

Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty

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INTRODUCTION

An exploration of the *law* of Medicare and Medicaid, fifty years in, will be viewed by some as asking for trouble. The search for “law” in health has had a quixotic quality: many forests have been sacrificed in service of arguments that the concept of health law has as much purchase as the concept of a law of concrete.¹

I do not subscribe to this view, but in any event, it is beside the point here. Whatever the merits of such arguments for some aspects of health, one should not be able to make claims about the difficulty of finding the “law” in Medicare and Medicaid. These two major health programs are *themselves laws*: they are major federal statutes. But for some reason, although thousands of pages have been written about Medicare and Medicaid *policy*, strikingly little has been written about their *source* and their *status* as federal statutes: what makes them different, as *laws*, than what came before?

Medicare and Medicaid began the transformation of health law from a field of local and private law (including professional self-regulation) to the field of *federal, statutory, public* law that it now undoubtedly has become, even if it is rarely described as such. The Affordable Care Act of 2010 (ACA)² stands as evidence of the completeness of this transformation and, from a legal perspective, this

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1. My colleague Jerry Mashaw deserves credit for this colorful analogy. The “law of the horse” is another favorite comparison. See Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 2 (2008). For a 2006 symposium devoted to health law’s lack of coherence, see Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 446 (2006); cf. Theodore Ruger, *Health Law’s Coherence Anxiety*, 96 GEO. L.J. 625 (2008).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

evolution changes much about where health law comes from and what influences it. Medicare and Medicaid injected an entirely new array of federal actors into the health arena—not just the federal courts (always the most obvious choice for lawyers) but, more importantly, Congress, federal administrators and even states, in their role as federal-law implementers. Although the ACA has drawn the attention, it was Medicare and Medicaid that started the legal conversation over the merits of government interference (and if so, which government) in health care.

Nevertheless, there has been little apparent academic interest in the federal statutorification of health law thus wrought in 1965. For one example of what has been absent, these two progenitor statutes lack much deep legal theorization relating to the norms that underlie them.³ In other subject-matter areas, legal scholars have developed theories of the particular field's "superstatutes"—the field of legislation's terminology for transformative federal laws.⁴ What values drive the federal immigration laws, voting rights legislation, environmental statutes, the Civil Rights Act, financial regulation and so on? No one feels compelled to seek out the "law" in these other areas, either, because we know where the law is—in the federal statutes.

So too, now, with health. In the context of the ACA, scholarship has in fact begun to emerge about that statute's normative basis. But the ACA builds squarely on the world of law and policy that Medicaid and Medicare created fifty years ago. It was Medicare and Medicaid that paved the way for the many federal statutes that followed in the interim, including the Health Maintenance Organization (HMO) Act of 1973,⁵ the Employee Retirement Income Security Act (ERISA) of 1974,⁶ and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.⁷ Together, and long before the ACA, these moves fundamentally changed the players in health governance and the legal structures that control them.

And so, what are these two fraternal-twin statutes about? What norms defined them at the start, and do the same norms define them today? How has the federal intervention—and also, importantly, the nature and attendant pathologies of federal *institutions*—changed how health law and policy has developed? And what

3. For important exceptions, see THEODORE MARMOR ET AL., *SOCIAL INSURANCE: AMERICA'S NEGLECTED HERITAGE AND CONTESTED FUTURE* (2014); and Michael J. Graetz & Jerry L. Mashaw, *Ethics, Institutional Complexity and Health Care Reform: The Struggle for Normative Balance*, 10 J. CONTEMP. HEALTH L. & POL'Y 93 (1994).

4. See William N. Eskridge & John Ferejohn, *Superstatutes*, 50 DUKE L. REV. 1215 (2001).

5. Health Maintenance Organization (HMO) Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. § 300(e) (2006)).

6. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2006)).

7. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

effect has the injection of Congress, federal courts, federal administrators and states had on matters ranging from scientific research and innovation to how the programs and rights created by the federal laws are paid for, modified and enforced?

If one looks to the caselaw for the answers to these questions one will be disappointed. Indeed, the propensity of legal scholars to look for “federal law” in only the federal courts may be a reason that health “law” has been so hard to find. As my own contribution to this conference illustrates, the U.S. Supreme Court is not intervening frequently or significantly in the field’s major questions. When the Court does intervene, it does so with little apparent interest in health itself and with no coherent or theoretical approach to how the web of health statutes that began with Medicare and Medicaid but progressed through the alphabet soup of laws that culminated (for now) with the ACA relate to one another. Eleanor Kinney’s contribution to the conference illustrates the same point with respect to how administrative law in the field has developed.⁸

This is another reason that focusing on the *statutorification* of the field is so important. Emphasizing the statutory source of Medicare and Medicaid broadens the legal landscape of health lawmakers. Congress emerges as paramount: Federal budget rules and Congress’s politics and internal structures—all matters completely unrelated to health law—are institutional forces that have a profound impact on how health law develops. So too federal administrators have their own toolbox of policy levers—ranging from administrative waivers to payment incentives—that they have deployed in this context to influence state and private actors in ways only possible for the federal government, with its unique leverage, to do.

