Wyoming Liberty Group

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Medical Freedom Zones

by Benjamin Barr & Stephen Klein

Executive Summary

A **medical freedom zone** is a legally recognized geographic area where health care professionals may provide services and conduct research governed by professional associations and private contracts.

Both the federal and state governments hamper doctors' ability to innovate in medicine and to offer more affordable or alternative care. While the federal government delays innovative medicine, state governments make affordable care more difficult by limiting the number of doctors and saddling those who do practice with difficult liability rules. Similarly, the ability of care providers and patients to fashion their own agreements governing medical procedures is entirely hamstrung through state regulation. The result? More than 500,000 Americans fled the United States in 2008 for medical tourism. The time for innovative reform is now.

This paper illustrates how one jurisdiction could take the lead in defining medical freedom in the United States and create a safe haven for innovation, alternative care, and affordable treatment. The task is not easy because many legal hurdles stand in the way. However, through careful construction, a veritable Mecca of medical excellence could be created, shaped by world-class contracts and standards. By permitting innovation and privately regulated care to exist in limited geographic areas, Wyoming could be the proving ground with little risk: those who prefer state managed care may stay in the system, while those favoring innovation and freedom may find an escape valve in medical freedom zones.

Different types of freedom zones have sprung up worldwide in a number of contexts. In

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2004, the United Arab Emirates created the Dubai International Financial Centre, which incorporates the legal protections of British common law for its financial markets. Dubai also implemented the Jebel Ali Free Zone that favors foreign investment and the Dubai Healthcare City, which serves as a free zone for medical services and innovation. Iceland recently set out to become a safe haven for whistleblowers around the globe, and it is accomplishing this by developing the world's best laws regarding free speech and freedom of information. By creating a safe haven for free speech, Iceland is encouraging market development in internet server and publishing house relocation to Iceland to take advantage of its attractive laws. With just such an approach, Iceland may very well reinvigorate its economy while providing a powerful protective effect for free speech worldwide. Though a free zone would be new to the United States, America is not unaccustomed to attractive law, as Delaware proves. At the end of 2009, Delaware was home to 63% of Fortune 500 companies, and realized $767 million in revenue to its general fund just from corporate taxes. This is the result of stable corporate law that has lasted over 100 years, and continues to attract a majority of new corporations. Wyoming ought to pay attention to the possibilities.

The first and most readily accessible market for a medical freedom zone is medical tourism. Currently a multi-billion dollar foreign market, deregulated healthcare markets are expected to grow in a speedy manner over the course of a few years. Given the geographic desirability of American states, close proximity works in the favor of jurisdictions wishing to become destinations for medical tourism. Beyond proximity, American states can borrow from some of the best law available to construct their own efficient and responsible legal systems for health care concerns, putting them at a distinct advantage over their foreign counterparts.

Another possibility is to create a medical Silicon Valley. On the international scene, this has already been realized in the Dubai Healthcare City—a free zone with its own custom-built set of regulations and qualifications for medical care. A number of effective treatments are currently unavailable in the United States, having been developed elsewhere and awaiting FDA approval. A medical freedom zone could welcome the world's best researchers and scientists to bring vibrant innovation back to the United States.

To properly construct medical freedom zones, several pillars of legal reform must be implemented. The Wyoming Liberty Group believes that this can be accomplished by adhering to dual federalism, that is, ensuring that the states and the federal government are each limited to specific powers, thus maximizing individual freedom. Recently, states have won challenges against the federal government precisely because of the United States Supreme Court's commitment to developing a theory of coherent dual federalism that protects the states' "residuary and inviolable sovereignty." Supporters of state sovereignty must instruct and shape the Court's reasoning, lest this battle

be surrendered to advocates of supreme federal authority.

At the time of this writing a number of states are proceeding in a lawsuit challenging the constitutionality of the individual mandate of the Patient Protection and Affordable Care Act (PPACA), relying on the Commerce Clause. The states argue that a decision not to purchase a product is not an economic activity, and thus not within the purview of the Commerce Clause. Whether the current multistate lawsuit succeeds or fails, medical freedom zones will need additional protection from any number of other federal incursions, whether based on the Commerce Clause or ever-expanding judicial misinterpretations of constitutional provisions.

The Wyoming Liberty Group approach combines a number of judicial threads to weave strong stability for freedom. The first thread accesses the history of incorporation, or the federal enforcement of the individual rights contained in the Bill of Rights against state and local governments. The most recent application of incorporation was in *McDonald v. City of Chicago* where the United States Supreme Court ruled that the right to bear arms applies in the city of Chicago. A second thread is Judicial Federalism, which focuses largely on making state constitutions more protective of the rights described within them. It is already well-established that if a state provides more protection for a constitutional right, there is no ground to appeal a state constitutional question to the United States Supreme Court.

These traditions must be considered in light of the Ninth Amendment, which states that the Bill of Rights is not the end-all be-all of individual rights, and that it is not a requirement for citizens to amend the U.S. Constitution in order to protect individual rights within their own state. When these threads are combined, it shows that a state protecting health care choice (including decisions to purchase health insurance and engage in risky medical treatments) must be protected from federal as well as state infringement.

It is not just the federal government Wyoming residents must be wary of; state governments pose their own threats to health freedom as well. Ancillary legal reform should focus on securing the necessary components of a free market for health care services in Wyoming. This includes securing the protection of arbitration and choice of law provisions in contracts. Wyoming's judicial system highly regards them both, in contrast to hazy jurisdictions that offer but partial protection due to vague "public policy" concerns. Wyoming has great respect for private arrangements, but law could be passed to further protect any shift from this.

Another state law concern that Wyoming should address is meaningful tort reform. Studies conclude that a comprehensive set of laws must work together to bring down the cost of malpractice insurance, litigation costs, and the use of defensive medicine. The first element to consider is limiting noneconomic damages. In this instance it

would be best to recognize not only arbitration agreements, but contracts in which health providers and patients can determine a proper limit, if any. Second, Wyoming should enact a modified collateral source rule. Under the traditional collateral source rule (current Wyoming law), juries cannot hear about other types of compensation a plaintiff receives in instances of medical malpractice. Reforming the collateral source rule would not prevent plaintiffs from recovering damages, but only from double-dipping their compensation. Finally, Wyoming should implement a cap on punitive damages. The Wyoming Legislature might consider implementing a limit of $250,000, or three times the amount of compensatory damages, whichever is greater. Wyoming should also consider requiring proof of punitive damages beyond a reasonable doubt, since they stem from behavior similar to criminal wrongdoing.

The final state concern is medical licensure and education. Overinflated licensing requirements are harmful because they establish barriers to professional entry and make health care more expensive as an end result. A substantial problem related to state-based medical licensure rests in the evidence that interest groups with strong lobbies shape scope-of-practice legislation. This practice produces a turf war of sorts, building barriers to entry to protect the economic interests of a relative few over consumers' interests in affordable health care. Wyoming can transition to recognizing private board certification, which is offered by hospitals and insurers and is recognized as an indicator of practitioner quality. In this way, licensure would compete in the same way markets do. For education, the state could partner with privatized post-secondary institutions to form a unique medical school that is sensitive to Wyoming's needs and embraces innovation and alternative care.

Beyond states, tribal nations are especially suited for more entrepreneurship in health care freedom due to their semi-sovereign status as Indian nations. The Constitution has less binding effect against tribal sovereigns than on states. In that sense, tribal nations enjoy sovereignty independent from state or federal authority. Native American tribes have made headway in protecting and preserving their own sovereignty through targeted litigation successes.

In many instances, tribal nations are immune from being sued in federal and state courts. They enjoy the right to establish independent governments and declare their own citizenship requirements. Tribes also have a limited authority to tax and regulate the conduct of non-Indians on tribal land. Stressing the consensual and voluntary nature of associations, the Supreme Court has upheld the exercise of tribal sovereignty where clearly documented relationships occur between Indians and non-Indians. A recent example of tribes' independent basis for exerting sovereign authority over a nascent industry is found in payday lending. Unfortunately, few tribal jurisdictions have taken the development of their own statutory law seriously. Were tribes to do so, both generally and in specific areas of law, they could bring world class governing rules to their jurisdictions while steadily increasing their autonomy.

While there are recognized weaknesses and difficulties with the tribal model, it does present significant strengths when compared to state jurisdictions. The creation of medical freedom zones on tribal lands is promising because tribal sovereignty precedent is significantly stronger than state sovereignty precedent, so it offers unlitigated opportunities to broaden its scope.

People tired of unavailable treatments, expensive medicine and low-quality care frequently travel—flee may be a better word—to other countries for medical care, going as far as Asia. Although the future of the PPACA is uncertain, even if it is repealed there will remain a severely over-regulated health care system. Enterprising states or tribal nations can create legal structures that support liberty, ingenuity, and success in contrast to the central planning that has engendered our "broken" health care systems. This may be accomplished in medical freedom zones.

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INTRODUCTION

A **medical freedom zone** is a legally recognized geographic area where health care professionals may provide services and conduct research governed by professional associations and private contracts.

In the United States, health care costs doubled from 1996 to 2006.[1] Similarly, employer-sponsored health insurance premiums have more than doubled in the past ten years.[2] Overall spending on health care grew from $187 billion in 1965 to $1.9 trillion in 2005.[3] Persistent gaps remain in quality of service, with the United States ranked with a score of only 65 out of 100 on a basis of 37 performance indicators.[4] Americans are left with few options to escape a system that systematically underperforms while being prohibitively expensive. Americans need one place, close to home, that provides more innovative and affordable care by escaping an overregulated medical system.

Among the many reasons why America's health care system is problematic is the imposition of bad rule traps. From the federal government to state governments, the ability to innovate in medicine and offer more affordable or alternative care is hampered. Studies have illustrated that medical devices are ordinarily approved two years earlier in Europe than when approved by the American Food and Drug Administration.[5] Likewise, beta-blockers were widely approved in Europe during the 1970s to reduce risks of secondary heart attacks.[6] It took the FDA until 1981 to approve their use in the United States.[7] This particular medicine was estimated to save some 17,000 lives a year—and as many as 100,000 people may have died from secondary heart attacks waiting for the FDA to approve their medicine.[8] These types of delays have led some to call the FDA a "killer agency."

While the federal government delays innovative medicine, state governments make affordable care more difficult by limiting the number of doctors and saddling those who do practice with difficult liability rules. Alternative care, such as homeopathy or herbalism, has been pushed entirely out of the legal mainstream, removing compelling complementary treatments for patients. Similarly, the ability of care providers and patients to fashion their own agreements governing medical procedures is entirely hamstrung through state regulation as well.

Because of these bad rule traps, more than 500,000 Americans left the United States in 2008 for medical tourism purposes. Ordinarily, patients are seeking either more affordable care, such as dentistry in South America, or more innovative care, such as cancer treatment in Europe. But Americans need not travel so far to get the care they desire. This paper illustrates how one jurisdiction could take the lead in defining medical freedom in the United States and create a safe haven for innovation, alternative care, and affordable treatment. The task is not easy because many legal hurdles stand in the way. However, through careful construction, a veritable Mecca of medical excellence could be created, shaped by world-class contracts and standards.

When this paper was conceived, the authors focused on the state of Wyoming and the Wind River Indian Reservation. Both offer different advantages and drawbacks in creating medical freedom zones, which are reviewed in turn. However, the overall scope of this paper is applicable to any jurisdiction with the will to take health care freedom seriously.

UNDERSTANDING THE FIRST PRINCIPLES OF MEDICAL FREEDOM

Before examining the depths of how medical freedom zones can revitalize the American medical landscape, a brief discussion of first principles guiding this reform is in order. A fundamental problem in health care today is government's interjection between care providers and patients. From the state to federal level, government intervention often eliminates choices, influences transactions, and limits private agreements. This creates a muddled system that features some aspects of free market choice while instilling command-and-control type authority elsewhere.

By and large, Americans do not face the "compassionate state," they face the "administrative state" that has delivered the likes of the Internal Revenue Service, Medicaid and the Post Office. The best health care providers in America are eager to help people without government intervention. The ability to do this is entrusted to their own character and skills—and not under the guidance of regulations, oversight boards and trial attorneys. As Alexis de Tocqueville noted, an important function of citizen associations is to prevent the growth of tyrannical government by learning how to be self-sufficient. In *Ancien Regime*, Tocqueville determined that bureaucratic schemes act as stifling mechanisms to free, open, and voluntary associations that prove beneficial in a free society. As human beings, we are endowed with free will and moral agency—two traits that wither quickly in the face of blossoming bureaucracies.

In a civil society, voluntary associations band together for all sorts of purposes—charitable, philanthropic, or ideological. But with the growth of the administrative state comes the decline of individual rights and complacency among individuals, who believe that the cryptic arm of the state will care for them. Health care is affected equally as other components of civil society. Where charities used to provide for the poor, offer medical services, and otherwise be compassionate toward other human beings, government has stepped in. And while not all charitable acts and associations have been demolished, the growth of a leviathan-like state ensures this withering away.

The Wyoming Liberty Group supports and celebrates active civil engagement in a free society. Just as a free people make informed choices in other aspects of their lives, so too must they do so in matters of utmost concern related to their health. Structuring legal reform based on the moral principles of individual rights and personal responsibility ensures positive results. An open sphere of freedom permits the fire of compassionate charity to be stoked and for innovation to take hold once again. This paper presents the concept of medical freedom zones – designed to reach exactly that.

When government has overstepped its essential duties to morph into an administrative and "nanny" state, people must be reminded of their own source of power. In providing limited areas where freedom is celebrated, the existing regime is not undone, but medical freedom zones provide an escape valve where individuals can experience how charitable association, innovation, and liberty work. In offering that foundation, a rebirth of liberty and belief in medical freedom can be had.

I. WHY FREEDOM ZONES?

Around the world, as countries have faced economic collapse or oppressive regulation, freedom zones have exploded as a natural remedy. From Iceland to the United Arab Emirates, nations unsatisfied with their economic success have embraced some form of a freedom explosion as an emerging trend in securing innovation and the rebirth of important markets.[9] Whether their focus is on the financial sector, as in Dubai, or on telecommunications and Internet markets, as in Iceland, one thing is clear: building diverse islands of freedom within jurisdictions offers a secure and invigorating approach to recapturing liberty.

Medical freedom zones represent the natural cure to malignant government programs that repress innovation and experimentation in health markets. Imagine the construct of Wyoming's own medical "Silicon Valley," where experimental and alternative treatments for cancer are developed outside the heavy hand of burdensome government regulation. Or picture the development of medical tourism islands, with customers waking up from medical procedures to witness the splendor of the Tetons or the natural beauty of the Snowy Range. To date, the United States has removed itself from a multi-billion dollar market, medical tourism, due to repressive government regulation.[10]

In today's political climate, many individuals have become habitualized to the notion of regular government intervention in their health care choices. With that understanding, any evolution to a free market health care system must be gradual. Medical freedom zones are a central part of that phase-in process. By permitting innovation and privately regulated care to exist in limited geographic areas, Wyoming will not fall into medical anarchy. Those who prefer state managed care may stay in the system, while those favoring innovation and freedom may find an escape valve in medical freedom zones.

Freedom zones offer another principled advantage over common ho-hum approaches to advance state sovereignty or secure reform: they have worked on the international scene. Evidence suggests that the deployment of freedom zones in but one jurisdiction within the United States could spur that state into becoming a Medical Mecca for medical investment and entrepreneurialism. Just as Delaware succeeded in attracting corporations, Wyoming, if it wants to, could be the freest state in the Republic for medical choice and innovation, thus ushering in a new age of free market medical care.

A. Federal and State Incursions into Medical Freedom

Wyoming has been no stranger to the slow decay in health markets due to the meddling of federal and state government programs. Between 1998 and 2008, federal funding for Medicaid alone grew 100 percent and state funding for Medicaid grew over 242 percent in nominal terms.[11] As it stands now, real state spending on Medicaid hovers at about 50 percent greater than in 2001.[12] Dr. Sven Larson's studies conducted through the Wyoming Liberty Group suggest a long term Wyoming-specific solution to the Medicaid menace that would allow the state to take control over its own medical affairs and decrease dependence on federal whims.[13]

Additional restrictions place cruel limits on innovative and experimental treatment available in the United States. Through the Food and Drug Administration, innovative cancer treatments are restricted to miniscule classes during an elaborate drug approval process.[14] As argued by one legal scholar, Eugene Volokh, three women—each faced with the need for medical self-defense—face dramatically different legal realities: "Alice may kill her viable fetus to protect her life, and may enlist her doctor's help to do so. Katherine may kill her attackers, whether guilty humans, morally innocent (for instance, insane or mistaken) humans, or morally innocent animals. Ellen should have at least an equal right to ingest potentially life-saving medicines, without threatening anyone else's life."[15] Recognizing that right for terminally ill patients would eliminate just such a cruelty that is grounded in current federal policy and practice. Wyoming can be that exceptional jurisdiction that brings innovation and compassion back to health care.

Wyoming must decide exactly what kind of state it wants to be in order to secure health care freedom. Recently, the Wyoming Legislature signed into law an experimental pilot program for broadened interference in health care markets in the state. Touted "Healthy Frontiers," the program creates a centralized medical use board and aims to limit medical spending and decrease use of health care services for a small group of participants.[16] Under the experimental law, a "benefit design committee" decides health care benefits and services available to enrollees under the law. Further, the Wyoming Legislature committed $750,000 to this test program—some three times the amount spent on Wyoming's trial of SCHIP. If expanded beyond its experimental phase, "Healthy Frontiers" could effectively transform Wyoming into the next Massachusetts of health care reform. This is not a positive direction, given the numerous problems faced by Massachusetts and others whenever centralized command and control over health care is put into place.[17] In Massachusetts, health care costs have risen much faster than the national average and insurance premiums have done the same, increasing eight to ten percent per year, about double the national average.[18] At a minimum, Wyoming should strive to avoid becoming the next Massachusetts of health care reform.

B. The Vision

Whatever Wyoming may elect as its overall state policy for health care reform, it should incorporate some trust of free markets and individual decision making. In that sense, the state benefits from emerging markets, investment, and secures an important portion of lost sovereignty. Important to note is that Wyoming is not alone. Throughout the world, citizens displeased with meager government reforms to open markets have sponsored freedom zones. These zones have served important roles: signaling investors about the stability of particular markets, welcoming investment and innovation, and permitting rapid economic growth to occur.

1. Dubai: An Oasis of Financial Liberty

Dubai is one of the seven emirates of the United Arab Emirates (UAE) and has largely enjoyed wide-scale economic success.[19] Part of the Dubai plan was to create free zones to encourage innovation and investment. Including tax-free trade zones and tax-free areas for internet companies has allowed Dubai to have the world's fifth highest gross domestic product per capita, and the UAE witnessed economic growth 36 times larger than its 1971 economy. In 2004, the UAE created the Dubai International Financial Centre (DIFC) that incorporates the legal protections of British common law for its financial markets.[20] The launch and operation of the DIFC included a heightened degree of transparency—illustrating a bright line between commercial law and Sharia law.[21]

What Dubai realized is that jurisdictions compete for the best laws available—which then act as a foundation for spirited investment and markets to evolve. The development and deployment of legally cognizable free zones offers many advantages: the cutting of red tape and bureaucracy so investments and start-ups can occur swiftly, building true legal autonomy in the free zone (protected from outside meddling), and an overall consistency and uniformity of contract enforcement. In very much the same way, jurisdictions can build legally defined free zones that protect from many types of federal or state interference.

