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Healthcare Reform: Let's Act Locally

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I. HEALTHCARE REFORM: WHERE WE STAND

Following heated debate and stark partisanship, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("Act").[1] It is the most significant health care reform legislation since the enactment of Medicare[2] and Medicaid[3] in 1965.

The discourse has not quieted since passage of the Act. If anything, the rhetoric has escalated. Healthcare reform remains a polarizing, emotional, and heavily politicized issue that raises a host of issues, including whether basic healthcare is a right, whether we should be forced to obtain health insurance coverage, whether the current healthcare system is effective, and whether it is sustainable.

As portrayed by the various factions, the Act will either end the abuses of the insurance industry and expand access to affordable

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1. Patient Protection and Affordable Care Act, 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.). On March 30, 2010, President Obama signed the reconciliation bill, which amended the Act. 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.).

2. Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in scattered sections of 26, 42, and 45 U.S.C.).

3. Grants to States for Medical Assistance Programs Act (Medicaid Act), Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (2006)).

coverage,[4] or serve as a job killing, expensive piece of legislation that creates an unprecedented infringement of government on private citizens.[5]

The law has spawned over twenty lawsuits and legislation has been proposed in at least forty-five states that would restrict or modify portions of the Act.[6] The lawsuits challenge various provisions of the Act, including the requirement that states expand their Medicaid coverage and the minimum contribution requirements for employers that either do not offer employees insurance coverage or offer inadequate coverage.[7] The core issue in these lawsuits, however, is the requirement that virtually all Americans maintain health insurance, or the so-called "individual mandate."[8] Similarly, it is the individual mandate that has generated the most public passion and dissension.

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4. News Release, Max Baucus, Senate Finance Committee Chairman, Baucus Applauds New Consumer Protections, End to Insurance Company Abuses (Sept. 23, 2010) (transcript available at http://finance.senate.gov/newsroom/chairman/download/?id=c91d662c-2ab1-45b1-807b-cd9da0e53e02); *The Bottom Line: How the Affordable Care Act Helps America's Families*, FAMILIES USA (Oct. 2011), http://www.familiesusa.org/resources/publications/reports/health-reform/helping-families.html.

5. *See* JOHN BOEHNER ET AL., OBAMACARE: A BUDGET-BUSTING, JOB-KILLING HEALTH CARE LAW 2-3 (2011). *See also The Disgrace of the Health Care Reform Debacle, Brought into Focus*, ETHICS ALARMS (Aug. 13, 2011, 9:17 PM), http://ethicsalarms.com/2011/08/13/the-disgrace-of-the-health-care-reform-debacle-brought-into-focus/.

6. *Factbox: Lawsuits Challenging Health Care Reform*, REUTERS (Mar. 23, 2011, 2:58 PM), http://www.reuters.com/article/2011/03/23/us-usa-healthcare-legal-idUSTRE72M5HU20110323. Many of the state legislative initiatives and the binding and non-binding resolutions involve measures to prohibit or restrict the individual mandate. Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2009-2010*, NAT'L CONF. OF ST. LEGISLATURES (March 14, 2011), http://www.ncsl.org/?tabid=18906.

7. Amy Goldstein, *Status of Legal Challenges to Obama Health Care Overhaul*, WASH. POST, http://www.washingtonpost.com/wp-srv/special/health-care-overhaul-lawsuits/ (last updated Jan. 31, 2011); Amy Goldstein, *Health-care Law Glossary*, WASH. POST, Dec. 13, 2010, http://www.washingtonpost.com/wp-srv/special/health-care-overhaul-lawsuits/glossary.html.

8. T.R. Goldman, *Health Policy Brief: Legal Challenges to Health Reform*, HEALTH AFFAIRS.ORG, 1 (July 8, 2011), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_49.pdf; Amy Goldstein, *Status of Legal Challenges to Obama Health Care Overhaul*, *supra* note 7. The language regarding the individual mandate is contained in § 1501 of the Act. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119 (2010) (codified as amended in 42 U.S.C. § 18091 and 26 U.S.C. § 5000A), *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.).

