
Passing the Affordable Care Act

Transaction Costs, Legerdemain, Acquisition of Control



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Only a decade ago, the Patient Protection and Affordable Care Act (PPACA) of 2010 would have seemed a dystopian vision, something that could not emerge in our nation as we then knew it. For the PPACA's effect on the nation is not merely evolutionary—it is institutionally revolutionary. It not only alters the organizational structure of major segments of the U.S. economy and government but also changes the behavior and intimate personal relationships of families, doctors, and patients. It alters the cost structure of businesses, government agencies, families, and individuals. It changes contractual relationships between employers and employees and between both groups and health-insurance and health-service-provider industries.

At its core, the PPACA transformed the fundamental relationship between the individual and America's national government, reducing both privacy and personal autonomy. As economist Thomas Sowell explains, "With the passage of the legislation letting the federal government take control of the country's medical care system, a major turning point has been reached in the dismantling of America's values and institutions. . . . With politicians now having access to our most confidential records and

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having the power of granting or withholding medical care needed to sustain ourselves or our loved ones, how many people will be bold enough to criticize our public servants, who will in fact have become our public masters?” (2010).

Such power to induce subservience outside the realm of medical care may become one of the act’s most profound legacies. Nonetheless, despite strong opposition in Congress, widespread public opposition, and the measure’s debatable constitutionality, President Barack Obama signed the PPACA into law on March 23, 2010.

This article’s primary purpose is to analyze a set of key tactics government officials used to secure PPACA’s passage and entrenchment—including deception, incrementalism, obscure modification of the bill, cost concealment, strategic timing, and an attempt to preclude future repeal of part of the act¹—showing how these and related behaviors are consistent with predictions made by the economic theory of political transaction-cost manipulation (TCM). While focusing chiefly on TCM’s role in securing PPACA’s passage, the article also examines TCM’s early use in creating legislative infrastructure upon which the PPACA would build, such as the Health Insurance Portability and Accountability Act of 1996 and the American Recovery and Reinvestment Act of 2009. I also note TCM’s potential use after passage of the PPACA in fleshing out powers not fully defined in the act’s text—including those of the Independent Payment Advisory Board, the Patient-Centered Outcomes Research Institute, the Center for Medicare and Medicaid Innovation, “value-based” programs, and entities related to health-information technology—as they define and expand their regulatory and implementation authority.

DNA of Power: Political Transaction-Cost Manipulation

Political transaction costs—also termed constitutional-level transaction costs—denote costs individuals incur in perceiving the content of and taking political action to resist legislative or other proposals that alter the scope of government power. This paper shows that in designing and securing passage of the PPACA and its precursor, the American Recovery and Reinvestment Act (ARRA) of 2009, legislators and executive-branch officials relied heavily on increasing the costs to political opponents and the public of resisting the bills, using tactics predicted by the economic theory of political TCM (Twight 1983, 1988, 1992). This theory asserts that government officials have the incentives and ability to increase political transaction costs borne by others in perceiving and resisting government power-changing measures that the officials favor but affected individuals otherwise might oppose. By so doing, these officials can expand their political power, sphere of influence, and control of government. Cumulatively,

1. See the later discussion of the Independent Payment Advisory Board. For detailed discussion of the PPACA’s legislative history, see Cannan 2013.

such manipulation of political transaction costs can reshape societal outcomes regarding the scope and contours of government power.²

Political TCM theory is an overarching concept for understanding the growth of government—one that wraps around, integrates, and broadens other economic theories of institutional change. It deepens traditional public-choice concepts such as “rent seeking,” viewing political TCM as a potent method of achieving rent seeking’s objectives. It builds on both “fiscal illusion” literature and prior economic analyses of “cost concealment” and bureaucracy,³ identifying key determinants of political transaction-cost-increasing behavior. In short, political TCM analysis examines the many ways in which politics shapes transaction costs and thus constrains or alters political outcomes.

Of course, some political transaction costs are unavoidable real-world constraints resulting, for example, from the large number of legislators engaged in communication and negotiation or from unavoidable costs of obtaining information. Such costs are not our concern here. Rather, we focus on “contrived” transaction costs willfully created by government decision makers to impede opposition. TCM theory predicts that a political decision maker’s choice to favor a transaction-cost-increasing measure is a positive function of the measure’s favorable impact on his or her political job security and perquisites, third-party payoffs, executive support for the measure, party support for the measure, ideology, and the measure’s complexity, as well as its perceived importance to constituents, the availability of appealing justifications for it, and time—but inversely related to publicity highlighting the measure’s transaction-cost-increasing features.⁴

Research has shown the pivotal role of political TCM throughout the past century in passing the income-tax-withholding statute (Current Tax Payment Act of 1942), the Social Security Act (SSA) of 1935, the National Defense Education Act of 1958, Medicare (1965), and other statutes that fundamentally reshaped the role of the U.S. government.⁵ Given that TCM has been a predominant factor for decades, spanning varied political administrations, in securing passage of diverse bills that expand federal authority, it seems almost a *sine qua non* of twentieth- and twenty-first-century government power expansion—the very “DNA” of political power. Together, the PPACA and ARRA provide an important test case.

As we explore the role that government TCM played in securing passage of and entrenching the PPACA and ARRA, we will see examples large and small—some readily understood and others complicated and inconspicuous, requiring extensive study of statutory language to understand. In the former group, government proponents of the PPACA produced a bill whose size and complexity curtailed public and congressional scrutiny, leaving much of the law’s power to be determined after passage via

2. Although TCM may sometimes occur in private markets, the incentives for it are greater and the constraints on it are much weaker in the public sector than in the private sector (Twight 1988, 140–42).

3. For extended discussion of TCM’s backdrop in the economic literature, see Twight 1983, 10–17.

4. Each of these factors is analyzed in Twight 1988, 133–40.

5. See Twight 1995, 1996, 1997, 2002.

implementing regulations. The PPACA's sheer size, some 2,700 pages in bill form, led even congressional supporters to acknowledge that it was impossible to read and that few if any legislators had done so. These and other TCM tactics culminated in the leadership's TCM-driven decision to hold the Senate's PPACA vote on the morning of Christmas Eve, December 24, 2009—detering resistance by holiday-bound senators and a distracted public.

The bill's structure throughout entails broad power, great discretion, and little accountability, exemplified by the authority conferred on the secretary of the U.S. Department of Health and Human Services (HHS). One researcher found that the PPACA used the word *secretary* roughly three thousand times, usually in formulations such as “the Secretary shall,” “the Secretary may,” and the like (Matthews 2010). HHS Secretary Kathleen Sebelius engaged in prodigious waiver granting following the act's passage, giving more than 1,400 one-year waivers to politically influential organizations (Malkin 2011; Wolf 2011). Analysts subsequently challenged the legitimacy of these waivers, arguing that the PPACA did not authorize them. Tina Korbe, for example, cited congressional testimony that the PPACA “doesn't actually grant the Department of Health and Human Services the authority to exempt employers from the law's annual minimum health care coverage requirements.” She stated that “[l]anguage granting HHS that power was never in the original law” and contended that “through new rules and regulations, HHS gave itself the power last summer using a broad interpretation of certain parts of the law” (2011).

