HEALTH CARE COST CONTAINMENT: NO LONGER AN OPTION BUT A MANDATE

Susan Adler Channick*

I. THE PROBLEM: THE UNSUSTAINABLE TRAJECTORY OF HEALTH CARE COSTS

The growth in health care costs in the United States in the past two decades has been staggering and extraordinarily burdensome not only to the federal and state governments but also to employers and individuals who purchase their health insurance in the private market. In 2009, national health expenditures ("NHE") in the United States grew by 4% to $2.5 trillion, or $8,086 per capita, and accounted for 17.6% of gross domestic product ("GDP").[1] According to the Office of the Actuary at the Centers for Medicare and Medicaid Services ("CMS"), growth in NHE is expected to increase an average of 5.7% per year over the period of 2011–2021, and to account for 19.6% of overall spending by 2021[2] and almost 50% of overall spending by 2082.[3] These predictions are troubling not only because the United States already spends more than one-sixth of GDP on health care but perhaps, more importantly, because growth in health care costs substantially outstrips both GDP growth[4] and real earnings.[5] This excess growth of health care costs over economic growth levies unsustainable burdens on all health care payers includ-

* Professor of Law, California Western School of Law; B.A., Cornell University; J.D., California Western School of Law; M.P.H., Harvard University School of Public Health.

[1] Julie A. Schoenman & Nancy Chockley, *Understanding U.S. Health Care Spending*, NAT'L INST. FOR HEALTH CARE MGMT. FOUND. (July 2011), http://nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf.

[2] Sean P. Keehan et al., *National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates*, 31 HEALTH AFF. 1600, 1600 (2012).

[3] CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 12–13 (2007), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8758/11-13-lt-health.pdf.

[4] *Id.* at 13; *see also* JOHN HOLAHAN ET AL., URBAN INST. HEALTH POLICY CTR., CONTAINING THE GROWTH OF SPENDING IN THE U.S. HEALTH SYSTEM 1 (2011), *available at* http://www.urban.org/uploadedpdf/412419-Containing-the-Growth-of-Spending-in-the-US-Health-System.pdf. A chart on the Trading Economics website demonstrates that GDP growth in the United States is projected to be at three percent for the first quarter 2012. *United States GDP Growth Rate*, TRADING ECON., http://www.tradingeconomics.com/united-states/gdp-growth (last visited Apr. 23, 2013). In the previous twenty quarters, only five had growth greater than or equal to three percent. *Id.*

[5] SYLVESTER J. SCHIEBER ET AL., SOC. SEC. ADVISORY BD., THE UNSUSTAINABLE COST OF HEALTH CARE 3 (2009), *available at* http://www.ssab.gov/Documents/TheUnsustainableCostofHealthCare_graphics.pdf.

ing the federal and state governments, employers, and health care consumers who are increasingly sharing the burden of rising costs.

According to a recent report by the Urban Institute Health Policy Center, four major and interrelated reasons are the significant drivers of the persistent rise in health care costs in excess of economic growth.[6] The first is over-insurance due to the favorable tax treatment of employer-sponsored insurance to which approximately fifty-eight percent of non-elderly Americans have access.[7] The second is "the development and dispersion of medical technology."[8] The third reason is the "increasing prevalence of chronic disease," which tends to be very expensive to treat and consumes a large share of health care costs.[9] The fourth is the consolidation and market power of health care providers and insurers.[10] As will be discussed, the Patient Protection and Affordable Care Act ("ACA"), enacted in March 2010 but not fully implemented until 2014, addresses some of these issues and attempts to mitigate their effects, but does so incompletely. According to many health policy experts, the ACA is limited in its efforts to contain health care spending, and either does not address certain issues at all or does so insufficiently. The process of finding successful ways to contain health care costs without jeopardizing access to care and quality of care is only in its infancy.

The excess of growth in health care costs over GDP is particularly dire for public insurance programs such as Medicare, Medicaid, and the Children's Health Insurance Program because, historically, Congress has not allocated more than eighteen percent of GDP for federal spending.[11] Entitlement programs such as Medicare and Medicaid mandate that the federal government spend whatever is required to provide benefits to those entitled to receive those benefits—the elderly, disabled, and deserving poor, including children. If the federal budget falls short of legislated demands on the public fisc, Congress has few choices: it can reduce benefits or beneficiaries, it can find ways to raise additional revenue,[12] or it can borrow to meet the demands. In the recent past, these options generally have been resolved in favor of borrowing, resulting in

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6 HOLAHAN ET AL., *supra* note 4, at 1.

7 *Id.*; *see also* TAX POL'Y CTR., THE TAX POLICY BRIEFING BOOK II-5-8 (2008), *available at* http://www.taxpolicycenter.org/briefing-book/TPC_briefingbook_full.pdf.

8 HOLAHAN ET AL., *supra* note 4, at 1; *See generally* DANIEL CALLAHAN, TAMING THE BELOVED BEAST: HOW MEDICAL TECHNOLOGY COSTS ARE DESTROYING OUR HEALTH CARE SYSTEM 31, 68–69 (2009).

9 HOLAHAN ET AL., *supra* note 4, at 1; ROSS DEVOL ET AL., MILKEN INST., AN UNHEALTHY AMERICA: THE ECONOMIC BURDEN OF CHRONIC DISEASE i (2007).

10 HOLAHAN ET AL., *supra* note 4, at 1.

11 Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1719 (2010).

12 CONG. BUDGET OFFICE, UPDATED BUDGET PROJECTIONS: FISCAL YEARS 2012 TO 2022, at 3–4 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/March2012Baseline.pdf. The Congressional Budget Office's (CBO) updated budget projections for fiscal years 2012 to 2022 estimate that federal revenues as a share of GDP will rise in 2012 and 2013 because of the "scheduled expirations of tax provisions—such as those that reduce income and payroll tax rates and limit the reach of the alternative minimum tax (AMT) . . . ." *Id.* at 1. Revenues will continue to rise relative to GDP largely because increases in taxpayers' real income will push more income into higher tax brackets as well as making more taxpayers subject to the AMT. *Id.*

an ever-growing federal debt of approximately $15 trillion, an amount that equals the size of the U.S. economy.[13]

More recently, however, fiscal conservatives led by Tea Party congressional freshmen have managed to hold the federal government hostage to their demands to balance the federal budget without additional revenue sources, either by raising the debt ceiling or by increasing taxes.[14] In particular, the House of Representatives' insistence on balancing the budget by relying on spending cuts alone threatens federal entitlement programs, particularly health insurance programs such as Medicare and Medicaid in which rising health care costs continue to burden federal spending. The dilemma in the public sector is how to keep health insurance safety net programs vibrant within reasonable budgetary constraints. If the debt crisis in the European Union provides the United States with lessons, one may be that too much austerity too fast is bad medicine.[15] Certainly Keynesian economists would advocate spending into a recession over stringent economizing in order to create jobs and grow the economy.[16] However, in times of slow economic growth coupled with a Republican mandate to neither increase taxes nor raise the debt ceiling, the choices in the public sector are few. One possible scenario is that Congress allocates less public money to federal and state health care entitlement programs. Lower reimbursement to providers in public insurance programs incentivizes physicians to, at least, prefer commercial insurance over public insurance and jeopardizes the care of vulnerable populations such as the elderly, the poor, and children.

Rising health care costs have an adverse effect on the private insurance market as well. A new study by the Kaiser Family Foundation that tracks employer-sponsored health insurance shows the average annual premium for family coverage in 2011 reached $15,073, an increase of nine percent over the previous year.[17] The study indicates that the cost of family coverage has almost doubled in just one decade.[18] As private insurers raise premium rates to meet the projected costs of health care, the burden of rising premiums falls on employers who often shift the rise in costs to employees. It is projected that rising private health insurance premiums will have an adverse effect on wage

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[13] Richard Wolf, *U.S. Debt Is Now Equal to Economy*, USA TODAY, Jan. 9, 2012, at A1.

[14] *See Federal Debt Ceiling*, N.Y. TIMES TOPICS, http://topics.nytimes.com/topics/reference/timestopics/subjects/n/national_debt_us/index.html (last visited Apr. 23, 2013).

[15] *See* Elaine Ganley & Greg Keller, *France President-Elect Hollande Has Full Plate*, FOXNEWS (May 7, 2012), http://www.foxnews.com/world/2012/05/07/hollande-defeats-sarkozy-5162-pct-to-4838-pct. On May 7, 2012, Socialist Francois Hollande was elected the new French president, defeating incumbent conservative Nicolas Sarkozy. He officially becomes the new French president on May 15, 2012. A leftist, Hollande has vowed to buck Europe's austerity trend. *Id.*

[16] *See, e.g.*, PAUL KRUGMAN, END THIS DEPRESSION NOW! 25, 117 (2012).

[17] KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 1 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf; *see also* Reed Abelson, *Health Insurance Costs Rising Sharply This Year, Study Shows*, N.Y. TIMES, Sept. 28, 2011, at A1, http://www.nytimes.com/2011/09/28/business/health-insurance-costs-rise-sharply-this-year-study-shows.html (referencing the Kaiser Family Foundation study).

[18] KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 14 (2012), *available at* http://ehbs.kff.org/pdf/2012/8345.pdf.

growth as well as the standard of living that individuals will be able to afford.[19] Slower wage growth not only affects individuals' standard of living but also contributes to a shrinking federal tax base, which, in turn, negatively impacts the share of national income that can be devoted to goods and services other than health care.[20]

The cost-shifting solution to the rise in health care costs in the private sector is no more a real solution to the problem than U.S. Congressman Paul Ryan's (R-WI) "Roadmap for America's Future."[21] Congressman Ryan, chair of the House of Representatives Committee on the Budget, has advocated that Medicare be redesigned from an insurance program to a premium support program in order to shift the risks of the rising costs of health care from the federal government to Medicare beneficiaries.[22] Although it is certainly true that cost shifting results in a decrease in health care costs for the payers (i.e., governments in the public insurance arena, and employers, individuals, and private insurers in the private insurance market), it surely does not result in any real reduction in health care costs. Cost shifting, as the term so clearly indicates, only shifts the burden of costs onto beneficiaries who are becoming increasingly unable to afford the rising costs of health care.[23]

Congressman Ryan's reintroduced proposal has been advertised as a "kinder, gentler form of premium support."[24] In addition to shifting the rising costs of health care from the federal government to Medicare beneficiaries,

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[19] HOLAHAN ET AL., *supra* note 4, at 5.

[20] *Id.*; *see also* JONATHAN GRUBER & IAN PERRY, BLUE CROSS BLUE SHIELD OF MASS. FOUND., BENEFITS OF SLOWER HEALTH CARE COST GROWTH FOR MASSACHUSETTS EMPLOYEES AND EMPLOYERS 1 (2012), *available at* http://www.wbur.org/files/2012/04/0426_health-care-cost-report.pdf.

[21] *See generally* PAUL D. RYAN, A ROADMAP FOR AMERICA'S FUTURE (2010), *available at* http://roadmap.republicans.budget.house.gov/uploadedfiles/roadmap2final2.pdf. *See also* PAUL RYAN, HOUSE COMM. ON THE BUDGET, THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE (2011) [hereinafter RYAN, THE PATH TO PROSPERITY], *available at* http://budget.house.gov/uploadedfiles/pathtoprosperityfy2012.pdf.

