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# Cost Containment and the Patient Protection and Affordable Care Act

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## **Cost Containment and the Patient Protection and Affordable Care Act**

*David Orentlicher\**

The legislation “puts into place virtually every cost-control reform proposed by physicians, economists, and health policy experts.”

- Peter Orszag and Ezekiel Emanuel<sup>1</sup>

"The job of figuring how to cover uninsured people used up all the political oxygen that was available. They didn't have the energy for costs."

- Alan Sager<sup>2</sup>

For decades, the U.S. health care system has grappled with two key problems – inadequate access to coverage and increasingly unaffordable health care costs. Paradoxically, the U.S. spends far more of its gross domestic product (GDP) on health care than do other economically-advanced democracies, yet provides health care insurance to fewer of its citizens.<sup>3</sup>

During the debate that led to the enactment of the Patient Protection and Affordable Care Act, public officials recognized the need to address the problems of both access and cost, but in the end, the Act does far more about increasing access than it does about cutting

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<sup>1</sup> Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 603 (2010).

<sup>2</sup> John Dorschner, *Cost Issues Remain Despite Healthcare Reforms*, MIAMI HERALD, Mar. 31, 2010 (quoting Alan Sager).

<sup>3</sup> TOTAL EXPENDITURE ON HEALTH PER CAPITA, OECDiLibrary, [http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health-per-capita\\_20758480-table2](http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health-per-capita_20758480-table2) (last updated Mar. 11, 2011).

costs. And this result is not surprising. As a matter of politics, it is much easier to sell the public on more benefits than greater sacrifice, so cost control was largely left to another day. To be sure, taking a wider-coverage-first, cost-containment-second approach is not unique to the Affordable Care Act. Health care reforms typically expand access initially and envision cost containment as the next step. That was the approach of Medicare and Medicaid in 1965;<sup>4</sup> it also was the strategy for Massachusetts when it passed its health care reform in 2006.<sup>5</sup> Still, we are left with the question of whether future Congresses will implement the measures necessary to tame health care cost inflation or whether uncontrolled costs will cause the Affordable Care Act to unravel.

### I. THE COST PROBLEM

For many years, the United States has spent more than other countries on health care, and the gap is only widening. In 2008, for example, the U.S. spent more than \$7,500 per capita on health care, which was more than double what Germany spent and nearly three times what New Zealand spent.<sup>6</sup> To some extent, it makes sense for the U.S. to spend more on health care – as a country's wealth increases, so does its ability to fund services like health care that can prolong life and improve health. But even as a percentage of GDP, the U.S. spends far more than other countries on health care. In 2008, for example, Germany spent at 66 percent of the U.S. level, and New Zealand spent at 61 percent of the U.S. level.<sup>7</sup>

It is not only the case that the U.S. spends much more than anyone else; there also is the problem that the U.S. realizes a smaller return on its health care dollar. In one study, researchers compared the actual improvement in health in different countries with the potential improvement that could have been achieved with the dollars that the countries spent.<sup>8</sup> By that measure, the U.S. health care system was less efficient than the systems in Western European countries like the UK, Spain, France, Germany, Austria and Italy; Northern European countries like Denmark, Norway and Sweden; Far Eastern countries

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<sup>4</sup> David Blumenthal & James Morone, *The Lessons of Success—Revisiting the Medicare Story*, 359 NEW ENG. J. MED. 2384, 2388 (2008).

<sup>5</sup> Jon Kingsdale, *Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned*, 28 HEALTH AFF. w588, w588, w589 (2009).

<sup>6</sup> OECDiLIBRARY, *supra* note 3, at 1.

<sup>7</sup> TOTAL EXPENDITURE ON HEALTH, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health\\_20758480-table1](http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health_20758480-table1) (last updated Mar. 11, 2011).

<sup>8</sup> David B. Evans et al., *Comparative Efficiency of National Health Systems: Cross National Econometric Analysis*, 323 BMJ 307 (2001).

like Japan, China and Australia; and Western Hemisphere countries like Canada, Mexico, Colombia and Venezuela.<sup>9</sup>

The inefficiency of the health care system is reflected in key statistics on the quality of health. Thus, life expectancy in the U.S. trails that of Japan, Switzerland, Canada, France, Italy, Spain, Israel, Germany, Greece and the U.K., while the infant mortality rate is higher in the U.S.<sup>10</sup>

To some extent, U.S. citizens benefit from the higher levels of spending. For example, survival rates for patients with breast or colon cancer tend to be higher in the U.S.<sup>11</sup> However, in many other ways, the greater spending does not translate into better health. People with asthma or diabetes are much more likely to need treatment in a hospital at some point during the year in the U.S. than in other countries. Americans are more than six times as likely as Canadians to be hospitalized for asthma and more than five times as likely as Italians to be hospitalized for diabetes.<sup>12</sup>

One might suppose that the U.S. gets less bang for its health care buck because Americans are not as healthy as citizens of other countries. That does not seem to be the explanation either. Americans are more obese than others, often much more so,<sup>13</sup> but they also are less likely to smoke tobacco or consume alcohol.<sup>14</sup> Americans also are younger,<sup>15</sup> which should mean lower health care costs. According to one study, Americans are overall less healthy than in other economically-advanced countries, but the additional cost from the greater

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<sup>9</sup> *Id.* at 309 fig.1.

<sup>10</sup> LIFE EXPECTANCY AT BIRTH, TOTAL POPULATION, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/life-expectancy-at-birth-total-population\\_20758480-table8](http://www.oecd-ilibrary.org/social-issues-migration-health/life-expectancy-at-birth-total-population_20758480-table8) (last updated Mar. 11, 2011); INFANT MORTALITY, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/infant-mortality\\_20758480-table9](http://www.oecd-ilibrary.org/social-issues-migration-health/infant-mortality_20758480-table9) (last updated Mar. 11, 2011).

