

THE BRIEF AND WONDROUS LIFE OF THE GRAHAM CASSIDY BILL: THE (UNCERTAIN) FUTURE OF HEALTH CARE FOR THE CHRONICALLY ILL

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INTRODUCTION: A SHORT STORY

Jerome Mitchell was a college freshman when he was diagnosed with HIV¹ in May 2002.² Although the seventeen-year-old was shocked and devastated by his diagnosis, he took comfort in knowing his health plan would assist with medical costs.³ However, Mitchell was quickly dropped by his insurer⁴ and could no longer afford his antiviral medication.⁵ The admittedly shy freshman was forced to retain legal counsel and sue his former insurance provider.⁶

Chronically ill patients like Mitchell are most affected by strict insurance provisions. The Affordable Care Act (“ACA”) eased discrimination against patients with pre-existing conditions, but its impending repeal leaves the future of health care unclear.

¹ HIV, fully named the Human Immunodeficiency Virus, weakens the body’s ability to fight off antibodies. The degenerative disease is transmitted through sexual conduct or blood. A common cold can be deadly due to an HIV patient’s lack of immunity. See Michael T. Isbell, *AIDS and Access to Care: Lessons for Health Care Reformers*, 3 CORNELL J.L. & PUB. POL’Y 7, 10 (1993).

² Murray Waas, *Insurer Targeted HIV Patients to Drop Coverage*, REUTERS (Mar. 17, 2010, 8:37 AM), <http://www.reuters.com/article/us-insurers-idUSTRE62G2DO20100317>.

³ *Id.*

⁴ Rescission is an equitable remedy that allows an insurer to retroactively “void a contract . . . entered into by misrepresentation or concealment of material facts.” Barry Zalma, *The Equitable Remedy of Rescission: A Tool to Defeat Fraud*, LEXISNEXIS LEGAL NEWSROOM INSURANCE LAW (Apr. 21, 2015, 1:04 PM), <https://www.lexisnexis.com/legalnewsroom/insurance/b/insurancelaw/archive/2015/04/21/the-equitable-remedy-of-rescission-a-tool-to-defeat-fraud.aspx>. Under the Affordable Care Act, rescission is illegal. See 45 C.F.R. § 147.128(a) (2016).

⁵ There remains no cure for HIV, however, strict adherence to antiviral regimens can slow the progress of the disease and reduce viral loads to undetectable levels. A lapse in treatment increases the risk of higher viral loads, transmission, and secondary infections. See Arkell C., *HIV Treatment and an Undetectable Viral Load to Prevent HIV Transmission*, CATIE, Mar. 31, 2018, <http://www.catie.ca/en/fact-sheets/transmission/hiv-viral-load-hiv-treatment-and-sexual-hiv-transmission>; see also Waas, *supra* note 2 (noting that without further treatment, the patient would die within two years of the HIV becoming AIDS).

⁶ Twenty-two months after Mitchell was diagnosed with HIV, his insurance was finally reinstated. See Waas, *supra* note 2.

I. LOOKING BACK TO LOOK FORWARD: THE PAST AND FUTURE OF INSURANCE DISQUALIFIERS

The flaws in our health care system were emphasized during the swift spread of the AIDS epidemic in 1981.⁷ The disease killed 50,000 Americans within the first eight years of its emergence.⁸ The epidemic shocked health institutions and scared society, which were familiar with common infections but knew little of chronic infectious diseases like HIV.⁹

Prior to the protections of the ACA, many insurance companies offered HIV patients costly plans with limited benefits or dropped HIV patients from coverage entirely.¹⁰ Insurers were reluctant to cover HIV patients and providers as they worried the virus would bankrupt the health care system.¹¹ However, these fears were unfounded. In 1993, the medical costs associated with HIV were merely 1% of the United States' health care spending, yet society's widespread fear of high HIV costs remained—and still remains—prevalent.¹² A study revealed that AIDS positive, homosexual men are thirty-three times more likely to

⁷ The final phase of HIV is referred to as Acquired Immunodeficiency Syndrome ("AIDS"). HIV first appeared in 1981 when five patients were diagnosed with *Pneumocystis carinii pneumonia*, a strain of pneumonia, and 26 were reported with Kaposi's sarcoma. Before the first reported case of AIDS, Kaposi's sarcoma was considered an extremely rare manifestation of cancer. Two years later, 100 similar cases were reported to the Centers for Disease Control. By 1991, the number of reported AIDS cases rose to 206,392. See Lynn Deitzer, *The Physician's Duty to Treat Persons with AIDS*, 27 NEW ENG. L. REV. 565, 566–67, n.24 (1992).

⁸ See Martin Delaney, *The Case for Patient Access to Experimental Therapy*, 159 OXFORD U. PRESS 416, 416 (1989).

⁹ See Daniel M. Fox, *AIDS and the American Health Polity: The History and Prospects of a Crisis of Authority*, 83 MILBANK Q. 1, 1 (2005).

¹⁰ This tactic is called "red-lining." Red-lining is when insurance providers strategically write policies to avoid funding specific groups. Insurers either directly deny coverage or selectively charge higher premiums for these groups. Some insurance carriers used to screen potential customers for HIV antibodies and denied coverage for those who tested positive. Many states enacted legislation to prevent HIV testing by insurers, but alternative testing, like the CD+4, can also screen for antibodies. A 1987 poll revealed that 90% of insurance companies consider HIV positive patients to be uninsurable. Isbell, *supra* note 1, at 17–18.

¹¹ *Id.* at 13 (citing Daniel M. Fox, *Financing Health Care for Persons with HIV Infection: Guidelines for State Action*, 16 AM. J.L. & MED. 223, 227-28 (1990)).

¹² *Id.*

not have health care coverage than undiagnosed gay men.¹³ In 1990, another study found that one in four AIDS patients were uninsured.¹⁴ Whether due to insurers refusing coverage or clinical trials being full, patients like Jerome Mitchell were forced to wait on a lengthy judicial process when they were already tapped for time.

