

# COST CONTROL AND THE AFFORDABLE CARE ACT: CRAMPING\* OUR HEALTH CARE APPETITE

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\* *Cramp*: “A compressing or restraining force, influence, or thing. . . . [*Cramp* (*one’s*) *style*[;] To restrict or prevent from free action or expression.” FREE ONLINE DICTIONARY, <http://www.thefreedictionary.com/cramp> (last visited Apr. 4, 2013).

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<sup>1</sup> This is the memorable phrase of Captain Louis Renault (Claude Rains) in the classic movie *Casablanca* with Humphrey Bogart and Ingrid Bergman, capturing the idea of easy investigation rather than an honest search for the culprit—finding scapegoats rather than the perpetrator. *CASABLANCA* (Warner Bros. 1942).

<sup>2</sup> Daniel Callahan, *Health Care Costs and Medical Technology*, in *FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS* 79, 81 (Mary Crowley ed., 2008), available at [http://www.thehastingscenter.org/uploadedFiles/Publications/Briefing\\_Book/health%20care%20costs%20chapter.pdf](http://www.thehastingscenter.org/uploadedFiles/Publications/Briefing_Book/health%20care%20costs%20chapter.pdf).

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INTRODUCTION

Health care cost increases have haunted United States policymaking since the late 1960s. Medicare was implemented in 1966; as a result, the federal government immediately began to pour millions of federal dollars into health care expenditures, which have rapidly grown to ever-higher percentages of our gross domestic product (“GDP”).<sup>3</sup> U.S. health spending has grown nearly five times as much as GDP since 1960.<sup>4</sup> Yet for all this spending, we do not achieve longer life or overall better health statistics than other industrialized countries with modern health care systems.<sup>5</sup>

Our system is wasteful, inefficient, and often unscientific, as well as unfair and inequitable for millions of Americans. We spend too much on services that too often give us little or no benefits.<sup>6</sup> Our high costs impose penalties on us at an escalating rate—access to employer-based insurance coverage continues to shrink,<sup>7</sup> hospitals are forced to cut back on services, and government programs are financially stressed at the state and federal levels.

<sup>3</sup> See Marian E. Gornick et al., *Thirty Years of Medicare: Impact on the Covered Population*, 18 HEALTH CARE FINANCING REV. 179, 179, 216 (1996), available at <http://199.173.225.5/history/pdf/ThirtyYearsPopulation.pdf>.

<sup>4</sup> “[T]he United States spends considerably more on health care than would be expected based on expenditures in other developed countries, even accounting for differences in income.” Twenty-three percent of total U.S. health care spending—or \$572 billion in 2009—exceeds “Estimated Spending According to Wealth.” JESSE W. BRADFORD ET AL., MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, ACCOUNTING FOR THE COST OF U.S. HEALTH CARE: PRE-REFORM TRENDS AND THE IMPACT OF THE RECESSION 2, 6, 8 (2011).

<sup>5</sup> ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, OECD HEALTH DATA 2012: HOW DOES THE UNITED STATES COMPARE 1–2 (2012), [www.oecd.org/unitedstates/briefingnoteusa2012.pdf](http://www.oecd.org/unitedstates/briefingnoteusa2012.pdf).

<sup>6</sup> At least this is true for us as patients and payers. For the providers who get reimbursed for this care, and the makers of drugs and devices, the benefit is obvious.

<sup>7</sup> See Michael Cooper, *Lost in Recession, Toll on Underemployed and Underpaid*, N.Y. TIMES, June 19, 2012, at A11 (“The real entry-level hourly wage for men who recently graduated from high school fell to \$11.68 last year, from \$15.64 in 1979, according to data from the Economic Policy Institute. And the percentage of those jobs that offer health insurance has plummeted to 22.8 percent, from 63.3 percent in 1979.”) (emphasis added).

Health care costs have long risen at a higher rate than general inflation.<sup>8</sup> The recession of 2008 has reduced this differential somewhat; health spending and GDP grew at similar rates in 2010, with health spending as a share of GDP steady at 17.9%.<sup>9</sup> National health expenditures growth has ranged from as high as 11.0% in 1990 to 3.9% in 2010.<sup>10</sup> The shrinkage in the use and intensity of health care goods and services in 2010 also reduced our share of personal health care spending growth.<sup>11</sup> Is it possible that structural changes in the health care economy are slowing the rate of increase of inflation? Some analysts argue that this is so,<sup>12</sup> and recent data confirms the slowing of health care expenditures to the lowest rate since 1998.<sup>13</sup>

Slowing in health care spending may be due to several factors. First, hospital inpatient utilization has declined between 2006 and 2010, falling 8.3% for those over sixty-five and 3.0% for those over eighty-five.<sup>14</sup> Since Medicare covers the bulk of these costs, one would not expect individuals to have foregone such treatment based on costs. Second, use-rate has dropped even in some states that have experienced only modest increases in unemployment. This suggests that forces other than recession-driven unemployment were causing the

<sup>8</sup> In a classic article, Joseph Newhouse examines several explanations for “why medical expenditure [constantly] increas[es], as opposed to [being] merely ‘high.’ ” Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 J. ECON. PERSP. 3, 5, 9–10 (1992). Newhouse ultimately concludes that medical technology is a primary driver of high rates of increase in expenditures. *Id.* at 11.

<sup>9</sup> Anne B. Martin et al., *Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009*, 31 HEALTH AFF. 208, 208 (2012).

<sup>10</sup> *See id.* at 210 (Growth was 4.7% and 3.9% respectively in 2008 and 2010, in contrast with growth of 7.6% in 2007 and double digits in the 1980s and 1990s.).

<sup>11</sup> Sheila Smith, Joseph P. Newhouse & Mark S. Freeland, *Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?*, 28 HEALTH AFF. 1276, 1283 (2009) (“Our model suggests that the unusual severity of the current recession will reduce spending growth in the near term by an amount roughly comparable in magnitude to that of the managed care era of the 1990s. Unfortunately, the model says nothing about how that reduction may be brought about. . . . Income growth will continue to drive a rising health share of GDP in decades to come, as spending on new medical technologies continues to increase more rapidly than incomes. Ultimately, this effect must diminish as the opportunity cost of additional growth in health spending rises—exacting a growing trade-off in the foregone consumption of all other goods and services.”).

<sup>12</sup> *See, e.g.*, Kenneth Kaufman, *Bending the Health Care Cost Curve: More Than Meets the Eye?*, HEALTH AFF. BLOG (Apr. 13, 2012), <http://healthaffairs.org/blog/2012/04/13/bending-the-health-care-cost-curve-more-than-meets-the-eye/>.

<sup>13</sup> The Altarum Institute recently concluded:

National health expenditures grew at an estimated annual rate of 4.3 percent in 2012, a bit higher than the 3.9 percent experienced for each of the years 2009–2011. While this estimate is subject to revisions, it portends a fourth consecutive year of record-low growth compared to all previous years in the 50-plus years of official health spending data.

Health care prices in December 2012 rose by 1.7 percent compared to December 2011, the lowest year-over-year growth since February 1998. The 12-month moving average at 2.0 percent was the lowest reading since December 1998.

Ken Schwartz, *Health Spending Growth Near 4 Percent for Fourth Year; Price Growth at 14-Year Low*, ALTARUM.ORG (Feb. 7, 2013), <http://www.altarum.org/health-systems-research-news-releases/7Feb13-health-spending-growth-4-percent-price-14year-low>.

<sup>14</sup> Kaufman, *supra* note 12.

use-rate drops.<sup>15</sup> The bad news is that such cost-curve abatement is unlikely to continue when the recession begins to recede and spending picks up. Many of the sources of inflation are still in place, particularly the size of the large cohort of baby boomers entering retirement. We need to consider cost-control ideas from every possible perspective.

The problem of cost in health care was not ignored by the Affordable Care Act (“ACA”),<sup>16</sup> contrary to the claims of its critics, who often have not read the ACA,<sup>17</sup> or who—like today’s congressional Republicans—have a political axe to grind without regard to facts or good policy. The ACA, in fact, unites cost and quality in many of its provisions.<sup>18</sup> It promotes evidence-based medicine; it aims to rationalize the delivery of health care and therefore improve patient benefits for the same amount of money.<sup>19</sup> Congress explicitly created in the ACA a broad portfolio of cost-control instruments<sup>20</sup>: accountable care organizations, comparative-effectiveness analysis, bundled payments, value-based insurance design, limits on the exclusion of employer-financed premiums from personal income tax, health insurance exchanges to promote competition among insurance plans, pay for performance models using performance information, and the Independent Payment Advisory Board, among others.<sup>21</sup> Demonstration projects are also an integral part of the ACA as part of a model of experimentation with strategies that might make health care more efficient,

<sup>15</sup> *Id.*

<sup>16</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>17</sup> See, for example, Scalia’s comments at oral argument in *Nat’l Fed’n of Indep. Bus. v. Sebelius*, indicating he had not read the ACA and had little intention of doing so. Transcript of Oral Argument at 38, *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (Nos. 11-393, 11-398, 11-400).

<sup>18</sup> Berwick and Hackbarth put it quite powerfully:

The ACA does not ignore waste reduction; indeed, many of its provisions aim for it. For example, value-based purchasing can encourage hospitals and physicians to adopt best practices, decrease patient injuries, and help reduce overuse of ineffective care. Accountable care organizations and bundled payment can give more patients the benefits of seamless care. Predictive analytics of Medicare claims and more aggressive enforcement ought to reduce fraud. Expansions of bidding procedures may lead to prices that better reflect actual production costs. If successful, these programs and others like them will reduce overall health care expenditures, provide a windfall of “indirect” savings to CMS, and all the while improve patient care.

Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 *JAMA* 1513, 1515 (2012).

<sup>19</sup> See Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 *U. PA. L. REV.* 1727, 1733, 1740 (2011) [hereinafter Furrow, *Regulating Patient Safety*] (examining a wide range of regulatory initiatives in the PPACA and providing an overview of the PPACA’s patient-safety provisions).

<sup>20</sup> Gawande objects: “Pick up the Senate health-care bill—yes, all 2,074 pages—and leaf through it. Almost half of it is devoted to programs that would test various ways to curb costs and increase quality. The bill is a hodgepodge. And it should be.” Atul Gawande, *Testing, Testing: The Complex Battle To Cut Health-Care Costs*, *NEW YORKER*, Dec. 14, 2009, at 34, 38.

<sup>21</sup> See JAMES R. HORNEY & PAUL N. VAN DE WATER, *CTR. ON BUDGET AND POLICY PRIORITIES, HOUSE-PASSED AND SENATE HEALTH BILLS REDUCE DEFICIT, SLOW HEALTH CARE COSTS, AND INCLUDE REALISTIC MEDICARE SAVINGS 2, 5–9* (2009), available at <http://www.cbpp.org/files/12-4-09health.pdf>. These are their list of cost-saving ideas in the Senate and House versions of the ACA, which I have summarized more briefly.

more competitive, and of higher quality, and dozens of these projects are now ongoing.<sup>22</sup>

The Congressional Budget Office (“CBO”) scored the final ACA legislation in 2010 (including the reconciliation bill) as reducing the deficit by around \$138 billion.<sup>23</sup> The Center for Medicare & Medicaid Services (“CMS”) most recently estimated that the ACA will increase the rate of growth in national health care costs by one-tenth of one percent annually from 2010 to 2020.<sup>24</sup>

Critics see the ACA as contributing to the federal deficit;<sup>25</sup> even if this is so, the ACA will expand coverage for millions of Americans now lacking it. On the other hand, CBO projections typically underestimate savings from reforms like those in the Affordable Care Act.<sup>26</sup> The CBO is particularly cautious about costing out innovative programs with no history of success. ACOs, medical homes, outcomes-and-effectiveness research findings disseminated to providers, and all the coordination reforms of the ACA are likely to be underestimated as to their cost-reducing successes. In fact, the ACA is off to a good start—during the first year of implementation, the ACA increased health care spending by less than one-tenth of one percent, less than anticipated.<sup>27</sup>

What I propose to do in this Article is to round up some of the “usual suspects” for health care cost inflation on the assumption that the recession’s impacts will eventually abate and more dollars will again pour into the health care economy. I will then look at some of the provisions of the ACA and their effect on the larger cost drivers in the U.S. system.

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<sup>22</sup> For a master list of CMS projects to date, see MASTER DEMONSTRATION, EVALUATION AND RESEARCH STUDIES FOR ORDI SYSTEM OF RECORD 09-70-0591, <http://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts/downloads/mastersorlist.pdf> (last visited Apr. 5, 2013).

<sup>23</sup> Letter from Douglas W. Elmendorf, Dir. of the Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, at 2 (Mar. 18, 2010), available at [http://cbo.gov/sites/default/files/cbofiles/attachments/hr4872\\_0.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/hr4872_0.pdf) (“[E]nacting both pieces of legislation—H.R. 3590 and the reconciliation proposal—would produce a net reduction in federal deficits of \$138 billion over the 2010–2019 period as result of changes in direct spending and revenue.”).

<sup>24</sup> Sean P. Keehan et al., *National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth*, 30 HEALTH AFF. 1594, 1604 (2011).

<sup>25</sup> For example, one critical analysis projects that it will add at least \$340 billion to the deficit over the next decade. CHARLES BLAHOUS, THE FISCAL CONSEQUENCES OF THE AFFORDABLE CARE ACT 5 (2012), available at [http://mercatus.org/sites/default/files/publication/The-Fiscal-Consequences-of-the-Affordable-Care-Act\\_1.pdf](http://mercatus.org/sites/default/files/publication/The-Fiscal-Consequences-of-the-Affordable-Care-Act_1.pdf).

<sup>26</sup> Savings from the Balanced Budget Act (BBA) of 1997, which, like the ACA, changed payment formulas under Medicare, were 50% greater than those forecast by the CBO for 1998 and 113% greater in 1999. Spending on the Medicare Part D prescription drug benefit under the Medicare Modernization Act of 2003 was about 40% below the CBO forecast. Jon R. Gabel, *Does the Congressional Budget Office Underestimate Savings from Reform?: A Review of the Historical Record*, 76 COMMONWEALTH FUND 1, 2 (2010), available at [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/1367\\_Gabel\\_does\\_CBO\\_underestimate\\_savings\\_from\\_reform\\_ib.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/1367_Gabel_does_CBO_underestimate_savings_from_reform_ib.pdf) (citing Jon R. Gabel, *Congress’s Health Care Numbers Don’t Add Up*, N.Y. TIMES, Aug. 26, 2009, at A23).

<sup>27</sup> See BARRY R. FURROW ET AL., *Introduction to HEALTH CARE REFORM: SUPPLEMENTARY MATERIALS* (2012).

## I. SPEND UNTIL IT HURTS: THE USUAL SUSPECTS

The history of U.S. health care reform displays a constant tension between expansion of health care coverage and a struggle to contain the escalation of costs of such coverage.<sup>28</sup> We have passed through three stages of health care reform in the last hundred years or so: *Progressive Health Insurance*, *Expansionary Health Insurance*, and *Containment Health Insurance*.<sup>29</sup> These stages illustrate the natural evolution of the American system as medicine gained power to treat and cure, requiring an increasingly expensive infrastructure of support.

The period of *Progressive Health Insurance*, from the 1890s to the 1920s, gets its name from Progressive political reformers, who saw health insurance as a way to stabilize incomes for workers. Progressive reformers' central focus was twofold: legislating workers' compensation statutes to protect workers in the workplace and improving public health regulation of water supplies and food.<sup>30</sup> They were mostly concerned about the negative features of industrial capitalism and high-density overcrowded cities, so insurance was focused on employment and its side effects during that period.

The *Expansionary Health Insurance* period, from the 1930s through the 1960s, was driven by the need to improve access to health care services.<sup>31</sup> As medicine developed tools to treat illness and the hospital became central to the delivery of these services, health care costs, particularly hospital costs, began to increase. Health insurance was the best way to cover hospital care, by expanding coverage for lower- and middle-income groups.<sup>32</sup> Blue Cross plans were developed during this era, and commercial insurance soon followed, competing with the Blues.<sup>33</sup> Health insurance tied to employment was a byproduct of wartime collective bargaining, when wage increases were not negotiable.<sup>34</sup> Locating health insurance in employment foreshadowed future health care coverage problems because health insurance as a fringe benefit of work meant that

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<sup>28</sup> Much of this historical discussion is derived from my article, Barry R. Furrow, *Health Reform and Ted Kennedy: The Art of Politics . . . and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL'Y 445, 446 (2011) [hereinafter Furrow, *Health Reform*].

<sup>29</sup> These periods of reform are developed in Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980*, 72 AM. J. PUB. HEALTH 78, 78 (1982) [hereinafter Starr, *Transformation in Defeat*]; see also PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE ix (1982) [hereinafter STARR, THE SOCIAL TRANSFORMATION].

<sup>30</sup> Furrow, *Health Reform*, *supra* note 28, at 449. See also DONALD W. ROGERS, MAKING CAPITALISM SAFE: WORK SAFETY AND HEALTH REGULATION IN AMERICA, 1880–1940, at 4, 66 (2009) (describing Progressive contributions to the development of workers' compensation laws in Wisconsin and elsewhere); see generally MICHAEL MCGERR, A FIERCE DISCONTENT: THE RISE AND FALL OF THE PROGRESSIVE MOVEMENT IN AMERICA, 1870–1920, at xiv (2003).

<sup>31</sup> See Starr, *Transformation in Defeat*, *supra* note 29, at 81–82; see also Furrow, *Health Reform*, *supra* note 28, at 449.

<sup>32</sup> Furrow, *Health Reform*, *supra* note 28, at 449.

<sup>33</sup> *Id.* For a more elaborate discussion of the struggles for health care from 1929 to 1945, including the emergence of the Blue Cross plans, see STARR, THE SOCIAL TRANSFORMATION, *supra* note 29, at 295–98.

<sup>34</sup> Furrow, *Health Reform*, *supra* note 28, at 449.

loss of employment meant losing coverage.<sup>35</sup> Unlike most national health systems, health care access was not portable and could be lost if a job was lost. As costs have risen, access to health insurance has dropped in the employment setting.

The *Containment Health Insurance* era began in the 1970s in response to rapid increases in health care spending driven by the recently enacted Medicare program (and Medicaid soon after).<sup>36</sup> Two groups of Americans with expensive health care needs, the elderly and the poor, were suddenly able to get health care services paid for by the federal government.<sup>37</sup> Medicare began to pour federal dollars into the health care marketplace as ten percent of the American population became Medicare- and Medicaid-eligible in the mid-1960s.<sup>38</sup> And this flow of federal dollars was largely unregulated from 1966 to 1983 when the prospective payment system was instituted to control Medicare hospital costs.<sup>39</sup> Health expenditures jumped from \$42 billion in 1965 to \$420 billion in 1985, a ten-fold increase.<sup>40</sup> Federal officials panicked in the face of such dramatic spending increases and the fear of ever-increasing health care cost inflation. Health reform efforts in the mid-1970s were pursued by the Nixon, Ford, and Carter administrations.<sup>41</sup> Health care cost inflation in this era was fueled by a range of economic drivers created by earlier federal policy decisions: biomedical research was now funded at a high level, the physician supply rapidly expanded, and hospitals were receiving federal subsidies for construction under the Hill Burton Act.<sup>42</sup> Hospitals expanded and their costs of care grew, predictably increasing consumer demand for health insurance.<sup>43</sup> New medical technologies were also coming online with new surgical and diagnostic tools promising to cure disease and improve people's lives.<sup>44</sup>

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 449–50; Starr, *Transformation in Defeat*, *supra* note 29, at 84–85.