Less obvious was that within and beyond ten mandated health-coverage categories the HHS secretary would have discretion to deem specific items “essential health benefits” that insurers must cover—implying correlative power to deem specific items *not* covered (PPACA 2010, §1302). Consistent with TCM, lawmakers' statutory language hindered public awareness of the act's true reach.

When President Obama signed PPACA into law, Americans expressed two fears:

1. Fear of government control over access to medical care
2. Fear of privacy loss resulting from medical records and health-information technology (HIT) mandates

But those ships already had sailed. In passing ARRA in 2009, Congress had employed TCM to establish government power over patient access to medical care and had increased government access to patients' health records.

Paving the Way—the Stimulus Act

On February 17, 2009, more than a year before the PPACA's passage, President Obama signed into law the American Recovery and Reinvestment Act, widely known as the “Stimulus Act.” The bill's title and massive spending authorization served as TCM,

focusing most public attention on the act's magnitude and stated economic objectives while deflecting attention from two other important ARRA objectives:

- “To provide investments needed to increase economic efficiency by spurring technological advances in science and *health*”
- “To invest in transportation, environmental protection, and *other infrastructure* that will provide long-term economic benefits” (ARRA 2009, §3)⁶

Under color of these two goals, in 2009 Congress used the ARRA to create and fund key infrastructure that would later undergird the PPACA in 2010, thus reducing the apparent cost of the later bill.

For example, section 804 of ARRA established the Federal Coordinating Council for Comparative Effectiveness Research to advise the president and Congress on “strategies with respect to the *infrastructure needs of comparative effectiveness research* within the Federal Government” and expenditures associated therewith (ARRA 2009, §804(c)). The council was to describe “current Federal activities on comparative effectiveness research and [make] recommendations for such research conducted or supported from funds made available for allotment by the [HHS] Secretary for comparative effectiveness research in this Act” (§804(e)(1)). Subsequent council reports were to include “recommendations concerning infrastructure needs, organizational expenditures and opportunities for better coordination of comparative effectiveness research by relevant Federal departments and agencies” (§804(e)(2)).

This “comparative effectiveness research” would later be used in the PPACA to justify health-care rationing. Yet, consistent with TCM, section 804 was made inconspicuous, spanning less than 1.5 pages in the 406-page ARRA and placed between a section titled “Eligible Employees in the Recreational Marine Industry” (§803) and one titled “Grants for Impact Aid Construction” (§805), dealing with local educational agencies.

Also paving the way for the PPACA was an ARRA “Health Information Technology” section, which created the Health Information Technology for Economic and Clinical Health Act, with its appealing acronym “HITECH Act” (ARRA 2009, 13001–13424). As the leading edge of what would become an end-run around impediments to “unique health identifiers,” the HITECH Act established the foundation for greatly expanded, government-orchestrated, nationwide exchange of individually identifiable health (and other) information. When coupled with the PPACA, that data exchange in time would give federal and state governments as well as countless private entities access to detailed information about deeply personal aspects of Americans’ lives.

First, the HITECH Act established a national coordinator for HIT, who is instructed to perform assigned duties “in a manner consistent with the development of

6. Unless otherwise noted, emphasis has been added to quotations.

a nationwide health information technology infrastructure that allows for the electronic use and exchange of information” (ARRA 2009, §3001(b)). The coordinator is to “establish a governance mechanism for the “*nationwide health information network*,” a label denoting the entire nationally integrated health-information system now being implemented (§3001(c)(8)). The coordinator is to set “specific objectives, milestones, and metrics” to achieve the “*electronic exchange and use of health information and the enterprise integration of such information*” as well as “*utilization of an electronic health record for each person in the United States by 2014*” (§3001(c)(3)(A)). Notwithstanding occasional deference to privacy, the ARRA HIT structure and objectives established a trajectory rendering future medical privacy protection unattainable.

Bait-and-switch tactics embodying TCM also facilitated ARRA’s passage. For example, a section titled “*Voluntary Application and Use of Adopted Standards and Implementation Specification by Private Entities*” asserted that *nothing* in the HITECH Act “shall be construed to require a private entity to adopt or comply with a standard or implementation specification adopted pursuant to that Act” (ARRA 2009, §3006). However, there was one exception. Entitled “*Application to Private Entities*,” the exception negated the rule, stating that federal agencies “*shall require* in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it *shall utilize*, where available, health information technology systems and products that meet *standards and implementation specifications* adopted under [the HITECH Act]” (§3112).

Thus, the “stimulus” bill put in place key bureaucratic structures governing electronic medical records and comparative effectiveness research upon which the PPACA would build. As we turn to the PPACA, the TCM activities highlighted fall within the two main categories of government action: health-care rationing and destruction of medical privacy.

Rationing—PPACA Control over Health-Care Availability and Access

Government control over citizens’ access to health care under the PPACA is ubiquitous. Months before the bill’s passage, Martin Feldstein (2009), chairman of the Council of Economic Advisers under President Ronald Reagan, forewarned the public in an article titled “PPACA Is All about Rationing.” Yet the health-care rationing spawned by the PPACA is not the old-fashioned kind but instead a more obscure form. Chidem Kurdas, financial journalist and economist, called it “political rationing” (2012, 12).

PPACA’s rationing architecture has two components: expanded federal bureaucracy and loose statutory authority embedded in code words for rationing—what I call the hard structure and soft rhetoric of rationing.

Less than four months after the PPACA became law, the Congressional Research Service reported to Congress the ill-defined magnitude of bureaucratic growth driven by the PPACA, concluding that “the precise number of new organizations and advisory bodies that will ultimately be created pursuant to the legislation is currently *unknownable*” (Copeland 2010, 2).

Against this backdrop, a powerful visual representation of the law’s complexity appeared in a flowchart entitled “Your New Health Care System” in 2010, with supporting documentation, issued by Republican members of the Joint Economic Committee (JEC). Aside from the chart creators’ obvious political motivations, the chart reveals the maze of new and expanded government entities created and regulations imposed on private entities as a result of the PPACA (JEC 2010b). It visually links conceptually related aspects of the PPACA—such as “mandates,” “government with expanded authority/responsibility,” “rationing potential,” and the like, highlighting twelve specific PPACA entities having “rationing potential.”

Among these twelve entities, I focus first on the two that are most relevant to rationing, the Independent Payment Advisory Board and the U.S. Preventive Services Task Force. These two and others discussed later in this article empower government officials to make decisions about what types of medical services will—and will not—be covered under health-insurance benefit plans. Chief among them is the Independent Payment Advisory Board.

Independent Payment Advisory Board—Genesis

In creating the Independent Payment Advisory Board (IPAB), legislators granted broad power to a small group of executive-branch appointees, limited congressional authority over the board, and empowered board members to restrict Americans’ access to medical services whether obtained through government programs such as Medicare or from private health-care providers.