Such was the genesis of the Yale Law School conference on The Law of Medicare and Medicaid at Fifty, and it is in this spirit that this Introduction frames the twenty-nine outstanding contributions to the event.⁹ Not every contribution—indeed, not most of them—wears the law on its sleeve. Approximately one-third of the panelists were not lawyers at all.¹⁰ But law this most certainly is. There is legal theory that lies within the conference debates about the values that now drive Medicare and Medicaid as well as the institutional analyses that the conference produced. Understanding the theoretical payoff of these explorations helps to chart

8. Eleanor D. Kinney, *The Accidental Administrative Law of the Medicare Program*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 111 (2015).

9. Not all twenty-nine presentations are published as essays in this volume, but this Introduction discusses them all, except for one contributor who requested that his presentation not be discussed. Some of the shorter contributions to the volume also appeared first on *Health Affairs Online*, which accounts for the variability of length among the essays.

10. Other contributors included historians, physicians, economists, political scientists, policymakers and members of the media.

a path toward a deeper understanding of what the law of the field really is.

Two major themes emerge. The first is the unsettled nature of the modern *identities* of the two programs. How entrenched are the programs and what is driving their operation today? At least in the eyes of our contributors, the answer seems very different for each half of the pair. Medicare, the program that has traditionally stood on more solid ground, may now be more politically vulnerable than ever before. It also seems to be in the midst of an identity crisis; embracing no fewer than three different payment models, each of which reflects a very different set of values from the other. On the other hand, Medicaid, which, as Sara Rosenbaum put it, “has always had to fight for its life,”¹¹ may be on the threshold of achieving a “universality” (Nicole Huberfeld’s term¹²) that once was associated with Medicare’s animating theory but that Medicare never achieved.

What is more, the values and questions driving the programs, if ever linked, seem to have diverged significantly—as least as seen by our diverse and interdisciplinary group of contributors. The Medicare papers for the conference are almost singularly obsessed with markets and cost. In contrast, the Medicaid papers have an entirely different center of gravity, focused more on the social-welfare question of inclusion and exclusion of different populations. The second major theme goes to the legal *players*, especially those that (because they are not courts) have been overlooked in the past. This kind of modernized, statute-focused institutional analysis is common in some fields of legislation, but has yet to be applied to health law as a field. But consider how Congress’s own institutional limitations deriving from sources totally unrelated to health law profoundly affect how the statutory law of health develops. Several participants, including Keynote Speaker Ezekiel Emanuel and myself, focused on how Congress’s general tendency toward policy incrementalism has had lasting effects on health law’s evolution.¹³ Others, especially Tim Westmoreland, focused on the impact of the federal budget rules which, as Westmoreland put it, have given rise to a world of “health economics instead of a broader view of health policy.”¹⁴

Federal and state administrators emerge in the contributions as other key players, with the recurring theme being the different ways in which government

11. Sara Rosenbaum, *Panel 2: Medicaid, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; see also Sara Rosenbaum, *Clash of the Titans: Medicaid Meets Private Insurance*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 197 (2015).

12. Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 67 (2015).

13. Ezekiel Emanuel, *Opening Remarks*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 27 (2015).

14. Timothy M. Westmoreland, *Panel 3: Historical Context, Legislation, Administration*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

uses its own policy levers—most notably its capacity to generate data and to leverage its power through payment incentives and federalism bargaining—to effectuate change both at the level of government policy but also on the ground, in the medical profession itself. This is a modern shift in the statutes’ original missions that should not be overlooked. By the statutes’ own terms, Medicare and Medicaid were not to “be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”¹⁵ Today, the government clearly views the programs as tools that influence how doctors work.

Finally, of course, courts and more formal aspects of administrative law also are present. But, notably, every paper to discuss them lamented the “accidental” (Kinney’s term¹⁶) and haphazard manner in which the caselaw and the administrative law have developed around the two programs. The incoherent doctrinal development, such as it is, provides further evidence that those who seek to know the “law” of Medicare and Medicaid—and likely the rest of health law—need to take a broader view of what health law is, where it comes from, and what influences it.

I. THEORIES OF MEDICARE AND MEDICAID—AND THEORIZING THEM TOGETHER

Medicare and Medicaid are fraternal twins that, like so many such pairs, have distinct personalities and life stories. The contributions to the conference strike recurring themes about the distinctive identities and modern preoccupations of each. Lawyers should care about these narratives because they have implications for legal interpretation and change. Understanding Medicaid, for example, as animated by the norm of universality would counsel a set of interpretations of that statute that might be different from an understanding of Medicaid as primarily occupied with certain needy populations. Understanding Medicare’s focus to be on the health care market has different implications for judicial review and legislative reform than an understanding of Medicare as animated by the questions of who the statute’s beneficiaries are or should be—for instance, Allison Hoffman’s argument in this volume that we should reconceptualize Medicare as a benefit not only for elderly but also for those who care for them.¹⁷

15. Social Security Amendments of 1965, Pub. L. No. 89–97, § 1801, 79 Stat. 286, 291 (codified as amended at 42 U.S.C. § 1395 (2012)).

16. Kinney, *supra* note 8.

17. Allison K. Hoffman, *The Reverberating Risk of Long-Term Care*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 57 (2015).