<sup>37</sup> Furrow, *Health Reform*, *supra* note 28, at 450.

<sup>38</sup> See THEODORE H. TULCHINSKY & ELENA A. VARAVIKOVA, *THE NEW PUBLIC HEALTH* 471 (2d ed. 2009).

<sup>39</sup> Furrow, *Health Reform*, *supra* note 28, at 450. The diagnosis-related groups (DRG) prospective payment system was mandated by Congress in 1982 to control Medicare costs. This system changes payment from a highly inflationary fee-for-service approach to a per-case reimbursement mechanism, which divides inpatient admission cases into categories called diagnosis-related groups. Medicare then pays hospitals a flat rate per case based on the particular DRG. The goal is to reward efficient hospitals and create incentives for inefficient hospitals to improve. See OFFICE OF INSPECTOR GEN., *MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED 1* (2001), available at <https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>.

<sup>40</sup> Furrow, *Health Reform*, *supra* note 28, at 450.

<sup>41</sup> *Id.* The history of health reform from the perspective of American presidents is well summarized in *American Presidents and Health Reform: A Chronolgy* [sic], *HOSPITALS & HEALTH NETWORKS* (Feb. 2009), [http://www.hhnmag.com/hhnmag/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN\\_CoverStory\\_WebExtra&domain=HHNMAG](http://www.hhnmag.com/hhnmag/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN_CoverStory_WebExtra&domain=HHNMAG).

<sup>42</sup> See FURROW, *Health Reform*, *supra* note 28, at 450; see also *Hill-Burton Act*, *FREE DICTIONARY.COM*, <http://medical-dictionary.thefreedictionary.com/Hill-Burton+Act> (last visited Apr. 5, 2013).

<sup>43</sup> Furrow, *Health Reform*, *supra* note 28, at 450. See also STARR, *THE SOCIAL TRANSFORMATION*, *supra* note 29, at 381–82.

<sup>44</sup> See STARR, *THE SOCIAL TRANSFORMATION*, *supra* note 29, at 386–87.

The regulatory tensions between cost control and access increased during this period. Fault lines in the Medicare and Medicaid programs became visible, with rapid cost inflation and uneven access for poor and rural residents becoming obvious.<sup>45</sup> The modes of reimbursement—fee-for-service payment to physicians and “usual, customary, and reasonable” charges—created a national crisis by 1970.<sup>46</sup> As costs skyrocketed, federal health care regulation of cost increases began in earnest. Several major pieces of legislation were enacted: price stabilization programs in 1972, the Health Maintenance Organization Act in 1973,<sup>47</sup> and the Health Planning and Resource Development Act and its Certificate of Need requirements in 1974.<sup>48</sup> Private employers began to cost-shift escalating insurance costs to their employees; their strategies included narrowing employee choice of plans, adding deductibles to coverage, and dropping employee dependents from plan coverage.<sup>49</sup> From these growing burdens on employment-based insurance, one could predict that problems of access to health care would only increase in the next three decades.<sup>50</sup>

Prior to 1989, physicians were compensated by both private insurers and Medicare by the usual, customary, or reasonable (“UCR”) method, with payment determined based on the lowest of: the bill submitted, the customary charge of the physician, or the prevailing rate in the area for those services. This mode of payment was inflationary, since physicians had a strong incentive to increase their fees over time to raise the reasonable rate calculation in the future.<sup>51</sup>

Smaller companies started to drop health insurance or shift employees from full-time to part-time to reduce their costs starting in the late 1990s and early 2000s. During this period, health care providers began to manifest hyper-entrepreneurship: the hospital industry witnessed a burst of non-profit acquisitions by for-profit hospitals, and managed care plans began expanding rapidly.<sup>52</sup>

The hospital as the “hub of health care” began to fade in the 1990s. The federal DRG program’s fixed prices for hospital procedures had the predictable effect of incentivizing administrators to move procedures out of the hospital and into unregulated settings where prices were not controlled by the DRG

<sup>45</sup> Furrow, *Health Reform*, *supra* note 28, at 450. *See also* STARR, *THE SOCIAL TRANSFORMATION*, *supra* note 29, at 382.

<sup>46</sup> Furrow, *Health Reform*, *supra* note 28, at 451 (quoting REXFORD E. SANTERRE & STEPHEN P. NEUN, *HEALTH ECONOMICS: THEORY, INSIGHTS, AND INDUSTRY STUDIES* 300 (5th ed. 2010)).

<sup>47</sup> Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e (2012)).

<sup>48</sup> Furrow, *Health Reform*, *supra* note 28, at 451.

<sup>49</sup> *Id.* (citing GERALD R. LEDLOW & M. NICHOLAS COPPOLA, *LEADERSHIP FOR HEALTH PROFESSIONALS: THEORY, SKILLS, AND APPLICATIONS* 292 (2011)).

<sup>50</sup> *Id.* (citing Barry R. FURROW, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 407 (2007) [hereinafter Furrow, *Access to Health Care*]).

<sup>51</sup> SANTERRE & NEUN, *supra* note 46, at 300.

<sup>52</sup> Furrow, *Health Reform*, *supra* note 28, at 451 (citing Furrow, *Access to Health Care*, *supra* note 50, at 409 and ROBERT KUTTNER, *EVERYTHING FOR SALE: THE VIRTUES AND LIMITS OF MARKETS* 134 (1996) (The description of a “hyper-entrepreneurial environment” is used by Robert Kuttner to describe the frenzy of market forces during these last decades)).



system.<sup>53</sup> More medical encounters were displaced to non-hospital settings, and surgical procedures were shifted to outpatient surgery settings. Patient care began a major shift out of hospital care into ambulatory care centers, home health agencies, hospices, and physician group practices.<sup>54</sup> Hospital care was a casualty; hundreds of hospitals closed starting in the early 1980s. This trend is continuing under the pressure of the Affordable Care Act; hospitals merge or transform themselves into other forms such as long-term care facilities.<sup>55</sup>

This expansion of outpatient care in pursuit of higher profits in a largely unregulated setting can produce profit margins sometimes exceeding twenty-five percent.<sup>56</sup> Such outpatient procedures have advantages: they often result in quicker patient recovery and can be performed less expensively than in the hospital. The problem is that the combination of lucrative fee-for-service reimbursement and customer convenience leads to high use of the outpatient services—convenience at a largely unregulated high price.

This historical overview reveals another source of high costs unique to the U.S. health care system—a fragmented, uncoordinated system. A progressive fragmentation of care has occurred as the result of the multiplicity of reimbursement sources for health care: Medicare is for the elderly; private employment-based insurance is available to working adults; Medicaid is for the poor;<sup>57</sup> hospital emergency rooms reluctantly care for undocumented immigrants under the mandate of the Emergency Medical Treatment and Active Labor Act (“EMTALA”);<sup>58</sup> and the Veteran’s Administration system treats the large population of veterans in need of treatment.<sup>59</sup> This complex system managed to cover health care costs for most working Americans for decades, as well as for the old and some fraction of the poor. But as costs have risen, the system has begun to stumble.

A fragmented reimbursement structure means two things. First, administrative costs are high compared to single-payer or highly regulated systems like the French or German health care systems. Hundreds of private insurers market their wares to thousands of employers and individuals, while a variety of federal and state programs exist in tandem for their eligible insureds. Second, the lack of a single strong payer or coordinated payers means that no single powerful agency confronts providers in the private insurance market in their demands for rising incomes and revenues.

The ACA has the potential to create a new era of health care reform—*Quasi-Social Insurance*. President Obama signed the ACA into law on March

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<sup>53</sup> *Id.* at 451.

<sup>54</sup> *See id.* at 451–52 (citing HARRY A. SULTZ & KRISTINA M. YOUNG, HEALTH CARE USA: UNDERSTANDING ITS ORGANIZATION AND DELIVERY 114 (2011)).

<sup>55</sup> *Id.* at 452. The Census Bureau reported 6,649 hospitals in 1990 and 5,708 hospitals in 2007. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2010, at 115 (2010), available at <http://www.census.gov/prod/2009pubs/10statab/health.pdf>.

<sup>56</sup> STEVE JACOB, HEALTH CARE IN 2020: WHERE UNCERTAIN REFORM, BAD HABITS, TOO FEW DOCTORS AND SKYROCKETING COSTS ARE TAKING US 204 (2012).

<sup>57</sup> Furrow, *Health Reform*, *supra* note 28, at 452.

<sup>58</sup> *See* Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians*, 14 PROCEEDINGS—BAYLOR U. MED. CENTER 339, 339 (2001).

<sup>59</sup> Furrow, *Health Reform*, *supra* note 28, at 453.

23, 2010. One week later, the president signed the Health Care and Education Reconciliation Act,<sup>60</sup> which amended some of the spending and revenue provisions of the ACA. Together, these statutes represent the most significant change in the American health care system in a generation. The ACA promotes access to health care through a change in the core definition of private insurance and the decoupling of poverty and Medicaid, while also shifting some responsibility to individuals to improve their own health. The ACA moves us closer to an ideal of universal coverage of all citizens as a right.

The ACA strengthens the pressure on employers to provide insurance for their employees, under threat of penalties, and the insurance exchanges set up under the act require that insurance offerings be transparent in their design and easily available and that the price of such policies bear some relation to the insured's ability to pay.<sup>61</sup> The ACA, in Tom Baker's words, "continues a long term trend in U.S. health care financing away from the ordinary market[-based] approach, [according to] which people pay for their own health care services at the point of consumption."<sup>62</sup> Baker notes that the ACA also asks people to "pay their fair share of the overall cost of health care, primarily through taxes and insurance premiums and [also] through cost-sharing at the point of consumption."<sup>63</sup> The ACA expands the private insurance market through a wide range of strategies: mandates and subsidies to promote private insurance market coverage; the expansion of Medicaid in those states that choose to do so; reductions in Medicare cost sharing; and a range of insurance restrictions, including limits on permitted cost sharing.<sup>64</sup> The ACA also requires insurance availability in the small-group and individual markets.<sup>65</sup>

The insurance reforms in the Affordable Care Act change health insurance from a model based on individual actuarial assessment of health risks to what Tom Baker calls a new concept of "fair share" in health care. Under the new model, insurance discrimination is largely eliminated in favor of determining an individual's share of health care costs according to an individual's ability to pay rather than on the volume of services consumed, and more on individual

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<sup>60</sup> Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 20, 26, and 42 U.S.C.).

<sup>61</sup> See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, §§ 1301-02 (codified as amended in scattered sections of 42 U.S.C.). The term "essential health benefits package" is defined as coverage that "limits cost-sharing for such coverage . . ." *Id.* § 1302(a)(2). Section 1302(b) defines the essential health benefits that must be provided. *Id.* § 1302(b). A separate section prohibits discrimination based on salary in the provision of insurance. *Id.* § 2716.

<sup>62</sup> Tom Baker, William Maul Measey Professor of Law and Health Sciences, University of Pennsylvania Law School, 2010 Hawley Lecture: Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act, at 11 (Aug. 26, 2010), available at [http://www.uiowa.edu/~ibl/documents/Health\\_Insurance\\_Risk\\_and\\_Responsibility\\_after\\_pptx](http://www.uiowa.edu/~ibl/documents/Health_Insurance_Risk_and_Responsibility_after_pptx).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> The ACA accomplishes this in Title 1 in several critical ways by mandating fair premiums, guaranteed availability and renewability of insurance coverage, prohibition of preexisting condition exclusions, prohibition of health status discrimination, comprehensive coverage, and limits on waiting periods. Patient Protection and Affordable Care Act §§ 2701-05, 2707-08.

choices than on genetic or preexisting health risks.<sup>66</sup> The ACA also fosters wellness and prevention programs by eliminating cost-sharing for preventive health services.<sup>67</sup> The wellness program in Title 1 of the ACA prohibits the use of health status to discriminate and decrees that wellness programs cannot be designed to use health-status factors.<sup>68</sup>

The Affordable Care Act tries to improve access to care for millions of Americans while reducing fragmentation and its resulting inefficiencies.<sup>69</sup> Congress intended to produce a better-integrated, more effective, more technologically innovative system.<sup>70</sup> The ACA develops several strategies to reduce the fragmentation of care that underpins many of today's cost problems.<sup>71</sup> Many ideas are new, although other ideas reinforce government policies that are in the process of being implemented on a trial basis. From a broad cost perspective, the ACA aims to reduce system costs per capita while providing efficient care for those who otherwise would be relegated to hospital emergency rooms or no care at all.

Let us dig a bit deeper into the range of possible explanations for our health care cost increases and see where the ACA helps and where it falls short.

#### A. *Scientific Advances: Technology as a Cost Driver*

The usual suspects cited by economists for rising health care costs are: aging of the population (2%); changes in third-party payment (10–13%); personal income growth (5–23%); prices in the health care sector (11–22%); administrative costs (3–13%); defensive medicine and supplier-induced demand (0%); and technology-related changes in medical practice (38–65%).<sup>72</sup>

<sup>66</sup> Baker, *supra* note 62, at 11.

<sup>67</sup> Section 2716 of the ACA prohibits discrimination based on salary, and section 2717(a)(1)(D) requires insurers to implement wellness and health promotion activities. Patient Protection and Affordable Care Act §§ 2716–17.

<sup>68</sup> *Id.* § 2705(a)(1).

<sup>69</sup> See Furrow, *Access to Health Care*, *supra* note 50, at 410. I have recounted elsewhere some of the factors that have led to and reinforced our fragmented system. *Id.* at 407–08 (describing shrinking of employment-based insurance coverage).

<sup>70</sup> See *supra* note 18 for a list of the sheer variety of cost conserving ideas in play in the ACA.

<sup>71</sup> See Einer Elhauge, *Why We Should Care About Health Care Fragmentation*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 1, 11–12 (Einer Elhauge ed., 2010) (citing, among other causes of such fragmentation, the law and legal doctrines that thwart efficiencies and the payment system of Medicare).

<sup>72</sup> PAUL B. GINSBURG, *HIGH AND RISING HEALTH CARE COSTS: DEMYSTIFYING U.S. HEALTH CARE SPENDING* 11 (2008), available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2008/rwjf32704/subassets/rwjf32704\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2008/rwjf32704/subassets/rwjf32704_1). For a more recent analysis, see Sheila Smith, Joseph P. Newhouse & Mark S. Freeland, *Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?*, 28 *HEALTH AFF.* 1276, 1276 (2009) (“[Technology] is the primary driver of health spending growth . . . [which] is fueled by rising incomes and more generous insurance coverage. We estimate that medical technology explains 27–48 percent of health spending growth since 1960—a smaller percentage than earlier estimates. Income (gross domestic product, or GDP) growth plays a critical role, primarily through the actions of governments and employers on behalf of pools of consumers. The contribution of insurance is likely to differ, with less of a push from increasing generosity of coverage and more of a push from changes in provider payment.”).

Technology is usually the number-one suspect as a cost driver. We love technology in the United States. We are early adopters, and we value many forms of technological innovation for their own sake. Medical technology is a major engine of health care cost increases.<sup>73</sup> It can account for an estimated one-half to two-thirds of spending growth.<sup>74</sup> Health care economists estimate that 40–50% of annual cost increases can be traced to new technologies or the intensified use of old ones.<sup>75</sup>

Medical technology takes many forms: it can be new surgical procedures, new drugs or medical devices, or infrastructure support tools such as electronic health records (EHRs).<sup>76</sup> The bursts in technology adoption are often quite striking. For example, in the period from 1996 to 2007, Jacob notes that “[u]se of advanced imaging technology in outpatient facilities tripled . . . . Knee and hip replacements increased 60 to 70 percent.”<sup>77</sup> Angioplasty surgeries to open blocked or narrowed coronary arteries went from low use of stents to more than ninety percent using stents by 2006, most coated with drugs.<sup>78</sup> U.S. procedures to treat blocked coronary arteries are double the OECD average; knee replacements are fifty percent above, cesarean sections are nearly twenty-five percent above.<sup>79</sup> All of these procedures are expensive and are largely responsible for a doubling in Medicare Part B reimbursement, which covers doctor and outpatient services, to \$14.1 billion, from 2000 to 2006.<sup>80</sup>

Technologies like those described may be of higher quality, or they may have lower costs per unit,<sup>81</sup> but they are likely to be delivered inefficiently

<sup>73</sup> David A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, 10 COMMONWEALTH FUND, May 2012, at 10, available at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/High-Health-Care-Spending.aspx> (“U.S. health care spending, which reached nearly \$8,000 per person annually in 2009, has outpaced GDP growth for the past several decades and far exceeds spending in any other country. The analysis in this brief suggests that this spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps because of more readily accessible technology and greater rates of obesity. Despite being more expensive, the quality of health care in the U.S. does not appear to be notably superior to other industrialized countries.”).

<sup>74</sup> GINSBURG, *supra* note 72, at 11.

<sup>75</sup> See Callahan, *supra* note 2, at 79. Ginsburg writes: “The dominant driver of long-term cost trends is advancing medical technology, where new options for diagnosis and treatment often replace older technologies that are less expensive or provide opportunities when none existed before. Advancing technology may have a particularly large impact on spending in the United States because of few requirements that effectiveness be demonstrated before technologies are used broadly and concern that their application tends to go beyond those patients likely to benefit the most from them. GINSBURG, *supra* note 72, at 19.

<sup>76</sup> JACOB, *supra* note 56, at 204.

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> ORGANISATION FOR ECON. CO-OPERATION & DEV., HEALTH AT A GLANCE 2011: OECD INDICATORS 90–93, 96–97 (2011), <http://www.oecd.org/health/healthpoliciesanddata/49105858.pdf>.

<sup>80</sup> JACOB, *supra* note 56, at 204. See also U.S. DEP’T OF HEALTH AND HUMAN SERVS., NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2009: WITH SPECIAL FEATURE ON MEDICAL TECHNOLOGY 68–78 (2010).

<sup>81</sup> GINSBURG, *supra* note 72, at 15. See also Glen Whitman & Raymond Raad, *Bending the Productivity Curve: Why America Leads the World in Medical Innovation*, POL’Y ANALYSIS,

through use of high inputs and often to patients who get only small or no benefits from the treatments.<sup>82</sup> We effectively subsidize innovation in medicine for the whole world at the price of our own high inflation rate.<sup>83</sup>

Control of the diffusion of technology is central to controlling health care costs. New technologies are not always innovations, and one of the hardest tasks is to sort the promising from the false innovation.<sup>84</sup> Innovations in new drug, medical device, and surgical technologies pose complicated assessment problems for health care. Although these new technologies raise costs by adding new diagnostic tools and surgical or other approaches to care whose benefits are rarely fully developed, innovative use of technologies of organization and data collection can reduce costs and improve quality. One study, for example, found that the vintage (or newness) of drugs used improved longevity in Germany and France. In France, chemotherapy innovation may have accounted for up to one-sixth or more of the decline in French cancer mortality rates during 2002–2006.<sup>85</sup> Another Australian study found hospital therapeutic innovations to be cost-effective, showing little impact on the cost of medical procedures.<sup>86</sup> Another study by the same author looked at cancer imaging and cancer drug improvements and concluded that:

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Nov. 18, 2009, at 1–4 (noting that the U.S has contributed the most innovations to medical advances. Areas include basic medical science, diagnostics, therapeutics, and business models such as retail clinics. The authors also note, “In general, Americans tend to receive more new treatments and pay more for them—a fact that is usually regarded as a fault of the American system. That interpretation, if not entirely wrong, is at least incomplete. Rapid adoption and extensive use of new treatments and technologies create an incentive to develop those techniques in the first place. When the United States subsidizes medical innovation, the whole world benefits. That is a virtue of the American system that is not reflected in comparative life expectancy and mortality statistics.”).