[22] *Proposed Budget Ends Medicare and Medicaid Programs As We Know Them*, 3 MEDICARE WATCH (Mar. 22, 2012), http://www.medicarerights.org/issues-actions/medicare-watch-archive/2012-11.php. Although Congressman Ryan's "Roadmap for America's Future" failed to win enough votes in the Senate, Ryan has recently reintroduced the proposal that converts Medicare from a true health insurance program to a premium support program, giving Medicare beneficiaries "a set payment to purchase coverage from a private insurance company or from Original Medicare," (i.e., the traditional fee-for-service Medicare insurance system for people sixty-five and older). *Id.* Ryan's proposal also converts Medicaid from an entitlement health insurance program under which the federal and state governments jointly fund the program to one in which the federal government's contribution is in the form of a block grant (i.e., is capped at a certain amount regardless of the number of state residents who are eligible for enrollment in their state Medicaid program). Block grants will have the effect of shifting any additional cost of care from the federal government to the states and/or Medicaid beneficiaries. *Id.* As discussed in the text, cost shifting, while benefiting the federal budget, will have no effect on the total cost of health care.

[23] *See* JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., RESTRUCTURING MEDICARE'S BENEFIT DESIGN: IMPLICATIONS FOR BENEFICIARIES AND SPENDING 2 (2011), *available at* http://www.kff.org/medicare/upload/8256.pdf.

[24] PAUL N. VAN DE WATER, CTR. ON BUDGET & POLICY PRIORITIES, WHAT YOU NEED TO KNOW ABOUT PREMIUM SUPPORT 1 (2012), *available at* http://www.cbpp.org/files/3-19-12health.pdf.

many believe that Ryan's budget resolution will weaken original Medicare—the traditional fee-for-service health insurance program for people sixty-five and older that has been the hallmark of the Medicare program since 1965.[25] The proposal contemplates a health insurance marketplace where Medicare beneficiaries can use the premium support voucher to either purchase a policy in the private market or purchase coverage from original Medicare. Private market insurers will be given wide flexibility in their benefit design and can therefore attract healthier Medicare beneficiaries who might prefer health insurance that is less comprehensive and concomitantly less expensive.[26] Such a design inevitably creates an adverse selection cycle in which less-healthy Medicare beneficiaries with serious health conditions disproportionately enroll in original Medicare causing it to incur higher costs because of the higher need and demand for health care resources. The end result may be the classic adverse selection death spiral: the premium costs will rise for all Medicare beneficiaries enrolled in original Medicare.[27] In addition to having to pay higher premiums in original Medicare, Congressman Ryan's budget resolution does nothing to contain the spiraling real costs of health care.

The myriad of attempts to shift the costs of health care from governments to individuals must not distract those who make public policy from continuing research, data collection, and public conversations about cost containment in the health care arena. Without real cost containment, we can anticipate a number of untenable scenarios may occur. According to the Centers for Medicare and Medicaid Services ("CMS"), by 2018, national health expenditures "will be over $4.3 trillion, or $13,100 per resident, and account for 20.3% of GDP."[28] If CMS projections are accurate, in a single decade, national health expenditures will account for one-fifth of all spending in the United States. More importantly, perhaps, is the fact that during that period, health care spending will have grown at the average annual rate of 6.2%, a growth rate substantially greater than the average projected growth in real GDP during the same period.[29]

There is some consensus about what drives rising health care costs. The opinion of many experts is that rising health care costs are more highly attributable to intense per capita spending than usage by a larger segment of the popu-

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[25] Marilyn Werber Serafini, *New Ryan Budget Would Transform Medicare and Medicaid*, KAISER HEALTH NEWS (Mar. 20, 2012), http://www.kaiserhealthnews.org/stories/2012/march/20/ryan-budget-medicare-medicaid-republicans.aspx.

[26] *Id.*

[27] *Id.*

[28] *Trends in Health Care Costs and Spending*, KAISER FAM. FOUND. (Mar. 2009), www.kff.org/insurance/upload/7692_02.pdf.

[29] Andrea Sisko et al., *Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook*, 28 HEALTH AFF. w346, w346 (2009). The Congressional Budget Office forecast for average real GDP growth from 2011 to 2017 is 2.4%, substantially less than the projected average growth rate in health care costs during the same period. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2012 TO 2022, at 43 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf.

lation accessing health care.[30] If the per capita evidence is correct, then universal access is not nearly as contributory to higher health care costs as is overutilization. Higher per capita spending, in turn, is attributed to a number of factors: expensive technology such as constantly improving imaging techniques; the rising incidence of chronic disease; aging and increased longevity of the population leading to increased prevalence of people with multiple chronic diseases; obesity in both the adult and children population; use of expensive pharmaceuticals to treat various chronic diseases; increased success in genomic research and attendant treatments for rare diseases; perverse reimbursement systems, particularly in the public insurance system, that incentivize quantity over quality; and a fragmented health care delivery system that often fails to successfully manage the care of the relatively small percentage of the population that consumes the lion's share of health care resources.[31]

Although these projections of growth in health care spending are ominous for the private sector with respect to the cost of health insurance premiums and the concomitant burdens on payers and insureds, the problems of the public sector have taken a political front seat. As has been noted by many health policy experts, the cost of entitlement programs, such as Medicare and Medicaid, creates a disproportionately high financial burden on governments.[32] The states, constitutionally required to balance their budgets, struggle to do so under the ever-increasing burden of the costs of Medicaid and the Children's Health Insurance Program.[33] The federal government, which can and regularly does deficit spend, particularly because of the growth in entitlement programs,[34] does so at the expense of federal debt.[35] Currently, the public and legislative concerns over a rising federal debt cannot be underestimated particularly in light of slower economic growth that is anticipated until approximately 2018.[36]

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30 Charles S. Roehrig & David M. Rousseau, *The Growth in Cost per Case Explains Far More of US Health Spending Increases than Rising Disease Prevalence*, 30 HEALTH AFF. 1657, 1657 (2011).

31 *See* HOLAHAN ET AL., *supra* note 4, at 1, 6–8.

32 *E.g.*, Susan A. Channick, *Taming the Beast of Health Care Costs: Why Medicare Reform Alone Is Not Enough*, 21 ANNALS HEALTH L. 63, 71 (2012).

33 *See* CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: WHERE DO OUR FEDERAL TAX DOLLARS GO? (2012), *available at* http://www.cbpp.org/files/4-14-08tax.pdf.

34 JOHN HOLAHAN & STACEY MCMORROW, URBAN INST., MEDICARE, MEDICAID AND THE DEFICIT DEBATE: TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES 9 (2012), *available at* www.urban.org/UploadedPDF/412544-Medicare-Medicaid-and-the-Deficit-Debate.pdf. The authors of this report argue that, with regard to public insurance programs such as Medicare and Medicaid, increases in enrollment have a significant effect on spending in these programs. While per capita spending is not projected to exceed per capita growth, the combined effect of both per capita spending as well as increased enrollment does drive up the cost of public insurance in excess of projected per capita growth. Therefore, in order to contain costs to the rate of GDP growth, proposals to limit overall spending must be explored. *Id.* at 1.

35 *See* JONATHAN HUNTLEY, CONG. BUDGET OFFICE, FEDERAL DEBT AND THE RISK OF A FISCAL CRISIS 1 (2010). The Congressional Budget Office has predicted that, absent change, U.S. public debt level will grow from its current sixty-two percent of GDP to ninety percent of GDP by 2020. *Id.* at 2–3.

36 *But see generally* KRUGMAN, *supra* note 16. Krugman argues that if Keynesian economics got us out of the depression of the 1930s, it can get us out of today's depression. *Id.* at xi. Since Keynesian economics dictates stimulus, not austerity measures, Krugman would have

Making changes that will significantly affect health care costs creates an enormous challenge, particularly with respect to maintaining high quality outcomes. Such methods must be palatable to politicians who serve constituencies that display a voracious demand for cutting edge technology and expensive pharmaceuticals without much awareness of costs. Insured Americans have grown accustomed to an overabundance of supply and heavily subsidized employer-sponsored insurance policies. Cost containment strategies must be acceptable to providers who too are relatively indifferent to costs and have, at the same time, become significantly more successful and powerful in their efforts to negotiate reimbursement with insurers.[37] With respect to for-profit players in the health care market, creating disincentives for unlimited profit margins is difficult and antithetical in a for-profit system. Finally, finding ways to enlist the various disparate constituencies in the quest of meaningful and fair health care cost containment policies will require significantly more empirical data and political will than currently exists.

In addition to the foregoing challenges, the inability of policymakers in Washington to tell the American people that we cannot afford every intervention that modern medicine can provide makes it impossible to have reasonable and reasoned public discourse about allocation of expensive health care resources. Both Democrats and Republicans fear a backlash from their constituencies unless they continue to make promises not to cut spending on health care, even interventions that have been demonstrated to be non-efficacious. When it comes to reforming health care, the difficulties raised by a discussion of health care rationing pervade political discourse. As physician and health policy expert Gregg Bloche said in a recent *New England Journal of Medicine* article,

> The R word's power to stop conversation reflects the popular belief that cost should be no object at the bedside. This belief has circumscribed elected officials' efforts to control medical spending. Both Democrats and Republicans have stuck to variants on a standard story: cutting services that yield no value will do enough.[38]

There are presently a number of initiatives at both the federal and state levels to control the costs of health care and health insurance. Some, like the Patient-Centered Outcomes Research Institute created by the ACA, and the American Board of Internal Medicine Foundation's new "Choosing Wisely" campaign, will move the goal of comparative effectiveness forward.[39] But, as

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the government do the kinds of things that promote jobs such as hiring back the public sector employees who have been laid off in the past years. *Id.* at xi, 202, 227–28. This, Krugman says, would put the country on a normal unemployment track which would get us back to something that would feel a lot more like prosperity than the current austerity measures have. *See id.* at 202.

[37] *See infra* notes 93–99, 152–59 and accompanying text.

[38] M. Gregg Bloche, *Beyond the "R Word"? Medicine's New Frugality*, 366 NEW ENG. J. MED. 1951, 1951 (2012).

