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What will Happen to Granny? Ageism in America: Allocation of Healthcare to the Elderly & Reform Through Alternative Avenues

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COMMENTS

WHAT WILL HAPPEN TO GRANNY? AGEISM IN AMERICA: ALLOCATION OF HEALTHCARE TO THE ELDERLY & REFORM THROUGH ALTERNATIVE AVENUES

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I hate the men who would prolong their lives
By foods and drinks and charms of magic art
Perverting nature's course to keep off death
They ought, when they no longer serve the land
To quit this life, and clear the way for youth.

Euripides, 500 B.C.[1]

I. THE HEALTHCARE DILEMMA: AN INTRODUCTION

Thelma Vette, a 102-year-old resident of Littleton, Colorado, loves to take her roll of nickels and go gambling—something she could not have done had she not had a knee replacement when she

1. Margaret P. Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, *in* SHOULD MEDICAL CARE BE RATIONED BY AGE? 69 (Timothy M. Smeeding ed., 1987). "These lines express a view again stirring controversy: that the elderly who are irreversibly ill, whose lives can be continued only with substantial medical support, ought not to be given treatment; instead, their lives should be brought to an end . . . that they 'have a duty to die.'" *Id.*; *see also* Claire Andre & Manuel Velasquez, *Aged-Based Healthcare Rationing*, 3 ISSUES IN ETHICS no. 3 (1990), http://www.scu.edu/ethics/publications/iie/v3n3/age.html (last visited Jan. 30, 2010) ("Has the time come when we decide that prolonging the lives of the elderly who 'no longer serve the land' is truly a burden on the youth of society? Is the day of rationing our nation's health care services on the basis of age close at hand? As the ranks of the elderly swell, and demands on the nation's scarce healthcare resources increase, the once whispered suggestions that healthcare should be rationed by age are now growing audible.").

was 100 years of age.[2] In the words of Euripides, Thelma has "kept off death" and enhanced life through multiple hip transplants. Some who read this may stop and ask, "Should Thelma have been entitled to her third joint replacement surgery at such an old age?" After all, American healthcare is a limited resource.[3] In recent decades, the growth of healthcare spending in the United States has "far exceeded" the growth of Gross National Product.[4] For this reason, there is an ongoing debate about how best to allocate the finite resource of healthcare.

As the "baby boomer" generation grows older and reaches the age of eligibility for Medicare, there will likely be a need to ration this finite resource. Allocation of resources away from the elderly has reemerged as a possibility.[5] Should doctors refuse to operate on those like Thelma who are elderly but healthy and instead require a "cut off" where seniors who are over a certain age are denied certain medical options? Or is this allocation already taking place among elderly populations through implicit or hidden rationing?[6] Is this a form of ageism[7] or discrimination, or is it a necessity?

To answer these questions, it may first be necessary to ask why the elderly have become the "target" of healthcare reform in recent years. Few scholars would challenge the proposal that healthcare reform is needed, but are there different and perhaps better avenues for eliminating wasteful spending on healthcare so that allocation—or at least allocation away from the elderly—is not a necessity? If healthcare allocation is inevitable, "it must be done fairly and

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2. JoNel Aleccia, *Surgery in the Super Old: Success at What Price?*, MSNBC, http://www.msnbc.msn.com/id/28282424 (last updated Dec. 18, 2008).

3. *See* George P. Smith, II, *The Elderly and Healthcare Rationing*, 7 PIERCE L. REV. 171, 176 (2009).

4. Stefan Felder, *Costs of Dying: Alternatives to Rationing*, 39 HEALTH POL'Y 167, 168 (1997).

5. *See generally* Andre & Velasquez, *supra* note 1.

6. *See generally* Marshall Kapp, *Rationing Health Care: Legal Issues and Alternatives to Age-Based Rationing*, *in* SET NO LIMITS: A REBUTTAL TO DANIEL CALLAHAN'S PROPOSAL TO LIMIT HEALTH CARE FOR THE ELDERLY 80 (Robert L. Barry & Gerard V. Bradly eds., 1991); *see also infra* Part II.

7. "Ageism" is "prejudice or discrimination against a particular age-group and especially the elderly." MERRIAM WEBSTER DICTIONARY, http://www.merriam-webster.com/dictionary/Ageism.

efficiently" for all.[8] Although much of the healthcare system is privately financed,[9] this Comment will concentrate on the allocation of public resources, discussing how healthcare reform may lead to the rationing of medical services to seniors. Just as millions of baby boomers begin joining the ranks of those on Medicare, the Medicare program itself faces almost a half trillion dollars in cuts over the next ten years.[10] How can Medicare provide adequate care for all the new arrivals while implementing such major cuts to the program? It seems apparent that the medical needs of a graying population will not be met without restricting access to treatment in some manner.

This Comment will focus on whether the new legislation passed in March of 2010, the Patient Protection and Affordable Care Act (PPACA),[11] will have a positive or negative impact on those who rely on Medicare and whether this tide of change is impacting America's elderly in a positive or a negative way. It will begin with a discussion of healthcare rationing—both explicit and implicit. Part II will compare programs which explicitly ration—specifically the National Health Service in the United Kingdom and the state of Oregon's Medicaid system—to show the effects of rationing. This Comment will then review the dire financial state of the Medicare system in Part

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8. *See* Daniel Strech et al., *Are Physicians Willing to Ration Healthcare? Conflicting Findings in a Systematic Review of Survey Research*, 90 HEALTH POL'Y 113, 114 (2009).

9. Peter Singer, *Why We Must Ration Healthcare*, N.Y.TIMES, July 19, 2009, at MM38, *available at* http://www.nytimes.com/2009/07/19. It is argued that the healthcare system has been implicitly rationed for years based on wealth: "The state of the health insurance system and indeed, the health care system in America today is, in large part, the result of the choice, whether conscious or negligent, to ration health care by price and wealth." Susan Adler Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 312 (2003).

10. *Health-Care Overhaul Proposals*, WALL ST. J. (Mar. 22, 2010), http://online.wsj.com/public/resources/documents/st_healthcareproposals_20090912.html. *See also* Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare & Medicaid Servs., to Policymakers on the Estimated Financial Effects of the "Patient Protection and Affordable Care Act" 4 (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (estimating the new health law cuts $575 billion from Medicare).

11. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 129).

III. Part IV will analyze several areas in which new legislation could potentially lead to resource allocation away from seniors—through the use of comparative effectiveness research and the Independent Payment Advisory Board. Section V will review the current state of law regarding the constitutionality of rationing healthcare to the elderly and any legal recourse seniors may have. Finally, in addition to legal reform, a list of proposals will be put forth for implementing healthcare reform that will neither discriminate against seniors nor force the elderly to bear the burden of financing healthcare reform. It is the hope of this Author that these recommendations are heeded so that the practice of rationing healthcare to the elderly—either explicitly or implicitly—will be avoided.[12]

A. Arguments for and Against Rationing: An Introduction

Healthcare rationing, also known as healthcare allocation or healthcare discrimination, has no universally accepted definition. Rationing has been defined as "denying individuals what all would agree is beneficial healthcare—albeit what is judged from some larger social point of view to be marginally beneficial, non-cost worthy healthcare."[13] Rationing or allocation has also been described as

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12. KEITH SYRETT, LAW, LEGITIMACY, AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE 45-50 (2007). There are many different types of rationing:

1) To ration by price ("restricting medical services to those with the ability to pay for them")
2) To ration by denial ("[T]his consists of a decision not to approve a particular beneficial medical treatment either to an individual . . . or to a group . . . .")
3) To ration by selection (which "amounts to an outright exclusion for access to a particular treatment"), or to ration by delay ("This technique finds expression in one of the most common features of publicly funded health systems, the waiting list, which applies particularly, though not exclusively, to cases of elective surgery.")
4) To ration by dilution ("which consists of a reduction in the quantity and/or quality of services provided")
5) To ration by termination ("which refers simply to the premature withdrawal of treatment, for example by discharge from hospital earlier than might be thought to be medically advisable") *Id.*

13. Leonard M. Fleck, *Last Chance Therapies: Can a Just and Caring Society Do Health Care Rationing When Life Itself is at Stake?*, 2 YALE J. HEALTH POL'Y L.

"withholding beneficial interventions for cost reasons."[14] Ethicist Daniel Callahan has explained that rationing is an action undertaken when there is recognition that resources are limited; and when faced with scarcity, a method must be devised to allocate those resources fairly and reasonably.[15] Allocating healthcare may involve setting limits as to what treatments should be paid for by the government.[16] In analyzing this issue, the question arises whether it is equitable, or just, to impose such limits on an entire group of people such as the elderly.

In many ways, medical resource allocation is not a new phenomenon in the United States. In fact, many healthcare analysts argue that allocation of healthcare to the elderly has already taken place.[17] For example, older patients are less likely than their younger counterparts to receive preventive care treatments and are less likely to be tested or screened for illnesses or diseases.[18] Older people are usually denied participation in clinical trials, even though they often comprise the largest group using approved drugs.[19] It is in the elderly age group where concerns about healthcare allocation—either implicit

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& ETHICS 255, 256 (2002). To "ration" means to "supply with or put on rations . . . equitably." MERRIAM WEBSTER DICTIONARY, http://www.merriam-webster.com/dictionary/rationing. This implies that goods are denied to those who can afford to buy them if they want more than their equitable share. This is the form of rationing Americans faced during World War II. *See* Trisha Torrey, *What is Healthcare Rationing? From Denial of Care to Healthcare Reform, Rationing is a Consideration*, ABOUT.COM (Oct. 16, 2008), http://patients.about.com/od/patientempowermentissues/a/rationing.htm. The issue for the United States has been whether healthcare should be rationed explicitly and/or implicitly or addressed through other non-rationing means.

14. Strech et al., *supra* note 8, at 114. Philosopher Peter Singer states, "In the current U.S. debate over healthcare reform, 'rationing' has become a dirty word. Meeting . . . with five governors, President Obama urged them to avoid using the term, apparently for fear of evoking the hostile response that sank the Clintons' attempt to achieve reform." Singer, *supra* note 9.

15. Daniel Callahan, *Symbols, Rationality, and Justice: Rationing Healthcare*, 18 AM. J. L. & MED. 1, 6 (1992).

16. Singer, *supra* note 9.

17. Clare M. Clarke, *Rationing Scarce Life-Sustaining Resources on the Basis of Age*, 35 J. ADVANCED NURSING 799, 799 (2001).

18. *Seniors Discriminated Against by Healthcare System, Says Alliance For Aging Research*, SENIORJOURNAL (May 19, 2003), http://seniorjournal.com/NEWS/Health/3-05-19healthcare.htm.

19. *Id.*

or explicit—typically arise.

II. IMPLICIT & EXPLICIT RATIONING: A COMPARATIVE CASE STUDY

There are two types of rationing—implicit and explicit. One example of implicit rationing is rationing done at the individual clinical level—the level of physician and patient.[20] Oftentimes, implicit rationing is inevitable because of budgetary constraints.[21] Other examples of implicit rationing are long waits for transplants and high patient copayment requirements.[22] This form of rationing occurs frequently and currently in our healthcare system.[23] On the other hand, explicit rationing is "rule-based," taking into account such criteria as the severity of the disease and the cost-effectiveness of health policy.[24] This form of rationing is typically made at a macro—as opposed to micro—physician-patient level.[25] Regardless of the form of rationing, the elderly are prime targets for resource allocation for a number of reasons.

