

THE CORPORATE PROFIT MOTIVE & QUESTIONABLE PUBLIC RELATIONS PRACTICES DURING THE LEAD-UP TO THE AFFORDABLE CARE ACT

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I.	INTRODUCTION	3
II.	SKY-ROCKETING COST, LOSS OF COVERAGE, & BANKRUPTCY	6
	A. <i>Extremely High and Rising Costs Overall</i>	6
	B. <i>Rising Insurance Premiums, Deductibles, and Out-of-Pocket Expenses</i>	6
	C. <i>Rising Costs Hurt the Economy</i>	8
	D. <i>Personal Financial Ruin</i>	9
III.	HEALTH CARE FINANCING IN THE UNITED STATES	10
	A. <i>Signing the Affordable Care Act</i>	10
	B. <i>Government Health Care Financing Programs</i>	10
	C. <i>Privately-Funded Medical Coverage</i>	12
	D. <i>The Underinsured & The Uninsured</i>	14
	E. <i>Financing Friction</i>	15
	F. <i>Corporate Interests Protected Through Public Relations Tactics</i>	16
	G. <i>Unsavory & Apparently Unlawful Public Relations Tactics</i>	17
	H. <i>The Challenges Ahead</i>	18
IV.	INSURANCE COMPANY RISK REDUCTION AND RISK AVOIDANCE TACTICS.....	19
	A. <i>Dropping Beneficiaries Who Get Sick</i>	19
	B. <i>Padding Profit Through Coverage Denial</i>	19
	C. <i>Dr. Linda Peeno’s Testimony Before the House of Representatives</i>	22
V.	WIN-AT-ALL-COSTS PUBLIC RELATIONS TACTICS.....	24
	A. <i>What Is Public Relations?</i>	24
	B. <i>Misleading Public Relations Tactics</i>	25
	C. <i>Specious Third-Party Front Groups</i>	27
	D. <i>Contrived Self-Serving Studies</i>	30
	E. <i>The Result of the Public Relations Gamesmanship</i>	31
VI.	POTENTIAL SOLUTIONS.....	33

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A.	<i>Congressional Hearings to Build a Record</i>	33
B.	<i>State-Based Licensing of Public Relations Professionals</i>	33
C.	<i>There Must Be Disclosure</i>	34
D.	<i>Existing Laws</i>	36
VII.	CONCLUSION.....	38

“IT IS A FACT THAT HEALTHY NATIONS ARE WEALTHY NATIONS. . . .”¹

Excerpt – 1:

. . . This is the fatal flaw. Many of those charged to fund medical care are incentivized, by corporate and fiscal law, to find ways to deny coverage.

This enticement has led each of the larger private health insurance companies to implement various morally unsettling, but often licit ways to deny payment based on technicalities and fine print. So doing positions the company to maintain a medical loss ratio in keeping with shareholder and investor expectations, not to mention mammoth executive compensation linked to stock performance.

Meanwhile, somewhere else in America, a patient goes untreated even though the technology and the medical resources may be available. Attending physicians are embarrassed, even frustrated or outraged. The patient feels the despair of abandonment. The anxiety and pain family and friends already feel is worsened by the idea that their loved one has been devalued by an anonymous, aloof, and apparently disinterested medical director ensconced in a distant office building overlooking the green fields of Connecticut.

Given the importance Americans place on individual rights, freedom, and the inherent value of each life, one would think that those charged to fund medical care would be incentivized by benevolence and good will rather than the bottom line, especially when those in need of care are at their most vulnerable in body and spirit.²

Excerpt – 2:

The time is now to clearly identify the extent of these two material problems: the *elevation of profit over the financing of care* on the

¹ Chas. E. Winslow, *The Physician and the State*, 23 JAMA 295 (1894).

² See *infra* Part IV. This is the first of two excerpts from the body of this Article highlighted to provide the legal, moral, civic, and emotional contexts for the thesis which follows.

one hand, and unchecked corporate duplicity guised as legitimate public relations on the other hand. Solutions must contemplate recalibration of the payment system so that those responsible for payment are motivated to fund medically necessary care rather than deny payment to increase profits. Solutions must equally embrace measures to require public relations firms to disclose the identity of their clients and certify the good faith basis of public claims so that debate about significant issues such as the health of America's citizens is free from disguise and unseemly manipulation. *A problem identified is a problem half solved.*³ Until these two problems are taken up, each remains poised to produce high-stakes problems in the future.⁴

I. INTRODUCTION

The purpose of this Article is two-fold: first, to highlight two problems which threaten the effectiveness of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act),⁵ and second, to invite civic and governmental dialogue to implement solutions to those problems. The Affordable Care Act is tailored to build upon what is good about the existing health care financing system in the United States. It is also calculated to maximize access to quality and affordable health care across the Nation. There remains, however, work that must be done to neutralize risks to the foundational requirements of consistency and predictability when it comes to payment for medical care.

First, for-profit health insurance companies will continue to occupy dominating and influential positions within the reformed framework. Because of legal obligations to shareholders to maximize profits, corporate efforts shall persist to implement cost-saving methods. If the past is prologue, these resource conservation devices will continue to inject inconsistency and unpredictability into whether or not care will be covered. The result is to all but incapacitate the security so indispensable to the legislative and executive intent behind reformed health care. Until America

³ W. CLEMENTS ZINCK, DYNAMIC WORK SIMPLIFICATION 122 (Robert E. Krieger Publishing Co. Inc. 1971) (quoting Charles F. Kettering, a notable American inventor and progressive thinker). The actual quote Mr. Zinck cites is "a problem thoroughly understood is always fairly simple." *Id.* The quotation, however, is adapted to comport with my former college professor's use of the phrase.

⁴ *See infra* Part V.B.

⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), to be codified in various sections of the Internal Revenue Code, the Public Health Services Act, and 42 U.S.C. chapter 6. *Id.* The bill itself is 2,409 pages, and another 153 from the reconciliation-passed add-on, for a total of 2,562 pages. *Id.* On July 14, 2009, three House Committees, Energy and Commerce, Ways and Means, and Education and Labor, all agreed on a single health care bill, the House Tri-Committee America's Affordable Health Choices Act (H.B. 3200). The next day, the Senate Health, Education, Labor, and Pensions (HELP) Committee passed their version of health care reform, the Affordable Health Choices Act (S. 1679). The following March, by a vote of 291 to 212, the House passed the Senate version, the Patient Protection and Affordable Care Act, H.R. 3590. By a vote of 220 to 211, the House passed the "sidecar" bill that revised the Senate legislation, the Health Care and Education Reconciliation Act.

removes the incentive for third-party payors to limit or deny coverage altogether, actually paying for care will remain less important than corporate earnings. As one commentator observed, “[s]o, if the private sector of our health system continues to be dominated by for-profit insurance plans, the industry’s well-financed lobby and its political influence will probably prevent any future reform proposals that might threaten its income.”⁶ It thus appears that payment for care will stay in the back-seat to profit.

The second problem involves the ease with which private health insurers employ the questionable tactics of public relations practitioners to mislead the public and lawmakers in important fiscal and health matters. Together, they spend millions of dollars to draw from a catalogue of proven schemes to misrepresent the facts to the public and lawmakers intending to secure public dollars for private gain. As discussed more fully below, in the heated debate preceding enactment of Affordable Care Act, this was done on a scale heretofore unseen.

Presently, there is no enforcement mechanism to compel honesty, fair dealing, and disclosure of the real parties-in-interest in public relations. To date, there has been no penalty for placing untrue sound-bites, discrediting attacks, and self-serving studies in television, radio, Internet, newspaper, and other media for dissemination throughout the country.⁷ Likewise, there has been no sanction for providing falsehoods to individual Members of Congress, their staffs, and the Presidential Administration to induce the authorization and appropriation of public dollars for private interest.⁸

These ploys are more than mere rhetoric. Their falsity coupled with the intent to deceive for private financial gain crosses both moral and legal lines. They are material misrepresentations designed to steer fiscal and policy decisions away from other viable alternatives, i.e., a single-payor system or a public insurance option.

An old college professor often noted in terms of critical thinking, “[a] problem identified is a problem half-solved.”⁹ Unless governmental corrective action is taken, health care financing in the United States will never truly get over *Mu*, that is, the coefficient of friction,¹⁰ between for-profit corporate interest and the moral imperative to care for the Nation’s sick.¹¹ Until states regulate public relations

⁶ Arnold Relman, *Health Care: The Disquieting Truth*, THE N.Y. REVIEW OF BOOKS (Sept. 30, 2010), available at <http://www.nybooks.com/articles/archives/2010/sep/30/health-care-disquieting-truth/>.

⁷ Dave Saldana, *A Law Against Lying on the News*, YES! MAGAZINE (Mar. 17, 2011), <http://www.yesmagazine.org/people-power/a-law-against-lying-on-the-news> (last visited Oct. 9, 2011).

⁸ There are, obviously, penalties for material misrepresentations to Congressional committees while under oath. Here, however, the focus is on lobbying individual Members and their staffs.

⁹ Clements Zinck, *supra* note 3.

¹⁰ REVISION WORLD, <http://www.revisionworld.co.uk/node/9755> (last visited on May 8, 2011). Friction is the resistance an object encounters in moving over another. The coefficient of friction is a number which represents the friction between two surfaces. Between two equal surfaces, the coefficient of friction will be the same. *Id.*

¹¹ Bernard Gert, *The Definition of Morality*, THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., Summer 2011 ed., 2011), available at <http://plato.stanford>.

professionals, state and federal disclosure requirements are enacted, and the federal government enforces civil and criminal penalties to protect society from widespread and well-heeled campaigns of deceit, the health insurance industry and its compatriots in public relations remain ready to once more abuse the public trust for their private economic gain.

Symptomatically, any movement to challenge the health insurance industry's reign will likely be met with the very tactics this type of reform seeks to remediate. Currently, the Secretary of the United States Department of Health and Human Services (HHS) is engaged in extensive administrative rulemaking to implement the new legislation.¹² At the same time, private insurers are using their resources to "reframe the debate" in the hope of securing industry-friendly regulations.¹³

The economic health of the Nation and the health of its people compel Congress to hold hearings and take appropriate action to prevent public relations abuses from negatively affecting health care, and other industries for that matter, again. When oversight and enforcement measures are in place, the path will be clearer to tackle the fiscal misalignment where those charged with financing health care are incentivized to deny payment to increase profit.

The balance of this article:

- i. discusses the drivers making American health care the most expensive in the world;
- ii. outlines the patchwork of public and private fiscal arrangements that comprise the American health care financing system;
- iii. reveals the legal means by which private insurance companies reduce or eliminate risk, through rescission, cancellation, coverage denials, and other methods;
- iv. evaluates the behind-the-scenes campaign America's Health Insurance Plans (AHIP), the public relations and lobbying arm of the health insurance industry, waged to thwart reform without exposing its self-serving profit motive;
- v. explains how the Affordable Care Act was enacted despite stiff opposition; and
- vi. concludes with a call to open a dialogue with a view toward focusing efforts to implement solutions, among them:

edu/archives/sum2011/entries/morality-definition/. Morality is a code of conduct that is put forward by a society and that members of that society accept as a guide for their behavior. It is possible for a society to regard morality as being concerned primarily with minimizing the harms, e.g., pain and disability, which all human beings can suffer. This view of morality is based on universal features of human nature.

¹² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), directs the Secretary to promulgate regulations to carry out the law's intent. This process, generally, involves: (1) notice of proposed rulemaking codified in the Code of Federal Regulations; (2) a public comment period wherein stakeholders and the public-at-large are free to tender comments in light of the agency's proposed rules; (3) a rule-making analysis recording and evaluating the public comments; (4) notice of final rule-making; and (5) publication of the final rules in the Code of Federal Regulations.

¹³ Wendell Potter, *The Insurers' Real Agenda for Change*, WENDELLPOTTER.COM (Feb. 8, 2011), <http://wendellpotter.com/>.

- a. that Congress conduct hearings to develop the record and take action in light of the unvarnished facts;
- b. that states adopt licensing and enforcement procedures for public relations;
- c. that federal law require public relations practitioners to disclose the real-parties-in-interest who fund spin efforts and certify the good faith basis of claims placed into the media; and
- d. that law enforcement authorities evaluate the suitability of using existing laws to address apparent fraudulent misrepresentations.

