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The Inevitability of Health Reform

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I. INTRODUCTION

Since Teddy Roosevelt called for national insurance and declared that "no country can be strong if its people are sick and poor,"[1] we have been in a continual process of reforming the United States health care system. In 1965, when it became apparent that the elderly, poor, and disabled in America could no longer afford health care, we passed Medicare and Medicaid.[2] The Health Maintenance Organization Act of 1973 was signed into law as one of many federal and state attempts to try to control health

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1. M.M. Matusiak, *A National Health Insurance System/Program: A Review of US History and Current Debate*, 3 INTERNET J. HEALTHCARE ADMIN., no. 2, 2005, at para 14, *available at* http://www.ispub.com/journal/the-internet-journal-of-healthcare-administration/volume-3-number-2/a-national-health-insurance-system-program-a-review-of-us-history-and-current-debate.html#e-3.

2. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified at 42 U.S.C. § 426 (2006)).

costs.[3] In 1997, recognizing that some ten million children in the United States were living without health insurance, the State Children's Health Insurance Program (SCHIP) was enacted.[4] In 2003, Medicare Part D expanded prescription drug coverage to seniors.[5] Then, in 2010, with the number of uninsured Americans nearing fifty million people, the Patient Protection and Affordable Care Act, popularly known as "ObamaCare" ("Affordable Care Act"), became the latest law of the land.[6] Although the Affordable Care Act itself may do relatively little to directly control health costs, it is likely to do so indirectly, and its passage in the midst of a recession and a federal budget crisis has served to bring urgency to a fundamental question for our economy and our people: *How can we provide quality care for all patients and at the same time bend the unsustainable cost curve of the United States health care system*?

One legacy of this century of health reform is that we have the most expensive health care system in the world. Annual United States health expenditures of more than $2.5 trillion represent nearly 18% of our gross domestic product ("GDP").[7] In just the last ten years, per capita health spending in the United States has nearly doubled from $4600 to over $8000 per person.[8] While it is difficult to make "apples-to-apples" comparisons between health care in the United States and many other nations, health spending in large developed countries like Australia, the United King-

3. Pub. L. 93-222, 87 Stat. 936 (codified at 42 U.S.C. § 300e (2006)). *See also* Christopher J. Connover & Ilse R. Weichers, *HMO Act of 1973* (Duke Univ. Ctr. for Health Policy, Law & Mgmt., Working Paper No. I-1, 2006), *available at* http://ushealthpolicygateway.files.wordpress.com/2009/07/i-1-hmo-act-of-1973.pdf (empirically studying and analyzing the cost and economic impacts of the HMO Act of 1973).

4. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 552 (1997) (codified at 42 U.S.C. § 1397aa-mm (2006)).

5. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

6. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

7. NAT'L INST. FOR HEALTH CARE MGMT., UNDERSTANDING U.S. HEALTH CARE SPENDING: NIHCM FOUNDATION DATA BRIEF 1 (2011), *available at* http://www.nccor.org/downloads/Understanding%20US%20Health%20Care%20Spending.pdf.

8. *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-2010*, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp (follow "National Health Expenditures by type of service and source of funds, CY 1960-2009" hyperlink) (last visited Feb. 28, 2012).

dom, Japan, and Germany comprises 8.1% to 10.5% of GDP and is only $2,700 to $3,700 per capita.[9] Operating under the assumption that "you get what you pay for," one would expect that being first in the world in per capita health spending means that we must have the healthiest people on the planet. Unfortunately, among 191 nations studied by the World Health Organization, the United States ranks 36th for life expectancy and 39th for infant mortality.[10]

Projections for health costs in the United States are even more daunting. By 2020, just eight years from now, health expenditures in this country are expected to exceed $4.6 trillion and make up nearly 20% of GDP.[11] Driven by an aging population and a struggling economy, the number of citizens entitled to enroll in Medicare and Medicaid is expected to increase the government-sponsored share to more than 50% of all health spending in the United States.[12] Given the current, estimated federal budget deficit of $1.1 trillion,[13] there is now near universal consensus that the level and rate of growth in United States health care expenditures is unsustainable. Even the rosiest estimates by the "non-partisan" Congressional Budget Office ("CBO") do not expect the Affordable Care Act to make a significant dent in health costs.[14]

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9. *International Comparisons: Total Expenditure on Health as a Share of GDP*, KAISER FAMILY FOUND., http://facts.kff.org/chart.aspx?ch=1958 (last visited Feb. 28, 2012) (citing ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, OECD HEALTH DATA, OECD HEALTH STATISTICS (DATABASE) doi: 10.1787/data-00359-en. (2010)); *Total Health Expenditure Per Capita*, KAISER FAMILY FOUND., http://facts.kff.org/chart.aspx?ch=1955 (last visited Feb. 28, 2012) (citing ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, OECD HEALTH DATA, OECD HEALTH STATISTICS (DATABASE) doi: 10.1787/data-00359-en. (2010)).