<sup>82</sup> GINSBURG, *supra* note 72, at 15–16.

<sup>83</sup> See Whitman & Raad, *supra* note 81, at 9.

<sup>84</sup> Emanuel uses the phrase “pseudo-innovation” to describe new technologies that offer little or no gains over existing medical tools. Ezekiel J. Emanuel, *In Medicine, Falling for Fake Innovation*, N.Y. TIMES OPINIONATOR (May 27, 2012, 7:49 PM), <http://opinionator.blogs.nytimes.com/2012/05/27/in-medicine-falling-for-fake-innovation/>.

<sup>85</sup> Frank R. Lichtenberg, *Contribution of Pharmaceutical Innovation to Longevity Growth in Germany and France, 2001–[2007]*, 30 PHARMACOECONOMICS 197, 210 (2012). In his study, Lichtenberg looked at “information on about 250 million prescriptions per year for over 600 active ingredients . . .” *Id.* at 201. Lichtenberg found that German states “with larger increases in drug vintage had larger increases in life expectancy . . . German life expectancy at birth increased by 1.4 years during the period 2001–[2007]. The estimates imply that about one-third of this increase was due to the replacement of older drugs by newer drugs. The estimate of the cost per life-year gained from the use of newer drugs is a small fraction of leading economists’ estimates of the value of (willingness to pay for) an additional year of life.” *Id.* at 210. In France, he looked at the “utilization of 11 cancer drugs by about 4000 cancer patients per year.” *Id.* He concluded that “[a] 10-year increase in mean drug vintage was estimated to reduce the age-adjusted mortality rate by about 6%. . . . The estimates implied that chemotherapy innovation accounted for at least one-sixth of the decline in French cancer mortality rates during 2002–[2006], and may have accounted for as much as half of the decline.” *Id.*

<sup>86</sup> Frank R. Lichtenberg, *The Impact of Therapeutic Procedure Innovation on Hospital Patient Longevity: Evidence from Western Australia, 2000–2007*, 77 SOC. SCI. & MED. 50, 50, 57–58 (2013).

[A]bout 9% of the decline in the mortality rate from *all causes* of death is attributable to cancer imaging innovation, and about 6% is attributable to cancer drug innovation. Life expectancy at birth may have been increased by just under three months between 1996 and 2006 by the combined effects of cancer imaging and cancer drug innovation.<sup>87</sup>

A third study looked at longevity in U.S. states. Three variables were considered: the average quality of diagnostic imaging procedures, defined as the fraction of procedures that are advanced procedures; the average quality of practicing physicians, defined as the fraction of physicians that were trained at top-ranked medical schools; and the mean vintage (FDA approval year) of outpatient and inpatient prescription drugs.<sup>88</sup> The author concluded:

Life expectancy increased more rapidly in states where (1) the fraction of Medicare diagnostic imaging procedures that were advanced procedures increased more rapidly; (2) the vintage of self- and provider-administered drugs increased more rapidly; and (3) the quality of medical schools previously attended by physicians increased more rapidly. States with larger increases in the quality of diagnostic procedures, drugs, and physicians did not have larger increases in per capita medical expenditure.<sup>89</sup>

If we apply Emanuel's test—demanding of the innovation solid evidence that “it prolongs survival, reduces side effects or improves quality of life—or maintains the current standard of care at a lower cost”—many new technologies fall short.<sup>90</sup> Drug innovations pose special problems, with a large industry that argues aggressively that prices need to be high enough to reward manufacturers for their research costs.<sup>91</sup> On the other hand, the studies cited suggest that many newer technologies and advanced procedures do produce real improvements in patient health.

Technology puts the policymaker between Scylla and Charybdis: it offers providers and patients tools for improved treatment and simultaneously allows them to charge more. Patients do not fret about the cost of new technology if they have good insurance, and too many providers want the new even if it lacks evidence of efficacy. Both government and private payers are cautious about resisting innovations, afraid they will be accused of condoning rationing, and the federal government has had at least one hand tied behind its back since the

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<sup>87</sup> Frank R. Lichtenberg, *Has Medical Innovation Reduced Cancer Mortality?* 15 (Nat'l Bureau of Econ. Research, Working Paper No. 15880, 2010), available at <http://www.nber.org/papers/w15880>.

<sup>88</sup> See generally Frank R. Lichtenberg, Abstract, *The Quality of Medical Care, Behavioral Risk Factors, and Longevity Growth*, 11 INT'L J. HEALTH CARE FIN. ECON. 1, 1 (2011).

<sup>89</sup> *Id.* (“This paper examines the effect of the quality of medical care, behavioral risk factors (obesity, smoking, and AIDS incidence), and other variables (education, income, and health insurance coverage) on life expectancy and medical expenditure using longitudinal state-level data.”).

<sup>90</sup> Emanuel, *supra* note 84.

<sup>91</sup> For a recent display of this argument, see JORGE MESTRE-FERRANDIZ ET AL., OFFICE OF HEALTH ECON., *THE MANY FACES OF INNOVATION: A REPORT FOR THE ABPI BY THE OFFICE OF HEALTH ECONOMICS* 51 (2d ed. 2012), available at <http://www.abpi.org.uk/our-work/library/industry/Pages/many-faces-of-innovation.aspx> (The report was commissioned by the Association of the British Pharmaceutical Industry (ABPI)).

mid-1990s, the result of congressional defunding of the Office of Technology Assessment.<sup>92</sup>

Without aggressive evaluation of new technologies and pushback by payers, we are left with providers who will buy new unproven and expensive medical tools, generate new tests and procedures of little benefit, and drive costs higher and higher. Hospitals, for example, will always want the new so they can market their cutting-edge technology to attract patients and better physicians to their staffs. The end result is that we come to view the newest technologies as proxies for higher quality in health care. As David Squires writes, “[t]his combination of pervasive medical technology and high prices showcases two potent drivers of U.S. health spending, and a possible explanation for the outsized share of resources we dedicate to health care relative to the rest of the world.”<sup>93</sup>

### B. *Physician Spending: Unnecessary Care*

Providers, particularly physicians, direct our individual care as our agents, shopping on our behalf when our ignorance renders us unable to make shopping decisions.<sup>94</sup> Physician-directed purchasing has long been criticized for buying unnecessary or wasteful care.<sup>95</sup> How much health care is unnecessary? Shannon Brownlee has argued that up to one-third of our health care dollars are spent on care that does nothing to improve our health.<sup>96</sup> The aggregate costs of surgery, diagnostic tests, and drugs eat up our health care budgets, often with little or no proven value. It represents a wasteful product. Some experienced health care analysts believe for example that “[t]he opportunity for waste reduction in health care is enormous.”<sup>97</sup> By contrast, other long-time health care observers are less sanguine.<sup>98</sup> Reducing waste seems intuitively obvious, a sensible ideal, although waste theory has been criticized since the 1990s for ignoring the difficulty in defining and reducing waste.<sup>99</sup> Waste is often the byproduct of diagnostic or treatment uncertainty, and until that uncertainty is reduced, waste remains likely.

<sup>92</sup> The Office of Technology Assessment was killed by Congress in 1995 during a particularly virulent congressional budget cutting session. See *Technology Assessment and Congress*, OFF. OF TECH. ASSESSMENT ARCHIVE, [http://www.fas.org/ota/technology\\_assessment\\_and\\_congress/](http://www.fas.org/ota/technology_assessment_and_congress/) (last visited Apr. 7, 2013).

<sup>93</sup> Squires, *supra* note 73, at 9.

<sup>94</sup> Barry R. Furrow, *Physician Payment Reform: Plugging the Drain*, 34 ST. LOUIS U. L.J. 821, 822, 829 (1990) (noting the limitations on the role of physicians as economic agents of patients) [hereinafter Furrow, *Physician Payment Reform*].

<sup>95</sup> *Id.* at 822–23, 852.

<sup>96</sup> SHANNON BROWNLEE, *OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER* 5 (2007).

<sup>97</sup> Berwick & Hackbarth, *supra* note 18, at 1513.

<sup>98</sup> Callahan, *supra* note 2, at 81 (“What then can be done about costs? There are a number of ideas available to meet the challenge, few of them rooted in any experience or evidence. The long-time favorite has been that of eliminating waste and inefficiency, which I liken to keeping the dust out of a drafty house located in the middle of a desert.”).

<sup>99</sup> The problems in the application of waste theory to medical technology has long been noted. See, e.g., Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778, 778–79, 781–82 (1986).

Broadly defined, waste includes several dimensions: failures of care delivery, failures of care coordination, overtreatment, administrative complexity, pricing failures, and fraud and abuse.<sup>100</sup> For U.S. health care overall, Berwick and Hackbarth calculate that “the sum of the lowest estimates is \$558 billion per year, or 21% of national health expenditures; and the sum of midpoint estimates is \$910 billion per year, or 34%.”<sup>101</sup>

Overtreatment is a complicated problem. It includes care that lacks a sound evidence basis but does not rise to the level of waste since we lack sufficient evidence to move it from possibly effective to wasteful. It also includes care provided in excess of clinical tests of necessity.<sup>102</sup> Studies of American medicine have found large practice variation around the country.<sup>103</sup> John Wennberg, whose studies in this area are often cited, has analyzed states and regions within states for variation in surgical and other practices. Wennberg gives the example of patient time in intensive care units in the last six months of life in selected teaching hospitals.<sup>104</sup> The number of days ranged from 11.4 at UCLA Medical Center to as low as 2.8 at Massachusetts General Hospital.<sup>105</sup> This has cost implications: the Dartmouth Atlas group looked at total Medicare reimbursements per decedent (adjusted for condition) during their last two years of life, and the amount spent per person ranged from \$25,000 to \$100,000, with the mean being around \$48,000.<sup>106</sup> The Dartmouth Atlas details wide variations in cost and practice approaches around the country.<sup>107</sup>

The causes of this variation are multiple and difficult to fix.<sup>108</sup> Procedures least subject to variation are those for which there is a professional consensus

<sup>100</sup> See Berwick & Hackbarth, *supra* note 18, at 1513–14 (explaining each of these elements of waste).

<sup>101</sup> *Id.* at 1514.

<sup>102</sup> For a discussion of unnecessary implantations, see Sana M. Al-Khatib et al., *Non-Evidence-Based ICD Implantations in the United States*, 305 JAMA 43, 48 (2011) (more than 40% of the total number of implanted ICDs are not based on evidence). Congress has even researched the problem of unnecessary implant procedures. See S. COMM. ON FIN., 111TH CONG., STAFF REP. ON CARDIAC STENT USAGE AT ST. JOSEPH MEDICAL CENTER 57, at 4–5, 10, 14 (Comm. Print 2010) (describing the overuse of stenting at one hospital and the cost to Medicare of such unnecessary procedures).

<sup>103</sup> See, e.g., John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 3 HEALTH AFF. 6, 9–15 (1984) (contending that norms of medical practice allow for a “wide range of professional discretion” and thus can result in significant differences in how patients are treated); *Understanding of the Efficiency and Effectiveness of the Health Care System*, DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org> (last visited Apr. 7, 2013) (using Medicare data to show “glaring variations in how medical resources are distributed and used in the United States”).

<sup>104</sup> DARTMOUTH ATLAS PROJECT, THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS: AN ONLINE REPORT ON THE MEDICARE PROGRAM 10 (2006), [http://www.dartmouthatlas.org/downloads/atlas/2006\\_Chronic\\_Care\\_Atlas.pdf](http://www.dartmouthatlas.org/downloads/atlas/2006_Chronic_Care_Atlas.pdf).

<sup>105</sup> *Id.* at 24.

<sup>106</sup> *Id.* at 47.

<sup>107</sup> See *id.* at 4; see also Wennberg, *supra* note 103, at 9. Wennberg is the author of the Dartmouth Atlas, which uses Medicare data to track medical practice variation over the country, by procedure. See *Tools*, DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/tools/> (last visited Apr. 7, 2013).

<sup>108</sup> Wennberg concludes that system causes of unwarranted variation include misuse of preference-sensitive care; poor communication between the doctor and patient regarding the



on the preferred place or style of treatment.<sup>109</sup> It is clear that modern medicine still lacks validation for many treatment modalities.<sup>110</sup> A recent study of advanced diagnostic imaging concluded that its costs and benefits have not been well-studied or justified. The authors concluded:

The increase in use of advanced diagnostic imaging has almost certainly contributed to both improved patient care processes and outcomes, but there are remarkably few data to quantify the benefits of imaging. Given the high costs of imaging—estimated at \$100 billion annually—and the potential risks of cancer and other harms, these benefits should be quantified and evidence-based guidelines for using imaging should be developed that clearly balance benefits against financial costs and health risk.<sup>111</sup>

We need to know more about treatments and what they achieve, more about differences in practice styles and the variation created, and more about what works and the limits to the use of treatments.

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risks and benefits of alternative treatments; patient dependency on a physician's opinion in sorting out preferences; inadequate evaluation of (evolving) treatment theory; and the effects of our health care finance system that rewards procedures, not time spent with patients or the quality of decision making. See generally John E. Wennberg, *Variation in Use of Medicare Services Among Regions and Selected Academic Medical Centers: Is More Better?*, 8 COMMONWEALTH FUND, Dec. 2005, at 4, available at [http://www.commonwealthfund.org/userdoc/874\\_wennbert\\_variation\\_medicare\\_svcs.pdf](http://www.commonwealthfund.org/userdoc/874_wennbert_variation_medicare_svcs.pdf) (noting “striking regional variations in the proportion of early stage breast cancer patients who undergo lumpectomy” and identifying “idiosyncratic practice style” as the “major source of such widely varying discretionary surgery rates”). For a graphic depiction of the variation, see John E. Wennberg, Active Emeritus Professor of Community & Family Medicine and of The Dartmouth Institute, Keynote Lecture at the Institute for Healthcare Improvement's National Forum in Orlando, Florida: Understanding Practice Patterns: A Focus on What the Quality Movement Can Do to Reduce Unwarranted Variations 4, 8 (Dec. 14, 2005), available at [http://www.ghdonline.org/uploads/Wenneberg\\_IHI\\_lecture\\_December051.pdf](http://www.ghdonline.org/uploads/Wenneberg_IHI_lecture_December051.pdf); John E. Wennberg et al., *Evaluating the Efficiency of California Providers in Caring for Patients with Chronic Illnesses*, HEALTH AFF. 526, 530–38 (Nov. 16, 2005), <http://content.healthaffairs.org/content/early/2005/11/16/hlthaff.w5.526.full.pdf>. See also Lars Noah, *Medicine's Epistemology: Mapping the Hazardous Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 382–83 (2002) (recognizing physicians' traditional reliance on personal experience and anecdotal information).

<sup>109</sup> Wennberg's studies are based on three categories of care: effective care, preference-sensitive care, and supply-sensitive care. Effective care describes interventions that are viewed as medically necessary on the basis of clinical outcomes evidence and for which the benefits so outweigh the risks that virtually all patients with medical need should receive them. Preference-sensitive care includes treatments, such as discretionary surgery, for which there are two or more valid treatment alternatives, and the choice of treatment involves tradeoffs that should be based on patients' preferences. Supply-sensitive care includes services, mostly for patients with chronic illness, such as physician visits, referrals to specialists, hospitalizations and stays in intensive care units involved in the medical (non-surgical) management of disease. *Executive Summary*, THE DARTMOUTH ATLAS OF HEALTH CARE, [http://www.dartmouthatlas.org/pages/executive\\_summary](http://www.dartmouthatlas.org/pages/executive_summary) (last visited Apr. 7, 2013).

<sup>110</sup> The resistance of physicians to externally imposed standards and values is a recurrent theme in American health care. For an excellent summary and analysis of the reasons for this recalcitrance, see Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 973–75, 992–1008 (2009).

<sup>111</sup> Rebecca Smith-Bindman et al., *Use of Diagnostic Imaging Studies and Associated Radiation Exposure for Patients Enrolled in Large Integrated Health Care Systems, 1996–2010*, 307 JAMA 2400, 2408 (2012) (footnotes omitted).

*C. Exuberant Patients: Spending Others' Money*

Patients are a common target for cost control. Worried about our health, overoptimistic about the power of modern medicine, and insured for most of our expenses, we may spend more than is either efficient or healthy on our treatments. We are price-insensitive. If a hundred-dollar treatment yields a measurable “value” of seventy-five dollars, we would not buy such a treatment if we paid out of pocket; if, however, we pay only twenty-five dollars and receive the seventy-five-dollar value, it is worth it to us. Although we do pay more total dollars out of pocket, we pay a smaller percentage (13%) of our health care costs out of pocket through deductibles and copayments than most of our counterparts: France pays 8%, Germany 13%, Canada 15%, Japan 17%, and Switzerland 32%.<sup>112</sup>

People’s tastes can also affect demand for health care, and Americans have a strong appetite. Cultural norms can encourage a desire for health care. One poll found that 34% of Americans thought that “modern medicine [could] cure almost any illness,” compared to only 27% of Canadians and 11% of Germans.<sup>113</sup> These American attitudes are likely to lead to greater trust in and reliance on advanced medical procedures.<sup>114</sup>

A popular proposal from market advocates is the use of consumer-directed health plans with high deductibles, shifting costs onto consumers to slow their spending.<sup>115</sup> Consumers will miraculously become smart shoppers. Cost shifting to consumers has been going on for a long time, and consumer-directed health care is the newest variant. If patients can shop and select their care, using their own money, they will be sensitive to price and cost, and a major cost reducer will take over—the sharp price-sensitivity of the buyer.<sup>116</sup> If it works with plasma televisions and cars, surely the health care marketplace is next. The consumer who bears a \$4,000 deductible will avoid unneeded trips to the doctor and be cost-conscious during visits.

The reality is that in this flawed market model consumers are far less likely to fill prescriptions or go to the doctor at all. Unable to choose between essential and non-essential care, and wanting to avoid spending money that is at risk, they are going to avoid going to the doctor. Workers with consumer-driven plans are healthier simply because the healthy workers are more likely to

<sup>112</sup> CHRIS L. PETERSON & RACHEL BURTON, CONG. RESEARCH SERV., RL34175, U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES 35–36 & fig.21 (2007).

<sup>113</sup> Minah Kim, Robert J. Blendon & John M. Benson, *How Interested Are Americans in New Medical Technologies?: A Multicountry Comparison*, 20 HEALTH AFF. 194, 198 tbl.4 (2001). Such beliefs may be uniquely American in our level of belief in unproven benefits and unseen saviors. For example, nearly eighty percent of Americans believe in angels as well. *Poll: Nearly 8 in 10 Americans Believe in Angels*, CBS NEWS (Dec. 23, 2011, 8:25 AM), [http://www.cbsnews.com/8301-201\\_162-57347634/poll-nearly-8-in-10-americans-believe-in-angels/](http://www.cbsnews.com/8301-201_162-57347634/poll-nearly-8-in-10-americans-believe-in-angels/).

<sup>114</sup> PETERSON & BURTON, *supra* note 112, at 37.

<sup>115</sup> TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 120 (2007).

<sup>116</sup> *Id.* at 17–19.

switch to consumer-driven plans than their less-healthy counterparts.<sup>117</sup> This marketplace fantasy underpins a great many conservative health care ideas.

