FLOW OF EVENTS IN NEW SYSTEM

LEGAL REVIEW GROUP
May 6-7, 1993

I. ISSUES IDENTIFIED DURING THE LAST SESSION THAT SHOULD BE PURSUED

1. How can we keep medical malpractice in the state courts?

2. Disclosure v. informed consent - where to draw the line between consumer and patient

3. Problems of unconstitutional delegation of taxing authority could be raised depending on what entity is determining and collecting benchmark premium

4. Authority to regulate contract between employers and plans outside of the alliance

5. Issues regarding states' balanced budget amendment laws, "anti-deficiency" laws

6. What state laws are preempted?

7. Are state public health authorities (such as communicable disease reporting requirements, quarantine and detention authorities) preempted?

8. Assume that states will decide whether the alliance will be a governmental entity, a non-profit or a for-profit corporation. Different legal problems emerge depending on structure and authorities of the alliance (i.e., unconstitutional delegation of governmental regulatory authority).

9. How does the program relate to ERISA?

10. Are there inconsistencies in the new program encouraging provider cooperation and anti-trust prohibitions in current federal and state law?

II. ADDITIONAL LEGAL QUESTIONS (THAT MAY NOT BE RAISED DURING DISCUSSION)

1. Federal legislation will list the categories of health services to be delivered when "medically necessary or appropriate."

- Is "medically necessary or appropriate" a useful standard? Should consumer/patient opinion or cost-effectiveness be considered?

- At what level should this determination be made?

- How should disagreements over a denial of benefits be resolved?

2. If reproductive health services are included in the comprehensive benefit package but a plan is unwilling to provide them, does a patient have the right to receive a particular service? Does a provider have the right to refuse to provide the service?

3. Should plans be required to have a stated and disseminated policy on controversial bioethical issues, (e.g., abortion, termination of care for the terminally ill) where state law would permit a range of options? If so, should this be required by statute or regulation? If by statute, what language might be appropriate?

4. Can federal funds be used to provide education and training for racial minorities and women providers in practice areas, such as primary care, where the characteristics of the provider may be reasonably related to their ability to provide appropriate care?

III. RESPONSE TO FACTUAL QUESTIONS RAISED BY THE LEGAL REVIEW GROUP

1. What is meant by the phrase "the Health Alliances bear no risk"?

Health alliances do not act as insurers. They are purchasers of health insurance.

2. How will the health alliance collect premiums? How will premiums be collected from self-insured individuals?

Employers and employees may contribute a fixed percentage of payroll each year to purchase health insurance. Under this option, employers contribute 80 percent of the cost and employees 20 percent. Self-employed persons contribute the full amount of the premium. Non-working individuals contribute a percentage of their unearned income comparable to the amount paid by employed individuals. The contributions of self-employed and non-working individuals are tax deductible.

3. How will states' budgets be established?

Under one option being considered, a national health budget will control all expenditures for the comprehensive benefit package whether coverage is obtained through an alliance or outside the alliance. The budgeted amount will

include contributions to premiums made by employers and employees as well as cost sharing. The budget will not cover expenditures for supplemental benefits not provided in the comprehensive benefit package.

a. Expenditures Through the Alliance

The National Board will establish an annual allowed percentage increase in health insurance premiums. The allowed increase will reflect the percentage growth in Gross Domestic Product adjusted, after consultation with each state, for demographic changes. The state's budget will consist of the previous year's budget plus the allowable premium increase.

Each state will in turn determine an allowed increase for health alliances within its borders with the total not to exceed the nationally designated percentage for the state.

During the first year of operation, when no base-line budget exists, the National Board will set an allowable premium increase simply as a target.

b. Expenditures Outside the Alliance

Each employer outside the alliance will calculate a premium equivalent for each employee. The National Board will provide to the Department of Labor a table showing the allowable premium increases for each state, which the Department will make available to employers. Based on this table, each employer outside of the alliance will calculate the allowable premium increase for its insurance plan by adding the previous year's premium to the allowable increase for a state multiplied by the number of employees the firm employs in that state.

The Department of Labor will monitor employers' compliance with budget requirements.

stored as legal.iss; revised April 30, 1993

GENERAL ISSUES IDENTIFIED BY LEGAL AUDIT GROUP

General

What does Federal statute have to include to ensure consistency, fairness, and enforceability of the program?

Medical Malpractice/Tort Reform

How can we keep medical malpractice in the state courts?

Enterprise Liability, with or without caps

Plans must offer ADR consistent with State statutes already in place - is program creating another layer?

What tort reforms make sense - caps on damages, caps on plaintiffs' attorneys' fees, mandatory collateral offset, uniform statute of limitations?

What private causes of action are necessary?

What type of interplan litigation will develop?

Disclosure v. informed consent - where to draw the line between consumer and patient

Benefits/Specific Availability of Benefits

What is medically necessary/medically appropriate - is consumer/patient opinion or cost-effectiveness be factored into medically necessary or appropriate decision-making?

Will individual who moves in and out of employment with large firms be forced to change plans, assuming large firm HA doesn't contract with same plans?

Should program create new statutory language or build on medically necessary/medically appropriate?

Federal/State interactions/Legal Authority for program

What is the underlying legal basis for the financing of the program?

Problems of unconstitutional delegation of taxing authority could be raised depending on what entity is

determining and collecting benchmark premium.

- Authority to regulate contract between non-HA employers and plans (program proposes to require employer plans to accept all dependents, collect data, etc.)
- Authority for requiring state "payback."
- 10th Amendment issues
- Issues regarding States' balanced budget amendment laws, "anti-deficiency" laws

Federal Pre-emption

- What State laws are pre-empted by the program?
- Are State public health authorities (such as communicable disease reporting requirements, quarantine and detention authorities) pre-empted by the program?
- How do national quality of care regulations pre-empt state laws and programs?

Legal Structure of HA

- Is the HA a governmental entity (part of State Health system or other State entity)
- Is the HA a non-profit private corporation?

Different legal problems emerge depending on structure and authorities of HA (i.e., unconstitutional delegation of governmental regulatory authorities)

- Exclusive v. Non-exclusive HAs - how can a large firm which forms its own HA perform the governmental, quasi-regulatory functions of the HA, such as rate setting, certification of plans, authority to reject certain plans, and approval of major expenditures of plans?

Forum of Dispute Resolution/Locus of Liability

- Who can sue whom, for what, and in what forum?
- What are procedural (i.e., standing) and substantive standards for dispute resolution

ERISA

- How does the program relate to ERISA

Confidentiality

How do Federal and State FOI laws relate to information collection provisions of program?

Provider confidentiality

How do information collection provisions relate to current Federal and State confidentiality laws (i.e, 42 U.S.C. 290aa, confidentiality of alcohol and drug abuse treatment programs)

1983 Suits Against States

Transition Issues

Anti-Trust/Anti-Kickback Issues

- Are there inconsistencies in new program encouraging provider cooperation and anti-trust prohibitions in current Federal and State law?

National Mandate v. State Variability

- What is the extent of state variability which will be allowed in, for example, supplemental insurance, supplemental benefits?

- Restriction of supplemental marketing raises questions of limiting commercial speech by plans or insurers - consumers may allege that government limiting the information available to evaluate plans.

M E M O R A N D U M

TO: Barbara McGarey
Deputy Director, Office of Technology
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FROM: Barbara Anthony
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DATE: May 3, 1993

Below are some additional comments on the general issues list:

1. Re: Medical Malpractice/Tort Reform

   a) What is disposition/redistribution of savings generated by providing tort immunity for practitioners?

   b) Are the rights of consumers being inadvertently curtailed by restricting tort claims to the health plans? Are there instances where "enterprise liability" will foreclose a right of action that the consumer may have had against an individual practitioner? Should there be some language added to insure that such is not the intent?

2. Forum of Dispute Resolution

   a) Is the federal claims dispute resolution system proposed intended to be an exclusive remedy?

   b) Is it intended to preempt access to state agencies or courts with respects to disputes about benefit claims? This should be clarified.

BA/bt

LEGAL REVIEW GROUP MINUTES -- APRIL 29, 1993

A. Legal Issues Raised By the Group

1. What standards and procedures will be established to define "medically necessary"? Will there be an administrative process? Can states vary in their definitions?

2. How "governmental" must the Health Alliances ("HA") be in order for them to be able to set and collect premiums? Do the powers of the HA's constitute an unconstitutional delegation of the federal taxing power? Is the answer different if the HA is a state agency? Is the answer different if the employer is not required to make contributions to the HA, merely denied the deductibility of his premium costs? Should the HA be a federal agency?

What if decision is left to the state?

3. What standards and procedures will be established to determine the setting of premiums?

4. What ERISA preemption issues are raised by using the HA's to establish premiums for qualified plans?

5. What effect do the states' legal and constitutional limitations on governmental taxing powers have on the ability of the HA's to set and collect premiums?

6. To what extent does the federal program preempt state law?

B. Legal Issues Raised By Task Force Members

1. What options are available to the federal government if a state refuses to comply with federal requirements? Can the federal government intervene and take over a state's program?

2. Is there a better phrase than "medically necessary"?

3. Who can sue whom for what?

C. Factual Issues Raised By the Group and Not Yet Answered

1. What exactly is meant by the phrase "the Health Alliances bear no risk"? not responsible for cost overruns

2. How will the HA's collect premiums? How will premiums be collected from self-insured individuals?

3. How will the states' budgets be established?

Fellow Auditors:

Following my conversation with Michael Graetz this afternoon, I revised the "resolution" section. In the first paragraph of that section, everything after the second sentence is new. The second paragraph is basically the second half of this morning's first paragraph, with the last sentence now in bold. The second paragraph from this morning's version has been deleted. There are no other changes.

Richard

Revised Draft
Richard Brittault
May 13, 1993

Health Alliances and State Constitutions

The Issue:

How would the proposed Health Alliances (HAs) be affected by state constitutional provisions governing state and local taxation and expenditures?

Discussion:

The central mechanism of national health care reform is likely to be Health Alliances (HAs). The federal government would induce states to create HAs. Among other powers, each HA would determine how much each employer within its jurisdiction would be required to contribute toward local health care coverage, and, using the employer contributions and other funds, each HA would purchase coverage for area residents.

Most state constitutions extensively regulate the fiscal practices of state and local governments. The specifics and the magnitude of the regulation differ significantly from state to state but one or more state constitutions contain one or more of the following provisions: (1) balanced budget requirements; (2) restrictions on the overall rates of growth of taxes and/or expenditures; (3) restrictions on the creation of new taxes; (4) restrictions on the delegation of the power to tax; (5) procedural requirements, such as a supermajority vote within the state legislature, or voter approval in a referendum, as a prerequisite for some new taxes.

Would an HA's collection and expenditure of funds be subject to any of these restrictions? This question has several aspects.

First, is the HA engaged in taxation?

(a) This may turn on the nature of the employer's payment. A contribution styled as a "wage-based premium" may be less likely to be seen as a tax than one expressly labelled a "payroll tax;" yet, as long as "premium" payments are compulsory and they are used for the purchase of coverage for persons other than the payor's employees, it is arguable that this is a tax.

(b) It may also turn on the nature of the state law restriction in the specific state. Some states restrict only specified taxes, especially taxes on real property. Some states restrict only taxes levied by specific entities, such as municipalities. On the other hand, some restrictions may be phrased more broadly.

(c) It may also turn on the extent of the HA's discretion in determining an employer's payment. If the HA's function can be characterized as largely ministerial, applying relatively specific federal criteria to local facts, then the HA may be seen as "assessing" rather than "taxing" and state restrictions on state/local taxation might not apply. On the other hand, if the HA has broader discretion, the "ministerial" argument might be more difficult to sustain.

Second, is the HA an entity subject to state and local fiscal constraints?

(a) As noted, many state constitutional restrictions apply only to

specific named bodies -- the state itself, cities, counties, etc. In such a state, then, so long as the HA is not considered to be a part of the state itself, it would not be subject to a restriction. With state constitutions that regulate more broadly -- California's Proposition 13 constrains "special districts" for example -- the HA might be subject to constraint. In addition, in some states the HA might be considered to be a part of the state itself.

(b) It is anticipated that in many states, HAs will be private, not-for-profit organizations. It is likely that state constitutional restrictions on taxing and spending would not apply to private HAs. But there may be questions about whether the state can delegate the power to tax to private organizations.

Third, as just noted, even if the HAs are not constrained by state constitutional provisions limiting state and local taxing and spending, there is the question of whether the states can delegate the power to tax to private HAs. Taxation is generally seen as a legislative power, and most state constitutions restrict the delegation of that power. The power to tax may be granted to local governments, but can it be granted to quasi-autonomous private entities? Again, the question may turn on whether the HA is engaged in taxation when it determines how much an employer pays.

Resolution:

Resolving these questions requires further refinement of the Task Force's proposal and considerable fifty state research concerning the details of the states' restrictions on state and local taxing and spending. Much may turn on the nature of the payment employers must make and on the role of the HAs in determining those payments. If the function of the HA in calculating and collecting employer payments is relatively ministerial, with individual employer payments determined according to a pre-set federal formula, courts might conclude that the employer contributions are the product of a federal mandate, not state or local action. Hence, state constitutional restrictions on state and local fiscal activity might not apply. The more discretion that HAs have, the more difficult this argument will be to make.

The questions of whether employer payments to state HAs are state/local taxes; whether HA taxing and spending are subject to state constitutional fiscal provisions; and whether states can delegate taxing powers to private entities should be referred to the National Association of Attorneys General for further consideration on a state-by-state basis. Given the novelty of the HAs and the entire federal-state-local relationship contemplated by the Task Force it may be that in some states there may be no clear answer until the state courts have spoken.

Thoughts on points to be raised with Ira Magaziner

1. Federal/State Taxing Authority

-mandated payments by employers and individuals may be construed to be a tax whether payment is characterized as a percentage of payroll or a premium

-if the mandate is created by each state's law, enactment will be subject to state law limitations on taxation. This may cause problems ranging from need for constitutional amendment to authorize tax to need for supermajority of legislature approving legislation. There may be variation among the state's in the nature and height of hurdles that must be overcome. Survey of state law under way through NAAG, but because some of these issues turn on a number of variables, definitive answers may not be available

-alternative is to create federal mandate administered either by federal entities or state entities. These options avoid most of the state constitutional law issues but present issues of federal delegation of taxing authority.

2. Nature of health alliances

-given functions we have be told the alliance will perform, alliances will be treated for legal purposes as a governmental entity

-governmental nature carries constitutional limitations and some statutory limitations unless exempted

-governmental nature may have some benefits (e.g., state action immunity from antitrust liability)

-may be possible for alliance/government to contact/delegate certain limited functions to a private entity.

3. Preemption

-central principle of preemption in federal health care reform bill should be precision.

-establish that no preemption intended except that expressly provided for

-attempt to be precise about the types of state laws preempted and the nature and degree of preemption

-ERISA/large employers issues. Need to specifically address extent to which state regulatory authority is preempted with respect to employer/union plans that are allowed to exist

outside the health alliances. [?]

-state abortion regulations. Be explicit about whether state regulation of abortion procedures is preempted (e.g. parental consent/notice requirements, waiting periods, etc.)

4. Issues about what is included in the benefit package

-recognize that there will be numerous and substantial disputes about what treatments and services patients are entitled to under the guaranteed benefit package. E.g., ...

-Need to have systems in place that provide for rational decision-making to resolve these disputes.

-Systems should include recognition at the appropriate levels three considerations: 1) medical knowledge and expertise, 2) cost (human and economic) and 3) value judgments (individual and societal)

5. Employee vs. independent contractor [?]

6. Rights/due process/procedures/remedies [?]

7. General principle: to extent states are given responsibilities under the new law, provide them with adequate authority, flexibility and resources.

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FACSIMILE TRANSMISSION

DATE: May 18, 1993

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IF THERE ARE ANY PROBLEMS RECEIVING THIS TRANSMISSION, PLEASE CALL:

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COMMENTS:

Jennifer,

This is a revised draft of my section 1983 paper that I think reflects the conclusions of the group. I will be faxing it to them today with comments due tomorrow. If there are any significant changes, I'll let you know.

Rick

SECTION 1983 LITIGATION UNDER THE HEALTH CARE REFORM STATUTE

Issue

Should a private claim for relief under 42 U.S.C. § 1983 be available for alleged violations of federal health care reform legislation?

Solutions

Section 1983 should not be available as a remedy for alleged violations of the health care reform statute, and the law should expressly say so. Instead, the legislation should create a comprehensive system for resolution of disputes that may arise at all levels of the health care system. The legislation should expressly describe who can assert which kinds of claims, as well as where each type of claim will be heard. For most types of claims, the system should provide for use of alternative dispute resolution methods, followed by administrative adjudication and limited judicial review. Claims of constitutional, as opposed to statutory, violations would not be limited by this process.

Discussion

Because the health care reform system will be established in federal law, the potential for section 1983 litigation is enormous. A private litigant could maintain an action under section 1983 for alleged violation of the federal health care reform statute against any participant in the system found to be acting "under color of state law." Since much of the system would be implemented under state law enacted pursuant to federal guidelines, not only state officials, but health alliances and, potentially, approved health plans might be deemed to be acting under color of state law. Section 1983 actions are not subject to an exhaustion of administrative remedies requirement, and attorneys fees are available to a prevailing plaintiff under 42 U.S.C. § 1988. Therefore, without a limitation on the use of section 1983, there will be a possibility of suit in federal court for any dispute arising under the health care reform law, without exhaustion of administrative remedies, and with the enticement of a potential attorneys fee award.