10. Christopher J.L. Murray & Julio Frenk, *Ranking 37th—Measuring the Performance of the U.S. Health Care System*, 362 NEW ENG. J. MED. 98 (2010), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp0910064#t=article.

11. OFFICE OF THE ACTUARY, CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010-2020, *available at* https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

12. *Id.* ("The government-sponsored share of health spending is projected to increase from 45 percent in 2010 to about 50 percent by 2020, driven by expected robust Medicare enrollment growth, Medicaid coverage expansions, and Exchange plan premium and cost-sharing subsidies.").

13. *The Budget and Economic Outlook: Fiscal Years 2012 to 2022*, CONG. BUDGET OFFICE (Jan. 31, 2012), http://www.cbo.gov/publication/42905.

14. *See generally* CBO's Analysis of the Major Health Care Legislation *Enacted in March 2010: Testimony Before the Subcomm. on Health of the H. Comm. on Energy and Commerce* (2011) (statement of Douglas W. Elmendorf, Dir., Cong. Budget Office), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf (analyzing the Affordable Care Act and projecting extensive expenditure data).

II. THE BACKDROP: COVERAGE EXPANSION IN THE AFFORDABLE CARE ACT

One of the key reasons that the United States ranks so poorly in overall health outcomes is the sheer number of uninsured in our country. Unlike most of the world's larger economies, some fifty million Americans, or about 16.3% of our population, lack health insurance coverage.[15] Uninsured persons often forego needed care, and those with cancer and other serious illnesses are diagnosed later and die earlier than those with coverage.[16] The costs of caring for the uninsured are passed along to doctors, hospitals, and the taxpayer through a complex system of "uncompensated care." Estimates of the actual shifting of costs from care provided to the uninsured to the premiums paid by employers and individuals vary widely, but one thing is for sure: somebody is paying for it.[17]

The Affordable Care Act would dramatically reduce the number of uninsured Americans and how their care, or lack thereof, is currently being reimbursed. The CBO estimates that the provisions of the Affordable Care Act will lead to an increase of thirty-four million non-elderly Americans gaining health insurance coverage if the law is fully implemented.[18] This coverage expansion is achieved through two new provisions. First, the Affordable Care Act expands Medicaid to persons under sixty-five with incomes up to 133% of the federal poverty level ("FPL").[19] In 2011, the FPL for the forty-eight contiguous states and the District of Columbia was $10,890 for a single individual and $22,350 for a family of

15. CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, CURRENT POPULATION REPORTS: CONSUMER INCOME: INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010 23 (2011), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf.

16. *The Uninsured and the Difference Health Insurance Makes*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED: KEY FACTS (Kaiser Family Found., Wash., D.C.), Oct. 2011, *available at* http://www.kff.org/uninsured/upload/1420-13.pdf.

17. KATHLEEN STOLL & KIM BAILEY, HIDDEN HEALTH TAX: AMERICANS PAY A PREMIUM 1 (2009), *available at* http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf. *See also* Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFFS. w399, w406 (2008), *available at* http://content.healthaffairs.org/content/27/5/w399.full.pdf (analyzing the effects on national health care spending if the uninsured are covered).

18. *See CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, *supra* note 14, at 1.

19. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 279 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

four.[20] For ease of reference, in 2011, individuals with incomes up to $14,484 and families of four making $29,726 would become eligible. The Medicaid expansion goes into effect, along with health insurance exchanges, in 2014.[21] As a result of which, the CBO and the Centers for Medicare and Medicaid Services ("CMS") estimate that between sixteen and eighteen million new members will be enrolled under the Medicaid expansion provision of the Affordable Care Act.[22]

The majority of the remaining expansion of health coverage in the Affordable Care Act is achieved through the intersection of what is widely known as the "individual mandate"[23] and a variety of premium and cost-sharing credits to individuals and families between 133% and 400% of the FPL.[24] Under the individual mandate, beginning in 2014, United States citizens and legal residents will be required to have health insurance or pay a tax of the greater of a fixed amount or a percentage of income.[25] (The fixed penalty is $95 in 2014, increasing to $695 by 2016, and the income-based penalty is 1% of income in 2014, increasing to 2.5% of income by 2016.)[26] In addition, employers with 50 or more employees will be required to offer coverage or pay a fee of $2000 per employee or $3000 for each employee that is receiving a premium tax credit.[27] Furthermore, employers with more than two hundred employees will be required to automatically enroll employees into health insurance plans.[28] By 2021, as a result of these provisions, the CBO estimates that an additional seventeen million Ameri-