There are three arguments that are typically raised by anti-rationing and pro-rationing-by-age scholars: (1) the "equal worth" argument, (2) the "fair innings" argument, and (3) the "prudential life span" argument.[26] The "equal worth" contention, advanced by anti-

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20. Strech et al., *supra* note 8, at 114. Another such example of implicit rationing is the "Do Not Resuscitate" order. *See* Ivy Lynn Borgeault et al., *Everyday Experiences of Implicit Rationing: Comparing the Voices of Nurses in California and British Columbia*, 23 SOC. HEALTH & WELLNESS 633, 641 (2001). "Rationing occurs when factors beyond the patients' interests or autonomy are figured into a treatment decision." John G. Francis & Leslie P. Francis, *Rationing of Health Care in Britain: An Ethical Critique of Public Policy-Making*, *in* SHOULD MEDICAL CARE BE RATIONED BY AGE? 119-20 (Timothy M. Smeeding ed., 1987).

21. Strech et al., *supra* note 8, at 114.

22. David Gratzer, *Canada's ObamaCare Precedent*, WALL ST. J., June 9, 2009, at A19, *available at* http://online.wsj.com/article/SB124451570546396929.html; *see also* Singer, *supra* note 9.

23. *See* Peter A. Ubel, *Time for Physicians to Take the Lead in Health Care Rationing*, 4 GERIATRIC TIMES 30, 30 (2003).

24. Strech et al., *supra* note 8, at 114.

25. *Id.*

26. Clarke, *supra* note 17, at 800-02. For a further comparison of these approaches, see Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 5 & n.4 (2001).

rationing scholars, claims that every person, no matter the age, has a life worth living, and treating the young and old differently is fundamentally unfair and morally objectionable.[27] In contrast, the "fair innings" argument advocates allocation by age, claiming that younger generations should be given priority because the elderly have already lived a full life—it is only "fair" to give the young that same opportunity.[28] Likewise, the "prudential life span argument" supports rationing by age in certain instances.[29] According to this view, rationing healthcare by age is not inherently discriminatory because all humans grow old and will experience rationing at some point.[30] Such arguments have found their way into the philosophical arena and have influenced both supporters and opponents of age-based healthcare rationing. In order to formulate alternatives to rationed care, it is first important to assess the arguments from both those who advocate and those who oppose age-based healthcare allocation.

A. Advocates for Age-Based Healthcare Allocation

The philosophical line of thinking that promotes rationing of care is Utilitarianism. Utilitarians seek to maximize the greatest benefits to the greatest number of people in society.[31] The Utilitarian approach to medical care is one measured by "social worth" or "benefit."[32] In other words:

> If society must choose to save one life in favor of another, it may be justified in considering the services to society the person has rendered or can be expected to offer .... After all, those who subscribe to social worth principles would say, society is investing a scarce resource in whoever receives it, and it ought to achieve the

27. Clarke, *supra* note 17, at 800-01.

28. *Id.*

29. *Id.* at 803.

30. *Id.*

31. LEIYU SHI & DOUGLAS A. SINGH, DELIVERING HEALTH CARE IN AMERICA, A SYSTEMS APPROACH 60 (4th ed. 2008).

32. Bradley Southern, *Medicare's End-Stage Renal Disease Program: Its Development and Implications for Health Care Policy*, 26 HARV. J. ON LEGIS. 225, 253 (1989); *See generally* GEORGE P. SMITH II, DISTRIBUTIVE JUSTICE AND THE NEW MEDICINE (2008).

maximum benefits possible.[33]

If the use of scarce resources will not be beneficial to a particular patient, Utilitarian reasoning suggests scarce resources should not be used on that patient. Because the elderly have a smaller remaining lifespan than the rest of the population, they would be less likely to receive medical benefits, such as dialysis, under the Utilitarian rationale.

Certain scholars in favor of rationing care have promoted limiting medical treatment for the elderly.[34] As a growing sector of the American population, the elderly consume much of the nation's healthcare resources. For instance, it is estimated that healthcare costs for an American senior citizen in his or her last year of life are approximately $30,000.[35] When the government decides which healthcare programs will be reimbursed with public funding, it is implicitly placing a dollar value on human life.[36] Therefore, the government is looking to get the best value for its resources. An example of this implicit rationing occurs when the government will pay for a generic but not a brand-name drug.

Advocates of healthcare rationing, however, often propose resource allocation away from the elderly as a means of saving resources. For instance, philosopher Peter Singer asserts:

> The death of a teenager is a greater tragedy than the death of an 85-year-old, and this should be reflected in our priorities. We can accommodate that difference by calculating the number of life-years saved, rather than simply the number of lives saved. If a teenager can be expected to live another 70 years, saving her life counts as a gain of 70 life-years, whereas if a person of 85 can be expected to live another 5 years, then saving the 85-year-old will count as a gain of only 5 life-years. That suggests that saving one teenager is equivalent to saving 14 85-year-olds.[37]

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33. Southern, *supra* note 32, at 253-54.

34. *See, e.g.*, DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 116 (1987).

35. Felder, *supra* note 4, at 171.

36. Singer, *supra* note 9.

37. *Id.* "The shift to a rationing decision occurs when considerations come into play about how resources could be used elsewhere—when the talk moves to how

In other words, these advocates posit that society would have a greater benefit from a healthcare system targeting younger generations rather than senior citizens. Daniel Callahan, mentioned above, has been a long-time proponent of rationing healthcare to the elderly. Callahan contends that for universal healthcare to succeed, it must be affordable.[38] In order for it to be affordable, we have to ration.[39] Callahan, and those who support his rationale, advocate that allocating healthcare resources away from the elderly fulfills the Utilitarian goal of promoting the greatest good for the greatest number of people.[40] These rationing proponents contend that such an allocation of resources away from the aged would decrease costs dramatically because it is often the older age groups who have complicated medical conditions that require expensive treatments and cutting-edge technologies.[41] In other words, the costs incurred by treating the senior population would be more productively directed toward treating younger people who incur less costly measures.[42] In fact, Callahan would go so far as to contend that no medical research funds for prolonging life should be allocated to people over a certain age.[43]

Proponents of age-based allocation also argue that healthcare is currently skewed toward the elderly with roughly $9,000 spent on every elderly person per year and only $900 spent per child each year in the U.S.[44] This reasoning contends that by the age of seventy and

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another patient might make better use of an intensive care unit bed." Francis & Francis, *supra* note 20, at 120.

38. Callahan, *supra* note 15, at 2.

39. *Id.*

40. *See generally* Raphael Cohen-Almagor, *A Critique of Callahan's Utilitarian Approach to Resource Allocation in Health Care*, 17 ISSUES L. & MED. 247, 247 (2002).

41. *Id.* at 251-53; Andre & Velasquez, *supra* note 1.

42. Andre & Velasquez, *supra* note 1.

43. CALLAHAN, *supra* note 34, at 116. Ironically, Callahan, at 79 years of age, recently underwent $80,000 worth of medical treatment for a heart condition. Beth Baker, *Ethicist Callahan: 'Set Limits' On Healthcare*, KAISER HEALTH NEWS (Dec. 10, 2009), http://localhealthguideonline.com/should-healthcare-for-the-elderly-be-rationed.

44. Andre & Velasquez, *supra* note 1. There are many theories for this disparity. Some say it is because the elderly can vote. *See generally* Dick Morris, *Elderly Lead Opposition on Obama Healthcare*, THE HILL (July 28, 2009), http://thehill.com/opinion/columnists/dick-morris/52425-elderly-lead-opposition-on-

beyond, people have lived out their natural life spans and therefore should be excluded from treatments that would extend their lives at the expense of the young who have not yet lived out a normal life span.[45]

Callahan and pro-rationists justify limiting Medicare and Medicaid to the elderly "for acute medical treatments oriented primarily toward extending life for persons who already have lived a 'normal life span,' which Callahan deem[s] to be somewhere around age eighty."[46] In other words, instead of finding a cure for a senior's ailment, Callahan supporters would advocate only palliative treatment that alleviates ailments temporarily and provides comfort as the senior moves "towards a decent 'tolerable death.'"[47]

As healthcare reform transitions from being an idea to a reality, this pro-rationing Euripidean approach should not be part of the reform's framework. Better alternatives are available to reduce costs—alternatives consistent with philosophical, legal, and medical theories and practices that will cut waste and save Americans money. Instead, our philosophical outlook should mirror those who oppose such allocation. To support this premise, it is imperative to evaluate the line of thinking that opposes age-based rationing of healthcare. Such an assessment should serve well to facilitate the development of alternative ethical solutions to the rationing dilemma.

B. Opponents of Age-based Rationing of Healthcare

Arguments against age-based rationing of healthcare are varied, ranging from an ethical perspective to a political one, to name a few. Unlike the Utilitarian philosophy of the greatest good for the greatest number,[48] Egalitarians claim that all persons are fundamentally equal.[49] Under Egalitarianism, if a good is not available to all of society, then it is only fair to distribute it through a lottery or on a

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obama-healthcare.

45. Andre & Velasquez, *supra* note 1.

46. Marshall B. Kapp, *De Facto Health Care Rationing by Age: The Law Has No Remedy*, 19 J. LEGAL MED. 323, 325 (1998).

47. *Id.*

48. *See* SHI & SINGH, *supra* note 31, at 60.

49. CHARLES J. DOUGHERTY, AMERICAN HEALTH CARE—REALITIES, RIGHTS, REFORMS 54 (1988).

first-come, first-served basis.[50] Under this type of reasoning, all persons—irrespective of age—would have an equal chance to receive medical treatment, either when their number is chosen or when their name moves to the top of the list.[51] This rationale ignores the reality that healthcare should be available to those who need it most— those whose current condition is most desperate.[52] This line of thinking, however, is somewhat more beneficial to seniors than Utilitarianism, as the elderly would have the same chance to healthcare as younger generations.

The social justice argument provides another view on allocation of healthcare. Social justice is typically defined as the "[f]air and proper administration of laws conforming to the natural law that all persons, irrespective of ethnic origin, gender, possessions, race, religion, etc., are to be treated equally and without prejudice."[53] People's lives are priceless at any age and determining how best to eliminate waste in the healthcare system should not become "an intergenerational contest."[54] Social justice philosophers support intergenerational reciprocity as opposed to conflict.[55] Such policy

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50. Kelli D. Back, *Rationing Health Care: Naturally Unjust?*, 12 HAMLINE J. PUB. L. & POL'Y 245, 252 (1991).

51. *Id.* In this way, Egalitarianism avoids favoritism, bias and influence, but it is arbitrary in its approach. *Id.*

52. *Id.*

53. BUSINESS DICTIONARY, http://www.businessdictionary.com/definition/social-justice.html (last visited Dec.8, 2010).

54. Patricia Lanoie Blanchette, *Age-based Rationing of Healthcare*, 54 HAWAII MED. J. 507 (1995), *reprinted in* 20 GENERATIONS 60, 60 (1996). Those against the rationing scheme proposed by Callahan propose the following extreme hypothetical to show that rationing is an "unworkable proposal":

> *Dr. Bob:* I am sorry, Mrs. Smith, but we cannot insert a gastrostomy tube to feed you because you are seventy-nine years old and you do not qualify for this sort of care. We will give you pain killers and ice chips to keep you comfortable as you starve and dehydrate to death.
>
> *Mrs. Smith:* But, Doctor, I can pay for this. You have the devices, the surgical suites, and the staff available to do this. I will die if you do not perform this simple procedure.

Robert L. Barry, *Mandatory, Universal Age-Based Rationing of Scarce Medical Resources*, *in* SET NO LIMITS: A REBUTTAL TO DANIEL CALLAHAN'S PROPOSAL TO LIMIT HEALTH CARE FOR THE ELDERLY 11 (Robert L. Barry & Gerard V. Bradley eds., 1991).