Health care is not a marketplace.<sup>118</sup> A market requires transparency of prices.<sup>119</sup> The prices of most services are now opaque, undiscoverable, and variable by insurance status for hospital care.<sup>120</sup> The price of our insurance at work may be transparent, but our employers have already limited our choices to almost nothing. Shifting the perils of shopping risks onto consumers means very little; they cannot shop on the basis of price except for over-the-counter drug products at the local pharmacy.<sup>121</sup>

The second market problem when shifting the risk of health care “shopping” onto consumers anywhere near the point of service is that they are ill-equipped to know what is “necessary” care absent a medical education. In other words, they will sometimes buy too little of what turns out to have been necessary care. This may save money now but, from a national budget perspective, will require care at much higher cost later if necessary care is delayed. We use physicians as our agents for the very reason that we do not often know enough to really “shop,” at least for care. We may be able to shop for the best hospitals or physicians in some cases, and the ACA and CMS will support us in our efforts, as we will see, but most of the time we lack the skill and incentives to shop meaningfully.

The third problem of shifting risks and burdens onto consumers in too draconian a fashion is that, unlike most markets we participate in, health care is not recognizably a “good” like consumer goods or houses or stocks. Health care is not a good—only its expected benefits are. As Robert Evans observes,

[t]he individual who undergoes care is by no means a “beneficiary,” to be envied by his fellow citizens, but an unfortunate who, given the option, would gladly forego both the care and the accompanying episode of illness or injury. Two weeks in the hospital costs much more than a two-week tropical vacation, but the individual who enjoys the former is not better off, on any measure, than the one who undergoes the latter.<sup>122</sup>

<sup>117</sup> For a critique of these assumptions, see *id.* at 120.

<sup>118</sup> Furrow, *Physician Payment Reform*, *supra* note 94, at 827–30 (discussing the problems with a market analysis in health care).

<sup>119</sup> Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 *HEALTH AFF.* 57, 67–68 (2006) (prices for health care goods and services in the U.S. are opaque; making consumer-directed health care very unlikely to succeed without major changes).

<sup>120</sup> Tara Siegel Bernard, *Getting Lost in the Labyrinth of Medical Bills*, *N.Y. TIMES*, June 23, 2012, at B1.

<sup>121</sup> We do find some price resistance in cancer patients, as private insurers today make patients pay a larger share of their drug bills. Drug companies have adopted a strategy with expensive drugs of offering to pay the patient’s share of the drug cost, which keeps soaring costs out of sight and less painful. The most expensive cancer drugs for example have inelastic demand since dying patients place a high value on their short remaining life. Firms can exact high prices. As one doctor notes, “[a]t some point it’s just corporate chutzpah . . . There’s no check in the system.” *The Costly War on Cancer*, *ECONOMIST*, May 28, 2011, at 67–68, available at <http://www.economist.com/node/18743951> (internal quotation marks omitted).

<sup>122</sup> Robert G. Evans, *Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control*, 15 *J. HEALTH POL. POL’Y & L.* 101, 124 n.9 (1990).

Shopping for chemotherapy may be desirable but it is not pleasurable—it is to be avoided whenever possible. If we are incentivized to have to bear the financial risk of our choices, we may just try to avoid thinking about them, since going to the doctor will chew up our deductible in an economy that has already shrunk our real wages.

#### D. *Negotiated Prices: Bargaining Disparities*

The American health care industry is highly fragmented, with 2300 separate entities making up the general acute-care industry. One study concluded that “[n]o other industry, particularly one so vital to the broader economy, even closely approaches this level of fragmentation.”<sup>123</sup> Fragmentation means inefficiency, duplication, and higher cost in most industries. Economies of scale and bargaining power are missing. Multiple payers, mixing private and several public payers, can only increase prices. In countries with all-payer regulation, single payers can bargain effectively with doctors, hospitals, and pharmaceutical companies, and can also set enforceable spending targets.<sup>124</sup> A complicated multi-payer system covered by fee-for-service payments for specialty care also has pernicious effects on the distribution of medical specialties, with cost implications. The United States, for example, has a much higher ratio of specialists to primary care physicians, which most likely reflects the higher level of specialist pay.<sup>125</sup> It is also clear that the high cost of medical education pushes young doctors toward higher paying specialties.<sup>126</sup>

Our fragmented system limits buyer-negotiating power when facing providers. If insurers lack power to negotiate lower rates, physicians and hospitals—paid more to do more regardless of outcome—will do more.<sup>127</sup> Fee-for-service payment and bonusing systems maximize these incentives.<sup>128</sup> Physi-

<sup>123</sup> JAMES BURGDORFER ET AL., GOVERNANCE INST., HOSPITAL CONSOLIDATION TRENDS IN TODAY'S HEALTHCARE ENVIRONMENT 11 (2010).

<sup>124</sup> Jonathan Oberlander & Joseph White, *Public Attitudes Toward Health Care Spending Aren't the Problem; Prices Are*, 28 HEALTH AFF. 1285, 1289 (2009) (The authors observe that “[o]ther nations achieve lower prices by paying for health services through either a single-payer or coordinated, multi-payer systems that set or negotiate fees with all providers. Analysts who seek greater productivity in medical care should recognize that productivity can be increased simply by paying less per service. Other OECD health systems also spend much less on administration, both because insurance is simpler and because providers do not face the burden of dealing with myriad payers and payment rules.”) (footnotes omitted).

<sup>125</sup> Bruce C. Vladeck, *Fixing Medicare's Physician Payment System*, 362 NEW ENG. J. MED. 1955, 1956 (2010).

<sup>126</sup> PETERSON & BURTON, *supra* note 112, at 17–19.

<sup>127</sup> One classic study examined a clinic that switched from salary to commission on fees generated. As a result, doctors scheduled more appointments and ordered more blood tests and x-rays. See David Hemenway et al., *Physicians' Responses to Financial Incentives: Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059, 1059–62 (1990) (concluding that switching from fee for service to a bonus system leads physicians to change their practice style; the authors concluded that “[t]he system of monetary rewards appears to have led virtually all the physicians to increase the number of patient visits and the rate of diagnostic testing.”).

<sup>128</sup> See JUDY ANN BIGBY ET AL., REPORT OF THE NATIONAL COMMISSION ON PHYSICIAN PAYMENT REFORM 3 (2013), [http://physicianpaymentcommission.org/wp-content/uploads/2012/02/physician\\_payment\\_report.pdf](http://physicianpaymentcommission.org/wp-content/uploads/2012/02/physician_payment_report.pdf) (“The commission’s recommendations focus on the near-term, calling for drastic changes to the current fee-for-service payment system and a

cians become quality-insensitive and income-sensitive. If physicians then risk losing money on higher-quality care, it is not surprising that such care is not regularly offered.<sup>129</sup> The result is high prices charged by health professionals.

Providers in many markets use their negotiating clout to get higher prices from commercial health plans; Robert Berenson writes that “hospital and physician payment rate increases that outpace the rate of cost increases are major contributors to rising premiums for employer-sponsored insurance. Providers’ growing negotiating strength also enables them to modify contract terms, blocking health plans’ attempts to steer patients to low-cost providers.”<sup>130</sup> A Massachusetts study found that health care cost increases in the state had been driven mostly by hospitals’ and physician groups’ market dominance, not by the cost of providing the actual care.<sup>131</sup>

Hospital pricing reflects this multiplicity of payers and the variable pricing that results.<sup>132</sup> One study found that hospital charges varied seventeen fold across California hospitals, but these charges were typically much higher than what was actually paid by insurers and the government.<sup>133</sup> The government-controlled systems of Canada, Europe, and Japan grant much more market power to the buy side, and their national health care costs reflect this bargaining power.<sup>134</sup>

*Administrative Costs.* We have a health care system that is administratively costly compared to single-payer systems around the world, or indeed any industrialized country’s system. Our median per capita spending on health

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five-year transition to a physician-payment system that rewards quality and value-based care. The recommendations pertain to the way physicians are paid throughout the health care system—both public and private payers.”)

<sup>129</sup> See, e.g., Ian Urbina, *In the Treatment of Diabetes, Success Often Does Not Pay*, N.Y. TIMES, Jan. 11, 2006, at A1, available at [http://www.nytimes.com/2006/01/11/nyregion/nyregionspecial5/11diabetes.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2006/01/11/nyregion/nyregionspecial5/11diabetes.html?pagewanted=all&_r=0).

<sup>130</sup> 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, 973 (2012).

<sup>131</sup> MARTHA COAKLEY, OFFICE OF THE ATT’Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 38–40 (2010), available at <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>.

<sup>132</sup> Reinhardt, *supra* note 119, at 67.

Asked by a Wall Street Journal reporter to explain how U.S. hospitals price their services, William McGowan, chief financial officer of the University of California, Davis, Health System and thirty-year veteran of hospital financing, responded: “There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges.”

... In 2004, for example, U.S. hospitals were actually paid only about 38 percent of their “charges” by patients or their insurers. The actual prices they were paid appear to vary much less than “charges” do, although even that variation is remarkable [sic] large. For example, in 2001 the prices hospitals were actually paid by private health insurers serving the Federal Employees Health Benefits Program (FEHBP) varied by “only” 259 percent across the United States.

*Id.* at 57 (footnotes omitted). See also Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, at 16, available at <http://www.time.com/time/magazine/article/0,9171,2136864,00.html> (lengthy discussion of the hospital “chargemaster” and the tremendous variation in hospital charges depending on who is paying for the service).

<sup>133</sup> Reinhardt, *supra* note 119, at 57.

<sup>134</sup> Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 102 (2003).

administration and insurance was seven times that of the OECD median (\$465 compared to \$66), based on twenty-one countries that reported in 2004,<sup>135</sup> and there is no reason to expect any improvement in that differential today. The United States, by one estimate, spends \$361 billion annually on health care administration, half of which is unnecessary and therefore better spent on useful medical services to patients in need.<sup>136</sup> The federal government has taken a chunk out of these administrative costs through several approaches; one of the biggest steps predates the ACA, and that is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides financial incentives for the acquisition of EHRs through its “meaningful use” requirement and specifies standards for the electronic transmission of clinical data.<sup>137</sup> If these standards were expanded for example to include electronic transmission of administrative data, like billing information, as much as \$2 billion could be saved annually. Combined with other reforms, one economist recently estimated that as much as \$40 billion annually could be saved.<sup>138</sup>

#### E. *Dying Too Slowly: Death-Denying Consumers*

The population of the United States is steadily aging, and older people, particularly those over eighty, require a great deal of health care. This aging has been accompanied by increases in male and female life expectancy, with males’ increase at birth going from 76.2 years in 2010 to 79.9 years in 2030; for females, the gains are more modest, from 80.5 years to 81.9 years.<sup>139</sup> We are living longer, and this means higher health care costs for this growing cohort of aging citizens. We spend a great deal on end-of-life care, and some critics contend that we need a new attitude toward death, welcoming hospice care and refusing high-cost care that gains only a few weeks of life at the end.<sup>140</sup>

A hard look at the data suggests however that only a small proportion of the general growth in health care costs is explained by end-of-life care increases, perhaps seven percent over the past thirty years. As people reach the age of sixty-five, they become eligible for Medicare (and for Medicaid if they are financially needy). Additionally, if they retire, they cease contributing to the Medicare trust fund and reduce payments of the taxes that support Medicaid.

<sup>135</sup> PETERSON & BURTON, *supra* note 112, at 29 (“Spending on health insurance and administration can be broken into three parts. The largest part, at least in the United States, comprises the difference between earned premiums and incurred benefits of private health insurers. This difference accounts for insurers’ administrative costs, net additions to reserves, rate credits and dividends, premium taxes, and profits or losses. The next largest part comprises the administrative expenses of government programs. The smallest part comprises the expenses associated with health activities of philanthropies.”).

<sup>136</sup> David Cutler, Elizabeth Wikler & Peter Basch, *Reducing Administrative Costs and Improving the Health Care System*, 367 NEW ENG. J. MED. 1875, 1876 (2012).

<sup>137</sup> Health Information Technology for Economic and Clinical Health (HITECH) Act, Pub. L. No. 111–5, 123 Stat. 226–29, 246–47, 467–70 (2009) (codified as amended in scattered sections of 42 U.S.C. § 300jj (2012)).

<sup>138</sup> Cutler, Wikler & Basch, *supra* note 136, at 1877–78.

<sup>139</sup> See Gary King & Samir Soneji, Abstract, *The Future of Death in America*, 25 DEMOGRAPHIC RES. 1, 1 (2011), [www.demographic-research.org/Volumes/Vol25/1/25-1.pdf](http://www.demographic-research.org/Volumes/Vol25/1/25-1.pdf).

<sup>140</sup> Daniel Callahan is most identified with this point of view. See Callahan, *supra* note 2, at 82.

The growth in the “very old” segment of the population also disproportionately affects public programs, which bear most of the cost of the very expensive long-term care consumed by this population. As Medicaid is the primary source of payment for nursing-home care in the United States, demographic shifts have hit Medicaid particularly hard. Although the elderly make up around ten percent of the Medicaid population, they account for twenty-five percent of the program’s costs.<sup>141</sup>

In spite of these cost concerns, the United States has one of the youngest populations of any developed nation, and all other countries have been able to keep their health care expenditures well below ours despite their older populations.<sup>142</sup> “Some of the best research shows that, although healthcare costs will begin to rise as baby-boomers age, the impact will be modest in comparison to that of other cost drivers, such as inflation and technological innovation,” perhaps as little as one percent per year until 2036.<sup>143</sup> The cost problem with the elderly in the United States is often poor coordination of care, with too many drugs given to patients with insufficient attention to side effects and interactions. More can be done to alter attitudes toward death and reduce end-of-life spending that is a poor value. The old and the aging are not, however, the primary driver of high health care costs.

*Medical malpractice reform.* I have not granted medical malpractice reform the status of a “usual suspect.” It is rather an “also ran.” Such reform is often touted as a significant cost-saving mechanism for physicians without regard to its possible value as a tool for patient safety. The primary driver of such reforms are physicians and their medical societies, with the goal of reducing their insurance premiums and their risk of ever being named as a defendant. Such selfish policy motivations are nothing new in health care politics. However, such reforms are hopelessly one-sided, ignoring patient safety issues and the high levels of adverse events that patients experience. Given the high level of medical adverse events in the United States, it is clear that the real problem with medical adverse events is underclaiming—too few patients ever file claims for adverse events, even serious ones.<sup>144</sup>

The overall evidence on health care savings from tort reform is ambiguous at best, with a small additional cost arguably imposed by malpractice litigation. However, no analysis is complete without pricing the benefits that tort litigation creates for improved safety and reduction of patient injury. One recent summary concludes that the “accumulation of recent evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort

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<sup>141</sup> See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER, 23 fig.13 (2010), <http://www.kff.org/medicaid/upload/7334-04.pdf>.

<sup>142</sup> See Joseph White, *(How) Is Aging a Health Policy Problem?*, 4 YALE J. HEALTH POL’Y L. & ETHICS 47, 50 (2004).

<sup>143</sup> Mythbusters, *Myth: The Aging Population Is to Blame for Uncontrollable Healthcare Costs*, CANADIAN HEALTH SERVICES RES. FOUND. 1 (Feb. 22, 2011), <http://www.chsrf.ca/publicationsandresources/Mythbusters/ArticleView/11-02-22/f20f6cb8-bfd0-453e-b470-6fb63c93a629.aspx>.

<sup>144</sup> See generally Barry R. Furrow, *Adverse Events and Patient Injury: Coupling Detection, Disclosure, and Compensation*, 46 NEW ENG. L. REV. 437, 440, 448–57 (2012) (proposing new regulatory strategies to discover and penalize adverse events that now go unreported and undetected).

reform can be a major element in health-care cost control.”<sup>145</sup> Eisenberg, having surveyed the empirical work to date on tort reform generally, concludes that

[e]vidence of the effect of tort reform in the medical malpractice field is mixed. Caps on non-economic damages have reduced costs, thereby likely decreasing pressure on hospitals to improve care. Consistent evidence of effects on physician behavior and physician supply has not emerged. Tort reform has rarely sought to address the well-established problem of widespread harm caused by poor quality care.<sup>146</sup>

Recent studies point to the merits of expanded tort liability in inducing major patient safety initiatives.<sup>147</sup> Reforming tort litigation may be justified by other arguments such as improvement of compensation or patient safety improvements. The Congressional Budget Office has calculated that implementation of tort reforms nationally might “reduce total national health care expenditures by about 0.2 percent.”<sup>148</sup> “The CBO also noted, however, that tort reform cost reductions might increase overall patient mortality rates by limiting the rights of patients to sue.”<sup>149</sup> Any figure that fails to include possible safety benefits from such litigation cannot be trusted.<sup>150</sup>

## II. CRAMP APPETITES: TEST “GOOD BUT PAINFUL IDEAS”<sup>151</sup>

A variety of strategies are being tried to improve health care quality, and many of these strategies predate the ACA but are being accelerated by it.<sup>152</sup> Here is a list of provisions of the ACA that aim at bending the cost curve, either directly or indirectly<sup>153</sup>:

- *Health insurance exchanges.* Exchanges are expected to facilitate consumer shopping for insurance plans that are transparently marketed, presumably allowing for rational choices of lower-cost plans if so desired by consumers. Insurers would compete on the insurance product’s cost and quality.<sup>154</sup>
- *Taxes on high-cost insurance plans.* The ACA limits the tax exclusion for employer health insurance, thereby reducing employer selection of more expensive health plans and discouraging high use.<sup>155</sup>

<sup>145</sup> Myungho Paik et al., *Will Tort Reform Bend the Cost Curve?: Evidence from Texas*, 9 J. EMPIRICAL LEGAL STUD. 173, 175–76 (2012).

<sup>146</sup> Theodore Eisenberg, *The Empirical Effects of Tort Reform*, in RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS (Jennifer H. Arlen ed., forthcoming Nov. 2013), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2032740](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740).

<sup>147</sup> Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 49–50 (2011) [hereinafter Furrow, *Epidemic*] (summarizing evidence that more, rather than less, malpractice litigation will spur patient safety efforts and lower the levels of adverse events in the long run).

<sup>148</sup> Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Orrin G. Hatch, U.S. Senator (Oct. 9, 2009), available at [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort\\_reform.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf).

<sup>149</sup> Furrow, *Epidemic*, *supra* note 147, at 43 n.7.

<sup>150</sup> See generally *id.* at 49–50.

<sup>151</sup> Callahan, *supra* note 2, at 81.

<sup>152</sup> I have discussed the range of ACA strategies in Furrow, *Regulating Patient Safety*, *supra* note 19, at 1731–33.

<sup>153</sup> See Horney & Van de Water, *supra* note 21, at 5.

<sup>154</sup> *Id.* at 6.