20. Annual Update of the HHS Poverty Guidelines, 76 Fed. Reg. 3637, 3637-38 (Jan. 20, 2011).

21. Patient Protection and Affordable Care Act §§ 1321, 2001.

22. *See* Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, U.S. Speaker of the House, 9 (Mar. 20, 2011), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf. *See also* Memorandum from Richard S. Foster, Chief Actuary, Office of the Actuary, Ctrs. for Medicare & Medicaid Servs., to the U.S. Admin. & U.S. Cong., 3 (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

23. Patient Protection and Affordable Care Act §§ 1501, 1502, 10106.

24. *Id.* §§ 1401, 1402, 10105, *amended by* Health Care and Education Reconciliation Act of 2010 § 1001.

25. *Id.* §§ 1501, 10106, *amended by* Health Care and Education Reconciliation Act of 2010 § 1002.

26. *Id.*

27. *Id.* §§ 1513, 10106, *amended by* Health Care and Education Reconciliation Act of 2010 § 1003.

28. Patient Protection and Affordable Care Act § 1511.

cans, currently without coverage, will purchase insurance through the exchanges.[29]

The impact of the millions of newly insured patients on the health delivery system could have significant capacity and cost implications. Studies have predicted that health care providers in the United States will see between fifteen and twenty-five million additional primary care visits annually; and up to 7000 new primary care physicians would be needed to handle this surge in demand.[30] While Medicaid accounts for about 15% of all health expenditures, Medicaid enrollees account for more than 25% of emergency department ("ED") visits.[31] Although an analysis of the coverage expansion in Massachusetts, for example, showed little increase in ED use,[32] there is a general consensus among experts modeling the impact of federal health reform that, nationally, there will likely be a sharp increase in ED utilization.[33] The Affordable Care Act requires the federal government to cover the majority of costs related to the Medicaid expansion, paying 100% initially and 90% after 2020,[34] but that has not stopped some states from challenging the law.[35] Unlike the challenges to federal authority under the Commerce Clause to mandate coverage,[36] the states have argued, to date unsuccessfully, that the Medicaid ex-

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29. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, *supra* note 14, at 1.

30. *See* Adam N. Hofer et al., *Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 MILBANK Q. 69, 69 (2011), *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00620.x/pdf.

31. RICHARD NISKA ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEPT. OF HEALTH & HUMAN SERVS., NAT'L HEALTH STATISTICS REPORT NO. 26, NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 2007 EMERGENCY DEPARTMENT SUMMARY 3 (2010), *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf.

32. *See generally* Christopher Chen et al., *Massachusetts' Health Care Reform and Emergency Department Utilization*, NEW ENG. J. MED. (Sept. 22, 2011), http://www.nejm.org/doi/pdf/10.1056/NEJMp1109273 (analyzing the effect health care reform in Massachusetts has had on emergency department use).

33. John C. Goodman, *Emergency Room Visits Likely to Increase Under ObamaCare*, BRIEF ANALYSIS (Nat'l. Ctr. for Policy Analysis, Wash., D.C.), June 18, 2010, at 1, 2, *available at* http://www.ncpa.org/pdfs/ba709.pdf.

34. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 279 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

35. *See, e.g.*, Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *cert. granted in part sub nom.* Florida v. Dep't of Health & Human Servs., 132 S. Ct. 604 (2011).

36. *See, e.g.*, *Florida*, 648 F.3d at 1268, 1282 ("[T]he individual mandate exceeds Congress's commerce power.").

pansion exceeds congressional power under the Spending Clause.[37] Nonetheless, if implemented, the coverage expansion provisions of the Affordable Care Act taken alone appear certain to drive national health expenditures higher.

III. MINIMAL BUT POTENTIALLY CATALYTIC COST CONTAINMENT IN THE AFFORDABLE CARE ACT

Initial estimates from the CBO found that if the entire Affordable Care Act were fully implemented, it would reduce the federal deficit by $143 billion over the first decade,[38] and it would reduce the deficit by $1.2 trillion over the second decade after passage.[39] Not only were these, and more recent, CBO estimates met with skepticism and political criticism, savings of $14 billion annually over the next ten years compared to annual federal expenditures on Medicare, Medicaid, and SCHIP of $732 billion is hardly cause for cheer.[40] There are, however, several provisions of the Affordable Care Act that could hold some promise of cost containment through care coordination, eliminating payments for avoidable expenses, and reducing fraud. Of course, none of these concepts are new, but the fact that these provisions actually became law and are beginning to be implemented may be signaling that we have finally reached the turning point in addressing the unsustainable costs of health care in our country.