Until the last minute before passage, there was no IPAB in the PPACA: there was only the Independent *Medicare* Advisory Board (IMAB). The IMAB was to be a fifteen-member board, appointed by the president and approved by the Senate, tasked to “reduce the per capita rate of growth in Medicare spending” (SSA 1965, §1899A(b); PPACA 2010, §3403(b)).⁷ Although the draft health-care bill gave large powers to the IMAB, its supporters assured critics that those powers applied only to Medicare, not to health markets generally. That limitation disappeared, however, during the rush to pass the PPACA in the Senate.

The vehicle for the change was a Manager’s Amendment. Senate Majority Leader Harry Reid (D–Nev.) unveiled this complicated 383-page amendment to the already

7. The PPACA (as passed) codified both its IMAB (§3403) and its IPAB (§10320) functions from itself to the SSA. For example, section 3403 of the PPACA codified the act’s IMAB provisions to SSA Title 18, §1899A, 42 U.S.C. §1395 et seq.

impenetrably long health-care bill in late December 2009, just days before the Senate vote on passage. The amendment both renamed IMAB as the Independent *Payment* Advisory Board and expanded its functions. No longer was the board restricted to actions involving government-funded health care, such as Medicare. It would instead be an executive-branch entity with up to fifteen members and empowered to ration *all* health care—including privately funded health services: Medicare directly and private services indirectly. As researchers Diane Cohen and Michael Cannon reported, the IPAB received power “to ration care for all Americans, whether the government pays their medical bills or not,” and the “power to ration or reorganize care even for those who are not enrolled in government programs” (2012, 5, 7).

Little of this was understood in the pre-Christmas rush to pass the PPACA. On December 19, 2009, Senator Reid released a complete version of the bill incorporating the Manager’s Amendment. The Senate approved the amendment three days later (60–39), and two days thereafter it passed the PPACA on Christmas Eve morning. The bill then was maneuvered through an intricate and controversial reconciliation process between the House and the Senate (described in detail in Cannan 2013) and even survived litigation reaching to the U.S. Supreme Court. As important as that story is, though, it is of necessity beyond the scope and purpose of this article.

On the day of the PPACA’s Senate passage, however, few senators knew the amendment had so radically transformed the IMAB. Consistent with political TCM, the change was hard to discover. Positioned far down the list of amendments to the PPACA, on page 180 of the 383-page Manager’s Amendment, the key addition was section 10320, bearing the seemingly innocuous title “Expansion of the Scope of, and Additional Improvements to, the Independent Medicare Advisory Board.” Neither the name “Independent *Payment* Advisory Board” nor its abbreviation IPAB appeared anywhere in the titles of changes included in the Manager’s Amendment.

Even the subsection within section 10320 that altered the board’s official name carried the bland label “Name Change.” Moreover, PPACA’s authors avoided repeated use of the name “Independent Payment Advisory Board” in the act, with statutory language stating only that “[a]ny reference in the provisions of, or amendments made by, section 3403 to the ‘Independent Medicare Advisory Board’ shall be *deemed* to be a reference to the ‘Independent Payment Advisory Board’” (PPACA 2010, §10320(b)). Not “labeled,” but “deemed.” Congress did not remove the name “Independent Medicare Advisory Board” or adjust the bill’s language to reflect the name change: it “merely” added a well-hidden interpretation instruction. As a result, casual readers of the PPACA would encounter many references to the IMAB but very few mentions of the IPAB, obscuring the IPAB’s role.

Other PPACA provisions created additional layers of political TCM. For example, section 3022 added a new section, 1899, to the SSA and codified Medicare Accountable Care Organizations within that section. As noted, PPACA section 3403 further amended SSA by creating SSA section 1899A and codifying to it both IMAB and portions of the Manager’s Amendment. By putting these provisions into SSA section

1899A, lawmakers curtailed public scrutiny as they changed IMAB to IPAB and expanded government power. Yet section 1899A itself makes no mention of its origin in PPACA section 3403, its amendment by the PPACA's Manager's Amendment, or the change of the board's name in section 10320(b).

Although use of the SSA appears logical for the Independent *Medicare* Advisory Board, it is less appropriate for the much broader Independent *Payment* Advisory Board. The practical effect of housing controversial PPACA provisions such as the IPAB in the SSA was to add another level of political TCM, creating additional obstacles for Americans seeking to understand the substance, breadth, and likely impact of the PPACA before it was passed into law. A reader trying to understand the bill would not think that a provision added to the SSA would apply beyond Medicare. The Manager's Amendment was a near quintessence of political TCM.

The IPAB's Role and Impact

According to the PPACA's headline language, the IPAB's purpose is to "reduce the per capita rate of growth in Medicare spending" based on projections by the Centers for Medicare and Medicaid Services (SSA 1965, §1899A(a); PPACA 2010, §3403(a)). In general, when that projected growth rate exceeds a statutorily determined "target," the IPAB must formulate and advance proposals "containing recommendations to reduce the Medicare per capita growth rate" in a statutorily specified time sequence (SSA 1965, §1899A(b), (c); PPACA 2010, §3403(b), (c)). However, although the IPAB's stated purpose refers chiefly to its power regarding Medicare, there is much more to it than that.

The IPAB also is authorized to issue proposals, reports, and recommendations to Congress reaching beyond government-funded health care to issues merely "related to the Medicare program" (SSA 1965, §1899A(c); PPACA 2010, §3403(c)). The statute requires the IPAB to produce public reports analyzing "system-wide health-care costs, patient access to care, utilization, and quality-of-care" that would facilitate "comparison by region, types of services, types of providers, and both private payers and the [Medicare] program" (SSA 1965, §1899A(a)(5); PPACA 2010, §10320(a)(5)). Further, the PPACA's requirements for such reports include a catch-all category of "any other areas that the Board determines affect overall spending and quality of care in the private sector" (SSA 1965, §1899A(a)(5); PPACA 2009, §10320(a)(5)). The IPAB is also to issue "advisory recommendations for non-Federal health care programs" designed "to slow the growth of national health expenditures," specifically excluding expenditures under federal health-care programs (SSA 1965, §1899A(a)(5); PPACA 2010, §10320(a)(5)).

Although none of these "analyses" is endowed with explicit implementation authority, as with IPAB Medicare proposals they may prove to be an opening wedge for assertions of such authority going forward. The PPACA's language regarding the

IPAB's power to impact private health care is so broad and obtuse and federal ambitions to control private health-care cost, availability, and quality so palpable that clarification of the IPAB's authority undoubtedly portends many years of litigation.

