sup>126</sup> However, all Medicare beneficiaries, by definition, have medical and hospital insurance for the costs of emergency treatment.<sup>127</sup> Moreover, Congress was particularly concerned about

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122. *Id.* § 1395dd(b). Under subsection (c), unless the transfer is requested by the patient, a physician must certify that the benefits of transfer outweigh the risks. *See id.* § 1395dd(c)(1)(A)(ii) (requiring a transferring physician to certify that the medical benefits of the transfer are "reasonably expected" to outweigh the patient's increased risks and to include a summary of the risks and benefits associated with the transfer). Even after a physician's certification to that effect, a transfer would not be appropriate unless the receiving facility has sufficient space and agrees to accept the patient and the patient is transferred in a proper vehicle with qualified staff. *Id.* § 1395dd(c). *See Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269, 1276 (E.D. Tex. 1990) ("[A] 1976 Ford Pinto with no medical equipment, whose only other occupant besides the patient is her boyfriend, is not the equivalent of an ambulance for the purposes of the Antidumping Act.").

123. *See* 42 U.S.C. §§ 1395dd(d)(1)(A), 1395cc(b)(2) (2000) (providing a civil penalty of no more than \$50,000 and giving the Secretary discretion in renewing and terminating provider agreements when a provider has failed to comply with regulations); 42 C.F.R. § 489.24(f) (2002) (allowing the Secretary to terminate the provider agreement when a hospital does not meet its requirements); *see also* U.S. GEN. ACCOUNTING OFFICE, GAO-01-747, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 17-25 (2001) (detailing the infrequency with which hospitals are sanctioned for EMTALA violations), *available at* <http://www.gao.gov/index.html>; Singer, *supra* note 117, at 136, 136 nn.129-30 (discussing possible sanctions when a hospital violates COBRA).

124. 42 U.S.C. § 1395dd(d)(2)(A) (2000). Courts frequently recite that "EMTALA . . . was not enacted to establish a federal medical malpractice cause of action nor to establish a national standard of care." *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1166 (9th Cir. 2002). However, commentators have recognized the potential for confusion and abuse. *See, e.g.*, Singer, *supra* note 117, at 121 ("By inherently raising concepts of malpractice, COBRA's protections invite overuse by plaintiffs and misuse by the courts.").

125. 42 U.S.C. § 1395dd(a-b) (2000).

126. *See, e.g.*, H.R. REP. NO. 99-241, pt. 1, at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 605 (discussing an increase in reports of hospital emergency rooms turning away uninsured patients). *But see* Hyman, *supra* note 26, at 810 n.46 ("[T]he legislative history is quite clear that EMTALA was sold to Congress on the basis of a few bad anecdotes.").

127. *See, e.g.*, 42 C.F.R. § 410.28 (2002) (detailing Medicare coverage for outpatient

women in labor, as indicated by the title of the Act, and few women of child-bearing age are beneficiaries of the Medicare program. Why, then, did Congress choose to use Medicare participation as the "jurisdictional hook" for emergency treatment requirements that were primarily intended to assist non-Medicare beneficiaries?

The relevant section of the Act is titled "Responsibilities of Medicare Hospitals in Emergency Cases."<sup>128</sup> However, the Act does not explain why an obligation of society to provide indigent care should be borne, without compensation, by hospitals that provide services to Medicare beneficiaries. One could argue, perhaps, that some amount of additional bad debt for emergency treatment is a reasonable quid pro quo for a hospital's privilege of participating in a lucrative federal purchasing program. In fact, the First Circuit reasoned that Congress used the financial benefits of Medicare participation as "a carrot to make health-care providers more receptive to the stick."<sup>129</sup> However, in the statute, Congress did not articulate that justification or any other for linking indigent emergency treatment with Medicare.

The legislative history of EMTALA is similarly unhelpful in this regard.<sup>130</sup> In committee reports, Congress expressed dissatisfaction with the status quo and concluded that a federal response was required,<sup>131</sup> but did not address why the federal response should be implemented as part of the hospital insurance

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hospital diagnostic services). As one commentator put it, "using the Medicare program to authorize and enforce COBRA's antidumping provision is curious since COBRA will have little effect on Medicare patients." Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1209 & n.159 (1986) (citing the findings of a study that found that only 3% of patients transferred to a public hospital were Medicare patients). See also McClurg, *supra* note 117, at 232 ("[T]here is little incentive to dump a Medicare patient . . .").

128. COBRA of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (1986) (codified as amended at 42 U.S.C. § 1395cc (2000)).

129. *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1189-90 (1st Cir. 1995). See also *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 874 n.1 (4th Cir. 1992) ("Congress sought to end patient dumping by requiring any hospital receiving federal funds to examine patients who seek treatment in an emergency department and treat any serious medical condition detected.").

130. See McClurg, *supra* note 117, at 197 n.106 (explaining that "[t]he anti-dumping provisions were only a small part" in the 1986 budget statute); Scaduto, *supra* note 117, at 946-48 (discussing EMTALA's legislative history but providing no basis for a relationship between the statute and Medicare).

131. See, e.g., H.R. REP. NO. 99-241, pt. 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. 726, 727 (discussing a growing concern with emergency room care offered to uninsured patients and endorsing a federal solution to this problem); see also *Bryant v. Riddle Mem'l Hosp.*, 689 F. Supp. 490, 492 (E.D. Pa. 1988) ("The legislative history of the Act contains much evidence of Congress's intent to provide a federal cause of action.").

program for the elderly and disabled.<sup>132</sup> The closest thing to a justification for using Medicare was a statement made by one of the sponsors, Senator Durenberger, that EMTALA would "make it clear that the Medicare Program will not do business with any institution which willfully and knowingly, or through negligence, turns its back on an emergency medical situation."<sup>133</sup> Nothing, however, indicates that other members of Congress agreed with Senator Durenberger's normative approach to participation in Medicare. Nor was there any serious discussion of the ramifications of adopting value-based criteria for Medicare participation.<sup>134</sup> Moreover, some confusion existed about the relationship between Medicare patients and the proposed EMTALA statute, as indicated by one senator's reference to what he described as "Medicare dumping."<sup>135</sup>

In a 1990 EMTALA case, the Sixth Circuit suggested that Congress had designed EMTALA as a way to impose obligations on those hospitals that had not received funding under the earlier Hill-Burton program.<sup>136</sup> This argument is a plausible theory because Hill-Burton funds were limited to hospitals operated by public entities and non-profit organizations.<sup>137</sup> Theoretically,

132. The House Ways and Means Committee did refer to Medicare's relatively new system of prospective payment as a possible reason that hospitals may be less willing than they were in the past to treat indigent emergency patients. See H.R. REP. NO. 99-241, pt. 1, at 27, *reprinted in* 1986 U.S.C.A.N. 579, 605 ("There is some belief that this situation has worsened since the the [sic] prospective payment system for hospitals became effective."); see also 131 CONG. REC. S28,570 (daily ed. Oct. 23, 1985) (statement of Sen. Proxmire) (sponsoring a federal antidumping program to be implemented through Medicare). Some members of Congress discussed the use of Medicare exclusion as a means of enforcing EMTALA, but without discussing why they thought it was appropriate to use the Medicare program as a means of enforcement. See *id.* at S28,569 (statements of Sens. Kennedy and Heinz) (stating that "[m]eaningful enforcement is essential" without explaining why termination of Medicare reimbursements was a proper enforcement mechanism). Senator Proxmire stated that "it is crucial that we act promptly to establish the fundamental principle that this behavior will not be tolerated by Medicare." *Id.* at S28,570. However, Senator Proxmire did not explain why he thought that the Medicare program should be involved in the issue of emergency care for patients who have no health insurance or Medicare coverage.

133. 131 CONG. REC. S28,568 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

134. See *infra* notes 294-301 and accompanying text (discussing the problems inherent in using normative criteria for Medicare participation and other government procurement activities).

135. See 131 CONG. REC. S28,570 (daily ed. Oct. 23, 1985) (statement of Sen. Domenici) ("[A]s I understand this bill . . . clearly this is something that has no opposition with respect to those who are involved in this notion of Medicare dumping.").

136. *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) ("Apparently dissatisfied with the effect of laws that had been limited to hospitals that received funds from the government under the Hill-Burton Act, Congress chose to attempt to meet the perceived evil by enacting the quoted language.") (citation omitted).

137. See 42 U.S.C. § 291 (2000) (noting that funding was to assist "programs for the

Congress might have concluded that for-profit hospitals, which had not received Hill-Burton funds or accepted Hill-Burton obligations of free care and community service, were even more likely than public and non-profit hospitals to deny emergency care to persons unable to pay.<sup>138</sup> Those for-profit hospitals do participate in Medicare, however, and could be subjected to federal mandates as a condition of Medicare participation.

Nevertheless, the most reasonable conclusion is that Congress simply used Medicare participation as the "hook" because it was convenient and it avoided the constitutional problems inherent in forcing private parties to give away their goods and services without compensation.<sup>139</sup> Participation in Medicare is literally voluntary, even though it is an economic necessity for acute-care general hospitals.<sup>140</sup> Therefore, courts have consistently rejected constitutional challenges to Medicare requirements on the basis of the voluntary nature of the program.<sup>141</sup> Moreover, under the Spending Clause,<sup>142</sup> Congress has the power to impose conditions on both state and private recipients of federal funds.<sup>143</sup>

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construction and modernization of such public or other nonprofit community hospitals"). However, there were weaknesses in the Hill-Burton program that extended beyond the exclusion of for-profit providers, including the lack of a private civil remedy, vagueness of its provisions, and a lack of commitment to enforcement. See Singer, *supra* note 117, at 132 & n.102 (describing general problems with the Hill-Burton scheme); Hyman, *supra* note 26, at 810 n.46 (noting reluctance to enforce obligations on hospitals receiving Hill-Burton funding).

138. See *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 680 (10th Cir. 1991) (stating that Congress was concerned about patient "dumping" by private hospitals); see generally Robert Kuttner, *Columbia/HCA and the Resurgence of the For-Profit Hospital Business*, 335 N. ENG. J. MED. 362 & 446 (1996) (two-part report).

139. As an analogy, the federal government could not require supermarkets to provide free food to every starving person who shows up in the produce department with no money. Therefore, instead of requiring supermarkets to give away food for free, the government subsidizes the purchase of food for the indigent with food stamps.

140. See Russell Korobkin, *Determining Health Care Rights From Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801, 829 (1998) ("In one sense, compliance with EMTALA is voluntary, as the law only binds hospitals that receive Medicare funds, but the practicalities of the health care business require hospitals to participate in Medicare to remain solvent.") (citations omitted); see also RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 89 (1997) ("Because the federal government does not license physicians, it has to look elsewhere for its power, and ironically it finds its mandate in a robust appeal to the principle of freedom of contract.").

141. See, e.g., *Garelick v. Sullivan*, 987 F.2d 913, 917 (2d Cir. 1993) ("All court decisions of which we are aware that have considered takings challenges by physicians to Medicare price regulations have rejected them in the recognition that participation in Medicare is voluntary."); *Ass'n of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 134 (N.D. Ill. 1975) (explaining that providing an economic incentive to participate in a federal program does not offend the Constitution), *aff'd*, 423 U.S. 975 (1975); see also Robert A. Berenson & Dean M. Harris, *Using Managed Care Tools in Traditional Medicare—Should We? Could We?* 65 LAW & CONTEMP. PROBS. 139, 162–65 (2002) (describing the limited success of constitutional

Even critics of EMTALA, such as Richard Epstein, acknowledge that EMTALA has had some "obvious successes."<sup>144</sup> Epstein and others, however, have severely criticized the mandate of EMTALA on the philosophical grounds of autonomy and freedom of contract, as well as on the practical grounds of anticipated adverse effects.<sup>145</sup> An unfunded mandate to provide emergency care may create inefficiencies<sup>146</sup> and may contribute to a reduction in emergency service capacity or cause undesirable changes in emergency department operations.<sup>147</sup> Although it is unrealistic to think that we can

challenges to Medicare claims).

142. U.S. CONST. art I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes . . . to pay the Debts and provide for the common Defence and general Welfare of the United States . . .").

143. See *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (noting that the Court has repeatedly permitted congressional use of the Spending Clause to "induce government and private parties to cooperate voluntarily with federal policy"). *But cf.* *New York v. United States*, 505 U.S. 144, 167 (1992) ("Such conditions must (among other requirements) bear some relationship to the purpose of the federal spending . . ."); *South Dakota v. Dole*, 483 U.S. 203, 207–08 & n.3 (1987) (discussing four types of limitations on the spending power, including the requirement that any condition imposed by Congress be related to the goal of the federal expenditure). However, the Court did not clarify the extent of relationship between the federal condition and the federal goal that would be needed to satisfy constitutional requirements. See *Dole*, 483 U.S. at 208 n.3 ("Our cases have not required that we define the outer bounds of the 'germaneness' or 'relatedness' limitation on the imposition of conditions under the spending power."). Andrew McClurg has suggested that EMTALA might violate the constitutional limitations on the spending power, but has recognized that any such challenge would be unlikely to succeed. McClurg, *supra* note 117, at 228–33 (discussing previous failed constitutional challenges to federal coercion through Congress's use of its spending power).