<sup>155</sup> *Id.*



- *Reducing administrative costs.* Standardization of insurer-provider transactions—enrollment, eligibility, prior authorization, and so on—will reduce administrative overhead and thereby reduce system costs overall.<sup>156</sup>
- *Researching comparative effectiveness.* The ACA creates several new entities to fund research on outcomes, comparative effectiveness, and best practices.<sup>157</sup> As I will show, such research has great potential to reduce costs and improve quality.
- *Promoting prevention and wellness.* The ACA has a range of provisions to encourage disease prevention and promote wellness and healthy behaviors; these include the expansion of preventive service coverage in Medicare, Medicaid, and private insurance.<sup>158</sup>
- *Licensing follow-on biologics.* The ACA promotes the use of generic drugs through an accelerated approval process, therefore allowing purchasers to buy lower cost equivalent drugs.<sup>159</sup>
- *Strengthening primary care.* The ACA pushes hard at the improvement of primary care through better coordination, qualified medical homes, and increased payments to primary care providers.<sup>160</sup>
- *Establishing quality measures and priorities.* The ACA defines quality in health services and outcomes, developing “new patient-centered and population-based measures of quality.”<sup>161</sup>
- *Promoting high-value care.* The ACA continues the existing government strategies of a value-based payment system, paying for performance.<sup>162</sup>
- *Establishing a center for innovation.* A center for innovation is created with the goal of testing alternative payment structures and approaches to patient-centered care, quality improvement, and cost reductions in federal programs.<sup>163</sup>
- *Enhancing program integrity.* The ACA has bolstered fraud and abuse enforcement through numerous provisions, including strengthened legal requirements for preventing fraud and abuse and for maximizing its detection through increased penalties and increased funding for enforcement.<sup>164</sup>
- *Reducing avoidable hospital readmissions.* The ACA mandates that CMS reduce readmission rates under the Medicare program by reducing reimbursement, creating sharp penalties for hospitals if they do not reduce their avoidable readmissions.<sup>165</sup>
- *Promoting accountable care organizations.* A range of new delivery models, from accountable care organizations (ACOs)—physician-led organizations responsible for the cost and quality of delivered care—to medical homes are promoted through shared savings of any Medicare moneys saved by the implementation of good practices.<sup>166</sup>
- *Facilitating payment bundling.* Bundled payments for Medicare services would force coordination and integration of cost-effective care.<sup>167</sup>

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<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* at 7.

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.* at 7–8.

<sup>166</sup> *Id.* at 8.

<sup>167</sup> *Id.*

These Affordable Care Act proposals together have the potential to reduce costs over time, but it is unclear whether they will be enough. One cynical commentator calls some of these ideas “faith-based cost control.”<sup>168</sup> Critics may however end up surprised at the effects of a range of proposals in our complex system where incentives often work at cross purposes. The ACA ideas are already changing system organization and provider behavior.

A. *Control Prices and Technology: From Payment Incentives to IPAB*

The United States has built new health care industries, in Robert Evans’ words, to “share the rich financial feast of health care costs.”<sup>169</sup> Monopoly power gives the payer the ability to offset the organizational power of physicians,<sup>170</sup> increasingly concentrated hospitals, and industries that produce medical technologies and drugs. Absent this monopoly power by a single payer or small group, the horde of private insurers and the competitive environment add to costs but not care. As Evans wrote more than twenty years ago:

A large and growing share of the American total is spent, not on doctors and nurses, but on accountants, management consultants, and public relations specialists. Their contribution to the health of the American public is difficult to discern (unless one is trained in neoclassical economics and able to see with the eye of faith).<sup>171</sup>

His observations are still accurate today in describing our fragmented system of payment. If we want real cost control, we need stronger control of the payment process, either through a single payer or highly regulated multiple payers, like Germany. The evidence of Canada is instructive. Evans observes that the competitive, fragmented U.S. environment

has thus permitted physicians to push their fees steadily upward, in the face of rapid and sustained increases in their numbers and output. . . . In Canada, the introduction of universal public insurance coverage coincided with the introduction of periodically bargained uniform fee schedules in each province that were binding on all practitioners. Under this fee-setting process, fee levels have roughly stabilized in real terms.<sup>172</sup>

And if we want, at the same time, to avoid a deeply tiered and unequal system of health care, then we must, in Uwe Reinhardt’s words, “enlist government somehow to impose on total health spending an annual budget that cannot grow faster than ability to pay—say, the rate of growth of gross domestic product per capita.”<sup>173</sup>

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<sup>168</sup> Gina Kolata, *The ABC’s of the Health Care Law and Its Future*, N.Y. TIMES, Apr. 3, 2012, at D5.

<sup>169</sup> Evans, *supra* note 122, at 123 n.7 (contrasting the Canadian single payer approach to America’s fragmented health care world).

<sup>170</sup> *Id.* at 117.

<sup>171</sup> *Id.* at 115.

<sup>172</sup> *Id.* at 116.

<sup>173</sup> Uwe E. Reinhardt, *The Fork in the Road for Health Care*, N.Y. TIMES BLOGS (May 25, 2012, 6:00 AM), <http://economix.blogs.nytimes.com/2012/05/25/the-fork-in-the-road-for-health-care/>.

### 1. Price Controls

The ACA has taken several steps in the direction of more control of prices.

#### a. The Independent Payment Advisory Board

The Independent Payment Advisory Board, or IPAB, is the most clearly defined price-control mechanism in the ACA (and therefore the most politically vulnerable). The IPAB's mission is to develop and submit detailed proposals to Congress and the President to reduce Medicare spending and improve the quality of care. The IPAB is designed as an expert, independent group, thereby increasing the ability of the IPAB to make controversial budget-cutting decisions while insulated from the possibility of congressional overrides. The potential power of the IPAB is immense. Peter Orszag, the administration's former director of the Office of Management and Budget, has claimed that IPAB represents "the largest yielding of sovereignty from the Congress since the creation of the Federal Reserve."<sup>174</sup>

The hope is that the IPAB process, which removes much of Congress's discretionary authority over recommendations on rates, will lead to Medicare payment decisions that are closer to the social optimum. It is a fifteen-member agency created in 2010 by the ACA, sections 3403 and 10320. The goal of the IPB is to achieve savings in Medicare without affecting coverage or quality. The IPAB replaces MedPAC and grants it the authority to make changes to the Medicare program, leaving Congress the power of overruling its decisions. The Board must recommend approaches to reduce Medicare spending by specified amounts if spending exceeded target growth rates. If they fail, the Secretary of HHS must develop a proposal and implement it. The hope is that the Board will manage to subject the Medicare program to spending limits through savings targets.<sup>175</sup> Any such attempts will meet ferocious Congressional opposition, however.<sup>176</sup>

The IPAB was designed to tackle Medicare's Physician Fee Schedule, with the long-term goal of a national system of value-based payment.<sup>177</sup> As one study observed, "[a]lthough the huge federal Medicare program . . . possess[es] some monopsonistic purchasing power . . . the highly fragmented buy side of the U.S. health system is relatively weak. The IPAB's assignment is to harness

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<sup>174</sup> See Ezra Klein, *Can We Control Costs Without Congress?*, WASH. POST (Mar. 26, 2010, 2:46 PM), [http://voices.washingtonpost.com/ezra-klein/2010/03/can\\_we\\_control\\_costs\\_without\\_c.html](http://voices.washingtonpost.com/ezra-klein/2010/03/can_we_control_costs_without_c.html).

<sup>175</sup> Henry J. Kaiser Family Found., *Explaining Health Reform: Medicare and the New Independent Payment Advisory Board*, FOCUS ON HEALTH REFORM (May 2010), <http://www.kff.org/healthreform/upload/7961-02.pdf>.

<sup>176</sup> See, e.g., Bob Herman, *House Approves IPAB Repeal*, BECKER'S HOSP. REV. (March 22, 2012), <http://www.beckershospitalreview.com/news-analysis/house-to-vote-today-on-ipab-repeal.html>.

<sup>177</sup> Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX: J. L.-MED. 75, 99 (2012). See also Robert A. Berenson, Nat'l Inst. Health Care Mgmt. Found., *Out of Whack: Pricing Distortions in the Medicare Physician Fee Schedule*, EXPERT VOICES (Sept. 2010), [http://nihcm.org/pdf/NIHCM-EV-Berenson\\_FINAL.pdf](http://nihcm.org/pdf/NIHCM-EV-Berenson_FINAL.pdf).

some of the monopsonistic purchasing power of the federal Medicare program by reworking physician payment standards.”<sup>178</sup>

The long-run effects of the IPAB on health care costs—if the Board survives, and if its implementation is successful—might be enormous.

The IPAB, if it works, will harness the enormous purchasing power of the federal Medicare program for the task of bending the cost curve not just for Medicare alone but for health care in general by reworking physician payment standards. But if it is to work at acceptable cost it must trigger improvements in the efficiency of the health-care delivery system and not just say “no” to cost increases.<sup>179</sup>

As President Obama describes it, the IPAB will bring the Medicare physician compensation into the public forum “by strengthening an independent commission of doctors, nurses, medical experts and consumers who will look at all the evidence and recommend the best ways to reduce unnecessary spending while protecting access to the services that seniors need.”<sup>180</sup> The IPAB can replace rubber-stamping of valuation of specialist-driven outpatient physician services.

If the ACA succeeds in meeting the projections of the Congressional Budget Office (CBO), which projects a two percent reduction in the U.S. Gross Domestic Product by 2040, the IPAB (if Congress does not handicap it)<sup>181</sup> will be a major force in slowing growth in physician charges, one of several initiatives slowing the growth of federal health care programs by a third over the next generation.<sup>182</sup>

The ACA places some significant restrictions on the recommendations that IPAB may put forward. It is “prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.”<sup>183</sup> In addition, for years prior to 2020, the Board may not propose payment cuts to hospitals and perhaps for hospice services; physician payment however remains fair game for the Board.<sup>184</sup>

IPAB’s success will largely depend on the kinds of changes it recommends, particularly whether its recommendations go beyond payment rates to include proposals to change the methods of payment and beneficiary responsibilities. IPAB’s successful implementation also depends on whether Congress acquiesces in or resists cost-cutting as it has done repeatedly with respect to physician payment under the SGR.<sup>185</sup> IPAB will also have responsibility for monitoring and making recommendations and proposals to Congress and the

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<sup>178</sup> Marciarille & DeLong, *supra* note 177, at 99 (quoting Anderson et al., *supra* note 134, at 102) (internal quotation marks omitted).

<sup>179</sup> *Id.* at 80.

<sup>180</sup> President Barack Obama, Remarks by the President on Fiscal Policy at George Washington University (Apr. 13, 2011), *available at* <http://www.whitehouse.gov/the-press-office/2011/04/13/remarks-president-fiscal-policy>.

<sup>181</sup> Marciarille & DeLong, *supra* note 177, at 79–80.

<sup>182</sup> *Id.* at 80.

<sup>183</sup> Cal. Healthcare Inst., *Independent Payment Advisory Board (IPAB) Summary*, CHI.ORG, at 1 (2011), [https://www.chi.org/uploadedFiles/Legislative\\_Action/Federal\\_Issues/CHI%20IPAB%20Summary.pdf](https://www.chi.org/uploadedFiles/Legislative_Action/Federal_Issues/CHI%20IPAB%20Summary.pdf).

<sup>184</sup> See Marciarille & DeLong, *supra* note 177, at 80, 94.

<sup>185</sup> See Timothy Stoltzfus Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103, 105 (2010), *available at* <http://healthpolicyandreform.nejm.org/?p=3478>.

President every two years beginning in 2015 regarding how to slow the growth of private expenditures on health care in the private sector.<sup>186</sup>

*b. State Rate Regulation*

This form of budgeting uses hard spending caps and regulatory controls to limit the production and supply of services and technologies. State “certificate of need” programs for hospital beds and high-cost capital equipment have operated as back-door cost control tools. State governments might revisit the merits of rate regulation, which proved unpopular in the 1990s and was largely abandoned. More direct regulation of provider rates might set upper bounds on permissible rates negotiated between health plans and providers in relation to Medicare rates.<sup>187</sup>

In [the heyday of rate regulation] in the 1970s and early 1980s, more than thirty states were involved in reviewing or actually regulating hospital payment rates for all public and private payers. A few states—including Maryland, Massachusetts, New Jersey, West Virginia, and New York—had functioning, reasonably successful all-payer programs. Although most of these states have since ended those programs, Maryland and West Virginia’s rate setting program continues.<sup>188</sup>

It may be time to revisit rate regulation, given its relative success in earlier decades, when states that had imposed mandatory controls on hospital rate increases reduced their rate of growth compared to states lacking control.<sup>189</sup> If costs keep rising as a percentage of GDP, we are likely to reach a point where low-value care has to be foregone in order to slow cost increases.<sup>190</sup> Desperate

<sup>186</sup> The House has already voted to kill the IPAB. See Robert Pear, *House Votes to Kill a Medicare Cost Panel*, N.Y. TIMES, Mar. 22, 2012, at A13. Business groups are worried about cost shifting to the private sector. See Legislative News, *Physician Payment: Business Groups Push for IPAB Repeal, Say Board Will Shift Costs to Private Sector*, 22 MEDICARE REP. (BNA), April 29, 2011, at 492. The White House responded with proposals to strengthen IPAB, that would (1) lower the target of Medicare growth per beneficiary to GDP per capita plus .5%, (2) “[g]ive IPAB additional tools to improve the quality of care while reducing costs, including allowing it to promote value-based benefit designs,” and (3) “[provide] IPAB [with] additional enforcement mechanisms such as an automatic sequester” of funds. See Press Release, The White House, Fact Sheet: The President’s Framework for Shared Prosperity and Shared Fiscal Responsibility (Apr. 13, 2011), available at <http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp>.

<sup>187</sup> See Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1400–01 (2009).

<sup>188</sup> Berenson et al., *supra* note 130, at 979.

<sup>189</sup> John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 143 (1997).

<sup>190</sup> This is not a new problem for any health care system. Earlier periods of cost escalation generated analyses of the need to cut back on “low value” care. See, e.g., Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCI. 418, 420–22 (1990) (“Physicians [under the British rationing system] make the denial of potentially beneficial care seem routine, or even optimal, by recasting a problem of medical scarcity in economic terms.”); David M. Eddy, *What Care Is “Essential”? What Services Are “Basic”?*, 265 JAMA 782, 782–84 (1991) (discussing dilemmas of separating “essential” and non-essential care); William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220, 224 (1987) (arguing that “cutting back on kinds of care that have the lowest expected value” is essential to appropriate allocation of resources); William B. Schwartz & Paul L. Joskow,

times may breed desperate measures, although an anti-regulatory political climate may make this difficult until we hit a crisis point. As Robert Evans writes, the pressures of the marketplace transmitted by individual patients have been totally ineffective, and no civilized country relies on them in any serious way. . . . Pressures exerted by a government, or quasi-governmental agency backed up by regulation, actually do work, because they mobilize and strongly motivate those with the capacity to do the job.<sup>191</sup>

### c. State Insurance Regulation

The ACA does provide regulatory power to push back against large premium increases for provider contracts. Section 1003<sup>192</sup> requires state insurance departments to conduct an annual review of “unreasonable” increases in premiums—increases of ten percent or more. Health insurers must justify premium increases, which means that, theoretically, large-payment-rate increases in provider contracts could lead to disapproval of the premium increase. The ACA promotes enhanced transparency of negotiated rates and increased scrutiny of health-plan-rate increases. This exposes provider prices and could lead, at a minimum, to pressures to restrain provider pricing. The power of provider pricing in rising health spending could stimulate both market-oriented approaches based on benefit designs that make consumers more aware of costs and give them direct incentives to select low-cost options; tiered insurance networks exemplify this approach. Employers are likely to be more willing to support choice-limiting networks with few providers and this could help balance negotiating leverage between providers and health plans.<sup>193</sup>

## 2. Technology Assessment

Medicare is our technology assessor at present for our largest public program.<sup>194</sup> It makes national coverage determinations about procedures and technologies, with a separate coverage decision for each new piece of technology available to providers.<sup>195</sup> “A national coverage decision for the use of a [new] imaging technology or pharmaceutical therapy” affects who gets access and when, levels of reimbursement if any, and whether a service is offered.<sup>196</sup> The ACA’s focus on comparative effectiveness research, best practices and outcomes, and the dissemination of research findings is likely to strengthen Medi-

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*Medical Efficacy Versus Economic Efficiency: A Conflict in Values*, 299 NEW ENG. J. MED. 1462, 1464 (1978) (discussing possibility that medically efficacious care will have to be sacrificed in pursuit of economic efficiency).

<sup>191</sup> Evans, *supra* note 122, at 122.

<sup>192</sup> The Affordable Care Act added Section 2794 to the Public Health Service Act of 1944, including a provision that requires state insurance departments to conduct an annual review of “unreasonable” increases in health insurance premiums, defined through regulation as an increase of ten percent or more. Patient Protection and Affordable Care Act § 1003 (2010) (codified at 42 U.S.C. § 300gg-94 (2012)).

<sup>193</sup> See, e.g., Reinhardt, *supra* note 119, at 65.

<sup>194</sup> See April M. Elliott, Note, *Medicare as Technology Regulator: Medicare Policy’s Role in Shaping Technology Use and Access*, 26 BERKELEY TECH. L.J. 1489, 1491–92, 1509 (2011).

<sup>195</sup> *Id.* at 1509.

<sup>196</sup> *Id.*

care's assessment potency. Commercial insurers have long piggybacked on Medicare decisions about new technologies.<sup>197</sup> They are likely to continue to do so.

The bundled payment and coordination initiatives of the ACA also work in tandem with research findings as part of technology assessment at the provider level. New technologies are likely to be purchased after careful assessment, because the bundled payment model sets a limit on total payments per episode of care in most cases. It promotes information on what works and at what cost. As one commentator has written: "Because providers would not be subject to coverage determinations altering payment rates, they would be incentivized to purchase new technologies only when expected quality benefits and cost-effectiveness justify the expenditure, while being discouraged from investing in unnecessarily risky or redundant technologies."<sup>198</sup>

### B. Rationalize Services: Of Fat, Waste, and Fraud

Waste and unproven or unnecessary products and tests are pervasive in the U.S. health care system as we have seen with medical practice variation.<sup>199</sup> Properly done testing can be both quality-enhancing and cost-reducing.<sup>200</sup> Comparative effectiveness research has emerged as a central feature of health-system reform.<sup>201</sup> The ACA provides funds for research into a range of issues, but it puts heavy emphasis on studies of health care delivery systems, including payment systems and comparative clinical effectiveness. The ACA and its many reform provisions have some power to slow what Emanuel calls "pseudo-innovations"; he notes that we need to define innovation as things that really work, by directing "capital and creativity away from technologies that don't improve outcomes or lower costs and toward ones that do. That should not be confused with killing innovation."<sup>202</sup> The ACA establishes several new entities and initiatives that have the potential to slow the adoption of new technologies.

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<sup>197</sup> See *id.* at 1498; see also JACOB S. HACKER, THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM: KEY TO COST CONTROL AND QUALITY COVERAGE, INST. FOR AMERICA'S FUTURE, at 14, [http://institute.ourfuture.org/files/Jacob\\_Hacker\\_Public\\_Plan\\_Choice.pdf](http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf) (last visited Apr. 9, 2013).

<sup>198</sup> Elliott, *supra* note 194, at 1520.

<sup>199</sup> See, e.g., Berwick & Hackbarth, *supra* note 18, at 1513; Allan S. Brett & Laurence B. McCullough, *Addressing Requests by Patients for Nonbeneficial Interventions*, 307 JAMA 149, 150 (2012); Deborah Grady & Rita F. Redberg, *Less Is More: How Less Health Care Can Result in Better Health*, 170 ARCHIVES OF INTERNAL MED. 749, 749 (2010), available at [archinte.jamanetwork.com/Issue.aspx?journalid=71&issueID=5765&direction=P](http://archinte.jamanetwork.com/Issue.aspx?journalid=71&issueID=5765&direction=P); 44 *Percent of Healthy Adults Getting Unneeded Heart Screenings*, CONSUMERREPORTS.ORG (Feb. 3, 2011), <http://pressroom.consumerreports.org/pressroom/2011/02/my-entry.html>.

<sup>200</sup> Editorial, *Treating You Better For Less*, N.Y. TIMES, June 3, 2012, at SR12 (giving examples of health system reforms that have produced substantial savings).

<sup>201</sup> Measuring efficacy has long been viewed as a challenging task. For academic struggles with the problem, see generally John P. Bunker, *Is Efficacy the Gold Standard for Quality Assessment?*, 25 INQUIRY 51 (1988); Robert W. Dubois & Robert H. Brook, *Assessing Clinical Decision Making: Is the Ideal System Feasible?*, 25 INQUIRY 59 (1988).