In other words legal scholars need a *theory* of each statute. Medicare in particular, at least among our contributors, seems to lack a coherent theory of its own purpose—or even a set of theories. Both Ezekiel Emanuel and Jonathan Cohn suggested that Medicare may be politically vulnerable for the first time in its life, making the question of its underlying normative foundation particularly important. Medicaid’s future always has seemed more precarious but, as several contributors pointed out, Medicaid has shown a remarkable ability to adapt and evolve to ensure its own survival.

A. Medicare’s Competing (or Lacking) Normative Visions

The most salient theme that emerges from the contributions about Medicare is the lack of a clear modern normative vision of what the program is trying to do, beyond its initial mission of coverage (the success of which no one seems to dispute). The program’s original emphasis, which was grounded in the hope of eventual universal health insurance, has given to way several different, and arguably conflicting, internal models each based on a different view of the relationships among social insurance, the marketplace, and the profession.

1. Medicare’s Multiple Models

Nicholas Bagley¹⁸ and Thomas Greaney¹⁹ each detail the three different “mini” programs within Medicare today: the original fee-for-service model; Medicare Advantage (added approximately thirty years later²⁰), which has a competition component; and the Accountable Care Organization (ACO) model (introduced by the ACA²¹), which incentivizes integration and coordination by providers in return for cost savings. As Greaney observes, each mini-program has a different normative foundation. Fee-for-service embraces the traditional value of the independent physician and the open market, with little emphasis on cost savings. Medicare Advantage aims to introduce more competition but is not a fully

18. Nicholas Bagley, *Panel 6: Looking Ahead, Medicare and Medicaid at 50 Conference*, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

19. Thomas L. Greaney, *Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 37 (2015).

20. Part C and the managed care plan were created in the Balanced Budget Act of 1997, which established Medicare+Choice. Some changes were made and the program was renamed Medicare Advantage by the 2003 MMA. See *Medicare Advantage Fact Sheet*, KAISER FAM. FOUND. (May 2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet>.

21. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3022, 124 Stat. 120, 395 (codified as amended at 42 U.S.C. § 1395jjj (2012)).

competitive model because plans must bet against an administratively determined price. ACOs embrace an entirely different view of what the system should look like: a vertically and horizontally integrated system of health care that puts a premium on cost savings.

Although not mentioned by the participants, it seems likely that the incremental way in which Congress tends to expand major federal programs bears at least some of the blame for Medicare's internal fragmentation. Each of the above-listed models was added during a different moment of expansion. Medicare's basic structure is also itself fragmented: Each of Medicare's four parts—Part A for hospital coverage; Part B for physicians; Part C for the Advantage Plans; and Part D for prescription drugs—has a different aim and the sources of funding vary across the programs. Only Parts A and B were added at the same time.

The way in which these papers highlight Medicare's internal variations also suggests an interesting link to Medicaid that has not yet been explored. Medicaid has always tolerated, even embraced, its own internal variety, because it is explicitly designed to allow flexible and diverse implementation by the states. Medicare, on the other hand, has always been theorized as the all-federal, someday-“universal” program with homogeneous benefits nationwide. But these distinctions seem overstated. As the contributions illustrate, Medicare in fact has its own story of internal diversity, not only in the different payment models but also, as Bagley notes, in its history of experimenting with different forms of peer review. I would also note here that Medicare benefits review determinations have a local character. Most coverage decisions are made by local-level clinicians who work with the Medicare administrative contractors that process Medicare claims.²² This is another way in which Medicare has resisted uniformity in its development even as universality has always been its dominant norm.

2. Medicare's Unaccomplished Universality

As noted, Medicare originated with a strong normative vision of universality of coverage in a social insurance model. In their contributions, James Morone and Ted Marmor and Kip Sullivan each detail how, in 1965, Medicare was assumed to be the first step toward an eventually-universal expansion.²³

22. Michael J. DeBoer, *Medicare Coverage Policy and Decision Making, Preventative Services, and Comparative Effectiveness Research Before and After the Affordable Care Act*, 7 J. HEALTH & BIOMED. L. 493, 506 (2012).

23. Ted Marmor & Kip Sullivan, *Medicare at 50: Why Medicare-for-all Did Not Take Place*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 141 (2015); Jim Morone, *Panel 1: Medicare, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

What changed? Relevant to the importance of identifying a compelling normative vision for the statute, Marmor and Sullivan argue that it was a set of *competing norms*—most importantly, the pro-competition philosophy of the 1970s—that undermined Medicare’s universalist vision.²⁴ Morone levies a different charge, one joined by Jonathan Cohn in his keynote address: changing politics.²⁵ Both argue that the particular circumstances of 1965 made this dual enactment possible in ways that could not be accomplished today and that could not sustain the original vision: A Democratic president who simply had to unite his *own* divided party (rather than overcome today’s partisan gridlock) in a political moment that—largely because of the triumph of the Civil Rights Act of 1964—was temporarily marked by a lack of racialized politics and so, relatedly, a temporary lack of suspicion of social welfare programs.

Whatever the reason, the problem for Medicare now is its vision for the next fifty years. The various models of payment detailed in the previous section open the possibility of different futures for Medicare that span the range from the social insurance model to a highly integrated regime driven primarily by cost. Morone argues that the Republicans have a clear vision of what Medicare should look like going forward—one grounded in privatization, a vastly different norm than that which underlay the program at its founding. The Democrats, he charges, have no such clear, competing view.²⁶ The other panelists made similar observations, with Cohn in particular emphasizing that Medicare is more at risk than ever to be fundamentally transformed.