[39] In 2010, medical ethicist Howard Brody published an article in the *New England Journal of Medicine* calling on physicians to think about five medical procedures that are overused. Howard Brody, *Medicine's Ethical Responsibility for Health Care Reform—The Top Five List*, 362 NEW ENG. J. MED. 283, 284 (2010). The article prompted the National Physicians Alliance to consult with various medical specialty societies in order to come up with a list of overused tests and procedures in primary care. *See, e.g.*, *When to Say "Whoa!" to Your

behavioral economist Daniel Ariely notes, there are certain arenas where cost-effectiveness is generally underutilized; philanthropy and policy are two of the more notable.[40] Although there is significant agreement in predictions about the effects of rising health care costs in both the public and private sectors and the need to bend the cost curve, there is relatively little empirical data and even less agreement about how to accomplish this. Even if it is true that as much as thirty percent of what is spent on health care is waste,[41] forging successful mechanisms to prevent the wasted health care resources is not so easily accomplished. Cost effectiveness research ("CER") is expensive, which creates a significant barrier to empirical research.[42] It is also unpopular with many stakeholders such as patients, politicians, and providers who view CER as improper government interference in health care decision making and a dangerous trend toward the practice of "cookbook" medicine.[43]

Consumer, provider, and even insurer preference for more and more expensive health care interventions has become a hardened norm, and changing behavior is never easy. If the future goal of health care is to provide universal, high quality health care without unnecessary cost, then we need to start thinking about health care as a finite rather than infinite resource. Constraining usage is always difficult, especially when infinite demand has, in the past, regularly been satisfied by additional spending. It is only when an irresistible force meets an unmovable object that constraint becomes inevitable.[44] The irresistible urge to consume health care resources is currently meeting a number of unmovable objects: the federal budget (i.e., the share of GDP allocated by Con-

Doctor, CONSUMER REP. HEALTH, June 2012. On April 2, 2012, the American Board of Internal Medicine (ABIM) Foundation, in an effort to spread the idea to as many medical specialties as possible, published nine lists, each identifying five overused or unnecessary tests or procedures in a different medical field as part of the ABIM's "Choosing Wisely" campaign. *See* Press Release, Choosing Wisely, U.S. Physician Groups Identify Commonly Used Tests or Procedures They Say Are Often Not Necessary (Apr. 4, 2012), *available at* http://www.abimfoundation.org/News/ABIM-Foundation-News/2012/Choosing-Wisely.aspx. A compilation of the forty-five tests is available at http://choosingwisely.org/wp-content/uploads/2012/04/Five-Things.pdf. The campaign focuses not only on shaping physician demand for their patient's care but also on patient education about their own medical care. CHOOSING WISELY, http://choosingwisely.org (last visited Apr. 25, 2013).

40 *See* Dan Ariely, *Surprises From Our Recent Economic History*, DAN ARIELY (Sept. 20, 2009), http://danariely.com/2009/09/20/surprises-from-our-recent-economic-history/. The behavioral economist Daniel Ariely argues that healthy scientific skepticism has not penetrated certain arenas that are driven, instead, by rational economics. *Id.* Politicians who design social policies such as health insurance systems tend to over rely on the established dogma that people are always rational actors and therefore eschew the effect of empirical data to the contrary. Under this assumption, providers should heed empirical evidence that conflicts with their normative decision making if the goal is to provide excellent health care while mitigating both overconsumption and misuse of resources.

41 Bloche, *supra* note 38, at 1951.

42 *See* Michael E. Gluck, *Incorporating Costs into Comparative Effectiveness Research*, ACADEMYHEALTH 4, http://www.academyhealth.org/files/publications/ResearchInsights CER.pdf (last visited Apr. 25, 2013).

43 Geri Aston, *Show Me the Evidence: Comparative Effectiveness Research Could Aid Treatment Decisions*, ENT TODAY (Apr. 2010), http://www.enttoday.org/details/article/684953/Show_Me_the_Evidence_Comparative_effectiveness_research_could_aid__treatment_dec.html.

44 *See* Newhouse, *supra* note 11, at 1719–20.

gress for federal spending);[45] significantly slower economic growth both domestically and worldwide; the politics of the federal debt ceiling;[46] the lack of appetite of employers to continue to pay for employees' health insurance; the enticing smorgasbord of expensive medical technology that American consumers demand and with whose demands providers generally comply; and the rise in chronic disease as a result of modern lifestyle choices and the aging of the population.[47]

With regard to the public sector, the question is whether Congress will allocate more than the usual percentage of GDP to health care. In the current political climate, it seems relatively certain that if additional spending on public health insurance programs can only be accomplished through deficit spending, Congress will not comply. If health insurance entitlement programs continue to grow at the current rate,[48] the only possible solutions will be a larger allocation of GDP to the federal government, a larger percentage of that allocation to health care, or cuts in programs such as Medicare, Medicaid, and the Children's Health Insurance Program. The current public discourse involves cutting costs to the federal government through various methods, such as changing the structural design of Medicare,[49] changing the Medicare reimbursement scheme for Medicare providers,[50] moving all Medicaid beneficiaries from fee-for-service

[45] Channick, *supra* note 32, at 64–65, 71.

[46] *See Federal Debt Ceiling*, *supra* note 14. Federal law requires Congress to authorize the government to borrow money any time that spending on programs authorized by Congress exceeds revenue. *Id.* This authorization, while not popular, has been fairly pro forma until May 2011 when the Republican House of Representatives refused to raise the debt ceiling until there was agreement on spending reductions. *See id.* The Republican House and the Democratic Senate and Administration could not come to an agreement on whether cuts to the federal budget should include increased taxes or just spending cuts. *Id.* By the end of July, it appeared that the United States would default, an unthinkable occurrence. *Id.* Finally, an agreement was announced by which authority to raise the debt by $2.4 trillion was given, contingent on spending cuts of $2.4 trillion over ten years. *Id.* In November 2011, the bipartisan Congressional Commission charged with designing an agreement on deficit reduction failed to reach an agreement. *Id.* Currently the federal debt limit is at $16.4 trillion. *Id.* In an effort to avoid the automatic across-the-board spending cuts triggered by the failure of the bipartisan commission as well as the automatic termination of tax cuts enacted by the George W. Bush administration, top business executives are lobbying Congress to reach a bipartisan deficit-reduction agreement by the end of 2012. Damian Paletta, *CEOs Press Congress on Debt: Executives Step into Deficit Debate Amid Fears of Looming Tax, Spending Measures*, WALL ST. J., May 11, 2012, at A4.

[47] *See* HOLAHAN ET AL., *supra* note 4, at 1.

[48] The United States Government Accountability Office's ("GAO") most current prediction of federal entitlement spending is that, with revenue and discretionary spending remaining at historical averages, spending on Social Security, Medicare, Medicaid, and interest would grow to about seventy cents on each dollar spent by 2040. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-521SP, THE FEDERAL GOVERNMENT'S LONG-TERM FISCAL OUTLOOK: SPRING 2012 UPDATE 5 (2012), *available at* www.gao.gov/assets/590/589835.pdf.

[49] RYAN, THE PATH TO PROSPERITY, *supra* note 21, at 25.

[50] *See* TIMOTHY K. LAKE ET AL., NAT'L INST. FOR HEALTH CARE REFORM, LESSONS FROM THE FIELD: MAKING ACCOUNTABLE CARE ORGANIZATIONS REAL 5 (2011), *available at* http://www.nihcr.org/Accountable-Care-Organizations.html.

to managed care,[51] or changing Medicaid from an entitlement program to a block grant program.[52] As is regularly noted by health policymakers, if cost containment is accomplished by reducing reimbursement for providers, physicians are likely to flee from the public sector to the private sector where private insurance reimburses at higher levels.[53] With regard to the private sector, the question is how much tolerance payers will continue to have for higher premium costs.[54]

The best hope and real challenge for both sectors is finding ways to cut the per capita cost of providing care, particularly to the relatively small segment of the population that consumes a disproportionately large percentage of health care resources. The remainder of this paper will discuss some of the initiatives currently in place at both the federal and state levels that, hopefully, will provide models for future health care cost containment as well as an analysis of the feasibility of the success of these models in driving down the cost of health care. There are many possibilities for reducing the costs of health care; this paper focuses on only a few. With respect to implementation of the ACA, Congress put a high premium on the success of so-called accountable care organizations ("ACOs") as the primary means of reforming health care delivery and reimbursement. This Article describes the ACO model and critiques its viability as a successful way to control costs in a private health care market. This Article also looks at two key states, Massachusetts and California, in which health industry activity has acted as signs of change and predictors of the direction of cost containment.

II. The Present and Future of Cost Containment Strategies: The ACA and the States

The ACA was enacted primarily to solve the problems of the current health insurance market. These changes—the minimum coverage requirement, the implementation of state health insurance exchanges supplemented by federal subsidies for citizens and legal residents with incomes between 133% and 400% of the federal poverty level, expanded Medicaid, as well as health insurance market reforms such as guaranteed issue and community rating—are intended to create a universal health care system in which private insurers cannot refuse prospective insureds because of either health or wealth status.[55] The recent decision of the United States Supreme Court to uphold both the minimum coverage requirement as a valid exercise of the federal government's tax-

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51 Drew Altman, *Duals: The National Health Reform Experiment We Should Be Talking More About*, Kaiser Fam. Found. (June 6, 2012), http://www.kff.org/pullingittogether/dual-eligibles-health-reform.cfm.

52 Edwin Park & Matt Broaddus, Ctr. on Budget & Policy Priorities, Medicaid Block Grant Would Shift Financial Risks and Costs to States: States Would Bear Impact of Recessions, Higher Medical Costs 1 (2011), *available at* http://www.cbpp.org/files/2-23-11health.pdf.

53 Channick, *supra* note 32, at 78.

54 *See infra* text accompanying notes 122–42.

55 *See Summary of New Health Reform Law*, Kaiser Fam. Found. 1, 6, 11 (Apr. 15, 2011), http://www.kff.org/healthreform/upload/8061.pdf.

ing power[56] and the concomitant health insurance market reforms means that, at least for the moment, the Congressional effort to achieve almost universal access to affordable and adequate health care has been launched.[57]

The consequences of severing only the minimum coverage requirement but leaving the market reforms intact would have been rising health insurance premiums for the insured because insurers would not have been able to refuse coverage to people who waited to purchase health insurance until they become ill.[58] In order to absorb the additional health care costs of this otherwise uninsured population, cross-subsidization by the insured population would have been necessary and adverse selection would have been highly likely to occur. Adverse selection because of rising health insurance premiums would have predictably caused a rise in the uninsured population and potentially driven private health insurers out of the market. The foregoing is the primary reason that the federal government argued against the severability of only the minimum coverage provision.[59]

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[56] Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2600 (2012).

[57] While there might be future legal challenges to certain provisions of the ACA, I think the biggest challenges will be implementing some of the key provisions such as state health benefit exchanges, expanded Medicaid and the large employer mandate. It appears, at least at this time, that more states are demonstrating a willingness to expand their Medicaid program and to participate in the design and implementation of state health benefit exchanges. Since both expanded Medicaid and the exchanges are intended to provide universal affordable adequate insurance, it is paramount that these pieces of health care reform work properly. It will be ironic if the cost of health insurance under the ACA becomes so expensive to be unaffordable. There is not much in the ACA to prevent private health insurers from drastically raising their rates. *See, e.g.*, Reed Abelson, *Health Insurers Raise Some Rates by Double Digits*, N.Y. TIMES, Jan. 6, 2013, at A1 (noting that one new regulation under the ACA requires insurers must only submit rate increases of ten percent or more to federal regulators for review and approval via the healthcare.gov website).

The challenges are likely far from over. *See, e.g.*, Lyle Denniston, *U.S.: New Challenge to ACA OK (UPDATE)*, SCOTUS BLOG (Oct. 31, 2012, 5:29 PM), http://www.scotusblog.com/2012/10/u-s-new-challenge-to-aca-ok/; Jennifer Haberkorn, *More Legal Challenges to ACA on Way*, POLITICO (July 3, 2012, 5:49 PM), http://dyn.politico.com/printstory.cfm?uuid=488DDB73-EF5D-4B33-95A0-5AADF2C392AB.