II. SKY-ROCKETING COST, LOSS OF COVERAGE, & BANKRUPTCY

“The system is broken; it costs too much, excludes too many, and delivers substandard care.”¹⁴ – Senator Tom Daschle

A. *Extremely High and Rising Costs Overall*

As former Senator Daschle observes, cost is a problem. “The United States spent nearly \$2.1 trillion on health care in 2006, twice as much as in 1996 and half as much as forecasters predict for 2017.”¹⁵ In 2009, the United States spent 17.3% of its gross domestic product, or \$2.5 trillion, on health care, the highest rate in the world.¹⁶ The United States spends nearly two times as much per person on health care as other industrial countries do on average, and more than 50% more than the next biggest-spender.¹⁷ The American “health care system is the most expensive in the world, more than twice as much *per capita* as the average among member nations of the Organisation for Economic Co-operation and Development.”¹⁸

B. *Rising Insurance Premiums, Deductibles, and Out-of-Pocket Expenses*

Both beneficiaries and employer-sponsors feel the escalating cost of premiums. Between 1999 and 2009, premiums rose 131%, with a worker contribution increase of 128%.¹⁹ That is, workers premiums rose from \$1,543 in 1999 to \$3,515 in 2009.²⁰ Equally wearisome, the employer contribution rose from \$4,247 to \$9,860 for the same period.²¹

¹⁴ Tom Daschle, *Policy Essay: Prospects for Health Care Reform in 2009*, 27 YALE L. & POL’Y REV. 173, 174 (2008).

¹⁵ *Id.*

¹⁶ Christopher J. Truffer et al., *Health Spending Projections Through 2019: The Recession’s Impact Continues*, 29 HEALTH AFFAIRS 522 (2010).

¹⁷ Meena Seshamani, *The Costs of Inaction: The Urgent Need For Health Reform* (2009), <http://www.healthreform.gov>.

¹⁸ Daschle, *supra* note 14.

¹⁹ Gary Claxton et al., *Employer Health Benefits 2009 Annual Survey 1* (2009), <http://ehbs.kff.org/pdf/2009/7936.pdf>.

²⁰ *Id.*

²¹ *Id.*

Even those who appear to be covered by an employer or individual insurance policy can suffer financially if serious illness strikes because “another 16 million are underinsured or lack coverage for catastrophic medical expenses.”²² As of 2007, 25 million American adults were underinsured to the extent that they have insurance, but not enough to cover high medical expenses, thereby forcing them to increase personal expenditures for health care service.²³ In recent years, the proportion of insured persons who are underinsured has grown by 60% since 2003, reaching nearly 25 million in 2007.²⁴ Each year, the uninsured receive an estimated \$56 billion in uncompensated care, and those costs are shifted to policyholders largely via increased premiums.²⁵

A significant number of Americans lack access to coverage because they are medically uninsurable, meaning that insurers refuse to sell them coverage at any price because of preexisting conditions.²⁶ Their costs would almost inevitably exceed high-deductible plan maximums, so any plan available to them would require extremely high premiums.²⁷

Due to the cost of co-payments and deductibles, some insureds forego medical care.²⁸ As an overall negative impact, as rising costs cause many to forego medical insurance, health care providers are confronted with even more uncompensated care.²⁹ This is then shifted back to the remaining insured, only exacerbating the problem and forcing others to drop coverage.³⁰

The lack of health care creates additional problems for insured and uninsured American families. The uninsured are likely to forego or postpone medical visits³¹ and “[p]ersons that delay or fail to receive timely health care are more likely to develop serious illness, become hospitalized for conditions that could have been

²² TOM DASCHLE, *CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 3* (St. Martin’s Press 2008).

²³ Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, HEALTH AFFAIRS (June 10, 2008), <http://content.healthaffairs.org/>.

²⁴ *Id.*

²⁵ Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, HEALTH AFFAIRS (Aug. 25, 2008), <http://content.healthaffairs.org/>.

²⁶ Meena Seshamani, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind* (2011), <http://www.healthreform.gov>.

²⁷ *Id.*

²⁸ *Snapshots From the Kitchen Table: Family Budgets and Health Care*, KAISER FAMILY FOUNDATION (2009), <http://www.kff.org/>.

²⁹ *Hidden Health Tax: Americans Pay A Premium*, FAMILIES USA (2009), <http://www.familiesusa.org>.

³⁰ *Id.*

³¹ INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *AMERICA’S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 5* (The National Academies Press 2009).

avoided, and ultimately die.³² The consequences extend beyond the ethical or moral, as all Americans, regardless of health status at any point in time, have a stake in how health care financing treats people in poorer health. As one study noted, “we simply cannot prevent illness and manage chronic disease if one in three Americans cycles in and out of coverage for at least one month over the course of two years.”³³

The uninsured generally have access to medical care at emergency rooms.³⁴ But emergency rooms cannot provide routine preventative care or deal with ongoing conditions.³⁵ Emergency rooms are supposed to be available for sudden crises and emergency care is really no substitute for affordable normal care.³⁶ Hospital bill collectors may hound nonpaying patients for years thereafter, and, if the bills cannot be collected, costs are shifted to others.³⁷ Hospitals charge paying clients higher rates; governments raise taxes to subsidize public and teaching hospitals; physicians have to forgive fees to help needy patients without insurance; and insurance companies hike premiums for everyone.³⁸ For those Americans who are not covered by a large employer’s plan or by a federal government program, hospitals normally charge their highest rates for tests and procedures because the citizen lacks the bargaining power of a large employer or the federal government.³⁹

C. Rising Costs Hurt the Economy

These great expenses hurt the American economy in many ways. Domestic businesses are negatively impacted, for example, because they are forced to absorb the rising health care costs of their workforce while trying to compete with international companies. “Businesses directly finance about one-fourth of all health system spending.”⁴⁰ In 2007, health care costs constituted \$1,525 of the price of every General Motors vehicle.⁴¹ Put another way, General Motors spent \$4.6 billion

³² William P. Gunnar, *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANN. HEALTH L. 151, 155 (2006).

³³ Daschle, *supra* note 14, at 183.

³⁴ See *The Cost of Not Covering the Uninsured: Project Highlights*, KAISER FAMILY FOUNDATION, Figure 4 (2003), <http://www.kff.org/uninsured/upload/Cost-of-Not-Covering-the-Uninsured-Project-Highlights.pdf>.

³⁵ Daschle, *supra* note 14, at 173.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

³⁹ *Steep Rate Hikes Show Reform Needed*, DES MOINES REGISTER (Feb. 16, 2010), <http://www.desmoinesregister.com/article/20100217/OPINION03/2170331/1035/Opinion/Steep-rate-hikes-show-reform-needed>.

⁴⁰ Daschle, *supra* note 14, at 173.

⁴¹ *Id.*

on health care in 2007, an amount greater than what the company spent on the steel used to produce its cars.⁴²

This annual expenditure for medical care “puts the company at a \$5 billion disadvantage against Toyota, which spends \$1,400 less on health care per vehicle.”⁴³ In the face of staggering annual expenditures that compromise domestic competition with international rivals, it can be no surprise that the “percentage of employers providing insurance to their employees has dropped from nearly 70 percent to 60 percent.”⁴⁴

These ever increasing costs limit businesses’ ability to invest, to improve workers’ wages, and increasingly, to offer coverage in the first place. Businesses cited rising cost as the number one reason for the elimination of offered coverage.⁴⁵ As Federal Reserve Board Chairman Ben Bernanke noted, “improving the performance of our health-care system is without a doubt one of the most important challenges that our nation faces.”⁴⁶

D. Personal Financial Ruin

The lack of affordable, quality health coverage has meant that many Americans with medical needs are driven to financial ruin. Indeed, because people value health and life so much, they do all they can to pay the price for care, and can even go bankrupt in the process.⁴⁷ In 2007, for example, medical debt was a central factor for 62% of personal bankruptcy filings.⁴⁸ Equally startling, among insured Americans health care costs now account for nearly 75% of personal bankruptcies related to medical care.⁴⁹ “[T]he hard truth about this country’s health-care system: just about anyone could be one bad diagnosis away from financial ruin.”⁵⁰

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. FOR SOC. JUST. 199, 222 (2007).

⁴⁵ THE KAISER FAMILY FOUND. AND HEALTH RESEARCH EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2007 ANNUAL SURVEY (2007), available at <http://www.kff.org/insurance/7672/upload/76723.pdf>.

⁴⁶ Ben S. Bernanke, Chairman, Fed. Reserve Bd., *Challenges for Health-Care Reform* (June 16, 2008), <http://www.federalreserve.gov/newsevents/speech/bernanke20080616a.htm>.

⁴⁷ David U. Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 8, 741-46 (2009).

⁴⁸ David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS (Feb. 2, 2005), <http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63/suppl/DC1><http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63/suppl/DC1>.

⁴⁹ *Id.*

⁵⁰ Karen Tumulty, *The Health Care Crisis Hits Home*, TIME, Mar. 5, 2009, at 26.

III. HEALTH CARE FINANCING IN THE UNITED STATES

A. *Signing the Affordable Care Act*

On March 23, 2010, President Barack Obama signed into law a milestone in American social legislation. As he placed his signature on the Affordable Care Act during a crowded White House ceremony, the President pointed to history and American values when he said “the bill I’m signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see,” preserving “the core principle that everybody should have some basic security when it comes to their health care.”⁵¹ To help provide that basic security, “the main thrust of this extensive legislation is to provide federal aid for mandatory expansion of coverage by Medicaid and by private insurance plans, and to expand benefits paid under Medicare.”⁵²

In the United States, the only industrialized nation that does not assure health care to all of its citizens,⁵³ the financing of this important societal function is unlike no other in the world. The payment structure is often called a *patchwork*.⁵⁴ It is a third-party payer, public and private system.⁵⁵ The public components consist of large tax-funded programs created by law and administered by the federal and state governments.⁵⁶ The private component is comprised largely of medical coverage provided as a benefit of employment.⁵⁷

B. *Government Health Care Financing Programs*

The public portion of the financing patchwork consists largely of Medicare, Medicaid, and the State Children’s Health Insurance Program. “Providing health coverage to nearly 98 million beneficiaries, public health programs currently fund approximately 46 percent of total health care costs.”⁵⁸ Medicare accounts for approximately 19 percent of health care expenditures and covers nearly 43 million Americans aged 65 or older or disabled.⁵⁹ “Medicaid, together with the State Children’s Health Insurance Program, is responsible for nearly 15 percent of national

⁵¹ Sheryl Gay Stolberg & Robert Pear, *A Stroke of a Pen, Make that 20, and It’s Official*, N.Y. TIMES, Mar. 24, 2010, at A19.

⁵² Arnold Relman, *Health Care: The Disquieting Truth*, 57 NEW YORK REVIEW OF BOOKS 14 (2010).

⁵³ Theodore R. Marmor & Jonathan Oberlander, *A Citizen’s Guide to the Healthcare Reform Debate*, 11 YALE J. ON REG. 495, 502 (1994).

⁵⁴ *How to Find Health Insurance For the Uninsurable* (March 9, 2011), http://www.eho.com/how_2100009_find-health-insurance-uninsurable.html.

⁵⁵ *Id.*

⁵⁶ These include Medicare, Medicaid, Veteran’s Affairs, Tricare, Tricare Reserve Select, and state-based programs.

⁵⁷ Elizabeth Fowler & Timothy Stoltzfus Jost, *Why Public Programs Matter—and Will Continue to Matter—Even After Health Reform*, 36 J.L. MED. & ETHICS 670 (2008).