A. Care Coordination Provisions

One of the key recognized challenges to bending the cost curve for health care is the lack of coordination among the myriad of providers in what is loosely referred to as a "system." The challenge of care coordination has many root causes, but central to them is the natural set of incentives in a payment environment that reimburses providers for each and every independent service they offer. The currently used fee-for-service ("FFS") method of payment rewards hospitals, physicians, and other care givers for

37. *See, e.g., id.* at 1262 (holding that the expansion of Medicaid does not violate Congress' Spending Clause power).

38. *See* Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, U.S. Speaker of the House, *supra* note 22, at 2.

39. Bruce J. Douglas and Kelly M. Burke, *Patient Protection and Affordable Care Act - How It Will Be Funded*, LARKIN HOFFMAN ATTORNEYS (July 13, 2010), http://www.larkinhoffman.com/news/article_detail.cfm?ARTICLE_ID=636.

40. CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: WHERE DO OUR FEDERAL TAX DOLLARS GO? 1 (2011), *available at* http://www.cbpp.org/files/4-14-08tax.pdf.

the volume of services they provide, often without regard to whether the services actually achieved the goal of improving the health status of the patient. This somewhat perverse incentive structure has led to a fragmented health delivery system that is difficult to navigate, emphasizes the use of well-reimbursed services, and lacks the efficiency and productivity of other modern industries. The results of our health system's inefficiency include costly preventable readmissions, redundant and sometimes unnecessary procedures, and high administrative costs—all of which contribute to the current unsustainable levels of spending. It can be argued that several provisions of the Affordable Care Act simply codified existing government and private-sector-led approaches to aligning payment incentives with outcomes, each approach now codified into law having the potential to make our health system more cost efficient.

B. Accountable Care Organizations

Much has been written about the Medicare Shared Savings Program of the Affordable Care Act, which promotes a new payment and delivery model known as an Accountable Care Organization ("ACO").[41] Similar to the early days of the HMO movement, many definitions and descriptions of ACOs can be found. ACOs are basically groups of providers that form a legal structure intended to coordinate care among Medicare FFS beneficiaries to improve quality and reduce the rate of spending growth.[42] The incentive for agreeing to be held financially *accountable* for achieving measured benchmarks in the Medicare ACO program is that ACOs will share in any savings generated from the delivery of better-coordinated, higher quality care.[43] The Department of Health and Human Services ("HHS") issued its final ACO regulations in November 2011 and spelled out the thirty-three quality performance standards ACOs must meet to participate in the Shared Savings

41. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

42. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528, 19,531 (Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425).

43. Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFFS. 982, 983 (2010), *available at* http://www.nber.org/public_html/confer/2010/OEf10/fisher1.pdf.

Program and receive the shared savings.[44] These quality measures cut across four domains: (1) at-risk populations, (2) preventative health, (3) patient experience, and (4) care coordination/patient safety.[45]

Almost every hospital, insurer, and group practice around the country has spent many person hours and substantial legal and consulting fees analyzing the ACO regulations to determine whether the rewards justify the risks of taking on either of the two payment models offered: a one-sided risk-sharing model or a two-sided risk-sharing model. Both models require a minimum three-year contractual commitment,[46] during which time ACO health-care providers will continue to be paid according to traditional fee-for-service Medicare reimbursement rules.[47] Under the one-sided model, an ACO shares the overall expenditure savings with Medicare, but not losses.[48] Under the two-sided model, an ACO shares savings as well as any losses with Medicare.[49] The two-sided model allows ACOs to receive greater percentages of shared savings while assuming greater percentages of risk for losses.[50] Under the proposed regulations, an ACO could elect to either (1) operate under the one-sided model for the first two years and switch to the two-sided model for the third year, or (2) operate under the two-sided model for all three years.[51]

Sensing a lack of provider enthusiasm for the Shared Savings Program articulated in the initial proposed regulations, HHS created a Pioneer ACO program in hopes of getting those health systems already integrating care to sign on as early adopters.[52] Several groups have taken the plunge and applied, including Arizona's largest system, Banner Health, but many of the "big names" in integrated care delivery, including the Cleveland Clinic, the University of Pittsburgh Medical Center, the Mayo Clinic, and

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44. *See* Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

45. *See generally* Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,802.

46. *Id.* at 19,531.

47. *Id.* at 19,532.

48. *Id.* at 19,534.

49. *Id.*

50. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 19,534.

51. *Id.* at 19,603.

52. *See* News Release, U.S. Dep't of Health & Human Servs., *Affordable Care Act Helps 32 Health Systems Improve Care for Patients, Saving Up To $1.1 Billion* (Dec. 19, 2011), (available at http://www.hhs.gov/news/press/2011pres/12/20111219a.html).