<sup>11</sup> *Disparities in Health Expenditure Across OECD Countries: Hearing Before the Subcomm. on Aging*, 111th Cong., 5 chs.4 & 5 (2009) (statement of Mark Pearson, Head, Health Division, OECD), available at <http://www.oecd.org/dataoecd/5/34/43800977.pdf>.

<sup>12</sup> *Id.* at 5 chs.6 & 7.

<sup>13</sup> OVERWEIGHT OR OBESE FEMALES, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/overweight-or-obese-females\\_20758480-table15](http://www.oecd-ilibrary.org/social-issues-migration-health/overweight-or-obese-females_20758480-table15) (last updated June 8, 2010); OVERWEIGHT OR OBESE MALES, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/overweight-or-obese-males\\_20758480-table16](http://www.oecd-ilibrary.org/social-issues-migration-health/overweight-or-obese-males_20758480-table16) (last updated June 8, 2010).

<sup>14</sup> TOBACCO CONSUMPTION, OECDiLIBRARY, [http://www.oecd-ilibrary.org/social-issues-migration-health/tobacco-consumption\\_20758480-table14](http://www.oecd-ilibrary.org/social-issues-migration-health/tobacco-consumption_20758480-table14) (last updated Mar. 11, 2011).

<sup>15</sup> *Median Age*, CIA, THE WORLD FACTBOOK, <https://www.cia.gov/library/publications/the-world-factbook/fields/2177.html> (last visited Apr. 1, 2011).

“disease burden” amounted to only \$25 billion out of nearly \$2 trillion in health care spending.<sup>16</sup>

If the high U.S. health care costs cannot be explained by a less healthy population or greater health benefits from health care spending, why does the U.S. spend more than other countries? Costs are higher in the U.S. in large part because prices for health care services are higher.<sup>17</sup> Coronary artery bypass surgery and hip replacements, for example, are twice as expensive in the U.S. as in Canada.<sup>18</sup> Similarly, physicians are more highly compensated in the U.S.<sup>19</sup> While the reasons for the higher costs are not entirely clear, experts cite the weaker bargaining power of purchasers of health care services in the U.S. and the greater bargaining power of sellers of services. On the purchasing side, governments in other countries typically negotiate standard fee schedules that apply across the board; private insurers in the U.S. have less leverage than governments in their dealings with doctors, hospitals and pharmaceutical companies.<sup>20</sup> On the selling side, mergers and other consolidations of services have enabled hospitals to implement higher charges.<sup>21</sup> Physician fees may be driven higher in part by the high cost of medical education in the U.S.; doctors in other countries graduate with substantially less educational debt.<sup>22</sup>

It also appears that U.S. health care costs are high because of high numbers of surgical procedures, particularly coronary artery bypass surgeries and other cardiovascular procedures.<sup>23</sup> Americans also are more than twice as likely as citizens of other economically-advanced countries to have an MRI or CT scan.<sup>24</sup>

<sup>16</sup> CARLOS ANGRISANO ET AL., ACCOUNTING FOR THE COST OF HEALTH CARE IN THE UNITED STATES 9-11 (Jan. 2007), [http://www.mckinsey.com/mgi/reports/pdfs/healthcare/MGI\\_US\\_HC\\_fullreport.pdf](http://www.mckinsey.com/mgi/reports/pdfs/healthcare/MGI_US_HC_fullreport.pdf). U.S. health care spending reached \$2.5 trillion in 2009. *National Health Expenditures 2009 Highlights*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf> (last visited Aug. 20, 2011).

<sup>17</sup> Gerard Anderson et al., *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22 HEALTH AFF. 89, 98 (2003).

<sup>18</sup> CHRIS L. PETERSON & RACHEL BURTON, U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES 22 (Sept. 17, 2007), [http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key\\_workplace](http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key_workplace). Price differentials are even greater for countries like India and Thailand, spurring the growth of “medical tourism.” I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1471-73 (2010).

<sup>19</sup> PETERSON & BURTON, *supra* note 18, at 17-19.

<sup>20</sup> Anderson et al., *supra* note 17, at 102.

<sup>21</sup> PETERSON & BURTON, *supra* note 18, at 42.

<sup>22</sup> *Id.* at 59.

<sup>23</sup> *Id.* at 3 fig.9; Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009, at 36.

<sup>24</sup> PETERSON & BURTON, *supra* note 18, at 12, 15 figs.12 & 13.

There are important structural features of the U.S. health care system that foster the high prices and high volumes that characterize American health care. For example, because health care insurance covers most of the costs for most Americans, patients become insensitive to the fees they are charged. When patients pay a co-payment of \$25, they will desire treatment as long as the value of the treatment to the patient is more than \$25. Thus, if a treatment provides a value of \$50, the patient will want it. But a treatment with a value of \$50 may have a total cost of \$150 (with the insurer picking up the other \$125 of the cost) and therefore really is not worth providing. In short, from the perspective of overall social benefits and costs, patients demand too much health care.<sup>25</sup>