[58] What remains to be seen is how many individuals choose to stay out of the insurance market and pay the "shared responsibility" tax instead. While it has been predicted by the CBO that approximately four million residents will choose the tax instead of insurance because of the cost differential, the effect of the minimum coverage provision is not yet clear. *See* Testimony of Walter Dellinger, *The Supreme Court's Ruling on Health Care: Ramifications for the Power of Congress to Lay and Collect Taxes*, COMMITTEE ON WAYS & MEANS, U.S. HOUSE OF REPRESENTATIVES (July 10, 2012), http://waysandmeans.house.gov/uploadedfiles/dellinger_testimony_7-10-12.pdf. If too many people delay the purchase of health insurance until they need health care, health insurers may be caught in an adverse selection cycle that will drive them to lobby Congress for relief.

[59] There have been a number of health care experts who allege that the Act can be an effective way to achieve universal coverage even without a minimum coverage requirement. Other incentives such as the premium subsidies or perhaps the ability of insurers to charge higher premiums to those who delay purchasing health insurance until illness may act as effective proxies for the mandatory coverage. The individual mandate provision has also been criticized for its fairly ineffective and inexpensive enforcement mechanisms; indeed, critics have noted that because the penalty for not purchasing health insurance is likely to be less than the cost of insurance, many young healthy individuals may opt to pay the penalty rather than comply with the mandate. *See, e.g.*, Mike Dorf, *Severability's Contradictions*,

Although the ACA has a number of provisions that are intended to contain costs of health care, the real effect of such provisions is, as yet, unknown. Since many of the provisions of the ACA will either not go into effect until 2014 or are quite controversial, immediate wholesale implementation is both impractical and inefficient.[60] As an alternative, the Act provides for multiple small demonstration projects to collect data on which cost containment strategies will reap benefits in the form of lower cost health care without jeopardizing outcomes and patient safety.[61] Although these demonstration projects are ongoing, the future of health care cost containment is uncertain. Economists have been puzzling over a three-year slowdown in the growth of health care spending prompted by the economy.[62] National health care spending growth was 3.8% in 2009 and is projected to be at 4% for 2011–2013.[63] The question, of course, is whether the slowdown is merely an artifact of a soft economy or whether it might signal a real change in health care spending.

A recent report from CMS Office of the Actuary should put to rest speculation that the current soft spending on health care is a permanent change.[64] The Office of the Actuary predicts that health care spending will continue to be soft until 2014 when the insurance provisions of the ACA are fully implemented, expanding health insurance coverage to an additional twenty to thirty million Americans who will be insured through Medicaid or the government-subsidized health insurance exchanges.[65] The addition of many more insured will push health care costs higher—7.4% in 2014—because of increased usage of health care resources, such as routine physician visits and pharmaceuticals.[66] The real question is whether the provisions of the ACA that are intended to reduce costs, and therefore mitigate the volume effect of the ACA, will be successful.

A. *Cost Containment Initiatives in the Affordable Care Act*

Although the ACA contains some provisions aimed toward cost reduction, whether and how these initiatives will work to actually reduce costs is uncer-

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DORF ON LAW (Apr. 9, 2012), http://www.dorfonlaw.org/2012/04/severabilitys-contradictions.html.

60 For example, the Independent Payment Advisory Board, created by the Affordable Care Act, "will have significant authority to curb rising Medicare spending if per beneficiary growth . . . exceeds target growth rates." Jennifer Haberkorn, *Health Policy Brief: The Independent Payment Advisory Board*, HEALTH AFF., Apr. 5, 2012, at 1, *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_67.pdf.

61 *See* Ateev Mehrotra et al., *Consumers' and Providers' Responses to Public Cost Reports, and How to Raise the Likelihood of Achieving Desired Results*, 31 HEALTH AFF. 843, 843 (2012).

62 *See* Keehan et al., *supra* note 2, at 1600.

63 *Id.* at 1600, 1609.

64 *See* Memorandum from Richard S. Foster, Chief Actuary, Office of the Actuary, Dep't of Health & Human Services, on Estimated Financial Effects of the "Patient Protection and Affordable Care Act," As Amended (Apr. 22, 2010), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf; *see also* Keehan et al., *supra* note 2, at 1600, 1603.

65 Memorandum from Richard S. Foster, *supra* note 64, at 2; Keehan et al., *supra* note 2, at 1600.

66 Keehan et al., *supra* note 2, at 1603.

tain. As one group of health care experts put it, "[t]he Affordable Care Act takes the general approach of 'letting a thousand flowers bloom'[67]—that is, testing myriad approaches to reducing costs" to see which initiatives produce real cost savings while continuing to provide quality health care.[68] Some of the more well-known initiatives provided for in the ACA include incentives to create competition across insurers in the health insurance exchanges, reductions in Medicare payments, a new excise tax on high-cost health care plans, and the Medicare shared savings program that incentivizes the use of integrated delivery systems and reimbursement schemes designed to provide more coordinated and concomitantly less expensive patient treatment.[69] For example, the CMS Actuary estimates that savings through 2016 of $68 billion can be accomplished by reducing excessive Medicare payments to private insurers who operate in Medicare Advantage, and that an additional $85 billion can be saved during the same time period by reforming provider payments by tying increases to the rate of growth in productivity in the economy at large.[70] This benchmark for growth is intended to force health care providers to become more efficient in order to remain profitable and to tie health care inflation to general economic growth.[71]

Many of the ACA's near-future savings are predicated on reduced reimbursement to providers to Medicare and Medicaid patients.[72] Although physi-

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[67] The Center of Medicare and Medicaid Services (CMS) Innovation Center has already launched a number of initiatives (e.g., demonstration projects, in order to collect data about which health care models work to reduce costs and which do not). CTRS. FOR MEDICARE & MEDICAID SERVS., THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE 6–7 (2012), *available at* http://www.cms.gov/apps/files/ACA-savings-report-2012.pdf. For example, the Innovation Center is testing major changes in primary care in the belief that the role of primary care physicians is key to cost reduction. *Id.* at 6. More PCPs will be needed to care for the additional thirty million Americans who will be entitled to health care under the ACA starting in 2014, a large percentage of which will be insured through Medicaid. *See* Keehan et al., *supra* note 2, at 1600. In addition, PCPs provide so-called "medical homes" for patients and are in the best position to manage and coordinate their care to ensure healthy outcomes. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra*, at 7. To that end, CMS is testing such initiatives as primary care bonus; a comprehensive primary care initiative, which is "a collaboration between public and private payers and primary care practices [to] support patient-centered primary care in communities . . . ."; an initiative to test "whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs"; and an "Independence at Home demonstration [to] encourage the use of in-home services" that certain chronically ill patients can receive in their homes. *Id.* at 6–7.

[68] Mehrotra et al., *supra* note 61, at 843.

[69] *See* Keehan et al., *supra* note 2, at 1603–04, 1608–09.

[70] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 67, at 2.

[71] How is this different from the sustainable growth rate, a method adopted by Congress in 1997 and intended to cap reimbursement to providers? The "Sustainable Growth Rate" formula was established to track provider reimbursement with both health care costs and the general economy. *See* Mary Carmichael, *Why Medicare's "Sustainable Growth Rate" Isn't*, NEWSWEEK: THE DAILY BEAST (Feb. 25, 2010, 10:02 AM), http://www.thedailybeast.com/newsweek/blogs/the-gaggle/2010/02/25/why-medicare-s-sustainable-growth-rate-isn-t.html. Congress has never been able to implement the SGR for fear that Medicare providers will abandon Medicare patients for more highly-reimbursed private insurance patients. *Id.*

[72] AM. HOSP. ASS'N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET 2 (2010), *available at* http://www.aha.org/content/00-10/10medunderpayment-1.pdf.

cians can attempt to raise revenues by reducing the percentage of Medicare and Medicaid patients in their practices, this choice is not realistic for hospitals and other institutional providers who continue to rely heavily on Medicare and Medicaid reimbursement.[73] Indeed, if private sector reimbursement levels drop due to pressure from employers and individual payers, the population continues to age, and the fully-implemented ACA expands the reach of Medicaid to include an additional fifteen-or-so million additional beneficiaries, even physicians who, in the past, have relied on the private insurance market may be in no position to refuse public health insurance reimbursement.

For the past year, the Center for Medicare & Medicaid Innovation ("CMMI") has been fleshing out the policy created by Congress in the ACA and has launched a number of voluntary initiatives that implement the vision of the ACA: "better population health, better patient experience, and reduced health care costs."[74] The mechanisms by which these goals will be met heavily incentivize physician-hospital integration in order to be able to take advantage of both federal grants that are available to providers who demonstrate an intention to provide more efficient, effective, quality health care through close alignment of physicians and hospitals, as well as the proposed Medicare shared savings incentive programs.[75] As reimbursement rates from both public and private insurers continue to decrease, more small- and medium-sized physician groups will seek alignment opportunities in order to survive.[76] Even prior to the ACA, the trend for many solo and small group medical practitioners, particularly younger physicians driven by life-style concerns, was toward hospital employment or practices that integrate physician groups and hospitals.[77] The incentives in the ACA have simply exacerbated this trend.

Much of the hope of cost containment rests on major changes in health care delivery systems and reimbursement incentives. In a pre-health reform world, providers are reimbursed for treating patients' illnesses rather than for keeping them well. The ACA is designed to shift the provider focus away from treating sickness and toward keeping people healthy. Health policy experts Ezekiel Emanuel and Jeffrey Liebman give one example of the perversity of the current reimbursement scheme:

> If a hospital hires a nurse to follow up with patients after they are discharged in order to reduce readmissions—for example, to help patients with diabetes improve blood

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[73] *Id.* at 1.

[74] Cleo Burtley et al., Cal. HealthCare Found., Physician-Hospital Integration 2012: How Health Care Reform Is Reshaping California's Delivery System 2 (2012), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianHospIntegration.pdf.

[75] *Id.* at 11. The new Medicare shared savings programs are intended to create incentives for providers to manage the care of Medicare patients in an integrated environment where risks of more costly treatment as well as the risk of outcomes are shared by the integrated provider organization. The theory is that the current fee-for-service reimbursement model incentivizes volume and fragments often duplicative care while integrated models will provide less volume, less duplication, and better outcomes leading to more cost-efficient care. *See id.* Providers whose practices produce savings to Medicare are entitled to share in the savings. *Id.*

[76] *See id.* at 16.

[77] Ann S. O'Malley et al., Ctr. for Studying Health Sys. Change, Rising Hospital Employment of Physicians: Better Quality, Higher Costs? 1–2 (2011), *available at* http://www.hschange.com/CONTENT/1230/1230.pdf.

sugar control—it must pay for the nurse, which is typically not reimbursed by insurance companies or Medicare, and it loses revenue by preventing the readmission.[78]

The post-ACA reimbursement scheme is designed to incentivize prevention and wellness in order to reduce expensive hospital admissions. David B. Nash, the founding dean of the Jefferson School of Population Health in Philadelphia, predicts that the health plans that survive into the new health care regime will be those that are "deeply invested in prevention and wellness and they will recognize that they bear the ultimate economic incentive to keep people well."[79] Instead of profiting by ordering more tests and procedures, providers will profit by ordering fewer at lower costs. "In other words," explains Nash, "they will be delivering population health just as the original plans for the HMO model suggested they would. It will be going back to the future, meaning they will start to make a real investment in prevention and wellness."[80] Although, as a matter of theory and philosophy, such a system makes sense, the perverse incentives that existed in the era of tightly controlled managed care to stint on patient care still exist.[81] The design of reimbursement incentives to promote wellness without stinting on care will be an important element in the effectiveness of health care delivery reform, as well as changes to the health care culture to align the interests of patients and providers.