It is not desirable to have all disputes over health coverage or treatment or even administration of the new system litigated in federal court under the rubric of section 1983. Rather, the new legislation should specifically identify which categories of disputes under the statute should be heard in administrative tribunals, state courts, or federal courts or some combination. An appropriate remedial mechanism should be provided for all types of claims. To eliminate the possibility of a claimant by-passing the intended claims resolution process in favor of a direct court action under section 1983, the legislation should expressly provide that claims based on violation of the federal health care reform statute are not within the scope of section 1983. An alternative way to achieve the same result is to state in the law that the claims resolution processes provided are the exclusive means for adjudication of those disputes. This express limitation should not, however, include claims alleging violation of the constitution or other specific civil rights laws.

Fed issues:

- Is the required payment a tax under fed law?
  - does it matter if $ used for paying HC costs of others?
- Can fed stat. delegate admin auth. regarding the mandated payment to the states, to the alliances through the states or directly to state-created alliances?
- Can the calculation of the payment be delegated from the fed govt [not clear from memo whether talking about state or fed] to alliance in whatever form they take?

Questions

What if states go single payer?

Opt-out

1. Michael Graetz option
   - fed law specifies amt to be paid to fed fund to satisfy fed mandate
   - fed law specifies how required contribution is calculated by health alliance
   - fed levy deemed complied w/ by any employer or individual who files certificate from health alliance indicating that required payments had been made

     [fed gov't must keep track of individuals who work for outside employers, if any?]
   - fed levy set at amount greater than health alliance amounts

   PROS:
   - no delegation to state health alliance for imposition of a tax
   - health alliance not imposing tax under state law

   CON:
   - can be characterized as a fed. tax →

2. fed law requires states to enact mandate to receive whatever fed funds or tax breaks incite states to participate

   [Go through questionnaires to pull out state law probs. e.g. in ____ states, this vid.]

Legal Issues

State / Fed Taxing issues - Jim / W. Dellinger

Employee v. independent Kor - AFL-CIO

The Problem:

The Health Reform Proposal will mandate employers, employees and other individuals to pay for a package of health insurance in a specified amount or a percent of wages ("wage-based premium"). The amount required to be paid will be set by a state-chartered "health alliance," and will vary geographically. It is not clear what proportion of these amounts will go toward the purchase of the individuals' own insurance or will fund insurance for others. Questions have been raised whether this might be a tax under state law and possibly trigger state procedural or supermajority requirements or run afoul of other state constitutional limitations.

The Solution:

It is important to investigate the constitutions of the fifty states to identify potential state constitutional issues. This avenue is being pursued through NAAG.

Alternatively, the federal law might specify a "wage-based premium" or capitated amount that would have to be paid to the federal treasury to satisfy the federal mandate for health insurance coverage and employer contributions. The federal law would also specify how the required contribution (the "benchmark premium") is to be calculated by the health alliance. The federal levy would be deemed complied with by any employer or individual who files a certificate from the appropriate health alliance (or perhaps large employer) indicating that required payments had been made and that insurance coverage had been secured. The federal levy should be set at an amount greater than the highest expected health alliance amounts so that there is no incentive to pay the federal fee rather than purchase health insurance. The federal premium would thus serve as an enforcement mechanism for the employer and individual mandates. It would also help defeat the arguments that Congress had delegated to the states' health alliances the imposition of a tax or that the health alliances were imposing taxes under state law, although a clear answer to this question may require further research. The obvious drawback is that this levy can be characterized as a federal tax, the distribution of which will be heavily on the middle class. The response, of course, is that the federal government does not intend or expect to collect a nickel; it is merely enforcing its mandate. The reply, of course, is that the mandate itself is a regressive tax, etc., etc., etc.

If federal funds are needed from this source, an offset for all but a small percentage of the federal levy could be allowed for the amount paid to the health alliance.

Tentative Draft
Richard Briffault
May 13, 1993

Health Alliances and State Constitutions

The Issue:

How would the proposed Health Alliances (HAs) be affected by state constitutional provisions governing state and local taxation and expenditures?

Discussion:

The central mechanism of national health care reform is likely to be Health Alliances (HAs). The federal government would induce states to create HAs. Among other powers, each HA would determine how much each employer within its jurisdiction would be required to contribute toward local health care coverage, and, using the employer contributions and other funds, each HA would purchase coverage for area residents.

Most state constitutions extensively regulate the fiscal practices of state and local governments. The specifics and the magnitude of the regulation differ significantly from state to state but one or more state constitutions contain one or more of the following provisions: (1) balanced budget requirements; (2) restrictions on the overall rates of growth of taxes and/or expenditures; (3) restrictions on the creation of new taxes; (4) restrictions on the delegation of the power to tax; (5) procedural requirements, such as a supermajority vote within the state legislature, or voter approval in a referendum, as a prerequisite for some new taxes.

Would an HA's collection and expenditure of funds be subject to any of these restrictions? This question has several aspects.

First, is the HA engaged in taxation?

(a) This may turn on the nature of the employer's payment. A contribution styled as a "wage-based premium" may be less likely to be seen as a tax than one expressly labelled a "payroll tax;" yet, as long as "premium" payments are compulsory and they are used for the purchase of coverage for persons other than the payor's employees, it is arguable that this is a tax.

(b) It may also turn on the nature of the state law restriction in the specific state. Some states restrict only specified taxes, especially taxes on real property. Some states restrict only taxes levied by specific entities, such as municipalities. On the other hand, some restrictions may be phrased more broadly.

(c) It may also turn on the extent of the HA's discretion in determining an employer's payment. If the HA's function can be characterized as largely ministerial, applying relatively specific federal criteria to local facts, then the HA may be seen as "assessing" rather than "taxing" and state restrictions on state/local taxation might not apply. On the other hand, if the HA has broader discretion, the "ministerial" argument might be more difficult to sustain.

Second, is the HA an entity subject to state and local fiscal constraints?

(a) As noted, many state constitutional restrictions apply only to

specific named bodies -- the state itself, cities, counties, etc. In such a state, then, so long as the HA is not considered to be a part of the state itself, it would not be subject to a restriction. With state constitutions that regulate more broadly -- California's Proposition 13 constrains "special districts" for example -- the HA might be subject to constraint. In addition, in some states the HA might be considered to be a part of the state itself.

(b) It is anticipated that in many states, HAs will be private, not-for-profit organizations. It is likely that state constitutional restrictions on taxing and spending would not apply to private HAs. But there may be questions about whether the state can delegate the power to tax to private organizations.

Third, as just noted, even if the HAs are not constrained by state constitutional provisions limiting state and local taxing and spending, there is the question of whether the states can delegate the power to tax to private HAs. Taxation is generally seen as a legislative power, and most state constitutions restrict the delegation of that power. The power to tax may be granted to local governments, but can it be granted to quasi-autonomous private entities? Again, the question may turn on whether the HA is engaged in taxation when it determines how much an employer pays.

Resolution:

Resolving these questions requires further refinement of the Task Force's proposal and considerable fifty-state research concerning the details of the states' restrictions on state and local taxing and spending. Much may turn on the nature of the payment employers must make and on the role of the HAs in determining those payments. Beyond that, the questions of whether these payments are state/local taxes; whether HAs are subject to state constitutional fiscal restrictions; and whether states can delegate taxing powers to private entities should be referred to the National Association of Attorneys General for further consideration on a state-by-state basis. Given the novelty of the HAs and the entire federal-state-local relationship contemplated by the Task Force it may be that in some states there may be no clear answer until the state courts have spoken.

An additional question is whether the federal legislation inducing the states to set up the HAs might also exempt them from any applicable state constitutional restrictions. This may be difficult given that the legislation is likely to take the form not of a mandate but as a condition for the continued receipt of federal health funds and/or continued availability of favorable federal tax treatment for payments for health insurance. Nevertheless, it may be possible -- although such a preemption proviso might be in tension with the commitment to federalism in the proposal. The Department of Justice should be asked to consider whether under the Commerce Clause and/or Spending Powers and consistent with the Tenth Amendment national health care reform legislation could preempt state constitutional restrictions on state and local taxation.

PREEMPTION DRAFT
May 12, 1993

Issue

How should preemption of state laws be dealt with in federal health care reform legislation?

Proposed Solutions

1. There should be a general statement in the federal health care reform bill providing that no state laws are preempted except as expressly stated in the law.

2. To the extent possible the law should identify by category or specific effect those state laws that are expressly preempted.

3. To the extent possible provisions preempting unspecified state laws "inconsistent with" or "in conflict with" a particular provision of the federal law should be avoided.

4. Where state laws are intended to be only partially preempted, the federal law should expressly state the nature and degree of preemption (e.g., that state laws more or less restrictive than the federal are not preempted)

Discussion

Briefing books and presentations to the legal audit group have made clear that a variety of state laws may be preempted by the federal health care reform legislation. The group believes that federal preemption should be achieved only by express provision in the law, with as much specificity as possible, to avoid inadvertent "implied" preemption or preemption much broader than intended.

Experience with the preemption provisions of ERISA has demonstrated the dangers of preemption provisions that are not narrowly drawn. ERISA provides for preemption of state laws that "relate to" covered employee benefit plans. The courts have construed this provision as creating an extremely broad preemptive effect, nullifying even state laws that are consistent with and further the purposes of ERISA. One federal court has characterized the ERISA preemption provision as a "quicksand [that] is fast swallowing up everything that steps in it or near it."

Because of the breadth of the health care reform legislation, it is possible that courts will be tempted to construe it as intending a similarly broad preemptive effect, based either on the language of the law or on the federal government's "occupation of the field." To avoid expansive, unintended preemption of state laws, the legal audit group strongly recommends that the legislation include a provision that eliminates that possibility of implied preemption by stating that state laws are preempted only as expressly provided.

Even where preemption is clearly intended, statutory language must be drafted with care. There will be some state laws that are to be preempted in their entirety. Others will be preempted only in certain respects that are in conflict with the goals of the federal law. Others

will be permitted only to the extent that they are more or less restrictive than the federal counterpart. For example, some "anti-networking" laws may be entirely preempted. Certain practice restrictions in state licensure laws may be preempted, but in general those licensure laws will remain in force. Some state enforcement laws that differ from federal law may be permitted if they are more stringent that the federal law. Therefore, where express preemption is intended, the language should be written as narrowly and specifically as possible. Effort should be made to identify with clarity the types of state laws preempted. Additionally, the nature and degree of the preemption should be specified.

#4

stored as a:\alliance; revised May 13, 1993
DRAFT

May 13, 1993

Memorandum

To: Ira Magaziner
Special Assistant to the President for
Policy Development

From: Legal Audit Group

Subject: Authority and Liability of Health Alliances

Problem: Health alliances may be exposed to significant potential liability under federal health care reform legislation.

Proposed solution: Federal legislation should afford the states considerable discretion in establishing, structuring, delegating responsibility to and monitoring health alliances. Federal legislation should not direct specific authorities to Health Alliances, but rather to states with permissive authority to delegate to health alliances. In this manner, states can control both the authorities of the health alliances and the potential liabilities of states and health alliances.

Discussion: The current health care reform proposal contemplates a central role for the so-called health alliances (HAs). Possible functions of HAs which have been discussed include: 1) negotiating with health plans; 2) determining eligibility of plans to participate in the system (including possible certification of plans and denial of ability to participate); 3) determining the risk adjustment applicable to health plans for certain populations; 4) approving and denying major expenditures of health plans; 5) setting standards for health plans regarding quality of care or access to care; 6) determining benchmark premiums; 7) regulating fees that may be charged by plan providers; 8) participating in the dispute resolution mechanism established to handle consumer and provider grievances; and 9) enforcing budgetary restraints and provision of required benefits by health plans.

Unless specifically provided otherwise by federal or state statute, health alliances, like any legal entity, will be subject to potential liability for the actions they undertake. Most of the functions considered for HAs are regulatory in nature and can be expected to generate potential liability for HAs as well as states. Assuming the HA is established as a state or quasi-state agency, sources of potential liability for HAs and states include state adminstrative procedure acts, freedom of information acts, anti-deficiency acts, contract laws, procedural and substantive

Constitutional guaranteess, record-keeping and privacy laws, and anti-trust laws.[1] Even if the HA is established by the state as a private non-profit entity, we believe states can expect to be brought into legal disputes against HAs, premised on arguments that the regulatory actions of HAs constitute state action.

Because of the significant potential liability stemming from the contemplated actions of the HAs, the legal audit group recommends that Federal health care reform legislation provide considerable discretion to states in establishing, structuring, delegating responsibility to and monitoring HAs. This provides states with the ability to control those aspects of the HAs for which the state will necessarily be responsible. If HAs are established by the state legislatively, broad state discretion allows states to enact statutory exemptions for HAs to pertinent state laws. Broad state discretion and permissive authority to states to delegate to health alliances also limits direct federal liability for actions of HAs.

Prepared by: Barbara M. McGarey, J.D.
National Institutes of Health
U.S. Public Health Service

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[1] This should be considered a partial list. Aggrieved parties and their lawyers are particularly adept at alleging inventive causes of action.

TO: LEGAL AUDIT TEAM

FROM: ELIZABETH A. RYAN
New Jersey Department of Health

DATE: MAY 12, 1993

SUBJECT: AUTHORITY OF STATES TO ENFORCE THE FEDERAL REQUIREMENTS

The outline kindly provided by Margaret Farrell of our "Group Wall Hangings" did not assign me any particular responsibility. I recollect that I was assigned a specific area under federal/state relations, which followed "State Discretion." What follows is that section of our report on basic legal issues.

1) **STATEMENT OF ISSUE** - Health Alliances (HAs) will be acting under color of state law, but states will bear fiscal responsibility for the HAs.

2) **PROPOSED SOLUTION** - With respect to setting up the Health Alliance, the Federal legislation should give states (not Health Alliances) direction with respect to what must be done. However, states should determine how to implement the system within the constraints of the Federal guidelines.

3) **DISCUSSION** - Although it is clear that the Federal legislation will give states great flexibility in setting up HAs, we believe it is essential that states be given the power to enforce the law since the states will ultimately bear the fiscal responsibility for failure to stay within the budget. Because of this, it should be clear that states are given the authority to regulate and set up HAs. State accountability requires state authority.

May 12, 1993

Defining Who Is An Employee Versus an Independent Contractor

The Problem: A proposal to require employers to contribute, say 80 percent of some "benchmark" amount, to the cost of health insurance coverage of their employees makes it critical to know whether an individual is an "employee" or an "independent contractor." Such a determination under both state law and the Internal Revenue Code now turns on application of twenty common law factors, such as whether the person performing the services is paid by the hour or week or by the job, whether the hours or work are set or flexible, whether the relationship is a continuing one, whether the person is free to provide services to two or more unrelated persons at the same time or to hire assistants, whether the services must be rendered personally, who supplies the tools, whether the payor can control how the results are achieved or whether the service provider is responsible only for results.

Application of this test is so inconsistent, its results so uncertain, that Congress in 1978 generally prohibited the IRS from challenging an employer's erroneous treatment of an employee as an independent contractor if the employer has a "reasonable basis" for such treatment. Congress also prohibited IRS from issuing regulations or rulings addressing the status of workers as employees or independent contractors until it "has adequate time to resolve the many complex issues involved in this area. In 1982 Congress extended this "interim" measure indefinitely.

The Treasury Department in 1982 and again in 1991 said that "applying the common law test in employment tax issues does not yield clear, consistent or satisfactory answers, and reasonable persons may differ as to the correct classification." The General Accounting Office in July 1992 described the rules as remaining "as unclear and subject to conflicting interpretations as we found them in 1977." The House Government Operations Committee called the twenty factors "an inadequate guide to compliance with tax and other laws," and described missclassification of workers as a "pervasive and serious problem." This shambles confirms Will Rogers' adage that when Congress makes a joke, it's a law.

The Solution: Despite repeated calls for cleaning up the definition of an "employee" under the Internal Revenue Code, no appropriate or acceptable definition has emerged, and none seems likely in the interval before the Health Reform Proposal goes forward. Probably the best that can be achieved is to indicate that the determination whether someone is an employee or an independent contractor will be the same as under current law, but that anyone who is claiming independent contractor status must notify both those for whom she works and the "premium collection authority" (whoever that turns out to be) that the individual is making such a claim and is solely responsible for purchasing the mandated insurance coverage (or paying the payroll tax). Experience under the Social Security, FUTA and income tax suggests that noncompliance will be rampant even with a requirement of such information reporting, but no better option seems available.

May 12, 1993

Assuring Large Employers that Their Health Care Costs will not Grow Faster than Employers and Others Who Purchase Through Health Alliances

The Problem: Large employers are concerned that if they enter health alliances, their costs will increase at a rate faster than if they remain outside the alliance and purchase benefits for their employees (even if they are required to comply with community rating requirements).

There are also issues relating to the scope of any federal preemption of state flexibility under the new system, given the history of judicial interpretations that have extended the ERISA preemption far beyond anything explicitly contemplated during the enactment of ERISA two decades ago.