⁵⁸ *Id.*

⁵⁹ *Id.*

expenditures and covers 55 million Americans, who are eligible due to being poor, seniors, disabled, pregnant, or children and their parents.”⁶⁰

Several smaller governmental programs cover veterans, members of the armed services and their families, and Native Americans, accounting for 13 percent of health care expenditures. Public programs are rounded out by adding in state and local public hospitals, mental hospitals, and community and mental health centers that provide services directly to the general public, in particular, recent immigrants and low-income households.⁶¹

Beyond financing the provision of health care to these specific populations, governmental programs accomplish other beneficial goals for the betterment of the greater good. Medicare, for example, is the largest funder of graduate medical education in the United States.⁶² Participation in Medicare provides the jurisdictional basis for the Emergency Medical Treatment and Active Labor Act.⁶³ The Act obligates participating health care providers to treat emergency patients to the point of stabilization and transfer, regardless of their means to pay.⁶⁴

Medicare participation likewise requires providers, pursuant to the Patient Self-Determination Act,⁶⁵ to inform adult patients of their right to refuse treatment and execute advanced directives.⁶⁶ Importantly, Medicare and Medicaid’s *disproportionate share* of hospital payments finance a significant share of the nation’s health care safety net.⁶⁷ Medicare also subsidizes rural hospitals and helps to finance clinical trials.⁶⁸ These tax funded programs make up a godly number of patches in the *patchwork*: the elderly, poor, veterans, active and reserve military

⁶⁰ *Id.*

⁶¹ *Id.* at 671.

⁶² ASS’N OF AM. MED. COLL., *MEDICARE PAYMENTS FOR GRADUATE MEDICAL EDUCATION: WHAT EVERY MEDICAL STUDENT, RESIDENT, AND ADVISOR NEEDS TO KNOW* (2006).

⁶³ 42 U.S.C. § 1395dd (2006).

⁶⁴ *Id.*

⁶⁵ 42 U.S.C. §§ 1395cc, 1396a (2006). Under this law, patients are given written notice upon admission to a health care facility of their decision-making rights and policies regarding advance health care directives in their state and in the institution to which they have been admitted. Patient rights include: (1) the right to facilitate their own health care decisions; (2) the right to accept or refuse medical treatment; and (3) the right to make an advance health care directive. Other requirements mandate facilities: (1) to inquire as to whether the patient already has an advance health care directive and make note of it in their medical records; (2) to provide education to staff and affiliates about advance health care directives; and (3) prohibit health care providers from discriminately admitting or treating patients based on whether they have an advance health care directive. *Id.*

⁶⁶ *Id.*

⁶⁷ Christie Provost Peters, *Medicaid Disproportionate Share Hospital (DSH) Payments*, NAT’L HEALTH POLICY FORUM (June 15, 2009), http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

⁶⁸ Dean M. Harris, *Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals*, 60 WASH. & LEE L. REV. 1251, 1291 (2003).

members, and their families enjoy medical care under these programs. These programs serve larger medical and societal interests.

C. Privately-Funded Medical Coverage

The private portion of the *patchwork* is dominated by large, for-profit insurance companies. “A large majority of Americans, nearly 64 percent as of 2009, rely on private insurance for health care coverage, most through employer-sponsored group health coverage.”⁶⁹ The insurance companies use their size and economic power as leverage to negotiate with employers on the one side, and medical providers, such as physicians and hospitals, on the other side.⁷⁰ In this employee benefit arrangement, employers elect to offer coverage to capitalize upon tax advantages while attracting and retaining employees, employees elect to buy coverage for themselves and their families, and insurers elect to sell either insured or administered products in certain employer markets.⁷¹

The individual health care insurance market is also present where individuals, mainly the self-employed, purchase coverage for themselves and/or their families on their own. A 2007 estimate concluded that nearly 17 million individuals purchased coverage from private carriers.⁷²

The largest and most profitable health insurance companies presently include: (1) UnitedHealth Group; (2) WellPoint; (3) Aetna; (4) Humana; (5) Cigna; (6) Health Net; and (7) Coventry Health Care.⁷³ The private health insurance industry is big business. In 2007, the CEOs of the ten largest publicly traded health insurance “companies collected [a] combined total compensation of \$118.6 million—an average of \$11.9 million each.”⁷⁴ Wendell Potter, the thirty year veteran of health insurance and public relations, assembled public filings from the Securities and Exchange Commission, as well as documents submitted to Congressional oversight committees.⁷⁵ He reported the following in his 2010 bestseller:

⁶⁹ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-268, PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS (2011).

⁷⁰ *Id.*

⁷¹ THE KAISER FAMILY FOUND. AND HEALTH RESEARCH EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY (2008), available at <http://ehbs.kff.org/pdf/7790.pdf>.

⁷² U.S. CENSUS BUREAU, ANNUAL SOCIAL AND ECONOMIC (ASEC) SUPPLEMENT: HEALTH INSURANCE COVERAGE STATUS AND TYPE OF COVERAGE BY SELECTED CHARACTERISTICS (2007), available at http://pubdb3.census.gov/macro/032008/health/h01_001.htm.

⁷³ *Fortune 500 2010: Industry: Health Care: Ins. and Managed Care*, CNN MONEY (Sept. 6, 2011), <http://money.cnn.com/magazines/fortune/fortune500/2010/industries/223/index.html>.

⁷⁴ *Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses*, HEALTHCAREFORAMERICANOW.ORG 7 (May 2009), http://healthcareforamericanow.org/site/content/new_report_private_insurers_consolidate_and_control_prices.

⁷⁵ WENDELL POTTER, DEADLY SPIN: AN INSURANCE COMPANY INSIDER SPEAKS OUT ON HOW CORPORATE PR IS KILLING HEALTH CARE AND DECEIVING AMERICANS 141 (Bloomsbury Press, 2010).

From 2000 to 2008, the ten largest for-profit health insurers paid their CEOs a total of \$690.7 million, according to corporate filings with the Securities and Exchange Commission. As outsized as the CEO pay is, it doesn't capture the full extent of the health insurance industry's wasteful overhead. In 2009, WellPoint employed thirty-nine executives who each collected total compensation exceeding \$1 million, according to company documents gathered by the House Energy and Commerce Committee. And WellPoint spent more than \$27 million on retreats for its staff at resorts in such destinations as Hawaii and Arizona in 2007 and 2008, the documents showed.⁷⁶

By design, the compensation structure motivates executives to go to great lengths to meet shareholder and investor expectations. Beyond their paycheck, some CEOs hold double-digit millions of dollars worth of their own company's shares, largely through options.⁷⁷ These holdings create an incentive for companies to repurchase shares of their own stock rather than improving a company's operations, reducing customer premiums, or paying for treatments.⁷⁸ William Lazonick, an economist at the University of Massachusetts, studied share buy-backs in the health insurance industry and noted the following in his 2010 report *The Explosion of Executive Pay and the Erosion of American Prosperity*:

Among the top 50 repurchasers for 2000 – 2008 were the two largest corporate health insurers: United Health Group at # 23 with \$23.7 billion in buybacks and WellPoint at # 39 with \$14.9 billion. For each of these companies, repurchases represented 104% of the net income for 2000 – 2008. Over this period, repurchases by the third largest insurer, Aetna, were \$9.7 billion, or 137% of net income, and the fifth largest, Cigna, \$9.8 billion, or 125% of net income. Meanwhile the top executives of these companies typically reaped millions of dollars, and in many years tens of millions of dollars, in gains from exercising stock options. A serious attempt at health care reform would seek to eliminate the profits of these health insurers, given that these profits are used solely to manipulate stock prices and enrich a small number of people at the top.⁷⁹

It is clear that these health insurance companies have priorities other than ensuring that health care is financed. As a consequence, Americans are denied coverage when they need it most.

⁷⁶ *Id.*

⁷⁷ William Lazonick, *The Explosion of Executive Pay and Erosion of American Prosperity*, FINNOV: FINANCE, INNOVATION, & GROWTH 24-25 (Sept. 6, 2011), <http://www.finnov-fp7.eu/publications/finnov-discussion-papers/the-explosion-of-executive-pay-and-the-erosion-of-american-pro>.

⁷⁸ *Id.*

⁷⁹ *Id.*

Combined, the public and private swaths of the *patchwork* protect the elderly, the poor, veterans, active and reserve military members, their families, as well as employees and their families with medical coverage.⁸⁰ This security comes at varying costs depending upon the arrangements between the payers and the providers, such as the rates the provider negotiates with the company.⁸¹ Consequently, a significant percentage of the population enjoys access to quality preventative and responsive care at negotiated and reasonably affordable rates.⁸² As long as these populations do not require lengthy care or incur catastrophic costs, it is quite reasonable that many may not recognize or even be inclined to fully appreciate the problems within the American healthcare system.⁸³

D. *The Underinsured & The Uninsured*

There remain, however, populations within the *patchwork* whom are not covered. These are the underinsured and the uninsured. The underinsured, though covered to some extent, are insufficiently protected because their plans typically contain high premiums, excessive co-payments, or high out-of-pocket costs coupled with caps on services and coverage limitations.⁸⁴ The uninsured are not covered at all. This population may play the odds that illness will not present, pay for care in cash, or are unemployed, between jobs, or simply cannot afford insurance.⁸⁵ The U.S. Census Bureau estimated that in 2008, approximately 52 million working-aged Americans and family members had no medical insurance coverage.⁸⁶

Whatever the moral imperative to care for the sick, to date the economic interests and domestic items with more pressing priority, among other variables, have precluded the concentration of expertise and momentum necessary to achieve true consensus on the problems within healthcare to be solved. The Affordable Care Act promises to go a long way toward turning the patchwork into a completed quilt—providing access to affordable, quality healthcare for all Americans. As has been long recognized, “[i]t is a fact that health nations are wealthy nations.”⁸⁷

⁸⁰ DR. WILLIAM KNOWLTON ET AL., INDUSTRIAL COLLEGE OF THE ARMED FORCES, HEALTH CARE, A REPORT ON THE INDUSTRY (2005), available at <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA449480&Location=U2>.

⁸¹ *Id.*

⁸² JOSHUA T. COHEN & PETER J. NEUWMANN, ROBERT WOOD JOHNSON FOUNDATION, THE COST SAVINGS AND COST EFFECTIVENESS OF CLINICAL PREVENTATIVE CARE (2009) available at <http://www.rwjf.org/files/research/48508.costsavingspreventivecare.report.pdf>.

⁸³ *Id.*

⁸⁴ *People Without Health Insurance Coverage by Selected Characteristics: 2007 and 2008*, U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY, 2008 AND 2009 ANNUAL SOCIAL AND ECONOMIC SUPPLEMENTS, www.census.gov/hhes/www/hlthins/data/.../2008/p60no236_table7.pdf (last visited Sept. 8, 2011).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Chas. E. Winslow, *The Physician and the State*, 23 J. OF THE AM. MED. ASS'N 295 (1894).

E. Financing Friction

Although the Affordable Care Act contains measures which remedy problems running the gamut of health care, there remains a fundamental disconnect in the design of the third-party payor financing structure. Publicly-traded health insurance companies in the business of selling peace of mind through health coverage have legal and fiduciary obligations to shareholders to maximize profit. In this industry segment, Wall Street values a company's stock based largely on the company's medical loss ratio.⁸⁸ That is, investors and the companies themselves view expenditures to cover medical procedures as financial losses, which depreciate the value of the company's stock reflected in less than anticipated share earnings.⁸⁹

This is the fatal flaw. Many of those charged to fund medical care are incentivized by corporate and fiscal law to find ways to deny coverage. This enticement has led each of the larger private health insurance companies to implement various morally unsettling, but often licit ways to deny payment based on technicalities and fine print. This places the company in a position to maintain a medical loss ratio in keeping with shareholder and investor expectations, not to mention mammoth executive compensation linked to stock performance.

Meanwhile, somewhere else in America, a patient goes untreated even though the technology and the medical resources may be available. Attending physicians are embarrassed, even frustrated or outraged. The patient feels the despair of abandonment. The anxiety and pain family and friends already feel is worsened by the idea that their loved one has been devalued by an anonymous, aloof, and apparently disinterested medical director ensconced in a distant office building overlooking the green fields of Connecticut.

Given the importance Americans place on individual rights, freedom, and the inherent value of life, one would think that those charged to fund medical care would be incentivized by benevolence and good will, rather than the bottom line—especially when those in need of care are at their most vulnerable in body and spirit.

Wendell Potter, a former Humana Health Care public relations senior executive, drew upon his first-hand observations spanning thirty years in the health care and public relations industries when he noted in his 2010 bestselling book, *Deadly Spin*, that:

The United States has entrusted one of the most important societal functions, providing health care, to private health insurance companies that have consolidated into huge players with weak competition. More than one out of three Americans is now enrolled in a plan administered by one of the seven largest insurance

⁸⁸ HARVEY W. RUBEN, *DICTIONARY OF INSURANCE TERMS* 296 (Barron's Educ. Series, Inc., 4th ed. 2000) ("Loss ratio" is a "relationship of incurred losses plus loss adjustment expense to earned premiums."); *New Affordable Care Act Rules Give Consumers Better Value for Insurance Premiums*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Nov. 22, 2010), <http://www.hhs.gov/news/press/2010pres/11/20101122a.html> (last visited Sept. 7, 2011) ("[I]nsurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing.")

