The Challenge of Protecting Liberty on Health Care:

The Supreme Court Ruling on the Health Law

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The Supreme Court Ruling on the Health Law

The Supreme Court and Medicine 1986-2005

- **Rehnquist Court**: 4 areas
  - Reproductive Rights
  - Medical Privacy
  - Discrimination
  - Federalism

- **Also decided**:
  - Affirmative Action
  - Campaign Financing
  - Separation of Church & State

- **Supreme Court has stressed** Personal Autonomy in “life-defining matters”
  - Marriage
  - Procreation
  - Parenting
  - Dying

Gostin LO. JAMA 2005; 294:1685-7
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The Supreme Court and Medicine 1986-2005

- Reproductive Rights
  - Planned Parenthood of SE Pennsylvania vs Casey
    - Overturned rigid “trimester rule” and created “undue burden” rule
  - Invalidated
    - State obstacles for abortion of a non-viable fetus
    - Spousal notification
    - Partial birth abortion bill struck down as it was not allowed in cases to safeguard the mother’s health
  - Upheld
    - 24-hour waiting period / parental notification
    - Affirmed government could deny funding to clinics that perform / assist in / counsel about abortion [“gag rule”]

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The Supreme Court and Medicine 1986-2005

• **Privacy**
  - Privacy in Roe, and re-iterated for medical testing:
    - Sterilization
    - Contraception
    - Marriage
    - Parenting
  - But permissive toward drug screening
  - Affirmed “liberty interest” / patient autonomy to refuse medical treatment except for “important government interest” [e.g. antipsychotics for inmates]

• [Cruzan v. Missouri Department of Health](https://www.scotus.org/supreme-court-decisions-cases/1984-1985/cruzan-v-missouri-department-of-health)
  - Absent “clear and convincing evidence” the state’s action to preserve life was constitutional

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**Discrimination**

- Disabled
- Handicapped Infants

**Disabled**

- Ruled: Asymptomatic HIV and Tuberculosis protected as a disability
- Later definition of disability “narrowed” [excluded carpal tunnel / hypertension]
- ADA: Individual must be disabled and “qualified” to work
  - Individual must not pose a direct threat to the health or safety of others or to themselves on the job

**Handicapped Infants**

- Life-sustaining treatment can be withdrawn without parental consent

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Supreme Court and Bedside Rationing by Private Health Insurance

- **Pegram v Herdrich**
  - Justice Souter:
    - “Inducement to ration care goes to the very point of any HMO scheme”
    - Since 1973, Congress has promoted the formation of HMOs and endorsed “the profit incentive to ration care”
  - State law has jurisdiction over *negligent treatment*
    - ERISA has jurisdiction over *improper administration of benefits*
      - Federal law awards no damages beyond the cost of the care that was withheld
      - “Rebuffed ERISA’s fiduciary duty provisions to limit pressure on physicians to depart from the ethical ideal of undivided loyalty to patients”

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Supreme Court and Bedside Rationing by Private Health Insurance

- **Aetna Health, Inc. v Davila and Cigna v Calad**

  - “When MCOs deny benefits they apply terms of an insurance contract and they are not making decisions regarding the care of patients, even when decisions are based on a finding that the care is not medically necessary”

- Under ERISA, MCOs are responsible only for the cost of wrongfully denied treatment.
- Liability for negligent medical judgment remains almost exclusively with treating physicians and hospitals.

Mariner WK. NEJM 2004; 351:1347-51.
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Supreme Court and Bedside Rationing by Private Health Insurance

- **Aetna Health, Inc. v Davila** and **Cigna v Calad**

  - ERISA gives a remedy for wrongful decisions by allowing the patient to: [1] challenge the MCOs decisions when made and/or [2] individually pay for treatment and sue for reimbursement

- Physicians are ethically and legally obligated to explain all reasonable treatment options
- Patients expect that their physicians will help them appeal MCO denials of care.

Mariner WK.  *NEJM* 2004; 351:1347-51.
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Bending the Cost Curve

- **ACOs**
  - “Based on current utilization data, Medicare beneficiaries could be assigned to a physician who in turn is a member of...an ACO”.
  - “The physician and hospitals associated with the ACO would share in any savings from providing care that meets quality standards at a cost lower than that established by the spending target”.
  - “Physicians not participating in such accountable incentive payment systems might be subject to reductions or penalties in updates of the MEDPAC fee schedule”
  - “Inducement to ration care goes to the very point of any HMO scheme”

Shortell SM. JAMA 2009; 302:1223-4
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Bending the Cost Curve

- **Comparative Effectiveness**
  - “A center for comparative effectiveness research is needed to provide...reliable and accessible data on the *efficacy, effectiveness, and cost of new treatments, technologies, and interventions*...”.
  - “The center should emphasize those conditions that contribute the greatest amount to the nation’s burden of disease and that are amenable to action”.
  - “Patients and employers should be provided with incentives to select the highest-performing, most cost-effective clinicians and health plans. This can take the form of reduced co-payments, decreased deductibles, or both”

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7 Provocative Principles for Health Care Reform

- Although health care systems are not transplantable, good ideas from other countries should be considered
- Every efficient health care system imposes caps on spending and engages in strategic rationing
  - “Systems with universal coverage contain costs by empowering a single payer or regulator to control the overall outflow of funds.”
  - “Alleviates the need for micromanagement of clinical decisions but does leave clinicians and hospitals with challenging mandate of allocating scarce resources”
  - ACA “…creates a complex system of entitlements involving not just individuals and families but a variety of public and investor-owned intermediaries”.