Intermountain Healthcare, decided to take a pass for now.[53] The program, which went into effect in January 2012, allows organizations already offering an ACO-like version of coordinated, patient-centered care to participate in a shared savings and losses arrangement, with greater risk and reward than the basic Shared Savings Program.[54] The Pioneer ACO program also allows participating organizations greater flexibility as to how fast they assume increased risk compared to the Shared Savings Program.[55] HHS also sweetened the pot for physician-owned and rural providers interested in participating in the Shared Savings Program through the Advanced Payment ACO Model, which offers additional start-up resources to build the necessary ACO infrastructure (e.g., new staff or information technology systems).[56] Whether many, or even the larger health systems, adopt the ACO model, these provisions of the Affordable Care Act, combined with the spectrum of budget cuts, have stimulated intensive planning among providers around quality measurement and care coordination.

C. *Payment Bundling*

Another provision of the Affordable Care Act that may serve to advance improved coordination of care among providers is the National Pilot Program on Payment Bundling.[57] Payment bundling in health care refers to a method of reimbursing multiple providers with a single or global payment for a clinically defined "episode of care," such as a cataract surgery or hip replacement.[58] Payment bundling has been the industry norm for years among the largest payers for organ and bone marrow transplants.[59] The transplant bundled payment includes all hospital, physician, and ancillary services for the transplant "episode:" evaluation, organ procure-

53. CTR. FOR MEDICARE & MEDICAID INNOVATION, CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL: GENERAL FACT SHEET (2011), http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf.

54. *Id.*

55. *Id.*

56. *Id.*

57. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3023, 124 Stat. 119, 399 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

58. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-126R, MEDICARE: PRIVATE SECTOR INITIATIVES TO BUNDLE HOSPITAL AND PHYSICIAN PAYMENTS FOR AN EPISODE OF CARE 2 (2011), *available at* http://www.gao.gov/new.items/d11126r.pdf.

59. *Id.* at 5.

ment, hospital admission, any readmissions, and follow-up care.[60] In January 2011, Medicare also implemented an end stage renal disease ("ESRD") bundled payment that covers dialysis treatment, routine drugs, laboratory tests, and supplies furnished at home or in a facility.[61] ESRD patients make up 1.3% of all Medicare beneficiaries but account for 8.1% of Medicare expenditures.[62]

Although the Affordable Care Act requires the National Pilot Program on Payment Bundling to become effective by January 2013, HHS has indicated its intention to move forward with implementation of a separate bundled payments initiative before that date.[63] The newly formed CMS Center for Medicare and Medicaid Innovation ("CMMI") has created a Bundled Payments for Care Improvement initiative that seeks payers and providers to participate in both retrospective and prospective bundled payment demonstration projects.[64] Based on historical data, applicants are asked to set a discounted target price for an episode of care and either be paid under FFS or a bundled payment.[65] To determine which care coordination methods work best on what conditions, total payments per episode will be compared to the target price.[66] While most bundled payment demonstrations have focused on a narrow set of more easily defined episodes of care, by giving providers flexibility to select any condition, the CMMI initiative could build on previous successful private sector innovation and result in expanded payment bundling. A recent RAND study found that payment bundling, if applied to the most costly chronic and acute conditions, is the most promising approach in the Affordable Care

60. *Id.*

61. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., MLN Matters No. MM7064, MLN MATTERS NEWS FLASH: END STAGE RENAL DISEASE (ESRD) PROSPECTIVE PAYMENT SYSTEM (PPS) AND CONSOLIDATED BILLING FOR LIMITED PART B SERVICES 2 (2011), *available at* https://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf.

62. NAT'L INSTS. OF HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., U.S. RENAL DATA SYSTEM: 2010 ANNUAL DATA REPORT VOLUME TWO: ATLAS OF END-STAGE RENAL DISEASE IN THE UNITED STATES 139 (2010), *available at* http://www.usrds.org/2010/pdf/v2_00a_intros.pdf.

63. CTR. FOR MEDICARE & MEDICAID INNOVATION, CTRS. FOR MEDICARE & MEDICAID SERVS., BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE FREQUENTLY ASKED QUESTIONS 2 (2011), *available at* http://www.innovations.cms.gov/Files/x/BundledPaymentsFAQ_2_29_12.pdf.

64. *Bundled Payments for Care Improvement*, CTR. FOR MEDICARE AND MEDICAID INNOVATION, http://innovations.cms.gov/initiatives/bundled-payments/index.html (last visited Feb. 29, 2012).