⁸⁹ RUBEN, *supra* note 88.

companies—all of them listed on the New York Stock Exchange and owned primarily by big institutional investors.⁹⁰

It therefore appears that the true failure for the American people is that the health care system developed the way it has in the first place. As two prominent political scientists who study health care in the United States described in their 2010 book *Health Care Reform and American Politics*:

For more than sixty years, our democracy has encouraged—and subsidized—profit-making businesses, researchers, and medical professionals, unleashing them to create wondrous medical innovations and make money by offering advanced health care—and by selling insurance for fortunate segments of the population, especially privileged employees and their families. But many in the working and middle class are falling into growing cracks, as more and more employers and families are being priced out of secure access to health care. No wonder that seven or eight out of every ten Americans have been consistently insisting that the health system needed fundamental change or needed to be completely rebuilt. The riches of health care beckon to frustrated and fearful people who need it, but it is as if growing portions of the American citizenry find themselves on rafts close to idyllic shores yet pulled outward by currents against which their oars, no matter how vigorously rowed, can make only limited headway.⁹¹

Despite great strides on many problems, the Affordable Care Act did not remove the misalignment wherein some third-party payers are disinclined to fund coverage.

F. Corporate Interests Protected Through Public Relations Tactics

A central reason this misalignment was not addressed can be attributed to corporate interests in insurance, pharmaceutical manufacturing, and medical devices, working hand-in-glove with sophisticated public relations firms. Their collective and frankly massive efforts nearly blocked President Obama's number one domestic agenda item designed to take care of the entire country, not just portions of it.

No matter one's political view, there is some common ground in recognizing the effects presented by sky-rocketing costs, the uninsured, the underinsured, and what some term abusive health insurance practices. These included practices where companies deny initial coverage, exclude procedures, rescind policies, cancel coverage, purge policyholders who make claims by raising premiums, increase co-payments, and elevate out-of-pocket costs, to keep their medical loss ratio⁹² at a point where Wall Street is satisfied, often to the detriment of the patient.⁹³

⁹⁰ POTTER, *supra* note 76, at 145-46.

⁹¹ LAWRENCE R. JACOBS & THEDA SKOCPOL, *HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW* 29-30 (Oxford Univ. Press 2010).

⁹² Ruben, *supra* note 88.

⁹³ Relman, *supra* note 6 (“Before paying doctors and other providers of care, investor-owned health insurance companies now spend as much as 15 to 30 percent of their premiums to cover their many overhead costs, which include extravagant salaries and bonuses for top management, dividends for shareholders, and retained corporate profit.”).

Partisan consonance on the broader flaws of the system ended along party lines with pinpointing and implementing specific solutions. Republican Congressmen and Senators opposed the legislation at all points along the way, siding with the market's invisible hand and corporate interests by uttering sound bites created, tested ahead of time by focus groups and held out as the unvarnished truth by public relations firms.⁹⁴ Some of the more familiar quips were: (1) *a government takeover of health care*; or *this is a move toward socialism and socialized medicine*; *to you'll have to wait forever to see your doctor*; or *President Obama wants to cut your Medicare*; and *a Washington bureaucrat will be between you and your doctor*.⁹⁵ None of the phobic comments was accurate in context.⁹⁶ The *dicta* degraded meaningful strategizing for solutions by inflaming emotions and clouding the real questions to foster misunderstanding of what reform was truly about. This was done not for the betterment of the country, but to protect the profits of those who stood to lose dollars and market share through reform. Put differently, corporate interests influenced lawmakers who espoused views helpful to industry without regard for the meaningful improvement of care for all Americans.

G. *Unsavory & Apparently Unlawful Public Relations Tactics*

What was, and remains largely absent from the record is that well-funded public relations campaigns were surreptitiously orchestrated by the lobbying arm of the health insurance industry to discredit reform efforts. AHIP, the trade association comprised of various health insurance companies, financed, developed, and led a complex yet mostly clandestine plan to defeat health care reform.⁹⁷ Initial discussions about the proposed legislation included a public option which would compete with private companies, as well as restructuring the payment system to a single-payor program.⁹⁸ These were death-knells to the private health insurance industry. Even amidst a fight for its very existence, the techniques employed by the health insurance industry through public relations went too far—so far to corrupt the debate and the resulting reform.

Certain of the more questionable activities involved: weathered tactics, such as spreading *misinformation* and employing *half-truths*, to massage views based on inference and implication rather than an appreciation of the facts; *suppressing facts*; *fear-mongering* to exploit irrational emotional opposition; *charm offensives* to speciously curry favor; sponsoring *spontaneous third-party grass roots* organizations which were not authentic,⁹⁹ rather, contrived by public relations firms to espouse the

⁹⁴ Robert Creamer, *Dirty Little Secrets the Republicans Don't Want You to Know*, HUFFINGTON POST (July 13, 2010), http://www.huffingtonpost.com/robert-creamier/dirty-little-secrets-the_b_645404.html.

⁹⁵ See e.g., POLITIFACT, <http://www.politifact.com/>.

⁹⁶ *Id.*

⁹⁷ See generally AMERICAN'S HEALTH INS. PLANS (Sept. 8, 2011), <http://www.ahip.org/>.

⁹⁸ *Id.*

⁹⁹ Also known as *Astroturfing*, a derivation of Astro Turf, the synthetic carpet designed to look like grass. The practice advocates support of a political or corporate agenda designed to give the appearance of a *grassroots* movement. The goal of these tactics is to hide the efforts of a political and/or commercial entity as an independent public reaction to some political

industry's views while industry's sponsorship remained disguised; placing materials in the media, as well as commentaries and op-eds in newspapers and other outlets; and even going so far to post *flogs*, which are manufactured blogs,¹⁰⁰ and fabricated studies held out as authoritative. These devices are discussed more fully below.

The tactics worked. Only when President Obama's Administration dropped insistence upon a public option and stressed the importance of the individual mandate did AHIP and lobbying arms of the pharmaceutical and medical device industries relent.¹⁰¹ It became apparent that these industries stood to benefit into the billions of dollars in the near and the long term by having, by law, millions of new paying policyholders and customers. And, as part of reform, the federal government earmarked billions of dollars to provide tax incentives and subsidies endeavoring to ensure that premiums could be paid.¹⁰²

In this way, notwithstanding the sweeping solutions to the more egregious problems, legislatively starting a new system was prevented by well-heeled corporate interests that initially stood to lose their very existence. Instead, chipping away at the main problems today, with a view toward additional reform down-the-line, was the way to go. Thus, the public option coupled with the individual mandate compromise was struck, and talk of a single-payor system was silenced.

H. The Challenges Ahead

The challenges ahead include administrative rulemaking to implement the law, the resolution of pending lawsuits, budgeting, and the creation and administration of state-based insurance exchanges. What also lies in remission, with the very real potential for metastatic proliferation, is the inbuilt friction between for-profit insurance providers and the provision of health care financing to Americans in need. What also lies dormant and poised to inflict confusion and misunderstanding is a public relations industry, both in-house and retained, capable of negatively affecting important, nary fundamental rights, through stealth, chicanery, and deceit with apparent impunity.

The time is now to clearly identify the extent of these two material problems: the *elevation of profit over the financing of care* on the one hand, and unchecked

entity, in this case, health reform. *Astroturfing*, WIKIPEDIA.ORG, <http://en.wikipedia.org/wiki/Astroturfing> (last visited Sept. 25, 2011).

¹⁰⁰ Pallavi Gogoi, *Wal-Mart's Jim and Laura: The Real Story*, BUSINESSWEEK, (Oct. 9, 2006), http://www.businessweek.com/bwdaily/dnflash/content/oct2006/db20061009_579137.htm. *Walmarting Across America* is a widely-known example of a public relations firm keeping the true identity of the sponsor a secret resulting in a fake blog, or *flog*. *Id.* Edelman is an international public relations firm and was retained by Wal-Mart to conduct a public relations campaign. *Id.* Edelman devised a blog which was purportedly written by two Wal-Mart fans who decided to travel the country in a camper, blogging about their fabulous Wal-Mart experiences along the route. *Id.* Although two people did make the trip, the stunt was ultimately uncovered to show that Wal-Mart paid Edelman to conduct the surreptitious campaign.

¹⁰¹ Ryan Grim, *Obama Health Care Plan Drops Public Option*, THE HUFFINGTON POST (Feb. 22, 2010), http://www.huffingtonpost.com/2010/02/22/obama-health-care-plan-dr_n_471320.html.

¹⁰² *Focus on Health Reform: Summary of New Health Reform Law*, KAISER FAMILY FOUNDATION (2010), <http://www.kff.org/healthreform/upload/8061.pdf>.

corporate duplicity guised as legitimate public relations on the other hand. Solutions must contemplate recalibration of the payment system so that those responsible for payment are motivated to fund medically necessary care, rather than deny payment to increase profits. Solutions must equally embrace measures to require public relations firms to disclose the identity of its clients and certify the good faith basis of public claims. This ensures that debate about significant issues, such as the health of America's citizens, is free from disguise and unseemly manipulation. "A problem identified is a problem half solved."¹⁰³ Until these two problems are taken up, each remains poised to produce high-stakes problems in the future.

IV. INSURANCE COMPANY RISK REDUCTION AND RISK AVOIDANCE TACTICS

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."¹⁰⁴ – Dr. Martin Luther King, Jr.

A. *Dropping Beneficiaries Who Get Sick*

Private, for-profit insurers boost profits through a number of mechanisms, which although legal, often conflict with traditional notions of fair play and decency. One tool is rescission, a process by which coverage for policyholders who need expensive treatment is terminated when the policyholder needs coverage the most.¹⁰⁵ A large news agency investigated and exposed startling conclusions about the use of rescission, noting that "tens of thousands of Americans lost their health insurance shortly after being diagnosed with life-threatening, expensive medical conditions."¹⁰⁶ Particularly irksome, the report cited congressional findings that "WellPoint was one of the worst offenders."¹⁰⁷ WellPoint, as a matter of ordinary business, searched the records of female patients newly diagnosed with breast cancer to try to find some evidence that would allow rescission of the policies before the company had to pay for expensive treatments.¹⁰⁸

B. *Padding Profit Through Coverage Denial*

Collection of premiums is undoubtedly expected. What is equally expected is the collection of premiums without having to pay for coverage. In other words, a percentage of policyholders in a risk pool will be lucky enough and healthy enough to pay premiums and not require coverage during the policy term. What is generally

¹⁰³ ZINCK, *supra* note 3.

¹⁰⁴ M. R. Zabel & D. P. Stevens, *What Happened to Health Care Quality When the Patient Plays?*, 15 *QUALITY & SAFETY IN HEALTH CARE* 146 (2006), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464852/>.

¹⁰⁵ *Rescission*, WIKIPEDIA.ORG, <http://en.wikipedia.org/wiki/Rescission> (last visited Oct. 11, 2011).