The ACA provides for accountable care organizations (ACOs), integrated networks of providers who will be paid a fixed amount per patient plus bonuses for achieving quality targets rather than a fee for each episode of illness.[82] Under the Medicare Shared Savings Program, providers who "can slow the growth in their patients' health care spending while maintaining or improving

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[78] Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance Companies*, N.Y. TIMES (Jan. 30, 2012, 9:00 PM), http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/.

[79] Joseph Burns, *Reform Forces Health Insurers to Reinvent Themselves*, 21 MANAGED CARE 24 (Apr. 2012), http://www.managedcaremag.com/archives/1204/1204.healthplan2020.html.

[80] *Id.*

[81] ROBERT A. BERENSON & RACHEL A. BURTON, URBAN INST., ACCOUNTABLE CARE ORGANIZATIONS IN MEDICARE AND THE PRIVATE SECTOR: A STATUS UPDATE 1 (2011), *available at* http://www.urban.org/uploadedpdf/412438-Accountable-Care-Organizations-in-Medicare-and-the-Private-Sector.pdf. One difference between 1990s health maintenance organizations and ACOs may be who is perceived to be making health care decisions on behalf of patients. *Id.* With HMOs, much of the health care decision making was perceived to be the purview of insurers rather than providers by using such price control strategies as preauthorization and refusal of insurers to pay for services. *Id.* In an ACO, providers themselves, control the diagnosis and treatment decisions. *Id.* In the ACO model, the providers make clinical decisions, but they "exercise this control under new payment incentives that encourage greater prudence in the use of health services." *Id.*

[82] *See* MICHEALLE GADY & MARC STEINBERG, FAMILIES USA, MAKING THE MOST OF ACCOUNTABLE CARE ORGANIZATIONS (ACOS): WHAT ADVOCATES NEED TO KNOW 1 (2012), *available at* http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf ("An ACO is an entity that is made up of health care providers across the continuum of care . . . that agrees to be held accountable for improving the health of its patients. If patients' health care costs end up being less than would otherwise be expected while health care quality is maintained or improved, the providers get to keep a share of that savings. Providers, therefore, have a financial incentive to work together to improve the health of their patients. A successful ACO should put the patient at the center of all its activities and ensure coordination of care.").

the quality of the care they deliver"[83] will be financially rewarded; hence the rush by health systems to adopt and effectuate the ACO model.[84] Although the drafters of the ACA included the ACO model to incentivize Medicare providers to adopt ACOs to replace the expensive fee-for-service reimbursement model, private insurers seeking to contain health care costs have adopted the integrated system model as well.[85] Indeed, the creation of integrated health care entities is not new. Large health care systems, like the Geisinger Health System and the Mayo Clinic, have provided integrated care across the continuum for decades.[86] What is new is the concept of payment reform to make providers accountable for the quality of care they provide.[87] The Geisinger model, though not mentioned by name, was what the Obama administration envisioned could be accomplished by adopting the ACO model.[88]

Emanuel and Liebman argue in favor of broad adoption of ACOs not only because ACOs will improve patient care quality, but also because ACOs will make traditional health insurance companies superfluous within the next decade.[89] Essentially, ACOs will receive a form of capitation payment directly from the payers—employers, Medicare, Medicaid.[90] Because an ACO's patient base is so large, the ACO can engage in its own risk-pooling (i.e., pooling the health care usage risks among the large number of patients in the pool).[91] With no more claims to deal with and their unique role in risk-pooling gone, Emanuel and Liebman argue that there will be no more reason for commercial health insurance, at least in its present form, to exist.[92]

Although it might be expected that two health policy experts who were advisors to the Obama administration in health care reform would be bullish on ACOs, acceptance of the ACO model as at least a beginning of delivery and payment reform is more difficult to believe coming from high-level insurance administrators. "[S]peaking at the HIMSS12 Conference in Las Vegas,[93] Aetna

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[83] BERENSON & BURTON, *supra* note 81, at 1.
[84] *See* Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528, 19,533 (proposed Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425).
[85] BERENSON & BURTON, *supra* note 81, at 2.
[86] *See* Lawton R. Burns & Mark V. Pauly, *Integrated Delivery Networks: A Detour on the Road to Integrated Health Care?*, 21 HEALTH AFF. 128, 130–31 (2002).
[87] *See* Ceci Connolly, *For this Health System, Less Is More; Program that Guarantees Doing Things Right the First Time, for Flat Fee, Pays Off*, WASH. POST, Mar. 31, 2009, at A1. Geisinger offers a ninety-day guarantee to patients who have elective cardiac surgery; if within the ninety days, the patient has to return to the hospital, Geisinger picks up the cost of additional care. *Id.* By 2009, three years into the guarantee program, Geisinger had cut its elective cardiac surgery costs by fifteen percent and had extended the guarantee to other procedures. *Id.*
[88] *Id.*
[89] Emanuel & Liebman, *supra* note 78.
[90] *Id.*
[91] *Id.* Since only a small percentage of people account for a large percentage of health care costs, ACOs should be able to not only predict risk, but also better identify and manage the care of high-risk patients. *See* Anna Wilde Mathews, *Can Accountable-Care Organizations Improve Health Care While Reducing Costs?*, WALL ST. J., Jan. 23, 2012, at R5.
[92] Emanuel & Liebman, *supra* note 78.
[93] The Healthcare Information and Management Systems Society ("HIMSS") "is a cause-based, not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of

CEO, Chairman and President Mark Bertolini, said a reckoning for the traditional health insurance model was at hand. 'The system doesn't work, it's broke today' Bertolini told attendees. 'The end of insurance companies, the way we've run the business in the past, is here.' "[94] Pointing to changes made by the ACA, Bertolini offered measured praise for the ACA, even for the end of medical underwriting[95] and the controversial medical loss provision.[96] Bertolini stated that regardless of the outcome of the U.S. Supreme Court's decision on the constitutionality of the ACA's minimum coverage provision or the November 2012 federal elections, reform is not going away.[97] For-profit insurers must change from their current traditional fee-for-service, commodified, defined benefit system to a model that uses its "new technologies to help accountable health systems serve their customers and drive out costs."[98] In the future, Bertolini predicts that insurance companies will position themselves to help usher in an era of coordinated care: " 'We need to move the system from underwriting risk to managing populations,' he said. 'We want to have a different relationship with the providers, physicians and the hospitals we do business with.' "[99]

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healthcare." *About HIMSS,* HIMSS.ORG, http://himss.org/ASP/aboutHimssHome.asp (last visited Apr. 26, 2013).

94 *Aetna CEO: Health Insurers Face Extinction*, HEALTH DATA MGMT. (Feb. 21, 2012, 10:11 PM), http://www.healthdatamanagement.com/news/HIMSS12-Aetna-CEO-insurers-face-extinction-44041-1.html [hereinafter *Aetna CEO*].

95 Medical underwriting, which is prevalent in the individual and small business market, has allowed insurers to contain their risk by setting insurance premiums based on the health status of the prospective insureds. *In the Spotlight: ACA Insurance Reforms*, BLUECROSS BLUESHIELD OF NORTH CAROLINA 1 (July 13, 2011), https://www.bcbsnc.com/assets/hcr/pdfs/spotlight_insurance_reforms.pdf. Those with preexisting conditions that are more likely to lead to illness and expensive consumption of health care resources have been excluded entirely. The ACA prohibits medical underwriting and requires a modified community rating system to be used to set the price of health insurance. *Id.* at 1–2.

96 *Aetna CEO*, *supra* note 94. The medical loss ratio provisions in the ACA require "health insurance companies to spend 80% of the consumers' premium dollars they collect—85% for large group insurers—on actual medical care rather than overhead, marketing expenses and profit." Rick Ungar, *The Bomb Buried in Obamacare Explodes Today—Hallelujah!*, FORBES (Dec. 2, 2011, 3:44 PM), http://www.forbes.com/sites/rickungar/2011/12/02/the-bomb-buried-in-obamacare-explodes-today-halleluja/. Insurers who fail to meet these requirements must rebate to their customers the amount underspent on actual medical care. *Id.*

97 *Aetna CEO*, *supra* note 94. On June 11, 2012,

> Aetna, Humana and UnitedHealth pledged to continue offering certain preventive services without a copayment and allow dependents to remain on their parents' policies up to age 26 . . . . All three insurers also said they would continue providing clear and simple ways for enrollees to appeal coverage claim decisions.
>
> Humana and UnitedHealth added that they will continue to stop lifetime dollar coverage limits on policies and eliminate rescissions . . . .

Aetna, Humana Pledge to Maintain Certain Reform Law Provisions, CAL. HEALTHLINE (June 12, 2012), http://www.californiahealthline.org/articles/2012/6/12/aetna-humana-pledge-to-maintain-certain-reform-law-provisions.aspx?topic=healthcarereform (internal citation omitted).

98 Joe Flower, *Even Aetna CEO Admits: We're Toast*, HEALTH CARE BLOG (May 11, 2012), http://thehealthcareblog.com/blog/2012/05/11/even-aetna-ceo-admits-were-toast/.

99 *Aetna CEO*, *supra* note 94.

Much hope for greater efficiency in both the public and private health care sectors rests on building a successful model to achieve cost containment. The multi-billion dollar question is whether the yet-untested ACO model will be successful in seriously moderating costs. The mantra of ACOs is that success equals reducing costs through improving care.[100] To improve care while striving to spend less, ACOs will need to invest heavily in consulting, systems, care managers, and IT staff, a hefty contribution for the possibility of achieving savings somewhere down the road.[101] The start-up cost of a real ACO is predicted to be $30 million or more in a midsize market; since physicians do not have that kind of capital, they will be looking toward organizations that can provide it (e.g., hospitals and even health insurance companies).[102] Providers, like all humans, follow financial incentives, and the financial incentives central to the design of ACOs may not suffice.[103] Tom Scully, formerly the administrator of CMS, believes that the greatest flaw in ACOs is that they are driving more power to the hospitals rather than to the doctors who traditionally have driven health care decisions and, therefore, spending.[104] In order to reap the financial incentives of ACOs, physicians are selling their practices to hospitals in droves.[105] Because of the lack of direct financial incentive for physicians, Scully believes that physicians will not be sufficiently incentivized to practice more efficient care.[106]

Jeff Goldsmith, president of Health Futures Inc., a health care consulting firm, is decidedly bearish on ACOs.[107] He believes that, although there are a number of really good ideas in the ACA for containing costs, the ACO is not one of them.[108] Citing data from the field-testing of ACOs by CMS from 2005 to 2010 that demonstrate the de minimis cost savings effects of ACOs,[109] Goldsmith believes that CMS inexplicably ignored its own data and backed the "wrong horse" in choosing ACOs as the primary method for cost contain-

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100 Mathews, *supra* note 91, at R5. Donald Berwick, most recently the administrator of CMS, helped oversee the agency's efforts to structure ACOs created by the ACA. He believes that the ACO model will succeed because "it is set up to reward the right combination of goals for our time: transparency, coordination, consumer power and intolerance of waste." *Id.*

101 *Id.*

102 *Id.*

103 Jeff Goldsmith believes that "[t]he ACO actually looks like a terrible business deal for providers." *Id.*

104 *Id.*

105 *See id.*

106 *Id.*

107 *See, e.g.*, Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 32 (2011).