144. EPSTEIN, *supra* note 140, at 104.

145. *Id.* at 84 ("The contrived creation of a binding obligation to provide care is not only wrong in principle, it is also ineffective in practice, in light of the anticipated response."); Richard A. Epstein, *Living Dangerously: A Defense of Mortal Peril*, 1998 U. ILL. L. REV. 909, 930 (1998) (arguing that private organizations will provide emergency care more effectively if not burdened by unfunded government mandates); see also Hyman, *supra* note 117, at 30 ("The premise of the statute is silly at best; one cannot impose open-ended obligations of this sort on private parties and expect them to meekly comply—and the inevitable adaptive responses make everyone worse off."). Other commentators have criticized EMTALA, or at least the prevailing judicial interpretation of EMTALA, for leading to excessive or inappropriate litigation. See, e.g., Singer, *supra* note 117, at 121 (arguing that contrary interpretations of the statute have led to an increase in litigation and eroded the law's utility); Scaduto, *supra* note 117, at 945–46 (attributing the increase in litigation to an expansive misinterpretation of EMTALA).

146. See Thomas S. Ulen, *Is America's Health Care System in Mortal Peril?: An Introduction to Mortal Peril*, 1998 U. ILL. L. REV. 683, 690–91 (1998) (discussing "inefficient strategic behavior" by noncharitable hospitals, indigent patients, and government officials charged with monitoring and enforcing EMTALA).

147. See Epstein, *supra* note 145, at 932–33 (discussing how "the hospitals that stay in business would alter their strategies in ways that are counterproductive in order to minimize the unfortunate impacts of EMTALA"); Hyman, *supra* note 117, at 53 (predicting an overall loss of

eliminate all unfunded mandates and cross-subsidies from the health care system, we certainly can demand a greater degree of transparency from the Medicare program in openly acknowledging that costs exist for providing uncompensated emergency care and that we are forcing community hospitals and their customers to shoulder those costs. As David Hyman put it, "there are no free lunches—even in the ED."<sup>148</sup>

In addition, it is important to recognize what EMTALA means for the nature of the Medicare program. Since the enactment of EMTALA, there is a clear precedent for using Medicare as a "hook" to require providers to give away a portion of their goods and services for free. Although Congress enacted EMTALA as a response to anecdotes and the legislation has significant costs, additional mandates to provide free goods and services could be proposed in the future. In light of the history of EMTALA, additional mandates would not be unthinkable.

### B. *The Patient Self-Determination Act (PSDA)*

In OBRA of 1990, Congress further amended Section 1866 of the Social Security Act by enacting the Patient Self-Determination Act (PSDA).<sup>149</sup> The

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emergency department capacity). *But see* Henry T. Greely, *Richard Epstein's Mortal Peril: Ebenezer Scrooge Meets the American Health Care System*, 1998 U. ILL. L. REV. 727, 737 & n.40 (1998) (criticizing Epstein's failure to provide sufficient evidence of the costs and benefits of EMTALA, as well as Epstein's interpretation of data on the reduction of hospital services).

148. Hyman, *supra* note 117, at 53.

149. *See* OBRA of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388, 1388-115 to -117 (codified at 42 U.S.C. § 1395cc(a)(1)(Q), 1395cc(f) (2000)) (amending Section 1566); *see generally* Elizabeth H. Bradley et al., *The Patient Self-Determination Act and Advance Directive Completion in Nursing Homes*, 7 ARCHIVES OF FAM. MED. 417 (1998) (analyzing the impact of the PSDA within the nursing home context and determining that it has had a favorable impact on the documentation of advance directives); Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997) (tracing the history and implementation of the PSDA and determining that the legislation has been modestly successful in achieving its desired outcome); Thaddeus M. Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139 (1999) (examining the effects that the PSDA has had on patient autonomy and arguing that a policy of informed consent would better preserve this goal of the Act); Jeremy Sugarman et al., *The Cost of Ethics Legislation: A Look at the Patient Self-Determination Act*, 3 KENNEDY INST. OF ETHICS J. 387 (1993) (evaluating the costs and benefits associated with implementing the PSDA for both health care providers and patients); Joan M. Teno et al., *The Impact of the Patient Self-Determination Act's Requirement that States Describe Law Concerning Patients' Rights*, 21 J.L. MED. & ETHICS 102 (1993) (examining the processes used by states in providing to patients a written description of their respective laws concerning advance directives, as required by the PSDA).

legislation added a new subsection (f) to Section 1866, which sets forth requirements for Medicare-participating facilities to establish written policies and procedures on advance directives.<sup>150</sup> In addition, the PSDA added a new requirement for Medicare provider agreements to the effect that hospitals and other health care facilities must agree to comply with the new requirements of subsection (f).<sup>151</sup>

Specifically, facilities are required to maintain policies and procedures to provide written information to all adult patients about their rights under state law to refuse treatment and to make advance directives.<sup>152</sup> Hospitals must provide the written information when the person is admitted as an inpatient.<sup>153</sup> Therefore, the requirements do not apply to outpatients. Health care facilities are also required to provide information to patients about the facility's policies on refusal of treatment and advance directives,<sup>154</sup> to make a notation about the existence of an advance directive in the patient's medical record,<sup>155</sup> to assure compliance with state laws on advance directives,<sup>156</sup> and to provide or cooperate in the provision of education on these issues for the facility's staff

150. See 42 U.S.C. § 1395cc(f) (2000) (requiring participants to maintain and provide written information regarding advance directives for each patient); see also 42 C.F.R. §§ 489.10(c), 489.100 to .104 (2002) (outlining advance directive requirements for program participants).

151. 42 U.S.C. § 1395cc(a)(1)(Q) (2000). These requirements apply to provider agreements with "hospitals, skilled nursing facilities, home health agencies, and hospice programs." *Id.* The applicability of Section 1866(f) is somewhat broader, and applies to Medicare+Choice organizations and certain prepaid or eligible organizations, as well as to providers. *Id.* § 1395cc(f)(1).

152. *Id.* § 1395cc(f)(1)(A)(i). The term "advance directive" is defined as a document authorized by State law with regard to a person who is incapacitated, such as a living will or a health care power of attorney. *Id.* § 1395cc(f)(3). The federal legislation also requires each State government to prepare a written description of State statutory and common law with regard to advance directives. *Id.* § 1396a(a)(58). See also Larson & Eaton, *supra* note 149, at 260 (stating that instead of requiring every state to enact an advance directive statute, the bill requires states to provide written information to patients regarding advance directives); Teno, *supra* note 149, at 103–04 (restating the requirements of § 1395cc(f)(1)(A)(i)-(ii)).

153. 42 U.S.C. § 1395cc(f)(2)(A). Similarly, skilled nursing facilities must provide the information when the person is admitted as a resident, but home health agencies must provide the information before the person comes under the agency's care. *Id.* § 1395cc(f)(2)(B), (C).

154. *Id.* § 1395cc(f)(1)(A)(ii).

155. *Id.* § 1395cc(f)(1)(B). As originally enacted, the existence of an advance directive had to be documented "in the individual's medical record." OBRA, Pub. L. No. 101-508, § 4206, 104 Stat. 1388, 1388-115 to 1388-117 (codified at 42 U.S.C. § 1395cc(a)(1)(Q), 1395cc(f) (2000)). Subsequently, Congress amended that provision to specifically require that the documentation be placed "in a prominent part of the individual's current medical record." Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4641, 111 Stat. 251, 487 (codified at 42 U.S.C. § 1395cc).

156. 42 U.S.C. § 1395cc(f)(1)(D) (2000).



and for the public.<sup>157</sup> Finally, health care facilities may not require a patient to execute an advance directive as a condition of providing care to the patient, nor may facilities discriminate against a patient who has made the decision to execute an advance directive.<sup>158</sup>

While the bill was under consideration, the U.S. Supreme Court issued its decision in *Cruzan v. Director, Missouri Department of Health*.<sup>159</sup> In *Cruzan*, the Court held that the State of Missouri had not violated Ms. Cruzan's constitutional rights by requiring clear and convincing evidence of her desires before permitting termination of artificial nutrition and hydration.<sup>160</sup> Although the Court's decision dealt with a fairly narrow constitutional issue, the practical implication was that federal courts would uphold reasonable state restrictions on termination of treatment. Therefore, patients who want to avoid being kept alive on life support would need to execute living wills or other advance directives in compliance with the requirements of the laws of their state.<sup>161</sup> Presumably, the federal PSDA would make it easier for patients to avoid unwanted treatment by requiring health care facilities to establish written policies and procedures for the use of advance directives and by making patients aware of their legal options. In fact, the requirements of the PSDA have been referred to frequently as a type of "Miranda warning."<sup>162</sup>

At least officially, the legislation was enacted as a federal effort to promote patients' rights and to give patients the option to avoid artificial means of life support.<sup>163</sup> The actions taken by Congress, however, were extremely

157. *Id.* § 1395cc(f)(1)(E).

158. *Id.* § 1395cc(f)(1)(C). Section 4206(c) of OBRA allows the continued application of any state law that permits a provider to object to the implementation of an advance directive on the basis of conscience. OBRA § 4206(c) (codified at 42 U.S.C. § 1395cc note). *See also* 42 C.F.R. § 489.102(a)(1)(ii) (2002) (requiring providers to issue a clear and precise written statement to patients if the provider cannot implement an advance directive on the basis of conscience); Larson & Eaton, *supra* note 149, at 255 & n.42 (stating that opposition to the legislation dissipated when a committee amendment verified state law exceptions for providers who do not implement advance directives on the basis of conscience). In addition, the Assisted Suicide Funding Restriction Act of 1997 (ASFRA) provided a clarification to the Patient Self-Determination Act (PSDA) to exclude "assisted suicide, euthanasia, or mercy killing." 42 U.S.C. § 14406 (2000).

159. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). After the original bill was introduced on October 17, 1989, the Supreme Court issued its *Cruzan* decision on June 25, 1990 before the President finally signed the legislation on November 5, 1990. Larson & Eaton, *supra* note 149, at 255-56.

160. *Cruzan*, 497 U.S. at 280, 282-85.

161. *See id.* at 280 (upholding the state's imposition of a "procedural safeguard").

162. Pope, *supra* note 149, at 142 & n.11; Larson & Eaton, *supra* note 149, at 251.

163. Section 4206 of OBRA is entitled "Medicare Provider Agreements Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting

limited. Congress did not create any federal right to refuse treatment or to terminate artificial means of life support. Nor did Congress attempt to establish a uniform, nationwide system of advance directives by means of a preemptive federal law or by federal funding to states that agree to adopt a model law meeting federal requirements. Instead, Congress merely required health care facilities to inform patients of whatever rights they may have under existing State law.<sup>164</sup> This approach has had limited success<sup>165</sup> and has required health care facilities to incur additional costs.<sup>166</sup>

Like EMTALA, the PSDA is an unfunded mandate for providers and is imposed as a condition of Medicare participation. Like EMTALA, the requirements are not limited to those who are eligible for benefits under the Medicare program. In the exigent circumstances of emergency treatment under EMTALA, it might be inefficient to attempt to distinguish between Medicare beneficiaries and non-beneficiaries. There would be no practical impediment, however, to singling out Medicare beneficiaries for special notice and recordkeeping requirements as part of the routine paperwork of non-emergency hospital admission. In fact, Section 1866 imposes a similar notice requirement that is explicitly limited to Medicare beneficiaries, by requiring hospitals to agree to provide a notice of rights to each Medicare beneficiary at or near the time of inpatient admission.<sup>167</sup> There is no practical reason, therefore, that the

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the Patient." OBRA of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388, 1388-115 to 1388-117 (codified at 42 U.S.C. § 1395cc(a)(1)(Q), 1395cc(f) (2000)). According to Edward Larson and Thomas Eaton, congressional proponents of the PSDA had six primary goals: 1) "empower people;" 2) increase the use of advance directives; 3) cause health care providers to comply with patients' advance directives; 4) promote enactment or clarification of state law; 5) reduce the futile treatment of dying patients; and 6) reduce health care costs. Larson & Eaton, *supra* note 149, at 256-62.

164. See BARRY FURROW ET AL., *HEALTH LAW: HORNBOOK SERIES* § 16-78 (2d ed. 2000) ("In the late 1980s many members of Congress were looking for a way to join the 'right to die' bandwagon without having Congress take a substantive position on any of the thorny underlying issues.").

165. See Larson & Eaton, *supra* note 149, at 284-85 (reviewing empirical studies). The authors noted:

Even for the minority of patients who have an advance directive, these documents often do not appear to influence actual treatment decisions. Moreover, the impact of advance directives on the level and cost of end-of-life treatment is not clear. Even under optimal circumstances, potential cost savings appear to be much less than first suggested by proponents of advance directives.

*Id.* at 285; see also Pope, *supra* note 149, at 156-157 ("[T]he PSDA, in spite of its title, not only fails to assure self-determination, but actually promotes uninformed and under-informed advance directives.").

166. See Sugarman et al., *supra* note 149, at 391, 394-95 (estimating the national startup costs of the PSDA).

167. 42 U.S.C. § 1395cc(a)(1)(M)(2000). This notice is commonly referred to as the

additional forms and records required by the PSDA could not be limited to beneficiaries of the Medicare program.