¹⁰⁶ Murray Waas, *Corrected: WellPoint Routinely Targets Breast Cancer Patients*, REUTERS (Apr. 23, 2010), <http://www.reuters.com/article/2010/04/23/us-wellpoint-breastcancer-idUSTRE63M5D420100423>.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

unexpected by policyholders and employers, however, is profit enhancement through coverage denial under questionable circumstances.¹⁰⁹

Health insurance companies often defend decisions to deny coverage as *medically unnecessary*.¹¹⁰ These determinations are often made by medical directors and physician employees who review files and medical records, but do not enjoy a direct physician-patient relationship.¹¹¹ Although these personnel communicate with attending and treating physicians, it is very rare if they communicate with the patient or her proxy.¹¹² One former medical director testified before Congress that she received praise, was rewarded financially for saving the company money, and subsequently promoted for her record of denying coverage for expensive procedures.¹¹³

Companies have internal and external review processes by which policyholders may seek review and reconsideration of coverage denial.¹¹⁴ Denied patients may file complaints regarding coverage denials with the state—generally the department of insurance or, for those with group health plans, with the U.S. Department of Labor.¹¹⁵ Most patients are not aware of such procedures, however, and when they are, the appeals process more often than not affirms the initial medical examiner's determination.¹¹⁶ In similar fashion, companies rationalize denials as not precluding access or care, rather, merely denying payment.¹¹⁷

Although intellectually distinct, the reality is that denial of payment is all too often denial of treatment. For example, the Employee Retirement Income Security Act of 1974 (ERISA),¹¹⁸ the overall legislative intent of which is to protect employee

¹⁰⁹ Linda Peeno, *Managed Care Ethics: The Close View Prepared for U.S. House of Representatives Committee on Commerce Subcommittee on Health and Environment Michael Bilirakis, Chair*, THE NAT'L COALITION OF MENTAL HEALTH PROFS. AND CONSUMERS (May 30, 1996), <http://www.thenationalcoalition.org/DrPeenotestimony.html>.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.* A sampling of the bases for claims denials include the following: (1) not medically necessary; (2) pre-existing condition; (3) experimental/investigational; (4) non-covered benefit; (5) failure to obtain pre-authorization; (6) treatment could have been provided at a lesser level of care; (7) "pending" for pre-existing investigation; (8) limited benefits; (9) termination of coverage; (10) untimely filing; (11) pending receipt of completed claim form; (12) denial for alcohol use; (13) the claim was submitted before coverage began; or (14) the individual has not met the cost-sharing requirements of the policy, such as the required deductible. Trudy Lieberman et al., *A Consumer Guide to Handling Disputes With Your Private or Employer Health Care*, KAISER FOUNDATION (2001) available at <http://www.kff.org/insurance/upload/Consumer-Guide-PDF.pdf>.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ 29 U.S.C. § 1001 (LexisNexis 2006).

pensions,¹¹⁹ has made it nearly impossible for the 130 million Americans who participate in employer-sponsored programs to seek redress in the courts when their insurance companies deny coverage.¹²⁰ The ERISA statute precludes meaningful judicial review of coverage denials.¹²¹

Measuring the breadth and depth of coverage denials is more of an art than a science at this time. “There are [sic] some national data on the extent to which applications for enrollment are being denied; however, there is not yet any comprehensive, national information on the extent to which coverage for medical services is being denied when consumers seek health care.”¹²² Recently however, the California state Nurses Association issued a press release relating that the California Department of Managed Health Care reported that in the first half of 2009, California’s six largest HMOs rejected more than 31 million claims or 21% of those they had received.¹²³

By contrast, the National Association of Insurance Commissioners, whose mission is to “assist state insurance regulators, individually and collectively, in serving the public interest”¹²⁴ said that the California Department of Managed Health Care did not know the state reporting requirements for insurance companies, nor did it collect data on the actual number of claims denials.¹²⁵ According to the Government Accountability Office, few states require insurers to report data regularly on the frequency of denials and internal appeals.¹²⁶ Nor has the NAIC issued any model regulations that include requirements for insurers to report such data.¹²⁷

To remedy this absence of data concerning coverage denials, the Affordable Care Act required HHS to begin collecting, monitoring, and publishing information on health insurance products.¹²⁸ In October 2010, HHS began publishing data from

¹¹⁹ 29 U.S.C. § 1001(a) (LexisNexis 2006) (“ . . . to provide for the free flow of commerce” and the general welfare, “that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans . . .”).

¹²⁰ John Wood, *Prudential Policy Language Insufficient to Trigger Abuse-of-Discretion Review*, ERISA ON THE WEB (June 22, 2008), <http://www.erisaontheweb.com/2008/06/articles/another-category/us-courts-of-appeals/prudential-policy-language-insufficient-to-trigger-abuseofdiscretion-review/>.

¹²¹ *Id.*

¹²² United States Government Accountability Office, *supra* note 69, at 1.

¹²³ Danielle Ivory, *In Health Care, Number of Claims Denied Remains A Mystery*, HUFFINGTON POST INVESTIGATIVE FUND (Sept. 18, 2009, 4:52 PM), http://www.huffingtonpost.com/2009/09/18/in-health-care-number-of_n_291881.html (last modified on Nov. 18, 2009 9:05 AM).

¹²⁴ See e.g., NAT’L ASS’N OF INS. COMMISSIONERS, http://www.naic.org/index_about.htm (last visited Oct. 11, 2011).

¹²⁵ *Id.*

¹²⁶ United States Government Accountability Office, *supra* note 69, at 10.

¹²⁷ *Id.*

¹²⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1103, 124 Stat. 119, 155.

insurers on denials of applications for enrollment and intends to collect data in the future on denials of coverage for medical services.¹²⁹

Notwithstanding the absence of specific data by state or across the Nation, the profit motive compels private insurers to draft policies and review claims with an eye towards denial rather than payment. As Sara Rosenbaum aptly observed in her 2009 article, “[u]nderlying these figures is a national approach to health care financing for the non-elderly that effectively increases the odds that those who are in poor health status will be uninsured or underinsured.”¹³⁰ That is, this portion of the patchwork is lawfully enabled and even incentivized to exclude the sick.¹³¹ Consistent with the American emphasis on the sanctity of life and individual liberty, one wrongful denial is one denial too many.¹³²

C. *Dr. Linda Peeno’s Testimony Before the House of Representatives*

Linda Peeno, M.D. quit two lucrative positions in comfortable offices working predictable shifts over 40-hour weeks as a medical director for two large health insurance companies.¹³³ What promised to be a rewarding position initially, turned out to be revolting to Dr. Peeno for many reasons—not the least of which was the company emphasis on seeking technical ways to deny payment for coverage even where the actual attending physicians recommended treatment.¹³⁴ Her testimony before the House of Representatives Committee on Commerce, Subcommittee on Health and the Environment is compelling for its honesty and even more so for what it reveals about the avoidable failures in American health care:

I wish to begin by making a public confession: In the spring of 1987, as a physician, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was “rewarded” for this. It bought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could indeed do what was expected of me, I

¹²⁹ Health Care Reform Insurance Web Portal Requirements, 75 Fed. Reg. 24,470 (May 5, 2010).

¹³⁰ Sara Rosenbaum, *Special Supplement: Legal Solutions in Health Reform: Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, 37 J.L. MED. & ETHICS 103, 103 (2009).

¹³¹ D. Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 652-59 (2008).

¹³² *Purging* is another practice health insurance companies have employed to enhance the bottom line. Here, the company *purges* less profitable policyholders, such as those who required coverage, by intentionally hiking premiums, co-payments, and other out-of-pocket costs to unaffordable levels. Wendell Potter, *Got Health Insurance? Pray You Won’t Get “Purged,”* HUFFINGTON POST (May 16, 2011, 8:52 AM), http://www.huffingtonpost.com/wendell-potter/have-health-insurance-pra_b_862346.html.

¹³³ *Linda Peeno*, WIKIPEDIA.ORG, http://en.wikipedia.org/wiki/Linda_Peeno (last visited Oct. 11, 2011).

¹³⁴ Peeno, *supra* note 109.

exemplified the “good” company doctor: I saved a half million dollars!¹³⁵

Dr. Peeno denied coverage for a procedure that she later confessed would likely have saved the man’s life.¹³⁶ Because he did not receive the treatment, he died.¹³⁷ As part of her personal atonement, Dr. Peeno continued:

I do this because I know the system inside and out. I know where the dangers are. Although many persons are quick to extol the ease and affordability of their plan, the real tests come when someone needs something expensive. Like a bucolic pasture turn[sic] battlefield, the landmines start exploding everywhere. (I know because I have helped set more than a few.) These landmines were part of my ordinary armamentarium . . .¹³⁸

During her testimony, Dr. Peeno exposed the following “landmines” as she refers to them, or ways insurance companies padded profit through reliance on fine print where treatment was apparently medically necessary:

- benefits restriction, or making the covered benefits as narrow as the market would allow (sneaking in a few exclusions that most consumers would not be knowledgeable enough to understand, *e.g.* in one of my plans we had regular meetings to determine what our highest costs were and how we could redesign benefits to control them);
- exclusions, which would multiply every year, and would rarely be known to the member or a treating physician until pulled out by plan to justify a denial;
- pre-existing exclusions, to ensure that persons with known conditions would either forgo our plan, or give us the mechanism to avoid payment for services, creating a game of wits to figure out ways to make current needs connect with some prior diagnosis;
- evasive and uninformed marketing so individuals in groups we wanted would only know the attractive elements of the plan, but none of the potential problem areas; in addition members would never know the exact coverage limits and rules of the plan until after the enrollment period when they would receive their benefit booklet;
- underwriting, or selection of the “best” groups, which meant that medical information of individuals and groups were reviewed in detail, with projections made about economic liability to the plan; making these kinds of predictions often put me, as a physician, into the role of “bookie” for the plan;
- contract design, especially for physicians; it is common knowledge in the health care business that few physicians read, much less understand, most of the terms of the contracts they would sign for us; furthermore

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

we would exploit their economic vulnerability by telling them they could either sign or be excluded;

- maze of rules for authorizations, referrals and network availability created ed[sic] in order to make “technical” denials possible (*e.g.* failing to go through convoluted procedures set out in a “certificate of coverage,” which we knew few persons ever read, would be grounds for denial of payment);
- claims of authority to extract compliance from members and physicians for the desired economic outcomes, *e.g.* offering a grievance process but making it a sham in its results or eliciting certain practice patterns by threats to de-selection; and finally
- denials for “medical necessity,” whether prospectively or retrospectively, determining that something is not “medically necessary,” according to criteria that is non-standard and rarely developed along accepted clinical methods, becomes the ultimate weapon for the plan, the “smart bomb” for “cost-containment.”¹³⁹

Dr. Peeno concluded her testimony with “I am the evidence that managed care is inherently unethical, in the areas of both medicine and business.”¹⁴⁰ The central point of these startling revelations is the interdependent nature of these profit-driven techniques to avoid or reduce financial risk. In some instances this is done legitimately; but more often the data shows managed care organizations use the profit driven techniques distastefully at the expense of consistency, predictability, and security. Moreover, the illogicality of a system wherein those largely responsible to pay for medical care are motivated by other priorities continues to disserve those Americans unlucky enough to require medical attention or expensive procedures.

V. WIN-AT-ALL-COSTS PUBLIC RELATIONS TACTICS

“Democracy abhors undue secrecy.”¹⁴¹ – U.S. District Judge Victor Marrero

What is not openly discussed as part of the continuing debate about the reform legislation is the pivotal role public relations efforts played to shape lawmakers’ and the publics’ views on issues within the overall reform legislation.

A. *What Is Public Relations?*

Public relations is defined as “the management function that establishes and maintains mutually beneficial relationships between an organization and the publics on whom its success and failure depends.”¹⁴² “It’s about the large scale efforts being made, often with impressive success, to channel unthinking habits, our purchasing

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *ACLU v. Ashcroft*, 334 F. Supp. 2d 471, 519 (S.D.N.Y. 2004) (striking as unlawful section 505—a provision that gives the FBI authority to issue national security letters to obtain transactional records from electronic communications service providers without judicial oversight).

¹⁴² GLEN M. BROOM ET AL., *CUTLIP & CENTER’S EFFECTIVE PUBLIC RELATIONS* 3 (Prentice Hall 10th ed. 2009).

decisions, and our thought processes by the use of insights gleaned from psychiatry and the social sciences.”¹⁴³ Public relations practitioners have been referred to as the *invisible persuaders*.¹⁴⁴

Wendell Potter shared the first line of his job description as in-house public relations manager at CIGNA—“protect, defend, and enhance the company’s reputation.”¹⁴⁵ He also related that “the best public relations is invisible” and practitioners create perceptions without any public disclosure of who is doing the persuading or for what purposes.¹⁴⁶ Mr. Potter further explains that “[w]hile it’s easy to spot advertising—the stuff that blatantly urges you to go buy something—public relations subtly convinces you to change the way you think.”¹⁴⁷

B. Misleading Public Relations Tactics

Some public relations efforts, however, accomplish these objectives through deliberate contrivance and misrepresentation. Since at least President Clinton’s Administration, the health insurance industry has exploited these tactics to its advantage to create the perception of its usefulness that obscures its real goal: profits.¹⁴⁸ For example, AHIP has a strategic advisory committee.¹⁴⁹ Mr. Potter was privy to the committee and he revealed the following unethical and ostensibly unlawful practices: The committee creates and publishes “misleading, intentionally provocative, and xenophobic talking points” to muddy waters.¹⁵⁰ Further, he states, “[We] created those talking points, with the help from language and polling experts, and [gave] them to the industry’s lobbyist with instructions to get them into the hands of every “friendly” member of Congress.”¹⁵¹

Claims such as *government takeover* and *putting a Washington bureaucrat between you and your doctor* were created to conflate the real issues. The full truth, as discussed more fully above, is that the government is already vastly involved in American health care, namely by administering Medicare, Medicaid, Veteran’s Affairs, Tricare, and annually funding mandatory spending on these programs. In reality, the Affordable Care Act relies heavily on private insurers and employers to provide coverage.¹⁵² It also provides government subsidies to help low and middle-

¹⁴³ POTTER, *supra* note 76, at 4.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 162.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 5, 58.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* Concerning “xenophobic,” Mr. Potter is referring to the idea that reform legislation is the movement towards socialism—a tactic derived by the American Medical Association to oppose health care reform efforts during the Cold War.