108 *See* Mathews, *supra* note 91, at R5.

109 *Id.*; The bottom line of CMS's Physician Group Practice Demonstration is that Medicare ACOs did "not seem to have succeeded in meaningfully reducing spending growth." BERENSON & BURTON, *supra* note 81, at 5. But—as noted by Berenson and Burton—this may be because there were few incentives for physicians to alter the way they deliver care to achieve such reductions. The demo has "been criticized for not including strong enough financial incentives to change provider behavior," such as "offer[ing] providers the option of taking on financial risk [and] giving them a more compelling business case for changing the way they deliver care." *Id.*

ment.[110] One of his criticisms of the ACO choice is that saving money on patients who are not very sick is extremely difficult to accomplish.[111] The well-known skewing of health care costs (i.e., that half the population accounts for only three percent of health resource consumption) dictates that efforts to save money should focus on the small percentage of the population that consume the largest percentage of resources.[112] Programs that focus on identifying these populations and better coordinating efforts to prevent serious illnesses and expensive hospitalizations are statistically likely to be significantly more successful.[113]

Goldsmith argues in favor of the patient-centered medical home as a better potential solution to the current delivery systems and physician reimbursement issues. Goldsmith believes that patient-centered medical homes that focus on care management are more likely to succeed in reducing health care costs than the ACA's current ACO concept.[114] Because of low reimbursement rates by both public and private insurers, primary care physicians are forced to see more patients in order to afford their overhead expenses.[115] As a consequence of high volume, PCPs have developed very low-touch practices.[116] The use of patient-centered medical homes—physician-led practices that incorporate care management, including protocols and guidelines for how specific clinical risks should be managed, as well as the use of allied health care professionals—presumably would facilitate collaboration to maintain continuity of care for patients.[117] This care management model would focus on preventing high-risk patients from requiring expensive health care interventions and hospitalizations by monitoring their compliance with less expensive outpatient treatment.[118]

A particular concern about governmental and institutional enthusiasm for ACOs is growing market consolidation in both the hospital and insurer market. Hospital consolidation has the effect of dampening competition among providers and insurers and giving particularly large hospital groups bargaining leverage in the reimbursement negotiations.[119] In order to satisfy consumer demand that certain prestigious hospitals be included in their insurance network, insur-

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110 Mathews, *supra* note 91, at R5.
111 *Id.* ("ACOs are unlikely to save the federal government any money.").
112 *Id.*
113 Atul Gawande, *The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?*, NEW YORKER (Jan. 24, 2011), http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande; *see also* THE COMMONWEALTH FUND COMM'N ON A HIGH PERFORMANCE HEALTH SYS., THE PERFORMANCE IMPROVEMENT IMPERATIVE: UTILIZING A COORDINATED COMMUNITY-BASED APPROACH TO ENHANCE CARE AND LOWER COSTS FOR CHRONICALLY ILL PATIENTS 6–7 (2012), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Apr/1596_Blumenthal_performance_improvement_commission_report.pdf.
114 *See* Goldsmith, *supra* note 107, at 37.
115 *Id.*
116 *Id.*
117 *Id.*
118 *Id.*
119 Anna S. Sommers et al., *Addressing Hospital Pricing Leverage Through Regulation: State Rate Setting*, NAT'L INST. FOR HEALTH CARE REFORM 2 (May 2012), http://www.nihcr.org/1tl92.

ers are paying a premium to include such provider groups.[120] By 2009, the gap between hospital prices paid by private insurers on average exceeded hospital costs by thirty-four percent, up from a sixteen percent gap in 2000.[121] Even in communities with dominant insurers, there is little incentive for health plans to constrain hospital costs as long as the increases can be passed on to employers and individuals.[122]

Provider consolidation is likely to get worse as health networks seek to take advantage of the ACA's economic incentives in favor of ACOs. Since the very definition of an ACO is provider integration, there is every reason to predict continued provider consolidation. Restating the position of former CMS administrator Tom Scully, "[t]he biggest flaw with ACOs is that they are driving *more* power to hospitals––not to doctors. . . . The goal of ACOs was to organize doctors to focus more on patients and keep the patients out of hospitals. Instead, doctors are selling practices to hospitals in droves."[123] Because of antitrust concerns, "the Department of Justice and the Federal Trade Commission had originally proposed a mandatory antitrust review for ACOs that met certain thresholds for provider concentration," but in the face of opposition by many would-be ACOs, CMS did not require mandatory antitrust reviews.[124] Because hospitals can foresee a less fortuitous payer mix when the expanded Medicaid program comes online in 2014, those with negotiating leverage with insurers are likely to continue to use their market power to get higher reimbursement rates from the private market in order to offset the losses that are anticipated from a higher percentage of Medicaid reimbursement.[125]

B. Experimenting in the Laboratories of the States

While awaiting full implementation of the Affordable Care Act, some states have been conducting empirical research into possible cost containment initiatives that could be effective not only intrastate but interstate as well. In addition, changes are occurring in the private health care market that are worthy of note. This Article will discuss two phenomena in particular: (1) empirical research on the effect of rising health insurance premiums on employers, employees, and the economy of Massachusetts and the need to contain health care costs in the commercial market, and (2) the recently noted phenomenon of insurers acquiring physician practices with data coming from California,

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120 *Id.*
121 *Id.*
122 *Id.* One way of forcing providers and insurers to hold the line on provider reimbursement is to use a market approach (i.e., "adopting insurance products that motivate enrollees to consider price" in making choices about insurance). *Id.* A tiered approach to enrollee health care cost sharing such as higher premiums or increased cost sharing by enrollees for more expensive providers is one way to shift preferences from more expensive to less expensive providers. *Id.*
123 Mathews, *supra* note 91, at R5.
124 Robert A. Berenson & Rachel A. Burton, *Health Policy Brief: Next Steps for ACOs*, HEALTH AFF., Jan. 31, 2012, at 5, *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_61.pdf.
125 Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 978 (2012).

although this phenomenon is occurring in other states as well. California is a state where provider consolidation and market power is generally high, and insurers, recognizing that they might be maneuvered out of the health care market, are beginning to go on the offensive. As noted above, Aetna's Mark Bertolini has stated that, given the changing health care environment and a future that does not look profitable for insurers who continue to reimburse on a per service basis, insurers are positioning themselves in leadership positions to usher in the new era of coordinated care.[126]

1. The Effect of Rising Health Insurance Premiums on Employers and Employees: Empirical Data from Massachusetts

Although providing affordable coverage for most of the population was a key goal of health care reform, cost reduction must be the next step.[127] According to Dr. Jonathan Gruber, a key architect of health insurance reform for the state of Massachusetts and a technical consultant to the administration on the Patient Protection and Affordable Care Act, "health care reform can be divided into two rounds: The 'coverage round,' which was answered by the new bill, and the 'cost-reduction round,' which will require long-term technological innovation and creative thinking."[128] This author would posit that even though the "coverage round" has survived constitutional scrutiny, the "cost-reduction round" is still essential. Currently, the state of Massachusetts is assessing the effects of health care reform on the state fisc.[129] Clearly, providing health insurance and health care to all legal residents of the state necessarily raises costs since more people are accessing health care under the new regime.

One of the assumptions of a universal health insurance market is that access to health care itself can drive down the costs of care through increased price competition in the private health insurance market and can lower spending per capita due to more consistent access to care and better patient care management. Both the Massachusetts health reform model and the federal model require that almost all legal residents and citizens purchase health insurance.[130] As a result, the market for individual health insurance (i.e., the state health insurance exchanges) should see an increase in the supply of insurers competing at least partly on cost for the business of individuals seeking health insurance. In a normal market, this phenomenon should drive down the cost of health insurance. A second felicitous effect of universal coverage is risk pools with larger numbers of healthy individuals who may have foregone the purchase of health insurance in a voluntary market.

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126 *Aetna CEO*, *supra* note 94.

127 Jingyun Fan, *After Health Bill, A Push To Curb Costs: Profs Study Medical Inflation*, 130 TECH 1, 1 (Apr. 2, 2010), http://tech.mit.edu/V130/PDF/N16.pdf.

128 *Id.* at 1, 15.

129 Massachusetts health care reform legislation was enacted in 2006. *See Focus on Health Reform: Massachusetts Health Care Reform: Six Years Later*, KAISER FAM. FOUND. 1 (May 2012), http://www.kff.org/healthreform/upload/8311.pdf. The plan has been successful in curbing the rise in the uninsured that has occurred in so many other states, but it has not been successful in driving the cost of care down. *Id.*

130 *Id.* at 9.

However, what might work in the individual insurance market does not work in the employer-sponsored insurance market where, at least in most states, members of employer risk pools could not be refused coverage. At the current six percent projected growth rate of health insurance premiums, Dr. Jonathan Gruber and his associate, Ian Perry, estimate that by 2019 employer contributions to the employer-sponsored insurance market will rise from $18.1 billion to more than $33 billion.[131] In an effort to demonstrate the effect of cost control on premium cost, Gruber and Perry studied the benefits of slower health care insurance premium growth on Massachusetts employees and employers.[132] The study does not speak to the methods by which health care costs can be lowered but only to the effects that lowering costs have on employer profits, employee wages, and state economic growth (Gross State Product).[133]

This study relies on the Gruber Microsimulation Model ("GMSIM") to estimate the effects of slower growth of health insurance premiums on employers and employees.[134] This model is based on evidence from the past.[135] The crucial assumption is that future "changes in health insurance premiums will have the same effects on employer and employee actions" as in the past.[136] As noted earlier in this Article, there is a direct correlation between employer-sponsored health insurance premium costs and wage growth; as employers are further burdened by higher health insurance premiums, workers' wages rise more slowly.[137] This slowdown in wage growth concomitantly affects the economy at large because workers consume less when they are paid less.