In the case of the PSDA, there may be more of a connection with the Medicare program than merely the ability of the government to use Medicare participation as financial leverage. First, Congress may have recognized that it would be convenient to use the Medicare law to impose notice and recordkeeping requirements on health care facilities.<sup>168</sup> In the legislative history of the PSDA, Congress noted that although Medicare had no requirements for advance directives, existing laws that set forth the obligations of Medicare-participating providers already were in place.<sup>169</sup> Congress also noted that, unlike the Medicare statute, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), through which many hospitals obtain "deemed status" for Medicare participation, already had a requirement for some hospital protocols on end-of-life care.<sup>170</sup> It was reasonable, therefore, to bring Medicare law up to the level of JCAHO accreditation requirements, although the PSDA went much further than contemporary JCAHO standards. Finally, there was some logic to using the Medicare program to promote the use of advance directives as a way of reducing the program's cost for the care of terminally ill beneficiaries. At least some advocates of the PSDA considered cost control to be one of the objectives of the proposed legislation.<sup>171</sup> Although the uninsured patients protected by EMTALA are not primarily Medicare beneficiaries,<sup>172</sup> many—if not most—terminally ill patients are indeed the elderly and disabled beneficiaries of the program.<sup>173</sup> Thus, there were more reasons to link the PSDA to the Medicare program than there were with EMTALA, but even less justification for extending the requirements of the PSDA to non-Medicare patients.

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"Important Message from Medicare."

168. See *infra* text accompanying note 180 (discussing a study panel of the National Academy of Social Insurance, which noted that Congress imposes some requirements by means of the Medicare program because "it is there").

169. H.R. CONF. REP. NO. 964, at 669, 775 (1990), reprinted in 1990 U.S.C.C.A.N. 2374, 2480.

170. See *id.* (referring to existing JCAHO requirements for protocols regarding "do not resuscitate" (DNR) orders).

171. See Larson & Eaton, *supra* note 149, at 261–62 (referring specifically to Senator Danforth who was one of the sponsors of the bill). "A legislative goal of less terminal medical treatment inevitably suggests the aim of reduced health care spending, especially since the federal government pays for most end-of-life treatment through Medicare." *Id.* at 261.

172. See *supra* notes 125–27 and accompanying text (discussing the patients that Congress intended to protect under EMTALA).

173. See Larson & Eaton, *supra* note 149, at 251 (reporting that Senator Danforth, who introduced the PSDA, sometime called it a "'Miranda warning' for the terminally ill").

*IV. Using Medicare Funds for the Benefit of the Broader Community*

The language and legislative history of the original Medicare Act demonstrate that, in 1965, Congress intended to assist a specific group of people and not the community at large. The Act does not contain an explicit statement of purpose within the statute itself, but it does have introductory language that sets forth the purposes of the Act, including establishing "a hospital insurance program for the aged" and "a supplementary medical benefits program."<sup>174</sup> The Act's introductory language also refers to expanding the program of medical assistance, improving public assistance programs, increasing Old-Age, Survivors and Disability Insurance (OASDI) benefits, and unspecified "other purposes".<sup>175</sup> However, Congress does not mention any intent to promote broader public goals or assist persons who are not eligible for benefits under those specific programs. In addition, the legislative history of the Act indicates that its purpose was "to provide a coordinated approach for health insurance and medical care for the aged."<sup>176</sup>

Nevertheless, Congress has permitted the use of Medicare funds to benefit the broader community by paying more than Medicare's proportional share for public goals such as medical education and indigent care.<sup>177</sup> In its 1999 report, the NASI study panel identified three reasons for using the Medicare program to subsidize these broader social goals. First, Medicare can use its reimbursement policies to assure the availability of health care providers for its

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174. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 286. The description of the hospital insurance program in Section 1811 of the Act explains the nature of the insurance program, the type of costs for which coverage is provided, and the limited category of individuals who are eligible for benefits. *Id.* § 1811 (codified at 42 U.S.C. § 1395c (2000)). Similarly, the supplementary medical insurance program under Part B that was established by Section 1831 of the Act is limited by its terms to "individuals 65 years of age or over who elect to enroll." *Id.* § 1831 (codified at 42 U.S.C. § 1395j (2000)).

175. Social Security Amendments of 1965, 79 Stat. at 286.

176. H.R. REP. NO. 89-213, at 2 (1965).

177. See NASI, *supra* note 12, at 39 ("Over the course of its history, Congress has directly and indirectly mandated that Medicare take on responsibilities beyond providing health insurance for older individuals and people with disabilities, including subsidizing medical education and certain 'safety-net' hospitals.") The NASI study panel also referred to these broader social goals as "public goods," which it defined as "goods or services which are available to or benefit everyone." *Id.* at 57. However, economists use a different definition of "public goods." See *infra* notes 221-224 and accompanying text (discussing economic meaning of "public good" and that term's relation to Medicare). Rather than referring to "public goods" or "social benefits," Michael Gusmano and Mark Schlesinger use the terminology of "collateral" uses of Medicare, on the ground that some of these activities are not pure public goods, but merely "localized public goods" or "mixed goods". Gusmano & Schlesinger, *supra* note 14, at 43.

own beneficiaries and to support providers in communities that would be unable to support the existence of necessary services on their own.<sup>178</sup> Second, Medicare is the national health insurance system in the United States, even though its benefits are limited to the elderly and disabled. Therefore, the United States uses its Medicare program to perform functions and accomplish goals that other nations assign to their national health insurance systems.<sup>179</sup> Third, Congress may have used the Medicare program to accomplish other public goals simply because "it is there."<sup>180</sup>

#### A. The Statutory Prohibition Against Cross-Subsidization

Usually, the term "cost shifting" is used to describe a health care provider's increase in its charges to privately insured patients as a response to inadequate payment from government payment programs.<sup>181</sup> If the Medicare program pays more than its "fair share" of a hospital's costs, however, then Medicare may be subsidizing the care of non-Medicare patients. Under those circumstances, hospitals might be able to reduce their charges to selected

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178. According to a NASI study panel, "because Medicare represents a large portion of all health care spending, it is also a logical means for influencing the structure of the health care system . . . ." NASI, *supra* note 12, at 39.

179. *Id.*

180. *Id.* As the report states, "Arguably, it has been relatively easy for Congress to attach ancillary programs on to Medicare because the program as a whole has been so large and so popular that legislators and the public will not focus on relatively small 'add-ons.'" *Id.* In their article, Gusmano and Schlesinger identified some additional reasons that would justify using the Medicare program to accomplish collateral functions, such as economies of scale, economies of scope, and "benefit externalities." Gusmano & Schlesinger, *supra* note 14, at 46. As they explained, "[m]ost generally, one would want to assign functions to the Medicare program if they can be done more efficiently or generate larger social benefits than under other institutional arrangements." *Id.*

181. See, e.g., David Dranove & William D. White, *Medicaid-Dependent Hospitals and Their Patients: How Have They Fared?*, 33 HEALTH SERVS. RES. 163, 165 (1998) ("A provider 'cost-shifts' by raising prices to privately insured patients in response to government cutbacks."); Jack Zwanziger et al., *Can Cost Shifting Continue in a Price Competitive Environment?*, 9 HEALTH ECON. 211 (2000) (discussing the concern that hospitals may respond to reductions in both Medicare and Medicaid payments to hospitals by increasing prices for privately insured patients). *But see* James F. Blumstein, *The Application of Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 IND. L. REV. 91, 114 (1998) ("[T]he ability of hospitals to shift costs assumes the existence of unexercised market power over at least a segment of the market"); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1514 n. 24 (1994) ("Costs, of course, have little to do with what is being shifted. Providers were engaging in classic economic price discrimination, charging net prices reflecting higher margins to those with less elastic demand.").

private payors, such as managed care organizations, and essentially "shift" some of the costs to the Medicare program.

In the public debate leading up to the enactment of Medicare in 1965, some health care providers expressed concern that costs would be shifted from Medicare to private patients.<sup>182</sup> In addition, some Republican members of Congress argued that the proposed program for the elderly might increase health care costs for patients under the age of sixty-five, and therefore hospitals should be paid for treating Medicare patients on the basis of their customary rates rather than under a formula of reasonable costs.<sup>183</sup> Proponents of the legislation, however, rebutted those concerns about cost shifting and argued that the proposed Medicare program would actually make it less necessary for hospitals to shift the cost of uncompensated care to other patients and third-party payors.<sup>184</sup>

To assure that costs would not be shifted from Medicare to other payors, Congress explicitly required the Secretary in the original 1965 Act to take indirect as well as direct costs into account in developing a methodology for

182. See, e.g., 111 CONG. REC. 16,110–12 (1965) (discussing a letter from the California Hospital Association that raised concerns about cost shifting).

183. See H.R. REP. NO. 89-213, at 243, 252–53 (1965) (stating separate views of Republican members in opposition). As those opponents stated:

Any cost which is shifted from the overage 65 patients in the cost formula prescribed by the Department, must necessarily be paid by someone . . . . If the entire burden is shifted from the overage 65 patients to the other patients, this will inevitably increase hospitalization costs for the patients under age 65.

*Id.* at 252–53.

184. See S. REP. NO. 89-404, at 37 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977–78. As that report stated:

The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible and coinsurance, for substantially all patients over 65 . . . .

The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.

*Id.* Congress also expressed its intent that the new insurance system for the elderly be self-supporting and actuarially sound. See H.R. REP. NO. 89-213, at 49 (1965) ("Your committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers . . . ."); S. REP. NO. 89-404, at 57 (1965). See BARRY FURROW ET AL., *supra* note 164, § 11:1 (2d ed. 2000) (discussing the prohibition against using general revenue funds to pay expenses under Part A, although such funds are used for Part B).

cost reimbursement.<sup>185</sup> As originally enacted, the hospital insurance program in Part A paid hospitals the reasonable cost of providing services, subject to certain exceptions.<sup>186</sup> The Act further provided that the reasonable cost of those services must be calculated in accordance with regulations to be adopted by the Secretary.<sup>187</sup> Although Congress gave the Secretary some flexibility in promulgating those regulations,<sup>188</sup> the Act explicitly required the Secretary to include the indirect as well as the direct costs of providing those services.<sup>189</sup> The purpose of reimbursing providers for their indirect costs was to assure that "the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs."<sup>190</sup> In that way, Congress prohibited cross-subsidization

185. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1861(v)(1), 79 Stat. 286, 322-23 (codified at 42 U.S.C. § 1395x(v)(1) (2000)).

186. *Id.* § 1814(b) (codified at 42 U.S.C. § 1395f(b) (2000)). As originally enacted, the insurance program under Part A of Medicare provided "basic protection against the costs of hospital and related post-hospital services." *Id.* § 1811. The current version of that section has been expanded to include "basic protection against the costs of hospital, related post-hospital, home health services, and hospice care." 42 U.S.C. § 1395c (2000). In contrast, Section 1831 of the Act established a supplementary medical insurance program under Part B. Social Security Amendments of 1965 § 1831 (codified at 42 U.S.C. § 1395j (2000)).

187. Social Security Amendments of 1965 § 1861(v)(1) (codified at 42 U.S.C. § 1395x(v)(1) (2000)). That specific directive to adopt regulations on reasonable cost was in addition to the general grant of rulemaking authority to the Secretary in Title XVIII. *See* 42 U.S.C. § 1395hh ("The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter . . .").

188. The Act gave the Secretary flexibility in the following respects:

Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

§ 1861(v)(1) (codified at 42 U.S.C. § 1395x(v)(1) (2000)).

189. *Id.* The same provision of the Act also required the Secretary to consider the principles of third-party payment that were generally applied by other organizations. *Id.* *But see* *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87, 94-95 (1995) (stating that although the statute requires the Secretary to consider principles adopted by other organizations, the Secretary is not required to reimburse hospitals in accordance with generally accepted accounting principles (GAAP)).

190. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1861(v)(1)(A), 79 Stat. 286, 323 (current version at 42 U.S.C. § 1395x(v)(1)(A)(i) (2000)); *see also* S. REP. NO. 89-404, at 36-37 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977 (discussing "reasonable costs" and how those costs should be borne). In the 1972 amendment to the statute, Congress replaced the phrase "costs with respect" with "necessary costs of efficiently delivering covered services." Social Security Amendments of 1972, Pub. L. No. 92-603, § 223(d), 86 Stat. 1548, 1625.

between the Medicare program and other payors and directed that Medicare funds should not be used to pay the cost of providing services to non-beneficiaries.<sup>191</sup>

Pursuant to this directive, the Secretary adopted a set of regulations that restated and implemented the statutory prohibition against paying for services rendered to non-Medicare patients.<sup>192</sup> In general, those regulations provide that "costs attributable to other patients of the institution are not to be borne by the program."<sup>193</sup> For example, the Medicare program refused to reimburse

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191. Courts have recognized the statutory prohibition against cross-subsidization and relied on that prohibition in resolving disputes over Medicare reimbursement. *See, e.g.,* *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87, 97–98 (1995) (recognizing that the Secretary's interpretive rule requiring amortization of defeasance losses "implements the statutory ban on cross-subsidization in a reasonable way"); *St. James Hosp. v. Heckler*, 760 F.2d 1460, 1470–72 (7th Cir. 1985) (concluding that the Secretary's attempt to remove malpractice costs from the pool of indirect general and administrative costs was a violation of the statutory prohibition against cost shifting); *St. Luke's Methodist Hosp. v. Thompson*, 182 F. Supp. 2d 765, 770 (N.D. Iowa 2001) ("The statute further prohibits Medicare and other payors from 'cross-subsidizing' each other . . .").