An interesting component of the Dubai approach to freedom zones has been the incorporation of the British common law in a region with sharply different legal traditions.[22] Free zones have become popular in Dubai, with a Jebel Ali Free Zone that favors foreign investment and the Dubai Healthcare City, which serves as a free zone for medical services and innovation.[23] With respect to the DIFC, international financial institutions function in a legal environment that is physically within the United Arab Emirates, but is not subject to its regular legal restrictions. Within the DIFC, the British common law and a limited number of statutory provisions govern financial transactions and disputes. The DIFC even borrowed from American law, fashioning a modified version of the Uniform Electronic Transactions Act of 1999 to govern DIFC transactions.[24]

The anchoring of the DIFC as a common law jurisdiction proved beneficial.[25] The adoption of a market-friendly legal sys-

tem familiar to foreign investors allowed Dubai to be as receptive to investment as common financial hubs. By establishing the common law, written in English and overseen by an independent judiciary and regulatory body, the DIFC stands head-and-shoulders above other financial centers in the Middle East.[26] This kind of approach by Dubai signaled the international business community that the DIFC was a place with the secure legal footing necessary for serious investment to occur. Jurisdictions benefit when they compete for and establish the best laws in a governing field.

2. Iceland: Free Speech Isle

In the wake of Iceland's financial collapse, the nation set out to become a safe haven for whistleblowers around the globe. It is accomplishing this goal by developing the world's best laws regarding free speech and freedom of information. On June 16, 2010, the Icelandic Parliament voted in favor of the "Icelandic Modern Media Initiative" (IMMI) to accomplish just this.[27] As stated by one member of the parliament, "We took all the best laws from around the world and pulled them together, just like tax havens do, in order to create freedom of information and expression, a transparency haven."[28] The import of the Icelandic example is straightforward: international jurisdictions compete for the best laws possible, triggering investment and market development as a result.

By creating a safe haven for free speech, Iceland is encouraging market development in internet server and publishing house relocation to Iceland to take advantage of its attractive laws. Stated directly by the IMMI:

> The legislative initiative outlined here is intended to make Iceland an attractive environment for the registration and operation of international press organizations, new media start-ups, human rights groups and internet data centers. It promises to strengthen our democracy through the power of transparency and to promote the nation's international standing and economy. It also proposes to draw attention to these changes through the creation of Iceland's first internationally visible prize: the Icelandic Prize for Freedom of Expression.[29]

Iceland's view is far-reaching, perhaps far-flung. But the idea of a sovereign jurisdiction taking responsibility for fresh innovation in its own law proves encouraging. The completed IMMI legal reform package would secure new horizons of free speech: protect whistleblowers, enable the creation of virtual limited liability corporations, afford broader source protection to investigative journalists, and deploy an "ultra-modern" freedom of information act. With just such an approach, Iceland may very well reinvigorate its economy while providing a powerful protective effect for free speech worldwide.

3. Delaware: Corporate Celebration

Favorable legal structure is an incentive to do business, and businesses respond accordingly. This is not just a foreign phenomenon: in the United States, states compete for business with their laws.

Delaware is considered the ideal state for businesses to incorporate. At the end of 2009, Delaware was home to 63% of Fortune 500 companies, and realized $767 million in revenue to its general fund just from corporate taxes.[30] Corporations are eager to pay taxes in Delaware because its government carefully maintains a predictable, stable corporate law that maximizes the freedom to do business. This is not an accident: since the late 19th century, Delaware has deliberately made itself the destination for incorporation.

When New Jersey enacted a corporations law in 1896 that attracted incorporation and increased state revenue through franchise taxes, Delaware noticed.[31] At the Delaware Constitutional Convention the following year, the members revised the state constitution to place no prior limitation on the duration of corporate existence and no restrictions on corporate purpose.[32] Shortly thereafter, in 1899 Delaware enacted a general corporation law that was even more favorable than the law in New Jersey.[33] In 1913, when Governor Woodrow Wilson signed a law prohibiting trust and holding companies in New Jersey, corporations began to rapidly re-incorporate in Delaware, and new businesses followed their lead.[34]

The stock market crash of 1929, the creation of federal securities laws, and favorable revisions by other states to their respective corporate law systems marked a slowdown to Delaware incorporation in the mid-20th century. But in 1967, after much study and input from businesses and attorneys, the Delaware legislature passed a new General Corporation Law.[35] Since then, "Delaware has continually revised its statute to accommodate changing business needs,"[36] and "remains the preeminent state for incorporation."[37]

Since the 1967 law, the Delaware Bar Association's Section on General Corporation Law has had the responsibility of revising the corporation law, making recommendations to the legislature as needed.[38] Lawrence Hamermesh, a law professor who previously served in this section, says its policy decisions are guided by conservatism, avoiding the disruption of preexisting commercial relationships, deference to common law development and resistance to regulatory prescription, and flexibility and the facilitation of private ordering.[39] Stability is key, and Hamermesh summarizes:

> Delaware lawyers and judges consistently and consciously articulate reasons for [our] high degree of stability. Most prominent is a pervasive belief that the system of corporate law supplied by Delaware has worked pretty well, and that change should not be made unless it is apparent that there will be a significant benefit from it without any countervailing disruption.[40]

The stability of Delaware corporate law has now lasted over 100 years, and continues to attract a majority of new corporations.[41] Just as Delaware deliberately established and deliberately maintains this attractive legal structure, Wyoming may do the same for the health care industry within the entire state, or specifically allow for targeted medical freedom zones that will prove how the freedom to do business produces the best results even in the complex field of health care.

The unique approaches of Dubai, Iceland and Delaware each represent conscious decisions of leaders to give innovation a chance free from burdensome, fickle government regulation. A medical freedom zone would require the same courageous leap of faith. However, the possible rewards are neither difficult to envision or farfetched.

C. The Entrepreneurial Dream

Were Wyoming to embrace a welcoming attitude toward medical freedom, what might happen for medical markets in the state? This section sketches some of the market openings available that are currently limited in the United States due to the heavy hand of medical regulation. We make no predictive claims about what free market entrepreneurs acting on their own accord might invent, develop, or bring to medical freedom zones. But given the current international landscape for medical innovation, Wyoming ought to pay attention to the possibilities.

1. Medical Tourism

In 2008 alone, some 540,000 Americans travelled abroad to seek deregulated healthcare offerings.[42] Currently a multi-billion dollar market, deregulated healthcare markets are expected to grow in a speedy manner over the course of a few years. In 2004, Jordan saw $500 million in medical tourism, while India is expected to generate $2.2 billion by 2012 in the same market.[43] Where medical service is affordable or innovative, people will flock in that direction. Underlying demographics detail why Americans are leaving the U.S. to seek healthcare abroad. Nearly forty percent of Americans would travel outside the country for medical treatment if the quality was comparable and cost was cut in half.[44] Top medical services sought by U.S. citizens travelling abroad include orthopedic, cosmetic, dental, and cardiovascular care. Data illustrates that proximity is important: Americans overwhelmingly select Mexico and Costa Rica for easier services due to shorter distances and lower costs while others elect Southeast Asia and India for orthopedic and cardiovascular care due to innovation and excellent care standards.[45]

Table 1—International Price Differentials in Medical Tourism[46]

Procedure	U.S. Retail Price	Insurers' Cost	India	Thailand	Singapore
Angioplasty	$98,618	$44,268	$11,000	$13,000	$13,000
Heart bypass	$210,842	$94,277	$10,000	$12,000	$20,000
Heart-valve replacement	$274,395	$122,969	$9,500	$10,500	$13,000
Hip replacement	$75,399	$31,485	$9,000	$12,000	$12,000
Knee replacement	$69,991	$30,358	$8,500	$10,000	$13,000
Gastric bypass	$82,646	$47,735	$11,000	$15,000	$15,000
Spinal fusion	$108,127	$43,576	$5,500	$7,000	$9,000
Mastectomy	$40,832	$16,833	$7,500	$9,000	$12,400

Examining cost savings available in international medical tourism illustrates even more bracing numbers (see **Table 1**).[46]

As noted by Dr. Arnold Milstein in one Congressional public hearing, the "typical combined facility and physician charges per surgery in these hospitals is, based on my international shopping observations, 65 to 85 percent lower than insurer-negotiated charges in the U.S."[47]

Beyond mere savings, the globalization of health care presents other pressing questions. International medical tourists must elect to have medical services performed in a jurisdiction that matches their cultural and legal expectations. If an American patient elects to have a hip replacement performed in Singapore, significant legal barriers exist in successfully bringing suit from the United States against a physician in Singapore, at least in a manner that readily addresses the liability issues at hand.

One benefit of the American medical landscape is that it offers patients more extensive legal protections to assure redress for medical liability. These include tort law, professional self-regulation, the National Malpractice Database, accreditation systems, and medical staff bylaws. In addition, the U.S. often provides more generous legal remedies than those found in other countries when medical liability occurs.[48] Borrowing from the best law internationally while making use of some American legal protections could create a self-contained world class jurisdiction for medical freedom.

An emerging medical tourism market makes sense in America. Given the geographic desirability of American states, close proximity works in the favor of jurisdictions wishing to become destinations for medical tourism. Beyond proximity, American states can borrow from some of the best law available to construct their own efficient and responsible legal system for health care concerns, putting them at a distinct advantage over their foreign counterparts.

2. A Health Care Silicon Valley

Within America, the time has come for the development of a Medical Mecca or Health Care Silicon Valley. On the international scene, this has already been realized in Dubai Healthcare City—a free zone with its own custom-built set of regulations and qualifications for medical care.[49] Dubai's vision even attracted the interest of Harvard Medical School, and the school is in the process of building a post-graduate medical education institute within the healthcare city. With the rise of increasing government control over health care in the United States, the timing could not be better for establishing a sanctuary for medical freedom. Doing so requires the construction of a formidable legal framework to protect the sovereign interests of the jurisdiction and the shaping of internal law to adequately permit innovation and free markets to work appropriately.

The freedom to develop new treatments and for patients to utilize them has already produced new inventions and innovations abroad. Effective treatments that are currently unavailable in the United States include different types of cervi-

cal/lumbar artificial disc replacement and certain hyperthermia treatments for cancer.[50] The movement to advance medical innovation in America is strong, with groups such as the Council for American Medical Innovation seeking to eliminate diabetes, Alzheimer's disease, and AIDS in the same way that polio has been nearly eradicated.[51] However, these interest groups largely believe it is more government funding and working within the established framework that will yield these results. Medical freedom zones provide a departure from both public funding and parts of the established framework, recognizing that unbridled ingenuity cured polio,[52] and may do the same for other diseases and ailments.

As discussed later in this paper, the very system of dual federalism that this nation embraces supports the notion of building specialized systems of law into local communities. Justice Louis Brandeis envisioned each state legislature as a "laboratory" willing to tackle new and innovative approaches in structuring its own policies and regulatory preferences.[53] The modern left-of-center and progressive movement has largely followed the call of Justice Brandeis in recognizing the import of radically reshaping state laws.[54]

Although conservative and right-of-center coalitions have been slow to recognize what the progressive movement has seen for some time, it is important to do so now. After all, medical freedom is not a left- or right-of-center issue, as coalitions from a variety of ideological spectra support the idea.

Embracing innovative approaches in securing sovereignty and liberty at the local level offers advocates of freedom secure methods to enshrine local control and protection of free markets from federal and state meddling with impressive end results. It is beyond the scope of this paper to formulate a business plan for practitioners, associations or companies who wish to establish a presence within medical freedom zones. But it is indisputable that the health care market is strong, that the United States is losing market share to foreign countries, and that this need not be the case.

II. THE LEGAL FOUNDATION OF FREEDOM ZONES

To properly construct medical freedom zones, several pillars of legal reform must be implemented. A first focus of reform must be dedicated to the prevention of future government meddling in private medical affairs. In that sense, a state Health Care Freedom Amendment (HCFA) makes sense since it offers the best cementation of the law and the most stringent protection against government meddling. This also affords the state an anchor of sovereignty rooted in the state's organic law, which is the best measure against federal intervention.

The HCFA raises a number of legal questions, each of which stem from the question of where individual and state sovereignty ends and where federal sovereignty begins. This section discusses the federal implications of state-based HCFAs and concludes that the United State Constitution, the federalist principles behind it and even Supreme Court case law support state sovereignty and individual

freedom for health care choice. Federal pre-emption concerns are also addressed, concluding that states may still successfully assert their sovereignty against federal law in the area of health care.

Following the HCFA—which will be placed on the November 2012 ballot in Wyoming—the focus of reform shifts to statutory enactments at the state level, which will be discussed in the next section. Section IV will consider tribal lands, an alternative jurisdiction for medical freedom zones.

A. Building Buoys Against Federal Intervention

A central challenge for any jurisdiction wishing to construct innovative reform is the underlying question posed by federalism: will the federal government permit it? Returning to first principles, what the Supreme Court announced in 1837 remains true today: a state retains the "same undeniable and unlimited jurisdiction over all persons and things, within its territorial limits, as any foreign nation, where that jurisdiction is not surrendered or restrained by the Constitution of the United States."[55] In describing the sovereignty of states, where powers have not been surrendered to the federal government, they are retained by the states and that state authority is "complete, unqualified, and exclusive."[56]

Most recently, states have won challenges against the federal government precisely because of the Court's commitment to developing a theory of coherent dual federalism that protects the states "residuary and inviolable sovereignty."[57] Of course, the Court's development of a meaningful federalism doctrine has fluctuated inconsistently over time. But it has attempted to develop a coherent theory of federalism based on the Tenth Amendment, the Enumerated Powers Doctrine, and other structural protections for state sovereignty found in federal and state constitutions. It is at this time that supporters of state sovereignty must instruct and shape the Court's reasoning, lest this battle be surrendered to advocates of supreme federal authority.

To be perfectly frank, the construction of a legally sound sovereignty anchor proves difficult for any jurisdiction. Faced with a wild fluctuation of tests designed by the Supreme Court to designate the proper role of federalism in the United States, any jurisdiction innovating in this area faces some plausible litigation risk. But it should not be forgotten that states *have won* in challenges against the federal exercise of power. The task properly set before any state seriously wishing to protect its own sovereignty is how to best secure an innovative legal framework to do so.

The Supreme Court has at least hinted throughout its federalism jurisprudence that certain core areas of state autonomy will be respected. Key to any successful sovereignty approach is centering reform efforts on areas where the Court has suggested or held that protection still remains. In both *Fry v. United States* and in *National League of Cities v. Usery*, the Court explained that Congress may not "exercise power in a fashion that impairs the States' integrity or their ability to function effectively in a federal system."[58]

Moving forward, the Court has retained its commitment to the principle that states "retai[n] a significant measure of sovereign authority."[59] Of course, to say the Supreme Court has been consistent in its own understanding of the Tenth Amendment would be unsupported. From the political truism standard to today's anti-commandeering approach to Tenth Amendment jurisprudence, the Supreme Court has been all over the constitutional map. With the recent change of several justices at the Supreme Court, now is the time to seize the higher ground for meaningful protection of state sovereignty in the context of medical freedom. If advocates of state and individual autonomy do not seize this opening now, their ideological opponents will do it for them.

Other cases illustrate where those areas of core state concern and local sovereignty might be upheld. Two recent challenges to federal authority illustrate some judicial hints toward state sovereignty that are encouraging. First, in *Horne v. Flores*, lower federal courts demanded that Arizona comply with federal requirements for bilingual education programs in contradiction to a measure enacted by Arizona voters. The Supreme Court reversed the lower courts, explaining the importance of states to retain authority over "areas of core state responsibility."[60] In addition, in *Gonzalez v. Oregon*, the Supreme Court upheld the state's euthanasia law even though it conflicted with federal law due to the protected authority of states to define standards of medical practice.[61] Jurisdictions wishing to be innovative about how they preserve their own sovereignty must not ignore these hints left by the Supreme Court.

What *Flores* and *Gonzales* reveal is a lesson well known in federalism jurisprudence: States retain significant authority to shape and control what is commonly referred to as police power. In analyzing a challenge to compulsory vaccination laws in Massachusetts, the Supreme Court explained:

> The authority of the state to enact this statute is to be referred to what is commonly called the police power - *a power which the state did not surrender when becoming a member of the Union* under the Constitution. Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a state to enact quarantine laws and 'health laws of every description;' indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other states. According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.[62]

In areas affecting the traditional police powers of state—and medical regulation is one such area—states traditionally enjoy greater protection of their own efforts to define their law and policy. This point is key because rooting state-based reform for the obtainment of innovative health markets in the traditional police powers of the state offers a strong legal defense to a wide variety of federal attempts at in-

tervention.

Building the right legal construct to protect health care freedom and local sovereignty must rest in the development of a holistic constitutional theory supporting both approaches. It is not enough to anchor support for local control in the Tenth Amendment when federal judicial application of the Tenth Amendment has varied with great inconsistency. Nor is it enough to create a test case for the Supreme Court to show, once and finally, that the Commerce Clause of the Constitution has definite and circumscribed limits.[63] A wide range of organizations and states have had varying degrees of minimal success focusing in narrow fashion on such theories. The Wyoming Liberty Group approach focuses on first principles, a study of strategic openings given past Court treatment of sovereignty concerns, and the invention of the most holistic approach to secure a single island of medical freedom within the United States.

By anchoring reform based on these principles, Wyoming may escape the reach of a federal government ever eager to seize control of our most intimate health care freedoms. To understand how this can be accomplished, federal constitutional concerns are first discussed, followed by necessary legal safeguards to be deployed at the state level.

B. Constitutional Concerns

It remains one task to design and secure the footing of medical freedom against possible future state interference. It remains quite a separate feat to build a similar protection against menacing federal government interference. From the endless reach of the Food and Drug Administration to the operation of omnibus federal health care laws, constructing a veritable sovereignty sanctuary proves challenging. A key to the establishment of the correct sort of sovereignty sanctuary rests in an adequate understanding of what has failed to protect local communities against federal government meddling in the past and what proves promising in the present.

1. Tenth Amendment: No Silver Bullet

As the federal government has gradually and steadily expanded its authority beyond its constitutional parameters, a wide array of movements have focused on the most effective means to restore constitutional sanity to the Republic. Within this movement is the modern Tenth Amendment push that, as the name suggests, includes a dedication to the Tenth Amendment as a solution to federalism problems. Many organizations have brought great fervor and national attention to this cause, and appreciably so.[64] However, examining the Supreme Court's treatment of the Tenth Amendment in isolation suggests that any legal theory relying solely on the exclusive protections offered through the Tenth Amendment will produce marginal results.

When it comes to the string of losses suffered by states in defending their sovereignty, repeating past failures makes little sense. Even the Tenth Amendment's most promising recent recognition in *Printz v. United States* merely produced a

line of reasoning called the anti-commandeering doctrine.[65] This diluted standard protects but the smallest portion of the Tenth Amendment: "The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program."[66] While *Printz* assures that the federal government may not directly bully states, it leaves unprotected the numerous ways the federal government indirectly compels states to act as it wishes, like federalized marionettes.

Taking a critical look at historic reliance on the Tenth Amendment in isolation suggests that future movements to restore sovereignty should embrace a more holistic constitutional vision. That is, although the Tenth Amendment affords great emotional fervor and excitement, the Supreme Court is waiting for a case that truly challenges its incoherent structure of dual federalism, forcing it, once and for all, to develop a more protective judicial test for state and personal sovereignty.