The Solution: It is possible to apply global budget targets and limitations to large employers to limit the size of annual rates of increase in health insurance costs to the same level applicable to smaller employers purchasing through health alliances. It does not seem practical to limit large employers to slower rates of growth than that applicable to [other] alliance purchasers. It is, of course, not possible — short of a constitutional amendment — to guarantee that a future Congress will not raise the budget ceilings in response to changes in circumstances or political tastes.

With respect to the ERISA preemption, it is impossible to be specific at this stage until additional policy decisions become known. As a matter of

general guidance, however, history strongly suggests great advantage in explicitly preempting in the new federal statute only those state actions that are intended to be forbidden with respect to large employers and stating in the statute that only those things explicitly preempted are precluded.

Prepared by: Peter J. Millock
General Counsel
NYS Department of Health

MEMORANDUM

Subject: State Powers to Assure Quality of Care

Statement of Issue: The President's Health Reform Proposal (the Proposal) anticipates an interim period of undetermined length during which the existing health care delivery and regulatory system will remain intact. The Proposal is to grant states great latitude in fashioning their own health care system within federally set parameters. The proposal, even if fully adopted in the states, gives the states broad responsibilities for maintaining quality of health care. For example, states will remain responsible for traditional public health prevention activities (e.g., smoking and drinking water controls); for some categorical aid programs and essential community providers for the underserved; and for professional and facility licensing.

Will the states retain enough power under the Proposal to carry out their responsibilities? Should the states have more or less power under the Proposal?

Conclusion: If the states are to bear substantial responsibility for maintaining quality of care, and they should, they must retain broad powers to survey, investigate and enforce applicable standards. States are in a better position to address problems particular to some areas through standard setting. The state power to gather and maintain the confidentiality of health data should not be impaired. Federal resources and legal authority are probably essential for data evaluation.

Discussion: State legal authority regarding quality of health care may be divided into four categories: data gathering and evaluation; standard setting; surveys and investigations; and enforcement.

The power to gather data was the first power vested in nascent public health agencies in the 19th Century. Only in recent years, have states begun to use the wide array of data collected by them to inform standard setting and to create new evaluation tools like risk adjusted outcome comparisons. The use of data is often circumscribed by confidentiality requirements to protect patient privacy and, to a much lesser degree, provider interests.

Any federal law should not seek to preempt or detract from state data gathering powers, but rather to add new, but not duplicative, power at the federal level. If the new federal Board gathers data directly, it should make that data easily available to the states, so the validity of the state data base is not compromised. For the same reason, all state data should be available to the federal Board.

Any federal law should not vest federal data gathering powers in the Alliances or Plans or force the states to delegate state powers to Alliances or Plans. The Alliances will and the Plans may lack the sophistication to evaluate data. The Alliances may and the Plans certainly will cover only parts of states. The Plans may overlap geographically. This could lead to inconsistent, if not chaotic, data gathering within states.

Finally, data can be misused. Patient confidentiality is better preserved by state governments with a history of data protection. Since health data can severely compromise an individual (e.g., DNA testing results, abortion history, HIV status) and can demand high value in the illegal market (e.g., adoption records), the legal authority to gather and hold data should not be spread too broadly. Federal law should set minimum confidentiality standards for state data gathering and should require states to share redacted data with Alliances and Plans to allow Alliances and Plans to utilize the data.

Data evaluation is a difficult task and most states lack the sophistication and resources to do it well. Evaluation may properly be the task of the proposed federal Board though the Board should have the power to contract with states to carry out evaluation projects.

Standard setting is another task which could be performed at the federal level. However, federal law should not preempt state standard setting. State standard setting is not "embroidery"; it can take into account public health problems particular to a particular area (e.g., AIDS, TB, Lyme disease). It can respond to the particular demands of groups disproportionately located in a state (e.g., the power of conservative religious groups on issues like DNR, health care proxies, determination of death). It can reflect a heightened community commitment to quality of care (e.g., New York's pre-CLIA laboratory proficiency testing program, New York's imposition of limits on residents' hours, New Jersey's laws on medical waste and Florida's prohibitions against physician self-referral).

Surveys, investigation and enforcement are best done at a state level closer to the trenches. These tasks cannot be directed from Washington or from understaffed and underenergized federal regional offices. Citizens deprived of quality care (e.g., by a chronically low quality hospital) or threatened by imminent dangers (e.g., a hopelessly negligent physician) look to their state government, and not to even more distant bureaucracies, for protection.

The State legal powers to survey, investigate and enforce cannot be vested in Alliances. By design, Alliances will not include persons with expertise in health care. The Alliance's role as a health care purchaser minimizing premiums may conflict with its enforcement of standards against Plans and providers. (This also argues for a federal mandate that state run Alliances be kept administratively separate from state quality oversight bodies. Similarly, the Plan's interest in selling services to Alliances may taint its enforcement of standards.

Allowing states to retain survey, investigation and enforcement powers would not prevent Alliances and Plans from improving quality through the terms of the Alliance-Plan and the Plan-Provider agreements. These agreements could be implemented through standard contract enforcement tools. The federal law should

mandate the inclusion of quality assurance provisions and implementation mechanisms in the agreements. The power of the purse will force quality improvements.

If Plans and Providers choose to hire non-governmental survey bodies like JCAHO to do surveys, certification and enforcement, Plans and Providers should bear the financial burden of that choice and the choice should not preclude state activities. Even if states are given the opportunity to survey, certify, and enforce, the federal government could retain "march-in" rights when states fail to perform. The Proposal should avoid the current melange of concurrent federal and state powers, but rather allow progressive federal takeover as a state fails to meet its oversight obligations.

Finally, the Proposal must distinguish between state laws which regulate quality and those laws which, in the name of quality, hinder the implementation of the Proposal. This will not be an easy task. For example, how will the Proposal treat New York's prohibition against for-profit hospital chains. The New York law reflects the political power of large voluntary providers in New York and genuine concerns about the motives and practices of for-profit chains. What about state laws setting standards for utilization review, limiting the cost of securing medical records for patients, and assuring patient access to records?

The simplest answer is to preempt states powers and prohibitions that directly contradict the precepts of the Proposal (state corporate practice of medical prohibitions) and force the state to bear the financial consequences through excessive premiums of other state statutes and regulations. Thus, if New York chooses to overreact to the hazards of medical waste on its beaches and to impose additional disposal costs on providers, these costs will be passed on to the premiums that Plans charge Alliances and possibly lead to federal penalties for excessive premium growth.

The Proposal should not ignore the states' need for funds to carry out quality assurance activities. If the Proposal really encourages the state to act, it should provide a source of funds other than state tax revenues to support the state work. If state funds are inadequate, initial state deferral to federal monitoring or later federal march in is inevitable. The federal support for state regulatory activity should be generous enough to allow states some latitude to go beyond minimum federal standards.

Prepared by: Peter J. Millock
General Counsel
NYS Department of Health

MEMORANDUM

Subject: Medical Malpractice

Statement of Issue: The President's Health Reform Proposal (the Proposal) may include the following medical malpractice reforms:

1. Periodic payments of malpractice awards
2. Uniform statutes of limitations
3. Collateral source deductions from awards
4. Sliding scale attorneys' fees
5. Prohibition against limits on economic damages
6. Limits on non-economic damages
7. Enterprise liability on plans
8. Mandated ADR before litigation

States would be allowed great latitude in fashioning their own tort reforms. The goals of all these reforms would be a broader distribution of benefits to injured parties, rationalized quality of care improvements and, presumably, reduced malpractice premiums.

Will these medical malpractice reforms achieve their goals? How should the reforms be altered to achieve their goals? Are other reforms appropriate?

Conclusion: The reforms should reduce access to the courts and, therefore, reduce premiums based on the risk of adverse court actions. They will not redistribute tort awards to a broader group of injured parties. One reform, enterprise liability, could be compatible with quality of care assurance elements of the Proposal. If states are to effect significant malpractice reforms, some changes in federal law would be appropriate.

Discussion: Reforms 1, 2 and 3 (periodic payments, uniform statute of limitations, collateral source deductions) should make the tort system more rational. Periodic payments may prevent wasteful use of large awards. Uniform statutes of limitations should prevent some gaming of disparate state claim filing deadlines. Collateral source deductions should prevent some double dipping. These reforms are already in effect in many states and have not prevented "high" premiums.

Reform 4 (attorney fees) should significantly deter plaintiffs' lawyers in some states from taking cases of lower value and higher risk. The reform will force lawyers to raise their threshold for cases they are willing to bring and reduce transactional costs for cases that are brought. This should retard premium growth while denying some victims of poor care access to the courts. It will not redistribute tort awards to a broader group of victims. It will have the opposite effect.

Reform 5 (prohibiting limits on economic damages) could have the untoward effect of creating an unfettered demand for benefits by the small number of successful plaintiffs. The prohibition should be worded carefully to avoid that result.

Reform 6 (Limits on non-economic damages) is the big ticket item for providers. If pain and suffering and potential lost earnings are severely constrained, premiums should decline substantially. However, standing alone, this benefit to providers will result in no redistribution to other victims.

Reform 7 (enterprise liability) preserves the deterrent effect of the tort system while focusing primary responsibility for achieving deterrence and the obligation to pay all premiums on the enterprise, in this case the plan. Enterprise liability is called "channelling" in New York and has been used by a consortium of hospitals under the auspices of the Federation of Jewish Philanthropies.

Enterprise liability will help achieve the quality assurance goals of the Proposal if the plans have the capacity to improve quality among the providers in the plan. If the plan can improve quality of care, actual malpractice (and premiums) will decline. Of course, if the plans have this capacity, they can reduce malpractice and premiums even without the impetus of enterprise liability.

Physicians may not like enterprise liability because they fear being sued anyway (this could be prohibited by statute) or more likely because they do not wish to be under the thumb of plan administrators.

Enterprise liability does not redistribute benefits to more victims.

Reform 8 (ADR) may help to resolve some disputes before resort to litigation. However, if ADR does not preclude litigation, it may become another wasteful hurdle in the inevitable litigation like the pre-trial conferences in New York. If use of ADR is not mandatory, it may become a high tone but little used alternative to litigation like arbitration.

If states are to be encouraged to adopt their own medical malpractice reforms particularly those aimed at redistributing benefits, certain federal impediments should be removed. Any state effort to redistribute current tort awards, like New York's current proposal for impaired newborns, must address (a) federal limits on taxes and fees imposed on less than an entire class of providers (e.g., obstetricians only) necessary to fund redistributed benefits and (b) limits on Medicaid as a payor of last resort if a new state benefit fund is not to replicate Medicaid benefits. Specific exceptions to these two laws would facilitate broader tort reform on the state level.

8

M E M O R A N D U M

TO: Legal Review Croup

FROM: Barbara B. Anthony

DATE: May 12, 1993

RE: Antitrust and Health Care Fraud Prosecution Jurisdiction for State Governments

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With respect to enforcement issues concerning the application of the antitrust laws and criminal anti-fraud statutes, I previously spelled out certain concerns with respect to these issues in a May 5 memo. I recommend that that memo be included in any recommendation which we provide to the Health Care Task Force.

Generally, the position advocated in the memo is to support the position embodied in the reform proposals that no special statutory exemption from antitrust should be created, and that national health care reform should recognize the role of state Attorneys General with respect to the primary and initial enforcement obligations which they have over antitrust matters in their states' health care markets. We also recommend a cooperative role between the federal and state government with respect to the development of antitrust policy so as to facilitate competitive health care restructurings in the market place.

With respect to any new federal criminal health care fraud statutes, we recommend that the states be provided with three to four years within which to pass equivalent state legislation and also to establish equivalent state forfeiture provisions. We also recommend that if a state has not passed such legislation within a designated period of time, that Attorneys General be provided with a parens patriae authority to pursue such cases in federal court on behalf of the states.

SCOTT HARSHBARGER
ATTORNEY GENERAL
(617) 727-2200

The Commonwealth of Massachusetts
Office of the Attorney General
One Ashburton Place,
Boston, MA 02108-1698

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DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2/24/11

M E M O R A N D U M

TO: Jennifer Klein
Special Assistant to Ira Magaziner

FROM: Barbara Anthony
Chief, Public Protection Bureau
Massachusetts Office of the Attorney General
One Ashburton Place
Boston, MA 02108
Telephone #: (617) 727-2200
Fax #: (617) 727-5762

DATE: May 5, 1993

RE: Recommendations Relating to Antitrust Issues and Health Care Fraud Prosecutions in Relation to the White House Health Task Force Proposals

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1. Antitrust Concerns

After reviewing the briefing materials on antitrust issues, it appears that there is no provision or reference to the role of the state Attorneys General with respect to antitrust law review or enforcement within the context of market restructuring that will occur as a result of national health reform. We are, however, very supportive of the position -- which is embodied in the reform proposals -- that no special statutory exemption from antitrust scrutiny should be created.

It is our experience that most market restructurings in health care involving institutional and practitioner providers will occur at the local and state levels. Local mergers, consolidations, combinations, joint ventures, patient allocation and equipment sharing arrangements occur within the context of local and state health care markets. Typically, state Attorneys General will be the first line of review for such market restructurings and integrations. Indeed, some of these restructurings are not large enough to trigger federal antitrust review.

Our concern is that the national health plan options do not take into account the above described facts. We recommend that the following adjustments to the national health plan be made to accommodate these concerns:

(a) The National Association of Attorneys General should be a full participant with federal antitrust authorities on any national antitrust health care policy development and implementation boards.

(b) For all intra-state or regional health care consolidations, joint ventures, mergers, and so on, state Attorneys General should be the first line of review. Parties which are seeking to accomplish transactions that trigger state antitrust scrutiny should be required to obtain an initial review from state antitrust authorities, namely, the state Attorney General's Office. In connection with this, we anticipate that during any transition period for national

health reform there will be an enormous number of intra-state transactions that will require review by state Attorneys General because they raise antitrust concerns. Accordingly, any federal legislation should include cooperative (not prescriptive) mechanisms for the coordination of state antitrust review and enforcement with federal antitrust authorities. Moreover, federal legislation should affirmatively acknowledge that state Attorneys General have the primary and initial enforcement obligation over antitrust matters in their state's health care markets.

There should also be an acknowledgement that the increased level of market restructurings at the state level will necessitate an increase in resources for state Attorneys General. Any global-budgeting provisions should affirmatively include enforcement costs as well as benefits of implementation of national health reform at the state level. If the global budget is allocated by states, states should be required to include a recognition of enforcement costs within the state budget.

There are other proposals in the health care plan that call for the forfeiture of ill-gotten gains by those who may violate federal and state laws implementing national health reform. We recommend that some of these forfeiture monies be earmarked to support antitrust review and law enforcement efforts at the state level as state Attorneys General proceed to implement national health reform.

2. Health Care Fraud and State Jurisdiction

As indicated above, there are provisions in the national health reform plan that create a federal criminal offense for making false statements to either state or federal authorities or health alliances in connection with implementation of health reform. If this provision is part of national health reform, Attorneys General should be able to enforce the federal law in federal court. (Precedent for this is found in the already enacted Telephone Consumer Protection Act.) The provision which I reviewed indicated that forfeiture of ill-gotten gains through such false statements or other fraud would be directed to a federal trust fund for use to support federal law enforcement efforts.

We recommend that consideration be given to a provision whereby states will have three to four years within which to pass equivalent legislation to bring such actions in state court and to establish an equivalent forfeiture provision. If such state legislation is not passed within this time, then states should be given concurrent jurisdiction to bring an action in federal court for damages on behalf of the state's citizens. This power would be similar to the parens patriae authority currently given to state Attorneys General in the Clayton Act.

3. Consumer Choice

There should be affirmative provisions throughout the component parts of national health reform to maintain and

ensure the concept of consumer choice with respect to provider and health plans.

4. Presentation to State Attorneys General

It seems clear that national health reform will place enormous new responsibilities on state Attorneys General in the management, oversight, regulation, and enforcement obligations connected to implementing national health reform through and by state governments. State Attorneys General will become more and more enmeshed in health care reform implementation through their antitrust, non-profit hospital oversight, rate-making advocacy, provider fraud, and consumer protection and education responsibilities. In addition, it is likely that state Attorneys General around the country will be defending state governments against a large array of new and novel legal claims generated as a result of state implementation of national health reform. We anticipate that national health reform will place serious and significant strains on law enforcement and defensive legal resources at the state level.

Therefore, prior to providing the Administration's health reform plan to Congress, we recommend that state Attorneys General through the National Association of Attorneys General receive a comprehensive briefing on the component parts of national health reform that require state implementation.

cc: Legal Review Group

8A

MEMORANDUM

TO: Legal Review Group

FROM: Barbara B. Anthony

RE: Legal Impediments to Implementation of National Health Reform

DATE: May 12, 1993

There are three questions concerning the implementation of national health reform that we are examining. I will try to provide answers over Thursday and Friday.

(a) Can an anti-injunction provision be included in federal legislation so as to insulate the new national health reform law from attempts to block its implementation in federal district court?

(b) Can either the federal or state government or both be provided with statutory immunity to insulate these entities from suit for various forms of liability under national health reform?

(c) Can the federal government condition the receipt by states of non-health care related grants as an incentive to implement national health reform?