65. *Id.*

66. *Id.*

Act to controlling health costs, potentially trimming health expenditures by 5.4%.[67]

D. Readmissions, HAIs, and Fraud and Abuse Provisions

In 2008, the Medicare Payment Advisory Commission ("MedPAC") reported that eighteen percent of all Medicare hospital admissions result in readmissions within thirty days of discharge, and that approximately $12 billion was being spent annually on potentially preventable readmissions.[68] To reduce preventable readmissions, MedPAC recommended that CMS penalize those providers with high readmission rates and allow hospitals to reward physicians for helping to reduce readmissions in order to foster shared accountability.[69] These recommendations, coupled with successful readmission reduction demonstrations by providers and health plans to identify high-risk patients and improve discharge planning, laid the foundation for the Hospital Readmissions Reduction Program in the Affordable Care Act.[70] The Hospital Readmissions Reduction Program adjusts payments for hospitals paid under the Medicare inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable readmissions.[71] Effective October 2012, this provision will adjust payments for high cost conditions based on input from the National Quality Forum.[72] The conditions for the first year of the Hospital Readmissions Reduction Program will be heart attack, heart failure, and pneumonia.[73] The CMS Office of the Actuary projects that the Hospital Readmissions Reduction

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67. Peter S. Hussey et al., *Controlling U.S. Health Care Spending—Separating Promising from Unpromising Approaches*, 361 NEW ENG. J. MED. 2109, 2110 (2009), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp0910315. RAND is a nonpartisan, nonprofit corporation, formed over sixty years ago, that uses research to help in policy-making on issues like health care, education, international affairs, and national security. *History and Mission*, RAND CORP., http://www.rand.org/about/history.html (last visited Feb. 29, 2012).

68. *Report to the Congress: Reforming the Delivery System: Before the S. Comm. on Fin.*, 9 (2008) (statement of Mark E. Miller, Executive Director Medicare Payment Advisory Commission, *available at* http://www.medpac.gov/documents/20080916_Sen%20Fin_testimony%20final.pdf.

69. *Id.* at 14.

70. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3025, 124 Stat. 119, 408 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

71. Hussey et al., *supra* note 67.

72. *Id.*

73. *Id.*

Program will save $8.2 billion in spending, from implementation through 2019.[74]

Many hospitals have made progress in reducing preventable healthcare-associated infections ("HAIs"), but HAIs continue to have significant economic consequences for the United States' health system. HAIs are infections acquired during the course of receiving medical care that were not present when the patient was admitted to a health care facility.[75] The Centers for Disease Control and Prevention (the "CDC") estimates that annual direct medical costs of HAIs to hospitals range from $35.7 billion to $45 billion.[76] Two provisions of the Affordable Care Act impose payment adjustments on hospitals for preventable HAIs, termed "healthcare-associated conditions" ("HACs") in Medicare.[77] Effective July 1, 2011, state Medicaid agencies are no longer allowed to make payments for certain HACs or for medical errors, such as surgery performed on either the wrong patient or the wrong body part.[78] CMS's list of HACs no longer eligible for payment include catheter-associated urinary tract infections, surgical site infections, stage three and stage four pressure ulcers, and manifestations of poor glycemic control in diabetic patients.[79] The Affordable Care Act also imposes a penalty of 1% of all payments to hospitals that are in the top 25th percentile of rates of HAIs.[80] These HAI payment adjustments sections are examples of provisions in the Affordable Care Act built upon effective programs enacted previously by private and Veterans Administration hospitals,

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74. Memorandum from Richard S. Foster, Chief Actuary, Office of the Actuary, Ctrs. for Medicare & Medicaid Servs., to the U.S. Admin. & U.S. Cong., tbl.3 (Dec. 10, 2009), *available at* http://src.senate.gov/files/OACTMemorandumonFinancialImpactofPPAA(HR3590)(12-10-09).pdf. tbl.3.

75. WHO, PREVENTION OF HOSPITAL-ACQUIRED INFECTIONS: A PRACTICAL GUIDE 1 (G. Ducel et al. eds., 2nd ed. 2002), *available at* http://www.who.int/csr/resources/publications/drugresist/en/whocdscsreph200212.pdf.

76. R. DOUGLAS SCOTT II, CTRS. FOR DISEASE CONTROL & PREVENTION, THE DIRECT MEDICAL COSTS OF HEALTHCARE-ASSOCIATED INFECTIONS IN U.S. HOSPITALS AND THE BENEFITS OF PREVENTION 07 (2009), *available at* http://www.cdc.gov/HAI/pdfs/hai/Scott_CostPaper.pdf.

77. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 2702, 3008, 124 Stat. 119, 318, 376 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

78. *See* Patient Protection and Affordable Care Act § 2702.

79. *Hospital Acquired Conditions*, CTRS. FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp (last modified Mar. 15, 2012).