55. Ann Neale, *American Values and Social Justice: Who Should Pay for*

recognizes "the necessity for a balance between the particular needs of older people and the social needs of all society."[56] Social justice philosophers view Social Security and Medicare as contracts for the common good and believe that all society will benefit from their continued support.[57]

Norman Daniels, ethicist and Harvard professor, has made great efforts to rebut Callahan and those who support his pro-rationing stance.[58] Daniels believes that by keeping people close to normal functioning, healthcare preserves their ability to participate in the political, social, and economic life of their society.[59] This assertion relies on the belief that senior citizens' Medicare needs should not be ignored because they can continue to be valuable members of society. It is morally right to assert that the elderly should continue to be a viable part of society for as long as possible.[60]

Furthermore, simply taking a cost-benefit approach to healthcare ignores other aspects that are equally important, such as distributive justice and human rights. The mere fact that the aged have reached a ripe lifespan does not mean their fundamental dignity should be compromised. Those promoting this line of reasoning contend that if the goal is to be more cost efficient, "then we ought to deny treatment to all patients whose prognosis indicates a short life span, chronic illness, or little likely improvement in the quality of life, rather than denying treatment simply on the basis of age."[61]

Opponents of rationing healthcare to seniors see Callahan's rationale as the elderly handing "the world over to the next generation and then step[ping] aside."[62] Marshall Kapp, Professor of Law and Medicine at Southern Illinois University, forecasts that following a Callahan approach of age-based healthcare rationing would have broad and negative social, ethical, and legal ramifications.[63] For

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Elders' Income and Healthcare Security?, 29 GENERATIONS 88, 89 (2005).

56. *Id.*

57. *Id.*

58. *See generally* NORMAN DANIELS & JAMES E. SABIN, SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES? (2002).

59. Daniels, *supra* note 26, at 3.

60. *Id.*

61. Andre & Velasquez, *supra* note 1.

62. Kapp, *supra* note 46, at 325.

63. *Id.* "[T]hese rationing proposals . . . have been attacked broadly and

instance:

> Arguments . . . over age-based rationing are predicated on the proposition that the elderly have special needs for health care, that society has special duties to the elderly, and that singling out the older population for less advantageous treatment in the health-care marketplace constitutes a malicious form of invidious discrimination. Among other things, it is claimed that overt age-based rationing would label the elderly as scapegoats and symbolically devalue them socially. Such a policy would send a negative public message about the old and also might have deeper implications for the attitudes of young people toward their futures and toward their aging family members. It would reinforce prevalent biases about the negative social worth of the elderly.[64]

Clearly, some of the economic factors discussed may help explain why many believe the U.S. should spend fewer healthcare dollars on a senior citizen than on a younger person.[65] But medical personnel and healthcare policy must be careful not to deny care on the basis of age in a manner that is disguised as cost containment.[66] Such decisions should instead focus on a patient's ability to function, his or her general health status, and the benefits of acute care—exclusive of factoring in age. As healthcare reform begins to take form, it is imperative for the U.S. to look to its states and other countries as comparative case studies in order for the U.S. to better execute a successful model nationwide.

C. Explicit Rationing: A Case Study from the United Kingdom

In formulating a better healthcare system, the U.S. can learn from the mistakes of other nations. Since its inception in 1948, Great Britain's National Health Service (NHS) has grown to become one of the largest publicly-funded health services in the world.[67] This

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vehemently on social, ethical, and legal grounds." *Id.*

64. *Id.* at 326-27.

65. *Id.* at 330.

66. *See* MARK R. WICCLAIR, ETHICS AND THE ELDERLY 80 (1993) ("Rationing should be distinguished from cost-containment measures that merely result in withholding medical services that are of no expected benefit to patients.").

67. *About the NHS: Overview*, NAT'L HEALTH SERVICE, http://www.nhs.uk/

organization covers everything from prenatal screening to end-of-life care, as well as from treating the common cold and flu to performing heart bypass surgery.[68] The British healthcare program employs more than 1.7 million people and treats a population of over 51 million.[69] Due to the massive size and longevity of this health system, the NHS serves as a relevant case study for its American counterpart.

Like its neighbor across the Atlantic, the United Kingdom has been embroiled in various debates over how and when to ration healthcare. When kidney dialysis first became available in the 1960s, British citizens over the age of 50 were denied such life-saving treatment[70]—a fact not welcomed by those who experienced this explicit age-based rationing. As recent as May 2008, a similar dispute arose over a research study that determined it would "be too expensive to keep some British people with kidney cancer alive."[71] In assessing the effectiveness of four new treatments directed at kidney cancer, this 290-page report reasoned that patients could benefit from such treatments; however, the price of the prescription medicine led the report to conclude the drug treatments should not be recommended as a viable option for cancer patients.[72] Such controversial recommendations force Britain's National Institute for Health and Clinical Excellence (NICE),[73] the body that decides which medical treatments the country can afford, to make some very difficult choices, which in actuality often determine who is to live and who is to die. By denying access to necessary drugs and treatments for those patients who would substantially benefit from them, Great Britain continues to engage in explicit healthcare rationing.

NICE was created with the primary purpose of collecting data and constructing models in an attempt to analyze the quality and cost of extending treatment to a patient.[74] In a move equally controversial to

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NHSEngland/thenhs/about/Pages/overview.aspx (last visited Jan. 30, 2010).

68. *Id.*

69. *Id.*

70. Jennifer Stanton, *The Cost of Living: Kidney Dialysis, Rationing, and Health Economics in Britain, 1965-1996*, 49 SOC. SCI. & MED. 1169, 1170 (1999).

71. Daniel Cressey, *Life in the Balance*, 461 NATURE 336, 336 (2009).

72. *Id.*

73. *Id.*

74. *Id.* at 337.

that prompted by the kidney-cancer report, NICE restricted access to popular drugs for treating Alzheimer's, including Aricept, for dementia patients.[75] To reach the findings behind such a move, NICE research teams analyze the quality of life that a treatment buys with the quality of that added time resulting in the "Quality Adjusted Life Year" (QALY)—a measurement often used by health economists.[76] This figure is calculated by multiplying the utility value of a "health state" by the length of time spent in that state.[77] For instance, one year spent in perfect health yields a QALY of one.[78] Such calculations, however, raise the questions of whether one's quality of life can accurately be measured and whether denial of healthcare based on mathematic calculations is a viable option for the U.S.

In short, Great Britain does indeed ration based on age. For years, British physicians have limited medical treatments to the elderly ranging from dialysis to coronary care to hypertension.[79] Additionally, cancer is often treated less aggressively in the United Kingdom if the patient is a senior citizen as opposed to a younger individual.[80] In Great Britain, a set amount of money is allocated to the healthcare sector.[81] Because of the limited amount allocated for healthcare, choices are made with regard to how and for whom the money is spent. As a result, healthcare that may be needed is not provided because there simply is not enough money.[82] As the new health reform law begins to be implemented, the U.S. should learn from Great Britain's struggles as an explicit-rationing country. The American healthcare system can also benefit from studying the state of Oregon's explicit-rationing scheme.

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75. Sue Rugg, *Healthcare Rationing: Goodwill to All?*, 13 INT'L J. THERAPY & REHABILITATION 540, 540 (2006). *See also* Michael Day, *Alzheimer's Sufferers Hit by Further Delay in NHS Approval for Vital Drugs*, TELEGRAPH (Sept. 18, 2005), http://www.telegraph.co.uk/news/uknews/1498612/Alzheimers-sufferers-hit-by-further-delay-in-NHS-approval-for-vital-drugs.html.

76. Cressey, *supra* note 71, at 338.

77. *Id.*

78. *Id.*

79. Kapp, *supra* note 46, at 329-30.

80. *Id.* at 330.

81. Back, *supra* note 50, at 247. This is also the case in Canada. *Id.*

82. *Id.*

D. Will the Federal Government Follow the "Oregon Trail" to Explicit Rationing?

To some extent, Oregon has directly and explicitly attempted to ration healthcare on a state level. In 1989, Oregon passed a bill to extend health insurance to an increased number of residents.[83] The previous year, the Oregon Medicaid Priority-Setting Project was formed to establish certain healthcare services that would be funded by the state for all state citizens who either could not afford private insurance or were not eligible for Medicaid.[84] To ensure this program would remain within affordable limits, the state sought to manage the use of services by patients and doctors. Instead of implicit rationing, Oregon sought explicit allocation where the legislature defined a list of services to be covered; those treatments not on the list were excluded from public coverage.[85]

Among other goals, the plan was created to extend coverage to those with preexisting health conditions who would normally find it difficult to receive health insurance coverage.[86] All employers who do not offer insurance to their employees have to contribute to the state insurance fund or start providing health insurance for their employees.[87] The Oregon Health Plan (OHP) sets limits on services that Medicaid clients are eligible to receive.[88] This program has allowed the state to save enough funds to extend healthcare to an additional 130,000 Oregon citizens, mostly from low-income groups.[89] Allocation under the OHP is based on length of life and quality of life.[90] In essence, this allocation reflects the agreed-upon

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83. Howard M. Leichter, *Oregon's Bold Experiment: Whatever Happened to Rationing?*, 24 J. HEALTH POL. POL'Y & L. 147, 147-48 (1999).

84. Candace Johnson Redden, *Rationing Care in the Community: Engaging Citizens in Health Care Decision Making*, 24 J. HEALTH POL. POL'Y & L. 1363, 1376 (1999).

85. Chris Ham, *Retracing the Oregon Trail: The Experience of Rationing and the Oregon Health Plan*, 316 BRIT. MED. J. 1965, 1965 (1998).

86. Leichter, *supra* note 83, at 149.

87. *Id.*

88. *Id.* at 148.

89. *Id.*

90. *See* Redden, *supra* note 84, at 1376.

design: priority for aggressive care[91] is delegated to those who are young.

For example, a list of services is ranked and those above a certain "line" are to be covered by the state's Medicaid funding.[92] Such "above the line" services are typically those deemed cost-effective in a cost-benefit analysis.[93] Because senior citizens typically have medical conditions that require expensive treatment, much of their services were excluded from public funding.[94] In recent years, public concern has grown in the state about the quality of life for those with disabilities,[95] many of whom are elderly. It is also worthy to note Oregon introduced an employer mandate to ensure basic healthcare packages are available to workers who are not entitled to Medicaid services.[96]

The Oregon Health Plan brought with it much criticism because of the moral and political implications of allocating resources.[97] Ethicists thought the medical benefits package was not adequate, and even considered it "threadbare."[98] In reality, however, physicians have not followed the "list" and Oregon's health plan has widely been considered a failure.[99] Additionally, the OHP has not been successful in its attempts to save the state substantial amounts of money by eliminating certain coverage from public funding.[100] Despite failure, the enactment of the OHP is significant; because some non-life

91. Aggressive care is care that is more comprehensive, intensive or severe than the usual dosage. MEDLINEPLUS, http://www.merriam-webster.com/medlineplus/aggressive (last visited Dec. 15, 2010).

92. Jonathan Oberlander, *Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan*, 164 CANADIAN MED. ASS'N J. 1583, 1585 (2001).

93. *See id.* at 1584.

94. *See generally id.*

95. *Id.* at 1584.

96. Ham, *supra* note 85, at 1965, 1969. "The purpose of the employer mandate was to move towards universal coverage by requiring businesses to offer protection to uninsured people who were working and whose incomes placed them above the federal poverty level." *Id.* at 1965. "The failure to implement the employer mandate means that many people who work and whose incomes are above the federal poverty level still lack coverage in the event of illness." *Id.* at 1969.

97. Leichter, *supra* note 83, at 150.

98. *Id.*

99. *See* Oberlander, *supra* note 92, at 1586.

100. *Id.* at 1585.

threatening conditions are not covered, it represents a departure from the typical American expectation of exercising all options available to the patient.[101] Oregon's pursuit to implement medical coverage for all its citizens has yet to be realized.[102] It will be engaging to follow the impact of the federal government's new healthcare plan on Oregon's state-wide medical system.

Although it appears the recent U.S. healthcare reform is veering away from explicit rationing, implicit rationing is still a concern. Another concern as the plan is launched over the next five years is the sustainability of Medicare—the primary social welfare program for senior citizens in the United States.