WPPBJ/41

May 12, 1993

Religious Opt-Outs

The Problem: The treatment of church employers, individuals with conflicting religious beliefs and providers affiliated with churches under the Health Reform proposals all involve the potential for legal challenges to aspects of the Health Reform Plan grounded in First Amendment claims. For example, some churches may challenge an employer mandate to provide health benefits to ministers, Christian Scientists may challenge the individual mandate to purchase health insurance, Catholic hospitals may refuse to provide basic benefits relating to reproduction and Jewish facilities may challenge any limitations on care at the end of life. Without analyzing each of these in detail, suffice it to say that some of these challenges may prove successful.

The Solution: Do not at the outset provide specific exemptions or elections to opt out on religious grounds to church employers, individuals or church-affiliated providers. Congress may well decide to provide special rules in some of these cases as it has in other laws, but there is no easy general solution to this problem. Keeping exceptions to a minimum has legal (as well as political) advantages, and it seems best simply to ignore this problem in legislation, as initially proposed.

Marjorie Shultz
Boalt Hall School of Law
University of California

Issues regarding Medical Necessity

1. To what extent does a mandate of a benefits package that limits care to that which is medically necessary conflict with

- constitutional rights (federal and state) such as privacy, reproduction, religion, bodily autonomy, personhood, equal protection, life and death, etc.

- statutory rights (federal and state), especially civil rights statutes (race, gender, age, disability).

2. To what extent can you bar/ require/ allow and create incentives or disincentives for opting out (as payors, as providers or as covered insureds)? Or opting in for more benefits? (allow individuals to seek extra coverage?)

- can individuals or groups decide they don't want to be covered, or want to be covered only on a much more limited basis -- as individuals, as employers, etc.? E.g. Christian Scientists, people who know in advance they don't want high priced heroic or extraordinary measures.

- Can individuals pay more and buy supplemental benefits (such as things categorically omitted like cosmetic surgery and eyeglasses) or for the risk of something they want being determined by their plan to be not medically necessary.

- Can states add on benefits beyond the federally mandated package?

- what role would personal responsibility and lifestyle choices play? While it's clear that employers and plans can't be allowed to skim risks for things people can't control, what about things they can control -- e.g. alcohol, smoking, etc? Would you be able to pay reduced rates. I assume not.

3. There are going to be a lot of disputes about medical necessity, however it is phrased. These will not be marginal; they will be numerous and will go to the core of the whole proposal. There's therefore a need to pay central and careful attention at all levels of the system (from micro to macro) to:

- Substantive criteria for deciding what is medically necessary
- procedures - who decides and how
- dispute resolution.

Decisions about medical necessity are not just resolvable through the invisible hand of medical expertise, even when that is filtered through available resources. There's much uncertainty in medical expertise. Different people have different values and would make different trade-offs of cost and benefit, as well as having some values and viewpoints that are non-negotiable in cost-benefit terms (from religious values to risk aversion). Moreover, costs include the costs in life, health and body paid by patients as well as the economic costs paid by patients and others in money terms. Decisions about what is medically necessary have to reflect:

- the input of medical knowledge and expertise
- the input of cost (human and economic)
= the input of value judgments (individual and collective)

Thus, decisions about medical necessity must be informed by medical expertise, but ultimately they represent judgements about benefits and risks that can only be made by lay persons (individuals and groups) who receive their benefits and bear their costs. This is the central learning of medical ethics over the past 30 years.

Yale University
The School of Medicine

ANGELA R. HOLDER, LL.M.
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To: Legal Review Group
May 10, 1993

Problem: Determination of a basic benefits package.

Question 1. What alternative health care providers will be allowed to participate? These may include recognized groups (chiropractors, podiatrists) and others, such as laetrile providers, crystal readers, massage therapists, aromatherapists. The difficulty with sorting groups between those with state licenses and those without is that many groups of highly trained professionals one would certainly wish to include as staff in any hospital or clinic (psychiatric social workers, child life professionals) are not state licensed although professionally accredited. What causes of action will excluded groups be able to bring against the Health Alliances/ Plans/ federal or state governments? What are the anti-trust implications? (cf. the chiropractors' action against the AMA.)

Proposed Solution: This question may be one of the most difficult to answer. At present, insurance companies have different views on willingness to pay alternative providers such as chiropractors. There are numerous decisions upholding their refusal to pay less-recognized providers, such as laetrile clinics, massage therapists, etc. Hospitals all over the country have been sued by chiropractors and podiatrists over refusal to grant them privileges. Private hospitals with by-laws delineating privileges to groups such as physicians, physician assistants, nurse practitioners, etc. have been successful in refusing to admit other groups to staff. I don't really know the status of these groups in public hospitals, but will try to find out before our next meeting.

Question 2: What restriction of privileges (if any) may plans or hospitals make based on Board certification of physicians? If quality control is based on a federal program, will hospitals and health plans continue to be able to make these determinations? If a national decision is made, for example, that only Board-certified surgeons will be compensated for surgical procedures, what will happen in rural areas where there are none? Conversely, what rights will non-Board-certified physicians have to continue to practice?

Proposed solution: This issue is best left as it currently is, with staff privileges determined by individual hospitals and medical groups.

Question 3: a. What body will determine, within what practice guidelines, what therapies will be made available, particularly in case of new therapies?

b. Should high-technology, expensive therapies (i.e. transplants, etc.) be offered at any institution that currently does them or might wish to do them or should their use be confined to a few nationally recognized institutions?

Proposed solution: An all-inclusive health system cannot possibly work if some therapies are included as a basic benefit in some areas and not in others. Where therapies are unusually expensive or complex, however, a decision to move patients to selected tertiary-care centers instead of having everything available everywhere would seem reasonable.

If the decision is made to restrict certain procedures to a few hospitals, will the health plans pay for transportation and out-patient living expenses for patients and family members who accompany them? If the procedure is covered as a basic benefit and the patient cannot otherwise afford to receive it, it would seem unlikely that the plan could avoid such expenses.

If procedures are geographically restricted and patients travel to a few medical centers, what provisions will be made to train physicians at other institutions to perform them so that new programs may be initiated when the procedure becomes standard therapy and probably less expensive?

It is unclear to me what recourse hospitals with existing programs will have if there is a decision to close such programs and refer patients to a few large centers.

It seems to me that these determinations are ones that only the National Health Board can make.

Question 4: If "experimental therapies" are excluded from coverage, who will define them and what will that definition be?

Proposed solution: In current case law, "experimental" is used to discuss both (a) bizarre "therapies" performed in such places as laetrile, etc. clinics and (b) patients on research protocols in medical institutions. We are, of course, considering only the latter.

As the law now stands, two insurance companies may come to opposite coverage decisions about patients receiving identical therapy from the same physician. For that matter, the same insurance company may come to opposite conclusions about two patients in different parts of the country receiving the same treatment. In one situation, the patient's coverage is denied on the grounds that the therapy is "experimental" and in the other, the payment is made. The situation is intolerable for patients, who don't find out that they are not covered until they are already seriously ill, and is an administrative nightmare for physicians. (See, e.g., Antman, et als, The Crisis in Clinical

Cancer Research: Third-Party Insurance and Investigational Therapy, 319 NEJM 46, July 7, 1988.)

There must a definition of "experimental" that is consistent, that recognizes advances in medicine and that mainstream specialists in the field who provide the therapy agree is reasonable. (See Bucci v. Blue Cross-Blue Shield of Connecticut, 764 F Supp 728, 1991 at 732 " A procedure may be found not to constitute accepted medical practice only where there is no reasonably substantial, qualified, responsible, relevant segment of the medical community which accepts the procedure as properly within the range of appropriate medical treatments, under the circumstances of the case, as judged by the standards of .. a reasonable number of practitioners qualified to treat the malady in question.") At present, insurance companies' determinations are made by physicians who may never have treated a patient with the disease in question and are frequently retired from all clinical practice. (See, e.g., Fuja v. Benefit Trust Life Insurance Company, 1992 WL 394216, ND Ill. and Adams v. Blue Cross/ Blue Shield of Maryland, 757 F Supp 661, DC Md 1991.)

With the institution of the fast-track drug approval process by the FDA, there is increased recognition that some uncertainty about safety and efficacy may be acceptable in cases of life-threatening illness where no effective therapy exists. This will increase pressure to permit other new forms of therapy, as well.

These determinations can, as a practical matter, be made only by the National Health Board, which presumably should have panels of specialists in the practice areas involved to which these questions may be referred for consensus. These panels must be able to act quickly in case of real break-throughs in treatments, lest people die while the issue is being debated.

Question 5: Will benefits include payments for treatment that will improve the quality of a patient's life but which will not affect the underlying medical problem? Rehabilitative services, at least theoretically, improve the patient's ability to function, but in some cases all medicine can do is to make the patient's condition more bearable. For example, very expensive neurosurgical procedures may be the only way to relieve a paraplegic's constant pain. Will the costs of such surgery be covered?

Proposed solution: As a political matter, it would be quite difficult to avoid coverage of such services, but it does not seem to me to be a legal question. As long as any particular treatment is not offered to anyone, no individual would have a claim to get it. It is only when the therapy is offered to some persons with condition X but not to others that claims will arise.

UNIVERSITY OF MICHIGAN MEDICAL CENTER
MEDICAL CENTER ATTORNEYS OFFICE

MEMORANDUM

TO: Jennifer Klein
Fax. # 202-456-7739

FROM: Edward B. Goldman EBG
Legal Audit Group

DATE: May 10, 1993

SUBJECT: Section II. E. of Legal Audit Paper on Basic Legal Issues (Mandatory Adjudication of Rights)

STATEMENT OF ISSUES:

1. What type of dispute resolution should be considered for consumer/patient disputes over the benefits offered by the plan?

2. What concerns exist about state licensure and scope of practice issues for providers?

PROPOSED SOLUTIONS;

1. Dispute resolution for in-plan benefits: There should be an internal grievance procedure for each plan followed by mandatory mediation within the plan followed by an appeal to a state administrative body (example: an existing board such as a State Consumer Complaints Board or a newly created State Government Board) followed by a limited appeal to State Court. There is also a need for a reporting mechanism of the final outcome of grievances (without patient names or identifiers) to the State Quality Program (SQP) which would then aggregate information and send it to the National Board for ongoing evaluation of the mandated benefits package.

2. Scope of practice issues: A cost effective system should allow for a broad scope of practice for providers and for broad delegation from physicians to other providers.

DISCUSSION:

1. Dispute resolution for in plan benefits: It is assumed that the new structure will result in certain plan benefit disputes. This section will discuss resolution of those disputes. This section does not cover provider claims based on being excluded or dropped from plans or based on economic credentialling nor does it cover Plan claims against the HA based on HA actions or consumer/patient claims based on benefits being excluded by the Federal Government. Some of these items are covered in the section dealing with due process rights of providers (see Section ___).

This section of the report is limited to those claims brought by consumers/patients within plans over action/inactions by the plan. These could include decisions to exclude specific practitioners, but are most likely to be based on service problems experienced by patients within the plans (from impolite clerks up to failure to provide alleged "lifesaving" benefits). In general, the Legal Audit Group feels that most claims should be reviewed first by dispute resolution mechanism at the lowest practical level followed by mandatory mediation within the plan with limited rights to appeal to state court after exhaustion of administrative remedies.

For in-plan patient complaints, there would be an informal but expedient (10 days for most issues, but 24-48 hours for emergent life threatening issues) grievance procedure. This would be similar to procedures presently employed by HMOs over benefit coverage. For "gripes" (impolite clerks or other minor issues) this grievance procedure would be final.

For lack of access, benefit coverage and other significant questions (question - do we want to create a list or create generic categories such as "suggestions for improvement" which end at the informal grievance level vs. "benefit issues" which have appeal rights) there would be an appeal to mandatory mediation within the plan. The process and structure would be spelled out in each plan based on federal standards and would include a defined hearing board chaired by an individual with significant administrative responsibility from the plan, expedited hearing, no formal rules of evidence, written decisions within 24 hours from the end of the hearing and a notice of appeal rights for unsuccessful applicants.

Mandatory mediation should resolve most disputes. For those still unresolved, appeal could be taken to an already established state mechanism. For example, the Michigan Department of Public Health has a Health Facilities and Agencies Advisory Commission to hear complaints from HMO enrollees. If no such mechanism exist, appeal could be to a state created board of review established pursuant to federal standards.

For any complaint unresolved after state review, there would be an appeal to State Court. The appeal would be limited to whether the state administrative findings are supported by competent evidence and legal analysis. There would be a presumption of proper administrative findings and exhaustion of administrative remedies prior to suit would be required.

We favor using state administrative review and the state court system over a federal system. This allows for the states to be creative but could result in a lack of uniformity. We would not allow diversity jurisdiction and would see federal cases only for claims that the federal law should have included a specific benefit. Individual claims about benefits such as bone marrow for metastatic cancer, whether a therapy is efficacious, genetic testing for patients without a suspicious history, etc. would be resolved in each state.

In order to do quality assurance and obtain benefit uniformity over time, reports on the final outcome of grievances would be sent on a regular basis (quarterly?) by each plan to the State Quality Program (SQP). For privacy reasons, those reports would not include patient names or identifying information. The SQP, in turn, would do a report (annual?) to the National Board so the Board would have data to consider for the design of future benefit packages and for quality assurance purposes. Results would also be sent to the State as required by State law.

2. State licensure and scope of practice issues for providers.

Licensure for health care professionals would remain at the state level to be handled under existing state mechanisms. The federal law may either preempt or create a basic standard for state scope of practice laws to avoid limiting the ability of nurses to act in an expanded nurse practitioner role. There is a potential problem that states could be too expansive and quality could suffer so the National Board may want to retain oversight ability. The federal law could also allow for broad delegation of authority from licensed individuals to licensed or unlicensed individuals who are otherwise qualified by education, training or experience to perform selected acts where the acts fall within the scope of practice of the delegators license and will be performed under supervision. Expanded scope of practice and delegation would allow for cost effective care.

DRAFT -- May 12, 1993

PROVIDER RIGHTS

Statement of Issues:

What legal rights and remedies should be available to providers against the accountable health plans, the health alliances, the state governments, and the federal government?

Proposed Solution:

The statute should include due process procedures and standards for providers at various stages of the system. The extent of such procedures can vary from notice and an opportunity to be heard at the rule making stage to more extensive protections (including a hearing and appeal process) when action is being taken which will result in the exclusion of a provider from the program. The standards should include a requirement that quality regulations and determinations be reasonably related to legitimate purposes, and that financial arrangements be "reasonable and adequate to meet the costs of efficiently and economically operated facilities" or a comparable standard. [Should sec. 1983 be retained or should an alternative be developed?]

Discussion:

1. The Constitution may require due process protections for providers.

Action taken at every stage of the system may have profound impact on patient care providers. Because the proposed program will eventually encompass virtually all health care delivered in the United States, the impact on providers may raise constitutional issues that were not posed by the Medicare and Medicaid programs. Courts have generally held that providers do not have a constitutionally protected property interest in Medicare and Medicaid. A condition of participation in these "voluntary" programs need only bear a rational relationship to a legitimate state interest, and constitutional challenges to reimbursement regulations have rarely been successful. However, where all patients participate in health plans selected by the health alliances [or large employers?], a different outcome is possible. If the effect of a decision is that an individual provider can no longer practice his or her profession, or that an institutional provider must close its doors, courts may analogize the process to state professional licensure, where due process rights have been recognized, or to a forced taking of property by the state. If this is the case, action by the federal and state governments, the health alliances or even possibly by the health

plans will be required to meet varying substantive and procedural due process requirements depending on the particular context. [Note: the "DOJ" memo suggests that due process concerns are raised only where the action in question disrupts existing contractual or licensure arrangements; does this mean that all providers and facilities licensed on the date the statute becomes effective have due process protection, but that no one who enters after that date has any rights? Seems rather arbitrary.]

The Department of Justice memorandum considers whether the availability in the alliance area of a fee-for-service option will be necessary to comply with due process requirements. The extent to which this approach reduces due process concerns depends on whether the fee-for-service alternative is a realistic one, or whether the economic incentives are so structure that few if any patients will be able to select it. In addition, a fee-for-service plan may also make determinations that have a significant negative impact on providers, or the health alliance may set the fee scale at a level that is insufficient. The DOJ suggestion that plans be required to contract with all licensed providers could unreasonably restrict the ability of plans to control the behavior of their participating providers.

2. Policy arguments also support including due process protections for providers in the statute.

Inadequate financial reimbursement forces providers to take cost savings measures that hurt the quality of patient care; the quality monitoring and disclosure system is unlikely to be able to uncover these problems until several years have passed.

Termination of the participation of a provider in the system may have a significant negative impact on patient access to care.

The wide discretion proposed to be given to the states, together with the state responsibility for meeting global budgets, make providers vulnerable to arbitrary action by the states.

The ultimate success of the program requires the cooperative participation of quality providers, and a perception by providers that the program is at least minimally fair is critical to this result.

3. Existing remedies, such as breach of contract actions against the plans, are not sufficient to achieve these goals and could result in widely disparate outcomes in different regions of the country. [1983 issues]?

SECTION 1983 DRAFT
May 12, 1993

Issue

Should a private claim for relief under 42 U.S.C. § 1983 be available for alleged violations of federal health care reform legislation?