3. Medicare, Markets, and its Modern Influence Over The Profession

The other striking aspect of the Medicare contributions is the almost singular focus on *cost* and *markets*. Almost no attention is given to the extent of Medicare coverage or to questions of inclusion and exclusion of populations under Medicare’s umbrella. Two exceptions come from Judith Feder and Allison Hoffman, who discuss the lack of coverage for long term care, and Michael Ulrich, who discusses the insufficiency of benefits for disabled persons.²⁷ But all three contributors focus on deficiencies in both programs; their arguments are not about Medicare per se. In the long term care context, in particular, Medicaid currently

24. Marmor & Sullivan, *supra* note 23.

25. Jonathan Cohn, *Obamacare, Medicare, and Baseball’s Greatest Pitchers*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 21 (2015); Morone, *supra* note 23.

26. Morone, *supra* note 23.

27. Judy Feder, *Health Affairs Blog Post: Social Insurance is Missing a Piece: Medicare, Medicaid, and Long-Term Care*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 233 (2015); Hoffman, *supra* note 17; Michael R. Ulrich, *Health Affairs Blog Post: Challenges for People with Disabilities Within the Health Care Safety Net*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 247 (2015).

carries most of the water with respect to coverage.

The other contributions focus on Medicare's impact on markets—and, interestingly, on the program's related impact on the profession. David Hyman and Tim Westmoreland focus on Medicare's complex and nontransparent budgeting, which is driven by the particulars of the federal budget process, further detailed below.²⁸ Jacob Hacker emphasizes cost control, but also argues that the focus on Medicare costs has been disproportionate to Medicare's influence, and urges for that debate to be brought into the broader health-policy context.²⁹ Bagley and Greaney focus on provider markets,³⁰ while Daniel Kevles discusses Medicare's influence over the development of prescription drugs,³¹ and Harlan Krumholz and Rahul Rajukumar focus on how CMS uses payment incentives and big data to influence the practice of medicine.³²

Almost all of these contributions are notable for their theorization of Medicare's market power as a tool of *leverage over the profession*, despite Medicare's own statutory promise not to affect the practice of medicine. This presents another big question for any developing theory of Medicare. Medicare's initial fee-for-service model indeed seems consistent with its initial vision of leaving the profession untouched. But now, the program seems to have evolved with a very different set of views both about the role of government in affecting the way that doctors practice and about the need for change in the profession, whether it comes in the form of cost savings or in the use of more evidence. Ted Ruger's contribution to the symposium calls this the triumph of a "Weberian" vision—an organized, hierarchical model of the profession—over the system's initial focus on the "Madisonian" values of pluralism and individualism.³³ Whatever it is, it signifies an important theoretical shift that has gone mostly unmined.

28. David Hyman, *Panel 1: Medicare, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; Westmoreland, *supra* note 14.

29. Jacob S. Hacker, *Panel 3: Historical Context, Legislation, Administration*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

30. Bagley, *supra* note 18; Greaney, *supra* note 19.

31. Daniel J. Kevles, *Health Affairs Blog Post: Medicare, Medicaid, and Pharmaceuticals: The Price of Innovation*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 241 (2015).

32. *Panel 4: Policymaking and Innovation*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

33. Theodore Ruger, *Panel 6: Looking Ahead*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

*B. Medicaid's "Mission Uncertainty"*³⁴

The Medicaid story seems completely different, at least from the perspective of our contributors. Here, there is a clear theoretical question staked out by virtually everyone who discusses the program: namely, whether Medicaid should be reconceptualized in its next half-century as a universal program or whether it should stay true to its initial mission of focusing on the poor. So understood, the heart and soul of Medicaid theorization—at least in this moment—is the question of “Medicaid’s mission uncertainty” (John Jacobi’s term).³⁵ The focus on inclusion and exclusion and on the program’s ultimate aims strikes a very different note from the Medicare papers.

1. Universality versus a Program Focused on the Poor

Medicaid’s own history supports a story of step-by-step expansion toward a universal paradigm to some extent. The program began with coverage for a small segment of the “deserving poor”—pregnant women and children—and then expanded over fifty years to include many more special populations. The expansion, of course, culminated with the ACA’s universalist-leaning expansion to *all* persons, regardless of special category, with incomes up to 138% of the poverty level.³⁶ The Supreme Court made the expansion optional,³⁷ but even so there has been a domino-effect among the states in expanding (just as in the case of Medicaid’s first iteration, with Arizona not adopting the program until 1982). In other work, Tom Baker, Nicole Huberfeld, Ted Ruger and I illustrate how this current expansion is highly dynamic and likely to culminate in complete adoption.³⁸

In this volume, our contributors disagree about Medicaid’s fundamental aims. Huberfeld’s vision of Medicaid’s “universality” is underpinned by a hope of continued expansion but also one that sees Medicaid as universal, even now. As she puts it, because Medicaid now pays for so much—almost 50% of births in the United States and 60% of long term care, “most of us are all going to be on Medicaid eventually.”³⁹ Thus, Huberfeld’s work re-theorizes Medicaid beyond its “poor-person” paradigm, pushing toward a broader acceptance on the part of most

34. John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 89 (2015).

35. *Id.*

36. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 120, 271 (codified as amended at 42 U.S.C. § 1396a (2012)).

37. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601–08 (U.S. 2012).

38. Tom Baker et al., *New Health Federalism* (unpublished manuscript on file with author).

39. Huberfeld, *supra* note 12.

Americans that they will benefit not only from Medicare, but Medicaid as well. In many respects, it is part of a project to remove Medicaid's stigma.

Other contributors take a different view. David Orentlicher still sees two-tiers in the program, which leads him to doubt its potential for true universality.⁴⁰ He details how the Medicaid expansion is distinct from the traditional Medicaid population, which means that the two groups may receive different benefits.⁴¹ He also argues that because Medicaid still only covers the less well off, the middle class and the rich continue to have no stake in the program, as they do in Medicare. Both factors, in his view, reduce the likelihood that the stigma will be erased.

Mark Hall and Tim Jost both emphasize Medicaid's relationship to racism, another barrier to a truly universal conceptualization. Hall sees a bias against the poor (often minority) population in states that resist expansion.⁴² Jost argues that the historical roots of state administration of Medicaid programs are found in racism and that the continued resistance of conservative states to Medicaid expansion carries on a history of discrimination.

Jacobi takes a stronger view in opposition to Huberfeld, urging that we cling to a theory of Medicaid grounded in its original mission to serve those without means.⁴³ In his view, a driving norm of universality might undercut that mission, resulting in less focus on the unique health needs of the extreme poor—Medicaid's initially-intended beneficiaries. Jacobi's vision of Medicaid expands beyond mere health coverage, too. He sees Medicaid's potential as the cornerstone of a program of interlinked social services which he calls Total Accountable Care Organizations (TACOs), which are designed to address not only health issues but also food, housing, and other social supports that have a large impact on health status and wellbeing. Economist Amanda Kowalski's contribution, which studies Medicaid's positive impact on the production of other social goods, such as tax payments later in life and college attendance,⁴⁴ lends support to this notion.

2. Medicaid's Flexibility and Its Federalism

Medicaid's "scrappiness" (Rosenbaum's term) emerges from the

40. David Orentlicher, *Medicaid at 50: No Longer Limited to the Deserving Poor?*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 185 (2015).

41. As in the Medicare context, here too one sees health law's multiplicity of programming even when the ostensible goal is universality.

42. Mark Hall, *Panel 5: Are There Any Plausible Reasons for States to Refuse Medicaid Expansion?* available at http://www.law.yale.edu/news/medicare50_video.htm.

43. Jacobi, *supra* note 34.

44. David Brown, Amanda Kowalski & Ithai Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?*, (Nat'l Bureau of Econ. Research, Working Paper No. 20835, 2015).

contributions as another distinguishing feature. Rosenbaum describes Medicaid as the “big shock absorber” that has had to “fight for its life,” and so learned to adapt and “do what no other program can.”⁴⁵ “Law” plays an important role here, in the sense that Medicaid’s dynamism is no doubt attributable in large part to its governance structure. Medicaid is the quintessential statutory federalism program, structured as joint enterprise between states and the federal government (in contrast to Medicare, which is essentially federal all the way down⁴⁶). Like most cooperative federalism programs, Congress designed Medicaid to take advantage of existing state programming in the subject-matter area and so the program preserves and facilitates ongoing policy variation.

Several contributors highlight Medicaid’s federalism as its defining characteristic, but also one that poses some interesting challenges for the future. Sidney Watson discusses the successful history of Medicaid’s Section 1115 demonstration waivers—the administrative waiver provision that has allowed many states to evolve their programs (and in fact, as I have discussed elsewhere,⁴⁷ often has facilitated the states as “testers” for the kinds of expansions later adopted by the federal government). Heather Howard focuses on how the ACA’s new section 1332 State Innovation Waiver provisions might likewise facilitate adaptation.⁴⁸

From a doctrinal perspective, however, waivers raise tricky questions. My own work has highlighted the legal black hole into which waivers fall: there are generally no process provisions, no guarantee that states will have equal bargaining power, and no requirements for transparency to or input from the public. Watson’s piece is very important on this point, as it highlights an until-now undernoticed provision of the ACA that for the first time makes waiver applications public; sets forth what must be specified in them; requires CMS to be similarly specific and publicly disclose what is being approved and why, along with public comments; and requires CMS to create a process for notice-and-comment at both the state and federal levels.⁴⁹ This is an important example of Medicaid leading the way on a

45. Sara Rosenbaum, *Panel 2: Medicaid, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

46. *But cf. supra* note 23.

47. Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 FORDHAM L. REV. 1749, 1763–65 (2013).

48. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 120, 203 (codified as amended at 42 U.S.C. § 18052 (2012)); Heather Howard, Panel 4, *Health Law Federalism, Especially after NFIB*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

49. *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10201, 124 Stat. 120, 917 (amending § 1115 of the Social Security Act, 42 U.S.C. § 1315 (2014), on Medicaid demonstrations); Sidney Watson, *Out of the Black Box and Into the Light: Using Section 1115*

cutting edge legal issue that has occupied federalism theories in general but has received little attention in the health context.