As of November 2011, three federal district judges have held that the individual mandate is constitutional[9] and three federal district judges have held it to be unconstitutional.[10] There are two federal appellate court decisions upholding the constitutionality of the individual mandate and one federal appellate court decision finding that the mandate is unconstitutional.[11] A fourth federal appellate court found that the insurance mandate penalties are a tax and, therefore, can only be challenged once collected, so the action was not ripe.[12] In November 2011, the Supreme Court agreed to hear appeals from the decision of the Eleventh Circuit Court of Appeals, arising out of Florida. The Supreme Court will review four aspects of the Act, including whether the individual mandate is constitutional and, if it is not, whether the remainder of the Act also is void.[13]

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9. Liberty Univ. v. Geithner, 753 F. Supp. 2d 611, 649 (W.D. Va. 2010), *vacated*, No. 10–2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882, 895 (E.D. Mich. 2010), *aff'd*, 651 F.3d 529 (6th Cir. 2011); Mead v. Holder, 766 F. Supp. 2d 16, 43 (D.C. 2011) *aff'd sub nom.* Seven-Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011). On appeal in *Liberty Univ.*, the Fourth Circuit held that the challenge was premature, determining that the mandate constitutes a tax and therefore could not be challenged prior to its effectiveness. 2011 WL 3962915, at *16.

10. Florida *ex rel.* Bondi v. U.S. Dep't of Health and Human Servs., 780 F. Supp. 2d 1256, 1306-07 (N.D. Fl. 2011) (granting summary judgment in favor of plaintiffs with the individual mandate struck down as an unconstitutional exercise of congressional power and ruling that the mandate could not be severed), *aff'd in part, rev'd in part sub nom.* Florida *ex rel.* Attorney Gen. v. U.S. Dep't of Health and Human Servs., 648 F.3d 1235 (11th Cir. 2011), *cert. granted sub nom.* U.S. Dep't of Health and Human Servs. v. Florida, 132 S. Ct. 604 (2011); Goudy-Bachman v. U.S. Dep't of Health and Human Servs., No. 1:10–CV–763, 2011 WL 4072875, at *21 (M.D. Pa. 2011) (holding that an individual mandate was unconstitutional and could be severed from the remainder of the Act); Virginia *ex rel.* Cuccinelli v. Sebelius, 702 F. Supp. 2d 598, 615 (E.D. Va. 2010), (striking down the individual mandate as an unconstitutional exercise of congressional power, but severing the mandate from the Act and leaving the remainder of the Act intact), *rev'd*, 656 F.3d 253 (4th Cir. 2011). On appeal in *Cuccinelli*, the Fourth Circuit dismissed the case, holding that the Commonwealth lacked standing. 656 F.3d at 272.

11. Seven-Sky v. Holder, No. 11-5047, 2011 WL 1113489 (D.C. Cir. Mar. 17, 2011) (circuit court affirmed the district court decision, finding the individual mandate to be within Congress' authority); Thomas More Law Ctr., 651 F.3d at 534 (upholding constitutionality, finding that the individual mandate is an appropriate exercise of Congress' authority under the Commerce Clause); Florida II, 648 F.3d at 1322 (holding that the individual mandate represented an unconstitutional exercise of congressional power, but upholding the remainder of the Act). Florida II is, perhaps, a case of heightened significance because the plaintiffs were the attorney generals and governors of twenty-six states.

12. *Liberty Univ.*, 2011 WL 3962915, at *16 (holding that the challenge was premature because the individual mandate constitutes a tax that could not be challenged prior to becoming effective).