Over thirty years later, the cure for HIV and AIDS remains unknown. Newer, non-standard treatments are often the most viable option for these patients. This Comment considers the struggles of one of our most vulnerable populations: patients with chronic diseases like AIDS.¹⁵ The article will focus on the current controversy surrounding coverage of patients with pre-existing conditions, access to their preferred treatments, and the Republican party's ("GOP") proposals for a new health care bill.

A. The ACA and AIDS

Many believe the ACA is one of the most positively influential legislative decisions in the fight against AIDS.¹⁶ However, President Trump has maintained a firm stance against the ACA.¹⁷ In 2018, the Trump administration will likely eliminate patient protection provisions. His new legislation may allow insurers to reinstate discriminatory practices like retroactive cancellation for policyholders like Jerome Mitchell.

¹³ *Id.* at 14.

¹⁴ *Id.* at 15.

¹⁵ The National Health Council defines "chronic disease" as "a disease lasting three months or longer. About 40 million Americans are limited in their usual activities due to one or more chronic health conditions." *About Chronic Diseases*, NAT'L HEALTH COUNCIL (Jul. 29, 2014), http://www.nationalhealthcouncil.org/sites/default/files/NHC_Files/Pdf_Files/AboutChronicDisease.pdf. For the purposes of this comment, a chronic disease is an incurable and ongoing disease such as HIV, AIDS, and cancer.

¹⁶ The ACA ensures coverage for patients with pre-existing conditions. This means that no insurer can drop or rescind a patient with HIV or AIDS. The ACA's patient protection provisions extend to other pre-existing conditions like cancer, asthma, and pregnancy. *The Affordable Care Act and HIV/AIDS*, HIV.GOV, <https://www.hiv.gov/federal-response/policies-issues/the-affordable-care-act-and-hiv-aids> (last updated Jan. 31, 2017).

¹⁷ Michael A. Memoli, *Trump Warns GOP: Vote for Obamacare Repeal or Lose Your Seat*, L.A. TIMES (Mar. 21, 2017, 8:52 AM), <http://www.latimes.com/politics/washington/la-na-essential-washington-updates-trump-warns-gop-vote-for-obamacare-1490110769-htmstory.html>.

B. Through the looking glass: the short-lived Graham-Cassidy bill

The four failed GOP health care bills attempted to repeal two of the most popular provisions of the ACA: mandatory essential health benefits¹⁸ and community rating rules.¹⁹ For example, Republicans' most recent health care reform effort—the Graham-Cassidy Health Care Bill (“Graham-Cassidy”)—offered states the flexibility to publicly fund alternatives for insurance coverage.²⁰ The legislation allowed states to opt out of consumer-protection provisions through a waiver system.²¹ State waivers required states to explain how they will “maintain access to adequate and affordable health insurance for individuals with pre-existing conditions.”²² Graham-Cassidy's waiver provision is too vague and provides no standard or review-system for ensuring states carry this out. Many vulnerable patients with pre-existing conditions may no longer be able to afford their insurance, or their only options will be minimal policies that don't cover the treatments they need.

Graham-Cassidy's erosion of patient protection did not benefit the GOP.²³ The waiver program pushed away moderate voters when Republicans were already struggling to gain conservative votes, and

¹⁸ The ACA's ten essential benefits include maternity care, newborn care, substance abuse treatment, lab tests, outpatient care, pediatric care, emergency room services, prescription drugs, hospitalization, and services to help patients with injuries, disabilities, or chronic disease. 42 U.S.C. § 18022(b) (2010).

¹⁹ Prior to the ACA, most insurers were allowed to charge higher premiums based on medical history (“patients with pre-existing conditions”). The ACA adjusted community ratings so insurers couldn't raise premiums based on medical history or gender. *See id.* § 18001; *see also* Santosh Rao, *Q&A: Community Rating & Adjusted Community Rating Under the ACA*, AMERICAN HEALTH LINE, <https://www.americanhealthline.com/analysis-and-insight/question-and-answer/q-and-a-community-rating> (last visited Feb. 8, 2018).

²⁰ H.R. 1628 § 106(A)(iv) (2017).

²¹ These waivers would be submitted to the Department of Health and Human Services. *Id.*

²² One type of waiver allows insurers to charge higher premiums to people based on their medical condition, a practice banned by the ACA's community rating rules. *Id.*

²³ M.J. Lee & Lauren Fox, *Collins to Vote 'No' on Graham-Cassidy Likely Killing Latest Obamacare Repeal*, CNN POLITICS (Sept. 25, 2017), <https://www.cnn.com/2017/09/25/politics/graham-cassidy-health-care-status/index.html>.

subsequently killed the bill.²⁴ The ramifications of this tactical error may indicate hope for a future bill with more patient protections.

Admittedly, comprehensive coverage for patients with pre-existing conditions is a wicked problem.²⁵ There are many possible answers and many complicated solutions, as shown through the GOP's four failed bills. Insurance coverage for the sick is a sensitive and contentious subject. For example, the American Health Care Act (AHCA) spurred massive media backlash for attempting to repeal the ACA's essential health benefits.

President Trump has been vocal about solving this wicked problem. He first expressed his interest in protecting patients with pre-existing conditions during the CNN GOP debate.²⁶ He said, "I want to keep pre-existing conditions. I think we need it. I think it's a modern age. And I think we have to have it."²⁷ However, his health care bill proposals have been vastly different from the ACA.

C. Article Overview

This Comment ponders the future of health care for the chronically ill. The removal of patient protection provisions may encourage insurers to return to discriminatory practices against patients with pre-existing conditions. We will analyze the Trump

²⁴ Republican Senator Susan Collins criticized Graham-Cassidy for not providing enough protections for patients with pre-existing conditions. She said the bill would "open the door for states to weaken protections for people with pre-existing conditions such as asthma, cancer, heart disease, arthritis and diabetes." *Id.* Late Republican Senator John McCain opposed Graham-Cassidy because the bill was not the "product of regular order." The GOP attempted to fast-track passage through reconciliation voting rather than allowing, "input from all committee members" and sending the "bill to the floor for debate and amendment." *Full Statement: John McCain to Vote "No" on Graham-Cassidy Health Care Bill*, POLITICO (Sept. 22, 2017), <https://www.politico.com/story/2017/09/22/full-statement-john-mccain-on-voting-no-on-graham-cassidy-243030>.