In a creative twist on this line of cases, a patient tried to use the federal statute that prohibits cost shifting as grounds for a counterclaim in a hospital's action in state court for payment of its bill. *See* *Methodist Med. Ctr. v. Taylor*, 489 N.E. 2d 351, 354 (Ill. App. Ct. 1986) (holding that the federal Medicare statute does not provide a cause of action for a private pay patient in a hospital's collection action).

192. *See, e.g.,* 42 C.F.R. § 413.9(b)(1) (2000) (restating the statutory definition of "reasonable cost"); *id.* § 413.50(b) (stating that principles on apportionment of allowable cost are designed to carry out the statutory directive); *see generally* JUDITH M. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 53–79 (1977) (describing the development of Medicare reimbursement principles). In light of the number and the extent of current Medicare regulations, it is interesting to note that there were no regulations in effect when the program began operation. *See* MEDPAC, *REPORT TO THE CONGRESS: REDUCING MEDICARE COMPLEXITY AND REGULATORY BURDEN* ix (Dec. 2001) [hereinafter *REDUCING MEDICARE COMPLEXITY*] ("Medicare started in 1966 without any regulations because there was not enough time between the passage of the act in 1965 and its implementation to write and approve them.") *available at* [http://www.medpac.gov/publications/congressional\\_reports/dec2001RegBurden.pdf](http://www.medpac.gov/publications/congressional_reports/dec2001RegBurden.pdf).

193. 42 C.F.R. § 413.5(a); *see also id.* § 413.50(a)(2) ("The share to be borne by Medicare is to be determined in accordance with principles relating to apportionment of cost."). As a practical matter, it was very difficult to apportion each provider's allowable costs between those attributable to Medicare patients and those attributable to other patients. The Secretary recognized that Medicare patients are not a representative cross section of a facility's patients, but rather utilize services in ways that are different from younger patients. *Id.* § 413.50(c). Therefore, the proper apportionment of costs is not as simple as merely dividing a facility's total costs by its percentage of Medicare patients. *Id.*

For example, under the original 1966 regulations, all of a hospital's indirect general and administrative (G & A) costs were "pooled," and then the Medicare program would reimburse the hospital for a percentage of its G & A costs on the basis of that hospital's Medicare patient utilization ratio. *See St. James Hosp.*, 760 F. 2d at 1463 (explaining how G & A reimbursements are calculated). Subsequently, the Secretary attempted to remove the cost of premiums for malpractice insurance from the pool of G & A costs and instead reimburse



providers for a proportional share of their charity care because allowances for charity care do not relate to patients who are covered by the Medicare program.<sup>194</sup> Similarly, Medicare does not reimburse providers for the bad debts that are generated by non-Medicare patients.<sup>195</sup>

### *B. Subsidizing Costs for Non-Beneficiaries*

Despite the statutory prohibition against cross-subsidization and the regulations designed to enforce that prohibition, the Medicare program does indeed pay some costs that are attributable to non-Medicare patients. The Medicare program subsidizes charity care and access to care for non-Medicare patients, and it subsidizes the training of medical personnel for the good of the broader community. For example, Medicare provides additional funds to those hospitals that treat a disproportionate share of indigent patients.<sup>196</sup> In authorizing exceptions and adjustments for disproportionate share hospitals (DSH) in the 1983 prospective payment system (PPS), Congress did not express any intent to use the Medicare program as a means of supporting the provision of indigent care, but rather emphasized the higher costs incurred by those hospitals that treat large numbers of indigent patients.<sup>197</sup> Subsequently,

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hospitals for malpractice insurance costs on the basis of loss experience. *Id.* Ultimately, the court concluded that the Secretary's malpractice rule violated certain provisions of the Medicare Act. *Id.* at 1473.

194. See 42 C.F.R. § 413.80(g) (2002) ("Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs."); see also § 413.5(c)(7) ("Charity and courtesy allowances are not includable . . ."). In addition, the Secretary characterized charity care as a deduction from revenue as opposed to an allowable cost. *Id.* § 413.80 (a), (c). The regulations also prevented hospitals from shifting to the Medicare program a portion of the indigent care obligations that they accepted as a condition of grants or loans under the federal Hill-Burton program. *Id.* § 413.80(b)(2); see generally *St. Mary of Nazareth Hosp. Ctr. v. Dep't of Health & Human Servs.*, 698 F.2d 1337, 1342-43 (7th Cir. 1983).

195. 42 C.F.R. § 413.80 (a), (d). The program will reimburse providers for bad debts incurred by Medicare beneficiaries who failed to pay their coinsurance or deductible amounts, because reimbursement for bad debts generated by Medicare beneficiaries is necessary to prevent costs from being shifted from Medicare patients to non-Medicare patients. *Id.* The regulations also provide that the Medicare program will not pay the cost of research, apart from ordinary patient care. *Id.* §§ 413.90, 413.5(c)(2).

196. 42 U.S.C. § 1395ww(d)(5)(F) (2000); 42 C.F.R. § 412.106 (2002).

197. As stated in the Senate report, "Concern has been expressed that public hospitals and other hospitals that serve such patients may be more severely ill than average and that the DRG payment system may not adequately take into account such factors." S. REP. NO. 98-23, at 54 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 194. The committee's grammar was somewhat awkward; it was the indigent patients as opposed to the hospitals that were "more severely ill than average."

the DSH adjustment was viewed as a means of assuring the continued existence of health care facilities to meet the needs of Medicare beneficiaries.<sup>198</sup> In addition, to assure access to care for Medicare beneficiaries in rural areas, the program also provides special treatment under PPS for certain categories of facilities, such as sole community hospitals, rural referral centers, critical access hospitals, and small rural hospitals that are dependent on Medicare.<sup>199</sup> These special payment rules not only protect the interests of Medicare beneficiaries, but also assist health care facilities, local communities, and non-Medicare beneficiaries.<sup>200</sup> Finally, in paying teaching hospitals for graduate medical education (GME),<sup>201</sup> Medicare pays more than the cost of providing medically necessary care to its beneficiaries and more than the actual costs incurred by teaching hospitals in educating their medical residents.<sup>202</sup>

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198. See MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 78 (Mar. 2001) (considering financial issues and implications of Medicare), available at <http://www.medpac.gov/publications/congressionalreports/Mar01%20Table%20of%20Contents.pdf>. The report stated:

The original justification for the DSH adjustment presumed that poor patients are more costly to treat, but ProPAC [the Prospective Payment Assessment Commission] adopted an alternative objective that had evolved over time: to protect access to care for Medicare beneficiaries, additional funds should be provided to hospitals whose viability might be threatened by providing care to the poor. Although the financial pressure from treating low-income patients can include any extra costs incurred, the primary threats are underpayment or nonpayment.

*Id.* The DSH adjustment formula is not based solely on a facility's treatment of low-income Medicare beneficiaries, but also includes consideration of a facility's percentage of Medicaid patient days. 42 U.S.C. § 1395ww(d)(5)(F) (2000). In fact, the formula is designed in part to provide greater assistance to those hospitals, such as inner city public hospitals, that have very high percentages of uncompensated care and very low percentages of Medicare patients. MEDPAC, REPORT TO THE CONGRESS: MEDICARE IN RURAL AMERICA 81–82 (June 2001) [hereinafter MEDICARE IN RURAL AMERICA], available at [http://www.medpac.gov/publications/congressional\\_reports/Jun01%20Table%20of%20Contents.pdf](http://www.medpac.gov/publications/congressional_reports/Jun01%20Table%20of%20Contents.pdf). Ironically, the Medicare program is promoting access for Medicare beneficiaries by providing greater financial support to those facilities that treat the lowest percentages of Medicare beneficiaries.

199. 42 U.S.C. § 1395ww(d)(5)(C), (D), (G) (2000); 42 C.F.R. § 412.90 (2002); see also MEDICARE IN RURAL AMERICA, *supra* note 198, at 58–59 ("These policies are intended to support rural hospitals that are important or solitary sources of medical services for Medicare beneficiaries.").

200. See MEDICARE IN RURAL AMERICA, *supra* note 198, at 59 (recognizing that these special Medicare payment programs "provide financial protection to hospitals" and "an adequate financial base for facilities in rural areas").

201. See generally John K. Iglehart, *Medicare and Graduate Medical Education*, 338 NEW ENG. J. MED. 402 (1998).

202. See *infra* notes 205–31 and accompanying text (analyzing Medicare's effect on graduate medical education).

In the original 1965 Medicare legislation,<sup>203</sup> Congress did not explicitly address the issue of reimbursement for a teaching hospital's education costs. That issue was subsumed in Congress's general directive to the Secretary to adopt regulations for reimbursement of a hospital's reasonable costs.<sup>204</sup> The legislative history, however, includes a statement of congressional intent that the Medicare program should pay an "appropriate" share of a teaching hospital's education costs as one part of the cost of patient care.<sup>205</sup> Congress recognized that medical education and residency programs improve a hospital's quality of care, and that there is a need to support those activities "until the community undertakes to bear such education costs in some other way."<sup>206</sup> Therefore, Congress indicated that a "part" of those education costs should be paid by the Medicare program "to an appropriate extent."<sup>207</sup> For many years, this one ambiguous sentence in the legislative history was the only evidence of congressional intent to pay for GME costs as part of the cost for treatment of Medicare patients.<sup>208</sup>

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203. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286.

204. See *supra* note 192 and accompanying text (discussing the congressional directive).

205. S. REP. NO. 89-404, at 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977. The authors of the report argued:

Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

*Id.* An identical statement appears in the House Report on the 1965 Medicare legislation. H.R. REP. NO. 89-213, at 32 (1965).

206. H.R. REP. NO. 89-213, at 32. In contrast to education expenses, the Senate Report notes that there is no need for Medicare to bear the costs of medical research, because other funds are available for that purpose. S. REP. NO. 89-404, at 36.

207. *Id.*

208. See, e.g., *St. John's Hickey Mem. Hosp. v. Califano*, 599 F.2d 803, 808 & n.7 (7th Cir. 1979) ("The legislative history of the Medicare Act clearly shows that the Medicare Program was intended to pay its share of a hospital's cost of educational activities contributing to patient care until such costs are borne by the community served by the hospital."); see also *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 271 (6th Cir. 1990) ("'Appropriate' is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation."); U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-94-33, MEDICARE: GRADUATE MEDICAL EDUCATION PAYMENT POLICY NEED TO BE REEXAMINED 7 & n.13 (1994) [hereinafter GRADUATE MEDICAL EDUCATION] ("The committee reports indicated that these educational activities enhance the quality of care in an institution and that Medicare should recognize these costs for reimbursement purposes until communities undertake to bear such costs in another manner."), available at <http://www.gao.gov/index.html>. Compare *Bryant v. Riddle Mem. Hosp.*, 689 F. Supp. 490, 492 (E.D. Pa. 1988) ("Statements in a congressional committee report recommending adoption of legislation are highly authoritative in

When initial Medicare regulations were adopted in 1966, the Secretary paraphrased and expanded on the concepts set forth in the legislative history.<sup>209</sup> In addition to recognizing the positive contribution of education to a hospital's quality of care, the Secretary explained that education programs "are necessary to meet the community's needs for medical and paramedical personnel."<sup>210</sup> Moreover, the rule went further than the legislative history by explicitly acknowledging that education expenses ought to be paid by the broader community, and that many communities have failed to meet their responsibilities in this regard.<sup>211</sup> Therefore, as one of the purchasers of health care services, Medicare would "participate appropriately in the support of these activities."<sup>212</sup>

In the early 1980s, the Medicare program addressed the issue of education expenses in making exceptions to the cost limits that were used at that time and in developing adjustments to the new system of prospective payment.<sup>213</sup>

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determining the purpose of that legislation.") *with* *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) ("We must be mindful, on the other hand, that it is the statute, and not a committee report, that is signed by the President and has therefore become law.").

209. 42 C.F.R. § 413.85 (1993). As that regulation sets forth:

These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities.

*Id.* Originally, that rule was codified as 20 C.F.R. § 405.421 (1967), and was later recodified as 42 C.F.R. § 405.421 (1977), and then as 42 C.F.R. § 413.85 (1993). *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 507 & n.1 (1994).

210. 42 C.F.R. § 405.421 (1977).

211. *Id.*

212. *Id.*

213. See Joseph P. Newhouse & Gail R. Wilensky, *Paying for Graduate Medical Education: The Debate Goes On*, HEALTH AFF., Mar./Apr. 2001, at 136, 138 (noting that Congress felt it necessary to decide "whether and how to account for teaching hospitals' higher costs"); U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-89-33, MEDICARE: INDIRECT MEDICAL EDUCATION PAYMENTS ARE TOO HIGH 12 (1989) [hereinafter *INDIRECT MEDICAL EDUCATION*] ("HCFA first made allowances for the indirect costs of medical education in 1980 by increasing for teaching hospitals the 'section 223' cost limits in effect at that time."), available at <http://www.gao.gov/index.html>.