Proposed Solutions

Section 1983 should not be available as a remedy for alleged violations of the health care reform statute, and the law should expressly say so. Instead, a comprehensive system for resolution of disputes that can arise at all levels of the health care system under the reform legislation should be created. In most circumstances this dispute resolution system should provide for use of alternative dispute resolution methods, administrative adjudications and limited judicial review. Individual disputes should be resolved between the parties involved on a functional basis. That is, the entity charged with performing the particular function in dispute should be the entity against whom a claim is brought. Neither the states nor the federal government should be liable on a vicarious or supervisory basis in individual disputes.[1] Some allowance may be made for actions on this basis for injunctive relief where systemic failures are alleged.

Discussion

Because the health care reform system will be established in federal law, the potential for section 1983 litigation is enormous. A private litigant could maintain an action under section 1983 for alleged violation of the federal statute against any participant in the system found to be acting "under color of state law." Since much of the system would be implemented under state law enacted pursuant to federal guidelines, not only state officials, but health alliances and, potentially, approved health plans might be deemed to be acting under color of state law. Thus, it may well be possible to "make a federal case" out of any and all disputes within the new health care system. This would create an enormous burden on both the parties and the courts. The availability of attorneys fees to the prevailing party in section 1983 litigation has proven to be a substantial incentive to litigation that would exacerbate the problem.

Besides clogging the federal courts, the availability of section 1983 actions for statutory violations of the health care reform law would itself generate numerous issues related to the limitations on 1983 suits. For example, states and their agencies are not themselves subject to suit under section 1983. Instead a plaintiff must sue responsible state officials and employees. They are sued in their individual capacities for money damages and in their official capacities for injunctive relief. The prospect of individual liability for health alliance board members, for example, may not be conducive to implementation of the new system. Local government units can be sued directly under section 1983, but only for actions taken pursuant to official

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1. Technically, neither the federal government nor states can be sued as such under § 1983. However, federal officials can be sued in analogous Bivens actions and state officials can be sued under § 1983.

policy. Adding litigation over that issue to the disputes that will have to be resolved seems unnecessary.

It is possible to provide adequate procedures for redress without incurring these pitfalls of section 1983 claims. The health care reform legislation should create a comprehensive alternative remedial scheme and expressly state that section 1983 actions are not available for violations of the health care statute.

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STATE OF MINNESOTA

Office of the Attorney General

TO : CHIEF DEPUTIES

DATE : May 11, 1993

FROM : RICHARD S. SLOWES
Assistant Solicitor General

PHONE : 296-6473

SUBJECT : **Health Care Reform and State Tax Law Limitations**

I am part of a legal review team that is evaluating the Clinton Administration's proposals for health care reform. Part of our function is to identify possible legal impediments to implementation of the various alternatives that are still on the table.

One set of issues that the team has identified concerns state law limitations on the states' taxing authorities. In particular we would like to know if state constitutional provisions will inhibit the ability of state legislatures to enact necessary implementing legislation. Because there is such a variety of state law on this issue, I am asking for your assistance.

Attached is a short survey through which we hope to elicit the information we need about each state's laws. Because of the Administration's confidentiality concerns the description of the proposal is necessarily lacking in detail.[1] I understand this may hamper your ability to give definitive answers to some of the questions. Please do the best you can with the information I have provided. If unknown factors would change your answers, please explain what those factors would be and how they would affect the responses.

Please feel free to call me if you have any questions. I will be in Washington Thursday and Friday, May 13 and 14. You may be able to leave a message for me at (202) 456-2316 (tell them I am with the legal audit team). Other than those two days, I can be reached at (612) 296-6473.

It would be extremely helpful if you could respond to the survey by **Tuesday, May 18.** You can respond simply by jotting your answers on the survey form and faxing it to me at (612) 297-1235 or by phoning me at (612) 296-6473. If you call on one of the days when I am in Washington, please ask for my secretary, Francie Thene, and she will be able to record your answers.

Thanks very much for your help.

slow.ww5

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1. Because of the those concerns, I would also request that this survey be treated as confidential within your office to the extent possible.

Health Care Reform Tax Issues Survey

Please respond by Tuesday, May 18.

For the purposes of this survey, assume the following facts. Health care reform legislation would provide for universal health care coverage. Federal law will determine the structure of the new system, but it will largely be implemented and administered on a state level. Therefore, state enabling legislation will be required.

The states will create health alliances (sometimes called purchasing cooperatives) that will purchase health coverage for large pools of citizens by negotiating and contracting with health plans. One option is that state law (patterned on federal requirements) would mandate that employers pay a designated percentage of a "benchmark" premium for coverage of their employees. The employees would be required to pay the balance of the premium.[1]

The method for determining the benchmark premium on which the employers' mandated contribution is based will be prescribed in the legislation. There will be a benchmark premium for each designated geographic area, such as a county. Health alliances will calculate the actual benchmark premium for each area based on premium bids submitted by health plans that wish to provide coverage within the area. As noted, the mandated employer contribution for each employee will be a certain percentage of the benchmark premium.

Questions

1. Under your state law, would a mandatory employer contribution levied to pay for employees' health coverage be considered a tax?

    a) Would the answer to question 1 change if part of the employer's contribution were used to pay for health care coverage for people other than the employer's employees?

    b) Would the answer change if the employer contribution were deposited to a federal trust account rather than the state treasury?

    c) What other factors would be considered in making this determination under your state law?

2. If the employer contribution would be a tax:

    a) Would state legislation mandating the employer contribution require more than a majority vote in your legislature?

    b) Would anything more than a legislative enactment (e.g., constitutional amendment) be necessary in order to mandate the contribution under state law?

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1. Provisions will also be made for coverage for the self-employed and unemployed, but those details are not necessary for purposes of this survey.

3. Could your state legislature delegate calculation of the tax described above to a health alliance:

a) if the health alliance were a state agency?

b) if the health alliance were a quasi-governmental public corporation?

c) if the health alliance were a private non-profit corporation?

d) Does the answer to question 3 depend on how much of the calculation of the benchmark premium is determined by legislation and how much is left up to the alliance? If the answer is yes, can you provide any guidance on how much detail must be made statutory?

4. Would the answers to any of the above questions change if the employer mandate were contained in federal law rather than state law, with implementation responsibility, including determination of the amount, delegated to the state? If so, how would would your answers differ?

5. Are there any other state constitutional provisions that might impede implementation of the system described?

TO: GREG
FROM: JEN
RE: SECTION 1983 PRIMER

Section 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or any person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

The court determines: (1) whether the defendant acted under color of state law; (2) whether the defendant could invoke good faith, qualified immunity; (3) whether the plaintiff is among the class of persons Congress meant to benefit directly by the legislation; and (4) whether there are sufficient standards provided in the legislation, in light of its history, to permit enforcement of the right.

In Suter v. Artist M., the Supreme Court held that a class of children beneficiaries of Adoption Assistance and Child Welfare Act did not have a cause of action under section 1983. In Wilder v. Virginia Hospital Association, the Supreme Court held that a class of providers of services under the Medicaid Act did have a cause of action under 1983 to enforce the federal act's requirement that states reimburse providers at rates that are "reasonable and adequate" to meet the costs of efficiently and economically operated facilities.

Permits recovery of attorneys fees.

RECOMMENDATION:

- Preclude application of 1983
- Preclude implied causes of action arising under the federal law against federal officials
- Individuals should be permitted to invoke non-binding alternative dispute resolution mechanisms provided by contracts at the alliance or plan level and be given a right to administrative review of such determinations by a state or federal agency, with judicial review in federal court
- Limitation should not apply to violation of consitutional rights

QUESTIONS FOR SARA:

- Why state court review for providers and federal court for individuals?
- Why 1983-like action?

- Why no exhaustion of remedies for individuals?

May 13, 1993

MEMORANDUM

To: Peter, Greg, Diane
Fr: Sara
RE: Legal stuff

Here is my crack at all the legal junk. As you can see, I am completely unsure what to do about providers and §1983 actions. For now, I have given providers no cause of action under §1983 and instead have required states to set up dispute resolution mechanisms that include a fair hearing procedure and review in state court. Should we give some access to federal courts if the amount in controversey is high enough or if other fundamental provider interests (such as denial of special protections for essential providers) are at issue?

May 12, 1993

SPECIFICATIONS FOR LEGAL PROTECTIONS IN THE NEW SYSTEM

1. Individuals

a. Right of action in federal court

1. Individuals enrolled through Alliances

• specify that individuals aggrieved under the Act will have a cause of action in federal district court without regard to amount in controversy, without exhaustion of any available administrative remedies and with the same legal and equitable rights that are available under Section 1983

2. Individuals enrolled through non-alliance employers

• specify that individuals aggrieved by non-Alliance plans have a separate cause of action governed by the terms and conditions of ERISA (I assume that we will have amendments to ERISA specifying new rights and protections for ERISA plans).

3. Civil rights acts

• clarify that nothing in this Act modifies any rights or duties accorded persons under Title VI or Title VII of the Civil Rights Act, Section 504 of the Rehabilitation Act, or the Americans with Disabilities Act

(I am completely unsure of whether we should give providers any right of action in federal court, as is the case under current law. What do you all think?)

2. State, non-Alliance employer, and federal administrative duties

a. States

1. establish fair hearing system meeting standards prescribed by the Secretary, for individuals with grievances against alliances or accountable health plans including, but not limited to:

• enrollment delays by Alliances

• failure to provide appropriate level of financial subsidy

- improper, misleading, fraudulent, and unlawful marketing, enrollment and disenrollment practices by plans

- complaints (which may be brought by either the patient or his individual provider) concerning actions by a plan which (in the absence of rebuttal evidence by the plan) could reasonably be interpreted to constitute wrongful delay, denial or withdrawal of covered care and services or an abandonment of the patient and that are not resolved through plans' initial internal grievance procedures.

2. establish procedures in accordance with standards set by the Secretary, for reviewing actions by either Alliances or plans that have the effect of adversely discriminating against individuals or communities on the basis of race, ethnicity, disability, health risk, or income, including, but not limited to:

- the establishment of AHP service areas within an Alliance that have the effect of discriminating against individuals and communities on the basis of race, income, ethnicity, disability or health risk

- AHP denial of affiliation requests sought by essential providers that serve disproportionate numbers of low income and minority persons and persons with or at risk for disability

- practices by plans that have the effect of delaying, denying or rendering less effective in the case of low income, racial and ethnic minority individuals and persons with disabilities the care and services which plans are required to provide or arrange.

State procedures shall include:

- a formal investigation,

- a public hearing at the request of the grievant (which may be an individual, an organization representing one or more individuals or a community of individuals, or one or more essential or other health care providers serving affected individuals)

- written findings, and

- the ability on the part of the decisionmaker

fashion and institute legally enforceable remedies.

3. establish in accordance with standards set by the Secretary, an administrative process for investigating and reviewing complaints by individual plans against alliances and by individual providers against both plans and alliances, including but not limited to :

- the denial of provider certification by an Alliance
- improper exclusion of a provider from a plan
- the failure of a plan to carry out essential provider payment and affiliation duties imposed on plans under this Act
- improper plan management practices that adversely affect providers and their patients
- the failure of a plan or an Alliance to pay a provider in accordance with applicable requirements and under the terms of the provider's contract with the plan

State procedures shall include a formal administrative hearing with judicial review.

4. collect, compile and make public individual and provider grievances filed against plans, by plan name and class of grievance and must make public information about the plan's resolution of grievances.

5. Oversee Alliance processes and promptly intervene in instances in which an Alliance is alleged to have taken no, or inappropriate, action against a plan alleged to be delaying or denying care or furnishing care of poor quality.

b. Non-alliance Employers

1. collect and make public to enrollees individual and provider grievances against plans, by the name of the plan and the class of grievance

2. require plans to maintain grievance procedures for providers and to furnish to the employer information on the nature of the grievance and its resolution

c. Federal Government

- oversight of state discrimination complaint investigation procedures, with the authority to independently institute actions on behalf of individuals, communities and providers for discriminatory actions

- HHS (?) authority to investigate and impose sanctions against alliances and states that fail to carry out their duties under the Act

- DOL (?) authority to investigate and take action against non-Alliance employers that fail to carry out duties under the Act, including enrollment, provision of basic health benefits, assurance of services that are of high quality and support, as required under the Act, for essential providers.

- HHS to set fraud and abuse standards for accountable plans which at a minimum, standards address the following:

  - fraudulent enrollment and disenrollment practices,

  - fraudulent dealings with affiliated providers,

  - excess profiteering, including the use of utilization control methods or other provider incentives or sanctions that have the intent or effect of denying or impeding access to medically necessary care.

Jennifer

Draft without scholarly apparatus. Please do not use or distribute for any purpose other than today's discussion of possible strategies.

24 May 1993

MEMORANDUM FOR: Interested Persons

RE: Legal Characterizations of Revenue-Raising Alternatives

FROM: Sallyanne Payton

You have asked (a) how to avoid creating an unconstitutional delegation of federal taxing authority and (b) how to avoid having any revenue-raising or revenue-collection action on the part of states be characterized as a "tax" within the meaning of various state laws that impose special requirements on states' taxing powers. The model that you have asked me to work through is a payroll tax model, but many of these observations would apply as well to a premium-based model.

None of the program designs under consideration requires or implies a delegation of the federal taxing power. There are abundant reasons why it would not be sound policy to assign to any non-federal actor final authority to set the amount of a federal tax or other imposition, and nothing in the program design requires the delegation of taxing power to a federal agency. The law on delegation was canvassed extensively in the Tollgate 3 papers, with the result that the system has already been designed to avoid obvious errors of constitutional dimension such as violating the Tenth Amendment, the separation of powers, or prohibitions on unconstitutional delegations. Large structural errors have already been avoided; the remaining questions are those of more refined technique. The more refined problems are not simple, but there is no reason to fear that the program as a whole has been developed without attention to constitutional limitations.

Here is the design of the financing mechanism as you have described it to me. The Health Alliance will determine the benchmark premium for its service area. The benchmark premium is to be based on the weighted average of the premiums for the plans that the Alliance has chosen to participate in the market for the year in question. The Health Alliance will be responsible for translating the benchmark premium into a percentage-of-payroll number, based probably on estimates of the number of potential enrollees, the number of employed persons, their assumed incomes, and so on. That percentage-of-payroll number, which will be

expressed as an employer share and an individual share, becomes the amount that employers and individuals in the Alliance area must pay into the health insurance system. There will be a federal maximum on this number. Individuals who are not employed or who are self-employed will be liable only for the amount paid by employed individuals; the remainder will be contributed by a government subsidy program. Collecting the tax from individuals whose incomes cannot be ascertained through the ordinary techniques used to regulate and tax the employed workforce creates a host of difficulties in characterizing the actions that must be taken.

Under the maximum state flexibility model, it appears that the states will have flexibility to create Alliances that range from passive purchasers to full-fledged entry-and-price regulators. If that is the case, the nature of the pool of bids from insurers that underlie the determination of the benchmark premium may vary markedly among the states: in some states the bids and therefore the benchmark premium will reflect the market; in others, the bids and the premium will be the products of regulation.

Given this variability in the nature of the underlying universe of bids from individual insurers, it would be misleading for the federal government to specify in legislation the technique by which the bids from insurers are used to derive the benchmark premium. Alliances with regulatory or market power would have the ability to arrive at the benchmark premium they wanted by controlling the universe of bids. State flexibility with respect to the level of market intervention therefore leads to the result that decisions made by non-federal officials will be central to the task of determining how much employers and individuals must pay. This will be the case even if the federal legislation specifies the techniques by which both the benchmark premium and the payroll tax are computed.

The question is how to accommodate the policy of allowing states to make crucial decisions with respect to the cost of the program within their states while respecting the fact that the program design must be constrained by restrictions on the delegation of the federal taxing power. Although it is not possible to say with certainty what all of those restrictions are, it is clear that Congress may not delegate to a person who is not a federal executive the power to set a tax. Indeed, no executive power under any statute, regardless of whether it is a tax statute or some other type, may be assigned to a person who is not a federal executive officer (this category includes officials of the "independent" agencies so long as they are appointed and removable by the President). Power to set the amount of a tax, or to make budgetary or regulatory decisions, may not be delegated even to employees of the Congress. This is inherent in the separation of powers, and the conservatives on the Supreme Court have been emphatic about protecting the constitutional allocation of powers within the Government of the

United States. It follows *a fortiori* that the executive power may not be delegated to someone who is not an officer of the United States at all but rather is a private person or an officer of some other government acting in his or her capacity as an official of that other government and not subject to appointment or removal by the President in that capacity (this finesses the issue whether officials of other governments may hold federal offices as well, as where a presidentially-appointed board composed of governors might be empowered to set the tax or the budget).

The fact that legal power to set the tax may not be delegated to persons who are not responsible to the President need not be fatal. Previous cooperative regulatory federalism schemes, including the Federal Unemployment Tax Act, have been structured to work around these limitations. There is a long history of success at this; the limitations mainly pose challenges to the ingenuity of legislative designers. It is, first, possible to have a cooperative tax system in which no federal taxing authority is delegated to anyone. It is, second, possible to position the mandated purchase of health insurance as a regulatory imposition rather than as a new "tax", even though in economic fact they amount to the same thing.