Alan Weil lauds Medicaid's successful history of policy experimentation, but also reprises another theme that has occupied the general federalism literature of late; namely, that state-led policy experiments, although they occur frequently in cooperative federalism programs, are rarely done with the scientific rigor of proper policy experiments.⁵⁰ Weil describes the lack of data management in, and the often-too-quick interstate adoption of, state experiments. This offers another contrast to Medicare. As Weil points out, Medicare is very good at formal experiment design, but has much less success than Medicaid in the uptake of successful experiments. Ted Ruger's contribution again comes to mind here, in the sense of whether this aspect of the health care system—innovation—best occurs through a top-down model or a more federalist structure.

Not all participants were so sanguine about Medicaid's federalism structure. As noted, Mark Hall and Tim Jost associate it with racism; Abigail Moncrieff simply finds it unsustainable, especially in light of recent Supreme Court decisions making it more difficult to enforce the statute against lax states. As she argues, the Court in *NFIB v. Sebelius*⁵¹ effectively eliminated HHS's power to cut off Medicaid funding from uncooperative states. Just a few months earlier, in *Douglas v. Independent Living Center*,⁵² the Court also implied that it would be very difficult for Medicaid providers or beneficiaries to challenge state implementation of the program in court.⁵³ As such, Moncrieff predicts the eventual federalization of Medicaid to ensure that the federal government can properly enforce it. Understood through the lens of these contributors, Medicaid's federalism structure adds yet another layer of complexity to understanding how the program can achieve its intended results and outcomes. Even as Medicaid federalizes the law of health finance, it still must interact with and remain heavily dependent on state law.⁵⁴

In the end, the apparent consensus (or resignation) as to Medicare's coverage scope seems to be driving Medicare theory into different areas than Medicaid, where the theoretical inquiries remain focused on themes of inclusion and

Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion, 15 YALE J. HEALTH POL'Y, L. & ETHICS 213 (2015); see also ERIN RYAN, *FEDERALISM AND THE TUG OF WAR WITHIN* (2011) (discussing the state-federal administrative bargaining process).

50. Gluck, *supra* note 47, at 1764.

51. 132 S. Ct. 2566 (2012).

52. 132 S. Ct. 1204 (2012).

53. Another case currently pending before the Court raises the same issue. See *Armstrong v. Exceptional Child Care Center, Inc.*, No. 12-35382 (U.S. Jan. 20, 2015).

54. Thanks to Sara Rosenbaum for this insight.

exclusion. When Medicare was first proposed, its own debate, too, focused on how many to cover and whether to expand. But, today, the question for Medicare appears not to be about transformational change but, rather, about modest internal improvements that may increase the program's stability and leverage over both the broader health market and the profession. Medicaid was barely discussed in terms of either markets or the profession, but at the same time was repeatedly referenced as more dynamic and more vibrant. As a whole, the papers thus map some rather striking differences in the modern identities of these fraternal twins.

II. INSTITUTIONAL THEORY: THE PLAYERS

Health law has not lacked for institutional analysis, but the institutions that have garnered most of the academic attention in the field are not the same intuitions at the center of the federal statutory field of health law that Medicare and Medicaid created. Health law scholars tend to talk about patients, doctors, insurers, markets, courts, and sometimes states in their field analyses.⁵⁵ Most lacking from this inquiry has been a study of how Congress's institutional pathologies affect health policy, and to a lesser extent (Jost and Kinney offer important exceptions⁵⁶) the role of federal administrators. In organizing the conference, we hoped that participants would bring out this more modern institutional story of health law.

A. Congress

Three themes emerge with respect to Congress's influence. Critically, these are elements of Congress as an institution that have nothing do with health law *per se* but that affect health law dramatically, thereby substantiating the importance for modern health law scholars of gaining a better understanding of how Congress works.

Of most importance was the role of the federal budget process in setting health policy. Tim Westmoreland's contribution details how the difference between mandatory and discretionary spending on federal programs has an enormous impact on how health policy develops.⁵⁷ Westmoreland describes mandatory spending as a "promise," whereas discretionary spending remains subject to the annual whims of politics. To me, this raises an important *expressive* aspect to the

55. See M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389 (2009); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004).

56. Timothy S. Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L. J. 1 (2004); Eleanor D. Kinney, *Administrative Law and the Public's Health*, 30 J. L. MED. & ETHICS 212 (2002).

57. Westmoreland, *supra* note 14.

fiscal structure of any government program. Programs grounded in mandatory spending, as are Medicare and Medicaid, wear their entrenchment on their sleeve by virtue of their financing structure.

