2011

The Real Constitutional Problem with the Affordable Care Act

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Among the main provisions of the Affordable Care Act (ACA) are Title I, the insurance coverage expansions; Title II, the Medicaid expansions; and Title III, "Improving the Quality and Efficiency of Health Care" (P.L. 111 – 148 [2010], 124 Stat. 119 – 1025). The real goals of Title III are not only to create incentives for improving quality and efficiency but also to squeeze enough money out of the Medicare program (about $330 billion after coverage expansions, according to the CBO) to make a big down payment on the insurance coverage and Medicaid expansions under Titles I and II (Congressional Budget Office 2010).

Most of the cost savings are slated to come from revising payment formulas for Medicare Advantage plans and reducing payment increases that were otherwise projected for providers and suppliers, particularly hospitals and home health agencies.[2] There are limits, however, to the cost control that can be accomplished by simply cutting provider payments. First, if payment cuts simply increase the disparity, already significant, between what Medicare pays and what private insurers pay, it is likely that at some point providers may simply cease providing services to Medicare beneficiaries (Foster 2010). Second, as this happens, Congress will come under increasing pressure to roll back the payment cuts. Although Congress has a better record of staying the course on Medicare cutbacks than is commonly believed, health plans and providers are politically powerful and have certainly been successful in overturning payment cuts in the past (Horney and Van de Water 2009). Third, payment cuts simply result in a one-time reduction in payment increases; they do not "bend the curve" of health care cost growth.[3]

What is needed are payment reform strategies that dramatically increase incentives to encourage efficiency of care delivery (and, if possible, to improve the quality of care as well). If alternative payment methods that discourage unnecessary utilization, encourage efficient provision of care, and improve the effectiveness and coordination of care can be implemented — for example, accountable care organizations (ACOs) or medical homes — then real, sustainable, "curve-bending" cost savings may be achieved. If these strategies prove attractive to private insurers, the disparity between Medicare and private payment may diminish. Moreover, if these strategies work, Medicare beneficiaries will be better off too, both because they will be receiving better care and because growth in their cost-sharing obligations will moderate.[4]

But where will these new cost approaches to provider payment come from? We cannot count on Congress to lead program innovation. For nearly three decades since the establishment

[1] Published in the *Journal of Health Politics, Policy and Law*, Vol. 36, No. 3, June 2011.
[2] For more on the politics of Medicare payment reforms, see Laugesen in this issue.
[3] For more details on cost-control provisions, see Oberlander; Rice; Gusmano; and Pauly in this issue.
[4] On ACOs, see Luft and Pauly in this issue.

of diagnostic-related group hospital payment in 1982, Congress has micromanaged Medicare provider payments, creating ever more Byzantine fee-for-Service or fee-per-admission prospective payment systems for virtually all providers (Jost 1999). The details of these systems have often been driven by pork-barrel politics, as particular providers have scrambled to make sure they get the largest possible piece of this growing pie. In the meantime, ten years' worth of recommendations from the Medicare Payment Advisory Commission to reform payment in more fundamental ways have gathered dust on the shelf (Dickerson 2009). Some recommendations have been implemented on a demonstration basis, but few have gone programwide. Attempts to make fundamental changes — such as competitive-bidding demonstration projects — have been blocked by Congress and by the courts.

The ACA appears to be an attempt by Congress to repent and mend its profligate ways. But Congress does not seem quite able to trust itself to know how best to proceed with payment reform or to resist the allure of pork-barrel politics in the future. Congress has, in Title III, created a threefold strategy that reflects this lack of confidence. First, the legislation authorizes a host of new payment methodologies, mostly in the form of demonstration and pilot projects. Wisely, new payment strategies will first be tested out before implementation. Second, Congress delegates sweeping authority to the executive branch for implementing cost-control strategies and limits its own authority over provider payment. In some instances, discussed below, Congress even allows the executive branch to simply ignore or alter existing law. Third, Congress also largely eliminates judicial review of executive decisions regarding provider payment methodologies, assuring that Health and Human Services (HHS) decisions will be able to move forward expeditiously, unimpeded by judicial intervention.

One provision of the legislation, for example, requires HHS to establish by 2012 an ACO "shared-savings" program (section 3022). Although the law lays out fairly specific requirements that the ACO program must meet, it also permits HHS to waive any requirement of the Medicare statute and of the civil and criminal penalty provisions of the Social Security Act that relate to federal health care programs. This provision also broadly prohibits judicial review of most of the decisions HHS will have to make in implementing the ACO program. A second section, which creates a pilot program for payment bundling, also permits HHS to waive any provisions of the Medicare title and of Title XI, which covers fraud and abuse, peer review, and other program administration issues (section 3023). The Independent Payment Advisory Board (IPAB), created by a third provision (section 3403), will have broad powers after 2014 to propose changes in Medicare provider payments to achieve specified cost-control targets, which HHS must put into effect unless Congress enacts cost-control measures that meet the same targets or votes to reject the IPAB proposal (by a three-fifths majority in the Senate). The decision of HHS to implement an IPAB proposal is absolutely immune from judicial review. Finally, and perhaps most dramatically, the ACA creates a Center for Medicare and Medicaid Innovation, which has the authority to institute a host of demonstration projects to test out new payment and delivery models and to take these models programwide if the demonstrations succeed (section 3021). Again, HHS is given authority to waive the requirements of the Medicare statute, Title XI, and even several provisions of the Medicaid statute, and most of the important determinations to be made under the program are unreviewable.