Just as patients have too great an incentive to seek care, physicians and hospitals have too great an incentive to offer care. Under the predominant “fee-for-service” method of reimbursement, providers of health care are paid more for doing more.<sup>26</sup> Whether needed or not, a surgical procedure pays very well, and there is good reason to think that financial incentives in the U.S. lead physicians to perform many unnecessary operations. As indicated above, U.S. physicians perform surgeries at much higher rates than their counterparts in other countries. In addition, when researchers compare the practices of U.S. physicians in high-procedure communities with the practices of U.S. physicians in low-procedure communities, they find that procedure rates are similar when there is strong evidence demonstrating the value of the care. However, when the benefit of the care is less clear, it is much more likely to be performed in the high-procedure communities.<sup>27</sup> In other words, it appears that the difference between high- and low-procedure communities is not that too few procedures are performed in the low-procedure communities but that too many procedures are performed in the high-procedure communities. And the financial rewards from performing extra procedures likely play a major role in the decisions of physicians and hospitals to provide

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<sup>25</sup> Of course, the incentive effects of insurance do not distinguish the U.S. health care system from systems in other countries. There too, insurance encourages patients to demand too much health care. However, other countries employ strategies that counteract the incentive effects of insurance. For example, as mentioned above, governments and insurers in other countries negotiate less generous fee schedules for reimbursement of physicians and hospitals.

<sup>26</sup> David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158 (1996).

<sup>27</sup> Elliott S. Fisher et al., *Health Care 2009: Slowing the Growth of Health Care Costs — Lessons from Regional Variation*, 360 NEW ENG. J. MED. 849, 850-51 (2009).

them. Indeed, when physicians are paid a salary, they are less likely to order lab tests, request radiologic scans or perform surgeries.<sup>28</sup>

The problem is exacerbated because physicians and hospitals often find that they lose money when they provide higher-quality, lower-cost care. Preventing the need for hospitalization pays much less than does treating a patient in the hospital. Mt. Sinai Hospital in New York learned that lesson after opening clinics for patients with diabetes. Patients treated at the clinics lowered their weight and reduced their blood sugar levels. While the clinics were successful in terms of improving patient health, they operated with substantial fiscal deficits and ultimately were closed.<sup>29</sup>

Other commonly-given explanations for the high costs of care in the U.S. are not supported by the data. For example, the legal costs from medical malpractice are less than one percent of total health care costs, and defensive medicine also represents a very small part of the health care budget.<sup>30</sup>

## II. WILL THE AFFORDABLE CARE ACT SOLVE THE HEALTH CARE COST PROBLEM?

While the Affordable Care Act includes many different provisions to contain costs, there is a serious question whether those provisions really address the cost problem. For the most part, the Act does not take on the major drivers of higher costs, other than to some extent through demonstration projects.

Before looking at the cost-containing provisions of the Affordable Care Act, it is worth considering the kinds of reforms that would be effective at controlling health care spending. Then we can see whether the Act includes potentially effective reforms.

How might the U.S. respond to the factors that drive health care costs higher? As discussed in the previous section, key factors include the existence of health care insurance (which makes patients too insensitive to the costs of their care), fee-for-service reimbursement (which makes physicians and other providers of health care too insensitive to the necessity of care), and the relatively weak bargaining power of insurance companies (which keeps health care prices too high). Patients are too willing to seek more care, physicians and hos-

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<sup>28</sup> David Hemenway et al., *Physicians' Responses to Financial Incentives*, 322 NEW ENG. J. MED. 1059, 1060-62 (1990).

<sup>29</sup> Ian Urbina, *In the Treatment of Diabetes, Success Often Does Not Pay*, N.Y. TIMES, Jan. 11, 2006, at A1.

<sup>30</sup> PETERSON & BURTON, *supra* note 18, at 41-42; see also Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 909-11 (2005).

pitals are too willing to provide more care, and prices are too high for the care that is provided.

#### A. Changing the Incentives for Patients

A number of commentators believe that health care cost inflation can be tamed by giving patients more “skin in the game.”<sup>31</sup> If patients were to pay a higher percentage of the costs of care *at the time they decide whether to seek care*, they will be less likely to demand too much care. Thus, for example, many employers have adopted health savings accounts that include high deductibles;<sup>32</sup> most employers also have raised patient co-payments or co-insurance percentages.<sup>33</sup> Proponents of patient incentives are correct that raising deductibles, co-payments, or co-insurance responsibilities will reduce the demand for health care.

However, the potential effectiveness of these incentives is limited. First, the idea behind patient incentives is to discourage the likelihood that patients will seek unnecessary care. Instead of going to the doctor when sick with the common cold, for example, patients will more appropriately nurse themselves at home. But when patients reduce their demand for care on account of higher deductibles and other fees, they often reduce their demand across the board, for both necessary and unnecessary care.<sup>34</sup> The individual with abdominal pain may hesitate to see a doctor, turning an uncomplicated appendicitis into a ruptured appendix that requires a longer hospitalization and post-operative recovery.<sup>35</sup> Second, patient deductibles, co-payments and co-insurance would have to be higher than what would be acceptable to people to make them truly effective. Consider, for example, the patient faced with coronary artery bypass surgery and a choice between a total cost at one hospital of \$40,000 and a total cost at another hospital of \$50,000. With either hospital, a deductible of even \$2,500 would be eaten up, so the existence of a high deductible would not drive the patient to the cheaper hospital. Having a 10 or 20 per-

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<sup>31</sup> MARK HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 991-93 (7th ed. 2007).

<sup>32</sup> A deductible refers to the amount of health care costs for which the insured individual is responsible before insurance kicks in. Deductibles in health savings accounts run from \$1,000 to \$2,500.

<sup>33</sup> Co-payments and co-insurance refer to the patient's share of health care costs once insurance does kick in. For example, a patient may pay a \$25 co-payment toward the cost of a visit to a physician and pay 10 percent of the costs of hospital care as co-insurance.

<sup>34</sup> Melinda B. Buntin et al., *Consumer Directed Health Care: Early Evidence About Effects On Cost And Quality*, 24 HEALTH AFF. w516, w523-25 (2006).