Naylor CD, Naylor K. JAMA 2012; 307:919-920
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7 Provocative Principles for Health Care Reform

• Fairness in finance and access to health care is an objective of health policy makers. However, fairness, is seldom defined
  ○ “Some data suggest that lower-income US residents already have better access to care than high-income earners in many other countries with universal coverage”

• Higher levels of spending do not correlate closely with quality of care but may lead to diminishing marginal health benefits

• Transactional micromanagement of health care is suboptimal, whether publicly or privately administered
  ○ “Whereas many nations...give clinicians substantial autonomy to allocate constrained resources, the US has built a massive industry based on micromanaging clinical care to contain costs”.

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Affordable Care Act Litigation

• Unprecedented 5½ hours for oral arguments on 4 issues:
  - Individual Mandate
  - Medicaid Expansion

• Anti-Injunction Act:
  o Since the mandate and tax penalties do go into effect until 2014, no harm incurred.

Gostin LO, Garcia KK. JAMA 2012; 307:369-70
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Affordable Care Act Litigation

• **Individual Mandate**
  
  o **Department of Justice position:**
    • Insurance industry / pharmaceuticals / medical devices / EMR cross state lines
    • Mandatory insurance: Medicare
    • Congressional regulation of inactivity: Inactivity part of Civil Rights Act that forces the hospitality industry to serve African-Americans
    • Necessary and Proper clause: Reforms insurance industry forcing coverage of all individuals without charging higher premiums based on pre-existing conditions, and eliminating capitation
  
  o Uninsured: cost-shift health expenses [$62 billion in 2009] with higher taxes and insurance

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Affordable Care Act Litigation

- **Severability**: “Imperil effective implementation of the ACA”

- **Medicaid Expansion**: Household incomes <138% of the federal poverty level
  - Due to federal funding, obligates states to participate in ACA
    - Federal government pays 100% of expansion for only 3 years, then 90% of expansion expenses
    - “Provide for the common defense and general welfare” allows increasing Medicaid access

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Patient Autonomy

- Federal Government’s reach into health care
  - 50+% of Americans on Federal Healthcare Program
    - Medicare / Medicaid / CHIPS: *de facto* single payer system
      - Like ACOs, reimbursement rates already dictated without free market influence or appeal
    - Medicare has the highest payment denial rate among all insurance carriers
  - As the reach of the Federal Government increases into medicine, the cost of medical care increases
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Patient Autonomy

- Federal Coordinating Council for CER:
  - Inserted into Title XI of the Social Security ACT
  - 15 Members appointed by the President
  - “Evidenced-based information to patients, clinicians, and other decision-makers”
  - Transforming from patient autonomy to governmental beneficence
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Patient Autonomy

- EMR, HIPPA, Clinical Research:
  - CER: Under ARRA and then PPACA, medical outcomes data sent to federally funded research centers for CER without formal informed consent
  - Required Care Measures: Quality Measures / Chronic Disease Management / Case Management / Care Coordination / HHS Core Compliance
- Community Based Care Transitions Program: “High risk” Medicare beneficiaries
  - Secretary HHS: defines “high-risk” / may expand the duration and scope of program to reduce spending without reducing quality
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Patient Autonomy

- EMR, HIPPA, Clinical Research:
  - Required Demographics: Preferred language / Race and/or Ethnicity / Body Mass Index / Record smoking status for patients 13+ yrs of age
  - Required Reports: Quality Improvement / Research / Reduction of Disparities / Outreach
  - Report ambulatory clinical quality measures to CMS for all patients

“Submit electronic syndrome surveillance data to public health agencies and actual submission according to applicable law and practice”

“Intelligently filtered and organized health and care”

“CMS will not issue additional guidance”
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*Patient Autonomy*

- Budgetary strains
  - $500 billion already cut from Medicare in PPACA
  - Now that CBO scores that PPACA will cost $2 trillion, additional Medicare cuts likely despite baby boomers entering system

- Independent Payment Advisory Board
  - “Authority to limit the growth of Medicare spending”
    - OTC Medications now require Rx
    - Rationing already exists: Lifetime limit for number of days in a Skilled Nursing Facility
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*Patient Autonomy*

- Independent Payment Advisory Board
  - By September 1, 2013, draft proposals to limit Medicare spending must be submitted to the Medicare Payment Advisory Committee and the Secretary of HHS
  - By August 15, 2014, the Secretary must implement the IPAB proposal unless:
    - Congress passes an alternative that achieves the Medicare savings
    - If Congress fails, or the President vetoes the legislation *and* the veto is not overridden
      - *The Secretary of HHS is required to implement the original IPAB proposal*
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Government Mandates in Medicine

- **Insurance**
  - Who gets insured, until what age, and at what rate
  - Requirements of policy [e.g. contraception]

- **Hospitals and Physicians**
  - Government will prescribe care based on CER / IPAB
    - What happens if the patient wants to choose another course of care?
  - Data collection agency for the government

But where is the patient in the decision making process
What happened to the doctor-patient relationship?
What happened to patient autonomy?