2. The Supremacy Clause

One of the foremost constitutional concerns about medical freedom zones is that if Wyoming establishes them, will the federal government be able to regulate them, thus negating their purpose? Could the federal government outlaw these zones in their entirety? A Health Care Freedom Amendment (HCFA), similar to those passed in Oklahoma,[67] Missouri[68] and Arizona[69] will provide Wyoming with the legal foundation to challenge the encroachment of the federal government.[70] This will be accomplished by balancing the Supremacy Clause with the entirety of the Constitution, especially the Ninth and Tenth Amendments.

a. Not Always so Supreme

Many have grown accustomed to the idea that the Supremacy Clause of the federal constitution makes any federal law trump a contrary state law, and even a state constitution. However, this is true only where specific powers have been granted to the federal government: the Supremacy Clause specifically states "[t]his Constitution, and the laws of the United States which shall be made *in the pursuance thereof* . . . shall be the supreme law of the land . . . ." Thus, for a federal law to be supreme, it must be constitutional. The Wyoming Legislature recently affirmed this in its legislative findings for the Wyoming Firearms Freedom Act in 2010.

At the time of this writing, a number of states are proceeding in a lawsuit challenging the constitutionality of the individual mandate of the Patient Protection and Affordable Care Act (PPACA). This mandate requires all Americans to purchase qualifying health insurance by 2014.[73] In other words, if PPACA stands there will be no way to escape government health care short of leaving the country or paying taxes on top of what one pays for health care. A number of states joined together in one challenge in the Northern District of Florida,[74] while the Commonwealth of Virginia proceeds with its own suit from the Eastern District of Virginia.[75] Both of these challenges to the PPACA are based on the Commerce

Clause, although the Virginia challenge includes some of its own unique sovereignty claims.

An enumerated power of Congress,[76] the Commerce Clause was designed to facilitate trade between the states and prevent burdensome restrictions by states upon interstate commerce.[77] This has been greatly expanded by the Supreme Court since the 1930s, even going so far as to allow federal regulation of wheat grown on one's own land for personal consumption.[78] But such activity and all others previously addressed under Commerce Clause-based laws involved voluntary economic actions. The lawsuits challenge the mandate because it requires a person to perform the activity that triggers Commerce Clause regulation.[79] The states argue that a decision not to purchase a product is not an economic activity, and thus not within the purview of the Commerce Clause.[80] At the time of this writing both the Florida case is proceeding to the United States Supreme Court with favorable rulings behind it at the District Court and Eleventh Circuit Court of Appeals. Other cases have failed at District Court or Appellate Courts and are also being appealed, while still others are proceeding in different circuits.[81]

If the challenges to the PPACA individual mandate are successful, then Wyoming and other states will be free to establish medical freedom zones, at least for a time: if the Supreme Court determines that the individual mandate is unconstitutional, then the law was not made in pursuance of the U.S. Constitution, and cannot be considered supreme under the Supremacy Clause. But whether the current multi-state lawsuit succeeds or fails, medical freedom zones will need additional protection from any number of federal incursions, whether based on the Commerce Clause or other ever-expanding judicial interpretations of constitutional provisions.

b. The Supremacy Clause Meets the Ninth and Tenth Amendments

State sovereignty does not end with a proper limit on the Commerce Clause. Limiting the Commerce Clause is thus a necessary, but not sufficient, condition to fully secure medical freedom. State constitutional protection of individual rights that exceed the protections of the U.S. Constitution, such as the HCFA, could stop *all* federal incursions against individual rights, even in the face of the Supremacy Clause. The HCFA is a step toward restoring the original intent of the Founders to have a limited federal government and expansive individual rights recognized in state constitutions.[82] Wyoming's HCFA would accomplish this by forcing the Supremacy Clause to confront the Ninth and Tenth Amendments to the Constitution, reviving the latter to their original intent. To date, this approach has not been accomplished in any jurisdiction.

The Ninth Amendment reads, "[t]he enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." The Tenth Amendment states that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States

respectively, or to the people." At the same time the Commerce Clause began its judicial expansion,[83] the Tenth Amendment was relegated to the status of "truism," that is, part of the Constitution that has no independent significance.[84] The Ninth Amendment gets little more respect, from liberals such as Laurence Tribe who state that it "is not a source of rights"[85] to conservatives such as Justice Antonin Scalia arguing that "the Constitution's refusal to 'deny or disparage' other rights is far removed from affirming any one of them . . . ."[86]

The Ninth and Tenth Amendments have not fared well in light of some case law, but a look at the recent history of constitutional rights—the last 100 years or so—tells a different story. Implicitly, the principles of individual rights and federalism are alive and well. It is this rich history that provides the map to explicitly restoring the Ninth and Tenth Amendments to their proper place, and preventing improper federal supremacy over individual rights and state governments.

The history of incorporation, the federal enforcement of the individual rights contained in the Bill of Rights against state and local governments, affirms that individual rights supersede control from all levels of government. The incorporation cases follow the Fourteenth Amendment, which was ratified in 1865 and declares that "[no] State [shall] deprive any person of life, liberty, or property, without due process of law."[87] The most recent example of incorporation is *McDonald v. City of Chicago*,[88] where the United States Supreme Court ruled that the Second Amendment, the right to bear arms, applies to the city of Chicago, and that the city's handgun ban violates the right. This is one of the last parts of the Bill of Rights to be incorporated: the Seventh Amendment right to a jury trial in civil cases and the Eighth Amendment prohibition against excessive bail and fines are among the few that remain.[89] Incorporation affirms that there are freedoms that cannot be infringed at any level of government in the United States and, perhaps more importantly, that judges are still aware of this.

c. The Import of State Constitutionalism and Judicial Federalism

In the late 20th Century, scholars studying the incorporation cases of the time—and even some judges who were making the rulings—began to advocate for greater protection of individual rights in state constitutions. No less than Justice William Brennan of the United States Supreme Court weighed in unequivocally:

> State constitutions, too, are a font of individual liberties, their protections often extending beyond those required by the Supreme Court's interpretation of federal law. The legal revolution which has brought federal law to the fore must not be allowed to inhibit the independent protective force of state law—for without it, the full realization of our liberties cannot be guaranteed.[90]

This movement, known as Judicial Federalism, is somewhat limited, because it focuses largely on making state constitutions more protective only of the rights described in the federal constitution, par-

ticularly the Fourth Amendment.[91] But recently, the philosophy has expanded: "The New Judicial Federalism recognizes that the United States Constitution is the baseline or the starting point for many basic freedoms, and state courts now commonly turn to state constitutions to support broader protections for such freedoms."[92]

Though Judicial Federalism as a philosophy appears new, it is actually a corollary of long-standing Constitutional tradition. The Supreme Court articulated this as early as 1874:

> [I]t is only upon the existence of certain questions in the case that this court can entertain jurisdiction at all . . . . [A case] must have been decided in a certain way, that is, against the right set up under the Constitution, laws, treaties, or authority of the United States . . . . The State courts are the appropriate tribunals, as this court has repeatedly held, for the decision of questions arising under their local law, whether statutory or otherwise.[93]

It is a logical inference, then, that if a state provides more protection for a federal constitutional right within its own constitution, there is no ground to appeal a state constitutional question to the United States Supreme Court. The Supreme Court follows this principle: "[A] state court is entirely free to read its own State's constitution more broadly than this Court reads the Federal Constitution, or to reject the mode of analysis used by this Court in favor of a different analysis of its corresponding constitutional guarantee."[94]

Recently, scholars have advocated for state constitutions to protect assisted suicide,[95] and some state supreme courts have interpreted their constitutions to require state law to recognize gay marriage.[96] These are hotly contested ideas, because these rights are not specifically enumerated, and thus criticized by many as judicial activism, or judge-made law. But in the case of health care freedom this is not a concern: the Wyoming Supreme Court, and the United States Supreme Court, would base their rulings on an individual right specifically recognized by the people of Wyoming. After all, Wyoming preserved the authority to protect the health of its residents in its Constitution at the time of its entry into the Union, and the HCFA would only clarify the nature of that authority. Judicial activism versus judicial restraint is an important argument, but it is not pertinent to this subject.

Federal, state, or local governments may not infringe the Bill of Rights, and state constitutions may be more protective of individual rights. Case law in many states illustrates expansion of rights, but often at the hands of judges and not the electorate. This history builds a better basis for the question at hand: can federal law trump the rights that states reserve for their citizens?

d. The Ninth and Tenth Amendments and the Wyoming Constitution Restrict the Supremacy Clause

Currently, federal law holds near-absolute supremacy, but it should not:

the time has come to revive the original understanding of the Ninth and Tenth Amendments. Securing health care freedom or any right at the state level is pointless if an ever-expansive federal government is able to subvert these rights under an unlimited Supremacy Clause. The maxims of individual rights and the expansive state protection of them may accomplish this with the Health Care Freedom Amendment.

Pursuant to the Ninth Amendment, the Bill of Rights is not the end-all be-all of individual rights, and it is not a requirement for citizens to amend the U.S. Constitution in order to protect individual rights within their own state. The Tenth Amendment complements this by unequivocally leaving all governmental powers not specifically granted to the federal government in the Constitution to the states and to the people. Based on Constitutional construction, no government power shall infringe upon state-recognized rights: in the same way that the Commerce Clause may not trump the Second Amendment, it shall not be able to trump health care freedom.

To be sure, the Supremacy Clause would still make the U.S. Constitution supreme both as a minimum platform for protecting individual liberty and in its federal powers. Some judges have dismissed the two-way street of dual federalism with unrealistic examples of states legalizing child pornography in their constitutions,[97] but this ignores the fact that assertions of individual rights are not meant to subvert or nullify the actions of the federal government, but merely to restore the footing that was originally intended, and expand freedom. The people cannot pass state constitutional amendments that commandeer authority over interstate commerce or the treaty power, or declare freedom from the federal income tax, because these are specifically enumerated federal powers and thus cannot be overridden by state constitutions.

There is an alternative argument regarding the Ninth and Tenth Amendment that should be addressed, because it is equally powerful. If judges cannot be persuaded by the amendments' text, then once again history may be used to support Wyoming's assertion of individual rights. And this is an especially powerful argument favoring Wyoming due to its unique constitutional heritage. According to this argument, health care freedom would not be a newly asserted right, but rather a clarification of a right always held by the people of Wyoming. As Robert Bork concludes, "it seems to me a perfectly straightforward statement that the [N]inth [A]mendment guaranteed that rights already held by the people under their state charters would remain with the people and that the enumeration of rights in the federal charter did not alter that arrangement."[98] Since Wyoming entered the Union, its constitution has stated

> As the health and morality of the people are essential to their well-being, and to the peace and permanence of the state, it shall be the duty of the legislature to protect and promote these vital interests by such measures for the encouragement of temperance and virtue, and such restrictions upon vice and immorality of every sort, as are deemed necessary to the public welfare.[99]

The argument would then be that, according to the Tenth Amendment, the protection of health (including, over forced purchase) was reserved to the State of Wyoming at the time it entered the Union. With a Health Care Freedom Amendment, the people of Wyoming would clarify that this was *never* meant to infringe upon freedom of choice in health care, and thus fully protects that right under the Ninth Amendment, because this was a right reserved to the people at Wyoming's founding. This argument will not apply to some states, because they did not grant such powers to the states in their original constitutions, but it is an excellent argument specifically for Wyoming.

Although the Wyoming Liberty Group's approach to securing medical freedom is novel, Supreme Court precedent also supports it. In *City of Mesquite v. Aladdin's Castle, Inc.*, the Supreme Court *refused* to decide the federal constitutional question put before it because claims were made under the Texas Constitution, which offered significantly broader protection of the liberty interest at stake.[100] Where states can make a showing that their constitution protects liberties significantly differently or more broadly than the federal constitution, review by the Supreme Court can be eclipsed. In that way, an expansive state constitutional protection of medical freedom can preserve that liberty at the local level, perhaps without extensive federal litigation.

It should be noted that the problem of federal supremacy over rights recognized by states is not limited to theoretical health care freedom, and that the expansions of rights are already ignored on a daily basis in some states. For example, in the wake of growing federal law enforcement agencies (the FBI, DEA, ICE, BATFE, etc.), the states that provide greater protections than the Fourth Amendment against search and seizure see this protection violated every day because, as it currently stands, federal agencies are not bound by more protective state constitutions.[101] There are even instances where state police agencies have turned over cases to federal authorities in order to circumvent state constitutions.[102] Proper recognition of the dual federalism contemplated by the Ninth and Tenth Amendments would remedy this by making the greatest protection supreme at both levels of government. But as this example illustrates, without dual federalism the greater state protections are not worth the paper that state constitutions are printed on.

"[S]tate courts can breathe new life into the federal due process clause by interpreting their common law, statutes and constitutions to guarantee a 'property' and 'liberty' that even the federal courts must protect."[103] Like the Commerce Clause, the Supremacy Clause is a heavily and heated topic of debate in courts and in legal scholarship, but the long history of precedents that has left the federal government with more and more control over the lives of citizens (with exceptions only for the federal Bill of Rights), and an appalling disregard of the Ninth and Tenth Amendments, may still be successfully challenged by the states. This should begin with the Health Care Freedom Amendment and medical freedom zones: By recognizing the right to entirely

voluntary action on the part of patients and medical providers alike, Wyoming law will be more protective of self government and not subject to federal incursion.

3. Preempting Preemption

Once traditional concerns about the Supremacy Clause have been overcome, another risk looms on the horizon: will the doctrine of preemption invalidate health care freedom amendments and medical freedom zones? Candidly stated, this is a valid concern. As defined by Black's Law Dictionary, preemption is "[t]he principle that federal or state law can supersede or supplant state or local law that stands as an obstacle to accomplishing the full purposes and objectives of the overriding federal or state law."[104] Federal law can preempt state law in at least three ways: express preemption, implied conflict preemption, and implied field preemption.[105]

Express preemption occurs when the Congress expressly declares a law's preemptive effect.[106] Implied field preemption occurs when local governments attempt to regulate in an area where Congress has signaled intent to exclusively occupy.[107] Implied conflict preemption occurs where it proves impossible to comply with both state and federal law.[108]

While the subject of preemption is a long and complicated one, some important observations should be noted. In any conflict that involves the historic police powers of a state, there exists a presumption *against* preemption. The regulation of health and safety is "primarily, and historically, a matter of local concern."[109] In fact, judicial consideration under the "Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law."[110] This built-in reluctance to find in favor of the displacement of state law reflects an underlying commitment to respect state sovereignty by the courts.[111] As explained earlier, the Supremacy Clause operates to trump state laws when the authority in question has been *properly delegated* to the federal government. Where a given power has not been properly delegated to the federal government, state sovereignty will and has trumped the exercise of federal power.[112]

On April 19, 2010, the Wyoming Legislative Service Office borrowed generously from a left-of-center article to pronounce that states were emphatically unable to legally resist federal health care reform.[113] The memorandum did not rely on the greater body of case law in which states have successfully resisted federal incursions due to protections offered by the Tenth Amendment. It did not discuss the limited power of the Commerce Clause. Nor did it discuss more recent developments by the Supreme Court about the rather restricted nature of preemption in general. Instead, it relied on one article from the *New England Journal of Medicine* to pronounce, with exaggerated pessimism, that Wyoming would be unable to effectively reform its own health care markets.[114]

a. Recent Positive Developments Favoring State Sovereignty in Preemption

The truth of the matter is that federal preemption is perhaps less of a legal boogeyman than states might make it. A trio of recently handed-down preemption cases illustrate that states can and do have significant leeway in shaping laws that match their policy preferences—even in the face of federal interference. These cases suggest a ray of hope for jurisdictions hoping to fashion their own medical freedom zones.

In *Altria Group v. Good*, the High Court held that the Federal Cigarette Labeling and Advertising Act did not preempt Maine's ability to regulate cigarette labeling under its state Unfair Trade Practices Act.[115] Significantly, the Court held that a presumption *against* preemption occurs when the Court analyzes even an express preemption provision in federal law. As stated by the Court, when "addressing questions of express or implied preemption, we begin our analysis with the assumption that the historic police powers of the States [are] not to be superseded by the Federal Act . . . ." Thus, a fundamental cornerstone of the Court's preemption jurisprudence is a respect for the historic police powers of the state—one of which is regulation to advance the health of its residents in the way it best sees fit.

Wyeth v. Levine held that the Food and Drug Administration's regulatory approval of a medication did not preempt Vermont's own medical laws.[116] Further, *Wyeth* noted that the Court relies "on the presumption because respect for the states as independent sovereigns in our federal system leads us to assume that Congress does not cavalierly pre-empt state-law causes of action."[117] Building on *Altria*, the Court was careful to preserve respect for state sovereignty even when federal regulatory agencies have spoken to the legal issue at hand.

Lastly, in *Cuomo v. Clearing House Association*, the Court held that federal banking regulations did not preempt the ability of states to enforce their own fair-lending laws.[118] There, the Court paid great attention to the historical trend of states in having some regulatory authority over national banks and illustrated a respect to the powers states retained in fashioning banking regulations appropriate to their own local needs. While federal banking regulations were of some import, the Court would not permit wholesale preemption due to the historic sovereign function of states to regulate these concerns locally.

The cases mentioned in this area share one negative attribute: they are all examples of where states regulated *more* than the federal government. In instances where state regulatory regimes prove contrary to federal regulation, but go beyond its scope, courts have been willing to uphold them. That is not necessarily a positive development for federalism if the courts will only uphold state experiments in policy when they regulate more. But that is not the case. The underlining reasoning given in many of these challenges is that the courts were seeking to protect against federal invasion in areas of key

state authority. It was not somehow that courts were only giving a green light to state experimentation for vigorous regulation. Thus, where federal regulation touches on the inherent police powers of a state, most especially in the areas of education and health, courts will be reluctant to permit federal programs to overtake state experiments, even when they are deregulatory in nature.

It remains entirely fair to suggest that the doctrine of preemption is an important legal consideration for any jurisdiction wishing to innovate their health care laws. And this is likely one area that will receive litigation treatment. The exact scope of protection courts will give to innovative jurisdictions is unknown at present when the doctrines of federalism and preemption collide. But taking clues from the courts and building rigorous and state-specific protection for their own policy preferences makes sense. To do otherwise would be to abdicate their last shred of sovereignty to the federal government.

b. Building Escape Valves for Liberty

Due to the complexity and obscurity of constitutional law, it is easy to view some components in isolation, which produces an understandably pessimistic effect. Taken in isolation, a review of the preemption doctrine might naturally lead an individual to presume that federal control over state health care policy is inescapable. To date, this assumption has been the leading conclusion for many states.

Some positive developments in constitutional law suggest there are opportunities to reclaim local sovereignty and escape federal monolithic control. First, it must be remembered that not every state sovereignty challenge has resulted in a loss. New York, Arizona, and Oregon, to name a few, have successfully built defensive litigation strategies in response to federal overstepping into their local affairs.[119] These have not been easy challenges, nor have they produced a sudden reclamation of the system of dual federalism discussed in this paper. But, they are still important as wins in the area of gradually restricting federal authority. Thus, arguments suggesting states have no strategic opportunity to effectively protect their sovereignty in the litigation arena remain unconvincing.