In providing adjustments for education costs under PPS, Congress emphasized the higher costs incurred by teaching hospitals and noted that Medicare has historically considered GME expenses to be "worthy of support." S. REP. NO. 98-23, at 1 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 192. As that report set forth:

Congress distinguished between direct costs of GME, including compensation of residents and faculty, and indirect costs of GME, which were the higher costs incurred by teaching hospitals for other reasons.<sup>214</sup> Under PPS, Medicare pays direct GME (DME) costs on the basis of an amount per resident,<sup>215</sup> but pays indirect GME (IME) costs by adjusting PPS payments on the basis of each hospital's intern-to-bed ratio.<sup>216</sup> On the basis of its statistical analysis, HCFA recommended a specific formula for increasing Medicare payments to teaching hospitals for their IME costs.<sup>217</sup> Because that formula would have worked to the disadvantage of teaching hospitals, Congress doubled the adjustment factor for determining the amount by which IME costs would increase Medicare payments to teaching hospitals.<sup>218</sup> At this point, it is beyond dispute that the Medicare program overpays teaching hospitals for their education expenses.<sup>219</sup> Moreover, as discussed below, the Medicare program really is subsidizing other functions of teaching hospitals, such as indigent care.<sup>220</sup>

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This adjustment is provided in the light of doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.

*Id.* at 192; *see also* H.R. REP. NO. 98-25, at 80 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 359 (same).

214. *See* Newhouse & Wilensky, *supra* note 213, at 138 ("The costs were presumed higher because teaching hospitals offered a broader array of technically sophisticated services and saw sicker patients whose resource needs were not fully captured by the PPS, but the source of the higher costs remains murky."); *see also* INDIRECT MEDICAL EDUCATION, *supra* note 213, at 2, 11 (distinguishing between direct and indirect costs of GME).

215. 42 U.S.C. § 1395ww(h) (2000); 42 C.F.R. §§ 412.1(a), 413.86 (2002).

216. 42 U.S.C. § 1395ww(d)(5)(B) (2000); 42 C.F.R. § 412.105 (2002). *See generally* INDIRECT MEDICAL EDUCATION, *supra* note 213, at 2-3, 11.

217. *See* Sean Nicholson & David Song, *The Incentive Effects of the Medicare Indirect Medical Education Policy*, 20 J. HEALTH ECON. 909, 912 (2001) ("Based on the teaching intensity regression coefficient, HCFA recommended that a hospital's Medicare price increase by 5.8 percent for every 0.10 increase in its resident to bed ratio.").

218. *Id.* at 912-13; INDIRECT MEDICAL EDUCATION, *supra* note 213, at 13.

219. *See* Kathleen Dalton et al., *A Longitudinal Study of the Effects of Graduate Medical Education on Hospital Operating Costs*, 35 HEALTH SERVS. RES. 1267, 1268 (2001) ("Evidence that the IME formulas overcompensate for cost differentials has been documented repeatedly . . ."); *see also* GRADUATE MEDICAL EDUCATION, *supra* note 208, at 8 & n.18 (noting that GAO, the Congressional Budget Office, HHS, and the Prospective Payment Assessment Commission all concluded that Medicare's IME payments were excessive).

220. *See* GRADUATE MEDICAL EDUCATION, *supra* note 208, at 8 & n.18 (discussing the use and levels of various types of Medicare payments). The GAO report stated:

While indirect medical education (IME) payments were intended to compensate hospitals for higher costs attributable to the involvement of interns and residents in

Representatives of teaching hospitals insist that Medicare, as well as all other payors, should pay for GME as a public good, because having a highly trained workforce is a benefit to society as a whole.<sup>221</sup> But in economic terms, a public good is not merely something that is good for the public; rather, it is a good from which no member of the public can be excluded.<sup>222</sup> As others have pointed out, GME is not really a public good in economic terms because some individuals do not have access to the services of physicians.<sup>223</sup> GME produces "human capital" that the physician owns and, therefore, it is a private good with a positive externality in the sense that it is likely to provide benefits to people other than the physician.<sup>224</sup>

Moreover, teaching hospitals do not really pay the cost of GME because the residents themselves pay those costs in the form of reduced wages for their services.<sup>225</sup> The Medicare program is either paying teaching hospitals for costs they do not really incur<sup>226</sup> or, alternatively, Medicare is really paying for something other than education costs.<sup>227</sup> The economic analysis supports the

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patient care, they are also used to compensate teaching hospitals for the higher costs associated with their urban location, treating more severely ill patients, and treating a disproportionate share of low-income patients.

*Id.* at 8. In addition, GAO took the position that it is not appropriate to pay for charity care by means of IME adjustments. *Id.* at n.18.

221. Newhouse & Wilensky, *supra* note 213, at 139; Adepeju L. Gbadebo and Uwe L. Reinhardt, *Economists on Academic Medicine: Elephants in a Porcelain Shop?*, HEALTH AFF., Mar./Apr. 2001, at 148, 150. The Council on Graduate Medical Education (COGME) has proposed a system of all-payor financing for the costs of GME. See David N. Sundwall, *Another Alternative for Financing Graduate Medical Education: A Proposal from the Council on Graduate Medical Education*, HEALTH AFF., Mar./Apr. 2001, at 156, 157 (setting forth proposal).

222. Newhouse & Wilensky, *supra* note 213, at 140, 146 n.4; Gbadebo & Reinhardt, *supra* note 221, at 150. Because no one can be excluded from a public good, individuals have an incentive to freeload rather than pay for it, and it is necessary to support production of the good by mandatory taxation. Newhouse & Wilensky, *supra* note 213, at 140.

223. Newhouse & Wilensky, *supra* note 213, at 146 n.4.

224. Gbadebo & Reinhardt, *supra* note 221, at 150. In their policy analysis, Gusmano and Schlesinger characterize Medicare's payments for GME as a "mixed" good that helps beneficiaries and also generates positive externalities, but they do not consider medical education to be a public good. Gusmano & Schlesinger, *supra* note 14, at 43–44, 68.

225. Newhouse & Wilensky, *supra* note 213, at 140–41; see Nicholson & Song, *supra* note 217, at 913 ("According to human capital theory, residents should pay for training costs (direct and indirect) by accepting a wage below their marginal revenue product.").

226. See Nicholson & Song, *supra* note 217, at 913 ("Therefore, IME payments are redundant: hospitals are reimbursed for training costs once by residents and a second time by the government.").

227. Newhouse & Wilensky, *supra* note 213, at 140 ("[T]he costs Medicare was and is reimbursing are not education costs at all.").

conclusion that GME payments are really subsidies for charity care and other nonteaching functions of academic medical centers. This conclusion does not necessarily mean that Medicare should stop providing the subsidies, but merely that Congress must justify the subsidies, if at all, on very different grounds from the education of new physicians.<sup>228</sup>

Recent analyses of GME costs have dealt primarily with statistical issues, such as IME formulas that pay teaching hospitals more than their actual costs, and issues of economic theory, such as whether Medicare is really paying for education or is actually paying for other types of expenses incurred by teaching hospitals. But a separate and more fundamental issue is: Should the Medicare program pay teaching hospitals for any costs that exceed what it would cost the program to purchase the same or similar service for a beneficiary at an ordinary, nonteaching hospital?

By agreeing to pay for education expenses at teaching hospitals, the Medicare program expanded its purpose beyond merely paying the cost of providing health care services to eligible beneficiaries. The Secretary recognized that education expenses are really an obligation of the community and not of the Medicare program or any other purchasers. Medicare only pays a share of those education costs,<sup>229</sup> but that does not change the fact that Medicare has assumed an obligation to the community to pay for something other than providing health care services to Medicare beneficiaries. Although the legislative history refers to education costs "as an element in the cost of patient care,"<sup>230</sup> in reality Medicare is paying for something other than the actual cost of providing medically necessary care, regardless of whether those

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228. Gbadebo and Reinhardt suggest that, despite economic theory, it is morally right to provide financial support for the safety net role that academic medical centers have been forced to play in the United States and in no other country. Gbadebo & Reinhardt, *supra* note 221, at 152; *see also* Nicholson & Song, *supra* note 217, at 913 (recognizing that IME payments may be justifiable on other grounds such as supporting charity care and medical research). In addition, some experts have argued that the Medicare program could use its financial support of teaching hospitals as a means to influence the distribution of physicians among particular specialties. *See, e.g.*, Gusmano & Schlesinger, *supra* note 14, at 68–70 (discussing the possible effects in specialization of changes in DME payments); Newhouse and Wilensky, *supra* note 213, at 140, 146 ("Many of those advocating federal support [for GME] appear to want to use that support to shape the total number of residents and their distribution among specialties.").

229. In fact, Medicare pays more than its allocable share of education costs because other third-party payors, such as managed care organizations, do not pay their allocable share. *See* Ralph W. Muller et al., *Does Economic Theory Justify Changing Policy That Works?*, HEALTH AFF., Mar./Apr. 2001, at 153, 155 ("[T]he fundamental flaw . . . lies in the current and potential future failure of many private payors in an increasingly price-competitive marketplace to pay their fair share of the costs . . .").

230. S. REP. NO. 89-404, at 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977.

costs are really attributable to education of physicians, charity care, or medical research.

Teaching hospitals argue that they have higher costs for providing patient care to Medicare beneficiaries. However, that argument begs the question of whether the Medicare program should pay a teaching hospital any more than it would pay a nonteaching hospital to provide the same or a similar health care service. To the extent that teaching hospitals have higher direct and indirect costs, those elevated expenses are really the costs of teaching or other functions of the teaching hospital, and not the actual costs of providing medically necessary care to Medicare beneficiaries. Rather than admitting that they are paying for something else, however, Congress and the Secretary persist in attempting to justify the subsidy to teaching hospitals as reimbursement for the hospitals' higher costs of providing covered health care services. In considering alternative justifications for the Medicare program to subsidize academic medical centers, we should strive for greater transparency by admitting openly that the purposes of Medicare include providing support for indigent care, medical research, and the infrastructure of public and private health care facilities.<sup>231</sup>

### C. *Judicial Recognition that Medicare Promotes Broader Public Goals*

In addition to considering the views of beneficiaries and policy elites with regard to using Medicare to accomplish broader goals,<sup>232</sup> it also is useful to consider the views of courts with regard to the nature and purposes of the Medicare program. Furthermore, one must analyze how the views of courts on those issues have evolved over time. Courts can serve as a barometer of contemporary views about an important public program and also as a catalyst to change the views of policymakers and the broader community.

Like the Social Security program, the Medicare program is an exercise of the power of Congress under the Spending Clause.<sup>233</sup> In describing the Social Security program, the Supreme Court explained that Congress used its spending power to enact "a form of social insurance."<sup>234</sup> The Court reasoned

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231. See REDUCING MEDICARE COMPLEXITY, *supra* note 192, at 9, 23 (acknowledging that supporting medical education, facilities for indigent care, and rural access are additional goals of the Medicare program).

232. See Gusmano & Schlesinger, *supra* note 14, at 49–58 (describing the results of telephone interviews, focus groups, and literature review).

233. See *supra* notes 142–43 and accompanying text (discussing the use and limitations of the Spending Clause).

234. *Flemming v. Nestor*, 363 U.S. 603, 609 (1960).



that the interest of a Social Security beneficiary is a "noncontractual benefit under a social welfare program"<sup>235</sup> and is not subject to the concept of "accrued property rights."<sup>236</sup> Like Social Security, the Medicare program is a tax-supported social welfare program as well as a system of insurance. At least implicitly, the Supreme Court has recognized this dual, or schizophrenic, nature of Medicare in describing Part A as "insurance" and Part B as a "social program."<sup>237</sup>

Over the years, courts have had the opportunity to consider the nature and purposes of the Medicare program. Until recently, almost all courts have found—or at least have assumed—that Congress enacted the Medicare program solely as a way to assist its elderly and disabled beneficiaries.<sup>238</sup> For example, the Seventh Circuit noted that the intent of Congress in creating the Medicare program was solely to pay hospitals for the cost of treating qualified Medicare beneficiaries.<sup>239</sup> Congress enacted the Hill-Burton Act<sup>240</sup> to assist in construction and improvement of hospitals, whereas the Medicare statute "was adopted only to provide medical care for the disabled and the aged who qualify as Medicare beneficiaries."<sup>241</sup> Other courts have considered the limited purpose of Medicare in concluding that health care facilities and practitioners have no property interest in continued Medicare participation because they are not the

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235. *Id.* at 611. As the Court explained, "It is apparent that the noncontractual interest of an employee covered by the Act cannot be soundly analogized to that of the holder of an annuity, whose right to benefits is bottomed on his contractual premium payments." *Id.* at 610.

236. *Id.* at 610 ("To engraft upon the Social Security system a concept of 'accrued property rights' would deprive it of the flexibility and boldness in adjustment to ever-changing conditions which it demands." (quoting Elmer F. Wollenberg, *Vested Rights in Social-Security Benefits*, 37 OR. L. REV. 299, 359 (1958))). See also *U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 174 (1980) (stating that social security benefits and railroad retirement benefits may be changed or eliminated because they are not contractual).

237. *Schweiker v. McClure*, 456 U.S. 188, 189–90 (1982). As the court stated, "Part B consequently resembles a private medical insurance program that is subsidized in major part by the Federal Government." *Id.* at 190; see also *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 506 (1994) ("Medicare is a federally funded health insurance program for the elderly and disabled.").