The question is whether and how the IPAB can restrict Medicare recipients' access to health care—that is, “ration” it. PPACA supporters contend the act explicitly forbids such restriction by mandating that IPAB proposals “shall not include any recommendation to *ration* health care” (SSA 1965, §1899A(c)(2)(A)(ii); PPACA §3403(c)(2)(A)(ii)). This statutory restraint on IPAB rationing is impotent, however—more political TCM than substance—for the act neither defines rationing nor provides any enforcement mechanism to prevent it. Left to bureaucratic discretion, an IPAB decision to adopt a narrow definition of rationing would allow the board broad leeway to take actions limiting access to health care (Cohen and Cannon 2012, 5). The antirationing provision also states that IPAB proposals “shall not . . . raise revenues or Medicare beneficiary premiums . . . , increase Medicare beneficiary cost-sharing . . . , or otherwise restrict benefits or modify eligibility criteria” (SSA 1965, §1899A(c)(2)(A)(ii); PPACA 2010, §3403(c)(2)(A)(ii)). Here too, though, the PPACA provides no enforcement mechanism to stop the IPAB from skirting its prohibitions (Cohen and Cannon 2012, 6).

Nonetheless, with or without an explicit statutory prohibition on rationing, few today would expect IPAB officials to attempt to ration health care overtly. Why should they, when a long-established path to *covert* rationing is so well worn?

As shown with the emergence of health-maintenance organizations (HMOs) in the 1970s and 1980s, the federal government has long understood that reducing payments to doctors and hospitals allows it to reduce people's access to health care—to ration care indirectly. Writing in 2001, Twila Brase, president of the Citizens' Council for Health Freedom, described the pivotal impact of passage of the HMO Act of 1973 and its aftermath. With the HMO Act, “congressional Republicans and Democrats agreed that American patients should gently but firmly be *forced* into managed care. That patients do not know this fact is evidenced by public outrage directed at the health maintenance organizations (HMOs) instead of [at] Congress.” For Congress, asserted Brase, HMOs provided the “perfect cover for its plans to contain costs nationwide through health-care rationing” (2001, 8, 11).

The IPAB uses the same principle. Because its central purpose is to reduce aggregate health-system expenditures through its proposals and recommendations, the latter necessarily must serve to decrease total payments to health-care providers, including doctors and hospitals. Mandated reductions in health expenditures will have the same impact observed in the government's earlier experience with HMOs, causing many providers to be unwilling to supply affected medical services. If the IPAB forces substantial price reductions, services rendered unprofitable will become unavailable.

The PPACA also gives the IPAB potent tools with which to override Congress. As noted, a primary IPAB function is to formulate “proposals” and “recommendations” to control growth of per capita Medicare spending whenever the projected growth rate of

that spending exceeds a statutorily determined “target” rate (SSA 1965, §1899A(c)(6); PPACA 2010, §3403(c)(6)). But this terminology is misleading—another instance of political TCM—falsely suggesting that Congress can accept or reject IPAB plans at will. Quite the opposite appears in the fine print, where the PPACA empowers the executive-branch IPAB to use its “proposals” and “recommendations” to supplant Congress’s core legislative functions.

One provision requires the “Secretary to implement [the board’s] proposals unless Congress enacts legislation pursuant to this section” (SSA 1965, §1899A(b)(3); PPACA 2010, §3403(b)(3)).

Another provision, labeled “Limitation on Changes to the Board Recommendations,” creates additional obstacles to congressional attempts to reject or modify an IPAB proposal (SSA 1965, §1899A(d)(3); PPACA 2010, §3403(d)(3)). Instead of making congressional approval a prerequisite of implementing the IPAB’s proposals, the statute *reverses* the political transaction costs involved, “requiring the [HHS] Secretary to implement such [IPAB] proposals *unless Congress enacts legislation*” to modify them (SSA 1965, §1899A(b)(3); PPACA 2010, §3403(b)(3)). Could there be a clearer example of political TCM?

Although the House and Senate may amend the IPAB proposal, the PPACA requires such amendments to attain at a minimum the overall cost-growth-rate reduction objectives established by the Center for Medicare and Medicaid Services *unless* the Senate’s vote achieves a three-fifths supermajority. Even then, the president can veto the proposal, causing, in the absence of a successful override vote, the IPAB’s proposals to prevail (SSA 1965, §1899A(c)(2), §1899A(d)(3)(D); PPACA 2010, §3403(c)(2), §3403(d)(3)(D)).

The PPACA also attempts to prevent future changes to the infrastructure it created pertaining to Congress’s power to modify or override the IPAB’s recommendations by requiring an affirmative vote of both chambers, including a three-fifths supermajority vote in the Senate (SSA 1965, §1899A(d)(3)(D); PPACA 2010, §3403(d)(3)(D)). It states, “It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection,” the subsection limiting changes to IPAB recommendations (SSA 1965, §1899A(d)(3)(C); PPACA 2010, §3403(d)(3)(C)).

Further, the PPACA specifies that “[t]here shall be *no administrative or judicial review* . . . of the implementation by the [HHS] Secretary under this subsection of the recommendations contained in a proposal” (SSA 1965, §1899A(e)(5); PPACA 2010, §3403(e)(5)). As attorney David Rivkin and constitutional law professor Elizabeth Foley have noted, the IPAB is an “Obamacare Board answerable to no one” (2013).

The act even attempts to constrain congressional action to eliminate the IPAB, specifying the only way it can be removed and the only time frame in which Congress can remove it. Under the heading “Joint Resolution Required to Discontinue the Board,” the act states that the IPAB can be eliminated only by a Joint Resolution introduced “in 2017 by not later than February 1” and passed by Congress “not later

than August 15, 2017” (SSA 1965, §1899A(f); PPACA 2010, §3403(f))—a seven-month window roughly seven years after the PPACA’s enactment. Further, the act specifies the exact wording that Congress must use in its Joint Resolution (SSA 1965, §1899A(f)(1); PPACA 2010, §3403(f)(1)) and requires that the Joint Resolution to eliminate the IPAB pass by a supermajority three-fifths affirmative vote in both houses of Congress (SSA 1965, §1899A(f)(2)(F); PPACA 2010, §3403(f)(2)(F)).

Cohen and Cannon called this statutory constraint on Congress’s lawmaking authority “anti-constitutional,” describing the IPAB as perhaps “the most anti-constitutional measure ever to pass Congress,” an entity that “will potentially empower just one unelected government official to impose any tax or regulation, to appropriate funds, and to wield other lawmaking powers” (2012, 1).

The administration itself provided descriptions of the IPAB that validated its critics’ concerns. Peter Orszag, President Obama’s director of the Office of Management and Budget until July 2010, was a key architect of the PPACA. The *New York Times* described him as the administration official who “pushed for and won a controversial provision to create” the IPAB (“Times Topics” 2012). In an interview at the Economic Club of Washington, D.C., on April 8, 2010, Orszag extolled the IPAB as follows:

This institution [IPAB] could prove to be far more important to the future of our fiscal health than, for example, the Congressional Budget Office. It has an *enormous amount of potential power*. . . . So this Independent Payment Advisory Board . . . has the responsibility to put forward proposals to hit a pretty aggressive set of targets over the long term. And furthermore the proposals take effect automatically, unless Congress not only specifically votes them down, but Congress specifically votes them down and the President signs that bill. *So the default is now switched in a very important way* on the biggest driver of our long-term costs which is the Medicare program. (Orszag 2010)

Stating that “it was under-appreciated that this is a very substantial change,” Orszag reiterated that “those [IPAB] proposals take effect *automatically* if Congress ignores them, if Congress votes them down and the President vetoes that bill. *So in other words inertia now plays to the side of this Independent Board*” (Orszag 2010).