¹⁵¹ *Id.* at 14.

¹⁵² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010).

income people buy private insurance on the state exchanges.¹⁵³ Analysts concluded that the exchanges will promote greater competition among insurers and a better deal for consumers, highly suggestive capitalism rather than socialism.¹⁵⁴ The claim concerning government bureaucrats is false. The truth is that insurance adjudicators and medical directors occupy the position between a patient and her physician.

The misrepresentation worked, to some extent. Illustratively, AHIP ensured that a warning against a government takeover was included in briefing packets for lawmakers in Washington, the industry's business allies, conservative pundits, talk show hosts, and editorial writers.¹⁵⁵ The effectiveness of this falsehood is reflected in comments by lawmakers. Upon his accession to Speaker of the House, Representative John A. Boehner of Ohio told reporters at the Capitol that, "[t]he American people are concerned about the government takeover of health care. I think it's important for us to lay the groundwork before we begin to repeal this monstrosity."¹⁵⁶ Similarly, Representative Zach Wamp commented during an appearance on MSNBC that:

[the reform legislation is] probably the next major step towards socialism. I hate to sound harsh, but . . . this literally is a fast march towards socialism, where the government is bigger than the private sector in our country, and health care's the next major step."¹⁵⁷

These claims or sound-bites originated with public relations and were injected into the debate to steer policy affecting substantial dollars. Right-leaning lawmakers adopted the health care insurance industry's position as conveyed in the guise of legitimacy and related that position to the public and the Presidential Administration, in how they voted the issue. The effects of these sound bites can also be found in Fox talk show host Sean Hannity, Rush Limbaugh, local Republican chapters, and the Tea Party, 90 percent of whom disapproved of reform because it moved the

¹⁵³ Robert Pear, *Health Care Overhaul Depends on States' Insurance Exchanges*, N.Y. TIMES, Oct. 24, 2010, at A23. There are essentially five steps in the functioning of a state insurance exchange under the Affordable Care Act. First, a consumer compares health insurance options and applies for coverage through the exchange. *Id.* Second, if the person is found eligible for Medicaid, the exchange helps the person enroll; otherwise, the process continues. *Id.* Third, the exchange sends the applicant's information to HHS. *Id.* Fourth, HHS seeks to verify citizenship or immigration status and eligibility for subsidies. *Id.* Fifth, the consumer enrolls in the chose health insurance plan through the exchange. *Id.* The United States Treasury sends monthly subsidy payments to insurance companies to help pay premiums and other costs for low and moderate-income people. *Id.* Members of Congress must get their health insurance through an exchange. *Id.*

¹⁵⁴ *Id.* "The Congressional Budget Office predicts that by 2019, about 24 million people will have insurance through exchanges, with four-fifths of them getting federal subsidies that average \$6,000 a year per person. People with incomes up to four times the federal poverty level [about \$88,000 a year for a family of four] will be eligible for subsidies." *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ Robert Pear & Reed Abelson, *Promise of Renewed Battle Over Reach of Health Care*, N.Y. TIMES, Nov. 4, 2010, at B4.

¹⁵⁷ Comments made during an appearance on MSNBC, FIRSTREAD MSNBC (Mar. 5, 2009 3:37 PM), http://firstread.msnbc.msn.com/_news/2009/03/05/4425103-is-health-care-a-privilege-for-some.

country toward socialism.¹⁵⁸ And, in the fall of 2009, despite AHIP's pledge to "play, to contribute, and to help pass health-care reform this year," the Senate Finance Committee adopted forty-eight amendments that responded to insurance company complaints.¹⁵⁹

Concerning the rising cost of medical care, the health insurance industry has claimed on the one hand, that it was best situated in the competitive market to manage care and costs efficiently, again underscoring its usefulness.¹⁶⁰ On the other hand, AHIP portrayed the industry as impotent in controlling medical costs through assigning responsibility to hospitals who charge companies more to make up for lower Medicare reimbursement rates.¹⁶¹

At first glance, these ostensibly logical statements appear reasonable and grounded in fact. But a closer look reveals the contrary. The Medicare Payment Advisory Commission, an independent expert panel created by Congress, found that a hospital's relative market strength, not what Medicare pays, determines the amount paid to hospitals by private insurers.¹⁶² AHIP shifted responsibility for premium hikes from its own profit-motive through misleading disinformation to protect itself at the expense of the public trust. AHIP was proverbially talking out of both sides of its mouth, or trying to have its cake and eat it too. So doing deserves the legislative process and suggests that AHIP cannot be taken at its word.

C. Specious Third-Party Front Groups

An additional disingenuous practice to shape views rather than present the truth is setting up and running front groups.¹⁶³ In the health care insurance industry, public relations firms created citizens' groups which announced to the public those matters which the health insurance industry declined to directly state.¹⁶⁴ The efforts, by deliberate design, gave the illusion of spontaneous "grassroots" uprisings, when in fact, the group was staffed by and its activities were directed by the public relations firms themselves.¹⁶⁵ As Mr. Potter reveals, "AHIP does not want the public to know anything about the PR strategies the firm creates and the front groups its sets up for the insurance industry."¹⁶⁶ They use third-parties to communicate what industry spokespeople could not do without revealing the main driver.

¹⁵⁸ Kate Zernike & Megan Thee-Brenan, *Poll Finds Tea Party Backers Wealthier and More Educated*, N.Y. TIMES, Apr. 14, 2010.

¹⁵⁹ Thomas A. Daschle, *Health Reform's Moment*, WASH. POST, Mar. 20, 2009 (quoting Karen Ignagni, chief executive of a major insurance lobby).

¹⁶⁰ *U.S. Health Care Costs*, KAISEREDU.ORG, <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx> (last visited Oct. 11, 2011).

¹⁶¹ *America's Health Insurance Plans: Health Care Costs*, AHIP.ORG, <http://www.ahip.org/content/default.aspx?bc=39|341|327> (last visited Oct. 11, 2011).

¹⁶² See e.g., MEDICARE PAYMENT ADVISORY COMMISSION, <http://www.medpac.gov/> (last visited Oct. 11, 2011).

¹⁶³ *Front Groups*, WIKIPEDIA.ORG, http://en.wikipedia.org/wiki/Front_organization (last visited Oct. 11, 2011).

¹⁶⁴ POTTER, *supra* note 76, at 35.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

An example involves APCO Worldwide,¹⁶⁷ the public relations and lobbying arm of the venerable Washington, D.C. law firm Arnold & Porter. APCO created *Health Care America*¹⁶⁸ for the purpose of discrediting Michael Moore's production of *Sicko*,¹⁶⁹ a documentary film designed to promote awareness of the problems in America's health care by featuring actual patients who have experienced the failings of American health and to offer solutions.¹⁷⁰ Some of the solutions involved assessing the financing and provision of medical care in countries such as Canada and France, single-payor countries.¹⁷¹ A single-payor system threatens the very existence of the private health insurance industry. As part of its attack to discredit Mr. Moore and his work, *Health Care America* posted the following on its web site: "[i]n America, you wait in line to see a movie. In government-run health care systems, you wait to see a doctor."¹⁷² In support, it rightly cited that America has the most technologically advanced health care in the world, the finest hospitals, and the most expert physicians.¹⁷³

Although America undoubtedly enjoys the most advanced technologies and the most sophisticated physicians in the world, comprehensive access to this standard of care is far from the norm. One need not look further than M.D. Anderson Cancer Center in Houston or Massachusetts General Hospital in Boston to observe examples of state-of-the-art technological and scientific developments. These institutions are staffed by accomplished physicians and providers with current expertise.

A significant portion of the American population, however, does not have access to the top-quality, world-renowned care available at America's finest treatment centers because of geographic, economic, and coverage limitations. Those who live near large university or teaching hospitals may be privy to state-of-the-art procedures and developments, while those who live near community hospitals or in rural areas are likely not. Notwithstanding breakthrough medical technologies, the United States ranks 54th, behind Bangladesh, in *fairness*—a measure of the extent to which the best care is available equally throughout a country.¹⁷⁴

The health insurance industry responded with a contrivance, shying away from the whole truth about the positive aspects of single-payor systems and omitting

¹⁶⁷ "Client service not only drives us, it defines us. At APCO Worldwide, we address clients' interests and objectives through communication and public affairs consulting that combines a global perspective with local expertise to understand the issues, events and trends that impact businesses and organizations around the world." APCO WORLDWIDE, <http://www.apco.worldwide.com> (last visited Apr. 19, 2011).

¹⁶⁸ Kevin Sack, *For Filmmaker, "Sicko" Is a Jumping-Off Point for Health Care Change*, N.Y. TIMES, June 24, 2007.

¹⁶⁹ *About the film*, SICKOTHEMOVIE.COM, <http://sickothemovie.com/about/> (last visited Apr. 19, 2011).

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Industry-Led Smear Campaign Against Sicko Makes Its Way to Drudge*, DEMOCRATIC UNDERGROUND, http://www.democraticunderground.com/discuss/duboard.php?az=view_all&address=389x1400505 (last visited Oct. 11, 2011).

¹⁷³ *Id.*

¹⁷⁴ WORLD HEALTH ORG., THE WORLD HEALTH REPORT 152-55 (2000).

equitability entirely.¹⁷⁵ This also left observers to draw the implication that a single-payer system was un-American and playing to emotions about America being the best.¹⁷⁶ While avoiding the whole truth, the industry simultaneously claimed to cite the reality concerning health care in countries wherein the government finances health care universally. “The reality is that government-run health systems around the world are failing patients [by] forcing them to forgo treatment or seek out-of-pocket care in other countries.”¹⁷⁷ Although this statement is accurate, the complete context is purposefully omitted to inflame emotions, promote misunderstanding, and monger fear.

Health Care America's web site describes its mantra. “We believe that unnecessary regulations, mandates, and frivolous lawsuits generate billions of dollars in excess health care costs and prevent millions of Americans from accessing the health care they deserve.”¹⁷⁸ The group describes its base of support as “consumer choice advocates, including employers, individuals, hospitals, pharmaceutical manufacturers, pharmacy benefit managers, health care professionals, and others.”¹⁷⁹ And, the group went so far as to publicly describe itself as a “nonpartisan, not-for-profit advocacy organization devoted to promoting the fundamental principles of access, choice, quality, innovation, and competition in our health care system.”¹⁸⁰

The truth was not told, though. The identity of the support base was not disclosed, only the general category, such as “employers” and “physicians.”¹⁸¹ The reality is that *Health Care America* was a front group funded by the health insurance industry and special interests, run out of the APCO offices.¹⁸² And the insurers funded the majority of the expenses to “run” *Health Care America*. The health insurance industry did not disclose its pivotal driving role. Neither APCO nor Arnold & Porter disclosed involvement, or upon whose behalf they were endeavoring to change public views to align with their clients’ objectives.¹⁸³

¹⁷⁵ Roger Bybee, *The Doctor's Revolt*, THE AM. PROSPECT (July 1, 2008), http://prospect.org/cs/articles?article=the_doctors_revolt (last visited Oct. 11, 2011).