238. See, e.g., *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 404 (1993) ("As a means of providing health care to the aged and disabled, Congress enacted the Medicare program in 1965."); *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 775 n.2 (1980) (noting that Medicare "is primarily for the benefit of the aged and disabled," whereas Medicaid "is primarily designed for the poor"); *Martinez v. Richardson*, 472 F.2d 1121, 1123 (10th Cir. 1973) ("This is an Act of 1965 to protect individuals 65 years of age and over from the high cost and the hardship of illness.").

239. *St. Mary of Nazareth Hosp. Ctr. v. Dep't of Health & Human Servs.*, 698 F.2d 1337, 1342 (7th Cir. 1983).

240. 42 U.S.C. §§ 291 to 291o-1 (2000).

241. *St. Mary of Nazareth*, 698 F.2d at 1343.

intended beneficiaries of the program.<sup>242</sup> For example, in holding that a physician did not have a protected property interest, the First Circuit observed that "[t]he Medicare Part B program is nothing more than a governmental insurance program for the aged."<sup>243</sup>

In 2000, however, the Supreme Court made a major change from the traditional view of the Medicare program in *Fischer v. United States*<sup>244</sup> by concluding that Medicare is "aimed at ensuring the availability of health care for the broader community."<sup>245</sup> *Fischer* was an appeal of a federal criminal conviction for, among other things, bribing an agent of an organization that had received benefits under a program of federal assistance.<sup>246</sup> As part owner and president of a corporation known as Quality Medical Consultants, Inc. (QMC), Jeffrey Fischer obtained a loan for QMC of \$1.2 million from the West Volusia Hospital Authority (WVHA), a municipal hospital authority that operated two Medicare-participating hospitals.<sup>247</sup> Fischer negotiated the loan with Robert Caddick, WVHA's chief financial officer, who asked Fischer for a loan of \$10,000 from QMC.<sup>248</sup> Subsequently, QMC gave \$10,000 in "consulting fees" to Caddick's mother, who had never performed services of any kind for QMC, and then she turned the money over to Caddick in accordance with his instructions.<sup>249</sup>

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242. See, e.g., *Koerpel v. Heckler*, 797 F.2d 858, 864 (10th Cir. 1986) ("Dr. Koerpel is not the intended beneficiary of the Medicare program . . .").

243. *Cervoni v. Sec'y of Health, Educ. & Welfare*, 581 F.2d 1010, 1018 (1st Cir. 1978). Although a few courts have held or assumed that providers have a property interest in continued program participation, those decisions were not necessarily based on an analysis of the underlying purposes of the Medicare program. See *Erickson v. United States*, 67 F.3d 858, 862 (9th Cir. 1995) (criticizing the Fourth Circuit's conclusion that a provider has a property interest, on the ground that the Fourth Circuit had inappropriately relied on a prior case involving the Medicaid program and state administrative regulations for peer review).

244. *Fischer v. United States*, 529 U.S. 667 (2000).

245. *Id.* at 680.

246. See *id.* at 670 (describing the indictments).

247. *Id.* at 669–70. As a public agency subject to legal restrictions on investment of its assets, WVHA had no authority to loan money to a private corporation such as QMC. *United States v. Fischer*, 168 F.3d 1273, 1274 & n.4 (11th Cir. 1999), *aff'd*, 529 U.S. 667 (2000). Moreover, Fischer had defrauded WVHA by pledging QMC's accounts receivable as security for the loan, even though they were already pledged to a different creditor, and by giving WVHA an illegitimate letter of credit. *Id.* at 1274. QMC was unable to repay the loan, and a draft from the bank that had issued the illegitimate letter of credit was not honored. *Id.* at 1275. In an unrelated matter, Fischer had been convicted several years earlier on three counts of mail fraud. *Id.* at 1275 n.5.

248. *Fischer*, 168 F.3d at 1274–75.

249. *Id.* at 1275.

Among other counts, Fischer was indicted and convicted for paying a bribe or kickback to an agent of an organization that receives benefits as part of a federal assistance program, in violation of 18 U.S.C. § 666(a)(2).<sup>250</sup> The conviction was predicated on the fact that WVHA had received more than \$10,000 per year in payments from the Medicare program, and in fact WVHA had received at least \$10 million from Medicare in 1993.<sup>251</sup> On appeal, Fischer argued that even though WVHA had received more than \$10,000 in payments under a federal assistance program, WVHA had not received "benefits" under that federal program.<sup>252</sup> In rejecting Fischer's argument and affirming his convictions,<sup>253</sup> the Eleventh Circuit explicitly disagreed with the district court's analysis in *United States v. LaHue*,<sup>254</sup> which held that Medicare Part B funds were not "benefits" within the meaning of § 666.<sup>255</sup> A few weeks after the Eleventh Circuit issued its decision in *Fischer*, the Tenth Circuit affirmed the district court's decision in *LaHue*.<sup>256</sup> On November 1, 1999, the Supreme Court granted the writ of certiorari in *Fischer*, apparently to resolve the circuit

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250. *Fischer v. United States*, 529 U.S. 667, 670 (2000). In pertinent part, § 666 provides as follows:

(a) Whoever, if the circumstance described in subsection (b) of this section exists . . . .

(2) corruptly gives, offers, or agrees to give anything of value to any person, with intent to influence or reward an agent of an organization or of a State, local or Indian tribal government, or any agency thereof, in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of \$ 5,000 or more; shall be fined under this title, imprisoned not more than 10 years, or both.

(b) The circumstance referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of \$ 10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.

(c) This section does not apply to bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business.

18 U.S.C. § 666 (2000).

251. *Fischer*, 529 U.S. at 670.

252. *Id.* at 670, 676. There was no dispute that Medicare is a federal assistance program, nor was there any dispute that WVHA had received more than \$10,000 per year in payments under that program. *See id.* at 676 ("The sole point in contention is whether those payments constituted 'benefits,' within the meaning of subsection (b).") (citing 18 U.S.C. § 666)).

253. *United States v. Fischer*, 168 F.3d 1273, 1277-78 (11th Cir. 1999).

254. *United States v. LaHue*, 998 F. Supp. 1182 (D. Kan. 1998), *aff'd*, 170 F.3d 1026 (10th Cir. 1999).

255. *Id.* at 1192 (concluding that those funds are not properly considered in determining how much federal funding an organization receives).

256. *United States v. LaHue*, 170 F.3d 1026 (10th Cir. 1999).

split on that issue.<sup>257</sup> In an opinion by Justice Kennedy, which six other Justices joined, the Supreme Court affirmed the decision of the Eleventh Circuit and held that participating hospitals receive benefits from the Medicare program and not merely compensation for services rendered.<sup>258</sup>

The specific issues before the Supreme Court in *Fischer* were whether the payments that hospitals receive from Medicare constitute "benefits" within the meaning of subsection (b) of § 666, and whether Congress excluded those payments from coverage of the statute under subsection (c) as mere compensation or reimbursement for services rendered in the ordinary course of business.<sup>259</sup> To reach its decision, the Court undertook a comprehensive analysis of the nature and purposes of the Medicare program, including its regulatory structure, reimbursement system, and goals.<sup>260</sup> First, the Court reviewed the extensive regulation of participating providers under Medicare statutes and rules<sup>261</sup> and noted that providers obtain important advantages by meeting the program's conditions of participation.<sup>262</sup> Second, the Court undertook a detailed review of the system of cost reimbursement and recognized that Medicare pays for the cost of broader social goals such as supporting graduate medical education and disproportionate share hospitals.<sup>263</sup>

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257. *Fischer v. United States*, 528 U.S. 962 (1999). As stated in the Court's subsequent opinion on the merits in that case, "[w]e granted certiorari to determine whether the statute covers fraud perpetrated on organizations participating in the Medicare program." *Fischer v. United States*, 529 U.S. 667, 669 (2000).

258. *Fischer*, 529 U.S. at 669, 679. Justice Thomas filed a dissenting opinion in which Justice Scalia joined. *Id.* at 682 (Thomas, J., dissenting).

259. *See Fischer v. United States*, 529 U.S. 667, 670 (2000) (describing the issues).

260. *Id.* at 671–75. One of the most interesting aspects of the Court's analysis is what it did not do. The Court did not accept the Government's suggestion to rely on the cases and regulations that treat Medicare payments as federal financial assistance to the hospital for purposes of civil rights and antidiscrimination laws. *See* Brief for the United States at 13, 28–30, *Fischer v. United States*, 529 U.S. 667 (2000) (No. 99-116). Among other theories, the government argued that Medicare-participating hospitals should be considered to be recipients of benefits under § 666 because hospitals are considered to be recipients of federal financial assistance for purposes of anti-discrimination laws. *Id.* at 30. The Government cited *United States v. Baylor University Medical Center*, 736 F.2d 1039 (5th Cir. 1984) and the Secretary's long-standing administrative interpretation to that effect. *Id.* However, the *Fischer* Court did not even mention that argument and instead undertook its own analysis on the basis of the nature and purposes of the Medicare program.

261. *Fischer*, 529 U.S. at 672.

262. *Id.* at 678.

263. *Id.* at 673–74. The Court stated: "Allowable costs include amounts which enhance the organization's capacity to provide ongoing, quality services not only to eligible patients but also to the community at large." *Id.* at 673. The Court also quoted from the Medicare reimbursement rule at 42 C.F.R. § 413.85(c), which recognizes the need for the Medicare program to "participate appropriately" in supporting activities such as medical education, until

The Court also identified other ways in which the reimbursement system is designed to assist providers, including the use of periodic interim payments (PIP) to assist providers in maintaining their cash flow and the use of incentives for creating funded depreciation accounts.<sup>264</sup> Although the Court recognized that elderly and disabled individuals are the primary beneficiaries of the program,<sup>265</sup> the Court concluded that health care providers also receive benefits under the program.<sup>266</sup>

In addition to concluding that providers receive benefits from their participation in the program, the Court determined that providers are not merely receiving compensation for services rendered in the ordinary course of business.<sup>267</sup> The Court distinguished Medicare providers from mere contractors that the government does not assist or regulate for long-term goals.<sup>268</sup> In contrast, the Court reasoned that the purposes of the Medicare program include assisting providers and assuring the availability of health care facilities for the good of the community.<sup>269</sup> The Court occasionally referred to the need to preserve a system of health care for elderly and disabled beneficiaries of the

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communities assume their own responsibility for those costs. *Fischer*, 529 U.S. at 673.

Although the *Fischer* court analyzed the system of cost reimbursement, its conclusions would generally apply as well under the current prospective payment system (PPS). Under the current system, Medicare still provides financial support for graduate medical education and disproportionate share hospitals, both of which were factors noted by the *Fischer* court. *See, e.g.*, 42 C.F.R. § 412.2(f) (2002) (noting that Medicare permits additional payments for specific costs); *id.* § 412.90 (stipulating that certain types of hospitals, such as sole community hospitals, receive special treatment under PPS); *see also Fischer*, 529 U.S. at 685 (Thomas, J., dissenting) (explaining that PPS "is also designed to reimburse hospitals for the cost of providing care to Medicare beneficiaries").

264. *Fischer*, 529 U.S. at 673–74.

265. *Id.* at 677.

266. *See id.* ("That one beneficiary of an assistance program can be identified does not foreclose the existence of others, however.").

267. *See id.* at 679 ("The payments are made for significant and substantial reasons in addition to compensation or reimbursement, so that neither these terms nor the usual course of business conditions set forth in subsection (c) are met here.").

268. *Id.* at 680. The Court emphasized that its reasoning would not subject all federal contractors, or even all federal assistance programs, to the coverage of the fraud or bribery penalties of § 666. Rather, it would be necessary to determine on a case-by-case basis whether an organization actually received "benefits" under the federal program in which it participates. *Id.* at 680–81. But, in his dissenting opinion, Justice Thomas wrote that the majority's reasoning would apply inappropriately to other organizations that participate in federal assistance programs, such as grocery stores that accept food stamps. *Id.* at 691–93 (Thomas, J., dissenting).

269. *See id.* at 679–80 ("Adequate payment and assistance to the health care provider is itself one of the objectives of the program.").

program,<sup>270</sup> but the Court also wrote more expansively of Medicare's role in ensuring the availability of high quality facilities for "the greater community."<sup>271</sup> As the Court observed, "[t]he structure and operation of the Medicare program reveal a comprehensive federal assistance enterprise aimed at ensuring the availability of quality health care for the broader community."<sup>272</sup>

#### V. Potential Uses of the Medicare Program to Accomplish Other Policy Goals

Together with the judicial recognition of the program's broader purposes, the current functions of Medicare provide a basis for considering other potential uses of the program. Gusmano and Schlesinger have suggested that Congress could use the Medicare program to promote the health status of beneficiaries through environmental and social interventions, as opposed to merely paying for treatment of their illnesses and injuries, and could provide health education to young people as well as to beneficiaries.<sup>273</sup> In addition, William Sage and Peter Hammer have suggested that the Medicare program, as a major buyer of health care services, could take a more active role in the antitrust arena by responding to proposed mergers or acquisitions of health care providers.<sup>274</sup>

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270. See, e.g., *id.* at 680 ("[T]he government receives long-term advantages from the existence of a sound and effective health care system for the elderly and disabled."). As the Court stated, "This scheme is structured to ensure that providers possess the capacity to render, on an ongoing basis, medical care to the program's qualifying patients." *Id.*

271. See *id.* at 679–80 (explaining that Congress makes Medicare payments in part to maintain quality medical care for the benefit of the community).