²⁵ "A wicked problem is a social or cultural problem that is difficult or impossible to solve for as many as four reasons: incomplete or contradictory knowledge, the number of people and opinions involved, the large economic burden, and the interconnected nature of these problems with other problems." WICKED PROBLEMS, https://www.wickedproblems.com/1_wicked_problems.php (last visited Dec. 8, 2017).

²⁶ Theodore Schleifer, *Trump Appears Open to Compromise on Obamacare*, CNN POLITICS (Nov. 12, 2016, 5:31 AM), <http://www.cnn.com/2016/11/11/politics/donald-trump-obamacare-interview>.

²⁷ *Id.*

administration's recent bill and propose two options to make the bill more appealing to Congress.

First, this Comment will consider alternative options for treatment. Many individuals with chronic pre-existing conditions—particularly patients with HIV, AIDS, or cancer—seek new, developing methodologies for their incurable diseases. Yet, the illusory “experimental procedure” often remains out of reach. Many patients are denied insurance coverage for their preferred treatment plans.²⁸ However, for some health plans, the ACA expanded approved clinical trials for the treatment of life-threatening diseases.²⁹ These patient protection provisions are essential for the adequate coverage of the chronically ill.

Second, this Comment will analyze the Graham-Cassidy bill and why it failed. One major mistake the GOP made was attempting to repeal essential health benefits without a viable or equitable alternative.³⁰ Liberal, moderate, and even conservative senators were wary of Graham-Cassidy's erosion of patient protection.

Third, this Comment will consider the effectiveness of federal-level oversight of state plans through a federally regulated ethics board or an independent agency. This option would ensure state adherence through enforcement litigation, alleviate the judiciary from making medical decisions through the agency's adjudicatory power, and most importantly, protect high-risk patients from insurance discrimination through their rule-making powers. This middle-ground option could sway on-the-fence voters to support the GOP's bill.

²⁸ For example, in a Texas state court, a physician claimed he was wrongfully terminated by a health maintenance organization (HMO). The doctor specialized in AIDS treatment and claimed his methods were the best option for his patient. *Gathe v. CIGNA Healthplan of Texas, Inc.*, No. 93-40135 (S.D. Tex., Aug. 4, 1993).

²⁹ This expansion of experimental coverage does not apply to grandfathered health plans. Grandfathered plans are health care plans instated before March 10, 2010 when the ACA was passed. Grandfathered plans are allowed to provide the same coverage they had before the ACA was signed into law. Barry L. Salkin, *Experimental and Investigational Treatments and Procedures under ERISA Group Health Plans*, 29 *BENEFITS L.J.* 1, 8 n.4 (2016).

³⁰ Graham-Cassidy allows states to opt out of health benefits through a waiver system. H.R. 1628 § 106(B) (2017).

Finally, this Comment proposes that the Department of Health and Human Services (HHS) consider minimal adjustments to state block grants in conjunction with waiver applications. This policy would incentivize states to provide essential health benefits to their constituents to avoid cuts to their federal funding. These adjustments, based on objective criteria provided in the state waiver application, are reasonable means to encourage health benefits for patients with pre-existing conditions. The GOP may not be averse to this policy since it will appeal to left-leaning voters and encourage the bill's passage through Congress.

III. THE ILLUSORY OPTION: INVESTIGATIONAL AND EXPERIMENTAL PROCEDURES

*It is as if I am in a disabled airplane, speeding downwards out of control. I see a parachute hanging on the cabin wall, one small moment of hope. I try to strap it on when a government employee reaches out and tears it off my back, admonishing, 'You can't use that! It doesn't have a Federal Aviation Administration sticker on it. We don't know if it will work.'*³¹

In 2002, the same year Jerome Mitchell was dropped by his provider, Kiaana Karnes, a forty-one-year-old mother of two, was diagnosed with advanced kidney cancer. Kianna had already exhausted all standard methods of treatment.³² First, Kianna had her tumor removed, but the cancer spread to her bones.³³ Then she tried interleukin-2, a painful form of medication that reduces the size of tumors in 15% of patients.³⁴ Her dad said the treatment was "brutal" but her family "didn't want to lose her."³⁵ However, the medication failed and Kianna was out of FDA-approved options.³⁶

³¹ The preceding quote is from an AIDS patient. The dark analogy paints the patient's feelings after he was denied treatment. Delaney, *supra* note 8, at 416.

³² Jerome Groopman, *The Right to a Trial: Should Dying Patients Have Access to Experimental Drugs?*, NEW YORKER (Dec. 18, 2006), <http://www.newyorker.com/magazine/2006/12/18/the-right-to-a-trial>.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* Interleukin-2 causes fever and an accumulation of fluids in the lungs.

³⁶ *Id.*

Her father, John Rowe, was also diagnosed with leukemia.³⁷ He researched alternative treatments and discovered a new drug called "Gleevec."³⁸ John was the final patient admitted into the clinical trial and has been in remission for five years.³⁹

John tried to enroll his daughter in a similar trial for kidney cancer; however, Kianna was disqualified because the cancer had already spread to her brain.⁴⁰ In 2005, desperate to save his daughter, John asked Congressman Burton to help him pass a new bill.⁴¹ The proposed legislation would require the Food and Drug Administration (FDA) to permit dying patients' access to experimental drugs.⁴² On March 24th, Kianna was granted "compassionate use" and prescribed the experimental drugs.⁴³ Kianna died that same day.⁴⁴

Two months later, the FDA approved the same drugs Kianna was denied.⁴⁵ Today, the drug is now considered a standard treatment for advanced kidney cancer.⁴⁶

Patients like Kianna Karnes's are faced with a difficult battle: having to fight the FDA's denial of treatments that could save their lives. The sluggish process of FDA approval limits access to new medications and procedures.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* Generally, admittance into clinical trials is severely competitive and limited, especially for women. Many trials exclude women due to concerns of causing birth defects if they become pregnant. Mireya Navarro, *Into the Unknown: AIDS Patients Test Drugs*, N.Y. TIMES (Feb. 29, 1992), <http://www.nytimes.com/1992/02/29/nyregion/into-the-unknown-aids-patients-test-drugs.html?pagewanted=all>.