Orszag’s acknowledgment of and enthusiasm for the fact that “the default is now switched in a very important way” so that “inertia now plays to the side” of government bureaucrats constitute an overt admission that federal officials deliberately restructured the costs to Congress and the public of resisting the growth of the federal government’s control over medical care. That is, these officials built political TCM into the PPACA’s core infrastructure.

Orszag attributed enormous importance to this IPAB maneuver. In an interview with the *Financial Times* in 2010, he concluded that the IPAB “could well turn out to

be as consequential for health policy as Federal Reserve policy was for monetary policy” (Luce 2010). The *New York Times* described Orszag as having “promoted and carried out an effort by the White House to *pry away from Congress* some of the responsibility for making hard decisions,” signaling “an administration . . . intent on altering the balance of power between the branches of government” (“Times Topics” 2012).

In an article titled “Too Much of a Good Thing: Why We Need Less Democracy,” Orszag described the broad reach of his approach. Seeking “ways around our politicians,” he argued that to “solve the serious problems facing our country, we need to minimize the harm from legislative inertia by relying more on automatic policies and depoliticized commissions for certain policy decisions . . . to counter the gridlock of our political institutions by making them a bit less democratic.” He advocated “backstop rules” specifying “events that take place if Congress doesn’t act,” rules that “[change] the default from inaction to action,” citing the IPAB as a “dramatic example” (2011).

Even Orszag, however, failed to capture the true extent of the centralization of power achieved by the IPAB’s structure. For example, if the president does not make any appointments to the IPAB, all of the Board’s rationing authority devolves to one person, the HHS secretary (Cohen and Cannon 2012). Alternatively, if only one IPAB member were appointed, that person would exercise all the Board’s power. By the end of his term, President Obama had not appointed any IPAB members, despite a change in Senate rules in 2013 restructuring political transaction costs by allowing approval of presidential appointments by a simple majority.

U.S. Preventive Services Task Force

Another part of the PPACA’s rationing bureaucracy is the U.S. Preventive Services Task Force (USPSTF), created in 1984. This is the same entity that in 2009 recommended that routine mammograms not be advised for women ages forty to forty-nine. It comprises sixteen volunteer members, experts in medical specialties selected by the Agency for Health Research and Quality. The USPSTF plays an important role in the PPACA’s rationing infrastructure by being tasked to identify and rank “evidence-based” preventive medical interventions and assign to each a grade of A, B, C, D, or I (the latter if insufficient information is available).

The USPSTF’s power resides in the “insurer mandate”—the PPACA requirement that group health plans and health-insurance issuers “shall, at a *minimum* provide coverage for, and shall *not impose any cost sharing requirements* for,” among other things, “*evidence-based* items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force” (PPACA 2010, §1001).

The problem for the insured is the mandate’s impact on the availability of preventive services *not* awarded an A or B grade. Although insurers *may* supplement required preventive services, health-care experts anticipate that the expense of covering

“minimum” preventive services will likely preclude insurers’ coverage of more than the minimum. With covered individuals facing zero marginal cost of acquiring those required preventive services, the total cost to insurers is expected to be huge. Physician Scott Gottlieb described the problem clearly:

Many services that get “Cs” and “Ds”—such as screening for ovarian or testicular cancer—could get nixed from coverage entirely. That’s because mandating coverage for all the “A” and “B” services will be very costly. . . . Health plans will inevitably choose to drop coverage for many services that don’t get a passing grade from the task force and therefore aren’t mandated. Insurance companies will need to conserve their premium money, which the government regulates, in order to spend it subsidizing those services that the task force requires them to cover in full. (2012)

Thus, a government entity may decide, by indirection, what preventive services will and will not be available.

Other concerns about the USPSTF include its exemption from review under the federal Administrative Procedures Act of 1946 as well as its record of lagging behind current medical practice (Gottlieb 2012). Further, in passing the PPACA, Congress greatly reduced its own future authority by simultaneously authorizing and appropriating in advance billions of dollars to the task force, sums reaching \$2 billion *per year* from fiscal year 2015 to all fiscal years thereafter, in perpetuity (PPACA 2010, §4002). This provision violated both the normal two-step process separating authorization from appropriation and the requirement that a federal entity submit an annual budget request—thereby increasing the political transaction costs to citizens and to legislators of curtailing USPSTF powers.

Together, the IPAB and the USPSTF—shielded by political TCM—thus are key elements of the PPACA’s rationing bureaucracy.

Further Portents of Rationing

Laced throughout the PPACA are additional requirements that its implementation be grounded in such things as comparative effectiveness research and evidence-based medicine. Operationally, such appealing phrases are not just a screen to select approved treatments but also a filter to limit access to medical services. If government officials (rightly or wrongly) deem certain procedures *not* congruent with comparative effectiveness research or evidence-based medicine, those treatments probably will not long be covered. That rationing potential also may explain why legislators built infrastructure for comparative effectiveness research into the “stimulus” bill in 2009.

For the general public, however, terminology such as *evidence-based medicine*, *comparative-effectiveness research*, and *essential health benefits* serves as political TCM,

fostering acceptance of a degree of government control that otherwise might not be tolerated. The PPACA is rife with such rhetoric. One example is the Patient-Centered Outcomes Research Institute (PCORI) created by the PPACA, which, though not a government entity, exerts a major influence on the medical services people are allowed to purchase (PPACA 2010, §6301). Despite the appeal of the institute's name, JEC analysts concluded that, taken together, the PCORI, with its role in developing "comparative cost effectiveness of medical treatments and therapies" data, and the IPAB, with its mandated use of those data to "impose hundreds of billions of dollars of Medicare cuts," coupled with "the enormous influence that Medicare's coverage and payment policies have on private health insurers and the new government controls over private health insurance markets," "have the potential to constitute the American version of NICE [U.K. National Institute for Health and Clinical Excellence]." The U.K. National Health Service tasked NICE with devising *valuation of an additional year of life* and with using that measure to impose restrictions on medical care allowed for categories of individuals, thus overtly rationing medical care (JEC 2010a, 3–4).

The PPACA created the PCORI as a nonprofit corporation to fund "comparative clinical effectiveness research" and charged it with

- identifying and adopting "*national priorities* for research,"
- establishing a "*research project agenda*," and
- "*carry[ing] out the research project agenda*" by issuing "contracts for the management of funding and conduct of research," giving "preference to the Agency for Healthcare Research and Quality and the National Institutes of Health." (PPACA 2010, §6301(d))

The PCORI is instructed to take into account "the effect on national expenditures associated with a health care treatment . . . as well as patient needs, outcomes and preferences" (§6301(d)(1)(A)). Funds flow to it from a tax-supported Patient Centered Outcomes Research Trust Fund "*without further appropriation*" (§6301(b)(3)).