<sup>35</sup> Paula Braveman et al., *Insurance-Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 446-48 (1994).



cent co-insurance rate might make a difference in the patient's choice of hospital, but health care policies typically blunt the impact of co-insurance by capping a person's annual out-of-pocket costs. If a plan had a 10 percent co-insurance rate and an annual out-of-pocket cap of \$2,400 (the cap that I have under my individual health care insurance policy at Indiana University), then participants would lose their incentive to consider costs once a procedure's costs exceeded \$24,000. Raising the out-of-pocket cap would encourage greater cost sensitivity, but it also would undermine the very purpose of health care insurance – the protection of individuals from unaffordable health care costs.

Another approach to changing patient incentives is included in Section 9001 of the Affordable Care Act, which imposes a so-called “Cadillac” tax. Starting in 2018, there will be a 40 percent tax on high-cost health care plans to the extent that the cost of the coverage exceeds a threshold amount. The threshold starts at \$10,200 for individuals and \$27,500 for families (which is about double the current average cost for health care coverage).<sup>36</sup> The threshold amount is adjusted upward for health care cost inflation and to take into account the higher costs of the purchaser's risk pool.<sup>37</sup> The tax is expected to generate revenues of \$32 billion in 2018 and 2019.<sup>38</sup>

The Section 9001 tax is designed to counteract the tax code's current incentive for employers to offer very expensive health care plans. Because health care benefits are not taxed as income, employees can use “pre-tax” dollars to purchase their health care insurance.<sup>39</sup> For people who pay 35 percent of their wages in payroll taxes and federal, state and local income taxes, a dollar spent on health care coverage costs them only 65 cents in foregone take-home pay.<sup>40</sup>

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<sup>36</sup> Richard S. Foster, *Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended*, CENTERS FOR MEDICARE & MEDICAID SERVICES, 17 (Apr. 22, 2010), [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf); LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, 968-70 (C.C.H. ed., 2010) (explaining ¶ 2205 Excise Tax on High Cost Employer-Sponsored Health Coverage).

<sup>37</sup> Foster, *supra* note 36, at 17 n.15; LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, *supra* note 36, at 969-71.

<sup>38</sup> CONGRESSIONAL BUDGET OFFICE Table 2 (Mar. 20, 2010), <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

<sup>39</sup> While people often think that their employer is paying for their health care benefits, in fact, the employer is simply taking part of the worker's compensation and paying it in the form of health care benefits instead of salary. David A. Hyman, *Employment-Based Health Insurance and Universal Coverage: Four Things People Know that Aren't So*, 9 YALE J. HEALTH POL'Y L. & ETHICS 435, 437-38 (2009).

<sup>40</sup> Jon Gabel et al., *Taxing Cadillac Plans May Produce Chevy Results*, 29 HEALTH AFF. 174, 174 (2010).

The Section 9001 tax likely will have only a small impact on health care costs. As critics of Cadillac taxes have observed, high-cost health care plans do not have high costs because of overly generous benefits. Rather, the high costs reflect the relatively poor health status of the workforce covered by the plan and the relatively high health care costs of the local community.<sup>41</sup>

While changing the incentives for patients does not seem very promising, changing the incentives for physicians, hospitals and other providers seems more promising.

### B. Changing the Incentives for Physicians and Hospitals

As discussed, fee-for-service reimbursement encourages physicians and hospitals to provide too much care, and society ends up with unnecessarily high costs, as well as a lower quality of care. Accordingly, replacing fee-for-service reimbursement with salaries or capitation fees<sup>42</sup> for physicians and fixed budgets for hospitals would delink provider income from the volume of services provided. Indeed, by eliminating fee-for-service reimbursement, good preventive care would be turned from a financial loser into a financial winner. If hospitals like Mt. Sinai were operating under a fixed budget and they kept patients with diabetes from needing expensive hospitalizations, the hospitals might increase their profits rather than run deficits.

Health policy experts also have urged a linkage between reimbursement and quality of care. Instead of paying physicians and hospitals for the amount of care that they provide, insurers would pay for health care services on the basis of the results that are achieved. And quality-based, “pay for performance” incentives have become common in health care in the past decade.<sup>43</sup>

In principle, a shift in reward from quantity to quality of care makes a good deal of sense and could do much to improve our health care system. However, for many reasons, it is difficult to implement quality-based reimbursement in practice: Patients may do well or poorly because of the physician’s care or because of factors beyond

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<sup>41</sup> *Id.* at 179-80. Accordingly, as mentioned, the threshold amount for the tax is higher for plans that insure groups with relatively poor health status or who receive care in communities with higher health care costs. Critics of Cadillac taxes also have observed that reducing tax subsidies for health care insurance may have a regressive effect (i.e., the higher taxes may represent a higher percentage of income for lower-income persons). David U. Himmelstein & Steffie Woolhandler, *The Regressivity of Taxing Employer-Paid Health Insurance*, 361 NEW ENG. J. MED. e101 (2009), available at <http://healthpolicyandreform.nejm.org/?p=1521>.

<sup>42</sup> With capitation, physicians are paid a fixed amount per patient per year to provide care for their patients. Orentlicher, *supra* note 26, at 158-59.

