to implement evidence-based decisions have been influenced by politics. It's ironic that as CMS launches value-based purchasing programs for providers, it is unable to apply value-based purchasing for technology.[5] Moreover, circumstances have forced the program into a disingenuous conversation about medical technology as it attempts to address its fiscal predicament while pretending that costs do not matter.[5]

Above all, in making coverage determinations, Medicare should be guided by the available clinical evidence. Beyond that principle, a legislative fix for the "reasonable and necessary" clause would help. Legal scholar Jacqueline Fox argues that amending the original statute so that it prohibits payment "for any expenses which are unreasonable and which are incurred for items and services" would provide CMS authority and legitimacy to consider costs openly (because reasonable would then modify expenses rather than items and services).[5] Another option is for Congress to rewrite the "reasonable and necessary" clause borrowing language from the 2008 Medicare Improvements for Patients and Providers Act, which permits CMS, in covering preventive services, to account for "the relation between predicted outcomes and expenditures" and thus to consider costs in coverage decisions pertaining to prevention.

Making such changes will be challenging in the current political climate, but the urgency of the situation — Medicare is projected to become insolvent in a decade — and postelection budget talks provide an opening. In the meantime, Medicare will continue its peculiar dance over technology policy, in which it intensely scrutinizes clinical evidence and emphasizes outcomes and subgroups, while cost considerations lurk offstage.

It may be tempting to believe that the matter will be rendered moot by payment reform and premium-support policies. That is, some may hope that the federal government can simply delegate coverage decisions to other parties, such as accountable care organizations, while forcing patients to consider the value of technologies through increased cost sharing. Such reforms are needed, since they will help move CMS out of the business of micromanaging coverage policy, though the details will be crucial. Offloading financial risk, however, does not absolve Medicare. Although it will shield CMS from certain controversies, questions will persist over how much geographic and socioeconomic variation in technology coverage the country will tolerate in a federal program. Moreover, the steady march of big-ticket, high-profile technology, such as cancer therapies, will demand a single response from Medicare regarding the adequacy and reasonableness of the evidence base.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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The Taxing Power and the Public's Health

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Many observers feared that the Supreme Court decision on the challenge to the Affordable Care Act (ACA)[1] would endorse a breathtaking expansion of the role of the federal government in regulating health matters. And it did — but not in the anticipated way. While enunciating limits on the commerce and spending powers, the Court opened the door for Congress to use its taxing power to achieve myriad policy objectives. The federal government may now increasingly join state and local governments in making creative use of taxes to pursue public health goals, though political obstacles may block immediate action.

Chief Justice John Roberts surprised pundits by joining the four liberal justices in upholding the individual insurance mandate in the ACA as an exercise of Congress's power to "lay and collect

Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States."[2] He wrote that the government has considerable power to tax "even in areas where it cannot directly regulate."

Congress deliberately did not call the ACA "shared responsibility payment" (SRP) levied on persons who don't buy insurance a "tax," so why did five justices find that it is one? The Court took a "functional approach," interpreting judicial precedent to mean that regardless of the label, if an exaction looks like a tax, works like a tax, and feels like a tax, it's probably a tax. Roberts noted that the SRP is paid into the Treasury when taxpayers file income tax returns; it doesn't apply to nontaxpayers; its amount is determined by some of the same factors determining income-tax liability; it's enforced by the Internal Revenue Service (IRS) and set down in the Internal Revenue Code; and it produces government revenue.

Roberts gave several reasons for rejecting the argument that the SRP is a "penalty" for violating a law. First, the amount of the SRP is modest. People may reasonably decide to pay the SRP rather than buy insurance, and they're free to do so. Second, whereas penalties are typically imposed only on persons who knowingly violate laws, the SRP is levied regardless of one's state of mind. Third, the way the SRP is collected and the fact that the IRS cannot use punitive enforcement measures are telling. Finally, a penalty is "punishment for an unlawful act or omission," but the ACA does not make it illegal not to buy insurance. Congress expected that millions of people would opt to pay the SRP and presumably "did not think it was creating four million outlaws."

Roberts embraced the full scope of Congress's taxing power, while articulating a few limits. At some point, he wrote, "the penalizing features" of a putative tax can cross the line and become a penalty. He did not indicate how this line should be drawn but announced that the SRP would clearly fall on the correct side of it. Furthermore, Roberts made clear that Congress can use the taxing power only to influence behavior by making people pay money; it cannot impose other sanctions. Finally, Congress cannot tax a person merely for existing, unless that "direct tax" is designed so that each state pays in proportion to the size of its population. To avoid this requirement, the tax must be triggered by some circumstance, such as not having insurance.