Second, contrary to modern reports of gloom and doom, not every state has lost pre-emption challenges brought to federal regulatory schemes. As illustrated in a recent trio of preemption cases, the Supreme Court still remains sensitive to protecting the historic police powers of states, including most especially the ability to regulate and decide health care policy preferences.[120] Importantly, Title I of the PPACA provides: "No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."[121] Read broadly, and in context with the Court's earlier adherence to protection of a state's historic police powers, this anti-preemption provision gives states some latitude in designing and implementing their own health care policy. So long as state measures do not "prevent

the application" of the PPACA, innovative state protections for medical freedom should receive protection under the plain language of the Act.[122] In this way, the PPACA's language tracks that of modern anti-discrimination statutes that include anti-preemption language and are designed to operate in harmony with state laws.[123] But if it is so that states do not act on this express statutory escape valve and take responsibility for their own health care policy, states should not expect the judiciary to do so for them.[124]

Third, the very language of the PPACA includes additional breathing room for states to opt-out or exempt themselves from some portions of the Act. Starting in 2017, states may apply to the Secretary of Health and Human Services to waive out of plans offered through health exchanges, premium subsidies, administration of exchanges, and employer and individual mandates.[125] While this is not currently in effect due its timing, the express language of the PPACA provides more fields for state experimentation than might initially have been thought. Again, the important dynamic here is that states seize upon these opportunities to define, rework, and claim responsibility for their own health care policy now.

Building the right legal structure to reduce the power of the Commerce Clause, assuring meaning and protection under the Ninth and Tenth Amendments, and restoring protection to state constitutions is the kind of across-the-board constitutional challenge necessary to restore dual federalism in the United States. And it is exactly this sort of comprehensive theory the Wyoming Liberty Group relies upon in fashioning its own medical freedom zones approach.

III. PROTECTION AGAINST STATE INTERVENTION

It is not just the federal government Wyoming residents must be wary of, but the state government poses its own threats to health freedom as well. State legislators come and go with election seasons. Local monopolistic political bodies pose considerable threats to medical innovation and entrepreneurialism since they often value hierarchical order and authority over individual creativity and market fluidity.[126] This represents a sort of localist thinking, aligning the "domain of the market with that of political power," producing disastrous results, like those found in Massachusetts.[127] As a result, any legal reform enacted today must carry the permanence necessary to prevent ideological opponents from easily undoing it in the future. That demands legal reform respecting the underpinnings of medical freedom—a liberty sorely missing in the American legal landscape today. The Wyoming Legislature took the crucial step toward remedying this by passing a Health Care Freedom Amendment in the 2011 Legislative Session, and this change to the Wyoming Constitution will be placed on the ballot for ratification by the people in November 2012. Following its ratification, there are a number of state reforms that the Wyoming Legislature can undertake.

Ancillary legal reform should focus on securing the necessary components of a free market for health care services in Wyoming. This includes securing the protection of arbitration and alternative

dispute resolution provisions in contracts, passing meaningful tort reform, developing safeguards for contractual choice of law provisions, and a move toward less regulation and licensing of the medical care profession. This paper is not exhaustive in that regard, and Dr. Sven Larson of the Wyoming Liberty Group has written extensively on other options states might embrace to make medical freedom a reality just the same.[128]

A. Protection of Arbitration and Choice of Law Provisions

At first glance, it might be difficult to understand why legal reform should focus on the enforcement of arbitration and choice-of-law dispute resolution mechanisms. After all, even the U.S. Supreme Court has routinely upheld the central role these mechanisms play in American courts, permitting private parties to efficiently negotiate resolutions.[129] In short, the recognized benefits of arbitration—confidentiality, speed, and party autonomy—have been valued within the overall fabric of the American judicial system. Nevertheless, although Wyoming is ahead of other states in recognizing both of these cornerstones to private legal agreements, it could go even further to ensure their protection.

1. Wyoming as a Safe Haven for Arbitration

While there exists a generally favorable attitude toward arbitration enforcement, this is not uniformly so. The New Mexico Supreme Court, for example, has refused to enforce choice of law and arbitration agreements centered in Texas law because they would "violate some fundamental principle of justice" found in New Mexico's public policy.[130] Likewise, Wisconsin appellate courts have been reluctant to enforce privately agreed upon arbitration agreements that import Delaware law. This has been so because the agreements barred reliance on remedies found in the Wisconsin Consumer Act, which Wisconsin courts found to violate Wisconsin public policy.[131]

Other courts have broadly supported private arbitration agreements, realizing the enhanced utility and efficiency they bring. Illinois appellate courts have given a presumption in favor of arbitration agreements, noting that its law "strongly favors arbitration."[132] By means of Illinois law, the question of arbitration enforcement is rather easy—if a "valid arbitration agreement exists and the claims raised are within the scope of the agreement, a trial court has no discretion but to compel arbitration."[133] Wyoming's judicial system shares a similar high regard for arbitration—recognizing its role for parties to "resolve their differences in a less expensive and more timely manner than traditional litigation does."[134] The Wyoming Supreme Court, in fact, "favors arbitration or other forms of alternative dispute resolution."[135] Thus, a central tenet of sensible health care freedom reform must also include a legal system that respects private parties voluntarily deciding their own method of dispute resolution. Hazy jurisdictions that offer but partial protection due to vague, floating "public policy" concerns cannot adequately protect the legal underpinnings of an open and vibrant medical freedom project. Those jurisdictions that respect

the legal autonomy of private contracting parties to decide upon their own method of dispute resolution offer a much safer and more stable territory within which to do business.

That Wyoming took an early lead in securing legal protection for arbitration speaks well of its cultural climate and positive default rules for freedom. Emerging alternative medical markets can take some sanctuary in Wyoming's pre-established legal climate favoring arbitration.

2. The Necessary Legal Underpinnings of Arbitration

The foundation of modern arbitration procedures is found in the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention") and the resulting UNCITRAL Model Law on International Commercial Arbitration along with UNICTRAL model arbitration rules.[136] The New York Convention of 1958 pushed for ratifying nations to pass legislation that would recognize and enforce foreign arbitral awards. The design of all these approaches was to support a neutral forum for commercial dispute resolution without geographic biases. To make arbitral awards enforceable and secure, the New York Convention of 1958 provided for civil court enforcement of international arbitral awards. Taken in sum, the net effect of these approaches was the development of specialized subject matter jurisdiction, expert adjudication, and enhanced efficiency.

Specifically within the United States, the Congress passed the United States Arbitration Act of 1925, which the Supreme Court interpreted as binding on state courts in 1984.[137] As noted earlier, there remain numerous ways that arbitration agreements may be voided pursuant to state law. Traditional contractual defenses of unconscionability, adhesion, and other state public policy factors do offer pathways to invalidate arbitration provisions in most states. Thus, the rooting of a health freedom sanctuary must select a jurisdiction that values the primacy of the arbitration process as an expression of the free will and voluntary exchange of private parties over and above government's ongoing desire to inject itself into matters of personal dispute.

Some states, like California, have established stringent, sometimes crippling, requirements for arbitration providers, including quarterly reports on consumer arbitration activity and disclosure of how many times non-consumer parties used an arbitration service.[138] Other states have witnessed arbitration services flourish in the light of a more deregulated private sphere. Buttressing the formation of a medical freedom zone, states that develop the best protection for the enforcement of private dispute resolutions will garner additional market strength as a haven for voluntary arbitration.

Within Wyoming, the state Uniform Arbitration Act provides that written agreements to submit to arbitration are "valid, enforceable and irrevocable," except based on any grounds existing in law or equity for the revocation of a contract.[139] The state judiciary has recognized that

the purpose of the Act is to limit the role of the judiciary and provide for enforcement "without undue delay or undue expense."[140] This trend has been strongly affirmed with the Wyoming state courts, demonstrating the security that contracting parties may enjoy if they elect to invest in Wyoming for alternative health care purposes.

3. Choice of Law

Part and parcel of building a viable medical freedom zone is the ability for private parties to employ the best laws possible to govern their transactions. Choice of law simply refers to the ability of parties to trust public courts in their enforcement of privately agreed upon decisions about which laws apply. For example, suppose Dell Computer Corporation in Texas enters into a shipping agreement with Shippers, Inc. in Wyoming. Their agreement stipulates that, outside of any arbitration contexts, Texas law will control the interpretation of the contract in question. The value gained in having secure choice of law provisions in contracts along with having them upheld by the judiciary is that it allows contracting parties to effectively import the best law available for their transaction. Jurisdictions vary in their support and enforcement of such selections. State courts may look to the plain language of the contract to enforce such provisions, or they may apply a more complicated set of factors, like examining the domicile of the parties or where relevant party assets are held, to fashion their own choice of law doctrine.[141]

With respect to medical freedom zones, choice of law proves important. Were it so that medical entrepreneurs in Wyoming wanted to employ Rhode Island law to govern enforcement of damage awards, Wyoming law for the interpretation of the arbitration provisions, and North Dakota law for the remainder of the contract, they must be secure in knowing that public courts will honor these actions. As in the context of arbitration, different state courts employ varying doctrines when approaching choice of law provisions, making them relatively friendly or unfriendly to investors, entrepreneurs, and those supporting health care freedom as a result.

Wyoming is doubly fortunate in the sense that its history of state judicial treatment of choice of law provisions is encouraging. For example, in *Bradley v. Bradley*, a case involving a premarital agreement and divorce, the Wyoming Supreme Court broadly affirmed the voluntary use of choice of law provisions. In *Bradley*, the Court upheld private parties' choice of Minnesota law to govern pre- and post-nuptial provisions that might otherwise have been invalid under Wyoming law.[142] Still, Wyoming courts are careful to examine the nature of a competing state's law and will not apply "foreign law when it is contrary to the law, public policy, or the general interests of Wyoming's citizens."[143] Wyoming's judicial system has a general track record of upholding choice of law provisions and respects the right of competent parties to freely contract for their own optimized laws governing dispute resolution.[144]

Existing judicial trends in Wyoming are supportive of the recognition and en-

forcement of choice of law provisions in private contracts. Still, judicial precedent suggesting that such agreements may be struck down if they are contrary to the "general interests of Wyoming's citizens" (as interpreted by public judges) is troubling, and statutory reform limiting the discretion of the judiciary in employing so vague and far-reaching an analysis may be warranted.[145]

Arbitration agreements and choice of law provisions add flexibility to the freedom to contract. In this sense, they are integral elements to advancing medical freedom and economic liberty in general.

B. Tort Reform

One of the most important steps Wyoming can take to implement and protect medical freedom zones—and to improve health care generally in Wyoming—is to enact comprehensive tort reform. Wyoming has made a few steps in this direction, but has yet to realize the benefits of extensive tort reform. Although Wyoming has adopted modified joint and several liability,[146] Wyoming should also have limits on punitive damages and a modified collateral source rule. For reasons that will be discussed, Wyoming should be weary of imposing limits on noneconomic damages and should instead continue to recognize arbitration agreements and become more amenable to enforcing private contracts that determine noneconomic damages. These reforms will cut the cost of malpractice insurance for health care providers and court costs from litigation. Indirect benefits of these reforms include a reduction in the practice of defensive medicine, which make up a significant part of health care expenditures.[147]

1. Limiting Noneconomic Damages

The Wyoming Legislature has made attempts at tort reform. In 2004, Legislature referred a constitutional amendment to Wyoming residents, titled Amendment D. Amendment D failed to pass by a very small margin, with 50.3% of Wyoming voters voting against the bill or failing to vote either way.[149] This amendment would have allowed legislators to cap the amount of noneconomic damages awards in claims against health care providers while keeping recovery for actual damages and economic loss uncapped.[150] Currently, the Wyoming Constitution states unequivocally that "[n]o law shall be enacted limiting the amount of damages to be recovered for causing the injury or death of any person."[151] Shortly before the vote on Amendment D, the Congressional Budget Office published a summary of various tort reform studies, some of which indicated caps on noneconomic damages decrease malpractice premiums and thus decrease costs of health care.[152] At the time, Wyoming's neighbors Colorado, Idaho, and Montana had limits on noneconomic damages,[153] and since then Utah[154] and South Dakota[155] have implemented such caps. Colorado and Nebraska law go an extra step and cap total malpractice damages at $1 million[156] and $1.75 million,[157] respectively. Nebraska currently enjoys one of the lowest malpractice insurance rates in the nation.[158]

Damage caps are a heated issue, and studies diverge on their effectiveness.[159]

But the absence of this reform in Wyoming cannot be ignored: since Amendment D, Wyoming has had one malpractice case reach an award of $770,000 in noneconomic damages,[160] and although the impact of this type of reform on settlement talks and arbitration is impossible to measure, it's safe to say that health care providers would sooner settle than defend a case with the risk of jury awards going so high. Given that more than six years have passed since Amendment D's narrow defeat and the current focus on health care in the wake of PPACA, it is likely an amendment similar to Amendment D would pass if the Wyoming Legislature again referred such an amendment to the people.

However, assuming the effect of noneconomic damages caps is to decrease health care costs in Wyoming, such a cap "would reduce health care costs for non-injured patients, but at the expense of leaving some injured patients with uncompensated losses."[161] Though people may rightly fear runaway juries that grant outrageous awards and insurance companies who must assume unlimited liability when they calculate malpractice insurance premiums, a legal cap on noneconomic damages will in some cases deprive plaintiffs of full recovery. In this instance it would be best to recognize not only arbitration agreements, but contracts where health providers and patients can determine the proper limit, if any, on noneconomic damages. As Michael Cannon describes in his working paper, *Reforming Medical Malpractice Liability Through Contract*, there are a number of arguments against replacing tort liability with contract liability[162]—and these currently prevent contract from replacing tort—but Cannon argues effectively that "contract provides the least-imperfect route toward optimality" for malpractice liability.[163] Though it would be unjust to place an arbitrary cap on noneconomic damages, respecting contract would provide both patients and providers the ability to determine the proper ceiling, and this would provide malpractice insurance companies with the data to determine more reasonable costs for providers' liability coverage.

2. Modified Collateral Source Rule

Wyoming should adopt a modified collateral source rule. The collateral source rule derives from common law, that is, it is law that results from years of cases before the courts. The Supreme Court of Wyoming has adopted the Restatement (Second) of Torts,[164] which states in a comment:

> Payments made by one who is not himself liable as a joint tortfeasor will go to diminish the claim of the injured person against others responsible for the same harm if they are made in compensation of that claim, *as distinguished from* payments from collateral sources such as insurance, sick benefits, donated medical or nursing services, voluntary continuance of wages by an employer, and the like.[165]

In other words, under the traditional collateral source rule juries cannot not hear about other types of compensation a plaintiff receives in instances of medical malpractice (from an insurance company,

etc.), leaving the jury to assume that there is no other source of compensation for the injury when they consider a damages award. This rule can be modified legislatively to allow evidence of collateral payments in certain circumstances, or for a jury award to be reduced by the amount compensated from other sources. Once again a number of Wyoming's neighboring states have already acted—Idaho,[166] Colorado,[167] and Montana.[168] The Congressional Budget Office summary indicates that "both economic and noneconomic damages were reduced by reforms that allowed evidence of payment from sources other than the defendant to be introduced at trial."[169]

A modified collateral source rule is a commonsense and effective reform that the Wyoming Legislature can introduce. Unlike a cap on noneconomic damages, reforming the collateral source rule would not prevent plaintiffs from recovering damages, but only from double-dipping their compensation. Some personal injury attorneys argue that the traditional collateral source rule is necessary and just: "It is a legal way of both rectifying financial damages and bringing the responsible parties to account for their actions. It is important to remember that the [defendant hurt] *you,* not Blue Cross Blue Shield. And the Collateral Source Rule is the courts [sic] way of recognizing that."[170] Reasonable persons can disagree on the extent to which tort recovery should go beyond cognizable damages, but for purposes of medical malpractice it does not rob plaintiffs to limit recovery when insurance covers certain damages. When tort actions seek to "punish" malpractice, the damages should be considered punitive, and this area of tort law should also be reformed in Wyoming.

3. Punitive Damages Cap

The final reform Wyoming should implement is limits on punitive damages. These are damages in addition to noneconomic and compensatory damages that focus solely on the defendant's behavior: if the defendant acted willfully and wantonly when committing malpractice, then additional damages are justified as punishment. Capping punitive damages would require an amendment to the Wyoming Constitution.[171]

Colorado limits the recovery of punitive damages to no more than the amount of actual damages awarded,[172] and requires the plaintiff to prove "willful and wanton conduct" on the part of the defendant, and to prove this beyond a reasonable doubt (the other states neighboring Wyoming only require proof by clear and convincing evidence, a lower burden for the plaintiff).[173] In Utah any punitive damages awards over $50,000 are paid for evenly by the defendant and the state.[174] Idaho limits punitive damages awards to $250,000 or three times the amount of compensatory damages, whichever is greater.[175] Montana limits punitive damages to $10 million or 3% of the defendant's net worth, whichever is less.[176] Since punitive damages punish willful or wanton misconduct—that is, deliberate or reckless action—Utah's use of state funds to pay damages is unjust to taxpayers. Idaho's appears the most just, allowing large punitive damage awards, but only in proportion to actual damages. The Wyoming Legislature should propose

something similar to the Idaho punitive damages cap, and should consider adopting Colorado's reasonable doubt standard of proof: if one is to pay a large award for wrongdoing, they should have the benefit of a high burden of proof, similar to criminal charges.

There is no magic bullet for tort reform: studies conclude that it is a comprehensive set of laws, such as those described in this section, that work together to bring down the cost of malpractice insurance, litigation costs and the use of defensive medicine.[177] If Wyoming is serious about implementing and protecting medical freedom zones and improving its current health care system, the legislature should embrace all of these suggested reforms: contractual respect for noneconomic damages, a modified collateral source rule, and caps on punitive damages. In addition, to the extent Wyoming courts faithfully uphold contractual agreements between parties, individuals may properly define their own tort liability in voluntary agreements.

C. Medical Licensing, Education, and Innovation

A pernicious effect of the progressive movement, a host of today's professions must seek government blessing before being able to offer their services in the free market. A rather customary view of medical licensing today is that this approach assures quality, keeps hoax or "quack" practitioners at bay, and improves safety. Another emerging view suggests that overinflated licensing requirements proves harmful by establishing barriers to professional entry and making health care more expensive as an end result.[178] Another inquiry focuses on innovation and medicine and whether wide-scale homogeneous and strict regulation of medical practitioners promotes innovation or ingrains the status quo. Medical licensing regimes place further limits on the degree of modernization in medical education and how novel care providers may be in offering new services in the market.

When analyzed from a perspective of first principles, some important observations come to mind. A jurisdiction that embraces a radically state-centric view of medical licensure does great damage to individual sovereignty. That is, licensure laws fundamentally alter the sovereign ability of an individual to contract with another for his or her healing preferences to a matter of state whim. In lieu of the power of the individual, the power of the state grows and becomes deeply intertwined in deep areas of personal sovereignty—deciding how best to keep us alive and well.

A variety of scholars examining the nature of medical markets have lamented the expansive use of licensing laws in the traditional American approach. Nobel Laureate Milton Friedman has suggested that state licensing laws reflect an artificial restriction on the supply of medical care.[179] Of course, the American experience suggests that a slow move toward deregulation has been the norm, with increased demands for medical services following the enactment of Medicaid and Medicare in 1965, leading to non-physician practitioners enjoying more freedom to practice medicine.[180] Thus,

the rise of nurses, midwives, podiatrists, and physician assistants has seen the delivery of more competitively priced services for intermediate care options, seemingly increasing access to care options in limited examples.

A substantial problem related to state-based medical licensure rests in the evidence that interest groups "with strong lobbies play a significant role in shaping [scope-of-practice] legislation."[181] This practice produces a "turf war" of sorts—building barriers to entry to protect the economic interests of a relative few over consumers' interests in affordable health care. That leads to a fundamental question of normative policy: does the issue of medical licensing belong in the public policy sphere? Or could a freedom-based approach centered in free markets, private accreditation, and existing legal protections (namely medical malpractice and insurance) provide better and more accountable results to a paying public?