13. Jennifer Haberkorn, *Supreme Court to Review Health Care Reform Law*, POLITICO (Nov. 14, 2011, 10:22 AM), http://www.politico.com/news/stories/1111/68300.html. Other questions before the Supreme Court include whether Congress can require states to expand Medicaid coverage, and whether the suit is ripe or whether a decision needs to wait until

The basic legal question raised by the individual mandate is whether the Commerce Clause of the Constitution permits the federal government to require individuals to purchase health insurance.[14] A determination that the individual mandate is unconstitutional, even if coupled with a finding that the individual mandate could be severed, leaving the remainder of the Act in place, could jeopardize the entire Act. Without the funds generated through the individual mandate, it is not clear that sufficient revenue to implement the other reforms will be available.[15] If the individual mandate is gone, but insurers are required to cover preexisting conditions, there is little incentive for young, healthy individuals to purchase coverage. After all, they can just wait until they get sick and then purchase insurance, since the insurer cannot refuse to cover preexisting conditions. If that phenomenon occurs, the insurance pool will be too heavily weighted with high utilizers of medical care, causing overall premiums to increase and coverage to become unaffordable.[16]

II. THE CASE FOR PAYMENT REFORM

While the challenges and discussions have overwhelmingly focused on the individual mandate, it is actually the payment reforms contained in the Act that will likely determine the long-term effectiveness of the Act and, moreover, the viability of our entire health system.[17] Without a material change in the way healthcare

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the mandate, and resulting penalties for failing to comply, are implemented. *See* Jess Bravin, *Supreme Test for Health Law*, WALL ST. J., Nov. 15, 2011, http://online.wsj.com/article/SB10001424052970204190504577037932371519676.html.

14. Peter Urbanowicz & Dennis G. Smith, *Constitutional Implications of an "Individual Mandate" in Health Care Reform*, THE FEDERALIST SOCIETY (July 10, 2009), http://www.fed-soc.org/publications/detail/constitutional-implications-of-an-individual-mandate-in-health-care-reform.

15. Bob Semro, *Straight Talk on Health Care Reform: Reform's Individual Mandate at Heart of Legal Challenges*, BELL POL'Y CTR. (June 7, 2011), http://bellpolicy.org/content/straight-talk-health-care-reform-reforms-individual-mandate-heart-legal-challenges.

16. Letter from John E. Dicken, Dir. of Health Care, U.S. Gov't Accountability Office, to The Honorable E. Benjamin Nelson, Chairman of the U.S. Senate Subcomm. on the Legislative Branch of the Comm. on Appropriations (Feb. 25, 2011) (on file with the U.S. Gov't Accountability Office).

17. Payment reform initiatives include, for example, payment bundling in § 3023 of the ACA, integrated payments surrounding hospitalization in § 2704, pay for performance in § 10326, community-based wellness programs in § 4202, independence at home in § 3024, and accountable care organizations in § 3022. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3023, 2704, 10326, 4202, 3024, 3022, 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

is delivered and financed, it is difficult to see how our system can be sustained.

In 2009, health care spending in the United States reached $2.5 trillion, accounting for over 17% of the Gross Domestic Product ("GDP"), or $8,086 per person.[18] Over one sixth of the nation's economy supports health care.[19] By 2018, healthcare spending is projected to rise to nearly $4.3 trillion, which is approximately 20% of GDP.[20] This percentage is projected to reach 34% by 2040, if costs continue to grow at historic rates.[21]

Not only are healthcare expenditures high, they are higher in the United States than in other countries.[22] Healthcare spending in the United States is approximately 50% more per person than the next most costly nation and is approximately double the average spending of other developed countries.[23] Whether that equates to the best health care in the world is debatable. A recent study conducted by the Organization for Economic Co-Operation

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scattered sections of 20, 26, and 42 U.S.C.). *See* CTR. FOR AM. PROGRESS, HOW HEALTH REFORM SAVES CONSUMERS AND TAXPAYERS MONEY (2010), *available at* http://www.americanprogress.org/issues/2010/06/pdf/cost_containment_memo.pdf.

18. *Covering Health Issues, 6th Ed. (2011 Update), Chapter 2—Cost of Healthcare*, ALLIANCE FOR HEALTH REFORM, http://www.allhealth.org/sourcebookcontent.asp?CHID=118 (last updated Oct. 21, 2011).