The Easy Model: Federal Tax with Relief for Participants in Authorized Plans

The easiest and simplest way to approach this problem is to have the Congress set a tax in the statute, and simultaneously delegate to an administrative agency authority to waive, suspend or otherwise modify the tax for employers and employees resident in states with approved plans of participation in the new system. The state plan could be required to include the state's technique for establishing the Health Alliance, setting the benchmark premium and calculating employer contributions as a percentage of payroll. The amount of the exaction would be subject to a federally-determined ceiling, so that federal approval of the state plan would result in **reducing** the otherwise applicable tax on business and individuals. There would be no unconstitutional delegation of the federal taxing power because no taxing power would have been delegated to either the state or to the federal agency: the only "tax" would be set in statute.

Delegation of the taxing power would disappear as an issue: the only delegation would be of power to waive or modify the tax in accordance with guidelines determined by the Congress. Existing case law and practice allow delegations of various types of power to administrative agencies so long as the Congress supplies an "intelligible principle" that allows courts to determine whether the agency is acting legally under its statute. The principle in this statute would be not merely intelligible but precise, since the standards for what the state would have to do to qualify its plan would be set forth in the statute. This

is roughly the model used for the Federal Unemployment Tax Act, which has been in successful operation since the 1930s and has been upheld against various constitutional challenges.

The question whether the Alliance or the state had exercised either federal or state taxing power ought also vanish: the Health Alliance, or the state as the case might be, would not have exercised any coercive power at all but would simply have made a report and recommendation to a federal agency authorized to grant waivers. There is no case in which a requirement that a federal agency receive and act on a report from an outside party, so long as the federal agency is not legally required to do what the report says, has been held to violate the non-delegation doctrine. Indeed, in the most egregious case of extensive delegation to private parties in American history, where private trade associations were given power under the Depression-era National Industrial Recovery Act to develop "codes of fair competition" to become law upon approval by the President, the Supreme Court invalidated the legislation not upon the ground that there was delegation to private parties but that the delegation to the President was excessive.

All of the litigated cases upholding delegations if there is an "intellgible principle" to guide the regulator have involved regulatory statutes, most of them enacted under the Commerce Clause, or tariffs and duties. It is possible that the Court might hold that there is a higher standard for delegations of exercises of the taxing power, since the Constitution itself has a special procedure for enactment of tax measures, requiring tax bills to originate in the House. Whatever that standard might be, it is difficult to believe that a tightly-drafted waiver authority delegated to a federal agency would not pass muster where the standards for the exercise of the waiver would amount to the federal specification for a national program.

Under this system, all of the payments made in the system can be transformed into "voluntary" payments: the federal tax would be owed, but might be offset by payments made to or for the use of non-federal entities (e.g., payment might be be made to a Federal Reserve account designated for the local Health Alliance). The non-federal entity would therefore exercise no taxing power, and the federal tax would never be collected in fact so long as the state participated in the program. The federal taxing power would be used only to create a backstop of incentives to induce payments to the nonfederal entities.

Under this system, the state would not have to use its taxing power. The state would as part of its initial plan of participation and annual updates report to the federal administrative entity the amount of money that it thought necessary to run its health insurance program for the year. It would thus request a waiver of the federal tax for individuals and businesses in its jurisdiction who paid the amounts charged to them under the state plan.

The problem would come in collection. There are two problems, one conceptual and the other practical. The conceptual problem is this: suppose that an employer or individual, exempt from the federal tax by reason of the state's participation in the plan, fails to pay the amount that he/she/it is supposed to pay under the state plan? What duty to whom has the employer or individual violated?

If the state were to impose a state tax in lieu of the federal tax, there would be no difficulty: the violator would owe the money to the state and would be subject to whatever remedies the state chose to impose. In order to bring about this result, however, the state would have had to have used its taxing power. That is the path to be avoided.

Another alternative is to require the businesses and individuals to enter into contracts with the Health Alliance as a condition of their personal waivers of the tax. That is, federal approval of the state's plan of participation would not itself waive the federal tax but would enable individuals and businesses to obtain waivers by enrolling in the Alliance and entering into whatever contractual arrangements that entailed. The Alliance or the state would report to the federal agency the taxpayer I.D. numbers of the enrollees and employers who had contracted with it. Their obligation to pay the Health Alliance would be governed then by ordinary contract law, and the Health Alliance could collect or make arrangements with someone else to collect.

The practical problem is collection. For reasons of administrative convenience, it would be sensible to collect the in-lieu-of-tax payments through the mechanisms currently used to collect payroll taxes such as Social Security and unemployment compensation. That is, it might be convenient to use the government's tax collection mechanism, but the payment itself would not be a tax. This raises the question whether a state may authorize its administrators to collect through its system of tax administration a payment that is not a tax. There ought to be no state constitutional impediments to doing so, since state legislatures have plenary legislative authority and restrictions on the use of state instrumentalities are not ordinarily found in state constitutions. The question would be whether a state court might decide that the use of the tax administration itself converted the contractual payment into a tax or into some forbidden state act such as the lending of credit. State constitutions are so various, and state courts so idiosyncratic, that this question bears looking into.

It might be prudent to think of ways to use federal collection mechanisms in order to avoid this problem. Federal agencies could be authorized in the legislation to contract their services to states. All of this can be nearly transparent to the employers and certainly to the employees: the employee will simply have another box on the monthly check stub indicating another deduction. For the employer, dealing with a known and

competent collection agency might be preferable to dealing with a new one that itself will have a learning curve. Middle-class self-employed persons or persons with unearned income might find it convenient to use the ordinary banking system and to authorize, for example, electronic funds transfers, credit card payments, or the like. Payors of pension funds, dividends, and so on can be required to transmit health insurance payments on behalf of the beneficiaries of the funds that they hold.

The convenience of using existing taxing agencies as collectors of the health insurance payments ought to be weighed against the desirability of designing payment techniques that mimic techniques of private-sector payments rather than of public-sector exactions. That is, it is generally better to make this payment **feel** like a premium paid to a provider of health insurance services rather than a tax paid to the government. The tax model is, however, fairly easy to design.

A Regulatory Model

May this program be run as a regulatory system rather than a taxing scheme? Suppose for example that the federal statute requires employers and employees to purchase health insurance. If the state has no approved plan, then they must buy into something the federal government designs (e.g., whatever the back-up system is). If the state has an approved plan, employers and individuals must buy through the Alliance from an approved Accountable Health Plan. All of the regulatory requirements may then be imposed on the state and the Health Alliance. This makes the federal government the regulator of states, Health Alliances and AHPs rather than a tax collector. All of the other elements of the plan design may remain in place, but must be expressed as requirements for Alliances. The regulation may require that Alliances express their contract prices as a percentage of payroll or income.

A Premium-Based Model

The premium-based model is an easier version of the regulatory model. I assume that someone else is working through this model, so I will make only a few comments.

It is plausible to deny that a coerced payment is a "tax" when it is designated for the purchase of goods or services to be used by the coercee, is paid to someone other than the person doing the coercing, and is not fixed in amount but is an instruction to the coercee to go into the marketplace and buy the thing in question. The conditions for the sale of the good or service may then be imposed as regulatory requirements on the sellers. In principle, this is no different from telling people that they must buy automobile insurance as a condition of their licenses and then regulating the number and composition of the

sellers of insurance, their prices, and so forth. The license fee itself is regarded as a tax; the cost of the insurance is not. There are numerous instances in the law in which an employer is told to supply something to an employee (e.g., much occupational health and safety regulation). The cost of these impositions is not included in the calculation of the incidence of federal taxation. The question is whether setting the price of the good or service in question by reference to the economic characteristics of the purchaser rather than of the product would change the characterization for legal purposes. This bears looking into. I think it would not. Price discrimination is extremely common and indeed is an approved technique in public utility regulation. The amount that businesses pay for, say, telephone service above and beyond their own cost of service, which amount goes to subsidize residential consumers, has never been regarded in law as a "tax" within either state or federal law.

Collecting from the individual

I have not given this sufficient thought to have any useful remarks on this subject at this time; nor do I have enough information to form any judgments.

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Marjorie Shultz
Legal Audit Group
5/18/93. Draft #2

"MEDICAL NECESSITY" AND THE BENEFITS PACKAGE

ISSUES:

1. The concept of "medical necessity," especially as concretely applied, is controversial and indeterminate. It routinely implicates important interests including constitutional ones. How can the reform plan take this into account in a reasonably sophisticated fashion without engendering crippling amounts of litigation?

2. What degree of variation in benefits (purchase, insurance, provision of services) should be allowed? Should supplemental insurance or benefits be possible for individuals to purchase and insure for and for providers/ plans to offer? Should individuals/ employers be able to opt out to any degree and receive lower prices or rebates for a lower option plan (and should plans be able to offer such options)?

PROPOSED SOLUTIONS

1. Phraseology alone will not solve the problem, but wording such as "appropriate medical treatment" usefully underscores that medical expertise provides vital information and evaluation, but lay values should ultimately decide. The Reform Plan should place high priority on creating extensive disclosure to consumer-patients and requiring extensive participation of laypersons in decisionmaking about care, policy formulation and dispute resolution.

2. While universal access and fairness are the goal, overly rigid standardization of health care is both difficult and undesirable. A market in supplemental services and insurance for spreading their cost should be maintained. Individuals, employers and states may all wish to add to the standardized benefit package. Such supplementation should be paid for with after-tax dollars.
Opt down or out plans and/or rebates should not be allowed at the outset but should be considered over the longer term.

DISCUSSION:

1. Two primary insights have come to the fore in the last 25 years in health law and policy. One is that where resources are limited, decisionmaking about consumption of care must connect real responsibility for cost with meaningful judgments about benefits. The other is that such judgments are not ultimately matters of professional expertise. Rather, medical expertise informs and recommends, but lay judgment must be the ultimate source of decision. Medical experts frequently differ; their knowledge is inevitably uncertain and incomplete. Uncertainty is radically accentuated because medical decision-making necessarily takes place at an individual rather than a categorical level. Standardized analysis is only a starting point; answers must be chosen and implemented at a personal level that takes account of myriad variations of individual bodies, circumstances, and values.

By contrast, it is clearly lay persons who experience the physical benefits and burdens of health care in their lives and bodies. If the system works properly, laypersons also pay the economic bills, either as individuals or as members of groups ranging from purchasers' collectives to taxpayers. Individual values differ about everything from the meaning and definition of life, to tolerance for pain and risk, to the importance of various outcomes that money can provide. Democracy affirms value pluralism and individual autonomy, particularly where interests as vital as those in health care are implicated.

Terms like "medically necessary" obscure the fact that medical recommendations are critically important to informed decision but medical expertise does not settle what choices should be made. "Medical necessity" is an effort to avoid political and values problems by conveying the idea that the invisible hand of expertise can make right decisions. Instead, the term "medical" should modify "information" or "recommendation" rather than being used to characterize "necessariness" which is actually a balancing-type judgment about value and cost. Decisions about "necessity" are cost-benefit trade-offs that should be made by individuals and society, i.e. by those who pay the bills and receive the benefits.

To incorporate these insights, disclosure of information to and provisions for decisionmaking by laypersons must be built into all levels of the system. Extensive information and discussion at the point of diagnosis and treatment are essential to preserving individual autonomy and value choice whose importance has been so highlighted by the development of informed consent doctrine and practices and by the medical ethics and patient consumer movements of recent years. In addition, patients, paying more directly through co-payments, choice of health plan, and tax-based redistribution need information that facilitates expression of their genuine preferences. In a system of capitated spending limits, individuals need information to protect them against incentives to underservice. Moreover, the consumption and cost-containing potential of telling patients what procedures and conditions really feel like and what outcomes are really to be expected has been seriously underestimated.

Individuals should have broad access to dispute resolution procedures with plans (cross reference Ed Goldman), and such procedures could mandate exchange with whoever is denying a patient's request as its first stage. Requirements for lay participation in development of a grievance procedures could be made by states or health alliances. Description of dispute resolution procedures should be mandatory for plans in recruiting enrollees.

At the macro level, consumer-taxpayer roles must be central to decisions in the states, in the Health Alliances, and in the Federal Health Board wherever cost and benefit decisions are being made. Informed by medical research and recommendation, lay persons as consumers and as payers should have major input into decisions about such matters as what benefits are to be provided; how changes in research and technology alter care under the standard package; what types of services and professionals are to be covered; what risk adjustment categories are to be accounted for; what budgets are to be established, how premiums and geographical boundaries should be set; how plans should be certified; how criteria and policies are determined, what data should be gathered, etc.

2. Given uncertain knowledge, individualized decisionmaking, and values pluralism, rigid standardization of medical care is exceedingly difficult. Broader, fairer access and cost containment are both essential, but standardization carried to extremes will be undesirable -- lacking in efficiency (defined as delivering benefits valued most by those bearing the physical, emotional, and economic costs) and perhaps illegal (as interfering with constitutional rights). Consequently, after-tax dollars should be spendable to purchase services that are not provided by the standardized benefits package (either categorically, or as determined for individual cases by relevant provider, plan or FHB decisionmakers). Sale of insurance for such services could probably be prohibited, but such measures seem inappropriate. Supplementation re-introduces some "tiering" in health care, but the personal and constitutional significance of the interests involved is sufficiently great that some supplementary market should be maintained.

States as well as individuals may wish to add services to the federally mandated benefits package because of variation in political priorities, health status, or environmental characteristics of their populations. Assuming they absorb economic responsibility for such additions, the model of flexibility at and primary responsibility for health care at the state level suggests that such variations should be allowed (see Mark Barnes'statement).

Choosing less expensive life-styles (e.g. non-smoking) or care options (e.g. refusal of life support near the end of life) would save health care money. Distribution of such savings to individuals in the form of rebates could create incentives to reduce consumption. However, allowing individuals to select or plans to offer low option alternatives threatens to open debate about the fundamental principle of community rating, and may therefore not be tolerable at the outset. (Constitionally-based religious opt-outs, e.g. by Christian Scientists, raise related but distinguishable problems). However, once the principle of community rating is firmly established, serious consideration should be given to such options as desirable incentives for health care choices.

If and when allowance of opt out or down alternatives were considered, difficult questions of when health consequential behavior is chosen and choosable as opposed to involuntary (and therefore not a legitimate basis for lower cost) would remain. Low cost options would also raise hard questions about when and whether individuals could change their minds about prospective decisions (e.g. to forego expensive care). Finally, if the pull toward poor people having to settle for less health care than rich people became significant, political support for a quality level of comprehensive could be unacceptably compromised. On the other side, however, is the fundamental and constitutional nature of values involved, the need to create health-choosing incentives, and the genuine variation of preferences having nothing to do with economic factors.

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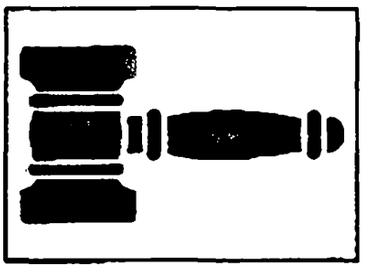

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1. Eleventh Amendment and Medicaid Challenges

The Eleventh Amendment bars certain suits against states in federal court. When a state participates in a joint federal-state program, private parties frequently attempt to assert a cause of action in federal court in order to assert federal questions concerning the construction of the statute. The Supreme Court has stated that "the rule has evolved that a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment." Edelman v. Jordan, 415 U.S. 651, 663 (1974). See also Quern v. Jordan, 440 U.S. 332, 337 (1979); Great Northern Life Insurance Co. v. Read, 322 U.S. 47 (1944).

The Eleventh Amendment protection is not absolute. First, the Eleventh Amendment does not bar suits for declaratory or injunctive relief that seek to compel a state official to carry out prospectively federal requirements. Edelman v. Jordan, 415 U.S. at 1356; Wilder v. Virginia Hospital Association, 110 S. Ct. 2510, 2525 (1990)(recognizing suits for prospective relief under 42 U.S.C. § 1983).

Second, a state may volunteer to waive its Eleventh Amendment rights. It is clear, however, that "[t]he mere fact that a State participates in a program through which the Federal Government provides assistance for the operation by the State of a system of public aid is not sufficient to establish consent on the part of the State to be sued in the federal courts." Edelman v. Jordan, 415 U.S. at 673. Moreover, a state's consent to waive its Eleventh Amendment privilege should be express, rather than implied. "[W]e will find waiver only where stated 'by the most express language or by such overwhelming implications from the text as [will] leave no room for any other reasonable construction. Murray v. Wilson Distilling Co., 213 U.S. 151, 171 (1909)'" Edelman v. Jordan, 415 U.S. at 673. Applying this principle to the Medicaid program, the Court, in Florida Department of Health and Rehabilitative Services v. Florida Nursing Home Association, et al., 450 U.S. 147, 150 (1981), ruled that states that participate in the Medicaid program did not waive the Eleventh Amendment protection merely by explicitly agreeing to obey federal law in administering the program.