<sup>43</sup> REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 22 (Institute of Medicine ed., 2007).

the physician's control, like the patient's underlying health status, and it is not always easy to determine which really mattered for a particular patient. For many kinds of care, it can take years to see results. And for many kinds of care, we really do not know the optimal approach.<sup>44</sup> While the jury is still out on pay for performance, a recent study yielded disappointing results from this approach to compensation for physicians.<sup>45</sup>

Besides changing the form of reimbursement, there is a second important way to counteract existing incentives for physicians and hospitals to provide too much care. Currently, the U.S. enjoys an abundance of hospital beds, surgical suites and MRI scanners. With the high capacity, it is too easy for physicians to provide unnecessary hospitalizations, operations or MRI scans. Even if their financial motive is diminished by salaried or capitated reimbursement, physicians still may be driven by the inclination to intervene and try to do something when a patient is sick. This behavior can be blunted by reducing health care facility capacity. If hospital beds, surgical suites and MRI facilities are closed, physicians will have to become more discriminating when they decide whether to recommend a diagnostic test or therapeutic procedure. And data demonstrate that physicians can do a good job when faced with lowered capacity. In communities that have closed hospitals, or in hospitals that have closed intensive care unit (ICU) beds, physicians hospitalize fewer patients and provide less intensive care for those who are hospitalized without compromising the quality of patient care.<sup>46</sup>

### C. Increasing the Bargaining Power of Purchasers of Health Care

As discussed previously, a key factor in the high U.S. health care costs lies in higher U.S. prices for health care. Accordingly, some experts support government-sponsored negotiation of standard fee schedules that would apply to all physicians and hospitals. This would increase the bargaining power on the purchasing side of health care, and prices should be lower, as seen in other countries that have this "all-payer" fee regulation.<sup>47</sup>

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<sup>44</sup> Orentlicher, *supra* note 26, at 183-86.

<sup>45</sup> Brian Serumaga et al., *Effect of Pay for Performance on the Management and Outcomes of Hypertension in the United Kingdom: Interrupted Time Series Study*, 342 BRIT. MED. J. d108 (2011).

<sup>46</sup> David Orentlicher, *Rationing Health Care: It's a Matter of the Health Care System's Structure*, 19 ANNALS HEALTH L. 449, 450 (2010).

<sup>47</sup> Jonathan Oberlander & Joseph White, *Systemwide Cost Control — The Missing Link in Health Care Reform*, 361 NEW ENG. J. MED. 1131, 1132 (2009).

While this approach would likely yield lower prices for health care and it might reduce overall health care costs, it would not provide a full solution to the cost problem. If fees are lowered, physicians could compensate by trying to make up the difference with a higher volume of services. Indeed, that is what has happened in Japan, where patients are more likely to see doctors and receive MRI or CT scans than in the U.S.<sup>48</sup> Fees can be reduced in response to increases in volume, but we would end up solving the cost problem without solving the quality problem. Our problem of high costs and too many unnecessary procedures would be converted into a problem of even more unnecessary procedures.

In sum, cost containment will require meaningful structural changes in our health care system – in the way we pay physicians and hospitals (salary or capitation instead of fee-for-service), in the way reimbursement levels are set (a single payment schedule for all insurers instead of multiple schedules for different insurers), and/or in the extent to which we supply doctors with hospital beds, MRI scanners and other health care facilities.

As we turn to the Affordable Care Act's cost-controlling provisions, we will see that they generally do not entail the kinds of structural changes that will "bend the cost curve." Indeed, according to estimates, the effect on health care cost inflation will be minimal. Between 2015 and 2019, health care costs are expected to rise 6.7 percent per year instead of the 6.8 percent projection made before the Act was passed.<sup>49</sup>

### III. COST CONTAINMENT PROVISIONS IN THE AFFORDABLE CARE ACT

The Affordable Care Act seeks to lower costs through a few strategies. For example, the Act includes cuts in Medicare reimbursement, adjustments in Medicare reimbursement based on quality of care, and greater cost sharing for Medicare beneficiaries. However, the Act calls for the kinds of major structural reforms that could have a substantial impact only through demonstration projects.

#### A. Cuts in Medicare and Medicaid Reimbursement

Under Section 3401 of the Affordable Care Act, hospitals, nursing homes and other health care facilities will receive fewer dollars over the next ten years in Medicare payments. On an annual basis,

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<sup>48</sup> PETERSON & BURTON, *supra* note 18, at 12.

<sup>49</sup> Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform through 2019*, 29 HEALTH AFF. 1, 4 (2010).

Medicare increases its reimbursement rates for health care facilities to reflect increases in the operating costs of the facilities. The Affordable Care Act maintains the annual reimbursement rate increases, but provides for smaller increases by changing the formula for calculating the rate increases. Through these reductions in the annual rate adjustment, health care spending should decline by \$205 billion between 2010 and 2019.<sup>50</sup>

Under Section 3201 of the Affordable Care Act, \$145 billion in savings are projected from the Medicare Advantage program.<sup>51</sup> Medicare Advantage is an option for Medicare recipients to enroll in a private health care plan rather than choosing traditional, fee-for-service coverage (Part C of Medicare). While the idea was to provide a more-efficient, lower-cost Medicare option, Medicare Advantage plans have turned out to be more expensive, with average premiums higher than the cost per beneficiary of traditional Medicare.<sup>52</sup> The higher costs have reflected more generous benefits, lower cost-sharing for Medicare beneficiaries and higher administrative costs.<sup>53</sup> Under the Affordable Care Act, Medicare will reduce payments to Medicare Advantage plans.

Another \$64 billion in savings are expected from a reduction in disproportionate share hospital (DSH) payments under the Medicare and Medicaid programs.<sup>54</sup> DSH payments are made to hospitals that treat a disproportionate share of low-income patients. Originally, Medicare DSH was introduced to compensate hospitals for the higher costs of treating low-income patients. When the cost differential between low-income and higher-income patients narrowed, the DSH payments were justified as a way to maintain access to care for low-income patients – without the payments, hospitals in low-income

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<sup>50</sup> Foster, *supra* note 36, at page 3 of Table 3. The Congressional Budget Office also has calculated estimates for the fiscal impact of PPACA, and there are differences between the two sets of estimates. CONGRESSIONAL BUDGET OFFICE, *supra* note 38, at 2. Part of the differences reflects the fact that the Centers for Medicare & Medicaid Services estimates look at the impact on total expenditures on health care in the United States, while the Budget Office estimates look at the impact on the federal budget. *Id.*

<sup>51</sup> Foster, *supra* note 36, at 8, page 2 of Table 3.