⁴¹ Groopman, *supra* note 32.

⁴² *Id.*

⁴³ *Id.* "Compassionate use" is the FDA provision that allows patients not admitted in the clinical trial to access experimental medication.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

A. Patient Preferred Treatment: The Elusive “Experimental Procedure”

Many health insurance providers deny coverage for “experimental” treatments. Common coverage exemptions include liver transplants and High Dose Chemotherapy with Autologous Bone Marrow Transplant for breast cancer patients.⁴⁷ The only alternatives to access these treatments are pricy out-of-pocket payments or admittance to limited clinical trials. Previously, a Gallup poll revealed that one out of eight patients did not receive their physician’s preferred treatment.⁴⁸ Critics argue the exemption stifles medical advancement, while insurers counter they are necessary for cost containment and consumer protection.⁴⁹ Should patients with no medical alternatives be denied their final hope? Many ethical concerns are raised with the exemptions of investigational methodologies.

B. The ACA’s expansion of experimental coverage

Prior to the ACA, many group health plans and insurers explicitly excluded coverage for clinical trials. Section 300gg-8 of the ACA provides the following:

- If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer —
- (A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);
 - (B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in trial; and

⁴⁷ See generally Emily Smayda, *Current Legal Intervention Regarding Experimental Treatments Must be Changed: An Analysis of High Doses of Chemotherapy with Autologous Bone Marrow Transplantation for Breast Cancer Patients*, 13 J.L. & HEALTH 257 (1998–1999).

⁴⁸ Richard S. Saver, *Reimbursing New Technologies: Why Are the Courts Judging Experimental Medicine?*, 44 STAN. L. REV. 1095, 1105–06 (1992).

⁴⁹ *Id.* at 1102. Insurance providers argue that experimental procedures are often unnecessary and possibly dangerous.

- (C) may not discriminate against the individual on the basis of the individual's participation in such trial.⁵⁰

A qualified individual is defined as an individual "eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition."⁵¹ Therefore, under the ACA, insurers may not deny their beneficiaries participation in approved clinical trials for the treatment of life-threatening diseases.

Clinical trials remain controversial. Trials are a primary way for researchers to test new drugs and medical device, however, these treatments are not FDA approved and may cause harmful side effects.⁵² Yet many HIV patients seek solace in risky clinical trials. For example, Jeff S. took two untested pills every day.⁵³ The medicine could make him physically ill or cause nerve damage in his limbs.⁵⁴ Fernando C., a bookkeeper diagnosed with HIV, took a combination of unapproved antiviral drugs as a part of a limited clinical trial.⁵⁵ These men believed the many risks of their medication were worth the possibility of treatment.⁵⁶ Fernando explains, "let's put it this way: I'll try anything You have to do what you have to do to stay alive."⁵⁷

However, admission into clinical trials is competitive.⁵⁸ Patients like Kianna Karnes may be waitlisted or ineligible for possibly life-saving trials.⁵⁹ Many high-risk patients must seek alternative remedies for their preferred treatment plans.

⁵⁰ 42 U.S.C. § 300gg-8(a)(1) (2012).

⁵¹ *Id.* § 300gg-8(b)(1).

⁵² Navarro, *supra* note 40.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Clinical trials are even more limited for women. Many trials exclude women due to concerns of causing birth defects if they become pregnant. *Id.*

⁵⁹ Ironically, some patients are too sick for clinical trials. For example, Kianna was denied access to a clinical trial because of her brain tumor. Groopman, *supra* note 32.

C. Judicial Remedy

There remains one option after insurance denial: judicial remedy. Although courts have addressed “experimental” denials in numerous cases, the term remains ambiguous. The judiciary lacks the expertise or knowledge to properly assess the risks and benefits of investigational methodology. Judges are also frequently criticized for basing their decisions on sympathetic sentiments rather than the law.⁶⁰ Furthermore, critically ill patients do not have the time or funds to fight a lengthy battle in court.

Although insurers remain hesitant, some jurisdictions have enacted statutes to ensure experimental procedures for certain diseases.⁶¹ For example, several states have allowed the controversial combination of bone marrow transplants and chemotherapy treatment for certain strains of cancer.⁶² Rhode Island statutory law “mandates that health insurance organizations cover investigational cancer therapies if they are provided in the context of a Phase III or IV clinical trial.”⁶³ California requires health insurance providers to provide an “independent, expert review of any decision to deny coverage for experimental or investigational treatments for patients with terminal conditions that are likely to cause death within two years and for which there is no effective therapy.”⁶⁴

Yet the majority of patients seeking investigational procedures are denied, allowing courts unfettered decision-making in interpreting coverage.⁶⁵ Option Two presented by this Comment considers an administrative board of experts for the assessment and adjudication of

⁶⁰ See generally Sharona Hoffman, *A Proposal for Federal Legislation to Address Health Insurance Coverage for Experimental and Investigational Treatments*, 78 OR. L. REV. 203, 204 (1999) (claiming the judiciary is often swayed by “compassion rather than the merits of the case”).

⁶¹ *Id.*

⁶² See *id.* at 205; see also Community Cancer Care Preservation Act of 2006, S. 2340, 109th Cong. (2006). The Ohio legislature has passed the Access to Cancer Clinical Trials Act of 2006 and 2007. The statute requires “group and individual health insurance coverage and group health plans to provide coverage for individuals participating in approved cancer clinical trials.”

⁶³ Hoffman, *supra* note 60.