<sup>202</sup> Emanuel, *supra* note 84 (emphasis omitted).

### 1. *The Patient-Centered Outcomes Research Institute*

The Patient-Centered Outcomes Research Institute (“PCORI”) is designed to develop comparative effectiveness and other outcomes research.<sup>203</sup> The Institute has funded over fifty research projects so far and has opened its draft of its national priorities for outcomes research for public comment.<sup>204</sup> “The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence . . . with respect to the relative health outcomes, clinical effectiveness, and appropriateness” of medical interventions.<sup>205</sup> Comparative effectiveness research certainly addresses a major gap in our medical-device and drug research and approval process as well as the generally thin evidence base for so much of the practice of medicine.<sup>206</sup> The research findings of the Institute may be used in coverage determinations by the Secretary of HHS but with significant limitations, including one directly related to disability status. Section 6301 provides: “The Secretary shall not use evidence or findings . . . in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.”<sup>207</sup> Evidence can be used however to compare the effectiveness of alternative treatments in extending life due to age, disability, or terminal illness.<sup>208</sup>

The bigger limitation written into the ACA with regard to a real cost comparison of different health care treatments, in Section 6301, is a prohibition on cost-effectiveness calculations. The language of the ACA bars use of a “dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual’s disability) as a threshold to establish what type of health care is cost effective or recommended . . . [or to] determine coverage, reimbursement, or incentive programs.”<sup>209</sup>

This provision appears to explicitly block study of a treatment’s cost-effectiveness. This contrasts with the mandate of United Kingdom’s National Institute for Health and Clinical Excellence (NICE), which has a positive international reputation for the development of clinical guidelines. NICE makes an

<sup>203</sup> See *Patient-Centered Outcomes Research*, PCORI, <http://www.pcori.org/research-we-support/pcor/> (last visited Apr. 9, 2013).

<sup>204</sup> See *Funding Opportunities*, PCORI, <http://www.pcori.org/funding-opportunities/> (last visited Apr. 9, 2013); *National Priorities for Research and Research Agenda*, PCORI, <http://www.pcori.org/research-we-support/priorities-agenda> (last visited Apr. 9, 2013).

<sup>205</sup> Patient Protection and Affordable Care Act § 6301, 42 U.S.C. § 1320e(c) (2012).

<sup>206</sup> For a robust criticism of comparative effectiveness research as developed in the ACA, see generally Richard S. Saver, *Health Care Reform’s Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 U. PA. L. REV. 2147 (2011) (arguing that the ACA is likely to be ineffective in producing a change in physician practice); M. Gregg Bloche, *Beyond the “R Word”?: Medicine’s New Frugality*, 366 NEW ENG. J. MED. 1951, 1951 (2012) (Gregg Bloche also observes that “high-quality studies of clinical effectiveness can cost tens of millions of dollars and take many years; they’re unlikely to identify much of the wasted 30% in the near term.”); Howard Brody, *From an Ethics of Rationing to an Ethics of Waste Avoidance*, 366 NEW ENG. J. MED. 1949 (2012).

<sup>207</sup> Patient Protection and Affordable Care Act § 6301, 42 U.S.C. § 1320e-1(c)(1).

<sup>208</sup> For a range of treatments of the cost issue, see Symposium, *Cost and End-of-Life Care*, 39 J.L. MED. & ETHICS 111 (2011).

<sup>209</sup> Patient Protection and Affordable Care Act § 6301, 42 U.S.C. § 1320e-1(e).



explicit determination of cost-benefit boundaries for medical technologies assessed.<sup>210</sup> One commentator states that NICE is “the closest anyone has yet come to fulfilling the economist’s dream of how priority-setting in health care should be conducted. It is transparent, evidence-based, seeks to balance efficiency with equity, and uses a cost-per-QALY benchmark as the focus for its decision-making.”<sup>211</sup> Such an approach has empirical and political dimensions of course, but as the approach matures, it is a necessary approach to evaluating the merits of new technologies.<sup>212</sup>

### 2. *The Center for Medicare and Medicaid Innovation*

The *CMS Innovation Center* is a second institutional creation of the ACA.<sup>213</sup> This Center will test different health care delivery and payment models to evaluate their effect on quality of care and cost of services.<sup>214</sup> It provides additional funding to the Agency for Healthcare Research and Quality to study health care delivery systems with a focus on quality improvement, patient safety, and best practices.<sup>215</sup> The HHS Secretary is charged with selecting models that not only reduce costs and enhance the quality of care but also improve “the coordination, quality, and efficiency of health care services.”<sup>216</sup>

### 3. *Demonstration Projects and Other Reforms*

The ACA establishes a posture of continuous, data-driven testing of the performance of health care professionals and facilities. The ACA also launches “demonstration projects” through which the federal government funds particular forms of health care or health care delivery systems with a requirement that their performance be studied to assess their potential for wider adoption.<sup>217</sup>

<sup>210</sup> MICHAEL SCHLANDER, HEALTH TECHNOLOGY ASSESSMENTS BY THE NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE: A QUALITATIVE STUDY 3–5 (2007).

<sup>211</sup> Alan Williams, Office of Health Economics Annual Lecture: What Could Be Nicer Than NICE? 3 (2004). A quality-adjusted life year (QALY) is a measure of quality that adjusts a year of life based on its quality or value. A year in perfect health equals 1.0 QALY. Less than perfect health would then be discounted to varying degrees. See, e.g., *Definition of QALY*, MEDICINENET.COM, <http://www.medterms.com/script/main/art.asp?articlekey=7924> (last visited Apr. 9, 2013).

<sup>212</sup> See SCHLANDER, *supra* note 210, at 173–86 (looking at fairness and political dimensions of NICE assessments).

<sup>213</sup> See *Welcome to the CMS Innovation Center*, CENTER FOR MEDICARE & MEDICAID SERVICES, [www.innovations.cms.gov](http://www.innovations.cms.gov) (last visited Apr. 9, 2013).

<sup>214</sup> Patient Protection and Affordable Care Act § 3021(a)(1), 42 U.S.C. § 1315a(a)(1).

<sup>215</sup> *Id.* § 3501(b), 42 U.S.C. § 299b-33(b).

<sup>216</sup> *Id.* § 3021(a)(1), 42 U.S.C. § 1315a(a)(1).

<sup>217</sup> The ACA has five pilot projects and thirty demonstration projects. Pilot initiatives include, for example: National Pilot Program on Payment Bundling, *id.* § 3023(a)(1), 42 U.S.C. § 1395cc-4 (2010); Healthy Aging, Living Well, *id.* § 4202(a), 42 U.S.C. § 300u-14(a) (2010); Demonstration Project Concerning Individualized Wellness Plan, *id.* § 4206, 42 U.S.C. § 254b(s) (2010); and Pilot Testing Pay-for-Performance Programs for Certain Medicare Providers, *id.* § 10326, 42 U.S.C. § 1395b-1 note (2012). Demonstration projects include: Demonstration Project to Evaluate Integrated Care Around a Hospitalization, *id.* § 2704, 42 U.S.C. § 1396a note (2012); Medicaid Global Payment System Demonstration Project, *id.* § 2705, 42 U.S.C. § 1315a note (2012); Pediatric Accountable Care Organization Demonstration Project, *id.* § 2706, 42 U.S.C. § 1396a note (2012); Independence at Home Demonstration Program, *id.* § 3024, 42 U.S.C. § 1395cc-5 (2010); and Medicare Hospice

It should be noted that with or without the ACA's mandates, medical societies have begun to unite to develop standards to reduce unnecessary testing and procedures. Medical societies have taken on responsibility for reducing unnecessary medical care through their Choosing Wisely campaign.<sup>218</sup>

#### 4. *Fraud and Abuse Expansions*

Finally, the ACA has added robust new tools to fight fraud and abuse activities. Title VI of the ACA, entitled "Transparency and Program Integrity," improves detection and prevention of provider fraud involving the Medicare, Medicaid, and SCHIP programs.<sup>219</sup> Provisions are aimed at preventing fraud perpetrated by small equipment providers and service providers or suppliers, typically enrolled with little oversight, who quickly receive payments for services not provided and then disappear before the authorities can locate them.<sup>220</sup> The ACA includes new and strengthened penalties, tightened legal standards, and steps to enhance State anti-fraud efforts. Provisions increase screening and oversight of new providers, improve information sharing, and mandate greater transparency.<sup>221</sup>

#### C. *Advance System Reform: Promoting Innovation and Value*

Cost containment is a "public good": a large part of society benefits from its success, but no one really wants the misery of having to do it. The problem for public policy, then, is to create organizational structures in which those responsible for exerting compressive forces not only have the ability and motivation to do the task but cannot escape it.<sup>222</sup>

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Concurrent Care Demonstration Program, *id.* § 3140, 42 U.S.C. § 1395d note (2012). Congress addressed demonstration projects throughout the Act. *See, e.g., id.* §§ 2601, 2704, 2705, 2706, 3126, 4206, and so on and on.

<sup>218</sup> Christine K. Cassel & James A. Guest, *Choosing Wisely: Helping Physicians and Patients Make Smart Decisions About Their Care*, 307 JAMA 1801, 1801 (2012) ("To help reduce waste in the US health care system and promote physician and patient conversations about making wise choices about treatments, 9 medical specialty societies have joined the ABIM (American Board of Internal Medicine) Foundation and Consumer Reports in the first phase of the Choosing Wisely campaign, including the following: American Academy of Allergy, Asthma & Immunology; American Academy of Family Physicians; American College of Cardiology; American College of Physicians; American College of Radiology; American Gastroenterological Association; American Society of Clinical Oncology; American Society of Nephrology; and the American Society of Nuclear Cardiology."). *See also* The Good Stewardship Working Grp., *The "Top 5" Lists in Primary Care: Meeting the Responsibility of Professionalism*, 171 ARCHIVES INTERNAL MED. 1385, 1385 (2011), available at <http://archinte.jamanetwork.com/article.aspx?articleid=1105881>.

<sup>219</sup> Patient Protection and Affordable Care Act § 6001, 42 U.S.C. § 1395nn (2010).

<sup>220</sup> Too many Medicare providers are scam artists, some with connections to organized crime, that have skillfully capitalized on the holes in the government's payment process. *See, e.g., 60 Minutes: Medicare Fraud Is Costing Us Millions of Dollars!* (CBS television broadcast Oct. 25, 2009), available at [http://www.youtube.com/watch?v=GUY\\_01n1XWQ](http://www.youtube.com/watch?v=GUY_01n1XWQ).

<sup>221</sup> *See* Newsroom, *New Tools to Fight Fraud, Strengthen Federal and Private Health Programs, and Protect Consumer and Taxpayer Dollars*, HEALTHCARE.GOV (Oct. 9, 2012), <http://www.healthcare.gov/news/factsheets/2011/03/fraud03152011a.html>. *See also* John K. Iglehart, *Finding Money for Health Care Reform—Rooting Out Waste, Fraud, and Abuse*, 361 NEW ENG. J. MED. 229, 229–31 (2009).

<sup>222</sup> Evans, *supra* note 122, at 122.

Services and products can drop in price over time at least outside the health care industry, as the cost of a laptop computer, a long-distance phone call, or a commercial flight illustrate. James Robinson notes three domains where costs have dropped: drugs and devices such as generics and diagnostic tests; improved processes that allow health care professionals with less training to provide care at lower cost; and care sites that provide simple but adequate care, such as ambulatory centers and retail clinics.<sup>223</sup> He notes the value of disruptive innovation and the regulatory and reimbursement barriers that slow innovation in delivery-system models.<sup>224</sup> The ACA has offered up a range of possibilities such as accountable care organizations and other models that may speed innovation and reorganize health care.

### *1. Reorganize: New Organizational Models*

Innovations in medicine include reorganizing care delivery. A recent study of knee-replacement surgery found substantial variations across the studied organizations in “surgery times, hospital lengths-of-stay, discharge dispositions, and in-hospital complication rates.”<sup>225</sup>

The study also revealed that higher surgeon caseloads were associated with shorter lengths-of-stay and operating time, as well as fewer in-hospital complications. These findings led the consortium to test more coordinated management for medically complex patients, more use of dedicated teams, and a process to improve the management of patients’ expectations. These innovations are now being tried by the consortium’s members to evaluate whether they increase health care value.<sup>226</sup>

Much study is needed to figure how to model care delivery for best value.

The push toward new delivery forms marks the core of the ACA and its coordination reforms. Section 3021 of the ACA provides a number of possible coordination reforms. These innovative payment and delivery arrangements include the promotion of various models of integration that reduce or eliminate fee-for-service payment systems; for example, patient-centered medical home models and other models “transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.”<sup>227</sup> Other models include direct contracting with groups of providers to promote new delivery models “through risk-based comprehensive payment or salary-based payment”<sup>228</sup> and coordinated-care models that “transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.”<sup>229</sup> A particularly intriguing model explicitly

<sup>223</sup> James C. Robinson & Mark D. Smith, *Cost-Reducing Innovation in Health Care*, 27 HEALTH AFF. 1353, 1353–54 (2008).

<sup>224</sup> *Id.* at 1354–56.

<sup>225</sup> Ivan M. Tomek et al., *Innovation Profile: A Collaborative of Leading Health Systems Finds Wide Variations in Total Knee Replacement Delivery and Takes Steps to Improve Value*, 31 HEALTH AFF. 1329, 1329 (2012), available at <http://content.healthaffairs.org/content/early/2012/04/30/hlthaff.2011.0935.full.html>.

<sup>226</sup> *Id.*

<sup>227</sup> Patient Protection and Affordable Care Act § 3021, 42 U.S.C. § 1315a(b)(2)(B)(i) (2010).

<sup>228</sup> *Id.* § 3021, 42 U.S.C. § 1315a(b)(2)(B)(ii).

<sup>229</sup> *Id.* § 3021, 42 U.S.C. § 1315a(b)(2)(B)(iv).

allows for testing of “all-payer payment reform for the medical care of residents of the State[s].”<sup>230</sup>

Accountable care organizations (ACOs) are “groups of providers of services and suppliers . . . [who] work together to manage and coordinate care for Medicare fee-for-service beneficiaries . . . .”<sup>231</sup> “[A] collection of primary care physicians, specialists, and potentially other health professionals [(including hospitals) will] accept joint responsibility for the quality and cost of care provided to its patients.”<sup>232</sup> “If the ACO meets certain targets, its members receive a financial bonus.”<sup>233</sup> The assumption is that groups of providers—“collectively accountable for meeting cost and quality targets, internal peer review and peer pressure”—will be motivated to identify and implement best practices, resulting in better cost controls and outcomes.<sup>234</sup> ACOs will most likely

operate as mini-health plans, building the infrastructure to manage utilization and insure [sic] quality-care delivery. To establish targets, cost trends, and provider payment and incentive distribution models, ACOs will require sophisticated financial and actuarial analyses. To control demand and improve the quality of care delivery, ACOs will need to have the tools, processes, and reporting for chronic-disease management, complex case management, and wellness/prevention services. To control medically unnecessary services, ACOs will need to have the tools, processes, and reporting for preauthorization, hospital utilization review, high-tech radiology management, specialty referral management, and pharmacy management.<sup>235</sup>

<sup>230</sup> *Id.* § 3021, 42 U.S.C. § 1315a(b)(2)(B)(xi).

<sup>231</sup> *Id.* § 3022, 42 U.S.C. § 1395jjj(a)(1)(A). See generally Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44, w51–w53 (2007), <http://content.healthaffairs.org/content/26/1/w44.full.pdf+html> (arguing for the use of ACOs at the level of “extended hospital medical staff” as a way to better coordinate patient care); see also Stephen M. Shortell & Lawrence P. Casalino, *Health Care Reform Requires Accountable Care Systems*, 300 JAMA 95, 97 (2008) (discussing the potential for ACOs to “be designed to create value by improving . . . patient outcomes” while simultaneously reducing costs). Much of the formative work of ACOs can be traced to the Dartmouth Institute for Health Policy and Clinical Practice headed by Dr. Elliott Fisher and Dr. James Weinstein. See, e.g., Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. w219, w222, w227 (2009), <http://content.healthaffairs.org/content/28/2/w219.full.pdf> (proposing Medicare-payment reform through ACOs); see also DARTMOUTH INST., ACCOUNTABLE CARE ORGANIZATION LEARNING NETWORK TOOLKIT 4 (2011) (providing resources on ACOs).

<sup>232</sup> Barry R. Furrow, *Patient Safety in American Health Care: Regulatory Models*, in PATIENT SAFETY, LAW POLICY AND PRACTICE 210, 219 (John Tingle & Pippa Bark eds., 2011) [hereinafter Furrow, *Patient Safety in American Health Care*]. See also Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED. e1(1), e1(1)–(2) (2011) (discussing the benefits and concerns surrounding the implementation of ACO reform measures).

<sup>233</sup> Furrow, *Patient Safety in American Health Care*, *supra* note 232, at 219. See Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 983 (2010) (discussing different ACO payment models). See also James C. Robinson et al., *The Alignment and Blending of Payment Incentives Within Physician Organizations*, 39 HEALTH SERVICES RES. 1589, 1604 (2004).

<sup>234</sup> Furrow, *Patient Safety in American Health Care*, *supra* note 232, at 219. See Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293, 1294 (2010) (increased coordination among clinical teams will induce better coordination).

<sup>235</sup> Robert Parke & Kate Fitch, *Accountable Care Organizations: The New Provider Model?*, INSIGHT (Oct. 13, 2009), <http://insight.milliman.com/article.php?cntid=6056>. See

Patient-Centered Medical Homes (PCMH) are another new model to improve primary care.<sup>236</sup>

A patient in a PCMH works closely with a specific [primary care doctor] and supporting clinical staff over time [with the care team orchestrating] the patient's medical care, either by providing care directly or by referring the patient for specialty care. Patients receive timely access through expanded office hours and multiple pathways to medical assistance. Quality and safety are enhanced through information technology and practice redesign.<sup>237</sup>

Health Care Innovation Zones are another idea to force integrated care. Because centers such as the Center for Medicare and Medicaid Innovation can channel millions of dollars toward research and expansion of payment and delivery reforms, their output is likely to be influential on the future of medical practice. Subsection 3021(a) aims to create such zones, comprised of "groups of providers that include a teaching hospital, physicians, and other clinical entities, that, . . . [can] deliver a full spectrum of integrated and comprehensive health care services to applicable individuals."<sup>238</sup> ACOs, PCMHs, and other coordination models fostered by current federal policy offer a model of better and more efficient care.<sup>239</sup> ACOs are already underway in both the public and private sectors. Medicare has announced more than 250 ACO contracts,<sup>240</sup> and private ACOs are developing; Leavitt Partners reports that 324 ACOs are being structured in forty-five states and the District of Columbia.<sup>241</sup> ACOs are being developed in many states for Medicaid populations.<sup>242</sup> However, "most of the activity is being driven by the private sector . . . . The interest is driven not only by theory but also by early evidence that this model seems to improve quality

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MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 56 (2009), available at [http://www.medpac.gov/documents/Jun09\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun09_EntireReport.pdf) (developing an ACO model as a recommendation for reforming Medicare's health care delivery system).

<sup>236</sup> Ann M. Mirabito & Leonard L. Berry, *Lessons That Patient-Centered Medical Homes Can Learn from the Mistakes of HMOs*, 152 ANNALS INTERNAL MED. 182, 182 (2010), available at <http://ssrn.com/abstract=2064823>.