<sup>52</sup> MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 257-59 (Mar. 2009), [http://medpac.gov/documents/Mar09\\_EntireReport.pdf](http://medpac.gov/documents/Mar09_EntireReport.pdf).

<sup>53</sup> *Id.* at 259-60. Thus, rather than covering the expenses for the more generous benefits and lower cost-sharing through greater efficiencies, the Medicare Advantage plans have covered the expenses by shifting them to taxpayers and Medicare beneficiaries in traditional Medicare. *Id.* at 252.

<sup>54</sup> Foster, *supra* note 36, at 8, 12, page 2 of Table 3, page 2 of Table 4 (describing \$50 billion in cuts in Medicare DSH payments, and \$14 billion in cuts in Medicaid DSH payments from Sections 3133 and 2551 of PPACA).

areas might not be able to afford to stay open.<sup>55</sup> Medicaid DSH was created for hospitals with high numbers of uninsured patients to help them cover the costs of care for the uninsured.<sup>56</sup> With the expansion of Medicaid eligibility and the subsidies for low-income individuals to purchase health care insurance under the Affordable Care Act, the disproportionate share hospitals will see significant growth in revenues. Hence, their need for subsidies will diminish.

The reductions in Medicare reimbursement, Medicare Advantage payments and DSH payments are important, but they are not designed to address the real drivers of health care costs in the U.S. They do not constitute the kinds of needed structural changes that were discussed in the preceding section of this article (i.e., elimination of fee-for-service reimbursement, adoption of a single payment schedule for all insurers, or a reduction in the number of hospital beds, MRI scanners and other health care facilities).<sup>57</sup>

#### B. Greater Cost-Sharing for Medicare Beneficiaries

In addition to saving money by reducing payments to hospitals and insurers, the Affordable Care Act will save money – but only for the government – by increasing the cost-sharing obligations of Medicare beneficiaries. Under Section 3402 of the Affordable Care Act, premiums for Part B of Medicare will rise for higher-income beneficiaries. Part B covers physician fees, laboratory fees and other outpatient services, and most Medicare beneficiaries pay 25 percent of the Part B premium, with the federal government picking up the other 75 percent. Currently, higher-income beneficiaries pay between 35 and 80 percent of the Part B premium, and the income thresholds at which the higher premiums kick in are adjusted each year for inflation.<sup>58</sup> The Affordable Care Act freezes the income thresholds at 2010 levels for ten years before resuming the annual adjustments.<sup>59</sup> Thus, the Act will make more Medicare beneficiaries subject to the higher premiums. This provision will save an estimated \$8 billion.<sup>60</sup> However, these are savings for the Medicare program but not for the overall

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<sup>55</sup> Linda E. Fishman & James D. Bentley, *The Evolution of Support for Safety-Net Hospitals*, 16(4) *Health Affairs* 30, 34-35 (1997).

<sup>56</sup> *Id.* at 36.

<sup>57</sup> We could see a reduction in health care facilities if lower reimbursement rates force some facilities to close down.

<sup>58</sup> LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, *supra* note 36, ¶ 1380, at 592.

<sup>59</sup> *Id.* at 593.

<sup>60</sup> Foster, *supra* note 36, at page 4 of Table 3.

health care budget. Medicare will spend \$8 billion less, but Medicare beneficiaries will pay \$8 billion more for their health care.

### C. Reimbursement Based on Quality of Care

Reimbursement based on quality of care rather than quantity of care has the potential for saving costs by reducing the amount of unnecessary – or unnecessarily expensive – care provided to patients. Accordingly, Section 6301 of the Affordable Care Act establishes the “Patient-Centered Outcomes Research Institute.”<sup>61</sup> The Institute is designed to promote comparative-effectiveness research (CER), research that evaluates and compares the benefits and risks of two or more medical treatments or services.<sup>62</sup> Thus, for example, CER might demonstrate that for many patients with back pain, spinal surgery provides no benefit compared to physical therapy. The Institute will set priorities for funding CER studies, and it will analyze data from CER studies and report to the public on the significance of the study results.<sup>63</sup> While the Institute may not recommend coverage changes based on its analyses,<sup>64</sup> Medicare and Medicaid may take the analyses into account in determining coverage policies.<sup>65</sup>

Because of concerns that the Institute could use its authority to ration care, the Institute is prohibited from employing a dollars-per-quality-adjusted-life-year (QALY) threshold, and the Medicare and Medicaid programs are prohibited from using such a measure as a threshold for coverage.<sup>66</sup> This prohibition is designed to prevent the Institute from assuming a role in the U.S. like that of the National Institute for Health and Clinical Excellence (NICE) in the UK. NICE evaluates drugs and other treatments to determine their cost-effectiveness, and the British National Health Service will not cover treatments if their cost per QALY is too high.<sup>67</sup> Thus, for example, treatments are generally covered if they cost no more than £20,000

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<sup>61</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 6301, 124 Stat. 119, 727-46 [hereinafter PPACA] (codified in scattered sections of 26 and 42 U.S.C.A. (West 2010)).

<sup>62</sup> 42 U.S.C. § 1320e(a)(2)(A) (2010).

<sup>63</sup> § 1320e(d)(1).