⁶⁴ *Id.*

⁶⁵ See Navarro, *supra* note 40.

state health care plans.⁶⁶ A similar option could be implemented for experimental treatments. The burden of interpretation should be alleviated from the bench and placed on decision-makers with knowledge in the medical services field. Experts are more qualified to weigh the benefits and risks of each contested procedure. Additionally, a specialized ethics board or agency is more adept at making expedited and informed judgments.

IV. OPTION 1 (“OFF THE SHELF”):⁶⁷ THE GRAHAM-CASSIDY HEALTH CARE BILL

The Graham-Cassidy bill was the latest republican effort to repeal and replace the ACA. Senators Lindsey Graham and Bill Cassidy’s plan proposed several major changes for health care reform.⁶⁸ One notable change was the bill’s waiver program.⁶⁹ This waiver provision favors state autonomy and decision-making over federal-level consistency for health care matters.⁷⁰ Media critics like *The New York Times* and *The New Yorker*, argue this system will adversely affect patients with pre-existing conditions.⁷¹

⁶⁶ See *infra*.

⁶⁷ Eugene Bardach, a political scientist, describes “off the shelf” policies as options political players are currently proposing. “Natural” change—including the political climate and current social values—led to the demise of the Graham-Cassidy bill. See EUGENE BARDACH, A PRACTICAL GUIDE FOR POLICY ANALYSIS: THE EIGHTFOLD PATH TO MORE EFFECTIVE PROBLEM SOLVING 17–18 (Charisse Klino et al. eds., 4th ed. 2012).

⁶⁸ In addition to the waiver system, Graham-Cassidy proposed Medicaid reforms through block grant funding, the removal of individual and employer mandates, and the end of insurance subsidies (President Trump has already implemented this portion of the bill). See Nancy Shute, *Biggest Flash Points in The Graham-Cassidy Health Care Bill*, NPR (Sept. 24, 2017), <https://www.npr.org/sections/health-shots/2017/09/24/552891450/biggest-flash-points-in-the-graham-cassidy-health-care-bill>.

⁶⁹ H.R. 1628 § 106(B)(i) (2017).

⁷⁰ *Id.*

⁷¹ See John Cassidy, *The Graham-Cassidy Health-Care Bill Is a Clear Danger to People with Pre-Existing Conditions*, NEW YORKER (Sept. 22, 2017), <https://www.newyorker.com/news/john-cassidy/the-graham-cassidy-health-care-bill-is-a-clear-danger-to-people-with-preexisting-conditions>; see also Elisabeth Rosenthal, *We All Have Pre-existing Conditions*, N.Y. TIMES (May 29, 2017), <https://www.nytimes.com/2017/05/29/opinion/pre-existing-conditions-health-care-bill>.

On September 20th, 2017, President Trump tweeted, “I would not sign Graham-Cassidy if it did not include coverage of pre-existing conditions. It does! A great Bill. Repeal & Replace.”⁷² However, the legislation does not provide the same patient protections as the ACA. The ACA requires insurers to provide coverage to patients with pre-existing conditions without price discrimination.⁷³ This coverage must include ten “essential health benefits.”⁷⁴ The ACA’s essential benefits include critical care, such as doctor’s visits, hospital care, and prescription-drug coverage.⁷⁵ The guarantee of essential health benefits means that no insurer can provide health plans that exclude these critical benefits.⁷⁶ Conversely, the Graham-Cassidy bill allows states to opt out of these requirements and create their own plans.⁷⁷ Although insurers cannot reject patients with pre-existing conditions, they can cap the amount they would pay for treatment outside of what their state deems “essential health benefits.”⁷⁸ States can re-define these benefits, allowing them to possibly provide less-comprehensive coverage.

Under the Graham-Cassidy bill, states must explain how they plan to “maintain access to adequate and affordable health insurance for individuals with pre-existing conditions.”⁷⁹ However, there is no set standard or federal review for ensuring states carry this out. Maintaining coverage of patients with pre-existing conditions without the ACA’s list of mandatory medical services may create conflict. Rodney Whitlock, a Republican staffer on the Senate Finance Committee when the ACA was passed, explains, “protections for pre-

⁷² Donald J. Trump (@realDonaldTrump), TWITTER (Sept. 20, 2017, 4:07 PM), <https://twitter.com/realdonaldtrump/status/910641701064204288?lang=en>.

⁷³ 42 U.S.C. § 18001 (2010).

⁷⁴ *Id.* § 18022(b).

⁷⁵ *Id.* § 18022(a).

⁷⁶ *Id.*

⁷⁷ *Shute*, supra note 68.

⁷⁸ Sarah Frostenson, *Graham-Cassidy Health Care Bill: What You Need to Know*, POLITICO (Sept. 19, 2017), <https://www.politico.com/interactives/2017/graham-cassidy-health-care-bill-what-you-need-to-know/>.

⁷⁹ Sarah Lueck, *Cassidy-Graham Would Unravel Protections for People with Pre-Existing Conditions*, CTR. ON BUDGET & POL’Y PRIORITIES (Sept. 26, 2017), <https://www.cbpp.org/research/health/cassidy-graham-would-unravel-protections-for-people-with-pre-existing-conditions>.

existing conditions only work as long as plans have to cover the services you need because of your pre-existing condition. By repealing, a plan may no longer have to cover those services, making the protection potentially meaningless.”⁸⁰ Without the ACA’s mandatory essential health benefits, patients may be limited to minimal aid at a higher price. States are placed in the dictatorial position of deciding what services should be provided to patients.⁸¹ This selective and disparate treatment is dangerous, and perhaps deadly, for high-risk individuals.⁸²

A. Mandates

The Graham-Cassidy bill would remove the most contentious part of the ACA — the individual mandate.⁸³ Additionally, the employer mandate requiring companies with 50 or more employees to provide health insurance would also be eliminated.⁸⁴ These mandates were a major source of additional funds for insurance providers. The ACA’s mandates were designed to ensure healthy people buy coverage so that insurers aren’t left with only sick customers, leaving the health care “marketplace spinning out of control” (i.e., a death spiral).⁸⁵ The \$15 billion reserved for state-run alternative programs, including high-risk pools, will likely be insufficient.⁸⁶ Under this new plan, many patients will be priced out of the market. The Commonwealth Fund

⁸⁰ Alison Kodjak, *GOP Health Bill Changes Could Kill Protections for Those With Pre-Existing Conditions*, NPR (Mar. 23, 2017, 12:00 PM), <http://www.npr.org/sections/health-shots/2017/03/23/521220359/gop-health-bill-changes-could-kill-protections-for-people-with-preexisting-condi>.