Roberts's opinion appears to invite more targeted, assertive interventions to promote public health.

As long as these limits are respected, Congressional action falls within the taxing power and can be used for various regulatory objectives. Congress can use tax incentives to encourage people to buy certain products, as it has done for purchasing homes and professional educations. It can also use negative incentives: federal taxes have been used to discourage such behaviors as using tobacco and selling sawed-off shotguns. Now, Congress can even apply taxes to "omissions" or inactivity, such as not buying something. To invoke ACA opponents' bogeyman, nothing in Roberts's opinion stops the government from taxing people who fail to purchase broccoli, as long as the tax is modest.[3]

The federal government has long used taxes to achieve public health goals, but in fairly limited ways. Taxes and tax penalties for individuals have generally been confined to products that cause health harms and associated social costs, such as tobacco, alcohol, firearms, and pollutants. Taxing of activities is rarer and confined to economic transactions; most recently, the ACA imposed a 10% tax on tanning-salon services. Broader use has been made of tax penalties and incentives to influence corporations to refrain from activities that threaten health, such as environmental contamination, or to engage in health-promoting activities such as subsidizing health insurance and wellness programs.

Roberts's opinion appears to invite more targeted, assertive interventions to promote public health. For example, instead of merely taxing tobacco sales, the federal government could require individuals to pay a tax penalty unless they declare that they haven't used tobacco products during the year. It could give a tax credit to people who submit documentation that their body-mass index is in the normal range or has decreased during the year or to diabetic persons who document that their glycated hemoglobin levels are controlled. It could tax individuals who fail

to purchase gym memberships. It could require taxpayers to complete an annual health improvement plan with their physician in order to obtain a tax credit, though that might be challenged under other parts of the Constitution. These strategies depart from traditional uses of taxes by targeting omissions and noncommercial activities that are important drivers of chronic disease.

State and local governments, too, can pursue such strategies. Levying taxes to achieve regulatory aims — even taxes resembling mandates with penalties — is well within their police-power authority. They've wielded this power to impose various "sin" taxes on unhealthful products, as well as in more innovative ways, such as the insurance mandate with an SRP that Massachusetts pioneered. The Court ruling makes clear that the federal government can enter territory historically dominated by the states.

Taxes are an appealing mechanism of public health regulation for several reasons. They proffer "nudges" and market-based solutions as alternatives to rigid mandates. Tax-based policies like the SRP retain an element of voluntariness, especially since lawmakers can calibrate the tax penalty to the importance of the desired behavior change. There's strong evidence that taxes affect consumption decisions. Finally, tax strategies are "win–win" for governments, either leading people to take health-enhancing steps or collecting revenue to fund health or other programs.

Yet even when proposed taxes make sense, they can be soundly defeated. Although tax credits, exemptions, and deductions tend to be well received, new taxes and penalties do not. Strong industry opposition is a formidable obstacle even when public sentiment isn't. Aggressive lobbying by the beverage industry, for example, defeated a soft-drink tax proposed for inclusion in the ACA, and a blitzkrieg by the tobacco industry sank California's Proposition 29, which would have hiked cigarette taxes by $1.00 a pack, with revenues allocated for cancer research. States, however, have sometimes had remarkable success in enacting new taxes; for example, New York passed a $1.60-per-pack increase in its cigarette tax in 2010, bringing the total state tax to $4.35 per pack, and 47 states have collectively increased their cigarette-tax rates more than 100 times in the past decade.[4]

Although no constitutional barriers block expanded federal use of tax-based strategies, political obstacles remain. Some interventions we've outlined would never survive the political process, given prevailing antitax sentiment. But such sentiment may fade as the economy recovers or become less important if Democrats regain control of the House of Representatives. Moreover, the Court decision affirms that Congress can facilitate passage of a tax by calling it something less controversial. The Court has highlighted an opportunity for passing creative new public health laws, authorized by the taxing power; this opportunity now awaits its political moment.

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"If I Had Only Known" — On Choice and Uncertainty in the ICU

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Of all the ways one can mark time in the intensive care unit (ICU), none is quite so concrete as the ebb and flow of the bedside chart. In our hospital, where we still keep most of our records on paper, charts fill up over days and weeks with the notes, forms, and reports that chronicle each patient's hospital stay. After about a month, having grown too heavy for practical use,