<sup>64</sup> § 1320e(d)(8)(A)(iv).

<sup>65</sup> § 1320e-1.

<sup>66</sup> § 1320e-1(e). A quality-adjusted-life-year is a measure that takes into account how much a medical treatment extends life and how much it improves quality of life. A treatment that provides an additional year of perfect health provides one QALY. If the treatment costs \$10,000, it costs \$10,000 per QALY. If another treatment prevents a 50 percent decline in health for five years, it provides 2.5 QALYs. If the treatment costs \$40,000 for the five years, it costs \$16,000 per QALY. Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 495 (1995).

<sup>67</sup> Robert Steinbrook, *Saying No Isn't NICE*, 359 NEW ENG. J. MED. 1977, 1977-79 (2008).

per QALY, and they are rarely covered if they cost more than £30,000 per QALY.<sup>68</sup> The unpopularity of cost-effectiveness thresholds like that employed by NICE is illustrated not only by the Affordable Care Act's prohibition on their use but also by the decision in the UK in October 2010 to strip NICE of its power to deny coverage of treatments based on QALY thresholds.<sup>69</sup>

The Affordable Care Act includes a number of provisions in the Medicare program to link reimbursement to quality of care:

1. Medicare will make incentive payments to hospitals that meet specified performance standards. The performance standards could be created for any number of illnesses, but they must at least be developed for the treatment of heart attacks, heart failure and pneumonia, the prevention of complications from surgery, and the prevention of infections transmitted during hospital care or the provision of other health care services.<sup>70</sup>

2. Medicare will adjust payments to physicians based on the quality and cost of care that they provide to their patients.<sup>71</sup>

3. Medicare will expand its reports to physicians that indicate how their use of resources in patient care compares to use by other physicians.<sup>72</sup> This will help physicians recognize when they are providing unnecessarily high or dangerously low levels of care.

4. Medicare will reduce its payments to hospitals that have high numbers of patients who become sicker because of their hospital care.<sup>73</sup> Many patients become infected or suffer other harms to their health from preventable causes during their hospital stays. The reductions in payment should spur hospitals to implement better precautions to protect patient welfare.

5. Medicare also will reduce its payments to hospitals that have excessive numbers of patients readmitted to the hospital after discharge.<sup>74</sup> This provision reflects the fact that readmission to the hospital shortly after a hospitalization often occurs because of inadequate care during the hospitalization.

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<sup>68</sup> At an exchange rate of 1.625 dollars to a pound, WALL ST. J., Sept. 1, 2011, at C4, £20,000 converts to \$32,500 and £30,000 converts to nearly \$49,000.

<sup>69</sup> Sarah Boseley, *NICE to Lose Powers to Decide on New Drugs*, THE GUARDIAN (Oct. 29, 2010), [www.guardian.co.uk/politics/2010/oct/29/nice-to-lose-new-drug-power](http://www.guardian.co.uk/politics/2010/oct/29/nice-to-lose-new-drug-power).

<sup>70</sup> PPACA, Pub. L. No. 111-148, § 3001, 124 Stat. 119, 353-63, codified at 42 U.S.C. § 1395ww(o)(2)(B)(i)(I).

<sup>71</sup> *Id.* § 3007, 124 Stat. 119, 373-76, codified at 42 U.S.C. § 1395w-4(p).

<sup>72</sup> *Id.* § 3003, 124 Stat. 119, 366-68, codified at 42 U.S.C. § 1395w-4(n).

<sup>73</sup> *Id.* § 3008, 124 Stat. 119, 376-78, codified at 42 U.S.C. § 1395ww(p).

<sup>74</sup> *Id.* § 3025, 124 Stat. 119, 408-13, codified at 42 U.S.C. § 1395ww(q).



Tying reimbursement to quality of care should blunt the incentives for physicians and hospitals to provide unnecessary care. However, as discussed above,<sup>75</sup> it is difficult to develop quality-based reimbursement policies that are effective, and the track record for quality-based incentives has been disappointing.

#### D. Structural Changes

Several provisions in the Affordable Care Act have the potential for making the kinds of structural changes needed to make a real difference in health care cost inflation.

Section 3403 of the Act charges an “Independent Medicare Advisory Board” with developing proposals to keep Medicare spending within statutory targets, and the Board’s proposals will automatically take effect unless Congress adopts substitute provisions.<sup>76</sup> The Board may propose changes in reimbursement for physicians and hospitals, but its proposals may not ration health care, raise costs to Medicare beneficiaries, restrict benefits or modify Medicare eligibility criteria.<sup>77</sup> The Board also will provide Congress with recommendations for slowing the growth of health care spending in the private sector.<sup>78</sup> The Board’s authority commences in 2015, with estimated savings of \$24 billion by 2019.<sup>79</sup>

The Advisory Board may achieve substantial savings in the long-term, particularly through its authorities to propose changes in reimbursement under Medicare and to recommend ways to slow the growth of health care spending in the private sector. However, the Board’s design and mandate suggest potential concerns. Will the Board focus on short-term fixes to keep Medicare spending within the annual statutory targets rather than long-term changes that really can “bend the cost curve?” Will Congress bypass the Board process and authorize increases in funding through independent legislation? Are the limitations on the kinds of proposals that the Board can develop too restrictive? Since cuts in physician reimbursement may become a key cost-cutting tool for the Board,<sup>80</sup> will the Board’s policies reduce patient access to physicians, as physicians opt for the higher payments of private-insurance plans?

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<sup>75</sup> See *supra* notes 70-74 and accompanying text.

<sup>76</sup> See Timothy Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103, 103-04 (2010).

<sup>77</sup> *Id.* at 104; 42 U.S.C. 1395kkk(c)(2)(A)(ii).