Within the scope of the growing field of medical tourism, private board certification offered by hospitals and insurers is recognized as an indicator of practitioner quality. In very much the same way consumer analysis of Cadillac brand recognition, data from Consumer Reports, or rankings by Underwriters Laboratories drives accurate consumer selection, so too can a free market approach work in medical markets. A promising development in health care markets is that a wide variety of private licensing and accreditation entities have sprung up. The independent National Commission on Certification of Physician Assistants provides private certification services for physician assistants, while a host of nurses rely on the private American Nurses Credentialing Center to provide specialized credentials in some 26 different areas of specialization.[182] Patients demand an assurance of quality in the care they receive, but that assurance need not come from government bodies.

Wyoming demands minimum postgraduate training of one year to pursue medical licensure, requires applicants to complete the United States Medical Licensure Exam within seven years, and limits the amount of times applicants may take such licensing tests to seven attempts.[183] The Wyoming Board of Medicine has established some 76 pages of rules and regulations guiding medical licensure in the state, including insurance requirements, continuing medical education dictates, and its own supervision and protocol requirements.[184]

Liberalizing Wyoming's currently state-constricted form of medical licensing is an important part of realizing medical freedom in the state. As a wide variety of alternative care providers emerge within American medical markets, jurisdictions with more permissive licensure standards will benefit from their innovation and creation of new medical markets. By means of example, naturopathic doctors are only permitted to practice in some 14 states.[185] Alternative care providers bring the promise of experimental medical treatment modalities to Wyoming, which offer hope for innovation and real advances outside the reach of the Food and Drug Administration. Alternative treatments for cancer, such as "HAMLET" (human alpha-lactalbumin), some forms of gene therapy, and insulin

potentiation therapy could find their home in Wyoming if a secure legal footing is offered to these markets.

A natural tie-in to licensure deregulation and securing a legal foothold for alternative and innovative treatment in Wyoming is the growth of alternative medical educational markets in Wyoming. At present, the University of Wyoming participates in the WWAMI Program—an "enduring partnership" between the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana, and Idaho.[186] The program works such that each of the participating states designates a specific number of medical school seats, which are supported through appropriated state funds and student tuition. What Wyoming lacks, however, is a state-specific medical school that ties into its particular needs as a unique jurisdiction. Partnering with privatized post-secondary institutions to form a unique medical school that is sensitive to Wyoming's needs and embraces innovation and alternative care could further cement the state as an exceptional jurisdiction for medical innovation and freedom.

The options for deregulating medical licensing are many. Acting as a recognized barrier to greater competition, more pioneering ideas, and lower costs, today's one-size-fits-all medical licensing schemes need renovation. Taking steps to open up the field to less bureaucratic control and more experimentation could help lead Wyoming as a national leader in health care freedom.

Since the passage of the Patient Protection and Affordable Care Act, the discussion of health care reform has focused on federal action. However, this section has shown that even the repeal and replacement of this law will leave a number of problems at the state level. Medical freedom zones would provide a proving ground for reform by allowing limited policy experiments. But whether looking to implement medical freedom zones or not, state policymakers should consider further protection of arbitration and choice of law, tort reform and licensure reform to maximize consumer choice and allow the health care markets to function.

IV. BUILDING THE BEST SOVEREIGN ISLAND: OF STATES AND TRIBAL NATIONS

Understanding the *what* of principled legal reform to protect health care freedom only takes interested audiences so far. Understanding the *where* of jurisdictional reform is important in designing medical freedom zones. In today's political climate, many Americans have come to tolerate, even embrace, deep government intervention in health care markets. The notion of completely freeing one state from the reach of federal intervention seems shocking for most and represents a call to medical anarchy for others, not to mention the risk of losing considerable federal funds. At the same time, full-scale government intervention into American medicine receives scant support in most jurisdictions. Americans want to have their medical cake, and eat it too.

The passage of medical freedom zones into statutory law is relatively uncomplicated, with their focal point being on the

establishment of limited geographic areas within the state where relatively deregulated medical care may be had. This section also discusses an alternative venue for medical freedom zones that may be pursued simultaneously or as an alternative to state recognition: Indian tribes. Tribal sovereignty is not necessarily a shortcut to medical freedom, but it provides solid footing to stand against government meddling and will likely face less opposition from special interest groups and narrow-minded politicians.

A. The State Approach

The creation of a medical freedom zone approach takes into account the sensible political concerns faced by most jurisdictions while embracing residents' natural desire for innovative and affordable medical care. By focusing on geographically discrete medical freedom zones, the whole of a state's health care market is not suddenly undone. Those residents preferring state-managed care or government subsidized medical packages may continue to participate. Individuals preferring medical care centered in a free market approach may avail themselves of medical freedom zones for many reasons: affordable care, expedited service, alternative treatments, or the preservation of their own sovereignty.

Following the medical freedom zone approach offers another principled advantage in that it permits the public to witness and contrast the offerings in medical freedom zones versus offerings in the status quo system. Deploying tiny islands of medical freedom thus represents a minimal threat to the status quo, offers security to existing stakeholders in the ongoing medical system, and provides some assurances of stability. As for the Wyoming Liberty Group approach, we believe it self-evident that medical freedom zones will be the vanguard of cutting edge medical care in the near future, permitting individuals a true escape valve from federal and state meddling.

Another advantage to the development of small islands of medical freedom, as opposed to an entire state, is that it presents better odds of surviving federalism challenges in the courts. One "renegade" state completely opting out of Medicaid, resisting the PPACA, and thumbing its nose at the federal government is likely to attract considerable negative attention, both in state-federal relations and in judicial treatment. One state offering but tiny islands of medical freedom as a means of policy experimentation presents a more negotiable and reasonable threat. It proves more difficult to say no to the concept of experimental zones—where medical freedom might be tested and tried out—than it does to an entire state rebelling against the rise of what some deem socialized care. There is sensibility and a shared commitment to moderation in agreeing upon medical freedom zones: let two systems with radically different starting principles openly and transparently compete with one another. Following the wisdom of left-leaning Justices Brennan and Brandeis, if states are to serve the role of proverbial laboratories of experimentation, then small steps to secure islands of freedom should be well respected, even lauded, across ideological spectrums.

Should the Supreme Court rule that one

state, incorporating health care freedom as a matter of constitutional concern, in but small geographic sections, and experimenting with liberalized respect for private and free market practice cannot be had, then the very notion of federalism, as expressed by both right-leaning and left-leaning members of the Court, is dead.

1. Medical Freedom Zones: The Statutory Construct

The core legal framework for establishing a medical freedom zone is found in the example of special purpose districts (SPD). Outside of states and cities, a variety of smaller jurisdictions exist across the American landscape. Counties, zoning boards, and school districts are but a small handful of such entities. SPDs are generally small jurisdictions that are independent from other government bodies and enjoy their own administrative and funding autonomy.[187] The scope of these special purpose districts' authority is then shaped by the legislature. Most districts subscribe to a narrow focus, such as the provisioning of sewer or fire protection services.

Special purpose districts are traditionally governed by boards and finance their services through user fees or bonds.[188] One popular national example of special purpose districts is found in business improvement districts (BID).[189] These efforts combine public and private resources to govern at a local level, focusing on implementing high quality laws and services.[190] Under the BID model, which is varied in its application, the district is a geographic subdivision of a city or county where property and business owners are subject to additional taxes. As suggested by the name, these districts aim to attract and retain businesses for the overall benefit of the community. Before such districts may be established, consent from local residents must be obtained.

The BID model speaks to the entrepreneurial spirit: being freed of "bureaucracies, entrenched interests, electoral calculations, or even ideology."[191] The former Chairman of New York's Grand Central BID put it this way: "Our whole purpose is to help government do what it's not been capable of doing."[192] Legal counsel from the Grand Central BID reasons that the "essential theory of the BID program . . . lies in allowing a private entity the freedom, relatively unencumbered by process and procedure, to experiment with new ideas and supplement traditional government activities in new ways."[193] In short, special districts allow local communities to be proactive and innovative in defining new preferences for the law.

Each state deploys special purpose districts in different ways, but certain themes remain constant. After passing legislative enactments permitting certain forms of SPDs, property owners or businesses usually initiate a petition to form a district. Such a petition is then submitted to a local governing authority, like a municipal board or county commission, for approval. That authority will help shape the boundaries, financing, budget, and functions of the SPD through final approval as a local ordinance. Some states offer local businesses a veto authority against the creation of the district after

the establishment of the public ordinance.

Mississippi, the most permissive outlier in this field, permits the creation of SPDs with less local government oversight.[194] Under Mississippi law, petitions with twenty percent of local property owner support will go forward to call a meeting of property owners in the proposed district.[195] A majority of those landowners must then agree to the technical components of the district: boundaries, improvements, governance, and assessments. The Mississippi plan affords some limited government oversight and review after formation, but is among the most minimally intrusive in the United States.

Under Wyoming law, a variety of special purpose districts may be established. They include, but are not limited to conservation districts, joint powers boards, rural health care districts, and even senior citizens' districts.[196]

A prime example of special purpose districts in Wyoming is found in the Improvement and Service District Act (ISDA).[197] Pursuant to the ISDA, counties may establish an improvement and service district to perform limited functions, such as to "[a]cquire, construct, operate and maintain improvements of local necessity and convenience."[198] To establish a district, a petition must be addressed to commissioners of the county in which it would be situated. Wyoming's law follows a "60/60" rule, requiring that sixty percent of people owning land in the district whose land has an assessed value of sixty percent or more of the assessed value of all the land in the district to sign the petition.[199] Upon its formation, state law establishes other requirements for a board, elections, and day-to-day functioning.[200]

Developing the legal construct of a medical freedom zone would borrow largely from existing provisions to fashion special purpose districts. In that sense, its construction is entirely voluntary—upon the submission of a certain threshold of local property owners, a meeting could be called to establish the purpose and functioning of the zone. However, a freedom zone would differ from a special purpose district in at least two significant ways. First, whereas most SPDs add additional services, taxes, or regulations, the overarching purpose of a medical freedom zone is to offer enlarged protection from government intervention. Second, medical freedom zones must be tied to a state constitutional source of authority that allows adequate breathing space for them to exist.[201] In that manner, the combined statutory and constitutional sources afford concrete bases of protection for would-be medical innovators and investors, as well as consumers.

Once medical freedom zones have been established through statutory language, the individual zones are saddled with the chore of importing the best laws and policy to govern medical operations and disputes. Earlier, this paper later detailed how the doctrines of choice of law, freedom of contract and tort reform, and others all make important differences for the success of medical freedom zones. Zones are able to select from the best rules internationally to govern transactions occurring within their jurisdiction, enabling them to establish more efficient dispute

resolution, such as that which occurs through arbitration. Zones celebrate choice and individual selection.

One of the primary benefits of medical freedom zones is that they permit any existing state regulation to operate outside of them, while offering deregulated and innovative offerings within. In contrast with traditional SPDs, which offer additional regulations or taxes within a district, a medical freedom zone would operate inversely, offering less regulations and less poorly fitted rules for those individuals wishing to opt into them. In a similar way, when many municipalities enacted smoking bans, certain clubs became established where each member expressly consented to waive their protection under the public law, thus allowing them to smoke within the club. In medical freedom zones, individuals may consent to waive standard, state-enforced rules while enjoying the benefits that flow from more deregulated offerings.

To note that special purpose districts have never been used in a manner that deregulates government rules is important. Traditionally, these districts afford a mix of private and public services when a majority or supermajority of landowners opt-in to their creation. But there is no principled reason why a similar statutory construct could not be used to achieve another result: relief from poor fitting, over burdensome government regulations where individuals expressly opt-out from their application.

B. The Tribal Nation Approach

Beyond intra-state medical freedom zones, another idea that could quickly capture attention and investment potential is the deployment of medical freedom zones in Native American tribal nations. These nations are especially suited for more experimentation in health care freedom due to their semi-sovereign status as Indian nations. Tribal nations are recognized legally as "unique aggregations possessing attributes of sovereignty over both their members and their territory."[202] In that sense, they are a "separate people" and they possess the "power of regulating their internal and social relations."[203] The Supreme Court has put some outer limits on the nature of that sovereignty. Briefly stated, "exercise of tribal power beyond what is necessary to protect tribal self-government or to control internal relations is inconsistent with the dependent status of the tribes, and so cannot survive without express congressional delegation."[204]

By the 1970s the Supreme Court pulled back from any firm jurisprudence upholding the sovereignty of tribal nations. By the 1980s the Court acknowledged as much, noting it had fully "departed from Mr. Chief Justice Marshall's view that 'the laws of [a State] can have no force' within reservation boundaries."[205] As in many other areas of constitutional law, the Court has come to favor balancing tests that allow weighing of state interests in deciding whether to enforce laws within tribal nations. Still, Native American tribes have made headway in protecting and preserving their own sovereignty through targeted litigation successes. These include favorable rulings from the Supreme Court against the application of the income tax to certain Indian forms of

income and protection against state intervention to regulate bingo activities on tribal land.[206] To say that tribal sovereignty litigation has been a complete success would be faulty because, just as with states, Indian nations have gradually lost some key areas of sovereign control in challenges against the federal government.[207] Still, prospects for exerting strong control over consensual business transactions occurring on their land are strong.

This section details the mechanics of tribal sovereignty, briefly discussing its history and offering current case law and other avenues to exerting sovereignty in light of medical freedom zones. Ultimately, given the current status of federalism jurisprudence (as discussed earlier[208]), working with tribal nations to build sovereignty sanctuaries within their semi-sovereign lands makes considerable sense and offers yet another buoy against federal and state intervention. Jurisdictions unwilling to step to the front of the national pack and prioritize health care freedom may find that innovative health care markets are the next gaming sensation on tribal nations. This invokes the right sort of balance between American states and tribal nations: jurisdictions competing to provide the best protection for medical freedom in the United States.

1. The Mechanics of Tribal Sovereignty: Consent and Binding Agreements

The scope of authority of the United States government over tribal nations is a complicated issue. Unlike states, there is no federal Supremacy Clause that restricts the exercise of tribal autonomy.[209] Because of this the Constitution has less binding effect against tribal sovereigns than state sovereigns. In that sense, tribal nations enjoy sovereignty wholly independent from state or federal sovereign authority.[210] However, the Supreme Court has generally described tribal sovereignty as being both unique and limited—possessing the power to govern both "their members and their territory."[211]

a. A Primer on Tribal Sovereignty

In 1871, Congress unilaterally asserted its authority to regulate tribal nations.[212] And while this power is described as plenary, it is not without limit. The federal trust doctrine limits actions Congress might take regarding tribal nations and land.[213] As such, the federal government must act in the role of a trustee for the benefit of the tribes as beneficiaries.[214] The federal government's duty has been described as one requiring it to protect the lands of tribe members and their right of occupancy and self-determination.[215] It is this last trust duty, self-determination, that offers tribal nations the best hope for exerting their strongest sovereignty claims.

Besides the trust relationship that connects tribal nations with the federal government, there are also federal statutes and joint tribal-federal agreements that shape this connection. One major federal statutory consideration is the Indian Major Crimes Act (IMCA).[216] It provides for federal criminal jurisdiction over certain crimes occurring within tribal lands. In

practice, the IMCA has left tribal governments with jurisdiction over only misdemeanor offenses occurring in their jurisdiction—leaving felonies to the federal government.[217] Another is the Indian Civil Rights Act, which made many provisions of the Bill of Rights applicable to tribal jurisdictions.[218] It is beyond the scope of this paper to examine the entire spectrum of governing federal-tribal laws and agreements, but a few observations are of note.

Concerning federal law, it is recognized judicial policy that application of any federal statute to tribes "must be viewed in light of the federal policies which promote tribal self-government, self-sufficiency, and economic development. Tribes retain inherent sovereign power to exercise some forms of civil jurisdiction over non-Indians engaged in commercial activities on Indian land."[219] Thus, even where federal law overlaps in a given area, preference must be given in favor of the recognition of tribal sovereignty, not federal supremacy. Second, since the Congress passed the Indian Reorganization Act in 1934, federal law has included a support for Indian self-determination and autonomy. Examples of this include the Indian Financing Act, Indian Civil Rights Act, and the Indian Child Welfare Act.[220] In other instances, the Congress either expressly includes tribes within a governing regulation, such as in the Safe Drinking Water Act, or entirely excludes tribes from its reach, as in the case of the Civil Rights Act of 1964 or the Americans with Disabilities Act of 1990.[221]

In the face of possible application of federal laws to tribal operations, federal courts are rather evenly split in their holdings. For example, the Second and Tenth Circuits have held that the Family and Medical Leave Act and portions of federal employment law do not apply to business disputes occurring on tribal land.[222] However, the Eleventh and Ninth Circuits have found that the Americans with Disabilities Act and Occupational Safety and Health Act do apply to businesses operating within tribal land.[223] Still, even when courts find that federal laws may *apply* to operations occurring within tribal lands, it still remains another question to decide whether the government has the authority to *enforce* the laws.[224] For instance, in the case of the Indian Civil Rights Act, the only enforcement authority is for habeas corpus relief—all other claims must be raised within the tribal jurisdiction.[225]

Understanding the furthest extent of tribal sovereignty is a complicated and sometimes contradictory process. This paper does not attempt to settle the many areas of unresolved law in this field. Instead, it seeks to illustrate the most optimal and promising areas of tribal sovereignty where real innovation might occur. To understand the significance of tribal sovereignty it is helpful to examine its scope. In many instances, tribal nations are immune from being sued in federal and state courts.[226] They enjoy the right to establish independent governments and declare their own citizenship requirements.[227] There is also a limited authority to tax and regulate the conduct of non-Indians on tribal land.[228]

Marking the high water points of tribal jurisdiction include authority over legisla-

tion and taxation on the reservation, excluding others from tribal land, and regulating domestic relations among tribal members.[229] On the other end of the spectrum, where non-member activity occurs on land owned in fee simple by non-Indians within a reservation, that authority is lost.[230] Thus, the general rule holds that the "inherent sovereign powers of an Indian tribe do not extend to the activities of nonmembers of the tribe."[231] There are two exceptions to this principle that allow tribal nations to employ "civil jurisdiction over non-Indians on their reservations, even on non-Indian fee lands."[232]

b. Sovereignty as an Independent Basis

To maximize tribal authority, one must pay attention to the Supreme Court's carefully crafted rules about tribal jurisdiction and sovereignty. One protected area is where non-Indians enter into certain relationships with a tribe or its members; tribal nations enjoy extensive jurisdiction over those individuals.[233] This might occur in instances where there are commercial deals, contracts, or leases entered into by non-Indians with tribes or their members. In those instances, individuals are ordinarily aware, or should be aware, of tribal authority to govern such transactions, themselves entering into them voluntarily. The second area allows a tribe to exercise "civil authority over the conduct of non-Indians on fee lands within the reservation when that conduct threatens or has some direct effect on the political integrity, the economic security, or the health or welfare of the tribe."[234] A variety of tribal sovereignty scholars have criticized the excessively limited nature of these exceptions.[235]

Of the two exceptions noted above, it is the former that demands the greatest attention for purposes of medical freedom zones. Stressing the consensual and voluntary nature of associations, the Supreme Court has upheld the exercise of tribal sovereignty where clearly documented relationships occur between Indians and non-Indians. Properly executed contracts, with provisions exerting tribal jurisdiction over individuals voluntarily entering into them, along with legally valid methods of consent would go a long way toward constructing a sovereignty-enhancing set of regulations and laws. Thus, if the Supreme Court has expressly demonstrated the contours of where tribal sovereignty is at its high mark, it makes practical sense to build that wisdom into governing regulations and private contracts to preserve it to its fullest degree. The second exception noted above rests on less certain ground, requiring a court to determine just when a tribal nation's "political integrity" or other nebulous factors have been compromised. Given that the first exception offers a concrete and defined way to protect tribal sovereignty, its effect should be employed when building medical freedom zones.