III. ECONOMIC HURDLES: SOBERING STATISTICS ABOUT MEDICARE—A ROADBLOCK TO REFORM

So why all the concern now about healthcare rationing? As of 2008, healthcare spending exceeded 1.9 trillion dollars, and comprised over 16% of the U.S. GDP.[103] Spending on healthcare in 2009 was projected to be $2.5 trillion or 17.6% of GDP.[104] Until healthcare reform became law on March 23, 2010, over forty-seven million Americans remained uninsured.[105] The passage of healthcare reform, however, brings with it concerns about Medicare's sustainability. According to the Congressional Budget Office, "The federal budget is on an unsustainable path, primarily because of the rising cost of health

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101. Leichter, *supra* note 83, at 148.

102. Oberlander, *supra* note 92, at 1584. Immediate benefits available to Oregon under the PPACA include closing the Medicare Part D donut-hole and providing a $5 billion temporary early retiree reinsurance program geared towards Oregonians who retire before they are eligible for Medicare. *The Affordable Care Act: Immediate Benefits for Oregon*, HEALTHREFORM.GOV, http://www.healthreform.gov/reports/statehealthreform/oregon.html (last visited Nov. 30, 2010).

103. Ani B. Satz, *The Limits of Health Care Reform*, 59 ALA. L. REV. 1451, 1451-52 (2008).

104. NATIONAL COALITION ON HEALTH CARE, HEALTHCARE FACTS: COSTS 1 (2009), http://nchc.org/sites/default/files/resources/Fact%20Sheet%20-%20Cost.pdf.

105. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE (2009), http://www.kff.org/uninsured/upload/7451.pdf.

care and the aging of the U.S. population."[106] Projected long-run program costs of both Medicare and Social Security do not appear to be sustainable under the current program framework.[107]

Medicare, established in 1965, is an insurance program that provides health and financial security for individuals sixty-five and older and for younger people with permanent disabilities.[108] Currently, Medicare provides health insurance coverage to forty-seven million people—thirty-nine million aged sixty-five and older and another eight million people under the age of sixty-five who have permanent disabilities.[109] Medicare comprises an estimated 12% of the 2010 $3.6 trillion federal budget[110] and 23% of the 2009 $1.9 trillion in national health expenditures.[111]

A critical issue amid this healthcare transition is the trust fund for Medicare Part A, the program that pays for inpatient hospital stays, nursing home stays, and hospice care.[112] Based on estimated savings under the new healthcare reform legislation, it has been projected that the Hospital Insurance trust fund will not be exhausted until 2029, rather than the 2017 date projected under the prior law.[113] These numbers, however, may be deceiving. The trust fund dollars cannot be counted twice—the lower expenditures and higher tax revenues cannot be used to finance the trust fund and to extend coverage to the

106. Scott Hensley, *Health Costs Loom Over Federal Budget*, NPR (Feb. 1, 2010), http://www.npr.org/blogs/health/2010/02/budget_deficit_medicare_medica.html (citing *The Long-Term Budget Outlook*, CONG. BUDGET OFFICE, DIRECTORS BLOG (July 16, 2009, 4:43 PM), http://cboblog.cbo.gov/?p=328).

107. *Social Security & Medicare Boards of Trustees, A Summary of the 2009 Annual Reports*, SOC. SEC. ADMIN., http://www.ssa.gov/OACT/TRSUM/index.html (last modified Aug. 5, 2010).

108. KAISER FAMILY FOUND., MEDICARE: A PRIMER (2010), at 1, http://www.kff.org/medicare/upload/7615-03.pdf [hereinafter MEDICARE: A PRIMER].

109. *Id.*

110. *Id.* at 15.

111. *Id.* Of the other main entitlement programs, Social Security comprises 19% of the 2010 fiscal year's budget. Spending on Medicaid and the Children's Health Insurance Program (CHIP) represents 8% of federal spending. *Id.*

112. KAISER FAMILY FOUND., MEDICARE AT A GLANCE FACT SHEET (2010), http://www.kff.org/medicare/upload/1066-12.pdf.

113. Foster, *supra* note 10, at 5.

non-insured.[114]

A number of factors present fiscal challenges for Medicare. These factors include rising healthcare costs, new expensive medical technology, an aging population, a decline in the number of workers per beneficiary, and an increasing life expectancy.[115] The numbers forecast a bleak future as well: "From 2010 to 2030, the number of people on Medicare is projected to rise from 47 million to 79 million, while the ratio of workers per beneficiary is expected to decline from 3.7 to 2.4."[116] With a crisis looming due to unfunded liabilities[117] of entitlement programs, legislators are scrambling to find ways to contain the ever-increasing, trillions of dollars shortfall in entitlement programs in general and Medicare in particular.[118] Medicare expenditures are projected to rise from 3.5% of GDP in 2010 to 6.4% of GDP in 2030.[119]

Under the 2010 healthcare reform law,[120] both policy and

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114. *Id.* On April 22, 2010, Medicare's Chief Actuary, Richard S. Foster, issued the following cautions regarding President Obama's healthcare reform law: (1) Medicare Part A cuts will threaten the viability of 15% of hospitals that become unprofitable within the next decade. *Id.* at 9-10; (2) The decreases in reimbursement to Medicare providers will challenge their ability to continue to take Medicare patients and make it difficult for them to participate in the program. *Id.* at 10; (3) Healthcare shortages are "plausible and even probable" because of increased demand for healthcare by the additional 34 million insured persons. *Id.* at 20; (4) The new "Medicare Tax" will not go to fund Medicare. The revenues generated by a new tax on unearned income are not allocated to the Medicare trust fund. *Id.* at 9; (5) Budgetary double counting will not improve Medicare's solvency. Medicare cuts cannot be simultaneously used to finance coverage expansion to millions of the uninsured and extend the life of the trust fund. *Id.*

115. MEDICARE: A PRIMER, *supra* note 108, at 19.

116. *Id.* at 19; *see also* CTRS. FOR MEDICARE AND MEDICAID SERVS., ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 63 (2009), www.cms.hhs.gov/reportstrustfunds/downloads/tr2009.pdf.

117. "[U]nfunded liability is the difference between the benefits that have been promised to current and future retirees and what will be collected in dedicated taxes and Medicare premiums. . . . [The] funding gap can only be closed . . . by substantial tax increases, large benefit cuts or both." Pamela Villarreal, *Social Security and Medicare Projections: 2009*, NAT'L CTR. FOR POL'Y ANALYSIS (June 11, 2009), http://www.ncpa.org/pdfs/ba662.pdf.

118. *Id.*

119. *See* MEDICARE: A PRIMER, *supra* note 108, at 19.

120. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-

lawmakers have sought to resolve this ever-burgeoning financial crisis by finding ways to restrain Medicare costs and reduce services, while attempting to cut out the often-referred-to waste in the system. With the projected cuts to the Medicare program of $533 billion,[121] its senior citizen beneficiaries will be subjected to more and more legislative scrutiny and benefit restrictions.[122] As the healthcare plan unfolds from paper to reality over the next decade, such reductions must not become an unfair and inequitable burden upon the shoulders of our senior population at the most vulnerable time in their lives.[123]

IV. ALTERNATIVES TO AGE-BASED RATIONING: THE CHANGING HEALTHCARE SITUATION—AN AVENUE FOR REFORM

A. The Current Climate

The new healthcare reform legislation has become a reality. In February, 2010, President Obama unveiled his healthcare reform proposal and in March, the PPACA, estimated to cost $940 billion, was passed by Congress.[124] It aims to extend health insurance coverage to the majority of uninsured Americans and to guarantee coverage regardless of health status.[125] Over the next several years, the new plan will also expand Medicaid to cover sixteen million more Americans and will ensure that those with preexisting conditions—

148, 124 Stat. 119 (2010) (amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 129).

121. MEDICARE: A PRIMER, *supra* note 108, at 17. Taking into account $533 billion in Medicare savings and $105 billion in new Medicare spending, it is projected that Medicare expenditures will be reduced by $428 billion over the next decade. *Id.*

122. *See* Foster, *supra* note 10, at 8-11.

123. Lawrence R. Huntoon, *Putting Tyrants in Control of Health Care*, ASS'N AM. PHYSICIANS & SURGEONS (Mar. 8, 2010), http://www.aapsonline.org/newsoftheday/00880 ("Government price-fixing in the Medicare program has led to covert rationing of care for Medicare patients and poorer quality care.").

124. *White House Unveils Revamped Reform Plan, GOP and Industry React*, KAISER HEALTH NEWS (Feb. 22, 2010), http://www.kaiserhealthnews.org/Daily-Reports/2010/February/22/President-Obama-Health-Care-Reform-Plan.aspx. *See generally Highlights of Health Care Compromise Bill*, CNN.COM (Mar. 19, 2010), http://www.cnn.com/2010/POLITICS/03/18/health.compromise.highlights/index.html [hereinafter *Highlights of Health Care Compromise Bill*].

125. *See Highlights of Health Care Compromise Bill*, *supra* note 124.

whether elderly or children—receive coverage.[126] It is evident that America will not be following an explicit rationing scheme similar to Oregon; however, implicit rationing will undoubtedly continue. The question is whether the elderly will continue to be targeted as a revised health bill is implemented.

B. Implementation of the PPACA and Concerns

1. New Appointee to Serve as CMS Administrator

On April 19, 2010, President Obama nominated Dr. Donald M. Berwick to be administrator of the Centers for Medicare and Medicaid Services (CMS).[127] In anticipation of a partisan battle over Berwick's nomination as CMS chief, President Obama made him a recess appointment so he could assume the post without being confirmed by the Senate.[128] Dr. Berwick has proven to be a controversial figure:

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126. Mark Thomas, *Who Benefits from Health Care Reform?*, CBS MONEYWATCH.COM (Mar. 22, 2010), http://moneywatch.bnet.com/economic-news/blog/maximum-utility/who-benefits-from-health-care-reform/539/. For more information on the PPACA and what will be implemented yearly through 2014, see KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW (2010), http://www.kff.org/healthreform/upload/8061.pdf. For those who are already insured, the PPACA "'grandfathers' health plans in existence . . . exempting them from many insurance market reforms." ELIZABETH ABBOTT ET AL., PPACA IMPLEMENTATION: CONSUMER RECOMMENDATIONS FOR REGULATORS AND LAWMAKERS 14 (2010), *available at* http://www.nationalpartnership.org/site/DocServer/NAIC_consrecs_PPACAimmreforms.pdf?docID=6522. The National Association of Insurance Commissioners (NAIC) recommends "setting reasonable, well defined limits on a health plan's ability to maintain grandfathered status through federal regulation to ensure that the law fulfills its promise for the maximum number of patients and consumers." *Id.*

127. Robert Pear, *Confirmation Fight on Health Chief*, N.Y. TIMES, June 22, 2010, at A18, *available at* http://www.nytimes.com/2010/06/22/health/policy/22medicare.html. Prior to his appointment, Dr. Berwick, a pediatrician and Harvard Professor was president of the Institute for Healthcare Improvement, a Cambridge-based healthcare think tank. William Branigin & N.C. Aizeman, *Obama Bypasses Senate by Appointing Medicare Chief*, WASH. POST (July 7, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/07/07/AR2010070700394.html?sid=ST2010070705230.