Insulated from public evaluation by its obscurity and the appeal of "patient-centered" terminology, this ostensibly private entity will exert significant influence over which medical interventions and procedures remain available. Its purview is broad. For instance, in defining "comparative clinical effectiveness research" and other research the PCORI will fund, the PPACA states that such research will include assessing and comparing the "risks and benefits" of "health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, *and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals*" (2010, §6301(a)(2)(B)). Thus, the terms *research* and *comparative clinical effectiveness research* include virtually

everything health related, reinforcing the JEC's conclusion about the PCORI's high rationing potential.

The Center for Medicare and Medicaid Innovation (CMMI), created by PPACA section 3021 within the Centers for Medicare and Medicaid Services and codified to Title XI of the SSA, also has potential power to impose rationing—in this case rationing on Medicare and Medicaid recipients. Indeed, Doug Badger has argued that the CMMI's broad authority under the PPACA in effect represents Congress's choice “to outsource some of its core constitutional responsibilities . . . allowing the HHS Secretary to expand a demonstration program nationwide” in certain circumstances, an action that “is the practical equivalent of amending the Medicare statute, a constitutional prerogative reserved to Congress” (2016). One example Badger cites is a CMMI proposal in 2016 to “substantially reduce Medicare payments for chemotherapy and other physician-administered drugs,” a reimbursement scheme “that effectively rewrites the statutory formula—across 75 percent of the country.” Accordingly, Badger labeled the CMMI, “more than any other aspect of Obamacare[,] . . . an imperial enterprise” (2016).

Other PPACA programs also have rationing potential—for example, the act's “value-based” government programs. These programs pertain exclusively to physicians, hospitals, and certain other medical entities participating in Medicare. Two such programs, both regarded by the JEC as potential sources of rationing, are the Hospital Value-Based Purchasing Program (PPACA 2010, §3001) and the Physician Value-Based Payment Modifier (§3007). Consistent with political TCM, these “value-based” descriptors provide cover—and a patina of legitimacy—for the HHS secretary's discretionary power over remuneration to physicians, hospitals, and others under Medicare.

Each of these programs empowers the federal government to micromanage health-care providers' activities and medical decisions by dispensing financial rewards to providers whose behavior government officials approve and punishing the rest. For each, the HHS secretary has authority to issue detailed administrative rules with little public scrutiny, wielding what is in effect unreviewable power (at least in the short run) to decide whether specific Medicare service providers will be rewarded or burdened financially.

The Hospital Value-Based Purchasing Program, for instance, requires federal officials to make “value-based incentive payments . . . to hospitals that meet the performance standards” created by the HHS secretary (PPACA 2010, §3001(a)(1)). The secretary establishes these standards, develops a method of assessing hospitals' performance, and assigns a “hospital performance score” each fiscal year to each participating hospital. Based on that score, the secretary calculates and distributes a “value-based incentive payment” to each hospital that “meets (or exceeds) the performance standards” for the relevant fiscal year (§3001(a)(6)).

But the Physician Value-Based Payment Modifier cuts more deeply into the essence of practicing medicine. Here the central government empowers itself to

single out individual physicians or groups of physicians and to alter their Medicare reimbursements based on the government’s assessment of the “quality of care” they provide compared to that care’s costs. Moreover, most of the key statutory terminology governing these determinations is to be defined at the sole discretion of the HHS secretary. The PPACA states that the HHS secretary “shall establish a *payment modifier* that provides for differential payment to a physician or a group of physicians . . . based upon the *quality of care* furnished compared to *cost* . . . during a *performance period*” (2010, 3007(2)). It then empowers the secretary to define every term I italicized in that quotation. For instance, “quality of care” will be assessed based on “a composite of measures” determined by the secretary. These measures in turn will “be risk adjusted *as determined appropriate by the Secretary*” (3007(2)). The payment modifier would be applied, beginning in 2015, “to specific physicians and groups of physicians *the Secretary determines appropriate*” (3007(4)). And cost? “The term ‘costs’ means expenditures per individual *as determined appropriate by the Secretary.*” Even the “performance period” means “a *period specified by the Secretary*” (§3007(8)). Is it not obvious that such discretionary government power creates extraordinary authority to influence what medical services remain available to the public?

In addition, most of the secretary’s decisions under this provision are deemed not subject to administrative or judicial review. The PPACA is explicit on this point. In the section “Limitations on Review,” the act states: “There shall be *no administrative or judicial review* under section 1869, section 1878, *or otherwise*” of

- “the establishment of the value-based payment modifier”
- “the evaluation of quality of care . . . including the establishment of appropriate measures of the quality of care”
- “the evaluation of costs . . . including the establishment of the appropriate measures of costs”
- “the dates for implementation of the value-based payment modifier”
- “the specification of the initial performance period and any other performance period”
- “the application of the value-based payment modifier,” and
- “the determination of costs.” (2010, §3007(10))

Thus, “value-based” language in this context is at root a euphemism for the HHS secretary’s broad discretionary power over remuneration to physicians, hospitals, and others under Medicare. The term *political TCM* seems almost too antiseptic to convey the power thereby transferred.

I now consider another concern about PPACA: its destruction of Americans’ medical privacy.

Eroding Medical Privacy: Health-Information Technology under the PPACA

As written, the PPACA's HIT requirements threaten privacy surrounding not only medical records but also other deeply personal information now linked to medical records or otherwise transferred to various government authorities. Although mandatory exposure of intimate details of our lives to federal bureaucrats once was unimaginable, it now is law. Again, due to political TCM, few Americans are aware of the powers granted.

PPACA incursions on Americans' privacy resulted from a confluence of five tactics:

- Using ARRA's HITECH Act bureaucracy as infrastructure for the PPACA
- Modifying "administrative simplification" laws
- Expanding data linkages and efforts to develop unique health identifiers
- Using private interests as drivers of evolving health information technology
- Positioning the Internal Revenue Service (IRS) as the public "face," monitor, and enforcer of the PPACA

First, ARRA's HIT bureaucracy provisions greatly facilitated the PPACA's passage. Because of ARRA and its HITECH Act, lawmakers promoting the PPACA in 2009–10 did not face questions about that bureaucracy's existence, only its specific assignments under the PPACA. In effect, ARRA's HIT entities provided an organizational springboard for expanding government access to individually identifiable data. With the PPACA's enactment, however, the power and reach of the national coordinator and HIT bureaucracy burgeoned as the HIT Policy and Standards Committees, overseen by the HHS secretary, began to design and implement the data centralization, standardization, and distribution measures mandated by the PPACA. Moreover, the PPACA augmented the ARRA bureaucracy with a new HHS review committee empowered to "ensure coordination . . . with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator" for HIT (PPACA 2010, §1104(i)(4)(B)). Today the repercussions of these statutory changes are facilitating what Twila Brase termed an "end-run" around the long-standing statutory ban on development of a unique health identifier for every American (2012, 13–15).