272. *Id.* at 680; cf. *United States v. Soileau*, 309 F.3d 877, 882 (5th Cir. 2002) (holding that Medicare is not a "financial institution" for the purpose of sentence enhancement under the federal sentencing guidelines).

273. Gusmano & Schlesinger, *supra* note 14, at 60–63. They correctly point out that "most of the behaviors that have health consequences in old age are established much earlier in life." *Id.* at 63. In that sense, every individual who is not yet eligible for Medicare could be viewed as a "pre-beneficiary." Under current law, the Secretary has statutory authority to provide education and assistance to eligible beneficiaries. 42 U.S.C. § 1395b-3 (2000). In addition, with regard to Medigap insurance, the Secretary has statutory authority to provide information to individuals who are entitled to Medicare benefits as well as to "individuals about to become so entitled." 42 U.S.C. § 1395ss(e) (2000).

274. See William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069, 1117 (1999) ("Although HCFA is the largest purchaser of physician and hospital services nationally, and plays a growing role in managed care, it does not currently take positions on health care competition or communicate views on particular practices or transactions to DOJ and FTC."). The Department of Defense (DOD) may provide a useful model for a more active role by the federal government as a large-scale buyer in protecting the competitive market. As the primary or sole buyer of military aircraft, DOD actively participated with the Department of

Two additional ways in which Congress might use Medicare to accomplish broader public goals are considered below. The first is the possible use of Medicare participation to promote compliance with other types of laws, such as labor and environmental regulations. The second is the further use of Medicare as a hook to promote even broader access to care.

*A. The Potential Use of Medicare to Promote Compliance with Other Types of Laws*

Although Medicare-participating providers must meet a variety of requirements that relate to their dealings with patients and the program, the Medicare program does not purport to regulate other areas of providers' activities, such as their labor and employment practices. Under current law, Congress may exclude health care providers from participation in Medicare for specified conduct, including certain criminal convictions that relate to patient care, financial integrity, and substance abuse. Medicare law, however, does not provide that any violation of an unrelated statute or regulation will be a basis for exclusion from the program.

In the analogous context of government procurement, the federal government proposed and ultimately rejected a plan to disqualify federal contractors who violated other types of laws, such as labor and environmental laws. Although that particular proposal did not apply to the Medicare program, it raises the interesting question of whether the program ought to exclude from participation any provider or supplier who violates other types of laws as a way to promote compliance with other specific laws. Put another way, should Congress amend the Medicare statute to provide that a violation of other types of laws is a basis for termination of a provider agreement or exclusion from participation in the Medicare program?

The Medicare statute and regulations already incorporate some obligations that are set forth in other legal authorities, such as applicable state laws. For example, the definition of "hospital" in the Medicare statute includes a requirement to meet the licensure standards of the relevant state or local hospital licensing agency.<sup>275</sup> Similarly, the conditions of participation for

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Justice in challenging the proposed merger of defense contractors Lockheed Martin and Northrup Grumman. Joel I. Klein, Statement on the Abandonment of the Lockheed Northrop Transaction (July 16, 1998), at <http://www.usdoj.gov/opa/pr/1998/July/334.html> (on file with the Washington and Lee Law Review).

275. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1861(e), 79 Stat. 286, 314-15 (codified at 42 U.S.C. § 1395x(v)(1) (2000)) (setting forth requirements that an institution must meet to qualify as a hospital for the purposes of this law). The statute reads, in

hospitals include a requirement to comply "with applicable Federal laws related to the health and safety of patients."<sup>276</sup> The purpose of incorporating the requirements of those federal, state, and local laws is to protect the interests of beneficiaries and other patients, and not to use the Medicare program as a way to promote compliance with laws that are unrelated to the welfare of patients.

In a similar manner, the grounds for termination of a provider agreement and exclusion from Medicare all arguably relate to the interests of patients or the Medicare program, and are not merely ways to encourage compliance with other types of laws. Under Title XVIII, only four grounds exist on which the Secretary may refuse to enter into a provider agreement, refuse to renew an agreement, or terminate an agreement.<sup>277</sup> These four statutory grounds for termination are: (1) the provider's failure to substantially comply with the provider agreement, Title XVIII and Medicare regulations, or a required corrective action; (2) the provider's substantial failure to meet the requirements set forth in the definitional section of the Medicare statute; (3) the exclusion of the provider from the program under specified sections of the statute; and (4) the provider's conviction of a felony for an offense that is harmful to the Medicare program and its beneficiaries.<sup>278</sup>

Aside from terminating a provider agreement, the statutes set forth grounds for exclusion from participation in Medicare and other federally supported health care programs.<sup>279</sup> The grounds for exclusion from participation are more detailed than the grounds for termination of a provider agreement, but again the grounds for exclusion relate to the interests of patients and the program, rather than an effort to use Medicare as a way to promote compliance with other laws. Certain criminal convictions, including crimes

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pertinent part:

[I]n the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing . . .

*Id.* § 1861(e)(7).

276. 42 C.F.R. § 482.11(a) (2002).

277. 42 U.S.C. § 1395cc(b)(2) (2000). In contrast, Congress does not require providers to participate in the program, and providers may terminate their agreements with proper notice and without cause. 42 U.S.C. § 1395cc(b)(1) (2000); *see also* Berenson & Harris, *supra* note 141, at 155 ("Although providers may terminate their agreements without cause, the grounds on which the Secretary may refuse to enter into an agreement, terminate an agreement, or refuse to renew an agreement are extremely limited.").

278. 42 U.S.C. § 1395cc(b)(2)(A)-(D) (2000).

279. *Id.* § 1320a-7; *see generally* William H. Dow & Dean M. Harris, *Exclusion of International Medical Graduates from Federal Health-Care Programs*, 40 MED. CARE 68 (2002).



related to the program, patient abuse, health care fraud, and controlled substances, trigger mandatory exclusion from federal health care programs.<sup>280</sup> Other specified conduct may lead to exclusion from the program in the discretion of the Secretary, such as other convictions involving fraud or controlled substances, license suspension or revocation, kickback arrangements, and providing services that were unnecessary or of inadequate quality.<sup>281</sup> Thus, some of the grounds for exclusion are related to health care services, but they are not limited to conduct involving Medicare or Medicaid patients.<sup>282</sup> Other grounds for exclusion are unrelated to health care services, but are directly related to financial misconduct in programs that are operated or funded by government agencies.<sup>283</sup> None of the statutory grounds for exclusion, however, would permit the Secretary to exclude a provider for violation of labor or environmental laws, much less for unproved allegations of such violations.

That is essentially what Congress proposed for non-Medicare procurement under federal rules that were issued in final form and later revoked. After publishing a proposed rule in 1999<sup>284</sup> and a revised proposal in 2000,<sup>285</sup> the Federal Acquisition Regulatory Council (FAR Council) published a final rule on December 20, 2000, in the waning days of the Clinton Administration.<sup>286</sup> Although the Medicare program purchases goods and services under a different set of procedures,<sup>287</sup> most federal agencies use a system of contracting set forth

280. 42 U.S.C. § 1320a-7(a)(1)-(4) (2000).

281. *Id.* § 1320a-7(b); *see also* Berenson & Harris, *supra* note 141, at 155-56 (suggesting this power would be used only in "the most egregious cases").

282. *See, e.g.*, 42 U.S.C. § 1320a-7(a)(2), -7(b)(6)(B) (2000) (including conviction of patient abuse or neglect as grounds for exclusion, as well as providing unnecessary or inadequate health care services to patients); *see also id.* § 1320a-7(b)(14) (noting that individuals may be excluded from participation in federal health care programs for failure to repay health education loans and scholarships); *id.* § 1395ccc (using the Medicare program to collect debts for scholarships and loans by means of offset); 42 C.F.R. § 405.380 (2002) (detailing procedure for offsetting past-due amounts on scholarships and loan programs against Medicare payments).

283. *See, e.g.*, 42 U.S.C. § 1320a-7(b)(1)(B) (2000) (indicating criminal activity "relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct" with respect to any government-financed, nonhealth care program could be grounds for exclusion).

284. Federal Acquisition Regulation (FAR), 64 Fed. Reg. 37,360 (proposed July 9, 1999) (to be codified at 48 C.F.R. pts. 9, 31).

285. FAR, 65 Fed. Reg. 40,830 (proposed June 30, 2000) (to be codified at 48 C.F.R. pts. 9, 14-15, 31, 52).

286. FAR, 65 Fed. Reg. 80,255 (proposed Dec. 20, 2000), *revoked*, 66 Fed. Reg. 66, 986 (Dec. 27, 2001).

287. *See* U.S. GEN. ACCOUNTING OFFICE, GAO-01-918T, MEDICARE CONTRACTING REFORM: OPPORTUNITIES AND CHALLENGES IN CONTRACTING FOR CLAIMS ADMINISTRATION

in the Federal Acquisition Regulation (FAR).<sup>288</sup> Even if a prospective contractor is in good standing, in the sense that it has not been suspended or debarred, the government may not award the contract unless the contracting officer determines that the prospective contractor is "responsible."<sup>289</sup> That requires, among other things, "a satisfactory record of integrity and business ethics."<sup>290</sup> The new rule was an attempt to define the type of record that would be considered to be satisfactory.<sup>291</sup>

As set forth in the December 20, 2000 final rule, the contracting officer would review the proposed contractor's history of legal compliance, not only for matters related to obtaining and performing government contracts such as fraud or bid-rigging, but also for matters related to tax, employment, environmental, and consumer protection laws.<sup>292</sup> Although the final rule specified that the greatest weight would be given to convictions, the rule also specified that contracting officers would be required to "consider all relevant credible information," including indictments, adverse decisions by federal administrative law judges, and administrative complaints that represent an adjudicated determination by a federal agency, commission, or board.<sup>293</sup>

Supporters of the new rule relied primarily on the normative argument that "[t]he Government ought not do business with lawbreakers."<sup>294</sup> In addition, this type of contractor responsibility rule can serve a deterrent function by providing an incentive for contractors to comply with all applicable laws.<sup>295</sup> However, industry organizations vigorously opposed the new rule on the grounds that the government already has an adequate system for suspension and debarment of contractors, and that the existing system is subject to substantive criteria and procedural protections that would not be available under the vague contractor responsibility rule.<sup>296</sup> In addition, industry representatives argued

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SERVICES 2-3 (2001) (comparing the system through which Medicare contracts for the services of intermediaries and carriers with the system of competitive bidding used by most federal agencies), available at <http://www.gao.gov/index.html>.

288. FAR, 48 C.F.R. ch. 1.

289. 48 C.F.R. § 9.103 (2002).

290. *Id.* § 9.104-1(d).

291. See FAR, 65 Fed. Reg. at 80,256 (summarizing the purpose of the rule).

292. 42 C.F.R. § 9.104.3 (2002).

293. *Id.*

294. FAR, 66 Fed. Reg. 66,986, 66,988 (Dec. 27, 2001) (codified in scattered parts of 48 C.F.R.) (summarizing public comments).

295. *Id.* ("Only doing business with law abiding contractors provides a positive incentive for voluntary compliance with tax, environmental, labor, civil rights, and consumer laws, as well as criminal laws involving contracting and certain other kinds of business activities.")

296. *Id.* at 66,988-89.

that contracting officers would lack the expertise and resources to determine violations of diverse laws, and the new rule could have the practical effect of interfering with the government's position of neutrality in disputes between labor and management.<sup>297</sup> Ultimately, the new administration of George W. Bush revoked the previous administration's final rule on December 27, 2001.<sup>298</sup> The FAR Council agreed that the government should only do business with contractors that comply with the law, but concluded that the appropriate means to accomplish that goal is the existing system for suspension and debarment.<sup>299</sup>

For many of the same reasons, the Medicare statute should not be amended to provide that a violation of other types of laws would be a basis for termination of a provider agreement or exclusion from participation in the Medicare program. Expanding the grounds for termination and exclusion to include a violation of unrelated laws would require HHS officials, without expertise or resources, to make complex determinations about other areas of the law, especially if the action by HHS was based on something less than a criminal conviction, final civil judgment, or final agency decision. Moreover, there already is an existing system for termination of provider agreements and exclusion from the Medicare program. That existing system includes substantive criteria and procedural protections, and it fulfills the normative function of making it clear that the government will not "do business with lawbreakers."<sup>300</sup> Finally, with regard to the goal of deterrence, no persuasive evidence exists that additional sanctions would cause health care organizations to do any more than they already are doing to promote compliance with the

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297. *Id.* at 66,988; *see also* Randel K. Johnson, Statement in Support of the Repeal of the Federal Acquisition Regulation: Public Comment on 65 Fed. Reg. 80,256 Before the Federal Acquisition Regulatory Council 9 (June 18, 2001) (asserting that unions could abuse the contracting process by filing claims against potential contractors as a way of pressuring contractors to agree to their demands and that a potential contractor could file a claim against another to gain an advantage in the contracting process), *available at* <http://www.uschamber.com/press/releases/2001/june/01-110.htm> (last visited Dec. 4, 2003) (on file with the Washington and Lee Law Review).