An important note about tribal sovereignty rests on the fact that few tribal jurisdictions have taken the development of their own statutory law seriously. One outlier in this sense is the Navajo Nation, which has begun its own process of stringently occupying and defining tribal law.[236] In doing so, the Navajo have strengthened their own jurisdiction and sovereignty by affirming and defining tribal law.[237] Were

other tribes to do the same, both generally and in specific areas of law, they could bring world class governing rules to their jurisdiction while steadily increasing their autonomy.

To make the most of tribal sovereignty in the context of health care freedom, tribal nations should take care to follow three steps. First, to shore up geographical jurisdiction, the acts, conduct, or business of concern should occur on tribal land. This is not an absolute requirement, as tribal civil jurisdiction may extend to non-member held land on a reservation. However, limiting the geographic situs to tribal lands helps avoid any problems of overlapping jurisdiction. Second, non-member visitors to tribal nations should be required to enter into contracts with medical providers and tribal authorities as to the scope and choice of law applicable to their visit. These agreements should be transparent and adequately inform visitors of an array of legal options they may select that will govern their conduct. Third, sufficient legal remedies, whether through tribal judicial councils or private arbitration, should be made available to all parties on an equal basis.[238] By ensuring that each of these three steps is met, medical freedom zones can be aligned with the Supreme Court's guidance in this area, assuring the most robust protection of tribal sovereignty and medical markets along the way.

A recent example of tribes' independent basis for exerting sovereign authority over a nascent industry is found in payday lending. Seventeen states have capped interest rates on these sort of loans or banned them entirely.[239] In the wake of this backlash, several lenders reincorporated or moved their operations to tribal jurisdictions. While certain jurisdictions may disfavor payday lending, Colorado Attorney General John Suthers explains, "We are largely powerless to stop them."[240] This is due to the protection tribes receive under the doctrine of sovereign immunity, protecting them from suit in neighboring state court jurisdictions.[241] Specifically, where business operations can be considered "arms of the tribe," tribal sovereign immunity will extend to protect such operations.[242] Indeed, the Colorado Supreme Court recently ruled in just such a manner, protecting two tribes from the reach of state jurisdictional authority with respect to payday lending laws.[243]

Absent congressional abrogation, tribal sovereign immunity may extend to contracts entered into between a part of the tribe and non-members.[244] Even when a contract is entered into off of tribal land between the tribe and others, tribal sovereignty will reign supreme.[245] Individual tribal members who submitted themselves to the personal jurisdiction of a state may, however, be rightfully subject to state court jurisdiction.[246]

Related to the doctrine of tribal sovereign immunity is the doctrine of tribal court exhaustion. The tribal exhaustion doctrine is not jurisdictional in nature but is a "product of comity and related considerations. Where applicable, this prudential doctrine has force whether or not an action actually is pending in a tribal court. Moreover, the doctrine applies even though the contested claims are to be defined substantively by state or federal

law."[247] In that sense, even if another government court could make a colorable claim for jurisdiction, the tribal court exhaustion doctrine holds that tribal jurists must have the first opportunity to decide and adjudicate such matters.

When compared to states, tribes offer budding companies and nascent industries several jurisdictional advantages. In the payday lending example, even lenders located in other states can be subject to the long arm jurisdiction of another state if sufficient business has been done there. However, that same rule does not apply when it comes to organizations that incorporate within tribal nations and make their offerings available to non-members. The Supreme Court has stated this explicitly in noting that tribal sovereign immunity is entirely different from state sovereign immunity and is "not subject to diminution by the States."[248] Even stronger is the case for tribal sovereignty and self-regulation when non-members voluntarily come to the tribal jurisdiction itself and avail themselves of its laws and optimally designed contracts. To claim that a competing state or federal government's jurisdiction is somehow superior to the intrinsic jurisdiction of the tribal nation in such an instance would prove especially difficult.

c. Sovereignty Through Compact and Statutory Design

There are a variety of legal options to secure the best medical freedom islands in American Indian nations. One approach that proved economically successful in the realm of expanding casino and gambling operations in tribal lands was the use of intergovernmental agreements. In 1998, Congress passed the Indian Gaming Regulatory Act (IGRA), which was designed to "provide a statutory basis for the operation of gaming by Indian tribes as a means of promoting tribal economic development, self-sufficiency, and strong tribal governments."[249] Within the context of the IGRA, tribal nations agreed to shared sovereignty and jurisdiction over three different classes of gaming activities, ushering in a variety of tribal-state compacts.[250] This approach proved largely beneficial—in 2004, there were roughly 200 tribes operating more than 320 gaming facilities of differing types, whose annual gross revenues from gaming approached $13 billion.[251]

Some branches of the federal government have even approached tribal nations in their capacity as sovereigns, forming government-to-government agreements.[252] The Federal Communications Commission has adopted this approach with respect to its Universal Service policy.[253] Were tribal nations to assert control over their own health care preferences and policies and request similar government-to-government treatment in the context of health care, this might provide considerable flexibility for shaping freedom zones. Specifically, under the Indian Self Determination Education and Assistance Act (ISDEAA), Indian tribes are given two pathways to exercise greater latitude than states in shaping their own health care policies and programs, even if they accept federal funding.[254]

Under the ISDEAA, tribes can negotiate agreements with the United States to take

over programs and functions that the federal government provides so that tribal governments themselves are responsible for delivering the health care services previously provided by the federal government.[255] In this narrow context, courts have given stronger protection to tribes, recognizing that once tribal governments submit a legally sufficient self-determination request to the federal government, it must be approved.[256] Still, the statutory or compact model is not without its own faults. In the development of gaming on tribal lands, some tribes lost important portions of their autonomy. This occurred due to the voluntary agreement of tribes to partake in large regulatory schemes developed by the federal government. In doing so, tribal ability to reject federal court jurisdiction over gaming operations is lacking, as described later in this section.

The interplay of the ISDEAA and the PPACA remains to be seen. However, given the broad parameters that exist under the legal framework of the ISDEAA for tribes to exert sovereignty, the creation of judicially enforceable medical freedom zones within tribal nations may just be a winning idea. Piggybacking the protections of the ISDEAA onto the legal foundation of the zones could establish a firm basis to defend these islands of innovation.

d. Tribal Sovereignty Pitfalls

Building a sovereign sanctuary for medical freedom is no easy task wherever it is located. Implementing medical freedom zones on tribal lands illustrates several positives about why just such a jurisdiction could be ideal in protecting against interfering state and federal laws. However, this approach is not without its own weaknesses. Making note of these exceptions is valuable for designing a properly secure medical freedom zone on tribal land.

One consideration that weakens tribal sovereignty is the intermingling of extensive federal regulatory programs or funding programs. Both the Tenth and Fifth Circuit Court of Appeals have permitted the exercise of federal court jurisdiction over disputes between tribes and non-tribe members where the issues involved were interlocked in federal regulatory programs.[257] Where tribes have entered into binding agreements with the federal government, federal court jurisdiction will generally be validated. In addition, where tribes have structured their business operations around the very operation of complicated and extensive federal regulatory programs, federal courts will also uphold jurisdiction. As stated by the Fifth Circuit Court of Appeals, "this extensive regulatory scheme demonstrates that tribal oil and gas leases represent a very specialized subset of contracts and, therefore, compels the conclusion that they belie characterization as routine contracts."[258] The lesson from these set of challenges is that tribes wishing to build wholly independent and sovereign medical freedom zones should structure them entirely separate from any federal programs or funding streams.

A second consideration buttresses the first. In the wake of economic success enjoyed by tribes through gaming under the IGRA, federal courts began to exercise jurisdiction more steadily over determin-

ing who were proper members of tribes—a function ordinarily held by tribes themselves. In Wisconsin, the Stockbridge-Munsee Mohican Community faced considerable controversy in the wake of gaming that resulted in federal mediation attempts.[259] The result of tribal membership being determined by federal courts that ordinarily had no place doing so was largely the result of tribes voluntarily sacrificing portions of their autonomy through the federal IGRA.[260] While federal agreements may reap immediate economic success and help establish political legitimacy, they come with the heightened loss of internal tribal autonomy. This exception illustrates that were medical freedom zones to become a success, it is in tribes' interest to be wary of intervening federal or state cooperative agreements that would lessen their sovereignty.[261]

Beyond judicial actions, it remains within the Congress' authority to limit or modify tribal powers of self-governance.[262] For example, while the protections offered under the Bill of Rights have not been held to apply to tribal nations, Congress implemented a federal statute to demand exactly that.[263] When the Congress speaks unequivocally, it may abrogate tribal sovereignty or immunity in specified areas. However, any abrogation carries disfavor judicially, as one federal district court noted to "abrogate tribal decisions, particularly in the delicate area of membership, for whatever 'good' reasons, is to destroy cultural identity under the guise of saving it."[264] For both political and legal reasons, a move on behalf of Congress to retaliate against medical freedom zones on tribal lands would face difficult challenges. In that sense, tribal development of effective public and congressional relations would be important.

Another point of federal constitutional concern is the Indian Commerce Clause. Article 1, Section 8, Clause 3 of the U.S. Constitution provides the Congress with authority "to regulate commerce with foreign nations, and among the several states, and with the Indian tribes." This power has been used broadly, with, for example, Congress making it a crime to sell or bring alcohol into tribal lands in 1834.[265] The Supreme Court upheld this exercise of congressional power in *United States v. Holliday* because of "the intercourse between the citizens of the United States and those tribes, which is another branch of commerce, and a very important one."[266] The Indian Commerce Clause is both helpful and problematic in the design of medical freedom zones on tribal lands. The Clause is helpful because it recognizes the sovereignty of intra-tribal operations and business. It is problematic because it affords Congress rather broad power to regulate trade or commerce coming in or out of such lands. Thus, while U.S. citizens might fly to a tribal medical freedom zone, Congress would be free to set limits on what they could bring back to their home jurisdiction.

Lastly, the interposition of criminal law by neighboring states or the federal government remains problematic. In *Oliphant v. Suquamish*, the Supreme Court announced that tribes have no general criminal jurisdiction over non-Indians.[267] However, the Congress empowered tribes to exert some criminal jurisdiction

by amending federal law.[268] In a complementary sense, Congress passed the Major Crimes Act in 1885, which imposed federal criminal jurisdiction for certain felonies occurring within tribal lands.[269] The end consequence of the Supreme Court's various tribal criminal jurisdiction cases is that non-Indians on tribal land can be subject to federal criminal jurisdiction.[270] Because of this, the outer extent of medical freedom—as realized in criminalized, experimental medicines—could not be reached solely through claims of sovereignty. This weakest link, then, must be solved through the court of public opinion and focused litigation.

It should be noted that the Court's holding in *Oliphant* is not without criticism by a wide range of legal scholars.[271] Indeed, in the wake of economic successes connected with gaming, it remains unfeasible for state or federal governments to maintain criminal jurisdiction over tribal land.[272] This is because gaming has brought a variety of non-Indians directly onto tribal lands in record numbers. In practice, *Oliphant* has led to deeper questions about prosecutorial authority on tribal lands—sometimes causing protracted lawsuits and clogged federal, state, and tribal courts as a result.[273] At the same time, the interplay of tribal law and federal law remains a confusing subject, with many courts noting the broad areas of concurrent jurisdiction enjoyed by dueling sovereigns—the federal government and tribal governments.[274]

In the wake of confusion[275] over the Supreme Court's holding in *Oliphant*, there is a growing trend asserting that tribal nations never lost their authority to prosecute non-Indians for criminal acts occurring on tribal land.[276] Indeed, post-*Oliphant*, there is considerable tension among federal circuit courts of appeal about the scope of federal or tribal jurisdiction—with some circuits reasoning that tribal powers of self-government were always retained and cannot be limited because they predate the federal constitution.[277] Even beyond the question of inherent powers of tribal jurisdiction is the flux of law concerning the tribal sovereign immunity doctrine as to criminal offenses. The Ninth Circuit has concluded that a defendant convicted of raping another tribal member could be charged under the Indian Major Crimes Act, but that enforcement of the conviction could not be had against a sovereign tribal government.[278] Still, some district courts have disagreed with the reasoning of the Ninth Circuit and permitted federal criminal law to be enforced within tribal jurisdictions.[279] Others have embraced the reasoning of the Ninth Circuit and broadly upheld the sovereign immunity of tribes.[280] These points remain to be litigated, perhaps expanding protection for this crucial element of tribal sovereignty in the near future.[281]

One bright point to be made comes from the Eighth Circuit Court of Appeals, itself noting that "areas traditionally left to tribal self-government . . . have enjoyed an exception from the general rule that congressional enactments, in terms applying to all persons, includes Indians."[282] In that matter, the court explained that Indians would retain the right to hunt bald eagles because hunting rights had been reserved and were governed by their tribal law. While it is difficult to escape the

reach of federal criminal jurisdiction, it is not impossible. Tribes making a showing that conduct occurring on their land that is part of their traditional history will receive heightened protection against the application of federal criminal jurisdiction.

While there are recognized weaknesses and difficulties with the tribal model, it does present significant strengths when compared to state jurisdictions. Each of the negatives just discussed have adequate remedies, with the last proving most difficult. Even with these limits, the creation of medical freedom zones on tribal lands is promising. Tribal sovereignty precedent is significantly stronger than state sovereignty case law, and offers unlitigated opportunities to broaden its scope.

2. A Matter of Choice: Inherent Sovereignty or Statutory Compromise?

In some quarters, criticism has arisen against the Indian Gaming Regulatory Act and the use of federal statutes to develop tribal gaming.[283] Indeed, serious arguments exist that the IGRA actually undercuts tribal sovereignty by permitting states and the federal government to interfere with governance issues. With the economic success of gaming came a plethora of tribal membership controversies, opening up intra-tribal governance issues to federal court jurisdiction at times.[284] In the wake of controversies and disputes following the IGRA over membership issues, tribal nations should critically examine whether including federal or state governments in other governance and business issues would increase or decrease their sovereignty. By relying on federal support and intervention, any future claims about the inherent sovereignty of the tribal nation in question are severally diminished.[285]

The natural benefit of including federal or state government involvement in medical freedom zones on tribal land is to build political legitimacy. But that supposed legitimacy comes at a steep price—the gradual surrender of key areas of sovereignty by tribal authorities. Conversely, relying on the recent developments in payday lending within tribal jurisdictions, tribal nations might strike out on their own to stake their own claims to sovereignty. In that sense, a greater risk of litigation and controversy ensues at the forefront, but, if successful, tribal nations would enjoy self-contained industries without the menace of intervening state or federal overlapping jurisdiction. That, in turn, would build the strongest foundation for tribal sovereignty and protection of medical markets within them.

V. PUTTING IT ALL TOGETHER: SECURING MEDICAL FREEDOM IN WYOMING

Building the legal foundation for medical freedom zones will not be an easy task. It will require a bold amendment to the Wyoming Constitution for health care freedom, and separate amendments for certain tort reforms. For reforms that can be made by statute, the Wyoming Legislature will face staunch opposition from health insurance interest groups, trial attorneys, and other powerful lobbies with vested interests in the status quo. Some

of these steps—especially the Health Care Freedom Amendment—require Wyoming to break new ground in securing its sovereignty. But each of these steps is necessary to secure medical freedom zones and to improve Wyoming's health care system.

It will take courage to establish health care freedom and to re-establish Wyoming's sovereignty. With the same courage, Wyoming can implement attractive, stable laws that protect arbitration and choice of law provisions, and eliminate burdensome licensing regulations. But in the midst of these difficult hurdles, the medical freedom zones approach offers not merely political palatability, but political force: instead of establishing new entitlements or regulations that apply to or affect each Wyomingite, medical freedom zones are escape valves that will succeed or fail based on voluntary investment and initiative. Those with genuine concern must be convinced to respect the freedom of others, and those who seek to protect their government patronage must be exposed and dismissed. Too often, politicians and bureaucrats pass the proverbial buck, to the dismay of the electorate; medical freedom zones require passing responsibility back to the people, and that responsibility will yield great rewards.

It is of some fortune that Wyoming houses two jurisdictions suitable for health care freedom reform. Nudging the State of Wyoming and Native American tribes to compete for the best health care laws possible works in the favor of liberty. Monopolistic political jurisdictions, like any other monopoly, tend to become exploitative and indifferent. When jurisdictions fall behind their competitors, capital and people leave for other opportunities, forcing jurisdictions to take notice. Requiring political bodies to respond to competitive pressure, in this case by competing for the best set of medical freedom laws, produces the best end effect for medical freedom in Wyoming, whether in the state or within tribal nations.

Individual liberty still drives America, and its spirit is especially alive in Wyoming. Liberty is not only one of the highest goods in and of itself, but is the key to cost savings, innovation, and nearly all improvements that will be made to the health care system. With the legal framework described herein, the destination is visible through the bog of regulation and government control, but the people of Wyoming must elect to make the journey.

States have long competed for business with their laws, and health care goes beyond our national borders into the global marketplace. People tired of unavailable treatments, expensive medicine and low-quality care frequently travel—flee may be a better word—to other countries for medical care, going as far as Asia. There is great demand for the best medical treatment, and the states that allow it to flourish stand to reap great rewards. Medical freedom zones are the answer: Wyoming may become the destination for not only American medical tourism, but patients from around the world.

For decades, state governments and the federal government have taken more control of health care and the insurance market, while simultaneously increasing enti-

tlement programs that also add significant burdens to taxpayers. The problems that follow—higher costs, lower-quality care, and less access—are not recognized as the result of this intervention, but are blamed on a "greedy" health care industry and considered a signal for even more government control. The popular outcry in the wake of PPACA indicates that government's foray into health care has reached its limit; from one point of view, it has become so bad that the only way many will participate is if government forces people to purchase insurance, which the law will soon do. Although the future of PPACA is uncertain, even if it is repealed there will remain a broken health care system. It is up to an enterprising state to allow American liberty, ingenuity, and drive to succeed where government planning has failed. Rather than fixing a broken health care system, medical freedom zones are the foundation for a new system based on the principles that have produced prosperity and affordability in every other industry.

Policy papers do not a system make: it is up to the Wyoming Legislature to implement medical freedom zones, encourage the people of Wyoming to follow its lead, and vigorously defend zones in their nascent stage, as they are certain to draw criticism from many vested interests. The success of medical freedom zones is not guaranteed, that is the nature of business, but there is a burgeoning worldwide health care market, and there is no reason Wyoming cannot compete for this demand. The best health care providers in America are eager to help people effectively, and the ability to do this guided by their own skills—and not under the guidance of government regulations, oversight boards and trial attorneys—is only becoming more attractive. Freedom has always been a grand experiment, and yet it is a safe bet for politicians: even if it fails, it will be purely voluntary.

With medical freedom zones come many other opportunities: a chance to re-assert state sovereignty, to increase individual rights, and to otherwise lead the way toward a more free society. In this way, medical freedom zones are an unequivocal statement that, contrary to progressive mantra, our collective prosperity rests in individual responsibility and individual action. Thus, it is freedom, protected by law rather than perturbed by it, that will open the door to an effective, affordable, and choice-driven health care system.

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[39] Lawrence A. Hamermesh, *The Policy Foundations of Delaware Corporate Law*, 106 COLUM. L. REV. 1749, 1771–86 (2006).