At the same time, Westmoreland and also David Hyman highlight how the way in which mandatory spending is budgeted—over a ten-year window—may skew aspects of health policy. For Hyman, the problem is a lack of transparency—a creative accounting that he views on par with the accounting related to the Enron scandal.⁵⁸ For Westmoreland, the issue is both the short-term nature of the budget—it must be costed out over ten years—and also the strange ways in which the budget deincentivizes programs that increase lifespan, because longer lives increase the short-term cost of federal programs. Coverage for vaccinations, for example, while sound health policy, creates budget difficulties for precisely this reason. Moreover, because the federal budget (not just the Medicaid/Medicare budget) must be balanced over a ten-year period, longer-term savings from certain proven interventions (such as reducing children's exposure to lead paint) face challenges at adoption because they must be paid for upfront.⁵⁹

Two other features of Congress's internal structure also emerge as relevant to understanding health law's development. Both Ezekiel Emmanuel's keynote address and my own contribution emphasize the well-known, institutionalized inertia of the legislative process. In the nation's libertarian tradition, Congress is structured to make legislation difficult. Fewer than 10% of bills escape committee review and make it to the floor for consideration by the full membership. As a result, sweeping legislative changes are highly unlikely in American governance; instead, ours is a tradition of policy incrementalism and path dependence.⁶⁰ That tradition explains in large part why Medicare and Medicaid, though born together, have such different governance structures. Medicaid followed the path of already-existing state-charity care programs and so built its structure on that pre-existing state terrain. It also explains why both programs were initially designed to reach smaller populations, with the hope of later expansion. And it explains why Congress left the status quo—the employer-provided insurance system—intact when it added the two new layers of federal insurance.

In this sense, Congress's tendencies toward policy incrementalism and path dependence also explain how Medicare and Medicaid put us on the path toward the kind of health governance fragmentation that so many health experts criticize. Understanding how Congress legislates as the explanation and also the obstacle

58. Hyman, *supra* note 28.

59. Westmoreland, *supra* note 14.

60. I have detailed this elsewhere. See Gluck, *supra* note 47, at 1760–65; see also Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79, 84 (1959) (discussing the incremental change in U.S. policies).

further explains why the ACA itself could not possibly have swept that fragmentation away (as many advocate it should have⁶¹) and started from scratch.

A third essential institutional feature of Congress is its division into policy-expert committees. My own work highlights how the committee system also has contributed to fragmentation and difficult implementation issues in the health arena and beyond.⁶² Different committees have jurisdiction over different aspects of health statutory law, and these committees oversee a variety of different agencies that are candidates to implement the laws. The result is fragmentation and complex administrative overlap. For instance, in the House of Representatives, Medicare and Medicaid are not even themselves completely under the jurisdiction of the same congressional committee. With respect to administration, ERISA is administered by the Department of Labor; Medicaid and Medicare by HHS; and the ACO provisions of the Affordable Care Act are administered by a range of agencies, including IRS, FTC, HHS; and DOJ. This type of institution-driven lawmaking and administrative fragmentation may well contribute to a lack of coherence in health policy in general, and also the particularly haphazard way in which the relevant caselaw and administrative law doctrines have developed.

B. Administrators, New Governance, and Innovation

Any statutory theory of health law also must include the administrators. I already have detailed several key features of the administrative landscape that emerge from the contributions. Kinney emphasizes the “accidental” evolution of health administrative law from 1965, when Congress envisioned only a small role for administrators, to today, when administrative law seems to do much more health-law work than the judicial system. Howard, Rosenbaum, and Watson, as discussed, focus on the landscape of federal and state administrative negotiations, which is critical to any legal understanding of Medicaid’s administrative law.

The additional theme that I wish to highlight here is what I would call health law’s “new governance” model of administration. The new governance literature is rarely extended to health law,⁶³ but many of the presentations from the

61. EINER ELHAUGE ET AL., *THE FRAGMENTATION OF THE U.S. HEALTH CARE: CAUSES AND SOLUTIONS* (Einer Elhauge ed., Oxford Univ. Press 2010).

62. Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside—An Empirical Study of Congressional Drafting, Delegation and the Canons: Part I and Part II*, 65 STAN. L. REV. 901 (2013) and 66 STAN. L. REV. 725 (2014).

63. An important exception is Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139 (2006), who discusses other ways that new governance appears in health law; cf. Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 56 (2008) (drawing on new governance literature to advocate “risk-pool governance structures” in the insurance context to “enhance[e] democratic norms in health care policymaking”).

conference point toward it as an appropriate and helpful frame. New governance is a term that emphasizes collaboration with third parties in addition to the government to manage traditional regulatory challenges in a new manner.⁶⁴ It is characterized by a recognition that multiple layers of review and multiple stakeholders—typically both inside and outside the federal government, including states and the private sector—can together produce, through redundancy and sometimes informal interaction, better and more innovative policy solutions than the federal government acting alone. Across the contributions to this volume, new governance emerged as an important way in which the federal government is working, through Medicare and Medicaid, to spur scientific research and medical innovation.

Two policy levers of health administrators seem to be paramount: data and payment. Krumholz and Weil both detail the way in which federal health-law administrators have used data to partner with both states and the private sector in encouraging policy and practice innovation.⁶⁵ Weil's contribution, as noted, goes to the respective advantages of CMS versus the states in conducting policy experiments. Krumholz focuses on one particular disease: he tells the story of the path-breaking Health Care Quality Improvement Initiative (HCQII)'s Cooperative Cardiovascular Project (CCP), a massive CMS-led, data-driven study of treatment of heart attacks that had a profound effect on how the profession treats the disease.