19. Katharine Q. Seelye, *Health Care's Share of U.S. Economy Rose at Record Rate*, N.Y. TIMES Prescriptions Blog (Feb. 4, 2010, 12:05 AM), http://www.prescriptions.blogs.nytimes.com/2010/02/04/us-health-care-spending-rose-at-record-rate-in-2009/.

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

21. Exec. Office of the President: Council of Econ. Advisors, *The Economic Case for Health Care Reform*, WHITE HOUSE BLOG (June 2009), http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf. While more money is spent on healthcare in the United States than in any other country, the public (governmental) expenditures by the United States are generally consistent with the rest of the Organization for Economic Co-Operation and Development ("OECD") countries. *Health Care Spending in the United States and Selected OECD Countries*, KAISER FAMILY FOUND. (Apr. 2011), www.kff.org/insurance/snapshot/OECD042111.cfm. However, the vast majority of the other OECD countries have universal coverage, except for the United States, Turkey, and Mexico. *Id. See also* ORG. FOR ECON. CO-OPERATION AND DEV., *Health Expenditure and Financing*, *in* HEALTH AT A GLANCE 2011: OECD INDICATORS 147, 147-59 (2011), *available at* http://www.oecd.org/dataoecd/6/28/49105858.pdf.

22. *Covering Health Issues, 6th Ed. (2011 Update), Chapter 2—Cost of Healthcare*, *supra* note 18; *OECD Health Data 2011—Frequently Requested Data, Health Expenditure: Total Health Expenditure Per Capita*, OECD (Nov. 2011), http://www.oecd.org/dataoecd/52/42/49188719.xls.

23. ORG. FOR ECON. CO-OPERATION AND DEV., *supra* note 21, at 148-149. *See also OECD Health Data 2011—Frequently Requested Data, Health Expenditure: Total Health Expenditure Per Capita*, *supra* note 22.

and Development ("OECD")[24] indicated that the United States delivers terrific medical care for cancer diagnoses.[25] For other metrics, however, the United States does not fare so well. For all of the money we spend on healthcare—more than any other nation in the world—the life expectancy in the United States ranks twenty-seventh of forty reported OECD and non-OECD countries.[26]

The real mandate in healthcare reform is this: we have to change the way we deliver healthcare. President Obama, in an address to the American Medical Association, styled the issue this way: "[m]ake no mistake: [t]he cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America."[27]

There are a multitude of reasons behind our high and escalating costs. Perhaps most notably, our payment system rewards medical utilization—we pay for procedures and tests. We pay for acute episodic care, rather than paying for outcomes, prevention, and wellness. Hospitals only remain viable if they have patients in beds and procedure rooms. Physicians only remain in business if they are treating and testing patients. Historically, no one has paid to prevent or limit the need for acute medical intervention. Essentially, the less procedures, the less money. The healthier the patient, the less money. Hospitals and physicians are doing exactly what the system incentivizes them to do. Our system so incentivizes hospitals to keep beds filled and procedure rooms full that we have drafted, literally, thousands of pages of regulations and guidance to try to prevent hospitals from paying physicians to refer patients to them.[28]

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24. The OECD is an international inter-governmental organization of thirty-four democratic countries. *About the Organisation for Economic Co-Operation and Development*, OECD, www.oecd.org (follow "About" hyperlink). Its mission is to promote policies that will improve the economic and social well-being of people around the world. *Id.*

25. Mark Pearson, *Written Statement to Senate Special Committee on Aging: Disparities in Health Expenditure Across OECD Countries*, OECD (Sept. 30, 2009), http://www.oecd.org/dataoecd/5/34/43800977.pdf.

26. ORG. FOR ECON. CO-OPERATION AND DEV., *Health Status, Life Expectancy at Birth, in* HEALTH AT A GLANCE 2011: OECD INDICATORS 25 (2011), *available at* http://www.oecd.org/dataoecd/6/28/49105858.pdf.

27. Barack Obama, President of the U.S., Remarks by the President at the Annual Conference of the American Medical Association (June 15, 2009) (transcript available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/).