[40] *Id.* at 1772.

[41] LEWIS S. BLACK, JR.., WHY CORPORATIONS CHOOSE DELAWARE 10 (2007), *available at* http://corp.delaware.gov/whycorporations_web.pdf.

[42] *Medical Travel Business Slows in U.S.*, BIOMEDME (Oct. 10, 2010), http://biomedme.com/general/medical-travel-business-slows-in-u-s_15533.html.

[43] MILICA Z. BOOKMAN & KARLA R. BOOKMAN, MEDICAL TOURISM IN DEVELOPING COUNTRIES 3 (2007).

[44] *Medical Tourism: 2008 Survey of Health Care Consumers*, DELOITTE (May 12, 2009), http://www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/consumerism/ee7a27b99eefd110VgnVCM100000ba42f00aRCRD.htm.

[45] *Medical Tourism Statistics and Facts*, HEALTH-TOURISM, http://www.health-tourism.com/medical-tourism/statistics/ (last visited Nov. 4, 2011).

[46] Devon Herrick, *Medical Tourism: Global Competition in Health Care*, NCPA POLICY REPORT (Nat'l Center Pol'y Analysis, Dallas, TX), Nov. 2007, *available at* http://www.ncpa.org/pdfs/st304.pdf.

[47] *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Spec. Comm. on Aging*, 109th Cong. (2006), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_senate_hearings&docid=f:30618.pdf.

[48] Glenn Cohen, *Protecting Patients With Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1489 (2010).

[49] *See supra* note 23.

[50] *Medical Tourism: Why?*, EUROPEAN MEDICAL TOURIST, http://www.europeanmedicaltourist.com/frontpage/Itemid,1/ (last visited Nov. 4, 2011).

[51] *See generally* COUNCIL FOR AMERICAN MEDICAL INNOVATION, http://www.americanmedicalinnovation.org (last visited Nov. 4, 2011).

[52] Joe Palca, *Salk Polio Vaccine Conquered Terrifying Disease*, NAT'L PUBLIC RADIO (Apr. 12, 2005), http://www.npr.org/templates/story/story.php?storyId=4585992.

[53] New State Ice v. Liebmann, 285 U.S. 262, 311 (1932).

[54] As explained by Common Dreams, a left-of-center news provider, "Today, it is state legislators who are proposing the nation's most far-reaching, proactive measures . . . . They are making legislatures a testing ground for the newest political debates. For progressives, the action is in the states." Ralph Nader, *State Legislatures as "Laboratories of Democracy,"* COMMONDREAMS.ORG (May 31, 2004), http://www.commondreams.org/views04/0531-12.htm.

[55] New York v. Miln, 36 U.S. (11 Pet.) 102 (1837).

[56] *Id.*

[57] Printz v. United States, 521 U.S. 898, 919 (1997) (quoting THE FEDERALIST NO. 39 (James Madison)).

[58] *See* Nat'l League of Cities v. Usery, 426 U.S. 833 (1976); Fry v. United States, 421 U.S. 542 (1975).

[59] Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 529, 549 (1985) (citing Equal Employment Opp'y Comm'n v. Wyoming, 460 U.S. 226, 269 (1983)).

[60] Horne v. Flores, 129 S.Ct. 2579, 2607 (2009).

[61] 546 U.S. 243 (2006).

[62] Jacobson v. Massachusetts, 197 U.S. 11, 24–25 (1905) (emphasis added).

[63] *See, e.g.*, Florida v. U.S. Dep't Health & Human Serv., No. 3:10-cv-91-RV/EMT, 2011 WL 285683, (N.D. Fla. Jan. 31, 2011).

[64] TENTH AMENDMENT CENTER, http://www.tenthamendmentcenter.com/ (last visited Nov. 4, 2011).

[65] 521 U.S. 898 (1997).

[66] *Id.* at 935.

[67] *See* S.J. Res. 59, 52nd Legis. (Okla. 2010), *available at* http://webserver1.lsb.state.ok.us/2009-10bills/SB/sjr59_engr.rtf. *See also Oklahoma Health Care Freedom Amendment, State Question 756 (2010)*, BALLOTPEDIA.ORG, http://ballotpedia.org/wiki/index.php/Oklahoma_Health_Care_Freedom_Amendment_(2010) (last visited Nov. 4, 2011).

[68] *See* H.R. 1764, 95th Gen. Assembly (Mo. 2010), *available at* http://www.house.mo.gov/billtracking/bills101/biltxt/truly/HB1764T.HTM. *See also Missouri Health Care Freedom, Proposition C (2010)*, BALLOTPEDIA.ORG, http://www.ballotpedia.org/wiki/index.php/Missouri_Health_Care_Freedom,_Proposition_C_%282010%29 (last visited Nov. 4, 2011).

[69] *See* H.R. Con. Res. 2014, 49th Legis. (Az. 2009), *available at* http://www.azleg.gov/legtext/49leg/1r/bills/hcr2014h.htm. *See also Arizona Health Insurance Reform Amendment, Proposition 106*, BALLOTPEDIA.ORG, http://www.ballotpedia.org/wiki/index.php/Arizona_Health_Insurance_Reform_Amendment,_Proposition_106_%282010%29 (last visited Apr. 6, 2011).

[70] *See* S.J. 0002, 61st Legis. (Wyo. 2011), *available at* http://legisweb.state.wy.us/2011/Enroll/SJ0002.pdf.

[71] U.S. CONST. art. VI (emphasis added).

[72] *See* WYO. STAT. ANN. § 6-8-406(a)(i)–(iii) (2010).

[73] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1501, 1513 (2010) (to be codified at I.R.C. §§ 5000A, 4980) (hereinafter PPACA).

[74] *See, e.g.*, Florida v. U.S. Dep't Health & Human Serv., No. 3:10-cv-91-RV/EMT, 2011 WL 285683, slip op. (N.D. Fla. filed Jan. 31, 2011), *available a*t http://plf.typepad.com/Florida%20Order.pdf.

[75] *See, e.g.*, Virginia v. Sebelius, 702 F.Supp.2d 598 (E.D. Va. 2010).

[76] U.S. CONST. art. I, § 8.

[77] *See* THE FEDERALIST NO. 11 (Alexander Hamilton).

[78] *See, e.g.*, Wickard v. Filburn, 317 U.S. 111, 118–29 (1942).

[79] *See* Florida v. U.S. Dep't Health & Human Serv., No. 11-11021 & 11-11067, slip op. (11th Cir. filed Aug. 12, 2011), *available at* http://www.uscourts.gov/uscourts/courts/ca11/201111021.pdf.

[80] *Id.*

[81] *See, e.g.*, Virginia v. Sebelius, No. 11-1057, slip op. (4th Cir. filed Sept. 8, 2011), *available at* http://pacer.ca4.uscourts.gov/opinion.pdf/111057.P.pdf; Liberty University v. Geithner, No. 10-2347, slip op. (4th Cir. filed Sept. 8, 2011), *available at* http://pacer.ca4.uscourts.gov/opinion.pdf/102347.P.pdf; Thomas More Law Center v. Obama, No. 10-2388, slip op. (6th Cir. filed Jun. 29, 2011), *available at* http://www.ca6.uscourts.gov/opinions.pdf/11a0168p-06.pdf.

[82] *See generally* THE FEDERALIST NO. 45 (James Madison).

[83] *See supra* note 78.

[84] United States v. Darby, 312 U.S. 100, 123–24 (1941).

[85] LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 776 n. 14 (1998).

[86] Troxel v. Granville, 530 U.S. 57, 91 (2000).

[87] U.S. CONST. amend XIV, §1.

[88] 130 S.Ct. 3020 (2010).

[89] *See* Minneapolis & St. Louis R.R. Co. v. Bombolis, 241 U.S. 211 (1916) (declining to incorporate Seventh Amendment right to a jury in civil cases); Murphy v. Hunt, 455 U.S. 478 (1982) (allowing state law to control pretrial bail).

[90] William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 491 (1977).

[91] *See, e.g.*, Joseph A. Grasso, Jr., *"John Adams Made Me Do It": Judicial Federalism, Judicial Chauvinism, and Article 14 of Massachusetts' Declaration of Rights*, 77 MISS. L. J. 315 (2007).

[92] Betsy Griffing, *The Rise and Fall of the New Judicial Federalism Under the Montana Constitution*, 71 MONT. L. REV. 383 (2010).

[93] Murdock v. City of Memphis, 87 U.S. 590, 626 (1874).

[94] *See* Fox Film Corp. v. Muller, 296 U.S. 207, 210 (1935); Oregon v. Hass, 420 U.S. 714, 728, (1975) (Brennan, J., concurring) ("It is peculiarly within the competence of the highest court of a State to determine that in its jurisdiction the police should be subject to more stringent rules than are required as a federal constitutional minimum."); City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283, 293 (1982).

[95] Griffing, *supra* note 92.

[96] *See, e.g.*, Goodridge v. Dep't Pub. Health, 798 N.E.2d 941 (Mass. 2003); Varnum v. Brien, 763 N.W.2d 862 (Iowa 2009); In re Marriage Cases, 183 P.3d 384 (Cal. 2009).

[97] *See* United States v. Spencer, 160 F.3d 413, 414 (7th Cir. 1998) ("The Ninth Amendment does not invert the supremacy clause and allow state constitutional provisions to override otherwise lawful federal statutes. Illinois could not by creating a state constitutional right to possess child pornography preempt the federal laws that prohibit such possession.").

[98] ROBERT H. BORK, THE TEMPTING OF AMERICA 185 (1997).

[99] WYO. CONST. art. 7, § 20.

[100] 455 U.S. at 293.

[101] *See* Tom Quigley, Comment, *Do Silver Platters Have a Place in State-Federal Relations? Using Illegally Obtained Evidence in Criminal Prosecutions*, 20 ARIZ. ST. L.J. 285 (1988).

[102] *Id.*

[103] Brennan, *supra* note 90, at 503.

[104] BLACK'S LAW DICTIONARY 1297 (9th ed. 2009).

[105] *See, e.g.*, Altria Grp. v. Good, 129 S.Ct. 538 (2008); English v. Gen. Electric Co., 496 U.S. 72, 79 (1990); Geier v. Am. Honda Motor Co., 529 U.S. 861, 873 (2000).

[106] Lorillard Tobacco Co. v. Reilly, 533 U.S. 525, 541 (2001).

[107] Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88 (1992).

[108] *Geier*, 529 U.S. at 873.

[109] *See, e.g.*, Hillsborough Cnty. v. Automated Med. Lab., 471 U.S. 707, 719 (1985); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

[110] Maryland v. Louisiana, 451 U.S. 725, 746 (1981).

[111] *See, e.g.*, Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 146–52 (1963); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 236–37 (1947).

[112] *Printz*, 521 U.S. 898.

[113] *Preemption of Federal Law in Conflict With State Law* (Wyo. Legis. Serv's Apr. 19, 2010) (copy on file with Wyoming Liberty Group).

[114] Timothy S. Jost, *Can the States Nullify Health Care Reform?*, 362 NEW ENG. J. MED 869. (2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1001345.

[115] *Altria Grp.*, 129 S.Ct. 538.

[116] 129 S.Ct. 1187 (2009).

[117] *Id.* at 1195 n. 3.

[118] 129 S.Ct. 2710 (2009).

[119] *See supra* notes 115–118.

[120] *See supra* notes 115–118.

[121] PPACA § 1321(d).

[122] *See, e.g.*, Wood v. County of Alameda, 875 F. Supp. 659 (N.D. Cal. 1995) (explaining that portions of state law offering additional protection were not preempted by the Americans with Disabilities Act).

[123] *See, e.g.*, Civil Rights Act, 42 U.S.C. § 2000e-7 (2010) ("Nothing in this subchapter shall be deemed to exempt or relieve any person from any liability, duty, penalty, or punishment provided

by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful employment practice under this subchapter"); Americans with Disabilities Act, 42 U.S.C. § 12201(b) (2010) ("Nothing in this chapter shall be construed to invalidate or limit the remedies, rights, and procedures of any Federal law or law of any State or political subdivision of any State or jurisdiction that provides greater or equal protection for the rights of individuals with disabilities than are afforded by this chapter").

[124] Of course, it is not just the PPACA that states should be mindful of when constructing their own healthcare policies. The long arm of the Food and Drug Administration, the criminal enforcement jurisdiction of the Drug Enforcement Agency, and other interfering federal statutes all act as inhibitory mechanisms when it comes to state experimentation in health care innovation.

[125] PPACA § 1332 ("Wavier for State Innovation").

[126] Martin Wolf, WHY GLOBALIZATION WORKS 98 (2004).

[127] *Id.*

[128] *See supra* note 13.

[129] Buckeye Check Cashing v. Cardengna, 546 U.S. 440 (2006).

[130] Fiser v. Dell Computer Corp., 188 P.3d 1215, 1218 (N.M. 2008).

[131] Coady v. Cross Country Bank, 729 N.W.2d 732, 740 (Wis. Ct. App. 2007).

[132] Hubbert v. Dell Corp., 835 N.E.2d 113, 121 (Ill. App. Ct. 2005).

[133] *Id.* (citing AutoNation USA Corp. v. Leroy, 105 S.W.3d 190, 195 (Tex. App. 2003)).

[134] Scherer v. Schuler Custom Homes Const., 98 P.3d 159, 163 (Wyo. 2004).

[135] Vogt v. MBNA America Bank, 178 P.3d 405, 409 (Wyo. 2008).

[136] *See International Commercial Arbitration and Conciliation,* UNITED NATIONS COMM'N ON INT'L TRADE LAW, http://www.uncitral.org/uncitral/en/uncitral_texts/arbitration.html (last visited Nov. 4, 2011).

[137] 9 U.S.C. §§ 1–307 (2010).

[138] CAL. CIV. PROC. CODE §§ 1281.91, 1281.92, 1281.96 (2010).

[139] WYO. STAT. ANN.§ 1-36-103 (2010).

[140] Stewart Title Guar. Co. v. Tilden, 64 P.3d 739, 742 (Wyo. 2003).

[141] Lea Brilmayer, *Rights, Fairness, and Choice of Law*, 98 YALE L.J. 1277 (1989).

[142] 164 P.3d 537, 542–43(2007).

[143] *Id.* at 543 (citing Resource Technology Corp. v. Fisher Scientific Co., 924 P.2d 972, 975 (Wyo. 1996)).

[144] *See* Nuhome Investments v. Weller, 81 P.3d 940, 945 (Wyo. 2003) ("This court has often showed its commitment to uphold the right of competent parties to freely contract for various provisions. For instance, under appropriate circumstances we allow parties the freedom to contract for forum selection clauses, choices of law clauses, and we rarely get involved in the adequacy of consideration."). *See also* Durdahl v. Nat'l Safety Assocs., 988 P.2d 525, 527–28 (Wyo. 1999); Resource Technology Corp. v. Fisher Scientific Co., 924 P.2d 972, 975 (Wyo. 1996); Brodie v. General Chem. Corp., 934 P.2d 1263, 1268 (Wyo. 1997).

[145] Smithco Eng'g v. Int'l Fabricators, 775 P.2d 1011, 1018 (Wyo. 1989).

[146] WYO. STAT. ANN. § 1-1-109 (2010). Comparative fault restricts recovery to the actual responsibility of a particular defendant in tort actions where there are multiple defendants. Under traditional joint and several liability, one could recover the entire damage award from one defendant, even if his fault was minimal. Every state surrounding Wyoming has also adopted this reform.

[147] *See Doctors: 21 percent of medicine defensive*, UPI.COM, Feb. 22, 2010, http://www.upi.com/Health_News/2010/02/22/Doctors-21-percent-of-medicine-defensive/UPI-13011266817340/.

[148] In 2004, the people of Wyoming also considered Amendment C, which passed with 53% of the popular vote, and authorized legislature to pass laws that "mandate alternative dispute resolution or review by a medical review panel before filing of a civil action against the health care provider." H.J. Res. 0002, 57th Leg., Budget Sess. (Wyo. 2004), *available at* http://legisweb.state.wy.us/2004/enroll/HJ0011.pdf. The following year, Legislature enacted the Wyoming Medical Review Panel Act of 2005, which requires any claim against a health care provider to be filed with the Medical Review Panel before any complaint may be filed in court. WYO. STAT. ANN. §§ 9-2-1513–9-2-1523 (2010). Though mandatory for filing, proceeding in the panel may be waived by agreement between the plaintiff and defendant. WYO. STAT. ANN. § 9-2-1519(a) (2010). Most health care providers, the defendants, make such agreements. Michelle Dynes, *Medical Panel Hasn't Lowered Doctors' Costs*, WYO. TRIB. EAGLE, Jan. 31, 2010, at A1, *available at* http://www.allbusiness.com/government/government-bodies-offices-legislative/13827643-1.html. As a result, and perhaps due to a lack of other more substantial reforms, the Medical Panel has not lowered the cost of malpractice insurance or other costs. *Id.* However, Eric Easton, director of the Medical Review Panel, believes it may be too soon to judge the panel's effect. *Id. See also* Eric A. Easton, *Wyoming Health Review Panel*, WYO. LAWYER, Aug. 2009., *available at* http://www.wyomingbar.org/bar_journal/article.html?id=245. Beyond this, the state-run Medical Review Panel proves largely unnecessary for the effectuation of medical freedom in Wyoming: the state need only provide breathing space for alternative dispute resolution as agreed upon between private parties, which Wyoming precedent currently favors.

[149] *Wyoming Health Care Damage Limit, Question D (2004)*, BALLOTPEDIA.COM, http://www.ballotpedia.org/wiki/index.php/Wyoming_Constitutional_Amendment_D_%282004%29 (last visited Nov. 4, 2011).

[150] H.J. Res. 10001, 57th Leg., Budget Sess. (Wyo. 2004), *available at* http://legisweb.state.wy.us/2004/enroll/hj1003.pdf .

[151] WYO. CONST. art. 10, § 4(a).

[152] CONG. BUDGET OFFICE, THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES (2004), *available at* http://www.cbo.gov/doc.cfm?index=5549&type=0&sequence=1.

[153] *Id. See also* COLO. REV. STAT. § 13-21-102.5(3)(a) (2010); IDAHO CODE ANN. § 6-1603 (2010); MONT. CODE ANN. § 25-9-411 (2010).

[154] UTAH CODE ANN. § 78B-3-410 (2010).

[155] S.D. CODIFIED LAWS § 21-3-11 (2010).

[156] COLO. REV. STAT. §13-64-302(1)(b) (2010).

[157] NEB. REV. STAT. § 44-2825 (2010).

[158] Joseph Morton, *Medical Malpractice back on the Table?*, OMAHA WORLD-HERALD, Feb. 24, 2010, *available at* http://www.omaha.com/article/20100224/AP13/702249907.

[159] *See* EFFECTS OF TORT REFORM, *supra* note 152.

[160] Chad Baldwin, *Jury awards $1.2M in Lawsuit*, CASPER STAR TRIB., May 13, 2005, *available at* http://trib.com/news/article_92fbc7dc-aee2-578b-86ca-f301015c0b16.html.

[161] Michael F. Cannon, *Reforming Medical Malpractice Liability Through Contract* 3 (Cato Inst., Working Paper No. 3, 2010), *available at* http://www.cato.org/pub_display.php?pub_id=12552.

[162] *Id.* at 11–18.

[163] *Id.* at 18.

[164] *See* Haderlie v. Sondgeroth, 866 P.2d 703, 723 (Wyo. 1993).