128. *Obama Bypassing Senate for New Medicare Chief*, U.S. NEWS & WORLD REP. (July 7, 2010), http://www.usnews.com/news/articles/2010/07/07obama-bypassing-senate-for-new-medicare-chief.html.

beloved by his followers as a visionary and regarded as a radical by his opponents.[129] On various occasions, Berwick has spoken of the need to ration healthcare and cap spending.[130] In a 2008 interview, Dr. Berwick stressed his belief in the importance of Comparative Effectiveness Research (CER) in helping "rein in . . . runaway healthcare costs."[131] In that interview, Berwick praised Britain's National Institute for Clinical Excellence (NICE), which advises the government-run healthcare system on how to allocate or ration medical spending based on cost-benefit analysis.[132] Berwick has professed to being enamored with NICE, attesting it "is extremely effective and a conscientious, valuable, and—important knowledge-building system,"[133] which rations healthcare in Great Britain. When asked whether CER will lead to the rationing of healthcare, Dr. Berwick said that "[t]he decision is not whether or not we will ration care—the decision is whether we will ration with our eyes open."[134] The concern is that as Administrator of Medicare/Medicaid, Berwick would limit senior citizens' access to needed medical care.[135]

2. *Compliance Concerns*

The PPACA mandates that physicians, medical suppliers and

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129. *Id.* In 2002, Berwick wrote in an article that "[m]ost people who have serious pain do not need advanced methods; they just need the morphine and counseling that have been available for centuries." Janet Adamy, *Sebelius Defends Medicare Nominee*, WALL ST. J. (June 4, 2010), http://online.wsj.com/article/SB10001424052748703340904575285034002114118.html. Dr. Berwick was urged by his doctors to receive a knee replacement years ago. Instead, he opted to have mere steroid injections "and the outcome," he states, "has been fine." Pear, *supra* note 127.

130. Pear, *supra* note 127.

131. *Rethinking Comparative Effectiveness Research*, BIOTECHNOLOGY HEALTHCARE, June 2009, at 35, *available at* http://www.biotechnologyhealthcare.com/journal/fulltext/6/2/BH0602035.pdf [hereinafter *Rethinking CER*] (interview with Dr. Donald Berwick).

132. *See generally* Cressey, *supra* note 71; *see also* text accompanying notes 66, 81.

133. *Rethinking CER*, *supra* note 131, at 36.

134. *Id.* at 36.

135. Health Secretary Kathleen Sebelius, however, recently defended Dr. Berwick, stating he has "outstanding qualifications." Adamy, *supra* note 129.

providers adopt a compliance program.[136] In essence, this means for the first time in U.S. history,[137] doctors and hospitals have to comply with Healthcare Reform guidelines. Congress set forth specific compliance guidance for nursing home facilities but less guidance for hospitals and other suppliers.[138] This may put a strain, however, on small suppliers such as hospitals and nursing home facilities because unlike their larger counterparts, they may not have a voluntary compliance program in place.[139] If a hospital fails to implement compliance programs, it may face law enforcement and False Claims Act liability.[140]

3. Comparative Effectiveness Research

A year before the passage of healthcare reform, President Obama "signed into law an initiative providing $1.1 billion to support research on the comparative effectiveness of drugs, medical devices, surgical procedures, and other treatments for various conditions."[141] Under the American Recovery and Reinvestment Act (ARRA), the President authorized the creation of a new council that will develop guidelines for physicians and medical personnel to follow when treating patients.[142] This comparative effectiveness research (CER)

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136. Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Section 6102: Accountability Requirements for Skilled Nursing Facilities and Nursing Facilities; Section 6105: Standardized Complaint Form Skilled Nursing Facilities and Nursing Facilities; Section 6106: Ensuring Staffing Accountability for Skilled Nursing Facilities and Nursing Facilities; and Section 6401: Changes to Medicare and Medicaid Provider and Supplier Enrollment Process).

137. Scott A. Memmott & Howard J. Young, *Healthcare Reform Law and Mandatory Compliance Programs*, MORGAN LEWIS, 1 (Apr. 27, 2010), http://www.morganlewis.com/pubs/WashGRPP_MandatoryCompliancePrograms_LF_27apr10.pdf.

138. *Id.* at 2.

139. *Id.* at 1.

140. *Id.* The False Claims Act (FCA) comes into play because failure to identify and prevent federal health care claims may result in a potential violation of the FCA. *Id.* The FCA can be found at http://www.taf.org/federalfca.htm.

141. Aanand D. Naik & Laura A. Peterson, *The Neglected Purpose of Comparative-Effectiveness Research*, 360 NEW ENG. J. MED. 1929, 1929 (2009).

142. Jordan M. VanLare et al., *Five Next Steps for a New National Program for Comparative-Effectiveness Research,* 362 NEW ENG. J. MED 970, 970 (2010). *See*

will provide information to healthcare personnel on the effectiveness of various medical interventions.[143] CER is defined as "evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition."[144] CER studies are simply studies that compare possible treatments that can be used for patients with particular problems and that can be generalized for all sorts of patients seen by physicians.[145]

The Obama Administration is sold on the importance of CER to healthcare reform while Senator Tom Coburn[146] has decried such a program as a plan to ration healthcare.[147] Coburn argued that seniors would die sooner once the healthcare reform bill was passed and that provisions in the new law would reduce the quality of life as well as the life span of every American, not just the elderly.[148] Section 6301 of the healthcare reform law creates new comparative effectiveness programs that Coburn compares to Britain's rationing commission, NICE.[149] CER has also been met with skepticism because of its potential to threaten personalized medicine between a doctor and patient and to discourage the development of therapies specifically tailored to a patient's needs, such as genomic tests to guide treatment choices.[150]

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also American Recovery and Reinvestment Act, Pub. L. No. 111-5, 123 Stat. 115 (2009).

143. *See* Alan M. Garber & Sean R. Tunis, *Does Comparative-Effectiveness Research Threaten Personalized Medicine?*, 360 NEW ENG. J. MED. 1925, 1925 (2009).

144. Robert M. Centor et al., *Comparative Effectiveness Research and the Medical Home—Made for Each Other?*, MEDSCAPE TODAY (Sept. 23, 2009), http://www.medscape.com/viewarticle/709197.

145. *Id.*

146. Coburn is a physician and a Republican Senator from Oklahoma. Tom Coburn, *The Health Bill is Scary*, WALL ST. J. (Dec. 16, 2009), http://online.wsj.com/article/NA_WSJ_PUB:SB10001424052748703514404574588842779569168.html.

147. *Id.* Representative Tom Price also expressed concern that the CER would act as a "permanent government rationing board prescribing care instead of doctors and patients." Jerry Avorn, *Debate About Funding Comparative-Effectiveness Research*, 360 NEW ENG. J. MED. 1927, 1928 (2009).

148. Coburn, *supra* note 146.

149. *Id.*

150. Garber & Tunis, *supra* note 143.

Yet, most literature on CER supports the concept in theory.[151] Some policy-makers have heralded CER "as the key to aligning payments with evidence-based use of prescription drugs, medical devices, diagnostic tests and surgical intervention."[152] Others, however, see CER as a threat to developing innovative medical treatments. To doctors, it represents an infringement on their professional judgment, and to conservatives, it is a means of rationing treatment by cutting costs.[153] The government-sponsored CER would be transparent and the reform law creates a nonprofit body[154] that may only publish its findings; because it is prohibited from making policy or recommendations for payment, coverage, or treatment, the hope is that such research will not lead to healthcare rationing.[155] If not misused, CER has the potential to encourage "use of the most relevant and valid information" regarding which treatments are most effective and for whom.[156] The nation needs to know what works best in medicine.[157] CER may be acceptable if used for its intended purpose—to provide the best care possible for seniors and for all Americans; however it will remain suspect if it is used mainly to cut costs or to force doctors to follow certain treatment guidelines that could have a negative impact on senior wellbeing.

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151. *See, e.g.*, Paul H. Keckley & Barbara B. Frink, *Comparative Effectiveness: A Strategic Perspective on What it is and What it May Mean for the United States*, 3 J. HEALTH & LIFE SCI. L. 53 (2009).

152. *Id.* at 55.

153. *Id.* As proof of potential rationing, critics refer to what happened when the U.S. Preventive Services Task Force announced in November of 2009 that, based on scientific evidence, it no longer recommended mammograms for women forty through forty-nine years old. Public outcry convinced Democrats to rewrite their healthcare reform legislation to guarantee mammography coverage. *See* Robert Lowes, *Can Comparative-Effectiveness Research Be a Physician's Best Friend?*, WEB MD, MEDSCAPE MEDICAL NEWS (Jan. 9, 2010), http://www.medscape.com/viewarticle/714897.

154. The nonprofit body is the independent Patient-Centered Outcomes Research Institute. Lowes, *supra* note 153.

155. *Id. See generally* Keckley & Frink, *supra* note 151, at 53.

156. Garber & Tunis, *supra* note 143, at 1926.

157. Avorn, *supra* note 147.

4. Independent Payment Advisory Board (IPAB)

The PPACA,[158] passed by the Senate in December of 2009 and by the House in March of 2010,[159] establishes a fifteen-member Independent Payment Advisory Board (IPAB), which has significant authority with respect to Medicare payment rates.[160] President Obama has fully supported the concept of the IPAB, which Administration officials say will improve healthcare quality, eliminate wasteful spending, and control costs.[161] In addition to cost effectiveness research, this is another area of the new healthcare reform law critics fear has the potential to lead to healthcare rationing for those on Medicare.[162] By making the IPAB accountable only to the President, this provision takes authority for Medicare payment adjustments away from Congress.[163] In the future, if seniors or their physicians are denied reimbursement for medical treatment, they cannot effectively complain to their elected representatives. It is argued that replacing elected officials with political appointments from the President will not remove politics from the question.[164]

When the Senate health reform bill included provisions for a Medicare payment advisory board, there was strong opposition from many physicians groups.[165] In a letter to Senate Majority Leader Harry

158. Patient Protection and Affordable Care Act (PPACA), Pub.L. No. 111-148, 124 Stat. 119 (2010).

159. Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, H.R. 124 Stat. 1029.

160. PPACA § 10320.

161. Kevin Bohn & Jessica Yellin, *Experts Debate Proposed 'Big Brother' Medical Council*, CNN.COM (July 23, 2009), http://www.cnn.com/2009/POLITICS/07/23/health.care.council/index.html. Note that under the current reform legislation the name of the Medicare advisory board has been changed to Independent Payment Advisory Board.

162. *See generally id.*

163. Letter from AIDS Action Baltimore et al., to Senate Majority Leader Harry Reid and Speaker of the House Nancy Pelosi (Jan. 11, 2010), *available at* http://www.aaoms.org/docs/govt_affairs/issue_letters/ipab.pdf (letter from numerous medical organizations requesting both leaders to oppose the inclusion of IPAB) [hereinafter Letter to Leader].

164. *See id.*

165. *See generally Organizations Advocate Against Independent Payment Advisory Board for Medicare*, MEDICARE UPDATE (Jan. 13, 2010),

Reid and House Speaker Nancy Pelosi, these groups noted that the purpose of the IPAB is to reduce the rate of growth in Medicare, but in "most years Medicare's per capita growth has been below or equal to growth in the private sector [in healthcare spending]."[166] Further, the creation of the IPAB will cause reductions in payments in addition to the $400-500 billion savings already included in healthcare reform measures.[167] Doctors are concerned such cuts will further jeopardize access for Medicare beneficiaries as well as the infrastructure of the entire healthcare system itself. Hospitals are exempt from cost reductions proposed by the IPAB through 2019,[168] so the burden of reimbursement reductions will fall upon doctors. It is feared that lowering payments to physicians will cause some of them to refuse to take new Medicare patients—resulting in rationing healthcare to seniors.

By creating barriers to Medicare beneficiaries' ability to work with Congress to improve the program, the IPAB may also make coverage of new procedures and technologies more difficult to obtain.

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http://medicareupdate.typepad.com/medicare_update/2010/01/independentpaymentadvisoryboard.html.