What is happening here is truly remarkable. Congress is delegating to HHS authority to waive the provisions of existing law, freeing it from judicial oversight and, in the case of the IPAB, even limiting Congress's own authority to override the decisions of an executive agency.[5]

Is this constitutional? The Constitution, as we have all been taught, creates a system of checks and balances, of separated powers. Three areas of constitutional doctrine would seem to apply here. The first of these is the nondelegation doctrine. The Supreme Court has long stated that Congress cannot simply delegate its responsibility and authority to adopt legislation to the executive branch (*A. L. A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 [1935]). Of course, as a practical matter, Congress must often grant executive agencies considerable discretion to implement complex bodies of regulatory law. The Supreme Court has repeatedly approved broad delegations of authority as long as Congress imposes an "intelligible principle" to guide the exercise of discretion (*Whitman v. American Trucking Assocs. Inc.*, 531 U.S. 457 [2001]; *Mistretta v. United States*, 488 U.S. 361 [1989]). Each of the sections listed above instructs HHS as to what sorts of spending-control methodologies are encouraged or forbidden, and this may be sufficient guidance to satisfy this requirement. The discretion granted by these provisions, however, is in stark contrast to the detail and specificity with which Congress has written Medicare payment statutes for the past quarter century, and these provisions grant breathtaking discretion, particularly to the IPAB and Center for Medicare and Medicaid Innovation.

A second relevant line of authority is the separation of powers doctrine. The Supreme Court has held that the Constitution's "finely wrought" procedure for enactment of legislation leaves no room for the president (and, by extension, the executive branch) to simply cancel legislation enacted by Congress.[6] Recent cases, however, have allowed the executive branch to waive legislative requirements for limited purposes or time periods (*Iraq v. Beatty*, 129 S.Ct. 2183 [2009]; *Defenders of Wildlife v. Chertoff*, 527 F.Supp.2d 119 [D.D.C. 2007]). It is likely that the ACA waiver provisions would be upheld, as they permit HHS to waive legal requirements only for specific programs, and for a limited time with demonstration projects. Again, however, the provisions are striking in the extent to which they represent an abdication of power in an area where Congress has long jealously guarded its own control.

Third, there is the problem of judicial review preclusion. The courts have in fact traditionally been quite reticent to second-guess the operation of the Medicare program, although at a few key points they have reined in administrative overreaching (Jost 1999). The Constitution gives 5. Congress the power to define the jurisdiction of the federal courts, and prohibitions on judicial review have often been upheld (*United States v. Fausto*, 484 U.S. 439 [1988]; *Cardiosom v. United States*, 91 Fed.Cl. 659 [2010]). The courts are reluctant, however, to construe review preclusion statutes to deny the courts jurisdiction to decide constitutional questions, which would seem to be necessary to protect the ultimate responsibility of the judiciary to interpret the Constitution (*Bowen v. Michigan Academy*, 476 U.S. 667 [1986]; *Bartlett v. Bowen*, 816 F.2d 695 [D.C. Cir. 1987]). If, therefore, a challenge were brought to these ACA provisions under the nondelegation or separation of powers doctrine, it would seem that the courts could address these questions, regardless of the limitations imposed by the statute.

[5] See Jacobs in this issue for a discussion on how agency discretion will create a new political dynamic.
[6] This was enunciated in the *Clinton v. City of New York* line-item veto case (524 U.S. 417 [1998]).

Although the ACA provisions may pass muster under each of these doctrines independently, the cumulative effect of this transfer of power to the executive is troubling. Although these sections may provide sufficient "intelligible principles" to survive a delegation challenge, if judicial review of the implementation of these principles is precluded by statute, do the principles really mean anything? Moreover, are not broad delegations of discretionary authority even more troublesome if they include authority to ignore whole titles of the federal code? One of the arguments for allowing administrative agencies (as opposed to the president) to waive federal law is that their decisions are reviewable under the Administrative Procedure Act (Bolton 2003). Is allowing agencies to waive legal requirements more problematic if review is barred?

To give one example, a complex body of laws regulates Medicare payment for chemotherapy (Bach 2009). The IPAB could propose a new payment system that would waive these requirements, dramatically reducing payments for the chemotherapy drugs or to doctors who administer them. This proposal might arguably violate the clause that enjoins the IPAB from establishing systems that ration care or restrict benefits, but these vague limitations certainly do not expressly prohibit such a proposal. Moreover, if HHS implemented the proposal, this decision would be immune from judicial review. Thus HHS could dramatically reduce access to chemotherapy, ignoring existing law and avoiding judicial review.

Desperate times require desperate measures, and Medicare's financial situation is certainly dire. Congress's temptation to tie itself to the mast in response to the siren song of special interests is understandable. It is also perhaps understandable that it should want to free Medicare payment reform from the impediments and complications of judicial review. But allowing administrative agencies virtually unbounded discretion to 506 Journal of Health Politics, Policy and Law rewrite the payment rules, disregarding existing law and free from judicial restraint, is a troubling challenge to our constitutional order.

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