¹⁷⁶ *Id.*

¹⁷⁷ *Health Care America*, SOURCEWATCH.ORG, http://www.sourcewatch.org/index.php?title=Health_Care_America (last visited Oct. 11, 2011).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ In a similar campaign, Philip Morris hired APCO to manage what it called a “massive . . . national effort aimed at altering the American judicial system to make it more hostile toward product liability suits” and to build a coalition to advocate for tort reform. Anne Landman, *Clinton Global Initiative Hires APCO Worldwide*, PRWATCH (Sept. 20, 2010, 4:13 PM), <http://www.prwatch.org/node/9469>. The tobacco industry paid APCO to implement behind-the-scenes tort reform efforts and to create chapters of “grassroots” citizens’ groups called Citizens Against Lawsuit Abuse. *Id.*

Although APCO mentions some of its clients on its web site under the heading of “client successes,” it does not disclose all of them.¹⁸⁴ As Wendell Potter reasons, “[y]ou will find no mention of AHIP there, likely because AHIP does not want the public to know about the PR strategies the firm creates and the front groups it sets up for the insurance industry.”¹⁸⁵ Bogus front groups are another deceptive tactic the industry was free to employ throughout the United States via the media without sanction or negative consequence.

D. Contrived Self-Serving Studies

The industry through AHIP even went so far as to commission a contrived PricewaterhouseCoopers study which it held out to be true.¹⁸⁶ The specious study claimed that health care reform would drive premiums up for all consumers and that consumers would pay for reforms via an excise tax on expensive health plans.¹⁸⁷ The finding flew in the face of Congressional Budget Office and other fiscal authorities’ calculations, and the study was determined to be false in its assumptions and false in its conclusions.¹⁸⁸ Ultimately, PricewaterhouseCoopers admitted that it conducted the study based only on the portions of the reform legislation that AHIP opposed. The Washington Post aptly pointed out, however, that “[t]he methodological inadequacies of the report made the results nothing short of deceptive. . . .”¹⁸⁹

The study was not short of deceptive. It was entirely deceptive. This is a blatant example of material misrepresentations as to the effect of the law designed to influence public dollars away from other possibilities and to the private health insurance industry. The report was released to the world via the Internet, distributed to the White House, and to individual Members of Congress.¹⁹⁰ Representative Tim Griffin of Arkansas posted the study and its claims to his Facebook page as part of his opposition to reform.¹⁹¹ It is reasonable to conclude that this is criminal fraud related to billions of dollars in federal appropriations.

Another falsehood claimed that reform would cut \$500 billion from Medicare, leaving the clear implication that benefits would be cut. In reality, the new law will slow the rate of increase in payment to providers over the next decade, and benefits for most beneficiaries will be as good or better as they were before March 2010.¹⁹²

¹⁸⁴ POTTER, *supra* note 76, at 35.

¹⁸⁵ *Id.*

¹⁸⁶ PRICEWATERHOUSECOOPERS, POTENTIAL IMPACT OF HEALTH REFORM ON THE COST OF PRIVATE HEALTH INSURANCE COVERAGE (2009).

¹⁸⁷ *Id.*

¹⁸⁸ Ezra Klein, *PricewaterhouseCoopers Backs Away from AHIP*, WASH. POST, Oct. 13, 2009, available at http://voices.washingtonpost.com/ezra-klein/2009/10/pricewaterhousecoopers_backs_a.html.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Representative Tim Griffin*, FACEBOOK.COM, <http://www.facebook.com/RepTimGriffin> (last visited Oct. 10, 2010).

¹⁹² See e.g., U.S. DEP’T OF HEALTH AND HUMAN SERVS., <http://www.hhs.gov> (last visited Mar. 10, 2011).

Critics also complained that reform would force the states to expand their Medicaid programs.¹⁹³ But critics failed to mention that the federal government will pick up the vast bulk of the added expense to cover millions of vulnerable citizens.¹⁹⁴ Moreover, states that do not access the federal subsidies will shortchange the health of its poorest citizens, who will likely continue to use emergency rooms for routine health care. Anything less than the unadulterated truth has no place in the legitimate synthesis and analysis of tough problems.

What was not said is the truth. Absent were facts. Reform prohibits insurers from dropping coverage after a beneficiary gets sick.¹⁹⁵ Dependents can stay on their parents' plans until age 26.¹⁹⁶ Insurers must cover preventative services and annual check-ups without cost-sharing.¹⁹⁷ Lifetime limits on how much insurance plans will pay for treatment are eliminated.¹⁹⁸ The major benefits start in 2014, when tens of millions of uninsured will gain coverage through Medicaid or by buying private insurance coverage with government help for low and middle-income people on the new competitive state exchanges.¹⁹⁹ If a citizen loses her job, she will not lose access to her insurance, and with government assistance, the coverage should be affordable.²⁰⁰ Insurers will be required to accept all applicants regardless of pre-existing conditions.²⁰¹ Understandably, private insurance is reluctant to relate the positives of reform for fear of drawing attention to itself and encouraging the reform-minded.

It goes without saying that the Administration's initial position, which included a government option and hinted at a single-payor program, jeopardized the very existence of the private for-profit health insurance industry. But a "do whatever it takes to win" approach, replete with misrepresentations and misleading sound bites, has no place amidst weighty and substantial questions involving the morality and legality of providing health care financing to all Americans. The time has come to end the misrepresentations.

E. The Result of the Public Relations Gamesmanship

The health insurance industry was successful in preserving its existence and solidifying its future. The United States did not adopt a single-payor financing system. The Administration dropped the government option from the legislation. The government option would have captured a substantial percentage of market shares

¹⁹³ January Angeles and Matt Broaddus, *Federal Government Will Pick Up Nearly All Costs of Health Reform's Medicaid Expansion*, CENTER ON BUDGET AND POLICY PRIORITIES (June 18, 2010), <http://www.cbpp.org/cms/index.cfm?fa=view&id=3161>.

¹⁹⁴ *Id.*

¹⁹⁵ Patient Protection and Affordable Care Act, PUB. L. NO. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

and economically competed with private companies to reduce premiums, billing costs, administrative fees, and other expenses. Millions of new paying policyholders will be compelled by law to buy insurance under the individual mandate.²⁰² Those who cannot afford the insurance will be subsidized by the federal government.²⁰³ The legislation even provides for the U.S. Treasury to electronically transfer premium dollars for poorer Americans directly to the private insurance company.²⁰⁴ Some call the legislation a “profit-generating dream for private insurers,” or “The Health Insurance Industry Profit Protection and Enhancement Act.”²⁰⁵ Undeniably, insurers stand to gain billions in new revenues from people required by law to buy their products, and billions more from the government to subsidize premiums for those who cannot afford them.

In a poignant twist, the health insurance industry, despite its public ridicule, was most troubled by the Senate Finance Committee’s proposed weakening of penalties for those who did not obtain coverage by 2014.²⁰⁶ Ironically, the industry publicly opposed reform in its entirety when the individual mandate could allow some to avoid coverage, thereby decreasing the pool of paying customers to only 94% of the American population.²⁰⁷ In other words, too little government moved insurers to indignation and combative hostility, which underscored the false rhetoric about government takeovers.

Beyond the health insurance industry, large pharmaceutical manufacturers are represented by the lobbying group Pharmaceutical Research and Manufacturers of America (PhRMA).²⁰⁸ PhRMA received tens of billions of dollars in new customer prescriptions from the newly insured and from “filling the donut hole” to improve Medicare’s prescription drug subsidies.²⁰⁹ The new law requires employers to provide prescription drug coverage for workers, requires states to subsidize drugs through Medicaid, and prohibits Americans from importing less expensive drugs from China, among other provisions.²¹⁰ Health care providers were told that reform would pay \$171 billion for hospitals and \$228 billion for doctors; in turn, the

²⁰² Reed Abelson, *President’s Speech Allays Some Fears in the Health Insurance Industry*, N.Y. TIMES, Sept. 10, 2009, at A16, available at <http://www.nytimes.com/2009/09/11/health/policy/11insure.html>.

²⁰³ *Id.*

²⁰⁴ Patent Protection and Affordable Care Act, *supra* note 195.

²⁰⁵ POTTER, *supra* note 76, at 6.

²⁰⁶ Reed Abelson, *In Health Care Reform, Boons for Hospitals and Drug Makers*, N.Y. TIMES, Mar. 22, 2010, at B1, available at <http://www.nytimes.com/2010/03/22/business/22bizhealth.html?pagewanted=all>.

²⁰⁷ *Id.*

²⁰⁸ See, e.g., PhRMA, <http://www.phrma.org/> (last visited Oct. 8, 2011).

²⁰⁹ Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010); see also Dan Egan, *Health-Care Effort Losing Important Player; Tauzin’s Resignation from PhRMA May Add to Democrat’s Problems*, WASH. POST, Feb. 13, 2010, at A04.

²¹⁰ Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010); see also Timothy P. Carney, *Obama Gives Sugar Plums To The Special Interests*, WASH. EXAMINER (Mar. 24, 2010), <http://www.washingtonexaminer.com>.

American Hospital Association agreed to accept \$155 million less in Medicare payments over ten years, while the American Medical Association consented to future payment reductions that amounted to \$80 billion.²¹¹

In the final analysis, it is very clear that the corporate interests conveyed through persistent yet dubious public relations tactics won its own future. Its hostility and antagonism ended when the dollars started flowing, with the earnest desire to care for the nation's sick somewhere else.

VI. POTENTIAL SOLUTIONS

“Sunshine is the best disinfectant.”²¹² – Justice Louis Brandeis

The American public and lawmakers must have connectivity with the truth, untainted and unvarnished, to measure health care problems correctly. The scope, scale, and totality of these challenges are too vast and too important to permit dishonesty and calculated manipulation to steer decisions or eliminate otherwise viable options.

A. Congressional Hearings to Build a Record

Now that the Affordable Care Act is law and the health insurance industry has a measure of security in the form of its financial future, the time is right for Congress to investigate public relations tactics in light of the nefarious practices uncovered during the lead-up to reform. Presently, there is no law to compel public relations practitioners to refrain from misrepresenting material facts. Practices such as spreading *misinformation* and employing *half-truths*, *fear-mongering*, *spontaneous third-party grass roots*, and *flogs* have no place in a public debate about caring for the Nation's sick.²¹³ It is essential to accurately identify the problem to sufficiently get at the solutions most likely to bring about real results. Clouding the issues, distorting the facts, manipulating the record, attacking individuals and organizations, and conducting cloak-and-dagger type campaigns must be stopped due to the very real danger posed to the public welfare.

A starting point is Congressional fact-finding through document subpoenas, document review, witness subpoenas, hearings, and the development of an accurate record. This will help to clearly bring into focus those practices which should be regulated and/or prohibited. Dr. Peeno's testimony in 1996 and Wendell Potter's testimony in 2009 helped to create a modest record. More can and should be done.²¹⁴

B. State-Based Licensing of Public Relations Professionals

In addition to Congressional hearings, various states can also contribute to the solution. Oversight in the form of licensing requirements, continuing ethics training, and enforcement procedures is not only an additional source of revenue for the states, but also a means by which to sanction offenders in the interest of transparency and good government.

²¹¹ Reed Abelson, *supra* note 206, at B1.

²¹² Ian C. Freeman, <http://www.iancfriedman.com/?p=102> (last visited Oct. 11, 2011).

²¹³ Gogoi, *supra* note 100.

²¹⁴ POTTER, *supra* note 76; Peeno, *supra* note 109.

The Public Relations Society of America (PRSA) has a voluntary Code of Ethics and claims that it is the industry standard.²¹⁵ Its web site recognizes that the “practice of public relations can present unique and challenging ethical issues,” and simultaneously avows sincere interest in “protecting integrity and the public trust are fundamental to the profession’s role and reputation.”²¹⁶ The PRSA Board of Ethics and Professional Standards sets out fundamental values like “advocacy, honesty, loyalty, professional development, and objectivity.”²¹⁷ It also advises public relations practitioners to “protect and advance the free flow of accurate and truthful information,” “work to strengthen the public’s trust in the profession,” “be honest and accurate in all communications,” and “reveal sponsors for represented causes and interests.”²¹⁸ The Code also counsels practitioners to “decline representation of clients requiring actions contrary to the Code.”²¹⁹ Admittedly noble in concept, the reality, as demonstrated more fully above, departs from the idyllic picture of honesty, integrity, disclosure, transparency, and serving the public trust.