⁸¹ H.R. 1628 § 106(B)(i) (2017).

⁸² Individuals with chronic diseases like HIV are viewed as a financial threat to health insurance providers; accordingly, insurers often interfere with doctors preferred treatments for HIV. See generally *Gathe v. CIGNA Healthplan of Texas, Inc.*, No. 93-40135 (Tex. Dist Ct. filed Aug. 4, 1993) (suing HMO for wrongfully terminating a doctor specialized in AIDS treatment).

⁸³ H.R. 1628 § 104 (2017).

⁸⁴ *Id.* § 105.

⁸⁵ Toni Wall Jaudon, *How to Escape a Death Spiral*, ATLANTIC (Oct. 6, 2017), <https://www.theatlantic.com/technology/archive/2017/10/death-spirals/542304/>.

⁸⁶ See Rosenthal *supra* note 71.

predicted about 15 million to 18 million people would become uninsured after the bill's first year.⁸⁷

B. Costs

The Congressional Budget Office did not have time to fully analyze the bill before the Senate voted.⁸⁸ However, independent analysts including the Kaiser Family Foundation, State Health & Values Strategies, the health care consulting group Avalere, and the left-leaning Center on Budget and Policy Priorities estimate the federal government would spend between \$160 billion and \$243 billion less on health care between 2020 and 2026 than under current law.⁸⁹

C. Is Graham-Cassidy Dead?

The Senate attempted to pass the bill through the budget "reconciliation" process, which requires only 50 votes instead of the usual 60.⁹⁰ However, this process had a firm deadline. These reconciliation privileges expired on September 30, 2017, giving the GOP about a month to lobby for votes.⁹¹ Republicans' failed to lobby the requisite votes but still hope to revive ACA repeal.⁹² Vox health policy journalist Sarah Kliff explains that although "Graham-Cassidy is dead . . . thanks to the reconciliation process . . . there is at least some level of support to keep this running through this time next year."⁹³ Senator Graham also remains hopeful, "the good news is I see

⁸⁷ John Ingold, *What is Graham-Cassidy and Why Would It Change Health Care in Colorado?*, DENVER POST (Sept. 22, 2017, 10:30 AM), <http://www.denverpost.com/2017/09/22/what-is-graham-cassidy-the-bill-that-would-re-write-colorados-entire-health-system/>.

⁸⁸ *Id.*

⁸⁹ *Id.* However, the states that did not expand Medicaid (including Texas) are likely to receive more money than they had before. The new block grants would expire in 2027, so Congress would need to renew them or states may lose billions.

⁹⁰ Kelly Swanson, *Graham-Cassidy Is Dead, But Budget Reconciliation Could Bring Back Obamacare Repeal in 2018*, VOX NEWS (Sept. 26, 2017, 5:10 PM), <https://www.vox.com/2017/9/26/16369382/graham-cassidy-dead-budget-reconciliation-2018>.

⁹¹ Frostenson, *supra* note 78.

⁹² Swanson, *supra* note 90.

⁹³ *Id.*

enthusiasm for the first time among Republicans about an alternative to Obamacare."⁹⁴

A Trump-backed bill with similar elements will likely be proposed in 2019.⁹⁵ After four failed bills, the GOP needs to reconsider their approach to health care reform. On a tactical level, Republicans have made three major mistakes: (1) using reconciliation voting, (2) repealing the ten essential health benefits, and (3) emphasizing quick passage over consensus-building.⁹⁶

Republicans shouldn't have attempted to fast track their bills through budget reconciliation rather than taking the time to legislate a coherent health care agenda.⁹⁷ Late Senator John McCain was hesitant to vote for a bill that was passed in an untraditional way and not a product of "regular order."⁹⁸ Senator McCain said, "I cannot in good conscience vote" for the Graham-Cassidy health care bill.⁹⁹

Even with reconciliation,¹⁰⁰ Republicans needed more votes. However, the repeal of the ACA's mandatory health benefits proved highly controversial. Moderates balked at Graham-Cassidy's erosion of patient protections and even Republican senators could not be lobbied into supporting a bill knowing their states would receive less

⁹⁴ Jennifer Haberkorn et al., *Inside the Life and Death of Graham-Cassidy*, POLITICO (Sept. 27, 2017, 5:06 AM), <https://www.politico.com/story/2017/09/27/obamacare-repeal-graham-cassidy-243178>.

⁹⁵ Dylan Scott, *If Republicans Hold On to Congress in 2019, Obamacare Repeal Could Come Back*, VOX (May 14, 2018, 8:00 AM), <https://www.vox.com/policy-and-politics/2018/5/14/17344184/2018-midterm-elections-obamacare-health-care>.

⁹⁶ See Jim Newell, *Why Trumpcare Failed: You Can't Unite a Party That is Fundamentally Divided*, SLATE NEWS (Mar. 24, 2017, 7:38 PM), http://www.slate.com/articles/news_and_politics/politics/2017/03/all_of_the_reasons_why_trumpcare_failed.html.

⁹⁷ See *id.*; see also David Leonhardt, *Why Trumpcare Failed*, N.Y. TIMES (Mar. 27, 2017), <https://www.nytimes.com/2017/03/27/opinion/why-trumpcare-failed.html>.

⁹⁸ A bill passed "through regular order" would be voted out of committee and with hearings. Christina Wilkie, *Sen. John McCain Says He Cannot Support Graham-Cassidy Obamacare Repeal Bill*, CNBC POLITICS (22 Sept 2017, 1:52 PM), <https://www.cnbc.com/2017/09/22/senator-john-mccain-says-he-cannot-support-graham-cassidy-obamacare-repeal-bill.html>.