28. *See, e.g.*, Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (codified at 42 U.S.C. 1320a-7b(b) (2006)); Safe Harbor Regulations, 42 C.F.R. § 1001.952 (a)-(u) (2011); Stark Act, 42 U.S.C. § 1395nn (2006); Stark Regu-

Some other factors also contribute to our high cost structure. Health care delivery is fragmented, with providers not communicating with each other, which results in duplicate tests and inefficient care for patients.[29] Additionally, medical technology has advanced at a rapid pace, allowing for more sophisticated equipment and more nuanced testing.[30] Many of these advances are reimbursed by the payers, resulting in more hospitals making the capital investment to acquire the latest technology, which, in turn, attracts patients and increases procedural volumes.[31] Technological advances allow better care and better outcomes for some individuals. However, medical technology advances also increase community expectations regarding the availability, sophistication, and frequency of testing and treatment. The utilization factor is further exacerbated by liability concerns that make physicians and hospitals practice defensive medicine, and consequently test more people more frequently.[32] One indicator of our utilization: the United States has the highest number of MRI and CT exams per capita of all reporting OECD countries.[33]

In conjunction with the general financial incentive to do more procedures and tests on more people, providers are facing reduced reimbursement as well as higher costs as a result of increased

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lations, 42 C.F.R. § 350-389. Also, see the federal register commentary relating to each set of regulations. *See also Advisory Opinions (AOs)*, CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/PhysicianSelfReferral/95_advisory_opinions.asp (last modified Oct. 25, 2011).

29. Alain C. Enthoven, *Integrated Delivery Systems: The Cure for Fragmentation*, 15 AM. J. FOR MANAGED CARE S284 *passim* (2009), *available at* http://www.ajmc.com/publications/supplement/2009/A264_09dec_HlthPolicyCvrOne/A264_09dec_EnthovenS284to290; Anthony Shih et al., *Organizing the U.S. Health Care Delivery System for High Performance*, COMMONWEALTH FUND, Aug. 7, 2008, *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx.

30. CONG. BUDGET OFFICE, TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING 1 (2008), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/89xx/doc8947/01-31-techhealth.pdf.

31. *Id.* at 9.

32. Rene Letourneau, *Defensive Medicine Adds Billions to Healthcare Costs*, HEALTHCARE FINANCE NEWS, Nov. 4, 2011, http://www.healthcarefinancenews.com/news/defensive-medicine-adds-billions-healthcare-costs; *Vast Majority of Physicians Practice 'Defensive Medicine,' According to Physician Survey*, SCIENCE DAILY (June 29, 2010), http://www.sciencedaily.com/releases/2010/06/100629094155.htm. One thing that the Act does not address is tort reform, which is arguably a critical component to reducing unnecessary testing.

33. *OECD Health Data 2011—Frequently Requested Data, Health Care Activities: MRI Exams, Per 1000 Population, Total, and CT exams, Per 1000 Population, Total*, OECD (Nov. 2011), http://www.oecd.org/dataoecd/52/42/49188719.xls.

administrative time dedicated to billing, paperwork, and trying to ensure compliance with a myriad of regulations,[34] which in turn lead to higher legal fees to comply with fraud and abuse regulations, billing rules, and appealing insurer denials. Collectively, hospitals and physicians are under enormous pressure to see more patients, to admit more patients, and to perform more procedures, just to maintain their historic levels of income.

It is no wonder that so many hospitals have focused on developing service lines that reimburse neuroscience, oncology, and heart procedures and closed down low-reimbursed services like behavioral health, despite the fact that mental disorders represent one of the five most prevalent chronic health conditions.[35] It is no wonder why physicians are competing with hospitals and opening specialty hospitals and ambulatory surgery centers, as well as integrating ancillary services, like lab and radiology, into their office practice. It allows them to survive.