Finally, Congress can abrogate the Eleventh Amendment immunity of the states; however, "Congress must make its intention 'unmistakably clear in the language of the statute.'" Hoffman v. Connecticut Department of Income Maintenance, 109 S. Ct 2818, 2822 (1989); but see Hoffman v. Connecticut Department of Income Maintenance, et al, 109 S. Ct. 2824 (Scalia, J., concurring) (suggesting that Congress does not have the power to abrogate the States' Eleventh Amendment immunity). In 1975, Congress briefly required states to amend their Medicaid state plans expressly to allow the states to be sued in federal court for money damages by certain hospitals that might challenge the states' payment rates. § 111, Pub. L. No. 94-182 (1975). This

provision was quickly repealed. § 2, Pub. L. No. 94-552. The legislative history showed that "upon reconsideration of this matter, the Committee is unconvinced as is the House of Representatives of the desirability of compelling States to waive their constitutional immunity to suit or of the feasibility of assessing monetary sanctions against States failing to do so in a time of economic stringency at all government levels." Committee on Finance, S. Rept No. 1240, 94th Cong., 3 (1976).

2. Status of Social Security Act's Bar to § 1331 Jurisdiction

A. Pre-OBRA'86 Litigation

The extent to which Medicare challenges may be brought in federal district court under § 1331 jurisdiction has been a major source of controversy, with the Supreme Court, on three occasions, addressing the issue. In the first of these decisions, United States v. Erika, Inc., 456 U.S. 201 (1982), the Court addressed a supplier's attempt to use § 1331 jurisdiction to obtain review of carrier fair hearing officers' determinations of the amount of benefits payable under Part B. The Court stated that the review provisions of the Medicare statute in effect at that time "fail[] to authorize further [beyond the fair hearing] review for determinations of the amount of Part B awards," and further noted that the legislative history of the statute unambiguously supports the view that "Congress deliberately intended to foreclose further review of such claims." 456 U.S. at 208. Given Congress' unequivocal expression of intent that there be no further review, the Court ruled that there was no § 1331 jurisdiction over the dispute. Later, in Heckler v. Ringer, 466 U.S. 602 (1984), the Court held that 42 U.S.C. §§ 405(h) and 1395ii, as then written, explicitly preclude federal question jurisdiction over claims "arising under" the Medicare Act. The Court noted that the Medicare Act provides a process for full administrative review of Part A claims and stated that this process provided the "sole avenue for judicial review" of those claims. 466 U.S. at 615. The Court also stated that Congress had not "provided for judicial review of the denial of Part B claims." 466 U.S. at 608 n.4.

With the Court's decision in both Erika and Ringer, it appeared settled that no judicial review was available for Part B appeals. That view was upset by the Court's decision in Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986). In Michigan Academy, plaintiffs challenged the validity of a Medicare regulation that governed certain aspects of physician reimbursement. The Secretary, as he had done in the prior cases, asserted that federal courts lacked jurisdiction over the challenge. The Court disagreed. The Court reaffirmed its position in Erika that no judicial review was available over challenges to the amount of Part B awards. The Court went on to

say, however, that challenges could be mounted to the method by which such amounts are determined, rather than to the determinations themselves. In coming to this conclusion, the Court stated that there is a strong presumption that Congress intends that there be judicial review of administrative action and that this presumption can be overcome only upon a strong showing of a contrary legislative intent. The Court ruled that the Medicare statute and its legislative history provide persuasive evidence that Congress intended to preclude from judicial review determination of the amount of Part B awards. This sort of determination, the Court recognized, is the sort of issue that the carrier can decide during the fair hearing process. However, carriers had no authority to rule on the validity of provisions of the Act, regulations or instructions, and the statute, as it existed at the time of the Court's decision, provided no right to administrative or judicial review beyond the carrier. This meant that there was no real opportunity for review of the Secretary's Part B payment methodologies. Because the Court could find no clear congressional intent to prevent payment methodologies from being reviewed, the Court ruled that "methodology" challenges could be reviewed in federal district court under § 1331.

B. Further Review Provided By OBRA'86

The basis for the Michigan Academy decision was short lived. Within a few months of the decision being handed down, Congress acted, in § 9341 of OBRA'86, to remedy the decision's factual predicate -- the absence of any review mechanism in the pre-1986 statute. In OBRA'86, Congress provided for both ALJ and judicial review over Part B claims, including challenges to both amount determinations and methodologies.

C. Litigation After OBRA'86

Congress' action, by extending to Part B beneficiaries and their assignees the same administrative and judicial review rights enjoyed by Part A beneficiaries, placed the Part B jurisdiction issue squarely within Ringer's analytical framework. In Ringer, the Supreme Court said that if there is a review process available under the Medicare Act, that process is the "sole avenue" for obtaining judicial review. Given this and given the review mechanism provided by Congress in § 9341 of OBRA-86, the Secretary has argued that OBRA'86 effectively rendered Michigan Academy a dead letter. Although a few district courts have ruled (mostly in unpublished decisions) that Michigan Academy somehow survives following OBRA-86, see, e.g., Griffith v. Bowen, 678 F. Supp. 945 (D. Mass. 1988), the majority of the courts, including the only courts of appeals to have examined the issue, agree with the Secretary that § 1331 jurisdiction no longer exists over Part B methodology challenges. See, e.g., Abbey v. Sullivan, 978 F.2d 37 (2d Cir. 1992), reh'g denied, No. 92-6055 (2d Cir. Dec. 3,

1992); National Kidney Patients Association v. Sullivan, 958 F.2d 1127 (D.C. Cir. 1992), cert. denied, 113 S. Ct.966 (1993); Cardiac Monitoring Services, Inc. v. Blue Cross and Blue Shield of Arkansas, 807 F. Supp. 1422 (E.D. Ark. 1992); Farkas v. Blue Cross and Blue Shield of Michigan, 803 F. Supp 87 (E.D. Mich. 1992); Roen v. Sullivan, 764 F. Supp. 555 (D. Minn. 1991); Colorado Clinical Labs, Inc. v. Newman, Medicare & Medicaid Guide (CCH) ¶ 39,056 (N.D. Tex. May 24, 1990); Oxygen Equipment Co., Inc. v. Sullivan, Medicare & Medicaid Guide (CCH) ¶ 37,989 (N.D. Ala. June 29, 1989), aff'd without opinion, 914 F.2d 268 (11th Cir. 1990), reh'g denied, 918 F.2d 184 (11th Cir. 1990) (en banc).

The courts of appeals' decisions in this area are most noteworthy. In the leading case, National Kidney Patients Association, the D.C. Circuit examined the competing decisions flowing from, on the one hand, Michigan Academy and, on the other hand, Ringer and Weinberger v. Salfi, 422 U.S. 749 (1975), the Ringer decision's predecessor in the Social Security area. The court concluded:

> Because Congress [in the 1986 amendments] has now brought Medicare part B disputes under the same regime as ones under part A, and because the Supreme Court has treated part A disputes as indistinguishable from Social Security ones, we find the Salfi-Ringer line controlling.

958 F.2d at 1130. The court expressly ruled that, in the wake of the 1986 amendments, the amount/methodology distinction created in Michigan Academy no longer exists. 958 F. 2d. at 1134 ("methodology disputes ... are fed through the same administrative-judicial system as parts of disputes over actual amounts").

Similarly, in Abbey, the Second Circuit was confronted with a Part B jurisdictional dispute, resolution of which required the court to "determine if congressional amendments to the appeals process for Medicare Part B claims now require that such claims be reviewed in the same manner as Part A claims." 978 F.2d at 41. The court held that they do, ruling that "the Social Security Act provides the sole authority for exercising federal question over Part B disputes." 978 F.2d at 43.

Finally, to the same effect, was the Oxygen Equipment Co. case, where the Eleventh Circuit, without opinion, affirmed a district court finding that Michigan Academy was no longer good law and held that the Part B claimants could obtain review only as provided by the Medicare statute.

As these cases demonstrate, the decisional law establishes the firm principle that the Medicare Act is now the sole source of judicial review of Part B claims.

3. § 1983 Actions--Reconciling Suter v. Artist M. with Virginia Hospital Association v. Wilder

Two recent Supreme Court cases governing actions against states under 42 U.S.C. § 1983 have generated a significant amount of debate because the Court does not appear to use the same analytical framework for deciding the cases. Recent opinions of the circuit courts, however, suggest that these cases can be reasonably harmonized to produce consistent results.

In Wilder v. Virginia Hospital Association, 496 U.S. 498 (1990), the Supreme Court applied a three prong test to determine whether the statute created a federal right that would serve as the basis of a civil action based on 42 U.S.C. § 1983. First, the Court focused on whether the provision in question was intended to benefit the putative plaintiff. 496 U.S. at 509. If (1) such a benefit was intended, the Court ruled, the analysis proceeds to the second and third steps with the Court deciding whether (2) the statute "reflects merely a 'congressional preference' for a certain kind of conduct rather than a binding obligation on the governmental unit" 496 U.S. at 509, or (3) the interest the plaintiff sought to challenge was "too vague and amorphous" so that it is beyond the competence of the judiciary to enforce. 496 U.S. at 509. In establishing a right of action under § 1983, the Wilder plaintiff satisfied the Court that the Boren amendment was intended to benefit hospitals, that the statute imposed binding obligations on the states, and that the interest the hospitals sought to enforce was not amorphous, but instead, was sufficiently concrete to be enforceable. Thus, the Court concluded that health care providers had an enforceable right to the adoption of rates that were reasonable and adequate to reimburse efficiently and economically operated facilities.

In Suter v. Artist M., 112 S. Ct. 1360 (1992) the Court did not apply the sequential test for determining whether a statute creates a federal right. Instead, in Suter, the Court focused on the language of the statute itself to determine whether Congress, in enacting the statute, "unambiguously confer[ed] upon the child beneficiaries of the Act a right to enforce the requirement that the State make 'reasonable efforts.'" 112 S. Ct at 1367. The Court ruled that Congress had not conferred such a right. In reaching this result, the Court concluded that the "reasonable efforts" language was ambiguous because it was not further defined in the statute and was a standard that varied from case to case. The Court held that, within broad limits, compliance was left up to the States, and that the statute, therefore, did not unambiguously confer an enforceable right upon the child

beneficiaries. 112 S. Ct. at 1368-1370. In his dissent, Justice Blackmun criticized the majority for not applying the Wilder test to determine whether a statute creates enforceable rights.

The recent courts of appeals' decisions discussing the Supreme Court's decisions in Wilder and Suter have noted the apparent tension in the Court's analysis. Of these, the Seventh Circuit has suggested that Suter has expanded the Wilder framework at the second step and that, in order to create an enforceable right, the statute must do more than require that a plan be approved by the Secretary. See e.g., Procopia v. Johnson, No. 92-1913 (7th Cir. May 6, 1993) (copy attached) (suggesting that the court was bound by circuit precedent to this broad interpretation); Clifton v. Schafer, 969 F.2d 278, 284 (7th Cir. 1992). Other courts have attempted to harmonize the decisions. See e.g., Stowell v. Ives, 976 U.S. 65, 68 (1st Cir. 1992) (noting that the Supreme Court cited to and relied on Wilder and that the Court did not propose a new analytical framework); Dorsey v. Housing Authority of Baltimore City, 984 F.2d 622, 630 (4th Cir. 1993) (recognizing that regulations may further define how reasonableness would be measured). Still, several courts have concluded that the result would have been the same under either framework. See e.g., Resident Council of Allen Parkway Village v. United States Department of Housing and Urban Development, et al., 980 F.2d 1043, 1052 (5th Cir. 1993) (finding no binding obligation on the State because statute was directed to federal agency); Stowell, 976 F.2d at 70 (statute directed to federal government does not create action cognizable against state under § 1983).

Although there have been only a handful of cases in the court of appeals discussing both Wilder and Suter, it appears that the courts may be able to harmonize the analytical differences between the opinions. After Suter, the courts of appeals have tended to focus carefully on the specific statutory provision, which allegedly gives rise to the federal right, to determine whether the statute merely reflects a congressional preference or a binding obligation on the governmental unit. If the statute does not clearly compel the State to take some action with respect to the putative plaintiffs, as opposed to a generalized obligation to submit a plan or plan amendment, courts are unlikely to find that the statute creates an enforceable right. Procopio, Slip op. at n. 12. In some cases, the courts may have reached the same conclusion by applying the second step of the Wilder framework. Thus, as the Supreme Court has admonished, if Congress intends to create rights which are enforceable under § 1983, "Congress must be cautious in spelling out the federal right clearly and distinctly." New York v. United States, 112 S. Ct 2408 (1992).

§ 1983; post Artist M.; cites Stovall

DOCUMENT 1

CA No. 7 (IL), No. 92-1913

JOSEPH and MARJORIE PROCOPIO, Plaintiffs-Appellants, v. GORDON JOHNSON, Former Director, Illinois Department of Children and Family Services; JESS MCDONALD, Former Interim Director, Illinois Department of Children and Family Services; SUE SUTER, Former Director, Illinois Department of Children and Family Services; STERLING M. RYDER, Director, Illinois Department of Children and Family Services; HEPHZIBAH CHILDREN'S ASSOCIATION, a Not-For-Profit Corporation; and LUTHERAN CHILD AND FAMILY SERVICES, a Not-For-Profit Corporation, Defendants-Appellees.

UNITED STATES COURT OF APPEALS

SEVENTH CIRCUIT

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 91 C 5495

Charles R. Norgle, Judge.

ARGUED NOVEMBER 9, 1992

DECIDED MAY 6, 1993

Before BAUER, Chief Judge, CUDAHY, Circuit Judge, and CRABB, District Judge. /*/

CUDAHY, Circuit Judge. The plaintiffs, hoping to adopt a child, became foster parents to a little girl born to an active drug addict. They nursed her through chronic narcotic withdrawal and cared for her for five years. When the birth parents successfully sought to have custody of the girl returned to them, the plaintiffs sued, asserting a violation of 42 U.S.C. sec. 1983 in addition to state law claims. The district court dismissed the case. We affirm.

I.

The lamentable story of Ashley K.'s childhood began on April 27, 1984, when Ashley was born to a drug-addicted woman who had used heroin and cocaine and prostituted herself during the pregnancy. /1/ On May 3, 1984, Ashley was found to be a neglected and dependent minor and was placed in the custody of the Illinois Department of Children and Family Services (DCFS).

About the same time, the plaintiffs, Joseph and Marjorie Procopio, contacted defendant Lutheran Child and Family Services (LCFS) to inquire about how they might adopt a child. LCFS informed the Procopios that they would have a better chance to adopt if they became licensed foster parents. The Procopios complied, received their foster parents license in April 1984 and became foster parents to Ashley about a month later. Apparently LCFS and DCFS officials repeatedly led the Procopios to believe that almost no significant barriers would prevent their adoption of Ashley and that she was "97 percent adoptable." In the interest of Ashley K., 571 N.E.2d 905, 907 (Ill. App. 1 Dist.), appeal denied, 580 N.E.2d 115 (1991).

During the first 16 months of Ashley's life, she was visited by her mother three times and her father twice. /2/ Ashley's mother, who had a significant arrest record for theft, child neglect, prostitution, forgery and possession of stolen property, was reported using heroin in March 1985. The DCFS nevertheless developed a service plan on April 25, 1985, to work toward the

goal of returning Ashley to her parents and to maintain an older sister and brother in the family home as well. On May 8, 1985, however, the state circuit court found Ashley's parents, who remained unmarried but who had lived together since 1980, unfit to care for her and granted guardianship to the DCFS. Ashley continued to experience withdrawal tremors and high fevers, but was otherwise progressing well with the Procopios. The September 4, 1985, update of the DCFS service plan continued to indicate a goal of returning Ashley to her biological parents.

In February 1986, Ashley's mother, who was completing a methadone drug treatment program, was charged with child abandonment, and her son and older daughter were taken into protective custody. She was arrested for prostitution in March 1986. On December 9, 1986, the circuit court found her to be an unfit parent, and the DCFS received guardianship of the two older children.

Two days later Ashley's mother entered an in-patient drug program, but left the program in March 1987 prior to completion. She enrolled instead in an outpatient methadone maintenance program. In June 1987 Ashley's mother purchased a house with her own mother; Ashley's father, who lived in the house with Ashley's mother and grandmother, also entered a methadone maintenance program.

Ashley's biological parents filed a juvenile court petition on December 29, 1988, seeking custody of Ashley. Although various psychological reports recommended that Ashley should remain with the Procopios, DCFS supported her return to her biological parents. In April 1989, DCFS began working with defendant Hephzibah Children's Association on a plan to effect Ashley's move. In July 1989, DCFS took Ashley from the Procopios and placed her with Hephzibah. At this point Ashley's parents had not used drugs for more than a year and had completed a DCFS service plan. On August 29, 1989, the juvenile court returned custody of Ashley to her natural parents. /3/

On August 29, 1992, the Procopios filed a three-count complaint in federal court against the DCFS, DCFS directors, Hephzibah and LCFS. This case presents a story of what must have been a severe and prolonged emotional trauma to Ashley, but the problem presented to the federal courts is a narrower one than that. The Procopios asserted one federal claim under 42 U.S.C. sec. 1983 alleging violation of their Fourteenth Amendment due process rights and two state claims alleging fraudulent misrepresentation and intentional infliction of emotional distress. Concluding that the Procopios failed to demonstrate that their long-term foster relationship with Ashley or the DCFS's assurances of adoption created a liberty interest, the district court dismissed the section 1983 claim for failure to state a claim upon which relief can be granted. Procopio v. Johnson, 785 F. Supp. 1317, 1320 (N.D. Ill. 1992). The court declined to exercise supplemental jurisdiction over the remaining state claims and dismissed them as well. Id. The Procopios appeal.