Years ago drafters of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 placed that act's main threats to Americans' privacy in an obscure section titled "Administrative Simplification." Only later did people learn that its provisions mandated creation of a uniform electronic database of health information, thus jeopardizing the privacy of medical records and intruding on doctor–patient relationships to a degree unprecedented in America at that time (Twight 1998, 1999, 2002).

Those provisions authorized requiring private practitioners to divulge patients' information to the government even if no federal health-care program was involved. Moreover, the "health information" required to be disclosed was defined broadly to include "any information, whether *oral or recorded* in any form or medium, that

- (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (B) *relates to the past, present, or future physical or mental health or condition of an individual*, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual. (HIPAA 1996, §262(a), §1171)

The HHS secretary was to "adopt *standards* for certain health-related transactions, and *data elements* for such transactions to enable [individually identifiable] health information to be exchanged electronically [and to] establish specifications for implementing each of the standards adopted" (HIPAA 1996, §262(a), §1172(d), §1173(a)). HIPAA privacy regulations adopted in 2002 proved to be inadequate protection against these broad disclosures (Twight 2002).

In 2010, the PPACA revisited this obscure but potent source of power, authorizing the "matching" of unrelated databases of individually identifiable personal information and the linking of that information with an individual's health data. For instance, the HHS secretary is now required "in consultation with the HIT Policy Committee and the HIT Standards Committee" to "develop *interoperable* and secure standards and protocols that facilitate *enrollment* of individuals *in Federal and State health and human services programs*, as determined by the Secretary" (PPACA 2010, §3021(a)(1)).

The information to be gleaned from such enrollments reaches far beyond health care. When one realizes that HHS alone includes more than three hundred programs, covering a "wide spectrum of activities" from Head Start and Medicare to "[a]ssuring food and drug safety," "[f]aith-based and community initiatives," "[s]ubstance abuse treatment and prevention," and beyond—the potential scope of government data mining is clear.⁸

Further, HHS standards and protocols for "electronic enrollment" in federal and state HHS programs must allow "*electronic matching* against existing Federal and State data, including *vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary* to serve as evidence of eligibility and in lieu of paper-based documentation" (PPACA 2010, §3021(b)(1)). Further extending the scope of planned data acquisition, the PPACA also requires the secretary

8. This list comes from the HHS website homepage at <http://www.HHS.gov>.

to “ensure that” within two years after its enactment “any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) *collects and reports* . . . data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants” (§3101(a)).

Other PPACA reporting and data-sharing mandates require anyone providing “minimum essential coverage” to an individual during a calendar year to report to the HHS secretary “at such time as the Secretary may prescribe.” A final open-ended mandate requires the provider to supply “*such other information as the Secretary may require*” (2010, §1502).

Central to the PPACA’s design and implementation was nationwide imposition of unique health identifiers for every individual, employer, health plan, and health-care provider in America. To facilitate implementation of these codes, the PPACA left in place the original HIPAA mandate for such identifiers to be established by the HHS secretary. For health plans, it imposed a deadline for issuance of a “final rule” establishing a “unique health plan identifier,” with an “interim final rule” to be effective “not later than October 1, 2012” (2010, §1104(c)(1)).

Regarding national imposition of unique *patient* health identifiers, we saw that ARRA sought to accelerate the timeline, requiring the national HIT coordinator to include in the Federal Health Information Technology (HIT) Strategic Plan “objectives, milestones, and metrics” pertaining to “utilization of an electronic health record for each person in the United States by 2014” (2009, §3001(c)(3)(A)). Meanwhile, state governments continued work on their own unique patient identifiers (Brase 2012, 6).

The PPACA went beyond ARRA, however, by adding provisions explicitly supporting machine-readable identification cards. For example, in describing requirements regarding operating rules for each listed “financial and administrative transaction,” it specified that “[t]he set of *operating rules* for eligibility for a health plan and health claim status transactions . . . *may allow for the use of a machine readable identification card*” (2010, §1104(b)). It also stated that adopted financial and administrative transaction requirements—meaning HHS-approved standards and operating rules—should “to the extent feasible and appropriate, enable determination of an individual’s *eligibility and financial responsibility* for specific services *prior to or at the point of care*” (§1104(b)(2)(B)). The consequences of these provisions are momentous. Though obliquely stated, such point-of-care determinations by implication would require a machine-readable patient identification card and unique patient health identifier (or their functional equivalents).

The national government’s overarching HIT objective is evident. All the mandated data matching, database integration, data collection, interoperability requirements, and financial inducements are components of a planned comprehensive and integrated system. All reflect the central government’s long-sustained quest for

a uniform health identifier for every American, coupled with a mandatory machine-readable health identification card linked to a cornucopia of each individual's personal information. It is the infrastructure of a surveillance state.

One question we must ask is, Who besides government sought this outcome?

Part of the answer is clear: diverse interests have been driving America's emerging HIT from the beginning. What is remarkable is the depth, breadth, and duration of these groups' influence. As early as 1996, the requirement for these groups' "input" appeared in federal health-care law, and their role grew with each new health-care measure. The HIPAA enacted in 1996 explicitly stated that no "standard" for information transactions and related data elements could be adopted by HHS unless an organization known as "WEDI," the Workgroup for Electronic Data Interchange, was consulted (§1172(c)(3)). This early involvement of WEDI foreshadowed things to come.

With passage of the HITECH Act as part of ARRA in 2009, the mandate for consultation with private interests grew. Regarding the Federal HIT Strategic Plan, for instance, ARRA required the national HIT coordinator to specify, among other things, "a *framework for coordination* and flow of recommendations and policies" among the coordinator, the HIT Standards and Policies Committees, health-information exchanges, and "*other relevant entities*" (2009, §(3)(A)(v)). Over time, those "other relevant entities" would include a bevy of powerful interests.

Mandates for such participation increased again when the PPACA, to "enable electronic exchange," required the HHS secretary to solicit input from "*standard setting organizations and stakeholders*, as determined appropriate by the Secretary" (2010, §10109(a)). Moreover, in mandating a "single set" of operating rules for each of the covered financial and administrative transactions, PPACA also required that the rules "shall be *consensus-based* and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under" HIPAA (§1104(b)). The PPACA further instructed the secretary to "consider recommendations for operating rules developed by a *qualified nonprofit entity*" that meets certain listed requirements, such as "focus[sing] its *mission on administrative simplification*" and "demonstrat[ing] a *multi-stakeholder and consensus-based process* for development of operating rules"—including "health plans, health care providers, vendors," and others (§1104(b)).

Though seemingly generic, this language in fact pointed directly to two private organizations that for years had played a major role in shaping federal HIT policy. To insiders, the instruction was almost tantamount to listing the names of the desired participants, for the language chosen exactly matched these groups' long-standing missions.