States can model the regulation of public relations professionals by referring to the processes governing the practice of law. These processes should include: (1) disclosing background education and character as a prerequisite to practice; (2) assessing minimum skills through examination; and (3) having an oversight body empowered to promulgate rules of practice, receive complaints, conduct investigations, and ultimately suspend, modify, or revoke a license to practice. Practitioners should be required to pay annual dues, attend annual education training, and maintain professional liability coverage. Violations of the rules of practice would be considered professional misconduct and subject to the suspension, modification, or revocation of one’s license. It is a legitimate government objective to further the health, safety, and morals of the citizenry by regulating a profession capable of influencing law and policy.

C. *There Must Be Disclosure*

Federal consumer protection laws contain disclosure requirements to level the playing field between the sophisticated businesses with superior knowledge and the ordinary citizen. For example, the Truth in Lending Act²²⁰ requires lenders and credit providers to fully disclose according to federal standards and the costs of the loan or credit being offered. The Fair Credit and Charge Card Disclosure Act (Truth in Lending Act Regulation Z) requires creditors to disclose specific information on all revolving credit statements, and the Fair Credit Reporting Act²²¹ ensures a citizen’s right to accurate credit reporting. The intent behind these laws is to ensure honesty and transparency, prevent abuses, and thereby empower citizens to make informed decisions.

²¹⁵ *PRSA Code of Ethics: Ethical Guidance for Today’s Practitioner*, PRSA.ORG, <http://www.prsa.org/aboutprsa/ethics/> (last visited Apr. 23, 2011).

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ Consumer Credit Protection Act, 15 U.S.C. §1601 (2009).

²²¹ 15 U.S.C. § 1681 (2004).

Not only does consumer protection law embrace disclosure, but state and federal campaign laws also require it. For example, the Illinois Compiled Statutes state that any political committee that circulates a “communication” directed at voters “shall ensure that the name of the political committee paying for any part of the communication is identified within the communication.”²²² Disclosure also extends to individuals and organizations that make financial contributions to advocate for the success or failure of a candidate.²²³ An example may be “any public relations entity that publishes a communication directed to voters or lawmakers shall ensure that the name of the entity paying for any part of the communication is identified within the communication.”

Public relations firms should be required to certify that the representations made within the communication are grounded-in-fact, and concomitantly supply the good faith basis supporting the representations. Illustratively:

these statements are made in good faith as part of a public relations campaign on behalf of and paid for by American Health Insurance Plans, an organization comprised of leading private health insurance companies. The basis for these statements is on-file with and available for inspection and copying at the Federal Trade Commission and the National Association of Insurance Commissioners.²²⁴

Penalties should apply for the knowing violation of these requirements designed to compel honesty, accuracy, and transparency.

Further underscoring the importance of good faith and informed decision-making which favor disclosure, as of this writing, President Obama is circulating a draft Executive Order that could enhance disclosure in federal campaign finance

²²² 10 Ill. Comp. Stat. 5/9-9.5(a) (2011).

²²³ 10 Ill. Comp. Stat. 5/9-12(3) (2011).

²²⁴ Similar disclosure and certification requirements are contained in the *Sarbanes-Oxley Act*. Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 705 (2002). The SEC has the authority to prohibit, conditionally or unconditionally, permanently or temporarily, any person who has violated laws governing the issuing of stock from acting as an officer or director of an corporation if the SEC has found that such person’s conduct “demonstrates unfitness” to serve as an officer or a director. *Id.* The SEC rules mandate that the principal executive officer and the principal financial officer certify in each annual or quarterly report the accuracy of certain information. *Id.* The signing officer must disclose to the auditors and audit committee any significant deficiencies in the design or operation of the internal controls, any fraud, whether or not material, that involves management or other employees who have a significant role in the issuer’s internal controls, and any significant changes in the internal controls. *Id.* Section 906 requires that the chief executive officer and chief financial officer provide written statements to be filed with each periodic report filed under the Securities Exchange Act of 1934 certifying that the periodic report containing the financial statements fully complies with the requirements of Sections 13(a) or 15(d) of the Securities Exchange Act of 1934 and that the information contained in the periodic report fairly presents, in all material respects, the financial condition and results of operations of the issuer. *Id.* A knowing violation of Section 906 is punishable by up to ten years in jail and a \$1 million fine. *Id.* A willful violation is punishable by up to 20 years in jail and a \$5 million fine. *Id.*

regulations.²²⁵ This order would require disclosure of contributions to “third-party” or “independent” expenditure groups by corporations receiving government contracts.²²⁶ During the 2010 elections, much of the unlimited election spending, made possible by the U.S. Supreme Court’s *Citizens United v. Federal Election Commission*²²⁷ decision, was kept secret by groups taking advantage of the tax code. The President’s proposed order would lift the veil on secret spending in time for the 2012 elections, at least for those corporations receiving government contracts.²²⁸ Similarly, the federal government can do the same when it comes to disclosing real parties-in-interest in public relations efforts.

With the principles of consumer protection and campaign disclosure laws in mind, flogs and contrived front-groups should be categorically outlawed. They are ruses that cloak the true stakeholders in anonymity, preventing an accurate assessment of motives and intent. Penalties should not only apply to those hired to actually perform the work, but also the public relations firm that retained them and the health insurance company that paid the public relations firm to orchestrate the overall endeavor.

D. Existing Laws

Law enforcement officials have a number of existing statutes that appear to apply to public relations misrepresentations. Title 18 of the United States Code (U.S.C.), section 1001 makes it a federal crime to make a false statement to federal authorities and subjects offenders to a fine, imprisonment, or both.²²⁹ The elements of the false statement charge are: (1) the making of a statement; (2) the falsity of such statement; (3) knowledge of the falsity of such statement; (4) relevance of such statement to the function of a federal department or agency; and (5) the false statement was material.²³⁰ To be material, the statement must have a natural tendency to influence, or be capable of influencing, a decision, but it need not have been actually

²²⁵ *Disclosure of Political Spending by Government Contractors*, Office of Management and Budget (Draft, Apr. 13, 2011), available at <http://federalnewsradio.com/pdfs/EC-contractorspending.pdf>.

²²⁶ *Id.*

²²⁷ *Citizens United v. Fed. Elec. Comm’n*, 130 S.Ct. 876, 898-91 (2010).

²²⁸ *With a Stroke of His Pen Obama Strikes Back at Citizen’s United*, POLITICUSUSA.COM (Apr. 21, 2011), <http://www.politicususa.com/en/obama-citizens-united>.

²²⁹ 18 U.S.C. § 1001(a) (2009). Additionally, the statute states that:

[e]xcept as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully—(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both.

Id.

²³⁰ *United States v. Hixon*, 987 F.2d 1261, 1266 (6th Cir. 1993).

influential.²³¹ Knowledge by the government agent that the statement is false does not alter the materiality of the statement.²³²

The PricewaterhouseCoopers study AHIP fabricated and held out as the truth appears to violate the statute.²³³ The study was false in its assumptions and false in its conclusions. AHIP: (1) made the statement; (2) the study was false; (3) AHIP knew the study was false; (4) the study directly related to the functioning of various federal departments and agencies and was made to various government personnel; and (5) the study was material because of its potential to influence fiscal decisions.

Additionally, the federal mail fraud statute, Title 18 of the U.S.C. section 1341, prohibits the use of the mails to execute “any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises.”²³⁴ As the Court long ago stated, however, the words “to defraud” commonly refer “to wronging one in his property rights by dishonest methods or schemes,” and “usually signify the deprivation of something of value by trick, deceit, chicane, or overreaching.”²³⁵ The federal wire fraud statute is similar.²³⁶

Fraud is commonly understood as dishonesty calculated for advantage. Fraud must be proved by showing that the defendant’s actions involved five separate elements: (1) a false statement of a material fact; (2) knowledge on the part of the defendant that the statement is untrue; (3) intent on the part of the defendant to deceive the alleged victim; (4) justifiable reliance by the alleged victim on the statement; and (5) injury to the alleged victim as a result.²³⁷

Applied to public relations activities upon behalf of private insurers, it appears that a fraud may have been perpetrated on the United States. Fabricated false studies, fake blogs, specious third-party front groups coupled with the calculated development, testing, and widespread release of misleading sound-bites about reform can be viewed as part of a conspiracy to defraud by diverting enormous sums of public dollars for private gain.

Lawmakers, by virtue of their use of phrases, sound bites, and adopted positions, relied to some extent on these statements. The injury is the billions of dollars, a percentage of which will be profit for private insurers. The injury is also to the health care financing system as a whole because a single-payor or public option was not enacted, largely due to public relations spin. The fact that fraud must be pled with particularity underscores the need for investigation of these activities. Once the

²³¹ United States v. Chandler, 752 F.2d 1148, 1151 (6th Cir.1985).

²³² United States v. LeMaster, 54 F.3d 1224, 1230-31 (6th Cir. 1995).

²³³ Klein, *supra* note 188.

²³⁴ Schmuck v. United States, 489 U.S. 705, 721 n.10 (1989) (“There are two elements in mail fraud: (1) having devised or intending to devise a scheme to defraud (or to perform specified fraudulent acts), and (2) use of the mail for the purpose of executing, or attempting to execute, the scheme (or specified fraudulent acts).”).

²³⁵ Hammerschmidt v. United States, 265 U.S. 182, 188 (1924).

²³⁶ 18 U.S.C. § 1343 (2010); *see also* United States v. Briscoe, 65 F.3d 576, 583 (7th Cir. 1995) (“[t]he elements of wire fraud under Section 1343 directly parallel those of the mail fraud statute, but require the use of an interstate telephone call or electronic communication made in furtherance of the scheme.”).

²³⁷ Shapiro v. UJB Fin. Corp., 964 F.2d 272, 284 (3d Cir. 1992).

metes and bounds of the misrepresentations have been determined, the federal conspiracy, mail, and wire fraud statutes may have indeed been violated.²³⁸

To the extent regulation and reform of public relations activities limits speech, the First Amendment's freedom of expression and speech provisions, as well as commercial free speech case law, are implicated. Current laws, however, have already passed constitutional muster as reviewed by the courts. The Supreme Court has determined that certain commercial speech is not entitled to protection.²³⁹ The informational function of advertising is the First Amendment concern; if it does not accurately inform the public about lawful activity, it can be suppressed.²⁴⁰ Here, the idea is to compel accuracy and discourage misrepresentations that are abusive of the public trust. Accordingly, the First Amendment is not a bar.

The goal of any nation's health care system is summed up nicely by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable.²⁴¹ By taking official action to investigate, expose for the record, and implement preventative and punitive measures against manipulation of the public trust, America will be closer to realizing that secure and predictable health care system.

VII. CONCLUSION

In a country conceived upon union and liberty and dedicated to adherence thereto, how is it that powerful corporate interests are free to connive and con the public and its lawmakers without penalty, but with reward?

Alexis de Tocqueville, the French aristocrat who wrote the celebrated and widely quoted *Democracy in America*, warned about the potentially fatal flaws in the American character.²⁴² He cautioned that a tendency toward self-indulgence and apathy toward the public good paves the way for the threat of tyranny.²⁴³

The financing of health care in the United States should not be a partisan issue relegated to pandering for votes or heeding to corporate interests. Nor is it an issue where the American people can tolerate deceit in the guise of legitimate public discourse. The financing of health care is on a higher moral plane. It ranks with those basic truths which are immovable in a civilized, advanced society—truths like governing to protect the health, safety, and morals of the citizenry.

Illness affects every family, and caring for our families and loved ones is too important to be side-tracked by corporate interests. Anybody who has waited for their mother to emerge from lung cancer surgery, or their father from carotid artery surgery, can tell you that there is nothing more important than your loved one's care.

In this Article, two critical problems left after the Affordable Care Act have been identified and potential solutions have been offered. Admittedly, those solutions

²³⁸ The Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1964 (2010). *et seq.*, may also apply.

²³⁹ *Cent. Hudson Gas & Elec. Co. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 563-64 (1980).

²⁴⁰ *Id.*

²⁴¹ INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASIM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 25 (National Academy Press, 2001).

²⁴² ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* (Penguin Classics, 2003).

²⁴³ *Id.*

require development based upon the overall facts adduced, but maybe they can begin the much-needed public dialogue on what to do to care for all Americans. This Article is also a call for officials to discern the truth from the spin, rise to the occasion, and provide leadership and character for the betterment of the country.