II.

We review the district court's dismissal of the plaintiffs' claims de novo. The Procopios' section 1983 action requires them to prove that they have a liberty interest in their family relationship with Ashley that the state could not impair without due process. /4/ If they demonstrate such an interest, they then must show that the process accorded them was not constitutionally

adequate. The Procopios contend that their liberty interest in their family relationship with Ashley derives from Illinois state law and from the federal statutory scheme governing reimbursement for various state and child welfare services, the Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. secs. 620-628, 670-679a (1980). We address these in turn.

The power of the state to regulate biological family relationships is limited. See, e.g., Stanley v. Illinois, 405 U.S. 645 (1972). How far that limitation extends to nonbiological families is less clear. The Supreme Court has recognized that biological relationships are not the "exclusive determination of the existence of a family" and that emotional attachments play a role as well. Smith v. Organization of Foster Families for Equality & Reform, 431 U.S. 816, 843-44 (1977). But the Court has stopped short of deciding that foster family arrangements achieve the status of a liberty interest that states cannot disrupt without due process. See id. at 847. /5/ The scope of the liberty interest at stake, according to the Court, is appropriately ascertained from the parties' expectations and entitlements as they are set out in state law. Id. at 846; Lindley v. Sullivan, 889 F.2d 124, 130 (7th Cir. 1989) (stating that a foster family's rights arise from state statute).

The Procopios contend that two different state law provisions support their claim that their relationship with Ashley amounts to a liberty interest. First, they argue that the Illinois Adoption Act confirms that foster parents are to be preferred above all others as the foster child's permanent family. Specifically, section 1519.1 provides that the child's legal guardian "shall give preference and first consideration to (the foster parents') application over all applications for adoption of the child but the guardian's final decision shall be based on the welfare and best interest of the child." Ill. Rev. Stat. ch. 40, sec. 1519(b).

We agree with the district court that this statutory language does not suffice to create a liberty interest in the Procopios' family relationship. Notwithstanding the preference state law grants to foster families seeking to adopt their foster children, this priority does not rise to the level of an entitlement or expectancy. Cf. Johnson v. Burnett, 182 Ill. App.3d 574, 579, 538 N.E.2d 892, 897 (1989) (describing a foster parent's role in Illinois as "that of a temporary way station on the road of a child's life," not a family for whom a future permanent situation is guaranteed). State law still requires that foster families who wish to adopt obtain the permission of the natural parents, Ill. Rev. Stat. ch. 40 sec. 1510(a), or of the legal guardian if the natural parents' rights have been terminated, as they were here. Id. at secs. 1510(b), 1519.1(a). Even given that permission, the Juvenile Court has the "sole discretion" to make the "final determination" about the adoption. Id. at sec. 1519.1(c). Ashley's guardian, the DCFS, never granted that consent, nor did the Procopios receive juvenile court approval of their adoption of Ashley. /6/

Second, the Procopios claim that the Illinois Juvenile Court Act of 1987, Ill. Rev. Stat. ch. 37, sec. 801-1 et seq., supports an expectancy of a permanent relationship with Ashley. The Act's statement of purpose indicates that, where possible, a minor removed from his or her family should be placed

"in a family home so that he or she may become a member of the family by legal adoption or otherwise." Id. at sec. 801-2(1).

We are not persuaded that this language in the Juvenile Court Act serves to create a liberty interest in the Procopios' family relationship. As the language preceding the quoted passage makes clear, the Act strives foremost to secure appropriate care and guidance for each child "in his or her own home" and to "strengthen the minor's family ties whenever possible." Id. Indeed, when guardianship is not feasible within the child's own home, the Act does advocate placing the child in a "family home" that affords the equivalent of parental care and discipline. Yet the Act's opening policy statement introduces this option as a subordinate alternative to the expressly preferred course of maintaining children in their own (original) home. /7/ Further, although the Act unmistakably endorses efforts to provide a home-like environment to children whose parents' custodial rights have been suspended or terminated, the legislature's articulation of this aim neither nullifies the state's ultimate prerogative to terminate the foster family unit nor otherwise confirms any legally cognizable expectancy in the foster family's permanence.

In addition, the Procopios have difficulty overcoming this court's decision in Kyees v. County Dep't of Public Welfare, 600 F.2d 693 (1979), where we held that Indiana law did not create a constitutionally protected liberty interest in a foster family's relationship that required due process before it was disrupted. Id. at 699. Kyees acknowledged that Indiana law creates an expectation that the foster child's situation will be altered only when in her best interest, but concluded that the law makes clear "the likelihood or virtual certainty of eventual termination of the foster relationship." Id. at 698.

Admittedly, Kyees addressed Indiana law, not Illinois law. But even if, as the Procopios argue, Illinois endorses more strongly than Indiana the idea of permanent foster care, the language in Kyees is telling. The Kyees court stated that "(b)ecause they can be ended by the state, foster families must, then, be seen as enjoying a considrably more limited 'liberty' than natural families or those related by adoption." Id. at 698. Despite the differing emphases on the possible permanence of foster families, the state's ultimate power to terminate those arrangements--a power that both Illinois and Indiana have--is dispositive. Under Kyees and Illinois statutory provisions that actually curb foster families' expectations of permanent family relationships, the foster family's existence is subject to the state's determination that it should continue, and Illinois law can create no expectancy of a constitutionally protected liberty interest. See also Drummond v. Fulton County Dep't of Family & Children's Serv., 563 F.2d 1200, 1207 (5th Cir. 1977) (concluding that "in the eyes of the state, which creates the foster relationship," the relationship gives rise to no state-created right), cert. denied, 437 U.S. 910 (1978).

The Procopios also argue that section 1983 provides a remedy for the defendants' violation of federal law--in this case, the Adoption Assistance and Child Welfare Act of 1980 (AACWA), 94 Stat. 500, 42 U.S.C. secs. 620-28, 670-79a (1980). /8/ Appellants' Br. at 27. The AACWA provides for federal reimbursement of a percentage of expenses for states' administration of foster

care and adoption services when states satisfy the Act's requirements. 42 U.S. C. secs. 672-674, 675(4)(A) (1988 ed. and Supp. I). Specifically, the Procopios invoke section 675(5)(C), which assures each foster child under state supervision "a dispositional hearing to be held . . . no later than eighteen months after the original placement." 42 U.S.C. sec. 675(5)(C). That hearing "shall determine the future status of the child (including . . . whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should . . . be continued in foster care on a permanent or long-term basis) . . . ." Id.

Section 1983 is available as a remedy for violations of federal statutes where the statute itself creates enforceable rights. Wright v. Roanoke Redevelopment and Housing Auth., 479 U.S. 418, 423 (1987); Maine v. Thiboutot, 448 U.S. 1, 4 (1980). In the recent case of Suter v. Artist M., 112 S. Ct. 1360 (1992), however, the Supreme Court held that another provision of the AACWA does not create rights enforceable under section 1983. The decision involved section 671(a)(15), which required states to have a plan providing for reasonable efforts to prevent removal of children from their homes and to facilitate reunification of families. 42 U.S.C. sec. 671(a)(15). The Court ruled, inter alia, that the provision was non-mandatory in all relevant respects and that Congress did not unambiguously confer upon the Act's beneficiaries the right to enforce the "reasonable efforts" requirement. 112 S. Ct. at 1367-70.

The plaintiffs contend that section 675(5)(C) is distinguishable from the provision considered in Artist M. and does create a federal right enforceable under section 1983. Appellants' Br. at 28-29. The Supreme Court has developed a three-part inquiry for evaluating a federal law's enforceability under section 1983: that inquiry examines (1) whether "the provision in question was intended to benefit the putative plaintiff," and if so, (2) whether the provision reflects merely a congressional preference instead of a binding obligation or (3) whether the interest the plaintiff asserts is so "vague and amorphous" that it is "beyond the competence of the judiciary to enforce." Wilder v. Virginia Hosp. Ass'n, 110 S. Ct. 2510, 2517 (1990) (citations omitted). /9/

We first examine whether section 675(5)(C) is intended to benefit the plaintiffs. On its face, the section defines the required "case review system" as a procedure for assuring that "procedural safeguards will be applied . . . to assure each child in foster care . . . of a dispositional hearing" within 18 months. 42 U.S.C. sec. 675(5)(C) (emphasis added). This language indicates a clear intent to benefit the children. The language following this assurance of timely dispositional hearings bolsters this conclusion by spelling out that such a hearing could bring about various outcomes--including the return of the foster child to the parent. Id. Under the plain language of the provision, then, it is difficult to conclude that Congress intended section 675(5)(C) to benefit foster parents such as the Procopios, particularly when the application of the provision presumably operates against the foster parents' interest in some instances. /10/ Even though enforcement of the timely hearing requirement may have benefited the Procopios in this particular case, such a

conclusion is speculative and that potential benefit was not Congress's focus in section 675(5)(C). See 42 U.S.C. sec. 670 (stating that the statute was enacted "(f)or the purpose of enabling each State to provide, in appropriate cases, foster care and transitional independent living programs for children") (emphasis added); cf. Artist M., 112 S. Ct. at 1367 (referring to the "child beneficiaries" of the Adoption Act).

But we need not base our decision on a definitive conclusion that section 675(5)(C) was not intended to benefit the foster parents. For even if it could be so construed, the provision cannot overcome the second hurdle for establishing a federal right enforceable under section 1983 in light of this circuit's recent interpretation of Artist M.'s effect on existing precedent on this issue. Under the Wilder framework, once the court perceives an intended benefit, the provision still does not create an enforceable right if the statute "reflects merely a congressional preference for a certain kind of conduct rather than a binding obligation on the governmental unit." Wilder, 496 U.S. at 509, 110 S. Ct. at 2517. Wilder held that the Boren Amendment to the Medicaid Act--an Act that, like the AACWA, required each state that sought federal reimbursement for costs to submit a plan describing the state's program--created substantive federal rights enforceable under section 1983. Id. at 2525. Notwithstanding Wilder, Artist M. seemed to hold that the AACWA provision does not create such enforceable rights in part because the requirement it imposes on the states "only goes so far as to ensure that the State have a plan approved by the Secretary which contains the . . . listed features." 112 S. Ct. at 1367. /11/

If Artist M.'s effect on Wilder's approach was unclear, this court's broad interpretation of Artist M. in the recent case of Clifton v. Schafer, 969 F.2d 278 (7th Cir. 1992), left little doubt that the Procopios' federal statutory argument is thwarted by Artist M.'s modified application of the Wilder scheme. Clifton held that a federal regulation providing for continuing payment of welfare benefits pending a hearing did not give rise to section 1983 liability because the statutory provision, like that in Artist M., "does not explicitly require continuing reimbursement pending a hearing," but instead "requires only that the state adopt a plan" providing for such requirements. Id. at 284.

As the Clifton court acknowledged, Artist M. also emphasized the vagueness of the AACWA provision at issue in that case; the provision at issue in Clifton, on the other hand, was admittedly "not nebulous and variable from case to case." Id. Downplaying that aspect of Artist M. as merely the Court's way of distinguishing Wilder, /12/ the Clifton court based its holding on Artist M.'s understanding of the binding nature of the provisions asserted. Under that approach, the provision at issue in Clifton conferred only the right to a plan complying with the requirements, not a right to challenge any deviation from those requirements. Because the plan itself was concededly legal, the plaintiff had no right enforceable under section 1983. Id. at 284-85. For better or for worse, then, under the authority of this circuit, Artist M. precludes the Procopios' federal statutory claim. /13/

It is somewhat unclear from the Procopios' brief whether they also argue that section 675(5)(C) of the AACWA is itself the source of a liberty interest

the deprivation of which requires due process. /14/ To the extent the Procopios make such an argument, it necessarily must fail. In a different context, this court has noted the fundamental logical flaw in viewing the process as a substantive end in itself. "If a right to a hearing is a liberty interest, and if due process accords the right to a hearing, then one has interpreted the Fourteenth Amendment to mean that the state may not deprive a person of a hearing without providing him with a hearing. Reductio ad absurdum." Shango v. Jurich, 681 F.2d 1091, 1101 (7th Cir. 1982). As the Supreme Court has made clear, a liberty interest is a substantive interest and "(p)rocess is not an end in itself." Olim v. Wakinekona, 461 U.S. 238, 250 (1983); see also id. at 250 n.12 (further noting that "an expectation of receiving process is not, without more, a liberty interest protected by the Due Process Clause"); Fleury v. Clayton, 847 F.2d 1229, 1231 (7th Cir. 1988) ("There is neither a 'liberty' nor a 'property' interest in procedures themselves."); Brandon v. District of Columbia Bd. of Parole, 823 F.2d 644, 648 (D.C. Cir. 1987) (stating that "the notion that naked process itself takes on constitutional dimensions has most troublesome implications"); Yale Auto Parts, Inc. v. Johnson, 758 F.2d 54, 58 (2d Cir. 1985) (stating that the mere existence of reasonable procedures entitling one to a hearing does not give rise to an independent substantive liberty interest). We likewise conclude that under the circumstances of the case before us, the procedural guarantees embodied in section 675(5)(C) of the AACWA do not give rise to a constitutional liberty interest.

Because we hold that the Procopios have not established that state or federal law creates a liberty interest in Ashley's foster family relationship, we need not consider whether the procedures the state afforded them were constitutionally adequate.

III.

Although the Procopios' plight is a sympathetic one, their long-term foster relationship with Ashley does not create an interest within the Fourteenth Amendment's protection of liberty, and the federal Adoption Act does not confer on them an enforceable right to a timely hearing under section 1983. For the foregoing reasons, we AFFIRM the ruling of the district court.

FOOTNOTES

/*/ The Honorable Barbara B. Crabb, Chief Judge of the United States District Court for the Western District of Wisconsin, is sitting by designation.

'Footnotes For The Majority Opinion'

/1/ The Illinois Appellate Court explains in great detail the circumstances surrounding Ashley's birth and early upbringing. See In the Interest of A hley K., 571 N.E.2d 905 (Ill. App. 1 Dist.), appeal denied, 580 N.E.2d 115 (1991).

/2/ Despite having visiting privileges, Ashley's mother and father saw her on only seven occasions during 1985. In 1986, they visited her only twice, although at least 16 appointments for visitation were scheduled.

/3/ The Illinois Appellate Court reversed the juvenile court and ordered a new hearing on Ashley's custody. Ashley K., 571 N.E.2d at 924, 930. The court held that the circuit court order transferring custody of Ashley to her biological mother and father was "palpably against the manifest weight of the evidence and an abuse of discretion, and must be reversed," id. at 924, and ordered that the circuit court base its decision regarding Ashley's custody "solely on the best interest of Ashley." Id. at 930. On remand--more than two years after Ashley had been moved to her biological parents' home--permanent custody was again granted to them.

/4/ Section 1983 provides a federal cause of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution and (federal) laws." 42 U.S.C. sec. 1983.

/5/ Smith found it unnecessary to resolve the question because the procedures employed by the state were adequate to protect whatever liberty interests the plaintiffs might have. 431 U.S. at 856. The Court did note, however, that "(w)hatever liberty interest might otherwise exist in the foster family as an institution, that interest must be substantially attenuated where the proposed removal from the foster family is to return the child to his natural parents." Id. at 847.

/6/ However imprudent or unauthorized any of the defendants' assurances to the Procopios may have been, we do not believe such promises transform the Procopios' expectation of adopting Ashley into an entitlement. Such a liberty interest derives from state law; the defendants' promises were not supported by state law, and certainly not in any "explicitly mandatory language." See Thompson, 490 U.S. 454, 463 (1989) (noting that a state creates a liberty interest when it uses "explicitly mandatory language" requiring a specific outcome under certain conditions).

/7/ The statement provides:

> Purpose and policy. (1) the purpose of this Act is to secure for each minor subject hereto such care and guidance, preferably in his or her own home, as will serve the moral, emotional, mental, and physical welfare of the minor and the best interests of the community; to preserve and strengthen the minor's family ties whenever possible, removing him or her from the custody of his or her parents only when his or her welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and, when the minor is removed from his or her own family, to secure for him or her custody, care and discipline as nearly as possible equivalent to that which should be given by his or her parents, and in cases where it should and can properly be done to place the minor in a family home so that he or she may become a member of the family by legal adoption or otherwise.

Ill. Rev. Stat. ch. 37, sec. 801-2 (1991).

/8/ Despite the Procopios' repeated suggestion that a timely hearing would have ensured their adoption of Ashley, see, e.g., Appellants' Br. at 31 ("Ashley would be with them today."), their remedy in a successful section 1983 suit directly under the AACWA--if one were permitted--presumably would be procedural rather than substantive. Even in the case of a constitutional violation, the Supreme Court has confirmed that the denial of procedural due

both. See, e.g., Appellants' Br. at 4 (stating that "the Procopios' interests also derive from the (AACWA)" and noting that if a timely hearing had been held, they "certainly would have concluded the adoption of Ashley"); id. at 27 (noting that section 1983 authorizes "constitutional claims based upon federal entitlements"); Appellants' Reply Br. at 22 (stating that the AACWA "supports the Procopios' claim that due process was violated by the failure to hold a timely dispositional hearing).