166. Letter to Leader, *supra* note 163.

167. *Id.*

168. *Reform Law Provision Sparks Controversy: What is the IPAB?*, SAN DIEGO CNTY. MED. SOC'Y (May 13, 2010), http://sdcms.org/print/9914. *See generally* KAISER FAMILY FOUND., SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS 20 (2010), http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf [hereinafter SIDE-BY-SIDE COMPARISON]. In fact, low pay for Medicare doctors jeopardizes health reform. Physicians who accept Medicare patients are reimbursed 25-30% below other care providers. Michael A. Newman, *Low Medicare Pay for Doctors Puts Health Reform at Risk*, WASH. POST, June 19, 2010, at A17. The American Medical Association (AMA) estimates roughly 60% of Medicare physicians are considering opting out of Medicare. *Id.* As reforms are implemented, Congress does not have anything in place to prevent the situation from worsening. *Id.* Moreover, the PPACA

> cuts $818 billion from Medicare Part A (hospital insurance) from 2014-2023, the first 10 years of its full implementation, and $3.2 trillion over the first 20 years, 2014-2033. Adding in ObamaCare cuts for Medicare Part B (physicians' fees and other services) brings the total cut to $1.05 trillion over the first 10 years and $4.95 trillion over the first 20 years.

Peter Ferrara & Larry Hunter, *How ObamaCare Guts Medicare*, WALL ST. J. (Sept. 9, 2010), http://online.wsj.com/article/SB10001424052748703649004575437311393854940.html.

However, as it currently stands, barring any new legislation to change its authority, the board will not have the ability to change eligibility or benefits or to submit proposals that ration care.[169] At this point, the effect of the projected cuts in Medicare is uncertain. Yet, as our country's deficit continues to rise, the biggest uncertainty is what future Congresses will do.

V. SOLUTIONS AND PROPOSALS
PROPOSAL I: ECONOMIC REFORM, CUTTING COSTS THROUGH NON-RATIONING MEANS

A. Cuts to Medicare, a Solution?

Regardless of party-lines, healthcare reform is going to happen on a large scale within the next five years. Medicare has been an essential component of the U.S. healthcare system for the elderly as it is America's health insurance program for people age sixty-five and older as well as for those of all ages who have permanent disabilities.[170] With forty-seven million people enrolled, the Medicare program pays for patient visits, hospitalizations and prescription drugs.[171] Yet health costs are rising faster than income for Medicare recipients; the average Medicare beneficiary paid 16.5% of their income on health costs in 2006.[172] Under the PPACA, Congress and the current Administration provided that Medicare funding be cut to help pay for coverage of millions of the uninsured.[173] Republicans,

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169. The Board is "prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing." SIDE-BY-SIDE COMPARISON, *supra* note 168, at 20.

170. *Id.*; MEDICARE: A PRIMER, *supra* note 108, at 2.

171. MEDICARE: A PRIMER, *supra* note 108, at 1.

172. *Id.* at 6. According to a recent study, a healthy sixty-five-year-old couple should plan on $305,000 in out-of-pocket health costs during their retirement. Dan Kadlec, *What About Health Care?*, TIME (Jan. 6, 2010), http://www.time.com/time/specials/packages/article/0,28804,1951190_1951441,00.html.

173. *Medicare Cuts Stay in Senate's Health Care Bill*, MSNBC.COM (Dec. 3, 2009), http://www.msnbc.com/id/34258944 [hereinafter *Medicare Cuts Stay*]. Seniors are experiencing a "double whammy: less spending on Medicare coupled with reduced subsidies for their Medicare Advantage plans. In many areas, Medicare Advantage enrollees will lose about one-third or more of their health insurance benefits." John C. Goodman, *How Seniors Will Pay for ObamaCare*, WALL ST. J.

with Senator McCain of Arizona in the lead, have emphasized how these Medicare cuts will have a direct adverse impact on seniors.[174] The money to pay for proposed universal healthcare coverage will likely come from a variety of sources, including cuts to Medicare and Medicaid.[175]

(Sept. 23, 2010), http://online.wsj.com/article/SB10001424052748704129204575505804034634066.html.

174. *Medicare Cuts Stay*, *supra* note 173. Even some Democrats acknowledge PPACA is far from perfect. In fact, Democrat Representative Mark Critz won a Congressional seat in November 2010 partly due to having on his platform a promise to amend the PPACA. Hal Scherz, *Dear Patients: Vote to Repeal ObamaCare*, WALL ST. J. (Sept. 1, 2010), http://online.wsj.com/article/SB10001424052748703369704575461840575037482.html.

175. The White House Proposal released February 22, 2010, provides that the President's proposed healthcare plan will be paid for by the following: $149.1 billion over ten years from a new excise tax on high-premium insurance plans, equal to 40% of premiums paid on plans costing more than $23,000 annually for a family and $8,500 for an individual; cuts to Medicare and Medicaid, with net savings estimated to be $438 billion over ten years, starting in 2014; $54 billion over ten years from a Medicare payroll tax hike on couples with income of more than $250,000 a year. For those families, the levy would be raised to 1.95%, up from 1.45%; customers of indoor tanning salons would pay a 10% tax (replaces a proposed tax on cosmetic surgery); $102.3 billion over ten years from fees on insurance companies and medical device/manufacturers, including $23 billion over ten years on fees on drug makers; and a tax on individuals without qualifying coverage, with a maximum penalty set at 2.0% of income. *Health-Care Overhaul Proposals*, *supra* note 10.

> The Obama health care proposal . . . would take away from America's senior citizens their current right to add their own money on top of the government Medicare contribution to get health insurance less likely to deny treatment through tightly controlled managed care . . . . [O]ther health care providers are leaving the Medicare program because of low government reimbursement rates—rates that under the Obama bill will decline still more in comparison to medical inflation—senior citizens will have nowhere to turn . . . . Their only option will be tightly managed plans that provide less and less treatment.

Steven Ertelt, *Health Care Rationing for Seniors is Another Problem in New Obama Plan*, LIFENEWS.COM (Feb. 22, 2010), http://www.lifenews.com/bio3058.html. "Medicare cuts could drive 15 percent of hospitals into debt and could drive people out of Medicare Advantage plans by as much as 50 percent." *CMS Actuary: Health Reform Will Cover More People, Cost More than Originally Projected*, KAISER HEALTH NEWS (Apr. 24, 2010), http://www.kaiserhealthnews.org/Daily-Reports/2010/April/23/Actuary-Report-health-reform.aspx. Cuts in Medicare "could help reduce the rate of cost increases beyond 2020." *Id.* Obama and Secretary of

B. Cuts Elsewhere

Because the reform bill increases the number of people covered in the U.S. healthcare pool at the expense of the Medicare program, there will need to be cuts somewhere, and the question arises whether these "cuts" will come in the form of rationing. Proposals have included cutting waste through eliminating administrative and overhead costs—the Veterans Association (VA), the Kaiser Foundation, and the Mayo Clinic can be worthy models for comparison.[176] President Obama has repeatedly emphasized the importance of slowing the growth of healthcare expenditures by eliminating "waste, fraud and abuse" in the Medicare system.[177]

Health and Human Services Kathleen Sebelius, however, continue to support the health bill stating that "the Affordable Care Act will cover more Americans and strengthen Medicare by cracking down on waste fraud and abuse, modernizing payment systems and improving benefits by providing free preventive services, supporting innovations that help control chronic disease and closing the prescription drug donut hole." *Id.*

176. Telephone Interview with Dr. Roderick Morgann, Doctor of Internal Med. (Feb. 4, 2010). "Obama . . . praised the Mayo Clinic as a 'classic example' of how a health-care provider can offer 'better outcomes' at lower cost." *Medicare and the Mayo Clinic*, WALL ST. J. (Jan. 8, 2010), http://online.wsj.com/article/SB10001424052748703436504574640711655886136.html?mod=WSJ_Opinion_AboveLEFTTopM. Yet in January, 2010, Mayo said it will no longer accept Medicare patients at its clinic in Arizona. *Id.* Mayo says it lost $840 million treating Medicare patients last year due to the program's low reimbursement rates and can no longer sustain such losses. *Id.* The $500 billion in Medicare cuts under the new healthcare law won't help counter this trend. *Id.*

177. John K. Iglehart, *Finding Money for Health Care Reform—Rooting Out Waste, Fraud and Abuse*, 361 NEW ENG. J. MED 229, 229 (2009). The Patient Protection and Affordable Care Act contains the following goals:

> Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs . . . [d]evelop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities.

KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW 9 (2010), http://www.kff.org/healthreform/upload/8061.pdf.

Medical fraud can occur when a Medicare beneficiary's personal information is stolen and used to purchase medical items such as expensive equipment with Medicare footing the bill.[178] Currently, there are Medicare Patrol Units trained to catch such scams in every state.[179] The government is also relying on whistleblowers because if fraud is spotted early on, significant money can be recovered for patients and taxpayers. The President's proposal calls for continued "health care delivery system reforms that hold the promise of reducing health care costs over time, and reducing waste in Medicare spending."[180] To many in the medical profession, "waste" includes running excessive and sometimes unnecessary tests. The new reform plan aims to increase the quality and efficiency of care by basing payments on the value of services, not the volume.[181] In other words, physicians will be paid based on value provided rather than the number of tests ordered. Moreover, a hospital that fails to cut back on "waste" may be penalized, perhaps receiving lower payments from the government.[182]

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178. *See Stealth Crew of Seniors Fights Medicare Fraud*, MSNBC.COM (Dec. 29, 2009), http://www.msnbc.msn.com/id/34622608/ns/health-health_care [hereinafter *Stealth Crew*]. One such example is when a thief generates a fake prescription for a prosthetic limb, fills out the Medicare form for services rendered, and, as a result, receives a direct deposit into a medical supply house bank account. *See* Michael S. Levinson, *Eliminating Medicare Medicaid Fraud*, OPEDNEWS.COM (Mar. 20, 2010), http://www.opednews.com/articles/Eliminating-Medicare-Medic-by-michaelslevinson-100319-775.html.

179. *Stealth Crew*, *supra* note 178.

180. Jeanne Sahadi, *How Obama Wants to Pay for Health Reform*, CNNMONEY.COM (Feb. 22, 2010), http://money.cnn.com/2010/02/22/news/economy/obama_proposal_payfors/index.htm.

181. The most common method of paying health care providers for services is called fee-for-service payment, where there are separate charges for office visits, tests, etc. Healthcare reform hopes to bundle payments—making a single payment for all services related to a condition. *Bundled Payment,* RANDCOMPARE, http://www.randcompare.org/print/policy-options/bundled-payment (last visited Nov. 19, 2010). However, such healthcare reform could impact the number of individuals who become doctors as well as the quality of healthcare. *The Medicus Firm Physician Survey: Health Reform May Lead to Significant Reduction in Physician Workforce*, MEDICUS FIRM, http://www.themedicusfirm.com/pages/medicus-media-survey-reveals-impact-health-reform (last visited Sept. 1, 2010).

182. Reed Abelson, *Weighing Medical Costs of End of Life Care,* N.Y. TIMES, Dec. 23, 2009, at A1, *available at* http://www.nytimes.com/2009/12/23/

This approach of eliminating waste by reducing medical testing, however, may run contrary to the philosophy of some medical institutions. Running numerous tests on a person adds costs, but this practice is followed by many hospitals often has beneficial results.[183] For example, one study showed that the medical facility that spent the most money on treating heart failure patients actually had one-third fewer deaths six months after an initial hospital stay.[184] Additionally, the recommendations that women not receive annual mammograms until they are fifty years of age (instead of the previous recommendation of forty) and that they only receive a mammogram every other year (as opposed to every year) were viewed by many as merely a means to cut costs in healthcare.[185] So, many of these proposed cuts do not look like "waste;" they take on the appearance of rationing.