III. DELIVERY REFORM INITIATIVES

With all the hoopla over the individual mandate, the delivery and payment reform components of the Act have been shunted off to the corner. And yet, these are the building blocks to a sustainable future. Recognizing that primary care is the key to prevention and wellness, the Act includes funding for scholarships for primary care doctors and nurses in underserved areas and increases Medicaid payments to primary care doctors.[36] The Act

34. Regulations have become so onerous that the simple failure to have a signature on a contract between a physician and a hospital, in and of itself, may violate Medicare billing rules and potentially require the pay back of all government reimbursements received from Medicare and Medicaid, resulting from services provided by the hospital by referrals of that physician. *See Inspector General: Audits, Legal Actions May Net Up to $3.4 Billion*, OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH AND HUMAN SERVS. (June 1, 2011), http://oig.hhs.gov/newsroom/news-releases/2011/sar_release.asp. Currently, there are approximately 18,000 codes used by hospitals and physicians to bill medical services. *See* Anna Wilde Mathews, *Walked Into a Lampost? Hurt While Crocheting? Help is on the Way*, WALL ST. J. Sept. 13, 2011, http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html. That number will expand to about 140,000 with the implementation of the new coding system. *Id.*

35. Mark W. Stanton, *The High Concentration of U.S. Health Expenditures*, RES. IN ACTION (Agency for Healthcare Res. and Quality, Rockville, M.D.), June 2006, at 6, *available at* http://www.ahrq.gov/research/ria19/expendria.pdf.

36. *See* Focus on Health Reform (last visited Feb. 29, 2012); *Focus on Health Reform: Summary of New Health Reform Law*, KAISER FAMILY FOUND., http://www.kff.org/healthreform/upload/8061.pdf (last modified Apr. 15, 2011); U.S. DEP'T OF HEALTH & HUMAN SERVS., *Fact Sheet: Creating Jobs and Increasing the Number of*

requires some free preventive care, including annual wellness visits for seniors, and it requires that new healthcare plans cover certain preventive services, such as mammograms and colonoscopies, without any deductible or co-pay charges.[37]

Finally, but perhaps most importantly, the Act establishes a number of pilots and demonstration projects that are designed to incentivize coordinated care across providers for the benefit of the patient, efficiency, prevention, and wellness. Pilot and demonstration projects include payment bundling (paying hospitals a lump sum for all treatments given during an entire episode of care, with hospitals distributing the payment between physicians and other providers); evaluation of community-based prevention and wellness programs for Medicare beneficiaries; development of individualized wellness plans; and paying for quality outcomes.[38] In addition to identified pilot and demonstration projects, the Act establishes an innovation center within the Centers for Medicare and Medicaid Services that will serve as a clearinghouse and funding vehicle for new health care delivery and payment system models.[39]

One of the primary vehicles promoted by the government in the Act to facilitate healthcare delivery reform is the concept of accountable care organizations ("ACOs").[40] ACOs are a bit of an amorphous creature and somewhat similar to the health maintenance organization model ("HMO"). Depicted initially in just seven pages of the 906 page Act, ACOs are intended to create incentives for health care providers to work together to treat an individual patient across care settings, including doctors' offices and hospitals, with the desired consequence, in theory at least, of coor-

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Primary Care Providers, HEALTH REFORM.GOV, http://www.healthreform.gov/newsroom/primarycareworkforce.html.

37. *See* Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through the Affordable Care Act*, 363 NEW ENG. J. MED. 1296 (2010), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1008560.

38. Specifically, § 3023 of the Act covers payment bundling, § 4202 covers evaluation of community-based wellness and prevention programs, § 4206 covers individualized wellness plans, and § 10326 deals with pay for performance. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3023, 4202, 4206, 10326, 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.).

39. *Our Mission*, CTR. FOR MEDICARE & MEDICAID INNOVATION, http://innovations.cms.gov/About/Our-Mission/index.html (last visited Feb. 29, 2012).