Based on past responses of employers to higher health insurance premiums, "the GMSIM model assumes that the 'first' place excess health care costs go is into lower wages" for employees.[138] If premiums continue to grow at the currently projected rate of six percent per year, "Massachusetts workers will lose around $17,000 per worker in overall take-home pay."[139] This loss does not include the employees' share of premium costs.[140] Employers too will suffer from higher premium costs that cannot be passed on to employees, which will likely result in a reduction in jobs or lower corporate profits.[141] Each of these outcomes is likely to have a negative impact on the state's economy.[142]

The report's authors have modeled the savings in employer-sponsored insurance that can be achieved through a reduction in premium costs.[143] Even

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131 GRUBER & PERRY, *supra* note 20, at 1.
132 *Id.*
133 *Id.*
134 *Id.* at 5.
135 *Id.*
136 *Id.*
137 *Id.* at 10, 12.
138 *Id.* at 5–6. However, past employer responses were to much smaller increases in premium costs than are modeled in this report. *See id.* at 6. It is possible that employers might respond to much higher rises in premium costs by focusing more on jobs and profits than the authors have modeled in their report. Therefore, the minimum effect of higher premiums could be seen on jobs and profits and the maximum effect could be seen on wages. *Id.*
139 *Id.* at 1.
140 *See id.*
141 *Id.* at 12.
142 *See id.* at 13.
143 *Id.* at 2.

the most modest reductions in health insurance premium growth can yield major benefits to employers, employees, and the state economy in general.[144] For example, over the period of 2011–2019, lowering the growth by just one percentage point is projected to save employers $10 billion, preserve $7.8 billion in employee take-home pay, and preserve $1 billion for workforce investments and business profits.[145] The most aggressive growth reduction scenario modeled in the report has health insurance premiums growing at two percent, four percentage points less than current growth and 1.5 percentage points less than projected gross state product (GSP).[146] Under this scenario, employer spending is reduced by $34.5 billion, $33.6 billion of employee take-home pay is preserved, and $4.1 billion of workforce investments and business profits is preserved.[147]

Although the GMSIM model predicts the effects of decreasing health insurance premium costs, it does not speak to any methods by which these benchmarks can be reached.[148] Negotiators from both houses of the Massachusetts legislature reached a compromise on health care cost containment legislation on July 30, 2012.[149] Though there is support for aggressive cost-cutting measures among employers, others are more cautious.[150] As always, in facilitating cost containment in health care, the multi-billion dollar question is how such savings will be achieved. Gruber makes no representations about how costs should be cut, only that there are large savings to be reaped if they can be.[151] Lynn Nicholas, president of the Massachusetts Hospital Association, warns against aggressive goals that can only be achieved by cutting jobs: "[W]e do know that as hospitals have taken billions of dollars out of their expenses over the last couple of years, most of that has come in labor."[152] Jonathan Gruber argues that it is not certain that saving money will require job cutting.[153] "As the focus shifts to prevention, we may need more lower-paid community health workers, for example, but less expensive testing."[154] Gruber does

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144 *Id.*
145 *Id.*
146 *Id.*
147 *Id.*
148 *Id.* at 6.
149 *See, e.g.*, WBUR Newsroom, *Mass. Legislators Reach Compromise on Health Cost Bill*, 90.9WBUR (July 30, 2012, 6:00 PM), http://www.wbur.org/2012/07/30/health-costs-containment-legislation. As this author understands it, the main thrust of the Massachusetts law, Chapter 224 of the Acts of 2012 (*An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*), is to tie health care cost growth to the growth in the state's economy. A new Center for Health Information and Analysis is tasked with collecting information about costs from all Massachusetts health care entities including hospitals, physician groups, ACOs and payers and notifying those that exceed the state benchmark to file and implement performance improvement plans. *See* 2012 Mass. Acts ch. 224.
150 *See* Martha Bebinger, *Report: Lower Health Care Cost Growth Means Big Savings*, 90.9WBUR (Apr. 26, 2012, 7:49 AM), http://www.wbur.org/2012/04/26/lower-health-cost-growth.
151 *Id.*
152 *Id.*
153 *Id.*
154 *Id.*

acknowledge that his predictive model does not determine the consequences of lower health care costs.[155]

2. Continuing Consolidation of Providers and Payers: Observations from California

Dr. Mark D. Smith, the president of the California Healthcare Foundation,[156] predicts that regardless of the outcome of the challenges to the ACA, health care reform is already happening and will continue to happen.[157] In that assertion, Smith is joined by a number of voices, many of them from the for-profit health insurance industry.[158] As Chas Roades, chief research officer of health care consulting firm Advisory Board Co. notes, health care costs associated with aging are inevitable; even the Supreme Court cannot overturn the aging process.[159] The costs associated with treating the multiple chronic diseases that are more prevalent in an older population are a well-recognized factor in the rising costs of health care.[160]

An example of how change is already affecting the delivery of health care is size (i.e., consolidation in both the provider and insurer markets). Smith argues that, in times of uncertainty, size is a benefit; even prior to the enactment of the ACA, there have been numerous hospital acquisitions of physician practices for the purpose of increasing market power to improve price leverage with payers.[161] Although provider consolidation may be beneficial to providers with respect to payers, the negative fallout could adversely affect health cost sustainability. In a study of the current negotiating environment between California providers and payers, health policy experts Robert Berenson, Paul Ginsburg, and Nicole Kemper found that increasing market power for providers caused a change that gave providers a stronger bargaining position than payers, resulting in higher insurance premiums.[162] The fear is that costs due to increased provider power could neutralize the potential of health care reform to drive down the cost of premiums through increased efficiency in delivery.[163]

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155 *Id.*

156 The California Healthcare Foundation is a non-profit organization that supports ideas and innovations to improve health care for all California residents. *See About CHCF*, CAL. HEALTHCARE FOUND., http://www.chcf.org/about (last visited Apr. 26, 2013).

157 Mark D. Smith, *Tea Leaves Are for Drinking: Health Reform After the Supreme Court Ruling*, JAMA F. (May 16, 2012, 3:03 PM), http://newsatjama.jama.com/2012/05/16/jama-forum-tea-leaves-are-for-drinking-health-reform-after-the-supreme-court-ruling/.

158 *See, e.g.*, Merrill Goozner, *Health Plans Undergo Major Changes to Cut Costs*, FISCAL TIMES (Mar. 6, 2012), http://www.thefiscaltimes.com/Articles/2012/03/06/Health-Plans-Undergo-Major-Changes-to-Cut-Costs.aspx?p=1; Jay Hancock, *Some Health System Changes Will Stay, No Matter How SCOTUS Rules*, KAISER HEALTH NEWS (June 19, 2012), http://www.kaiserhealthnews.org/Stories/2012/June/19/health-system-changes-supreme-court.aspx. Reforms in the private sector are already underway report top officials in the health insurance industry. Goozner, *supra*; Hancock, *supra*.

159 Hancock, *supra* note 158.

160 *Id.*

161 Smith, *supra* note 157.

162 Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 699 (2010).

163 *Id.*

Historically, provider consolidation in California was a response by providers to the market power of payers who were able to negotiate very favorable risk contracts with providers, both physicians and hospitals.[164] When these risk contracts became burdensome to provider groups, they responded by consolidating through mergers and acquisitions and forming tighter alliances with physician organizations.[165] Over the years, "hospitals and physicians have become increasingly sophisticated in developing organizational forms primarily to increase their negotiating clout with health plans."[166] In this effort, they have been aided by consumer/patient demand for broad provider networks, a demand that incentivizes payers to have the largest provider networks possible.[167] This strategy has a counter effect: it neutralizes the health plans' negotiating tool of network exclusion as a lever for reduced provider reimbursement.[168] As a result of provider consolidation, the price of care rises and concomitantly affects the price of private insurance premiums.[169]

In their January 2012 op-ed piece for the *New York Times*, health policy experts Emanuel and Liebman predicted that by 2020, American health insurance would be extinct, replaced by ACOs.[170] In order to combat the rise in provider reimbursement, insurers are starting to compete with hospitals, particularly for primary care physician practices.[171] Insurers are interested in physician practices to attract patients, particularly the non-Medicaid population who, with mandated health insurance under the ACA, will be searching for primary care physicians.[172] Health plans that are able to fill that demand will profit under the new regime.[173] As Emanuel and Liebman note, some health insurers see the move from the current third payer climate to ACOs as inevitable, as evidenced by recent incursions by insurers into the ACO business.[174] "If [the insurers] don't want to go the way of the dinosaurs, insurance companies will have to find a new business to be in, one that is useful in the new world of coordinated care."[175]

Aetna's Mark Bertolini agrees. "Regulatory, demographic, and economic factors are forcing health insurers to reinvent themselves."[176] The ACA's ban

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164 BONAR MENNINGER, CAL. HEALTHCARE FOUND., ACCOUNTABLE CARE ORGANIZATIONS: AVOIDING PITFALLS OF THE PAST 3–4 (2010), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/A/PDF%20AccountableCareOrganizationsAvoidingPitfallsPast.pdf.
165 *See* Berenson et al., *supra* note 162, at 701. In ways, it is ironic that hospitals and physicians have allied with each other given the culture of distrust that has characterized physician-hospital relationships in the past. MENNINGER, *supra* note 164, at 9.
166 Berenson et al., *supra* note 162, at 701.
167 *Id.*
168 *Id.* at 701–02.
169 *Id.* at 702.
170 Emanuel & Liebman, *supra* note 78.
171 *See* Rebecca Vesely, *Insurers Buy Medical Practices as Health Landscape Shifts*, BUS. INS. (Jan. 15, 2012, 6:00 AM), http://www.businessinsurance.com/article/20120115/NEWS03/301159994.
172 *See id.*
173 *See id.*
174 Emanuel & Liebman, *supra* note 78.
175 *Id.*
176 Burns, *supra* note 79.

on medical underwriting as well as the new eighty-five percent medical loss ratio limitation will cut into the for-profit insurers' revenue.[177] Some insurers believe that the efficiency of health care delivery will be more effective if insurers own rather than contract with their provider groups and are able to manage the coordination of patient care.[178] Charles Kennedy, CEO of Aetna Accountable Care Solutions, explains:

> Traditionally, insurers contracted with providers for advantageous fee schedules and a national network. That was a win-lose negotiation focused on rates.
>
> In the new ACO model, there will no longer be a relationship based on negotiations over rates. It will be a relationship based on data, care management, and analytics . . . . [T]he core premise of health plans, which is contracting with providers at discounted rates, is dying. When people say health insurance companies will go away, that's what they mean.[179]

Insurers recognize that tighter management of health care resources at the front end is essential to manage the rising costs of health care.[180] That necessarily means enlisting doctors whose medical treatment orders drive most health care spending.[181] Such strategies are particularly important to control the costs of expensive and wasteful medical interventions, such as the choice to use expensive stent surgery to treat cardiac patients rather than lower cost pharmaceuticals.[182] Under the current insurance model in both the public and private sectors, providers who are paid to do more are incentivized to overtreat, even when overtreatment is unnecessary and perhaps even dangerous to the patient.[183] Under this new model, providers would be employed by the insurer who would pay salaries to doctors and incentivize them to achieve quality and efficiency goals.[184] The counter fear, of course, is that the new model will incentivize providers, employed by payers, to undertreat (i.e., to do less than what is necessary to provide good, safe care for their patients).[185] The blurring of lines between providers and payers is all too reminiscent of the managed care models of the 1990s, against which there was enormous pushback by both patients and providers and eventually culminated in much looser patient care management and the consolidation of provider groups in order to achieve market power with respect to insurers.[186]

Although it is easy enough to see why insurers might choose to acquire physician groups, it is more difficult to understand why physician groups are consolidating with insurers rather than continuing to form alliances with other

[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] Christopher Weaver, *Managed Care Enters the Exam Room As Insurers Buy Doctor Groups*, KAISER HEALTH NEWS (July 1, 2011), http://www.kaiserhealthnews.org/Stories/2011/July/01/unitedhealth-insurers-buy-doctors-groups.aspx.
[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] Anna Wilde Mathews, *Insurer's Cost-Cut Plan: Buy Hospitals*, WALL ST. J., June 29, 2011, at B1.
[185] Weaver, *supra* note 180.
[186] *See* Curtis Kauffman-Pickelle, *Predator or Prey?*, IMAGINGBIZ (July 16, 2011), http://www.imagingbiz.com/articles/view/predator-or-prey; *see also* Weaver, *supra* note 180.