<sup>237</sup> *Id.*

<sup>238</sup> Patient Protection and Affordable Care Act § 3021, 42 U.S.C. § 1315a(b)(2)(B)(xviii) (Supp. IV 2010).

<sup>239</sup> See Furrow, *Regulating Patient Safety*, *supra* note 19, at 1758–65 (discussing other coordination models including bundling and medical homes).

<sup>240</sup> See Jay Greene, *Tracking the ACO Remedy*, CRAIN'S DETROIT BUS. (Feb. 11, 2013, 10:23 AM), <http://www.craindetroit.com/article/20130210/NEWS/302109992/tracking-the-aco-remedy-execs-say-early-reports-show-savings-improved-patient-care>; see also *Program News and Announcements*, CMS (Jan. 11, 2013, 10:14 AM), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html> (announcing 106 new ACOs selected for January 1, 2013 Shared Savings Program; this number is on top of 87 selected for a July 1, 2012 start date, and 27 selected for an April 1, 2012 start date).

<sup>241</sup> Natalie Gochnour, *Leavitt Partners and KLAS Research Release Comprehensive Report on Accountable Care Organizations*, PR NEWSWIRE (Nov. 29, 2012), <http://www.prnewswire.com/news-releases/leavitt-partners-and-klas-research-release-comprehensive-report-on-accountable-care-organizations-181468431.html>; see also DAVID MUHLESTEIN ET AL., CTR. FOR ACCOUNTABLE CARE INTELLIGENCE, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS 3, 10 & tbl.1 (Leavitt Partners, 2012).

<sup>242</sup> TRICIA MCGINNIS & DAVID MARC SMALL, CTR. FOR HEALTH CARE STRATEGIES, ACCOUNTABLE CARE ORGANIZATIONS IN MEDICAID: EMERGING PRACTICES TO GUIDE PROGRAM DESIGN (2012), [http://www.chcs.org/usr\\_doc/Creating\\_ACOs\\_in\\_Medicaid.pdf](http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf).

and slow cost growth.”<sup>243</sup> ACOs and other organizational ideas have gained traction with the ACA’s incentives for shared savings for providers in such organizations. Such organizations reduce fragmentation and promote coordination and integration. As such, it is easier for payers to negotiate over price with more integrated health care organizations.<sup>244</sup>

ACOs present a risk of cost inflation, however, in some markets. They may foster provider consolidation, creating too much market power by providers against insurers. According to Thomas Greaney, “the ACO phenomenon may well encourage some mergers, joint ventures, and alliances that will exacerbate” the market concentration problem.<sup>245</sup> Economic evidence has shown “that hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.”<sup>246</sup> Dominant providers can use their market power to seek higher reimbursements, as well as to deny employers and health plans the ability “to obtain and use cost and quality data [to] enable them to shop more effectively.”<sup>247</sup>

## 2. Inform: Health Information Technology

The use of health information technology (“HIT”) tools are at the center of most of these coordination strategies since they assume adoption and utilization of such tools, “whether for practice management, sharing of patient records and service information across practitioners and sites, or as knowledge management tools to provide the most current clinical and comparative effectiveness research findings, clinical care standards and institutional protocols. These HIT tools promise long-term cost benefits but have high front-end costs.”<sup>248</sup>

The benefits of electronic health records (EHRs) are many. They include: (1) quick, accurate, and complete information about patients, available to a provider before she even sees the patient, so that physicians can spot problems earlier; (2) easy sharing of information among doctors, hospitals and systems,

<sup>243</sup> Elliott S. Fisher, *Room for Debate: The Court Can’t End the Pressure for Reform*, N.Y. TIMES (June 17, 2012, 5:00 PM), <http://www.nytimes.com/roomfordebate/2012/06/17/what-will-change-after-the-supreme-courts-health-care-ruling/whatever-the-health-care-ruling-a-need-for-changes>.

<sup>244</sup> Evans, *supra* note 122, at 122–23 (observing that “the policy objectives of providers are best served by an environment in which no organization has effective responsibility for or control over total costs, but in which funds flow through numerous and complex channels and the opportunities for shifting are legion. This creates a form of prisoner’s dilemma for payers. The optimal individual strategy is to spend one’s energy on efforts to shift costs, thereby increasing them in total, because individual efforts to constrain the total have almost no chance of being effective. It is hard to imagine a more satisfactory environment for providers.”).

<sup>245</sup> Greaney, *supra* note 232, at e1(2).

<sup>246</sup> *Id.* (citing C. H. Williams et al., *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, ROBERT WOOD JOHNSON FOUND. (2006), <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>).

<sup>247</sup> *Id.*

<sup>248</sup> Edward Berger, *Four Ways to Control Healthcare Spending*, MASS DEVICE (Sept. 9, 2010), <http://www.massdevice.com/blogs/edward-berger/four-ways-control-healthcare-spending?page=show>.

allowing for better coordination and care; (3) patient engagement in their care, allowing patients and their families to view and share health information.

The Health Information Technology for Economic and Clinical Health (HITECH) Act enables HHS to establish new programs to promote health IT, including electronic health records (EHRs) and health information exchanges (HIEs).<sup>249</sup> The HITECH Act creates substantial incentive payments for hospitals and eligible health professionals when they adopt certified EHR technology and then use it to meet specific goals.<sup>250</sup>

HITECH also provides federal grants to the states to establish statewide health information exchanges (HIEs). These health information exchanges are intended to amplify the gains in quality and efficiency that are expected generally from electronic medical records. In its most basic form an HIE allows clinicians treating a patient to access necessary patient records—including lab test results, allergies, diagnoses made by others treating the patient, and so on—through a one-stop portal rather than by contacting each of the patient’s health care providers individually. With a master patient index that gives each patient and each provider a unique identifier, the HIE consolidates patient health information from the patient’s many health care providers into one virtual record.

### 3. *Pay: Value-Based Reimbursement*<sup>251</sup>

The goal of pay-for-performance (“P4P”) is to try to use outcome measures tied to pay to begin the process of moving from payment per procedure to true outcome-driven health care. The federal government has been incrementally building such approaches into Medicare reimbursement since before the ACA was passed. The early steps in P4P often seem oversimplified and easier to conceptualize than to implement.<sup>252</sup> The ACA builds on health economic ideas about how to transform physicians’ economic incentives. The fee-for-service system is inherently inflationary, rewarding increases in volume of services without regard to patient value or outcome measures. Other payment models, such as paying physicians a base salary with additional incentives based on quality, are likely to produce better patient results at the same or

<sup>249</sup> See Health Information Technology for Economic and Clinical Health (HITECH) Act, Pub. L. No. 111-5, 123 Stat. 226 (2009) (codified as amended in scattered sections of 42 U.S.C.).

<sup>250</sup> Policymaking, Regulation, & Strategy, *Meaningful Use*, HEALTHIT.GOV, <http://www.healthit.gov/policy-researchers-implementers/meaningful-use> (last visited Apr. 10, 2013).

<sup>251</sup> See generally Arnold M. Epstein, Thomas H. Lee & Mary Beth Hamel, *Paying Physicians for High-Quality Care*, 350 NEW ENG. J. MED. 406 (2004).

<sup>252</sup> Bruce C. Vladeck, Letters, *Ineffective Approach*, 23 HEALTH AFF. 285, 285–86 (2004). Vladeck, former Administrator of the Health Care Financing Administration (predecessor agency to CMS), finds little to support in P4P, which he describes as “the kind of seductive focus group-tested catch phrase that . . . is largely devoid of real content.” *Id.* at 285. He writes:

Is the increasing commodification of health care, especially as embodied in “pay for performance” schemes, consistent with a thoughtful, long-term strategy to maximize quality? A comprehensive quality improvement strategy needs to focus on reinforcing the norms and values of professional responsibility, rather than on undermining them through the exercise of economic muscle.

*Id.* at 286.

lower cost. The ACA promotes experimentation by providers with modes of payment, which might include forms of capitation payments of a fixed amount for a defined bundle of services, with some practitioner risk factors for costs in excess of the capitation amount.<sup>253</sup> In the 1970s, health maintenance organizations promised efficient lower cost care.<sup>254</sup> Unfortunately, the excesses of some managed care plans led to the discrediting of capitation and risk-sharing. Current ACO models under the ACA offer a “kinder and gentler” version.<sup>255</sup> CMS has already implemented bundled payment for chronic end-stage renal disease services.<sup>256</sup> Such a disease-management model offers quality improvement coupled with reasonable return to providers. Global payments, being tried in Massachusetts at the state level, also shift incentives away from fee-for-service toward managing units of care.<sup>257</sup> Kenneth Kaufman writes:

As U.S. healthcare begins to move from an activity-based business model that incentivizes utilization of services to a value-based model that incentivizes population health management across the continuum of care, thousands of healthcare “science projects” are taking place in communities nationwide. Data emerging from the early initiatives by organizations that are aggressively transforming care delivery and payment should identify whether a “premium” of curve-bending change is occurring through these value-based efforts.<sup>258</sup>

Value is very hard to measure in our fragmented, non-electronic delivery system, and most providers fail to measure value.<sup>259</sup> Porter argues that

[c]osts, like outcomes, should instead be measured around the patient. Measuring the total costs over a patient’s entire care cycle and weighing them against outcomes will enable truly structural cost reduction, through steps such as reallocation of spending among types of services, elimination of non-value-adding services, better use of capacity, shortening of cycle time, provision of services in the appropriate settings, and so on.<sup>260</sup>

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<sup>253</sup> Berger, *supra* note 248; see also James C. Robinson, *Theory and Practice in the Design of Physician Payment Incentives*, 79 MILBANK Q. 149, 149 (2001) (“There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of ‘ping-pong’ referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else’s problem.”).

<sup>254</sup> Mirabito & Berry, *supra* note 236, at 182. For a discussion of the full range of tools used by managed care plans in the 1980s and into the 1990s, see generally Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 433–42 (1997).

<sup>255</sup> Berger, *supra* note 248.

<sup>256</sup> See *ESRD Payment*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Mar. 23, 2012, 1:17 PM), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/ESRDpayment/index.html?redirect=/ESRDpayment/>.

<sup>257</sup> Robert Steinbrook, *The End of Fee-for-Service Medicine?: Proposals for Payment Reform in Massachusetts*, 361 NEW ENG. J. MED. 1036, 1036 (2009).

<sup>258</sup> Kaufman, *supra* note 12.

<sup>259</sup> Michael E. Porter, *What Is Value in Health Care?*, 363 NEW ENG. J. MED. 2477, 2478 (2010).

<sup>260</sup> *Id.* at 2481.



Such a patient-centered valuation model, using electronic health records and close tracking of costs, will certainly promote more efficient care. The pressures of the ACA and new requirements for electronic health records (EHRs) are pushing hospitals rapidly toward new ways of thinking about treatment value.

*Labor Productivity Improvements.* Our health care system is very labor intensive, with very few productivity improvements over the past twenty years. We spent \$2.6 trillion in 2010 on health care, of which fifty-six percent was wages for health care workers.<sup>261</sup> Kocher and Sahni note that “[t]he combination of a risk-based payment model tied to outcome goals, on the one hand, and coding rules that are appropriate regardless of how providers achieve their clinical goals, on the other, could inspire the implementation of innovative, technology-based, analytically informed approaches that increase productivity.”<sup>262</sup> Only weak incentives exist to improve labor productivity. As Kocher and Sahni write:

If the health care sector is to achieve even the average improvement in labor productivity seen in the overall U.S. economy, we will need to redesign the care delivery model much more fundamentally to use a different quantity and mix of workers engaging in a much higher value set of activities.<sup>263</sup>

Productivity-enhancing ideas include using lower-level providers (such as nurses in place of physicians when appropriate), using more technology and teams, standardizing far more processes, and using evidence-based medicine all the time to reduce complications and side effects.

Enthusiasm for health care cost-control ideas often outruns what works. The mantra of innovation, often touted by economics and business academics, promises rapid change that delivers better care at lower cost, but innovation in health care is often stymied by payment rules, inertia, and fear of the disruption inherent in large-scale change. Nor will innovation always be cheaper—by delivering care at lower cost through efficiency techniques, it will spread such care to more people, raising health care expenditures as a percentage of GDP.

#### *D. Maximize Competition: Insurance Exchanges, Websites, and Other Market Reforms*

Consumers have faced incentives for cost reduction for decades. Since the growth of managed care, consumers have had to pay co-payments and deductibles as features of their health insurance coverage, on the theory that some discretionary health care use would be reduced.<sup>264</sup> The movement in the ACA toward information transparency is evidence in the insurance exchange concept, which aims to make insurance products in the individual market transparent as to coverage and price.<sup>265</sup> The federal government’s move toward quality information on websites such as Physician Compare and Hospital Compare is

<sup>261</sup> Robert Kocher & Nikhil R. Sahni, *Rethinking Health Care Labor*, 365 *NEW ENG. J. MED.* 1370, 1370 (2011).

<sup>262</sup> *Id.* at 1372.

<sup>263</sup> *Id.* at 1371.

<sup>264</sup> *See, e.g.*, GINSBURG, *supra* note 72, at 20–21.

<sup>265</sup> Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, COMMONWEALTH FUND, at 15 (2010), available at <http://www.commonwealth>

another example of enabling consumers to shop.<sup>266</sup> In theory, consumers can choose lower cost providers if prices can ever be posted in a transparent way. Research on effectiveness and provider willingness to calculate and post prices are required to make such shopping workable for consumers.

### 1. Insurance Market Reforms

Insurance reform is a major reform of the ACA. By 2014, the ACA will have driven a substantial expansion of Medicaid, implemented premium tax credits to make private plans purchased through new state insurance exchanges affordable, and implemented new insurance market rules to make private insurance coverage more affordable for individuals, families and small businesses. All individuals (with some exceptions) will have to obtain insurance coverage through employers, public programs, the individual market, or the health insurance exchanges for the individual and small group markets.<sup>267</sup>

The ACA provisions aim to stimulate market competition among health plans, incentivizing them to offer affordable, value-based options through the new insurance exchanges.<sup>268</sup> The health insurance exchange is a consumer-friendly market for health insurance, resembling a farmer's market, stock market, or online travel service. It will be a place where consumers can go, browse through the range of available insurance options, and choose the best insurance plan for themselves and their families. Small-business health options ("SHOP") exchanges will offer the same opportunities to small businesses.<sup>269</sup> The expectation is that insurers will be driven to present understandable and transparent information so consumers can shop well, making intelligent choices.

These exchanges will provide consumers choices among pre-approved health plans that are easier to choose among.<sup>270</sup> Qualified health plans (QHPs) will be the only plans allowed on the exchanges, and the "ACA also requires two QHPs participating in each exchange to be multi-state plans or MSPs."<sup>271</sup>

[fund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426\\_Jost\\_hlt\\_insurance\\_exchanges\\_ACA.pdf](http://fund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf).

<sup>266</sup> See, e.g., Mary Ellen Schneider, *Medicare Launches Physician Compare Website*, AM. C. SURGEONS (Jan. 6, 2011), <http://www.facs.org/surgerynews/2011/compare0111.html>; see also *Hospital Compare*, MEDICARE.GOV, <http://www.medicare.gov/hospitalcompare/?AspxAutoDetectCookieSupport=1> (last visited Apr. 10, 2013).

<sup>267</sup> Jane Hyatt Thorpe, Trish Riley & Teresa Cascio, *Multi-State Health Plans*, HEALTH REFORM GPS (June 7, 2012), <http://healthreformgps.org/resources/multi-state-health-plans/>.

<sup>268</sup> *Id.*

<sup>269</sup> *Affordable Insurance Exchanges: Choices, Competition and Clout for Small Businesses*, HEALTHCARE.GOV (July 11, 2011), <http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011c.html>.

<sup>270</sup> Thorpe, Riley & Cascio, *supra* note 267. By 2014, the Patient Protection and Affordable Care Act (ACA) will provide expanded health insurance coverage through three major features: (1) "a substantial expansion in Medicaid," (2) premium tax credits to make more "affordable private plans purchased through new state insurance exchanges," and (3) insurance market reforms to "make private coverage more accessible to individuals and families as well as small businesses." All individuals, with some exceptions, "will be required to obtain insurance coverage through employers, public programs, the individual market, or the health insurance exchanges for the individual and small group markets." These reforms are access-enhancing. The ACA's market competition to control costs should be noted, however.

*Id.*

<sup>271</sup> *Id.*

These MSPs may provide the foundation for a national approach in which state plans are uniform and portable, enabling consumers to move without having to shop again for insurance.<sup>272</sup> It is this combination of uniformity and portability that promises to provide consistency in health coverage, giving consumers greater ability to shop and resulting in cost savings as the fragmentation of the old system is replaced by a simpler, fairer system. Costs should drop as a result.

## 2. *Consumer Shopping Tools*

The ACA reflects the growth of a consumerist movement in health, giving patients information about health care risks and costs to maximize their choice. Kristin Madison defines consumerism as “individual choice within a health care marketplace characterized by the exchange of money for health care goods or services.”<sup>273</sup> The consumer relies on information from many different sources, particularly websites. This consumerist approach moves us from a passive patient to an aggressive shopper trying to gain information to satisfy her preferences for treatments, risks, and costs. Sources of information includes web-based sites such as WebMD, health care report cards issued by private and public organizations, and, with the force of the ACA, a range of government-run websites: Physician Compare and Hospital Compare.<sup>274</sup> Infection comparisons among hospitals have been added to the shopping list.<sup>275</sup>

Consumerism has limits. It turns patients into consumers and health care into a business, risking a more predatory “buyer beware” world. We see this with the use of social media to post complaints about doctors, using Angie’s List or other websites to post hostile comments with a counterattack by compa-

<sup>272</sup> *Id.*

<sup>273</sup> Kristin Madison, *Patients as “Regulators”?: Patients’ Evolving Influence over Health Care Delivery*, 31 J. LEGAL MED. 9, 15 (2010), available at <http://www.tandfonline.com/doi/abs/10.1080/01947641003598195>.

<sup>274</sup> See, e.g., *Hospital Compare*, *supra* note 266 (this government-run site already allows consumers to compare hospital choices).

<sup>275</sup> *Id.* (Medicare is reporting three sets of patient safety measures on the Hospital Compare website: Serious Complications, Hospital-Acquired Conditions, Healthcare-Associated Infections).

The Serious Complications and Deaths measures, developed by the Agency for Healthcare Research and Quality (AHRQ), provide information about how likely it is that patients will suffer from complications and deaths while in the hospital. Some of these complications and deaths might have been prevented if the hospital followed procedures based on best practices and scientific evidence.

The Hospital Acquired Conditions measures show how often patients got certain serious conditions while in the hospital, that might have been prevented if the hospital followed procedures based on best practices and scientific evidence.

The Healthcare Associated Infection measures are developed by Centers for Disease Control and Prevention (CDC) and collected through the National Healthcare Safety Network. They provide information on infections that occur while the patient is in the hospital. These infections can be related to devices, such as central lines and urinary catheters, or spread from patient to patient after contact with an infected person or surface. Many healthcare associated infections can be prevented when the hospitals use CDC-recommended infection control steps.

*Quality Definitions and Methodology: Patient Safety Measures*, AM. HOSP. DIRECTORY (Aug. 24, 2012), [http://www.ahd.com/definitions/qual\\_acq\\_cond.html](http://www.ahd.com/definitions/qual_acq_cond.html); see also *Measures of Readmissions, Complications and Deaths*, MEDICARE.GOV, <http://www.medicare.gov/HospitalCompare/Data/RCD/Overview.aspx> (last visited Apr. 10, 2013).

nies that offer doctors a retaliatory option.<sup>276</sup> Treating physicians began to treat patients as potentially threatening consumers, turning a professional relationship into a business contract. The bigger problem with consumerism is that it is doomed to failure at many levels. It assumes that most patients have the ability to be active consumers.<sup>277</sup> The fault in this assumption is that often the time when patients are most likely to engage the health care system is when they are ill, dependent, and weak. Shopping is the last thing on their minds.