Also, under the new healthcare legislation, private Medicare plans called Medicare Advantage will see their payments frozen in the year 2011.[186] Many on both sides of the aisle see these cuts to Medicare

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health/23ucla.html. Another key strategy in decreasing health care costs without rationing is reforming the health care delivery system. Current health care entities, including Medicare, still use the inefficient fee-for-service model, which incentivizes health care personnel to over supply services to patients. Henry J. Aaron & Paul B. Ginsburg, *Is Health Spending Excessive? If So, What Can We Do About It?*, 28 HEALTH AFFAIRS 1260, 1273 (2009). Another proposal would be to integrate more Accountable Care Organizations (ACOs) so that the elderly, who as a group utilize the healthcare system frequently, can be exposed to the efficient model of coordinated care. ACOs are sets of providers associated with a defined population of patients, accountable for the quality and cost of care delivered to that population. *See* Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, URBAN INSTITUTE, 1 (Oct. 2009), http://www.urban.org/UploadedPDF/411975_acountable_care_orgs.pdf. An additional way to decrease cost is through bundling episodes of care. Bundling provider payments as a lump sum fee (as opposed to paying a fee for each service) promotes the coordination of care which streamlines health care and removes the incentive to generate additional services for added reimbursements. *See* Harold D. Miller, *From Volume to Value: Better Ways To Pay For Health Care*, 28 HEALTH AFFAIRS 1418, 1420-21 (2009).

183. *See* Abelson, *supra* note 182.

184. *Id.*

185. *See* Robert D. Truog, *Screening Mammography and the "R" Word*, 361 NEW ENG. J. MED. 2501, 2503 (2009).

186. Susan Heavey, *Factbox: Winners and Losers in House Healthcare Bill*, REUTERS (Mar. 22, 2010), http://www.reuters.com/article/idUSTRE62K1I

benefits as jeopardizing "access to care for millions," including the elderly.[187] Do revised recommendations such as these foreshadow the future of healthcare for seniors in America? Such proposed cuts affect the elderly on the whole in greater proportions because it is typically the older populations that are diagnosed with cancer and other life-threatening diseases. It is important for the current Administration to cut true waste, whether it be from administrative overhead costs within the health sector or through eliminating medical fraud; however, it is imperative that cuts to programs seniors rely on to such a high degree, such as Medicare, not be made.

PROPOSAL II: LEGAL RECOURSE AVAILABLE TO THE ELDERLY & LEGAL REFORM—LAWS PERTAINING TO DISCRIMINATION & EMPLOYMENT MUST BE EXTENDED TO RATIONING OF HEALTHCARE

A. The Current Legal Situation

What legal recourse, if any, do senior citizens have when they have been subjected to age-based healthcare allocation? Do elderly patients have any prospective legal remedies against physicians who covertly ration healthcare at the bedside? Perhaps older persons can reasonably look to the legal system to protect them against harm caused by the implicit rationing of medical care on the basis of age.[188]

B. Constitutional Arguments

The arguments of Callahan and other pro-rationists raise concerns

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187. Lori Montgomery, *Report: Bill Would Reduce Senior Care*, WASH. POST (Nov. 15, 2009), www.washingtonpost.com/wp-dyn/content/article/2009/11/14/AR2009111402597.html. Unfortunately, Medicare fraud is still prevalent. For instance, the DOJ broke up a fraud ring—but not until after the ring had already defrauded Medicare $35 million by using stolen doctor and patient identifications. Michael Rothfeld, *Medicare Scheme Netted $35 Million, Officials Say*, WALL ST. J. (Oct. 14, 2010), http://online.wsj.com/article/SB10001424052748703673604575550002841068546.html. The Medicare fraud industry in Florida is now larger than the cocaine industry "because bilking Medicare is much easier and the risk of being caught and punished is much smaller." Amitai Etzioni, *Don't Touch My Medicare*, CNNOPINION (Nov. 24, 2010), http://blog.amitaietzioni.org/2010/11/ dont-touch-my-medicare.html.

188. *See* Kapp, *supra* note 6, at 77.

about the constitutionality of their proposals. The elderly who are able to afford medical expenses without Medicare live longer, so the notion of shortening people's lives based on age and economic status seems to contravene the Fourteenth Amendment's Due Process Clause, under which "no person may be deprived of life, liberty or property without due process of law."[189] An official age-based healthcare rationing program may also be attacked as a deprivation of the equal protection rights guaranteed to all persons under the Fifth and Fourteenth Amendments.[190] Some have challenged governmental age classifications under the Equal Protection and Due Process Clauses of the United States Constitution.[191] "While the [Equal Protection Clause] is not applicable to the federal government, it has been held that most acts by the federal government that would deny equal protection constitute a 'deprivation of liberty' within the Fifth Amendment's Due Process Clause."[192] Persons are entitled to be treated fairly by the government regardless of their age.[193] Therefore, many opponents of age-based healthcare rationing contend that resource allocation that targets the elderly is unfair, as the term "life" includes potential beneficial medical care.[194] "Similar to a person's race or gender, aging is involuntary and uncontrollable."[195] Proponents of this argument believe that much like racism and sexism, ageism should be rejected on similar grounds—it is a natural part of life to grow old.[196]

The "rational basis" test is typically used for determining whether a classification is permissible under the Fourteenth Amendment's

189. *Id.* at 77; *see also* U.S. CONST. amend. XIV, §1.

190. Kapp, *supra* note 6, at 77; *see also* U.S. CONST. amend. XIV, §1; U.S. CONST. amend. V.

191. *See generally* Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 317 (1976).

192. Nancy Neveloff Dubler & Charles P. Sabatino, *Age Based Rationing and the Law: An Exploration*, *in* TOO OLD FOR HEALTHCARE? 92, 97 (Robert H. Binstock & Stephen G. Post eds., 1991). *See also Murgia*, 427 U.S. at 317.

193. *See* Kapp, *supra* note 6, at 71-89.

194. *Id.*

195. *Id.*

196. *Id.* at 77. Moreover, many elderly citizens are institutionalized, often against their will, in long-term care facilities and are subject to conservator and guardianship appointments by the courts. *Id.*

Equal Protection Clause.[197] "This test requires only that the classification be 'rationally related' to a proper state interest" and, in reality, the U.S. Supreme Court rarely finds a violation of equal protection under this low-level test.[198] However, "if a legislative classification seems to interfere with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class," courts will implement the "strict scrutiny test."[199] Under strict scrutiny, a violation of the Equal Protection Clause occurs unless there is a compelling state interest behind the classification. Courts may also use the "sliding-scale" approach, under which "the degree of care with which a court scrutinizes a government program depend[ing] on the constitutional and societal importance of the interest adversely affected and the invidiousness of the basis upon which the classification is drawn."[200]

C. An Analysis of Case Law

Daniels and others contend that an "age-based healthcare rationing scheme ought to be subjected to a higher level of equal protection analysis—that of 'strict scrutiny.'"[201] "Under this test, the government bears the burden of proving that its policy of discriminating among citizen groups is necessary . . . to accomplish a compelling . . . public interest."[202] The U.S. Supreme Court, however, has held that age is not a suspect classification and is not entitled to a strict scrutiny standard of review, but instead should be analyzed under the rational basis test.[203] In other words, the U.S. Supreme Court held that elderly persons do not constitute a "suspect class" for purposes of equal protection.[204] The Court explained in *Massachusetts Board of Retirement v. Murgia* that

> while the treatment of the aged in this Nation has not been wholly

197. Dubler & Sabatino, *supra* note 192, at 98.
198. *Id.*
199. *Id.* (citation omitted) (internal quotation marks omitted).
200. *Id.* at 105.
201. Kapp, *supra* note 6, at 78.
202. *Id.*
203. Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 313-14 (1976).
204. Dubler & Sabatino, *supra* note 192, at 105.

> free of discrimination, such persons, unlike, say, those who have been discriminated against on the basis of race or national origin, have not experienced a "history of purposeful unequal treatment" or been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities. . . . Instead, it [old age] marks a stage that each of us will reach if we live out our normal span.[205]

Accordingly, states may discriminate on the basis of age without violating the Equal Protection Clause "if the age classification in question is rationally related to a legitimate state interest."[206]

In *Murgia*, a Massachusetts statute requiring state police officers to retire upon reaching the age of fifty was found not to violate the Equal Protection Clause.[207] Therefore, "on its face, the constitutional status of elderly Americans appears to be no different than that of any group of citizens."[208] To this day, the U.S. Supreme Court "seems reluctant to find additional fundamental rights"[209] or "suspect classes."[210] *Murgia,* however, applied to an employment setting, not to a setting where the elderly are ill or facing life-threatening situations.[211] This distinction may be important if litigation regarding the rationing of healthcare to the elderly arises and if the issue of denying life-sustaining care to seniors comes before the Supreme Court.

In *Public Employees Retirement System of Ohio v. Betts*,[212] the

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205. *Murgia,* 427 U.S. at 313-14.

206. Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 83 (2000).

207. Dubler & Sabatino, *supra* note 192, at 98. In response to the plaintiff's involuntary retirement, the majority in *Murgia* held that "the Massachusetts Legislature does not deny appellee equal protection of the laws." *Murgia*, 427 U.S. at 317.

208. Dubler & Sabatino, *supra* note 192, at 99.

209. *Id.* at 105.

210. *Id.*

211. *See id.* at 109 ("The narrow holding in *Murgia* was only that 'the class of uniformed state police officers over 50' does not constitute a suspect class. Had older persons in need of medical care and over some age limit—say 75 years of age—imposed by rationing stood before the Court, the Court's equal protection analysis might have tilted toward greater scrutiny." (quoting *Murgia*, 427 U.S. at 313)).

212. 492 U.S. 158 (1989).

U.S. Supreme Court considered whether the Public Employees Retirement System of Ohio (PERS) was contradictory to the meaning of the Age Discrimination in Employment Act of 1967 (ADEA).[213] Under the retirement scheme in *Betts*, those over the age of sixty who retired because of a disability were restricted in their retirement benefits.[214] The Court held that the plan was constitutional but did acknowledge that the elderly cannot be excluded from coverage altogether.[215] Perhaps future litigation on behalf of seniors will strengthen their rights with respect to healthcare rationing.

D. Statutes and Legislative Acts

Through legislation, the government has made attempts to alleviate age discrimination. The ADEA seeks "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; [and] to help employers and workers find ways of meeting problems arising from the impact of age on employment."[216] Moreover, the Federal Public Health and Welfare statutes expressly "prohibit discrimination on the basis of age in programs or activities receiving federal financial assistance."[217]

Similar to the ADEA, the Age Discrimination Act assures that elderly are not excluded from federal programs. It provides that

> [n]o person in the United States shall, on the basis of age be excluded from participation, in, be denied the benefits of, or be subjected to discrimination under, any program or activity

213. *See id.*; *see generally* Dubler & Sabatino, *supra* note 192.

214. Dubler & Sabatino, *supra* note 192, at 107; *Betts*, 492 U.S. at 169.

215. Dubler & Sabatino, *supra* note 192, at 107-08.

216. Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621(b) (1989). The U.S. Congress "has expressed a clear . . . [policy] that the elderly [should] be accorded . . . the attention required by their special needs and equality of treatment in the workplace." Robert A. Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL'Y 71, 77 (1986).

217. 42 U.S.C. § 6101 (2006).

receiving Federal financial assistance.[218]

In reality, the Age Discrimination Act was not designed to prohibit age discrimination, but rather only exclude discrimination which is "unreasonable."[219] Thus, if "a legislative body makes a policy choice to permit an age distinction in a given program, the Age Discrimination Act will not be a barrier."[220]

E. Other Possible Recourse

Injunctive relief is also an available option for elderly who have been denied medical care. If an older patient is in danger of having potentially beneficial medical treatment withheld or withdrawn, the patient may seek declaratory or injunctive relief in the form of a court order declaring the rights and responsibilities of the parties and ordering the doctor to provide the particular medical intervention.[221] Typically, however, elderly patients (or their advocates) do not have notice that the doctor intends to impose rationing. Thus, they are unable to get a court order before medical treatment is denied.[222] Time, or the lack thereof, is also an issue for seniors seeking this type of relief.