⁹⁹ *Id.*

¹⁰⁰ Reconciliation requires a simple majority. Therefore, Graham-Cassidy needed only 50 votes, not the usual 60, for passage. Sarah Ferris, *Reconciliation Explained*, POLITICO (Oct. 02, 2017, 5:00 AM), <https://www.politico.com/interactives/2017/what-is-reconciliation/>.

money than under current law.¹⁰¹ It was a mistake to repeal the ACA's essential health benefits — and lose a group of moderates—when Republicans were already hesitant to commit their votes. The GOP could only afford to lose three republican votes, and without McCain's support, their bill inevitably failed.¹⁰²

D. Can the GOP's dead bill be resuscitated?

For their next proposal, the GOP needs to recapture republican support and lobby for moderate votes. The Trump administration should avoid reconciliation, provide a clear vision for health care, and place limitations on the broad decision-making powers they have given states. This Comment proposes two policy-alternatives to gain the votes the GOP needs for passage of their health care bill. These options will protect patient rights — a key concern of moderate voters — while maintaining state flexibility.

V. OPTION 2: AGENCY OVERSIGHT

My first proposal is federal-level oversight of state plans through a federally regulated ethics board or an independent agency. This option will ensure state adherence through enforcement litigation, alleviate the judiciary from making medical decisions through the agency's adjudicatory power, and most importantly, protect high-risk patients from insurance discrimination through their rule-making powers. Liberal, moderate, and even conservative senators were wary of Graham-Cassidy's erosion of patient protection. This middle-ground option will sway on-the-fence voters to support the GOP's bill.

¹⁰¹ Graham-Cassidy proposes block grant funding. The bill would cap the federal government's contributions based on enrollment. The legislation uses a complex funding formula, considering elements like population density and percentage of population in poverty. Congress would divvy the money amongst the states and they would decide how to spend it. Therefore, federal funding would fluctuate based on inflation, not need. Critics argue this will hurt states in the event of costly epidemics or other health emergencies. Ingold, *supra* note 87; John Harwood, *Trump and the GOP wasted precious tax-reform time on another health care failure*, CNBC (22 Sept 2017, 6:46 PM), <https://www.cnbc.com/2017/09/22/trump-and-the-gop-wasted-precious-tax-reform-time-on-another-health-care-failure.html>.

¹⁰² Wilkie, *supra* note 98.

A. Why an independent agency?

The typical federal agency exists only because Congress has created it to deal with a particular problem.¹⁰³ Congress drafts a statute to deal with a problem and delegates statutory interpretive powers to an agency.¹⁰⁴ An independent agency — unlike an executive agency like HSS — is insulated and not directly accountable to the President.¹⁰⁵ Furthermore, the President must show good cause to eliminate an independent agency.¹⁰⁶ This would help prevent political bias within the agency and encourage the bill's passage through Congress.

B. Administrative agencies are creatures of statute

Under this proposal, Congress would instate an organic statute that designates to the agency the authority to enforce “adequate and affordable health insurance for individuals with pre-existing conditions”¹⁰⁷ and to assess individual treatments through enforcement litigation. Generally, agencies are given a purposefully broad statute to interpret.¹⁰⁸ This “expertise-based”¹⁰⁹ deference rule is based on the concept that agencies know best/most about the subject matter they promulgate. If Congress leaves gaps in a statute, there is an express delegation of authority to the agency to fill those gaps.¹¹⁰ With this delegated power, the agency may provide guidelines and definitions for ambiguous language like “adequate and affordable” coverage.

¹⁰³ MATTHEW C. STEPHENSON, *Statutory Interpretation by Agencies*, in RESEARCH HANDBOOK ON PUBLIC CHOICE AND PUBLIC LAW 286-92 (Daniel A. Farber & Anne Joseph O'Connell eds., Edward Elgar Pub. 2010), <http://www.law.harvard.edu/faculty/mstephenson/2011PDFs/Statutory%20Interpretation%20by%20agencies.pdf>.

¹⁰⁴ *Id.* at 285–86.

¹⁰⁵ *Id.* at 298.

¹⁰⁶ *Id.*

¹⁰⁷ H.R. 1628 § 106(A)(iv) (2017).

¹⁰⁸ STEPHENSON, *supra* note 103, at 285.

¹⁰⁹ See generally *Chevron, U.S.A., Inc. v. Nat. Res. Defense Council, Inc.*, 467 U.S. 837 (1984).

¹¹⁰ STEPHENSON, *supra* note 103.

The proposed agency, similar to Canada's Research Ethics Board (REB),¹¹¹ would include specialists in health and alternative methodology. When enforcement litigation arises, these experts would be qualified to make informed decisions about health care coverage by assessing the risks and benefits of each individual treatment.

C. Ethics Committee to protect more vulnerable patients with pre-existing conditions

Another viable alternative is the creation of a centralized state or federal ethics board that could supervise and adjudicate denied coverage or costs for high-risk¹¹² patients. For example, New Zealand instated an ethics board for approval of individual treatments.¹¹³ The New Zealand Ministry of Health's board must ensure that the patient was informed of the risks of the procedure, the procedure is intended to treat the patient's condition, and there are "appropriate safeguards" and "appropriate evaluative mechanisms to assess the effectiveness of the practice."¹¹⁴ High-risk patients that have been denied cost-effective treatment or care—believing their state and/or insurer are not "providing adequate and affordable health insurance"¹¹⁵—can file claims with the ethics committee for individual adjudication.

D. Political Feasibility

The creation of a federal ethics committee or independent agency may not be feasible or realistic. The GOP's main objective is to create a

¹¹¹ Canada's REB board "reviews applications for human participants ethics approval, oversees and advises on the ethical aspects of all research involving human participants in which NRC participates, and provides a resource for education, guidance and leadership in the application of ethical principals in the conduct of research involving human participants." *About the Research Ethics Board (REB)*, NAT'L RES. COUNCIL CANADA, https://www.nrc-cnrc.gc.ca/eng/about/ethics_integrity/research_ethics_board.html.