There is room for improved shopping in the U.S. system in spite of the problems noted above. Shopping for quality services in advance, thinking about provider choices before getting sick, and selecting the right insurance policy is all part of a rational approach to consumer shopping in health care.

Enabling consumers to shop for quality is a significant policy goal of the ACA. Section 3015 provides for performance websites, which are to:

make available to the public . . . performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.<sup>278</sup>

Websites now in existence include Hospital Compare, Physician Compare, and Nursing Home Compare.<sup>279</sup> These websites require a range of performance-based information including patient clinical conditions and provider information.<sup>280</sup> Such public posting of provider performance information assumes that consumers will use these websites to facilitate making choices among providers.<sup>281</sup> More important, perhaps, is that providers will work harder to achieve high-quality care to avoid being shamed by bad ratings.

#### E. Promote Moderation: From Wellness to Dying Well

*When thinking about life and death moved from the library to the laboratory, the light of history dimmed. The future trumped the past. Youth vanquished age, and death grew unthinkable. The more secular ideas about immortality have become, the less well anyone, including and maybe especially doctors and scientists, has accepted dying, or even growing old.*<sup>282</sup>

If an individual promotes his own wellness through exercise, diet, and good health habits, his long-term health is likely to improve. An obvious strategy is to improve individual health to reduce long-term social costs. One of the features of the insurance reforms in the ACA is to focus on individual health

<sup>276</sup> See *Making Healthcare Safe for Doctors*, MED. JUST., <http://www.medicaljustice.com> (last visited Apr. 10, 2013). Its slogan is “Relentlessly protecting physicians from frivolous lawsuits.” They offer to deter frivolous malpractice claims, address unwarranted demands for refunds, and protect doctors’ reputations online.

<sup>277</sup> See Paul Krugman, *Patients Are Not Consumers*, N.Y. TIMES, Apr. 22, 2011, at A23.

<sup>278</sup> Patient Protection and Affordable Care Act § 3015, 42 U.S.C. § 280j-2 (2012).

<sup>279</sup> See, e.g., *Hospital Compare*, *supra* note 266; *Physician Compare*, MEDICARE.GOV, <http://www.medicare.gov/find-a-doctor/provider-search.aspx> (last visited Apr. 10, 2013); *Nursing Home Compare*, MEDICARE.GOV, <http://www.medicare.gov/NursingHomeCompare/> (last visited Apr. 10, 2013).

<sup>280</sup> Furrow, *Regulating Patient Safety*, *supra* note 19, at 1750.

<sup>281</sup> For information on the critiques of website information, see *id.*

<sup>282</sup> JILL LEPORE, *THE MANSION OF HAPPINESS: A HISTORY OF LIFE AND DEATH* xii (2012).

coupled with a concept of a “fair share” in health care—costs according to an individual’s ability to pay rather than on the volume of services consumed and individual choices more than genetic or preexisting health risks.<sup>283</sup> The ACA fosters wellness and prevention programs by eliminating cost sharing for preventive health services.<sup>284</sup> This focus on wellness and prevention promotes individual responsibility and moderation as a cost-conserving strategy. It is hardly unique to the ACA, but simply recognizes what is already happening in the workplace: private employers and insurers are designing programs with incentives for individual subscribers to be healthy.<sup>285</sup>

Will such programs make much of a difference? The evidence is not clear; the programs are popular with those who think that illness is largely the fault of individuals with bad health habits, who should have to bear their own health costs rather than impose such costs on others.<sup>286</sup> Advocates claimed, for example, that the Safeway Company’s wellness programs<sup>287</sup> were a success story of cost savings, claims that turned out to be largely false.<sup>288</sup>

A second major feature of health promotion is a range of public health programs that reduce smoking, use of drugs, driving risks, and other behaviors. A report released by the Trust for America’s Health in 2008 concluded that a small investment in disease prevention could result in significant savings in U.S. health care costs: “[A]n investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years. This is a return of \$5.60 for every \$1.”<sup>289</sup>

<sup>283</sup> See Baker, *supra* note 62, at 11 (partial draft prepared for the University of Pennsylvania Law School’s health law symposium).

<sup>284</sup> See, e.g., 42 U.S.C. § 300gg-16(a) (2010); *accord* 42 U.S.C. § 300gg-17(a)(1)(D) (2010). Section 2716 of the ACA prohibits discrimination based on salary, and section 2717(a)(1)(D) requires insurers to implement wellness and health promotion activities. See Patient Protection and Affordable Care Act §§ 2716–17.

<sup>285</sup> Katherine Baicker, David Cutler & Zirui Song, *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFF. 304, 304 (2010) (finding that “medical costs fall by about \$3.27 for every dollar spent on wellness programs and that absenteeism costs fall by about \$2.73 for every dollar spent.”).

<sup>286</sup> See NANCY LEE JONES ET AL., CONG. RESEARCH SERV., R40661, WELLNESS PROGRAMS: SELECTED LEGAL ISSUES 15 (2010), available at [http://www.disabilityleavelaw.com/uploads/file/CRS%20Wellness%20Report\(1\).pdf](http://www.disabilityleavelaw.com/uploads/file/CRS%20Wellness%20Report(1).pdf); Anita K. Chancey, *Getting Healthy: Issues to Consider Before Implementing a Wellness Program*, 2 J. HEALTH & LIFE SCI. L. 73, 73 (2009); Lucinda Jesson, *Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations*, 15 VA. J. SOC. POL’Y & L. 217, 220 (2008).

<sup>287</sup> See, e.g., Steven A. Burd, *How Safeway Is Cutting Health-Care Costs*, WALL ST. J., June 12, 2009, at A15. The Safeway idea was to motivate workers to improve their own health. The focus was on personal responsibility; Safeway concluded that up to seventy percent of all health-care costs are the result of individual behavior, and that most of these costs are due to four chronic conditions (cardiovascular disease, cancer, diabetes and obesity), conditions that are largely preventable.

<sup>288</sup> David S. Hilzenrath, *A Success Story That Isn’t Shapes Health-Care Debate: Blood Tests and Weigh-Ins Misleading Claims Drive “Safeway Amendment”*, WASH. POST, Jan. 17, 2010, at G1.

<sup>289</sup> *Prevention for a Healthier America*, TRUST FOR AMERICA’S HEALTH (July 2008), <http://healthyamericans.org/reports/prevention08/>.

The National Prevention, Health Promotion, and Public Health Council was created by executive order to coordinate prevention activities across the federal government to promote the nation's health.<sup>290</sup> To support the expansion of prevention activities, a new Prevention and Public Health Fund was created by the ACA with the goal of creating and supporting the needed infrastructure for prevention, detection and management of conditions before they become severe.<sup>291</sup> This new initiative will increase the national investment in prevention and public health, improve health, and enhance health care quality. This significant focus on and funding for prevention includes a wide range of initiatives, from Community and Clinical Prevention (\$126 million) to strengthening the public health infrastructure at the state and local levels, to more research and training on public health issues.<sup>292</sup> Here regulators need to be careful not to blame the victim. Take the problem of obesity. It may be the primary health-damaging disease in the United States and many other countries as well. Wellness programs in the workplace may help, as will public education. But one analyst had argued that the primary cause of obesity is simply an excess of cheap food, which leads to overconsumption by consumers. Food no longer takes work to harvest and prepare—between processed foods in the average supermarket and fast food restaurants in the United States in particular, we are surrounded by marketed temptation.

The epidemic was caused by the overproduction of food in the United States.

Beginning in the 1970s, there was a change in national agricultural policy. Instead of the government paying farmers not to engage in full production, as was the practice, they were encouraged to grow as much food as they could. At the same time, technological changes and the “green revolution” made our farms much more productive. The price of food plummeted, while the number of calories available to the average American grew by about 1,000 a day.<sup>293</sup>

Our food is too cheap, our portions are too large, and manufacturer package design and marketing exacerbates the problem, adding another factor leading to overeating.<sup>294</sup> New strategies are needed to reduce our intake. Marketing

<sup>290</sup> *Affordable Care Act: Laying the Foundation for Prevention*, HEALTHREFORM.GOV (Nov. 2, 2012, 1:22 PM), <http://www.healthreform.gov/newsroom/acaprevention.html>; see also Exec. Order No. 13,544, 75 Fed. Reg. 33,983 (June 10, 2010), available at <http://www.whitehouse.gov/the-press-office/executive-order-establishing-national-prevention-health-promotion-and-public-health> (established under the authority of the ACA).

<sup>291</sup> *Affordable Care Act: Laying the Foundation for Prevention*, supra note 290.

<sup>292</sup> For a full discussion of the range of public health issues, see Symposium, *Public Health Reform: Patient Protection and Affordable Care Act Implications for the Public's Health*, 39 J.L. MED. & ETHICS 307 (2011).

<sup>293</sup> Claudia Dreifus, *A Mathematical Challenge to Obesity*, N.Y. TIMES, May 14, 2012, at D2 (reporting on a mathematical analysis of obesity by Dr. Carson Chow). For slides of Dr. Chow's talk, see Carson C. Chow, Lecture: The Math Behind the Myths of Obesity (Feb. 20, 2012), available at <http://sciencehouse.files.wordpress.com/2012/02/aaas122.pdf>.

<sup>294</sup> Pierre Chandon, *How Package Design and Packaged-Based Marketing Claims Lead to Overeating* 12 (INSEAD, Working Paper No. 2012/61/MKT, 2012), available at <http://ssrn.com/abstract=2083618>.

[A] promising approach may be to change the choice context at the point of purchase and at the point of consumption so that the healthy choice becomes the easy choice. Obviously, a combination of smart regulation, promotion of mindful eating, and mindless nudges is more likely to work than any of them in isolation.

*Id.* at 27.

of food should be regulated more aggressively, especially to children; price supports for agricultural production should be cut; and we should develop strategies for eating less (e.g., cook more, buy raw ingredients). In other words, it is not just our fault but, rather, the combined pressures of external forces. The technologies of modern agriculture and food marketing doom us, and a strong public-health pushback by regulators is needed to protect us from ourselves and these forces.

A third perilous area of cost conservation is how to die well and frugally if we so choose. As Daniel Callahan asks: “Should death be seen as the greatest evil that medicine should seek to combat, or would a good quality of life within a finite life span be a better goal?”<sup>295</sup> He proposes a change in social expectations and norms about dying so we learn not to exert every last bit of energy on health expenditures that promise minimal gains at high prices.<sup>296</sup> Here the law can induce individual reflection on dying well. Use of advance directives is the best example of a process of such induction. We know that advance directives do matter.<sup>297</sup> One study looked at a population of aged patients, particularly that segment (about one third) who would become too incapacitated over time to make needed decisions about end-of-life care.<sup>298</sup> The study found that in this population, “nearly all of those with a living will [who request] limited or comfort care only [in fact] did receive such care at the end of their lives. And those patients who specified all care possible were far more likely to receive aggressive care than those who did not request it.”<sup>299</sup> Advance directives work, allowing precise instructions to care givers. Managing the end of life with such directives may have cost-conserving effects by reducing low-benefit, high-cost scrambling at the end of life when the patient is incompetent and family is conflicted or absent.

The ACA avoided the perils of advance directives and “death panels,” the rhetorically felicitous phrase coined by Sarah Palin and her handlers.<sup>300</sup> But the ACA does promote decision aids as a tool to improve the informed-consent process, requiring physicians to offer them to patients with regard to treatment choices for preference-sensitive care.<sup>301</sup> This is care in which the clinical evidence does not clearly support one treatment option over another, confronting the patient and provider with significant tradeoffs among different outcomes for each treatment.<sup>302</sup> The goal is to give patients full information about treatment tradeoffs and ensure that their preferences are incorporated into the treatment

<sup>295</sup> Callahan, *supra* note 2, at 82.

<sup>296</sup> *Id.* at 79, 82.

<sup>297</sup> Maria J. Silveira, Scott Y.H. Kim & Kenneth M. Langa, *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 *NEW ENG. J. MED.* 1211, 1211 (2010).

<sup>298</sup> Pauline W. Chen, *Making Your Wishes Known at the End of Life*, *N.Y. TIMES* (Apr. 15, 2010), <http://www.nytimes.com/2010/04/16/health/15chen.html>.

<sup>299</sup> *Id.*

<sup>300</sup> For a useful history of the phrase and its sponsors, see *Death Panel*, *WIKIPEDIA* (Apr. 3, 2013, 12:14 AM), [http://en.wikipedia.org/wiki/Death\\_panel](http://en.wikipedia.org/wiki/Death_panel).

<sup>301</sup> 42 U.S.C. § 299b-36 (Supp. IV 2010).

<sup>302</sup> John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies?*, 37 *WAKE FOREST L. REV.* 925, 934 (2002).

plan. Perhaps such aids could be developed to help patients converse about treatment choices from hospice to extraordinary measures. As decision aids are developed and adopted, it may well be that a range of treatments for terminal illness will help patients to understand the costs and benefits of costly end-of-life treatments and choose to forego them in some cases. Jill Lepore reminds us that “[i]n *Man versus Death*, being clever helps, but the best you can hope for is to prolong the game. Death always wins. Death is a bastard. Death cheats.”<sup>303</sup> Advance directives help us regain control over death, and if we choose not to “prolong the game,” we will be passing the savings on to our children.

#### CONCLUSION

Cost inflation in the United States is stressing the existing employment-based health insurance system, and government program budgets. The average American’s income is falling further and further behind rises in health coverage costs.<sup>304</sup> Reducing the growth of new spending on low value technologies is the central cost control goal of the next decade.<sup>305</sup>

The ACA has created powerful new tools to limit the diffusion of new technologies until we have evidence on effectiveness, outcomes, and innovation. We should begin to narrow medical practice variation as we differentiate between high-value care and low-value care. This requires robust technology assessment tools that reduce political pressures that might jeopardize funding, no easy process to achieve in American politics. The research must also look beyond raw comparative effectiveness to the costs of care associated with that technology. Private insurance may have potential to lead the way, unconstrained by Congressional discomfort with any version of cost effectiveness.

A second way to cramp cost is to continue payment reform in all of its forms, including coordination tools such as the ACOs and medical homes pay-for-performance aimed particularly at hospitals, and IPAB evaluation of physician payment in the Medicare system. The system has to move from a focus on profitable services to a more robust focus on good outcomes for groups of patients.

The American system is changing with or without the innovations of the ACA. But the range of ACA innovations is already accelerating these changes. Employers may exit the process of providing health care benefits altogether with or without ACA insurance reforms. The irony of resistance to the ACA is that government may be forced increasingly to be the primary provider of coverage for much of the population through state exchanges that will be created, Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), the military health system, Federal Employees Health Benefits (FEHB) Program, the Indian Health Service (IHS), Veterans’ Affairs (VA), and other programs.<sup>306</sup> We may well be moving toward a federalization of health care, in which the federal government accumulates real bargaining power vis-à-vis providers.

<sup>303</sup> LEPORE, *supra* note 282, at xviii.

<sup>304</sup> GINSBURG, *supra* note 72, at 20.

<sup>305</sup> *Id.*

<sup>306</sup> Paul Keckley, *Health Reform Memo—June 18, 2012*, CFO J. (June 21, 2012, 11:18 PM), <http://deloitte.wsj.com/beta/2012/06/21/health-reform-memo-june-18-2012/>.



Other shifts that impact cost are occurring in the health care system. Young doctors want more control over their lives and are rejecting the previous physician generation's desire for solo practice and control over income in a fee-for-service system. Doctors have typically been high users of services and heavy investors in labs and clinics to set their target incomes high. Fraud and abuse laws have curtailed much of this investment, and this cohort is also leaving the workforce in droves, replaced by younger physicians who want a predictable income without entrepreneurial anxiety. Hospital employment of physicians has grown thirty-two percent since 2000.<sup>307</sup>

The problem with these demand shifts of young physicians is that primary care practice lacks sufficient economic incentives to attract larger numbers of physicians to practice. The ACA provides strong incentives to increase the numbers of primary care physicians.<sup>308</sup> Some of the ACA features include: a ten percent bonus to primary care practitioners who see Medicare patients (2011–2015); increase in payment rates to Medicare levels for two years for primary care physicians who see Medicaid patients (2013–2014); training of more than 16,000 new primary care providers over the next five years; a doubling of the capacity of community health centers, “serving 15 million to 20 million more people by 2015, to help meet the demand of the newly insured.”<sup>309</sup>

The other shift in employment is fostered by moves to integrate the practice of medicine. The focus by the ACA and the CMS on bundled payments means that providers must operate in more efficient groups. Large group practices are growing. It takes a group to afford modern practice, which will require protocols to reduce practice variation in care delivery, chronic disease management, case management, and other modern (and expensive) tools. These larger practices, whether owned by hospitals, insurers, or investors, will have more capital and human resources required to successfully reduce care costs.

The reality of defining high-quality health care and how it relates to cost will also continue to confound simplified models of cost control. A recent study of care in Canadian hospitals concluded that quality may cost more, not less.<sup>310</sup> Efficiencies may not reduce the costs of good outcomes. The authors found that “[a]mong Ontario hospitals, higher spending intensity was associated with lower mortality, readmissions, and cardiac event rates.”<sup>311</sup> “[I]n Ontario, a

<sup>307</sup> See AM. HOSP. ASS'N, AHA HOSPITAL STATISTICS (2012).

<sup>308</sup> Melinda Abrams et al., *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers*, 1 COMMONWEALTH FUND 1, 1 (2011).

<sup>309</sup> Melinda Abrams, *How Will the Affordable Care Act Bolster Primary Care?*, COMMONWEALTH FUND BLOG (Jan. 4, 2011), <http://www.commonwealthfund.org/Blog/2011/Jan/Affordable-Care-Act-Bolsters-Primary-Care.aspx>.

<sup>310</sup> See Therese A. Stukel et al., *Association of Hospital Spending Intensity with Mortality and Readmission Rates in Ontario Hospitals*, 307 JAMA 1037, 1037 (2012). “Our objective was to assess whether acute care patients admitted to Canadian hospitals that treat patients more intensively (and at higher cost) have lower mortality and readmissions and higher quality of care.” *Id.* at 1038. “We found that higher hospital spending intensity was associated with better survival, lower readmission rates, and better quality of care for seriously ill, hospitalized patients in Ontario in a universal health care system with more selective access to medical technology.” *Id.* at 1042.

<sup>311</sup> *Id.* at 1037.

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province with global hospital budgets and fewer specialized health care resources than the United States, outcomes following an acute hospitalization are positively associated with higher hospital spending intensity.”<sup>312</sup>

Higher spending on evidence-based services delivered in the acute phase of care for severely ill hospitalized patients—by far the largest component of spending for our cohorts—is indeed likely to be beneficial.

...

... Higher spending intensity, in turn, is associated with greater use of specialists, better patient care, and more use of advanced procedures.<sup>313</sup>

These results suggest that it is critical to understand not simply how much money is spent but whether it is spent on effective procedures and services. If improved mortality and fewer adverse events are the result of high spending intensity, those savings have to be factored into the cost-value equation.

Cost control may also require a lowering of patient expectations of care. Is this likely to happen in the United States, where death is unwelcome and technology is loved beyond reason? Americans overrate the effectiveness of health care and they need to get over it.

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<sup>312</sup> *Id.* at 1044.

<sup>313</sup> *Id.* at 1043–44.