physician groups and hospitals. In November 2011, UnitedHealth Group Inc.'s Optum business acquired Monarch HealthCare, an independent practice association with 2,300 physicians.[187] Dr. Bart Asner, CEO of the California practice association, says that UnitedHealth's Optum "has 'the same vision and values of caring for our patients.' "[188] The three things the Monarch Board agreed were necessary to deliver superior care were upgraded technology, clinical programs, and capital for growth, all of which it perceived Optum could deliver.[189] Health policy experts are pointing to these acquisitions as a key strategy change by insurers "to persuade and enable provider organizations . . . to take on progressively more responsibility for the cost of care."[190] Other large insurers have announced deals involving consolidation with doctors as well. For example, WellPoint acquired CareMore,[191] a health plan operator that owns twenty-six clinics and is based near Los Angeles, in an effort to stem rising health care costs by managing care on the front end.[192]

Certainly, these consolidations can be viewed as giving both the payers and physician providers a competitive edge in the marketplace where millions will soon be able to purchase health insurance.[193] Insurance companies with a lot of cash, like UnitedHealth Group, are positioned well to take advantage of this growing trend and provider groups will profit from increasingly higher provider group valuations.[194] However, in states like California where hospitals have held a negotiating edge over insurers in the recent past, insurer-physician consolidations pose a threat to large hospital groups. This so-called landgrab of physicians, and particularly primary care physicians, will inevitably create "a clash between the insurance industry and hospital industry as both fight to control primary care," which is at the center of care management, the holy grail of accountable care.[195] The fear is that these acquisitions blur the lines between the business of health care and medical decision making.[196] In the 1990s, during the era of tightly controlled managed care, insurers were so consistently accused by both physicians and patients of making medical decisions using the cost-containment tools of managed care, such as prior authorization, that patients finally rebelled causing a severe backlash against the health mainte-

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[187] Vesely, *supra* note 171.
[188] *Id.*
[189] *Id.*
[190] Ken Terry, *Why Are Health Plans Buying Physician Groups?*, HOSP. & HEALTH NETWORKS, Jan. 2012, at 30.
[191] Gregg Blesch, *WellPoint Completes CareMore Acquisition*, MODERNHEALTHCARE.COM (Aug. 22, 2011, 1:30 PM), http://www.modernhealthcare.com/article/20110822/NEWS/m308229938.
[192] Weaver, *supra* note 180.
[193] On June 28, 2012, the Supreme Court substantially upheld the constitutionality of the ACA assuring that sixteen million or so Americans without access to affordable, adequate health insurance will be able to purchase such insurance through regulated private markets operated by the various states. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012).
[194] Vesely, *supra* note 171.
[195] Molly Gamble, *The Quiet Takeover: Insurers Buying Physicians and Hospitals*, BECKER'S HOSP. REV. (July 11, 2011), http://www.beckershospitalreview.com/hospital-management-administration/the-quiet-takeover-insurers-buying-physicians-and-hospitals.html.
[196] Kauffman-Pickelle, *supra* note 186.

nance organization ("HMO") model.[197] The real possibility that insurers reclaim the driver's seat because of rising health care costs and the inability of providers to solve the problem looms large, particularly for health systems that have flourished economically in the last decade.

Wendell Potter, a former executive at the health insurer Cigna, provides a possible explanation for health insurers' acquisitions of provider groups.[198] In recent years, health insurers have been able to remain profitable in spite of rising health care costs because of their lawful refusal of coverage to certain applicants with predicted high cost health care usage.[199] That model, however, was already becoming unprofitable and would become even less effective in a health insurance marketplace of guaranteed issue and community rating.[200] Without continuing to raise premiums, a practice that is becoming intolerable to employers and employees, insurers have wrung most of the profit out of health insurance.[201] The profit-maximizing options available to insurers include insuring volume (i.e., having more healthy lives to insure, or changing their model to increase the bottom line profit).[202] Acquiring, rather than contracting with, physician practices in order to apply coordinated care techniques to physician behavior may be one way to reduce costs and increase profit margins.[203]

Despite what appears to be the specter of a reappearance of managed care, some experts believe that the acquisition of providers by a few large health plans represents only a small portion of the insurance companies' effort to transform the delivery of health care.[204] "Paul Ginsburg, president of the Center for Studying Health System Change, predicts that insurer-provider collaboration on [coordinated care] is going to be a major trend" and that the large insurers' acquisitions of provider groups is just a hedge against the possible failure of provider-led ACOs to accomplish cost containment.[205] Gail Wilensky, a UnitedHealth board member and health official in the George H.W. Bush administration, believes that insurers' purchases of provider groups is one strategy that large insurers are trying out in an effort to reinvent themselves and be relevant in an era of record-high health care costs.[206] Steven Shortell, dean of the University of California Berkeley School of Public Health, argues that the pervasiveness of the practice will depend on the nature of the provider market.[207] The practice, he believes, will not "be spreading like wildfire across the country."[208] Todd Cozzens, CEO of Optum Accountable Care Solutions, a sub-

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197 Terry, *supra* note 190, at 31; *see also* Mathews, *supra* note 184, at B1.
198 Wendell Potter, *Analysis: The End of Health Insurance As We Know It?*, Center for Pub. Integrity (Mar. 13, 2012, 11:52 AM), http://www.publicintegrity.org/2012/03/05/8312/analysis-end-health-insurance-we-know-it.
199 *Id.*
200 *See id.*
201 *See id.*
202 *Id.*
203 *See* Jeffrey J. Lauderdale & Molly A. Drake, *Law Does Not Stop Payers from Buying Providers*, Managed Healthcare Executive, May 2012, at 12.
204 Terry, *supra* note 190, at 30.
205 *Id.* at 30–31.
206 *See* Weaver, *supra* note 180.
207 Terry, *supra* note 190, at 31.
208 *Id.*

sidiary of UnitedHealth Group, predicts that the new insurer-provider model will be looking to share profit margins rather than fighting over them.[209]

III. The Imperative of Cost Containment Regardless of the Survival of the ACA

This is a time of great uncertainty for the direction of U.S. health care. Although the ACA mostly survived constitutional scrutiny, four members of the Supreme Court would have struck down the Act in its entirety and seven members agreed to seriously constrain the effect of the ACA's expanded Medicaid provision.[210] Such an outcome may broadcast a continuing fight over the future of federal power, certainly a preeminent piece of the current Republican agenda.[211] The common wisdom among Republicans is that current health care reform, however heavily oriented to the private market, is a step in the direction of European socialism. All attempts to persuade legislators to enact reform that would provide single-payer, universal health insurance is anathema to those persuaded that the private market can best solve access and affordability issues. Even though the Court upheld the individual mandate provision, there is no guarantee the provisions of the ACA will be successful in driving down the costs of health care or that legislators opposed to the ACA will not try to otherwise dismantle it and begin the health care reform process anew.[212]

Notwithstanding the future of the ACA, the United States has reached a tipping point with respect to costs: employer-sponsored insurance is getting more expensive for employers and employees; actuarial underwriting by insurers bars an increasing number of people from affordable health insurance; the number of uninsured and underinsured continues to rise; and public payers, as well as employers and individuals, can no longer reasonably bear the costs of health care. How to make health care more affordable is clearly a difficult, unpredictable task, particularly in an environment of extreme political partisanship. Although achieving universal health care seems to be a task made for public solutions, it is difficult to imagine how this will happen. On the other hand, Americans have learned to accept and revere Medicare, a federal entitle-

209 *Id.*
210 Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012); *see also id.* at 2642, 2666–67 (Scalia, J., dissenting).
211 On Monday, June 25, 2012, the U.S. Supreme Court gave the Obama administration a nominal victory by striking down three of four provisions in Arizona's immigration law, S.B. 1070, in a 5–3 decision (Kagan, J., recusing). Arizona v. United States, 132 S. Ct. 2492, 2497, 2510–11 (2012). The Court also found that mandatory life imprisonment without the possibility of parole of juveniles violated the Eighth Amendment of the U.S. Constitution. Miller v. Alabama, 132 S. Ct. 2455, 2475 (2012). While such decisions appear to make the argument that the Court may be inclined to find the individual mandate constitutional, another fair reading is that the seemingly less conservative decisions in *Arizona* and *Miller* make a states' rights decision to strike down the individual mandate more palatable. *But see* Nat'l Fed'n of Indep. Bus., 132 S. Ct. at 2608.
212 Indeed, Mitt Romney stated prior to the Court's ruling that if the Court found the individual mandate constitutional, his job (if he won the presidential election) would be to work with Congress to completely dismantle the ACA. *See, e.g.*, Tim Reid, *Romney Presses Attacks on "Obamacare" Before Ruling*, Reuters (June 26, 2012, 4:34 PM), http://www.reuters.com/article/2012/06/26/usa-campaign-idUSL2E8HQBAA20120626.

ment health insurance program for those sixty-five and older, in spite of its rocky beginnings.[213]

Although the ACA survived its constitutional challenge relatively intact, it still must be implemented. Apparently, what Congress has given, Congress can at least attempt to take away. Threats by a Republican-dominated House of Representatives to repeal portions of the Act or refuse to allocate the funds needed for successful implementation jeopardize its potential for success. The commitment to cost containment must be as clear as the commitment to universal access. The incentives to control costs must be significant enough so that the natural gravitation toward a profit motive do not overcome the necessity of not only universal but also affordable and decent insurance.

There is much talk in the health policy community about finding and eliminating waste in the health care system as the portal to cost containment. As former CMS Director Donald Berwick has noted, the savings potential from cutting waste from the health care system is far greater than from more direct and blunter cuts, such as eliminating unhealthy people from insurance pools or severely limiting the coverage of those in the pools.[214] Berwick and Hackbarth look at six potential sources of waste and the savings that they estimate could occur by making changes.[215] The authors estimate, for example, that $2.2 trillion in additional savings in the next decade is necessary to keep health care costs at a sustainable trajectory, defined as one that lies close to overall GDP growth.[216] Though the sustainable cost trajectory is the prize on which health policy experts, health economists, and legislators must keep their eye, cost containment must be thoughtful and cognizant of the first principles of health care reform: access, affordability, and safety. It has taken many decades to create the enormous problem of sky-rocketing health care costs; the solution will not be had in a day. The Affordable Care Act has a number of initiatives that might work, but it is only when we mine the data from various initiatives that we will be able to most effectively and fairly rein in health care costs.

[213] *See generally* Don Wolfensberger, *Health Care Reform and the Medicare Analogy*, WOODROW WILSON INT'L CENTER FOR SCHOLARS: SEMINAR ON UNIVERSAL HEALTH CARE (Sept. 21, 2009), http://www.wilsoncenter.org/sites/default/files/Health%20Intro%20Essay.pdf (discussing the history of Medicare).

[214] Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513, 1513 (2012).

[215] *Id.* Although not exhaustive, the authors present the following list: failures of care delivery; failures of care coordination; overtreatment; administrative complexity; pricing failures; and fraud and abuse. *Id.* The authors estimate that in 2011, the United States unnecessarily spent between $558 billion and $1.2 trillion on health care interventions that did not add value to the health of Americans. *Id.* at 1513–14.

[216] *Id.* at 1514.