298. FAR, 66 Fed. Reg. 66,986 (Dec. 27, 2001).

299. *See id.* at 66,989 ("The suspension and debarment rules contain well-established and defined decision-making criteria and due process safeguards, which have evolved through case law precedent and agency practices."). *But see* Press Release, AFL-CIO, AFL-CIO Vigorously Opposes Elimination of Contractor Responsibility Rules, (Dec. 27, 2001) (announcing that organized labor supported the Clinton Administration's rule and opposed its revocation by the Bush Administration), *available at* [www.aflcio.org/mediacenter/prsptrm/pr12282001.cfm](http://www.aflcio.org/mediacenter/prsptrm/pr12282001.cfm). As the press release states, "It is an outrage for the Bush Administration to revoke the contractor responsibility rules designed to protect the public and the government from corporate contractors that do not respect labor, civil rights, and environmental laws and consumer protections." *Id.*

300. FAR, 66 Fed. Reg. 66,986, 66,988 (Dec. 27, 2001) (summarizing public comments).

law.<sup>301</sup> Even if additional deterrence were necessary and effective, the Medicare program should not be used as a tool to promote compliance with unrelated statutes and regulations.

*B. The Further Use of Medicare to Promote Even Broader Access to Care*

The current uses of Medicare, such as the subsidy for disproportionate share hospitals, indicate that one of the broader purposes of the program is to promote access to care for those not eligible for Medicare benefits. In theory, it would be preferable to fund indigent care directly and explicitly, rather than indirectly and covertly through Medicare payment formulas and unfunded mandates.<sup>302</sup> It is very unlikely, however, that a decision could be made in the political arena to reduce the level of Medicare's support for indigent care or to eliminate the unfunded mandate for hospitals to provide emergency care. Nevertheless, it is possible that we could change the ways in which we use Medicare to support indigent care so that we could address that goal in a more effective manner.

One possible alternative is to modify the current EMTALA mandate to focus on important health care needs that do not qualify as medical emergencies. Another alternative is to also require Medicare-participating providers to participate in state-sponsored discount or rebate programs that are approved by the Secretary of the federal HHS. In each case, it would be necessary for Congress to amend the Medicare statutes because the Secretary does not currently have the statutory authority to implement these alternatives. However, no constitutional barriers would prevent these statutory changes because Congress has substantial flexibility to impose conditions under its spending power and because Medicare participation is voluntary.<sup>303</sup>

Under current law, a hospital's EMTALA obligation is limited to determining whether the patient has an emergency medical condition and, if so,

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301. See Publication of the OIG Compliance Program Guidelines for Hospitals, 63 Fed. Reg. 8987 (Feb. 23, 1998) (indicating that health care organizations throughout the country have already instituted compliance programs that are designed to assure compliance with applicable laws as a means of gaining favorable treatment under the federal sentencing guidelines); see also *In re Caremark Int'l, Inc.*, 698 A.2d 959, 969–70 (Del. Ch. 1996) ("The Guidelines offer powerful incentives for corporations today to have in place compliance programs to detect violations of law, promptly to report violations to appropriate public officials when discovered, and to take prompt, voluntary remedial efforts.").

302. See *supra* notes 7–11 and accompanying text (setting forth indirect means for accomplishing broad social goals).

303. See *supra* Part III.A (discussing the requirements and history of EMTALA).

providing a proper transfer or the additional examination and treatment that is needed to stabilize the emergency condition.<sup>304</sup> For example, a patient in cardiac arrest would receive treatment to stabilize the condition, but not necessarily a coronary artery bypass graft to correct the underlying condition. A patient with lung cancer might receive emergency treatment for difficulty in breathing, but not necessarily radiation or chemotherapy to treat the cancer. As one commentator has explained, EMTALA does not apply to "primary or urgent care services."<sup>305</sup> Aside from the practical difficulty of distinguishing mandated emergency care from nonmandated urgent care, it is theoretically problematic to draw a line at emergencies and exclude from the mandate all other types of medically necessary care. We may have a vague sense that emergency care is always more important than other medical needs. In some cases, however, other types of care, such as corrective surgery for a child, may be more compelling and more justifiable in ethical terms than emergency care. In addition, it might be more cost-effective to provide primary care, rather than waiting until the patient's condition deteriorates to the point of qualifying for "free" emergency care.<sup>306</sup>

If we accept the existence of EMTALA's unfunded mandate as a given, in light of the political realities, then the remaining question is whether Medicare-participating hospitals should also be required to provide certain non-emergency care, such as prenatal checkups and well-baby visits, without regard to the patient's ability to pay. From a public health perspective, this modification of the EMTALA mandate might bring about a significant improvement in the health status of the population at a very reasonable cost. Of course, it would be important to conduct empirical research to evaluate the costs and benefits of this alternative.

If it is supported by the cost-benefit analysis, this alternative could be implemented by amending the EMTALA statute and its implementing regulations. Congress has the power to modify the obligations of participating hospitals, regardless of the hospitals' reliance on the law that was in effect at the time they executed their provider agreements.<sup>307</sup> As a practical and political

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304. 42 U.S.C. § 1395dd(a)-(b) (2000); see *supra* note 120 (giving statutory definition of "emergency medical condition," with a specific application to women in labor).

305. Olson, *supra* note 117, at 480.

306. See Ulen, *supra* note 146, at 691 ("[O]ne gets a state of affairs in which the indigent may delay seeking medical attention precisely because it becomes free to them in an emergency."); see also Hyman, *supra* note 117, at 51 (recognizing the higher expense of treating patients in the emergency department setting).

307. See *Am. Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 182-84 (7th Cir. 1983) (rejecting the industry's challenge to regulations that arguably changed the obligations that hospitals had accepted under the Hill-Burton program).

matter, the hospital industry would want something in exchange for undertaking an expanded EMTALA obligation, but Congress would be unlikely to eliminate or reduce the existing mandate to provide emergency screening and stabilization in the hospital emergency department. There may be room for compromise, however. Congress could eliminate or reduce hospitals' EMTALA obligations at their off-campus facilities as a quid pro quo for more effective EMTALA obligations on the main hospital campus.<sup>308</sup>

Another possible alternative is to amend Section 1866 of the Social Security Act to require Medicare providers to participate in additional government-sponsored programs. As discussed above, providers that participate in Medicare must also participate in the CHAMPUS, CHAMPVA, and VA medical programs.<sup>309</sup> In recent years, state governments have developed a variety of new publicly-sponsored assistance programs that are designed to promote access to goods and services such as prescription drugs. Some states have expanded their existing Medicaid programs under federally-approved demonstration projects,<sup>310</sup> while the State of Maine also developed a completely new program, apart from Medicaid, to enable all state residents to obtain discounts on prescription drugs.<sup>311</sup>

So far, these state-sponsored assistance programs have generally obtained rebates from pharmaceutical manufacturers, but other state programs could be developed on the basis of rebates from health care providers, suppliers, or practitioners. By requiring Medicare-participating providers to also participate in state discount programs, it may be possible to improve access to care. There is a danger, however, that state programs could impose unreasonable

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308. See *supra* note 119 (discussing proposed amendments to existing regulations regarding a hospital's off-campus facilities). As part of modifying the EMTALA obligation, Congress could also reduce the regulatory burden on hospitals by clarifying that EMTALA does not apply to inpatients. See *supra* note 119 (discussing the inherent ambiguities of when EMTALA actually applies).

309. See *supra* note 113 (discussing these participation requirements).

310. See, e.g., *Pharm. Research & Mfrs. of Am. v. Thompson*, 251 F.3d 219, 226 (D. C. Cir. 2001) (finding that the federal government lacked authority to approve a Vermont demonstration project that required manufacturers to pay rebates without any state Medicaid expenditure); see also *Pharm. Research & Mfrs. of Am. v. Thompson*, 191 F. Supp. 2d 48, 62–66 (D.D.C. 2002) (finding the identical Maine Medicaid demonstration unlawful on the same grounds), *rev'd*, 313 F.3d 600 (D.C. Cir. 2002), *amended by* No. 02-5110, 2003 U.S. App. LEXIS 4037 (D.C. Cir. Mar. 5, 2003).

311. See *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 123 S. Ct. 1855, 155 L. Ed. 2d 889 (2003) (refusing to enjoin a Maine program to obtain funding for discounts through rebates from manufacturers who choose to participate in the program—if a manufacturer refuses to participate, that manufacturer's products would be treated less favorably under Maine's Medicaid program by requiring prior authorization for its drugs).

requirements on participating providers. Therefore, if Congress were to amend Section 1866 to add a new requirement that Medicare providers must agree to participate in state-sponsored programs, that new requirement should be limited to those state programs approved in advance by the Secretary.

### VI. Conclusion

In 1965, Congress merely intended to provide insurance coverage for a specific group of people and not to provide assistance to the broader community. In fact, by prohibiting cross-subsidization, Congress made clear its intent that Medicare funds should not be used for the benefit of non-Medicare patients. Since 1965, however, Congress has expanded the role of the Medicare program and used it to promote broader public goals, such as providing financial support for indigent care, rural health care facilities, and graduate medical education. The role of Medicare has also been expanded by using participation in the program as a "hook" to impose unfunded mandates that apply to non-Medicare as well as Medicare patients. As demonstrated above, Medicare has not been expanded in a calculated manner to accomplish a previously identified mission, but rather has been expanded in a reactive mode as a response to a series of largely unrelated concerns.

In their research, Michael Gusmano and Mark Schlesinger found that policy elites often based their views on the broader uses of Medicare on their underlying ideological positions.<sup>312</sup> Liberals were more likely to favor an active role for the Medicare program in supporting activities such as medical education, indigent care, and rural facilities, whereas conservatives tended to believe that Medicare trust funds should only be used for the benefit of Medicare patients.<sup>313</sup> Gusmano and Schlesinger recognized that conservative elites were not necessarily opposed to any government involvement in those activities, but generally opposed using the Medicare program for those purposes.<sup>314</sup> Under that view, direct funding would have the advantages of greater accountability and competition with other funding priorities.<sup>315</sup> In

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312. Gusmano & Schlesinger, *supra* note 14, at 59; *see also* NASI, *supra* note 12, at 57 (explaining the distinct ideological differences among policy experts).

313. Gusmano & Schlesinger, *supra* note 14, at 59.

314. *See id.* (finding that conservative elites "strongly objected to using money from the Medicare trust fund").

315. *See* Newhouse & Wilensky, *supra* note 213, at 139 (describing the position taken by the majority of members on the Bipartisan Medicare Commission).

addition, most economists favor explicit funding of public needs over hidden cross-subsidization.<sup>316</sup>

Unfortunately, the economist's preference for explicit and adequate funding is intellectually satisfying, but not politically realistic. After so many years, it is unreasonable to assume that the scope and functions of the Medicare program could be significantly reduced and that the broader uses of Medicare could be untangled from the program. Moreover, many people would argue that the scope and functions of the Medicare program should not be reduced and that those broader uses should not be untangled. I will argue, therefore, in favor of a compromise position of retaining the status quo but providing much greater transparency.

As other writers have pointed out, the lack of transparency is one of the most serious problems in the American health care system.<sup>317</sup> The use of Medicare to covertly subsidize broader public goals is both a symptom and a contributor to that problem. According to the NASI Study Panel, if broader social goals were not connected to the Medicare program, then Congress would be forced to develop health policy for the nation "much more overtly than at present."<sup>318</sup> That is an accurate statement, but we do not have to give up completely on the goal of transparency. At the very least, we should try to encourage more overt development of policy, even if we are not able to untangle all of those broader goals from the Medicare program. The taxpayers, who have money deducted from their paychecks for something called "Medicare," have the right to know what is really being done with their money.

Specifically, we should insist that Congress and the Secretary openly acknowledge the broader purposes of Medicare and honestly account for its costs. Rather than continuing to pretend that the hidden subsidies are merely reimbursement for the higher costs of patient care, Congress and the Secretary should publicly acknowledge that a portion of Medicare spending is used to

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316. See Gbadebo & Reinhardt, *supra* note 221, at 149 ("Economists . . . certainly would like these to be funded adequately and explicitly by society."). *But see id.* at 152 (concluding that the moral imperative of funding the safety net outweighs the dictates of economic theory in this situation).

317. See, e.g., Havighurst, *supra* note 42, at 78 ("Virtually everyone involved in the never-never land of health care thinks—rightly in some cases, wrongly in others—that someone else will pay the bill, including whatever costs law and legislation may impose."). In addition, David Hyman and Mark Hall have pointed out that the lack of transparency in the cost of employee health coverage has contributed to the public opposition to managed care, because employees did not realize that they were saving their own money as a result of cost containment techniques. David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, II *YALE J. HEALTH POL'Y, L. & ETHICS* 23, 28 (2001).

318. NASI, *supra* note 12, at 46.



support important activities such as indigent care, medical research, and rural health care facilities.<sup>319</sup> In addition, Congress should require the Secretary to prepare and issue realistic estimates of the cost of complying with unfunded mandates that are imposed as conditions of participation. The Supreme Court has recognized that the purposes of Medicare include "ensuring the availability of quality health care for the broader community,"<sup>320</sup> and it is time for Congress and the Secretary to do the same.

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319. See Gusmano & Schlesinger, *supra* note 14, at 46–47 (suggesting that the legitimacy of the Medicare program could be enhanced and intergenerational conflict could be reduced by pursuing collateral functions that benefit people under the age of 65).

320. *Fischer v. United States*, 529 U.S. 667, 680 (2000); see *supra* notes 244–272 and accompanying text (discussing Supreme Court's rationale in *Fischer*).