40. *See* Patient Protection and Affordable Care Act § 3022. See also 76 Fed. Reg. 67,802 (Nov. 2, 2011) for final ACO regulations and commentary.

dinated, more efficient, less expensive care, resulting in better health and quality of life for the patient.[41]

The incentive for hospitals and physicians to align in order to participate in an ACO is that the government will share a portion of the overall savings with the ACO providers.[42] The downside is the high anticipated cost of providers/insurers creating the necessary infrastructure to become an ACO and, at least in some models, the fact that the ACO shares that risk that there may not be savings, but rather excess costs.[43]

While nearly everyone applauds the concept behind ACOs, it is hard to get a concrete handle on what one looks like and how it operates. Interest has been keen, but the draft regulations issued in March 2011, a year following the passage of the Act, have generated less than an enthusiastic response, with providers and insurers roundly criticizing the ACO model as too expensive and the risks too high.[44]

There are other issues that make the viability of ACOs vulnerable. For now, at least, participation is purely voluntary and the number of volunteers seems to be slim.[45] So slim, in fact, that the government issued a modified "Pioneer ACO" model that minimiz-

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41. Jane Cys, *Accountable Care Organizations: A New Idea for Managing Medicare*, AM. MED. NEWS, Aug. 31, 2009, http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm.

42. *See* 76 Fed. Reg. 67,804 (Nov. 2, 2011). *See also* Jordan T. Cohen, *A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill*, HEALTH REFORM WATCH (Mar. 11, 2010), http://www.healthreformwatch.com/2010/03/11/a-guide-to-accountable-care-organizations-and-their-role-in-the-senates-health-reform-bill/.

43. DEP'T OF HEALTH & HUMAN SERVS., *New Affordable Care Act Tools Offer Incentives for Providers to Work Together When Caring for People with Medicare*, , HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/10/accountable-care10202011a.html (last updated Oct. 26, 2011); Letter from Am. Med. Group Ass'n to Donald Berwick, Ctrs. for Medicare & Medicaid Servs., Adm'r (May 11, 2011), *available at* http://www.amga.org/Advocacy/MGAC/Letters/05112011.pdf. *See also* AM. HOSP. ASS'N & MCMANIS CONSULTING, THE WORK AHEAD: ACTIVITIES AND COSTS TO DEVELOP AN ACCOUNTABLE CARE ORGANIZATION 16 (2011), *available at* http://www.aha.org/content/11/aco-white-paper-cost-dev-aco.pdf.

44. The final rule, 76 Fed. Reg. 67,802 (Nov. 2, 2011), modified a number of the ACO criteria contained in the proposed regulations. *See* Jenny Gold, *Administration Offers New Path for ACOs*, KAISER HEALTH NEWS, May 17, 2011, http://www.kaiserhealthnews.org/Stories/2011/May/17/ACO-initiatives.aspx; Robert Lowes, *Final ACO Regulations Released: Now More Physician Friendly*, MEDSCAPE (Oct. 20, 2011), http://www.medscape.com/viewarticle/751868; Bryn Nelson, *A Chilly Reception*, HOSPITALIST (Aug. 2011), http://www.the-hospitalist.org/details/article/1309385/A_Chilly_Reception.html.

45. Haydn Bush, *The Fear of ACO Commitment: It's All in the Details*, HOSPS. & HEALTH NETWORKS (July 27, 2011), http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=874000506; Gold, *supra* note 44.

es the ACO's risk, but continues to reward improvement, in an effort to jumpstart interest.[46] Furthermore, and maybe more significant, hospitals and physicians participating in an ACO will still be paid on a fee-for-service basis for procedures,[47] so the promise of sharing in future potential savings will be competing with the very real, immediate loss of fee-for-service reimbursement, if less tests and procedures are performed.

Sometimes big changes are hard. Nonetheless, paying for coordinated care, rather than fragmented care, and paying for wellness and maintenance care, rather than episodic care in response to acute events, make sense. The federal government, the ACO regulations, and the individual mandate lawsuits should not bury a good idea.

IV. HOMEGROWN REFORM IN WESTERN PENNSYLVANIA

So let us focus on our hometown. While the federal government battles through its legal challenges and while others page through the federal ACO regulations and try to determine whether the proposal is workable, let us change our corner of the world. Western Pennsylvania offers a nearly perfect scenario to develop innovative health care payment and delivery models that enhance quality of life and reduce costs. We have two local, community-based, well-funded systems to develop and test integrated health care delivery and payment innovations: University of Pittsburgh Medical Center ("UPMC") and Highmark.