80. Patient Protection and Affordable Care Act § 3008.

state governments, and CMS. Federal payment adjustment for preventable HAIs was first introduced in the Deficit Reduction Act of 2005.[81]

The total impact of fraud and abuse on the United States' health system is difficult to measure, but recent convictions and settlements indicate that many billions of dollars are paid annually for invalid charges to Medicare, Medicaid, and private insurance. On February 14, 2012, HHS and the FBI announced that in 2011 they recovered $2.4 billion dollars in civil cases under the False Claims Act and another $1.3 billion in criminal prosecutions of pharmaceutical and device manufacturing companies.[82] Several provisions of the Affordable Care Act institute new requirements on providers aimed at eliminating costs associated with fraudulent Medicare claims and payment.[83] One such provision gives HHS authority to dis-enroll a Medicare physician or supplier that fails to maintain and provide access to written orders or requests for payment for durable medical equipment ("DME") and certification for home health services.[84] Another provision requires a face-to-face encounter with a patient before physicians may certify eligibility for home health services or DME.[85]

IV. LEGAL CHALLENGES, THE SUPERCOMMITTEE, AND THE INEVITABILITY OF FUTURE REFORM

Although the individual mandate is the central issue in most of the legal challenges to the Affordable Care Act, the provision which establishes an independent board to control Medicare costs is also subject to constitutional and political dispute. The Affordable Care Act creates a fifteen-member Medicare Independent Payment Advisory Board ("IPAB"), tasked with presenting to Congress comprehensive recommendations to reduce cost growth in Medicare.[86] If Congress rejects the IPAB recommendation and Medicare costs exceed specific targets, then the recommendations

81. *Hospital-Acquired Conditions (Present on Admission Indicator) Overview*, CTRS. FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/HospitalAcqCond/ (last modified Mar. 8, 2012).

82. *Health Care Fraud Prevention and Enforcement Efforts Result in Record-Breaking Recoveries Totaling Nearly $4.1 Billion*, U.S. DEP'T. OF HEALTH & HUMAN SERVS., http://www.hhs.gov/news/press/2012pres/02/20120214a.html (last visited Mar. 1, 2012).

83. *See, e.g.*, Patient Protection and Affordable Care Act §§ 6406, 6407.

84. *Id.* § 6406.

85. *Id.* § 6407.

86. *Id.* §§ 3403, 10320.

would take effect, unless Congress passes alternative measures that achieve the same level of savings.[87] In addition to being characterized as one of the "death panels" in the Affordable Care Act, the creation of IPAB is being challenged in the United States District Court for the District of Arizona on the grounds that it violates the separation of powers between the executive and legislative branches.[88] This case is currently under a stay of proceedings until the United States Supreme Court decides, this term, on the constitutionality of the Affordable Care Act and the severability of its provisions.[89]

In *Coons v. Geithner*, the Goldwater Institute's Sharf-Norton Center for Constitutional Litigation is representing small business owner Nick Coons, United States Representatives Jeff Flake, John Shadegg, and Trent Franks, and twenty-nine members of the Arizona state legislature against the Obama Administration.[90] Among other things, the suit claims that the Affordable Care Act "entrenches" IPAB from being reviewed and altered by future Congresses and thereby burdens United States Representative Flake and other federal legislators from being able to exercise their liberty and "voting duties."[91] The Goldwater Institute has argued that IPAB would "be able to dictate how much doctors can charge for medical care, how insurance companies will pay for it, and when patients can get access to cutting-edge treatments."[92] According to the complaint, it is because IPAB decisions cannot be reviewed by Congress or the courts that it violates the separation of powers doctrine.[93] Creating spending backstops and implement-

87. *Id.* § 3403. *See also id.* § 6404.

88. *See* Amended Civil Rights Complaint for Declaratory and Injunctive Relief at 29-32, Coons v. Geithner, No. 10-01714 (Dist. Ct. Ariz. Mar. 11, 2011), ECF No. 35, *available at* http://goldwaterinstitute.org/sites/default/files/5843.pdf.

89. Hadely Heath, Coons *Case, Like Others, Stalls Out While Waiting for Florida*, HEALTH CARE LAWSUITS (Jan. 23, 2012), http://healthcarelawsuits.org/blog/detail.php?c=2786757&t=Coons-Case%2C-Like-Others%2C-Stalls-Out-While-Waiting-for-Florida.

90. Indep. Women's Forum, *Coons v. Geithner*, HEALTH CARE LAWSUITS, http://healthcarelawsuits.org/detail.php?c=2262259&t=Coons-et-al-v.-Geithner-et-al- (last visited Mar. 1, 2012). *See also* Amended Civil Rights Complaint for Declaratory and Injunctive Relief, *supra* note 88, at 3-4.

91. Second Amended Civil Rights Complaint for Declaratory and Injunctive Relief at 23-29, *Coons*, No. CV-10-1714-PHX-GMS (Dist. Ct. Ariz. May 10, 2011), ECF No. 41, *available at* http://ohpcenter.org/writings/reference/REFERENCE-coons-v-geithner-second-amended-complaint.pdf.