As elaborated, there is no over-arching law that protects senior citizens from the explicit or implicit rationing of healthcare. In the medical setting, the Age Discrimination Act provides little relief for Medicare's rationing of heart transplants to the elderly.[223] In 1987, however, Medicare did decide to extend reimbursements for heart transplants to Medicare patients.[224] On another positive note, unlike the policy under the British healthcare system, kidney dialysis, which costs over one billion dollars a year, is also covered by Medicare.[225] Scholars predict that the U.S. Congress, which enacted this coverage after a dialysis patient was wheeled onto the floor of the legislature,

218. *Id.* § 6102. *See also* Dubler & Sabatino, *supra* note 192, at 106.
219. Dubler & Sabatino, *supra* note 192, at 106.
220. *Id.* at 107.
221. Kapp, *supra* note 6, at 77.
222. *Id.* at 78.
223. Dubler & Sabatino, *supra* note 192, at 114.
224. *Id.*
225. *Id.*

will never again permit explicit rationing to occur.[226] Nonetheless, the Age Discrimination Act and the Age Discrimination in Employment Act are valuable tools for seniors, even though such acts do not provide much protection for seniors in the area of healthcare. Perhaps the most viable option is to work on changing the law. With seniors being such a powerful voting bloc,[227] Congress must be encouraged to pass future legislation further protecting the rights of the elderly against healthcare discrimination.

PROPOSAL III: MEDICAL REFORM THROUGH ELIMINATING MEDICAL ERROR AND ENHANCING PATIENT SAFETY

There are other avenues to reducing costs aside from rationing explicitly or implicitly. One proposal is to minimize medical error and increase patient safety. In layman's terms, medical error is defined as a "mistake, inadvertent occurrence, or unintended event in a healthcare delivery which may, or may not result in patient injury."[228] Patient safety is a growing concern in modern healthcare.[229] For instance, the number of daily deaths attributable to medical error is equivalent to more than a 757 jumbo jet crashing every day of the year.[230] In fact, more fatalities occur due to medical error than to deaths due to breast cancer, AIDS, and highway fatalities.[231] Dr. Bryan Liang, Professor of Law at California Western School of Law, has likened the complexities of the healthcare system to that of aviation.[232] In the world of aviation, everyone involved in the system,

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226. *Id.*

227. In 2010, there are 40.2 million Americans age 65 or older. By 2050, this number is projected to more than double to 88.5 million, meaning 20% of the population will be senior citizens. GRAYSON K. VINCENT & VICTORIA A. VELKOFF, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P25-1138, THE NEXT FOUR DECADES, THE OLDER POPULATION IN THE UNITED STATES: 2010 TO 2050, POPULATION ESTIMATES AND PROJECTIONS 1 (2010), http://www.census.gov/prod/2010pubs/p25-1138.pdf.

228. Bryan Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, 24 SOUTHERN ILL. U. L.J. 541, 542 (2000).

229. *Id.* at 541-42.

230. *Id.* at 543.

231. *Id.*

232. *Id.*

from ground level to top ranks, participates to reduce aviation error.[233] They collectively address the problem by making system-based changes and following up with continuous assessments.[234] Because of the safety structure implemented by aviation, commercial flying has now become the safest mode of travel.[235] Medicine, on the other hand, "has done none of [the] things" that the field of aviation has throughout the past century to reduce error.[236] Dr. Liang sets forth risk management examples, which include seminars and encouragement for health professionals to get together and study the malpractice system.[237]

Additionally, Dr. Liang recommends clinical practice guides which are "generally consensus documents that indicate, for example, what the best practices are for a particular disease state, entity, or clinical practice area."[238] Individuals, as well as insurance providers, are obliged to learn about and participate in patient safety. To facilitate this process, the medical field (in particular insurance companies) should eliminate "terminate without cause" clauses in physician contracts.[239] Such action, in effect, would allow the medical field to separate out what works clinically and what does not, including which providers are doing a good job clinically and which providers are not (with respect to error and injury). This analysis would certainly provide opportunity to both study error and to implement corrective action rather than to terminate the provider if he or she is "high cost," without regard to the actions of the provider that promote or retard patient safety efforts.[240]

Error reporting is key and the medical system would be encouraged to report medical error if they were given immunity from legal enforcement.[241] For example, if the hospital reports a medical

233. *Id.* at 544.

234. *Id.* at 544-45.

235. *How Safe is Flying?*, BOEING, http://www.boeing.com/commercial/safety/howsafe.html (last visited Nov. 30, 2010).

236. Liang, *supra* note 228, at 545.

237. *Id.* at 546.

238. *Id.*

239. *Id.* at 565.

240. *Id.*

241. *Id.* at 564. Effective October 1, 2012, Medicare will reduce payments to hospitals that have high rates of hospital readmission within 60 days. Kenneth E.

error incident, it can work with the Institute of Medicine (IOM) to prevent the problem from reoccurring instead of having the error become a legally actionable matter.[242] Conversely, if a hospital does not report medical errors, licensure suspensions should be put into place.[243] Additionally, "we need to educate patients as to their rights and responsibilities regarding their own health care needs, personal medical history, and ability to participate in error reduction."[244] Eliminating medical error is one viable option to lessen costs, improve medical performance, and divert the medical system away from rationing medical resources for the elderly. Eradicating waste and error from the healthcare system is the "real moral imperative, and those matters must be addressed completely before any rationing decisions receive a moral seal of approval."[245]

The biggest concern in transitioning into healthcare reform will not be explicit rationing—but rather, implicit rationing. Although general guidelines or protocols can be used, because many decisions about medical treatment for elderly patients may literally lead to life or death, it is essential to consider the specific details of each case. It is also imperative to have collaboration between the doctor and the patient, or the patient's advocate for those seniors who no longer have adequate decision-making capabilities. Doctors must continue to inform their elderly patients of the various treatment alternatives and expected outcomes so an informed decision can be made. Subsequently, doctors must avoid rationing care at the bedside without informing the patient. If treatment choices are limited due to cost (e.g., Medicare does not reimburse) or scarcity of resources (e.g., a transplant is not available), doctors should share this vital information

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Thorpe & Lydia L. Ogden, *The Foundation that Health Reform Lays for Improved Payment, Care Coordination and Prevention*, 29 HEALTH AFFAIRS 1183, 1183-84 (2010).

242. Liang, *supra* note 228, at 563.

243. *Id.*

244. *Id.* at 566. Dr. Liang acknowledges that intentional torts are not included under the definition of medical error: "[T]he tort system should be reserved for intentional injury or reckless actions of the provider. Recall that's what medical error is not; and in this way we will be able to get at these volitional activities, these *malum in se* people." *Id.*

245. Fleck, *supra* note 13, at 260 ("But, among other things, closer inspection often will show that one person's 'waste and inefficiency' is another person's chance at life-sustaining medical care.").

with their patients. Such doctor/patient dialogue would yield positive cost-effective results to both the physician and individual patients. If a physician or a government protocol relies on age alone as the sole indicator of the suitability of a particular treatment, then such a decision to withhold treatment constitutes discrimination based on age.[246]

PROPOSAL IV: MORAL REFORM, GENERATIONAL JUSTICE & INTEGRATION

Ben Franklin said, "All would live long, but none would be old."[247] As Americans are living longer, inevitably, we as a society are getting older. The question arises as to why we should even categorize healthcare by age at all. We as a society also tend to unjustifiably group the elderly, whether infirmed or not, together. For instance:

> Merely being old in years does not signify that one has lost physical or mental capacity. Labeling an entire group as "the elderly" merely because of the infirmities of some inevitably leads to the perception and widespread belief that all members of the group suffer from diminished physical and mental capacity . . . . By grouping the chronologically old together and labeling them "elderly" we impute to them characteristics associated with the label.[248]

Therefore, labeling all aged as "elderly" may isolate them as a group and hinder integration into society. Recently, the concept of "generational justice" has emerged among philosophers—a concept which concerns how much the young, in essence, "owe" the elderly.[249] It proposes that current generations have a "duty" to care for the older generations, who in their time, have contributed to society to help future generations. In other words, "present generations may be obligated by considerations of justice not to pursue policies that create

246. WICCLAIR, *supra* note 66, at 108.

247. *Poor Richard Speaks: the Wit and Wisdom of Benjamin Franklin: His Enduring Wisdom Leads us to a Higher Appreciation of his Genius*, SATURDAY EVENING POST (July 1, 2007), http://www.encyclopedia.com/doc/1G1-166944886.html.

248. Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L.J. 683, 685 (1991).

249. *Id.* at 707; *see also supra* notes 53-56 and accompanying text.

benefits" only for themselves.[250] Rather, they should remember and be aware of generations that have not only come in the past, but will emerge in the future.[251] Integration of the elderly, who are often individuals isolated from our society, is essential in order to prevent ageism. In turn, such integration should extend into the healthcare arena. Justice and fairness may require that we care for those who so lovingly cared for us in the past. It would do the U.S. society some good to look to other cultures, such as those found in Asian countries, that place a high priority on the elderly in particular and the family in general.[252]

IN CONCLUSION

The number of years a person has lived is not conclusive as to that patient's overall health status or suitability for a particular medical treatment. "Advancing and pursuing healthcare, then, is an obligation that 'a good society owes its citizens in justice.'"[253] How to control costs and limit access to healthcare resources is a dilemma confronting healthcare today.[254] The solution to this dilemma will not be easily

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250. Lukas Meyer, *Intergenerational Justice*, STANFORD ENCYCLOPEDIA PHIL., http://plato.stanford.edu/entries/justice-intergenerational (last revised Feb. 26, 2008). In fact, "some proposed that reducing the deficit by cutting Medicare services and coverage is highly immoral." Etzioni, *supra* note 187.

251. Frolik & Barnes, *supra* note 248, at 694.

> Since the creation of Social Security and Medicare, younger workers have funded programs for the elderly. It's a compact in which workers paid for retirees with the understanding that they'd be looked after by the generation behind them. The health overhaul diverges by tapping a program for the elderly to help provide insurance to 32 million Americans of younger generations. Nearly half the funding for the law is supposed to come from paying lower fees to hospitals, insurers and other health-care providers that participate in Medicare, the federal insurance program for Americans age 65 and older, as well as younger disabled people.

Janet Adamy, *Health Law Augurs Transfer of Funds from Old to Young*, WALL ST. J. (July 27, 2010), http://online.wsj.com/article/SB10001424052748703340904575285002595068326.html.

252. Tom Plate, *The Age of Insecurity: The Elderly in Asia Versus America*, ASIA MEDIA ARCHIVES (June 2, 2004), http://asiamedia.ucla.edu/article.asp?parentid=11693.

253. SMITH, *supra* note 32, at 11.

254. *Id.* at 17.

reached. But certainly a senior citizen's access to equitable healthcare must be safeguarded—no matter what the new healthcare reform ends up looking like over the next decade.

There are means to allocation other than rationing by age—a combination of legal, medical, economic, and ethical avenues must be explored. One such avenue is implementing legislation and bright-line rules that directly and positively impact the elderly in the medical arena; because as it stands now, laws are sparse regarding this matter on the federal level. Moreover, decreasing medical error and enhancing doctor/patient dialogue would greatly offset the added cost of healthcare reform. We cannot look at this issue only through a legal or economic lens. We must also assess the moral implications of rationed care and the ramifications that rationed care would have on sectors of society such as the elderly. In fact, allocation does not have to be targeted at a sector of society at all. We do not need to heed to the words of Euripides. With these proposals, Americans—old and young alike—can enjoy the benefits of this new wave of healthcare reform without the fear of or need to ration. In the words of Pope John Paul II, "each stage of life has its own beauty and its own tasks."[255] We must not let seniors—whether 65 or 102 years old such as Thelma, be left behind.

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255. *Letter of Pope John Paul II to the Elderly*, OFFICIAL WEBSITE OF THE VATICAN (Oct. 1, 1999), http://www.vatican.va/holy_father/john_paul_ii/letters/documents/hf_jp-ii_let_01101999_elderly_en.html.

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