[165] RESTATEMENT (SECOND) OF TORTS § 885 (1979) (emphasis added).

[166] IDAHO CODE ANN. § 6-1606 (2010).

[167] COLO. REV. STAT. § 13-21-111.6 (2010).

[168] MONT. CODE ANN. § 27-1-308 (2010).

[169] *See* EFFECTS OF TORT REFORM, *supra* note 152.

[170] *Collateral Source Rule – Unfair Tort Law?*, MD. INJURY & DISABILITY LAW, Jul. 9, 2009, http://www.mdinjurydisabilitylaw.com/2009/07/articles/personal-injury/collateral-source-rule-unfair-tort-law/.

[171] *See supra* note 151 and accompanying text.

[172] COLO. REV. STAT. § 13-21-102 (2010).

[173] COLO. REV. STAT. § 13-25-127 (2010).

[174] UTAH CODE ANN. § 78B-8-201 (2010).

[175] IDAHO CODE ANN. § 6-1604 (2010).

[176] MONT. CODE ANN. § 27-1-220(3) (2010).

[177] *See supra* note 152.

[178] Lawrence D. Wilson, *The Case Against Medical Licensing*, FUTURE OF FREEDOM FOUND., Jan. 1994, http://www.fff.org/freedom/0194d.asp.

[179] *See* MILTON FRIEDMAN, CAPITALISM AND FREEDOM (1962).

[180] *See, e.g.*, *Findings from the March 2004 National Sample Survey of Registered Nurses*, HEALTH RES. & SERV'S ADMIN., http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/ (last visited Nov. 4, 2011); *2004 Physician Assistant Census Report*, AM. ACAD. PHYSICIAN ASSISTANTS, http://www.aapa.org/about-pas/data-and-statistics/aapa-census/2004-data (last visited Nov. 4, 2011).

[181] Shirly Svorny, *Medical Licensing: An Obstacle to Affordable, Quality Care*, POL'Y ANALYSIS (Cato Institute, Washington, D.C.), Sept. 17, 2008, *available at* http://www.cato.org/pubs/pas/pa-621.pdf.

[182] *Id.*

[183] *State Specific Requirements for Initial Medicine Licensure*, FEDERATION OF STATE MEDICAL BOARDS, http://www.fsmb.org/usmle_eliinitial.html (last visited Nov. 4, 2011).

[184] *See* WYOMING BOARD OF MEDICINE RULES AND REGULATIONS, *available at* http://wyomedboard.state.wy.us/pdf/BOM%20Rules%20August%202009.pdf.

[185] *Frequently Asked Questions*, COUNCIL ON NATUROPATHIC MEDICINE, http://www.cnme.org/faq.html (last visited Nov. 4, 2011).

[186] *See WWAMI Program*, U. WASH. MEDICINE, http://uwmedicine.washington.edu/Education/WWAMI/Pages/default.aspx (last visited Nov. 4, 2011).

[187] *See* WYO. STAT. ANN. § 18-12-101–140 (2010).

[188] WYO. STAT. ANN. §§ 18-12-112(a)(xxi), 18-12-137 (2010).

[189] *See, e.g.*, MD. CODE ANN. CORPS. & ASS'NS art. 23A, §2(35) (2010); ARIZ. REV. STAT. § 48-575 (2010); 53 PA. STAT. ANN. § 302 (2010).

[190] *See* Heather Barr, *More Like Disneyland: State Action, 42 U.S.C. § 1983, and Business Improvement Districts in New York*, 28 COLUM. HUM. RTS. L. REV. 393, 395 (1997).

[191] Dan Finnigan, *Private Efforts to Clean Up Downtowns May Sweep America*, L.A. TIMES, June 25, 1992, at A5, *available at* http://articles.latimes.com/1992-06-25/news/mn-1574_1_city-district.

[192] Richard Briffault, *A Government for our Time? Business Improvement Districts and Urban Governance*, 99 COLUM. L. REV. 365, 372 (1999) (internal citations omitted).

[193] *Id.*

[194] *See* Mississippi Business Improvement Districts Act, MISS. CODE ANN. §§ 21-43-101–133 (2010).

[195] MISS. CODE ANN. § 21-43-111 (2010).

[196] *See* WYO. STAT. ANN. § 16-12-103 (2010).

[197] *See* WYO. STAT. ANN. § 18-12-101–140 (2010).

[198] WYO. STAT. ANN. § 18-12-103(a)(i) (2010).

[199] WYO. STAT. ANN. § 18-12-106 (2010).

[200] *See, e.g.*, WYO. STAT. ANN. §§ 18-12-120–139 (2010).

[201] WYO. CONST. art. 7, §20.

[202] United States v. Mazurie, 419 U.S. 544, 557 (1975).

[203] United States v. Kagama, 118 U.S. 375, 381–82 (1886); McClanahan v. Arizona State Tax Comm'n, 411 U.S. 164, 173 (1973).

[204] Montana v. United States, 450 U.S. 544, 564 (1981).

[205] White Mountain Apache Tribe v. Bracker, 448 U.S. 136, 141–45 (1980).

[206] McClanahan v. State Tax Comm'n, 411 U.S. 164 (1973); California v. Cabazon Band of Mission Indians, 480 U.S. 202 (1987).

[207] *See, e.g.*, Worcester v. Georgia, 31 U.S. 515 (1832); Brendale v. Yakima Indian Nation, 492 U.S. 408 (1989); Duro v. Reina, 495 U.S. 696 (1990).

[208] *See supra* section II.

[209] Robert N. Clinton, *There is no Federal Supremacy Clause for Indian Tribes*, 34 ARIZ. ST. L. J. 113 (2002).

[210] United States v. Wheeler, 435 U.S. 313 (1978).

[211] United States v. Mazurie, 419 U.S. 544, 557 (1975).

[212] *See* Antoine v. Washington, 420 U.S. 194, 201–02 (1975).

[213] *See* United States v. Sioux Nation, 448 U.S. 371, 415–16 (1980).

[214] *See* United States v. Mitchell, 463 U.S. 206, 225 (1983).

[215] *See generally* Reid P. Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213 (1975).

[216] 18 U.S.C. § 1153 (2010). The Indian Major Crimes Act was passed in response to *Ex Parte Crow Dog*, 109 U.S. 556 (1883), where the Supreme Court held that a federal court lacked jurisdiction to try an Indian for the murder of another Indian.

[217] The Indian Civil Rights Act, 25 U.S.C. §§ 1301–03 (2010), limits tribal court punishments to the maximum of six months imprisonment or a $500 fine.

[218] *Id.*

[219] Nat'l Labor Relations Bd. v. Pueblo of San Juan, 280 F.3d 1278, 1284 (10th Cir. 2000).

[220] *See* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 210–11 (Nell Jessup Newton ed., 2005).

[221] *See, e.g.*, Safe Drinking Water Act, 42 U.S.C. §§ 300f–300j (2010); Civil Rights Act of 1964, 42 U.S.C. § 2000e-1–17 (2010); Americans with Disabilities Act of 1990, 42 U.S.C. § 12111–12300 (2010).

[222] Chayoon v. Chao, 355 F.3d 141, 143 (2d Cir. 2004); Curtis v. Sandia Casino, 67 Fed. Appx. 576, 577 (10th Cir. 2003).

[223] Florida Paraplegic Ass'n v. Miccoskee Tribe of Indians of Florida, 166 F.3d 1126 (11th Cir. 1999); U.S. Dep't of Labor v. Occupational Safety & Health Rev. Comm'n, 935 F.2d 182 (9th Cir. 1991).

[224] Kiowa Tribe of Okla. v. Mfg. Tech., Inc. 523 U.S. 751, 755 (1998) ("There is a difference between the right to demand compliance with laws and the means available to enforce them.").

[225] 25 U.S.C. § 1303 (2010).

[226] *See, e.g.*, Santa Clara Pueblo v. Martinez, 436 U.S. 49 (1978).

[227] 25 U.S.C. § 476 (2010); United States v. Quiver, 241 U.S. 602 (1916).

[228] Plains Commerce Bank v. Long Family Land & Cattle Co., 554 U.S. 316 (2008).

[229] *See, e.g.,* Kerr-McGee Corp. v. Navajo Tribe, 471 U.S. 195, 201 (1985); Duro v. Reina, 495 U.S. 676, 696–97 (1990); Fisher v. Dist. Court of Sixteenth Judicial Dist. of Montana, 424 U.S. 382, 387–89 (1976) (*per curiam*).

[230] *Plains Commerce Bank*, 554 U.S. at 328.

[231] Atkinson Trading Co. v. Shirley, 532 U.S. 645, 651 (2001).

[232] *Montana*, 450 U.S. at 565.

[233] *Plains Commerce Bank*, 554 U.S. at 329; *see also Montana*, 450 U.S. at 566 ("A tribe may regulate, through taxation, licensing, or other means, the activities of nonmembers who enter consensual relationships with the tribe or its members, through commercial dealing, contracts, leases, or other arrangements.").

[234] *Plains Commerce Bank*, 554 U.S. at 329–30.

[235] Matthew L.M. Fletcher, *Resisting Federal Courts on Tribal Jurisdiction*, 81 U. COLO. L. REV. 973 (2010).

[236] *See* NAVAJO NATION CODE ANN. tit. 7, §253(a)(3)(2010).

[237] *See, e.g.*, MacArthur v. San Juan County, 497 F.3d 1057 (10th Cir. 2007).

[238] This is not to say that the legal or equitable remedies offered must be uniform. Indeed, one advantage of medical freedom zones is the capacity of individuals to contract for an individually acceptable amount of liability coverage for a particular procedure or transaction. Some patients may demand higher liability protection, and pay more, while others may elect affordability with lesser liability coverage.

[239] Jessica Silver-Greenberg, *Payday Lenders Join With Indian Tribes*, WALL ST. J., Feb. 10, 2011, *available at* http://online.wsj.com/article/SB10001424052748703716904576134304155106320.html.

[240] *Id.*

[241] Kiowa Tribe of Okla. v. Mfg. Techs., Inc., 523 U.S. 751 (1998) (tribe enjoyed sovereign immunity defense against suit on promissory note regardless of whether the note was signed on or off the reservation); Santa Clara Pueblo v. Martinez, 436 U.S. 49 (1978) (suits against tribes under the Indian Civil Rights Act are barred by tribal sovereign immunity).

[242] Federal courts have applied the "arm of the tribe" analysis in exempting tribal entities from federal laws. *See, e.g.*, Pink v. Modoc Indian Health Project, 157 F.3d 1185 (9th Cir. 1998); Dillon v. Yankton Sioux Tribe Housing Auth., 144 F.3d 581 (8th Cir. 1998).

[243] Cash Advance & Preferred Cash Loans v. Colorado, 242 P.3d 1099 (Colo. 2010).

[244] *See* Kiowa Tribe v. Manufacturing Technologies, Inc., 523 U.S. 751 (1998).

[245] *Id.*

[246] *See* Puyallup Tribe v. Dep't of Game of the State of Wash., 433 U.S. 165, 171 (1977).

[247] Ninigret Dev. Corp. v. Narragansett Indian Wetuomuck Housing Auth., 207 F.3d 21, 31–32 (1st Cir. 2000); *see also* Crawford v. Genuine Parts Co., 947 F.2d 1045 (9th Cir. 1991).

[248] *Kiowa Tribe*, 523 U.S. at 756.

[249] 25 U.S.C. § 2702 (2010).

[250] Kathryn R. L. Rand, *There are no Pequots on the Plains: Assessing the Success of Indian Gaming*, 5 CHAPMAN L. REV. 47 (2002).

[251] Steven Andrew Light & Kathryn R. L. Rand, *Reconciling the Paradox of Tribal Sovereignty: Three Frameworks for Developing Indian Gaming Law and Policy*, 4 NEV. L. J. 262, 266 (2004).

[252] FEDERAL COMMUNICATIONS COMM'N, STATEMENT OF POLICY ON ESTABLISHING A GOVERNMENT-TO-GOVERNMENT RELATIONSHIP WITH INDIAN TRIBES 4–5, FCC-00-207, (June 23, 2000), *available at* http://www.ncai.org/fileadmin/governance/FCC_Tribal_Policy.PDF.

[253] FEDERAL-STATE JOINT BD. ON UNIVERSAL SERVICE, TWELFTH REPORT & ORDER, MEMORANDUM OPINION & ORDER, & FURTHER NOTICE OF PROPOSED RULEMAKING, 15 FCC Rcd. 12,208 ¶ 124 (Jun. 8, 2000), *available at* http://www.universalservice.org/_res/documents/about/pdf/fcc-orders/2000-fcc-orders/FCC-00-208.pdf.

[254] 25 U.S.C. § 450a (2010).

[255] 25 U.S.C. § 450f (2010) (recognizing the right of Indian tribes to enter into self-determination contracts with the federal government for tribal assumption of select federal programs). *See also* Cherokee Nation of Oklahoma v. Leavitt, 543 U.S. 631 (2005).

[256] Southern Ute Indian Tribe v. Leavitt, 497 F. Supp. 2d 1245 (D. N.M. 2007) (government's acceptance of tribal agreement to assume responsibility and self-determination for internal health care management is ministerial in nature); *Cherokee Nation of Oklahoma*, 543 U.S. 631 (government is obliged to honor its contractual obligations under the ISDEAA even where funds have not been appropriated).

[257] Comstock Oil & Gas, Inc. v. Alabama and Coushatta Indian Tribes of Texas, 261 F.3d 567 (5th Cir. 2001); Tenneco Oil Co. v. Sac & Fox Tribe of Indians of Oklahoma, 725 F.2d 572 (10th Cir. 1984).

[258] *Comstock*, 261 F.3d at 575.

[259] *Mohican Political Feud Heats Up Again*, WIS. ST. J., Dec. 22, 1994, at 3B; *Federal Mediator to Help in Tribal Dispute*, WIS. ST. J., Mar. 8, 1994, at 3B.

[260] Kathryn R. L. Rand & Steven A. Light, *Virtue or Vice? How IGRA Shapes the Politics of Native American Gaming, Sovereignty, and Identity*, 4 VA J. SOC. POL'Y & L. 381, 421 (1997).

[261] At the same time, it remains feasible to construct a dualistic health care system within tribal nations. That is, most tribal nations receive a variety of health care funding streams from the federal government. It is possible to retain those programs so long as the tribe in question erects a "Chinese Wall" of sorts between wholly private medical freedom zones that play no role in the federal regulatory structure and federal programs operating within tribal boundaries.

[262] *Santa Clara Pueblo*, 436 U.S. at 57 (internal citations omitted).

[263] 25 U.S.C. § 1302 (2010).

[264] Martinez v. Santa Clara Pueblo, 402 F. Supp. 5, 18–19 (D. N.M. 1975), rev'd, 540 F.2d 1039 (10th Cir. 1976), rev'd, 436 U.S. 49 (1978).

[265] Indian Intercourse Act, 4 Stat. 729 (1834).

[266] 70 U.S. (3 Wall.) 407, 417 (1865).

[267] 435 U.S. 191 (1978).

[268] 25 U.S.C. § 1301(2) (2010).

[269] 18 U.S.C. § 1153 (2006).

[270] This remains problematic because of the Food and Drug Administration's prohibition of access to many experimental medicines and procedures. *See, e.g.*, *Abigail Alliance*, 445 F.3d 470.

[271] *See, e.g.*, Ann E. Tweedy, *Connecting the Dots Between the Constitution, the Marshall Trilogy, and* United States v. Lara*: Notes Toward a Blueprint for the Next Legislative Restoration of Tribal Sovereignty*, 42 U. MICH. J.L. REFORM 651 (2009); Marie Quasius, Note, *Native American Rape Victims: Desperately Seeking an* Oliphant-*Fix*, 93 MINN. L. REV. 1902 (2009).

[272] *See The Needs and Challenges of Tribal Law Enforcement on Indian Reservations: Oversight Field Hearing Before the H. Comm. on Natural Resources*, 110th Cong. 7 (2007), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:36020.pdf.

[273] *See, e.g.*, In re Garvais, 402 F. Supp. 2d 1219 (E.D. Wash. 2004).

[274] *See, e.g.*, Wetsit v. Stafne, 44 F.3d 823 (9th Cir. 1995) (acknowledging that tribes have not surrendered their concurrent authority to prosecute crimes); United States ex rel Standing Bear v. Crook, 25 F. Cas. 695 (D. Neb. 1879) (jurisdictional power will not cease to exist because of non-use).

[275] For example, for the designation of "major crimes" occurring on tribal land by Indians against Indians, concurrent federal and tribal jurisdiction exists. *See* Indian Major Crimes Act, 18 U.S.C. §1153 (2010). Tribes have retained their sovereignty to prosecute exclusively "non-major" crimes by Indians against Indians. When it comes

to crimes by non-Indians against non-Indians on tribal land, state jurisdiction is often employed. *See* United States v. McBratney, 104 U.S. 621 (1882).

[276] Alex Tallchief Skibine, United States v. Lara, *Indian Tribes, and the Dialectic of Incorporation*, 40 TULSA L. REV. 47 (2004).

[277] Poodry v. Tonawanda Band of Seneca Indians, 85 F.3d 874, 880–81 (2d Cir. 1996).

[278] United States v. James, 980 F.2d 1314 (9th Cir. 1992), *cert. denied*, 510 U.S. 838 (1993). Indeed, construction of the Indian Major Crimes Act has varied among federal courts. *See* United States v. Petersen, 622 F.3d 196 (3d Cir. 2010) (since IMCA did not specify simple assault as one of the crimes to which federal jurisdiction would attach, no jurisdiction could be had).

[279] United States v. Velarde, 40 F. Supp. 2d 1314 (D. N.M. 1999) (permitting a subpoena to be enforced within tribal land under the Indian Major Crimes Act).

[280] *See, e.g.*, Catskill Development v. Park Place Entertainment Corp., 206 F.R.D. 78 (S.D.N.Y. 2002).

[281] One major point of unexplored controversy is defining the exact scope of federal criminal offenses deemed applicable on tribal lands. Generally, the Enclave Act and the IMCA control this determination, but some courts have given this question a more expansive interpretation. For example, the Seventh Circuit Court of Appeals determined that other federal criminal offenses might be prosecutable on tribal land even if they were not mentioned in the Enclave Act or the IMCA. *United States v. Brisk*, 171 F.3d 514 (7th Cir. 1999). There, the court held that the "federal government has a significant interest in nationwide enforcement of its anti-drug laws" and upheld the power of the federal government to enforce federal anti-drug laws on tribal land. *Id.* at 521–22. The Eighth Circuit reached a similar result in *United States v. Blue*, 722 F.2d 383 (8th Cir. 1983). These opinions remain in opposition to the Supreme Court's holding in *United States v. Quiver*, 241 U.S. 602 (1916). In that challenge, the Supreme Court held that because federal criminal statutes did not include adultery or bigamy in its purview, no such jurisdiction could be extended to tribal lands. Whether *Quiver* is still reliable precedent remains to be seen, and tested.

[282] United States v. White, 508 F.2d 453, 455 (8th Cir. 1974).

[283] Suzianne D. Painter-Thorne, *If You Build it, They Will Come: Preserving Tribal Sovereignty in the Face of Indian Casinos and the New Premium on Tribal Membership*, 14 LEWIS & CLARK L. REV. 311 (2010).

[284] *See, e.g.*, Arviso v. Norton, 129 F. App'x 391 (9th Cir. 2005); Lewis v. Norton, 424 F.3d 959 (9th Cir. 2005).

[285] *See Comstock*, 261 F.3d 567.

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