92. Jack Minor, *President Proposes Giving More Power to 'Death Panels,'* GREELEY GAZETTE, May 31, 2011, http://www.greeleygazette.com/press/?p=9671.

93. Second Amended Civil Rights Complaint for Declaratory and Injunctive Relief, *supra* note 91.

ing direct Medicare cost controls like IPAB have proven elusive in our country's legislative history, and it is expected that this provision will also be subject to intense political debate in the 2012 national election cycle.

With the Affordable Care Act's well-intentioned care coordination and cost containment provisions mostly taking a pilot program approach and potentially affecting costs down the road, the unsustainability of health spending again took center stage during the sovereign debt crisis in the United States, culminated by the creation of the so-called Congressional "Supercommittee."[94] The twelve-member Joint Select Committee on Debt Reduction ("Supercommittee") was created in the Budget Control Act of 2011 and tasked with proposing at least $1.5 trillion in budget cuts over the next ten years.[95] Under this law, if a majority of Supercommittee members endorsed the proposal, the plan would have been required to be given an "up or down" floor vote in both chambers of the Congress.[96] Similar to the effect of IPAB, but procedurally more palpable, if a majority of the Supercommittee was unable to agree on a proposal, a "trigger mechanism" would enact $1.2 trillion in automatic, across the board spending cuts.[97] Reflective of the partisanship that has characterized the 112th Congress, the Supercommittee was disbanded on November 21, 2011, without consensus, and the automatic spending cuts are scheduled to become effective in 2013.[98] Under the trigger mechanism, the cuts will be evenly split between defense and non-defense discretionary

94. *See The Budget Control Act of 2011: Implications for Medicare*, KAISER FAMILY FOUND.: MEDICARE POLICY: ISSUE BRIEF (Kaiser Family Found., Wash., D.C.), Sept. 2011, at 1, 1, *available at* http://www.kff.org/medicare/upload/8216.pdf.

95. *See* Budget Control Act of 2011, Pub. L. No. 112-25, §§ 365, 401(b)(2), 125 Stat. 240, 259. *See also Where to Find $1.5 Trillion: 'Super Committee' Works on Deal*, ABC NEWS BLOG: NOTE (Oct. 13, 2011, 1:55pm), http://abcnews.go.com/blogs/politics/2011/10/deficit-super-committee-working-against-the-clock-on-deal.

96. Sarah A. Binder, *Congressional Super Committees: How Super Are They in Resolving the Budget Deficit Debate?*, BROOKINGS INST. (July 26, 2011), http://www.brookings.edu/opinions/2011/0726_congressional_supercommittees_binder.aspx.

97. Mary Agnes Carey & Phil Galewitz, *FAQ: 'Super Committee' Could Have Big Impact on Medicare, Medicaid Spending*, KAISER HEALTH NEWS, Aug. 11, 2011, http://www.kaiserhealthnews.org/Stories/2011/August/03/debt-deal-FAQ.aspx.

98. Richard Cowan, *Analysis: Fallout from Deficit-Reduction Panel Failure*, REUTERS, Nov. 21, 2011, http://www.reuters.com/article/2011/11/21/us-usa-debt-supercommittee-idUSTRE7AK0AF20111121.

spending, with Medicare payments to hospitals and other providers likely trimmed by 2%.[99]

V. CONCLUSION

Analyzing current United States' health spending and our long legislative history of feeble enactments to control health care costs, it is a good bet that health reform will continue to be a fact of life in America. If we are, indeed, at the economic breaking point, then the coverage expansion of the Affordable Care Act may go down in history as the proverbial straw that broke the camel's back. It does appear that, as a nation, we may be finally ready to deal with the long term consequences of continued, huge federal deficits. To come up with more than $1 trillion and certainly the $3 trillion to $4 trillion in spending cuts being called for by some, we will have to dramatically change how the federal Medicare and Medicaid entitlements are reimbursing health care. In codifying some of the most promising private sector and government approaches to delivering more efficient care, the Affordable Care Act has served a useful purpose in this century-long struggle. By catalyzing care coordination and cost containment through national initiatives like payment bundling and creating financial incentives to reduce preventable readmissions, the *Affordable* Care Act might actually someday be viewed as living up to its name. However, in some ways, whether the Affordable Care Act is upheld by the United States Supreme Court or is even repealed and replaced by the next Congress may be immaterial. Economic forces stronger than politics or the law will demand that we continue to address the unsustainable costs of our health care system. Health reform is inevitable.

99. *See Health Industry Raising Alarms About Cuts to Medicare After Super Committee Failure*, KAISER HEALTH NEWS, Nov. 23, 2011, http://www.kaiserhealthnews.org/Daily-Reports/2011/November/23/health-costs.aspx.