<sup>78</sup> 42 U.S.C. § 1395kkk(o)(1).

<sup>79</sup> Foster, *supra* note 36, at page 4 of Table 3.

<sup>80</sup> Jost, *supra* note 76, at 104.

The Affordable Care Act also includes funding for demonstration projects to test out a number of promising structural reforms in health care delivery.

1. Medicaid and Medicare will test “bundled payments” to cover the cost of a patient’s care during a hospitalization and for the month following discharge.<sup>81</sup> This approach seeks to reduce health care costs by giving physicians and hospitals incentives to provide more cost-effective care rather than simply more care. Because the government will pay a fixed amount to cover all of the patient’s care during the hospitalization and post-discharge care, hospitals and doctors will lose money if they order unnecessary tests or provide unnecessary treatments. Moreover, they will lose money if they deliver inadequate care, and as a result, the patient needs to be re-hospitalized shortly after discharge.

I call this approach “capitation lite” because it draws on the economizing incentives of capitation payments, but it does so only for individual episodes of hospital care. Doctors and hospitals still can make money by hospitalizing patients who really do not need to be in a hospital. In other words, doctors and hospitals will be able to make up in volume what they might lose in lower payments per patient.

2. While bundled payments for hospital care may constitute capitation lite, the Affordable Care Act also will test full capitation payments. Under this demonstration project, Medicaid will select large safety net hospital systems or networks in five states that will be reimbursed with global capitation fees.<sup>82</sup> In other words, the systems will receive a fixed annual fee per individual to cover all of the individual’s health care needs during the year. Given the ability of capitated compensation to reduce the incentive for doctors and hospitals to provide too much care, this demonstration project could be very important.

3. Medicaid and Medicare will offer incentives for doctors, other professionals and hospitals to form “accountable care organizations” that will become “accountable for the quality, cost and overall care” of beneficiaries assigned to them. Accountable care organizations will receive bonus payments if they meet standards for quality while delivering care at a lower cost.<sup>83</sup>

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<sup>81</sup> PPACA, Pub. L. No. 111-148, § 2704, codified at 42 U.S.C. § 1396a; § 3023, codified at 42 U.S.C. § 1395cc-4.

<sup>82</sup> § 2705, codified at 42 U.S.C. 1315a.

<sup>83</sup> § 2706, codified at 42 U.S.C. 1396a; § 3022, codified at 42 U.S.C. § 1395jjj.

Many health policy experts have promoted accountable care organizations for their ability to provide comprehensive, coordinated and cost-effective care for patients.<sup>84</sup> Because all of a patient's caregivers are associated in a single organization, it becomes easier for the different caregivers to assume responsibility for the patients' overall care rather than for just their particular part of the care. The Mayo Clinic is an important example of an accountable care organization.

While accountable care organizations promise higher-quality, lower-cost care, there are reasons to be concerned as well. Large health care organizations can achieve a substantial level of market power and use that power to maintain high prices for their services.<sup>85</sup>

If successful, the demonstration project reforms could have a major impact. However, because they are demonstration projects, they would still have to be expanded to the entire Medicare and Medicaid systems. Moreover, they also would have to be adopted by private insurers to have a meaningful effect on overall health care costs.

#### IV. CONCLUSION

The Affordable Care Act, with its individual mandate to purchase health care, looks very much like health care reform in Massachusetts in its approach to increasing access to health care.<sup>86</sup> The Act also looks very much like health care reform in Massachusetts in its failure to come to grips with the need for health care cost containment.

The Massachusetts legislature recognized the need to follow up its expansion of coverage with measures to address costs, and the state created a Special Commission on the Health Care Payment System in 2008.<sup>87</sup> In 2009, the commission recommended the replacement of fee-for-service reimbursement with capitation payments to physicians and hospitals that have formed accountable care organizations.<sup>88</sup> In light of the similarities between the Massachusetts and federal laws,

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<sup>84</sup> Elliott Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. w219, w220 (2009).

<sup>85</sup> Robert Pear, *Health Law Provision Raises Antitrust Concerns*, N.Y. TIMES, February 9, 2011, at A19; Barak D. Richman & Kevin A. Schulman, *A Cautious Path Forward on Accountable Care Organizations*, 305 J. AM. MED. ASS'N 602, 602-03 (2011).

<sup>86</sup> Jonathan Gruber, *Massachusetts Points the Way to Successful Health Care Reform*, 30(1) J. POL'Y ANALYSIS & MGMT. 184, 184-85 (2010).

<sup>87</sup> Kaiser Family Foundation, *Massachusetts Health Care Reform: Three Years Later* (Sept. 2009), [www.kff.org/uninsured/upload/7777-02.pdf](http://www.kff.org/uninsured/upload/7777-02.pdf).

<sup>88</sup> *Id.*

we can expect Congress to follow up in future years with more serious efforts to contain health care costs, once the Affordable Care Act's provisions for expanding access to care have been implemented.

An important question is how future Congresses will respond to the need for health care cost containment. If cost containment is done properly, access to health care coverage can be maintained by making care more cost-effective. However, when states have been faced with cost pressures in the past, they often have responded by reducing access rather than streamlining costs. Thus, for example, when the Oregon Health Plan experienced serious cost problems several years ago, it balanced its budget by raising eligibility thresholds and ended up with levels of uninsured persons that were comparable to the levels seen in Oregon before the Health Plan was implemented.<sup>89</sup> Hence, this article ends where it started – will Congress implement effective cost controls, or will uncontrolled costs cause the Patient Protection and Affordable Care Act to unravel?

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<sup>89</sup> Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFF. w96, w99 (2007).