The two groups are the Council for Affordable Quality Healthcare (CAQH) and the Committee on Operating Rules for Information Exchange (CORE). In written testimony given to the National Center on Vital and Health Statistics in 2010, the CAQH described itself as a "not-for-profit alliance that is uniquely focused on

simplifying administrative processes in healthcare” (CAQH 2010, 3). Further, it identified CORE as an entity whose vision was “[p]rovider access to administrative information before or at the time of service, using the electronic system of their choice, for any patient or health plan”—a “[m]ulti-stakeholder effort with [a] transparent voting process” (2010, PowerPoint, 5–6). How was it that in 2010 the CAQH could so quickly provide exactly the type of organization the PPACA was then calling for?

The CAQH and CORE long predated the PPACA. The CAQH emerged in 2000, soon after HIPAA set in motion the push for electronic databases of health information and unique patient identifiers in 1996. In 2005, still years before the Stimulus Act (ARRA) and the PPACA, the CAQH “conceived and established” CORE to “address health plan and provider needs to exchange more robust administrative transactions in real time” (CAQH 2010, 3). It testified that it created CORE as a “multi-stakeholder collaborative, based on a shared recognition that *operating rules* could build upon standards” (2010, PowerPoint, 2). By 2010, CORE had more than 115 participating organizations. The CAQH described its action as “based on a shared recognition by a wide range of stakeholders that operating rules were needed—in addition to standards—to achieve the goals of HIPAA, to support the evolution of clinical/administrative information exchange, to provide a method to accelerate greater standardization” (2010, 5).

With the CAQH providing CORE’s infrastructure, including “more than seven full-time people who are solely devoted to moving the CORE initiative forward,” and covering “over 85% of all CORE expenses,” by 2010 CORE had become “the only national effort solely engaged in the development of operating rules for the facilitation of administrative healthcare transactions” (CAQH 2010, 3, 23, 24). CORE sought “to build consensus among all essential healthcare stakeholders on a set of operating rules that facilitate administrative interoperability—starting with eligibility, and then moving sequentially to the other transactions in the [health-care] claims process” (CAQH 2010, PowerPoint, 5; full testimony, 10). Its goal was “stakeholder commitment to the promotion of *administrative and clinical data integration*”—that is, integration of each person’s medical and financial information (CAQH 2010, 10).

To that end, in 2010 CORE joined with other groups such as WEDI that “support the vision of a *common health identification card*” (CAQH 2010, 32). Indeed, CORE described its proposed “phase III operating rule for the ID card” as an “[i]ncremental step towards [the] long-term goal of *integrated electronic health ID card*” (CAQH 2010, 26, 32).

This chronology clarifies the impetus for PPACA-mandated “operating rules.” As the CAQH explained in its testimony in 2010, “Over the past five years CORE has *brought the concept of operating rules to healthcare*” (3). Thus, the idea of operating rules did not arise in Congress *sui generis* but was instead presented to Congress by the CAQH and CORE. The National Committee on Vital and Health Statistics in turn advised HHS to select CORE to author key operating standards. These nongovernmental entities and affiliated organizations urged transforming into statutory law

their vision for efficiency-enhancing but privacy-threatening “operating rules” for HIT, thus advancing a national patient ID system.

Yet the PPACA’s data-collection, data-sharing, government-sponsored research, programmatic-funding, income-redistribution, and household-level health-insurance mandates could not be implemented without muscle. Implementation required an enforcement mechanism electronically sitting astride vast repositories of federally mandated current and historical business and personal information encompassing financial, household, family, employment, insurance, and health data, *inter alia*. The mechanism had to be capable of punishing noncompliance and rewarding compliance. Details of each business’s and individual’s activities had to be accessible by this enforcement mechanism.

The PPACA’s authors tasked the IRS, with its existing intelligence and enforcement infrastructure, with that role. The IRS is to administer new taxes and tax credits spanning all major aspects of the PPACA, coordinating with other entities inside and outside government—including “the exchanges, employers, and family service agencies” (IRS 2010, 25). Thus, in administering the PPACA, IRS personnel have become intermediaries between individual taxpayers, employers, social service entities, and insurers, on the one hand, and remote private and governmental health care bureaucracies, on the other.

The IRS must now compel reporting of or otherwise determine “household” income, not just income of individuals and married couples, because certain PPACA credits/subsidies depend on household income in relation to the federal poverty level. This aggregation is problematic for privacy because it often includes the income of unrelated individuals, some of whom have earnings from multiple sources or have lived in multiple households during a given tax year. Neither IRS bureaucrats nor employers previously had access to this kind of aggregated data.

Moreover, for the first time, individual health insurance and medical history also will be part of or linked to those tax records. As an IRS report to Congress in 2010 stated, “The IRS will have to walk a fine line between providing employers with the information they need to defend against . . . [a PPACA] penalty and protecting individual taxpayers who do not want to share their personal health care and household income information with their employer” (30). In that report, the Taxpayer Advocate Service cited citizens’ “privacy concerns” and acknowledged that “some taxpayers may feel uncomfortable” about “sharing” with the IRS the new information demanded (IRS 2010, 20). IRS officials anticipated that individuals who “do not want to share their healthcare information with the IRS may not file returns or may file incomplete ones” (IRS 2010, 27).

Thus did the five tactics identified earlier facilitate the PPACA’s erosion of Americans’ medical privacy. From use of the HITECH Act bureaucracy and modification of administrative simplification laws to extensive new data linkages and unique health identifiers—from nongovernmental interests shaping the design and integration of health-information technology to use of the IRS as the PPACA’s public “face” and

enforcer—the result was destruction of personal privacy, largely outside the purview of ordinary Americans.

Conclusion

Political transaction-cost manipulation drove the PPACA's passage and its transfer to the federal government of enormous power over Americans' health care. TCM's use by the PPACA's key legislative- and executive-branch advocates prior to the act's passage served to thwart objective analysis by political opponents as well as by individuals and entities concerned about the availability and cost of quality health care.

Had the PPACA's contents instead been forthrightly presented—free of deliberate political TCM—its passage and entrenchment would have been far less likely. If clearly seen, the act's nationwide powers of data collection and dissemination, surveillance, monitoring of individuals and doctors, rationing of health care, and erosion of medical privacy would have markedly reduced its political appeal. But political TCM has become endemic in U.S. legislative processes. Its contemporary power is clearly demonstrated by its extensive use in facilitating the PPACA's transformation of health care in America into a system now profoundly and comprehensively under political control.

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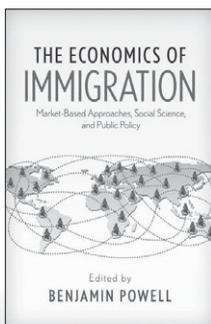
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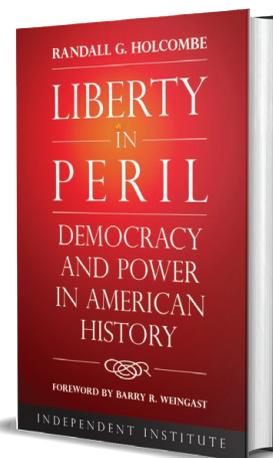
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