¹¹² Generally, "high-risk" includes vulnerable patients with incurable and life-threatening diseases. See generally Sara Fovargue, *The (Ab)use of Those with No Other Hope?*, 22 CAMBRIDGE Q. HEALTHCARE ETHICS 181–89 (2013).

¹¹³ *Id.* at 187.

¹¹⁴ *Id.*

¹¹⁵ H.R. 1628 § 106(A)(iv) (2017).

bill that offers states flexibility.¹¹⁶ Graham-Cassidy appealed to conservative senators because it allowed them to curate their own health care plans.¹¹⁷ The Trump Administration may be wary that a new agency or committee with regulatory authority would hinder the state-level autonomy they seek.

VI. OPTION 3: ADJUSTMENT OF BLOCK GRANTS BASED ON WAIVERS

The Graham-Cassidy bill provides a lengthy list of consumer-protection provisions that states can waive.¹¹⁸ With an approved waiver, insurers can discriminate against “an individual or small group market” and raise premiums for patients with pre-existing conditions.¹¹⁹ Should this option be implemented, state block grants should be minimally adjusted in conjunction with waiver applications. Under Graham-Cassidy, states must submit to HHS an application that describes how they will use their allotted funds towards one or more of the health benefits listed *supra*.¹²⁰ Under this proposal, block grants may be reassessed and recalculated once a waiver is submitted. This policy would incentivize states to provide essential health benefits to their constituents to avoid cuts to their federal funding.

A. Is this constitutional?

Judicial precedent has long recognized that Congress may attach conditions to the federal funds it disburses to states under its spending powers.¹²¹ However, these powers are limited. Congress’ spending

¹¹⁶ Mike Konczal, *Republican Rhetoric About Giving States ‘Flexibility’ Over Health Care Is a Sham*, VOX, <https://www.vox.com/the-big-idea/2017/9/27/16373572/graham-cassidy-federalism-states-health-care>.

¹¹⁷ See H.R. 1628 § 106(B)(i) (2017).

¹¹⁸ *Id.*

¹¹⁹ See *id.*

¹²⁰ *Id.*

¹²¹ Spending powers are meant to ensure that federal funds go towards the general welfare. U.S. CONST. art. I, § 8, cl. 1 (explaining spending powers are meant to ensure that federal funds are spend toward the general welfare).

power cannot be used to invade states' reserved rights, coerce the states into accepting particular programs or regulations, or circumvent other constitutional rules.¹²² In *Nat'l Fed'n of Indep. Bus. v. Sebelius*, the Supreme Court found the ACA's condition on federal grants to states unconstitutionally coercive.¹²³ However, block-grant adjustments are not coercive like the ACA's mandate for Medicaid expansion. This policy proposal does not strong-arm states to provide health benefits in exchange for the entirety of their block grant. Rather, it allows Congress to consider the totality of the state's health care plan in assessing their allotted funds.

Congress may condition federal funds as long as they adhere to the following: (1) Congress has made a clear and unambiguous statement of the funding conditions, thereby "enabling the state to exercise their choice knowingly," and (2) the condition on the federal funds is reasonably related to a federal interest in the particular program.¹²⁴ Congress has previously conditioned 5% of state highway funding on changing the minimum drinking age.¹²⁵ The Court held that Congress, acting indirectly to encourage uniformity in states' drinking ages, was within constitutional bounds.¹²⁶ The legislation, like the policy proposed here, was in pursuit of "the general welfare" and the means chosen were reasonable.¹²⁷ Under my proposal, states may apply for waivers with the knowledge that their block grants may be accordingly adjusted based on the objective criteria provided in their applications. These adjustments are reasonably related to Congress' interest in protecting the essential health benefits of patients with pre-existing conditions and therefore constitutional.

¹²² See *United States v. Butler*, 297 U.S. 1, 72 (1936) (holding that Congress cannot purchase "with federal funds submission to federal regulation of a subject reserved to the states").

¹²³ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) (threatening to take away a state's Medicaid funds if they didn't cover 10% of ACA funding).

¹²⁴ See *South Dakota v. Dole*, 791 F.2d 628, 631 (11th Cir. 1986).

¹²⁵ *Id.* at 631-62.

¹²⁶ *Id.*

¹²⁷ *Id.*

VII. COMPARISON AND CONCLUSION

The stories of Jerome Mitchell and Kianna Karnes illustrate the importance of high-risk patient protection provisions.¹²⁸ The GOP's next health care bill should fence states' broad discretionary powers in curating their own health care plans. This Comment's policy proposals will protect patients with pre-existing conditions, appeal to moderate voters, and allow more state flexibility than the ACA. The conditional waiver system would be the most feasible, cost-efficient, and practical option.¹²⁹ Minimal block grant adjustments based on objective criteria is a reasonable means to encourage health benefits for patients with pre-existing conditions. The GOP may not be averse to this policy since it will appeal to left-leaning voters and encourage the bill's passage through Congress.

¹²⁸ Waas, *supra* note 2; Groopman, *supra* note 32.

¹²⁹ The outcomes matrix below compares my three proposed options. "Graham-Cassidy + Adjustment of Block Grants Based on Waiver Applications" scores the highest.

Outcomes Matrix
Comparative Analysis of Graham-Cassidy Alternatives

Criteria	Option 1: Graham-Cassidy	Option 2: Graham-Cassidy + Agency/Ethics Board Oversight	Option 3: Graham-Cassidy + Adjustment of Block Grants Based on Waiver Apps
Equity	1 (poor)	3 (better)	3 (better)
Efficiency	3 (better)	2 (moderate)	2 (moderate)
Fairness	1 (poor)	3 (better)	3 (better)
Affordability	3 (better)	2 (moderate)	3 (better)
Political Feasibility	2 (moderate)	2 (moderate)	3 (better)
State Flexibility	3 (better)	2 (moderate)	2 (moderate)
Total Score	13	14	16