Daniel Kevles and Rahul Rajukumar detail the power of payment in innovation policy. Kevles details how Medicare and Medicaid had relatively little impact on the pharmaceutical industry until 2003, when Congress enacted Medicare Part D, the prescription drug benefit. Part D not only spurred pharmaceutical R&D but in particular, Kevles emphasizes, it also promoted R&D with respect to drugs related to the specific population—the elderly—associated with Medicare.

Rajukumar describes CMMI's use of payment mechanisms to incentivize physicians to collaborate, save money and use evidence-based practice methods. This more modern vision of what role Medicare is playing in the broader system relates directly to Bagley and Greaney's discussion of how Medicare's new payment models reflect how new norms are animating the program.

There is a broad health policy literature on how difficult it is to change the

64. Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, 28 *FORDHAM URB. L. J.* 1611, 1623 (2001); see also Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 *MINN. L. REV.* 342, 343 (2004) (discussing how the new governance model challenges the standard focus on formal regulation as the primary method of creating change).

65. *Panel 4: Policymaking and Innovation*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

culture or practice of the medical profession.⁶⁶ Although none of the contributors engage that literature in the context of these topics, the link to it seems obvious. New governance strategies appear to be particularly effective tools here. All of the contributors on these topics reference physicians as “partners” in the programmatic efforts—a way of thinking about regulation that is quite consistent with a new governance model. Moreover, as relevant to this Introduction’s focus on where the “law” is, as Louise Trubek notes, “new governance is transformative of law in that it challenges what we think of as law”—in particular, informal processes, interactions, and negotiations take on much deeper significance, even though most cannot be challenged or enforced in court.⁶⁷

C. Courts

Courts make only a minor appearance among the contributions, further suggestive evidence that courts are not the primary lawmakers when it comes to Medicare and Medicaid (and likely not the rest of the health statutes, either). The main themes here are the lack of doctrinal coherence and what might be called a lack of “health-law-awareness.”

Moncrieff, as noted, juxtaposes the Supreme Court’s decisions in the *Sebelius* case⁶⁸ and the *Independent Living Center* case⁶⁹ to illustrate how the Court has effectively eviscerated the federal government’s ability to enforce Medicaid. She argues that the Court likely has done so unwittingly, without attention to how one decision affects other aspects of the program, or how the two decisions relate to one another.⁷⁰

My own contribution, which relays the results of an empirical study of all of the Court’s decisions concerning Medicare and Medicaid since 1965, corroborates Moncrieff’s intuition.⁷¹ The Court almost never references a sibling health-law statute when it interprets another. Thus, the Court does not consider how its Medicaid decisions might affect Medicare, and so on. Nor does the Court invoke health policy, or interpret the statutes through the lens of any of the traditional

66. See Richard S. Saver, *Health Care Reform’s Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 U. PA. L. REV. 2147, 2155 (2011).

67. Trubek, *supra* note 63, at 149.

68. 132 S. Ct. 2566, 2601–08 (U.S. 2012).

69. 132 S. Ct. 1204 (2012).

70. Abigail R. Moncrieff, *Panel 3: Historical Context, Legislation, Administration, Medicare and Medicaid* at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

71. Abbe R. Gluck, *Panel 3: Historical Context, Legislation, Administration, Medicare and Medicaid* at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; see Abbe R. Gluck, *Health Law as Public Law* (unpublished manuscript on file with author).

norms long utilized and advocated by health-law professors (including solidarity, dignity, trust, vulnerability of health consumers, quality of life, the value of health, health economics and so on). Instead, the Court appears to treat each health-statutory case as a “one-off” case of routine statutory construction.

One takeaway, then, is that health lawyers need to pay more attention to the *law of statutes* in this modern age of federal statutory health law. Just as I have emphasized how Congress’s pathologies unrelated to health law profoundly affect health law’s development, so too, the Court has its own institutional preferences when it comes to statutory cases that do not stem from health law but may strongly influence it. For instance, the rise of textualism as the dominant interpretive philosophy on the Court means that the Court may now take a more text-centric approach to interpreting Medicare and Medicaid, even if it had not done so when the statutes were first enacted. The Court’s panoply of administrative-law deference doctrines, which continues to grow, also has a significant effect on health-law case outcomes. Understanding these statutory-law doctrines may now be as important to health lawyers as understanding health policy. Another takeaway, of course, is that health lawyers have an important role to play in educating the courts about the health statutes themselves, and the relationships among them.

CONCLUSION

To an important extent, the Supreme Court’s shortcoming in the Medicare and Medicaid context is a red herring. The Court has decided remarkably few cases concerning the programs over the past fifty years: fewer than thirty Medicare cases and fewer than fifty Medicaid cases. These numbers provide further evidence that one must look beyond traditional legal domains to find much of the “law of Medicare and Medicaid.”

But that does not mean that the law is not there. The twenty-nine insightful contributions to this conference reveal a legal landscape far richer than one that could be created by courts alone. These are *federal statutes*, and so we find much of their law in public law’s central institutions and in theories of the statutes themselves. As such, we find the law of Medicare and Medicaid in the Congress, the agencies, and the states—and in their interactions with one another and with the profession. And we find it when we look into the statutes and push for a deeper normative account of what values and questions drove them at their enactment and what drives them today. These are the legal lessons of Medicare and Medicaid’s first fifty years, and they have only begun to be uncovered. Far more lie ahead in the next fifty, should we choose to look in the right places.