Nationwide, hospitals and insurers, recognizing that some form of payment reform is around the corner, are scrambling to acquire physicians and trying to figure out how to work together.[48] Pitts-

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46. Haydn Bush, *Interest in Pioneer ACO Experiment Heats Up*, HOSPS. & HEALTH NETWORKS (Oct. 2011), http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/10OCT2011/1011HHN_Inbox_paymentreform&domain=HHNMAG; Gold, *supra* note 44; Jenny Gold, *'PosterBoys' Take a Pass on Pioneer ACO Program*, KAISER HEALTH NEWS, Sept. 14, 2011, http://www.kaiserhealthnews.org/Stories/2011/September/14/ACO-Pioneers-Medicare-hospitals.aspx.; *Pioneer ACO Model*, CTR. FOR MEDICARE & MEDICAID INNOVATION, http://innovations.cms.gov/initiatives/aco/pioneer/ (last visited Feb. 29, 2012).

47. *Pioneer Accountable Care Organization Model: General Fact Sheet*, CTR. FOR MEDICARE AND MEDICAID INNOVATION (Dec. 19, 2011), http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf.

48. *See* Robert Kocher & Nikhil R. Sahni, *Hospitals Race to Employ Physicians—The Logic Behind a Money-Losing Proposition*, 364 NEW ENG. J. MED. 1709, 1790 (2011); Anna Wilde Mathews, *United Health Buys California Group of 2,300 Doctors*, WALL ST. J., Sept. 1, 2011, http://online.wsj.com/article/SB10001424053111903895904576542553422509280.html.

burgh is already there. UPMC is a fully integrated system. It has a network in western Pennsylvania of tertiary and community hospitals.[49] It has 400 physician offices and over 3,000 employed physicians.[50] It has 17 retirement and long-term care facilities.[51] It operates an insurance company.[52]

Highmark has the dominant insurance network, with a market share of over 65%, and is intending to enter the provider market with the second largest health system in Pittsburgh, which comes with its own integrated network of employed specialists and primary care doctors.[53] Our community also benefits from the resources, expertise, and passion of the Pittsburgh Regional Healthcare Initiative ("PRHI").[54] PRHI is dedicated to perfecting patient care and has been on the forefront of patient care-focused initiatives.[55]

All of these Pittsburgh-based community organizations are already thinking and acting innovatively. As UPMC Health Plan's President and CEO recognizes, "[a]t UPMC, we actually have the ability to be a laboratory for change, to measure what's an effective treatment, what's an effective impact with benefit design, what is the right way to improve access, and what is the right way to enhance coordination of care."[56]

Highmark and UPMC provide benefits such as wellness programs, offer telephone and on-line tools, and invest in electronic medical records, which are a fundamental building block of coor-

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49. *UPMC Provider Services Division Fast Facts*, UPMC (2012), http://www.upmc.com/aboutupmc/fast-facts/Pages/provider-services-facts.aspx.

50. *Id.*

51. *Id.*

52. *UPMC Insurance Services Division Fast Facts*, UPMC (2011) http://www.upmc.com/aboutupmc/fast-facts/Pages/insurance-services-facts.aspx.

53. *UPMC-Highmark Dispute: Hearing Before the Pa. State S. Comm. on Banking and Ins.* (testimony of David Balto, Senior Fellow, Center for American Progress) (2011), *available at* http://www.acms.org/2011Testimony/%5BUPMC%20Highmark%5D%20Senate%20Banking%2009132011.pdf; Steve Twedt, *Highmark, WPAHS Announce Agreement; ER to Reopen*, PITT. POST-GAZETTE, Nov. 1, 2011, http://www.post-gazette.com/pg/11305/1186664-100.stm. *See also* WEST PENN ALLEGHENY HEALTH SYS., www.wpahs.org (last visited Mar. 13, 2012).

54. PRHI is a supporting organization of the Jewish Healthcare Foundation and is dedicated to perfecting patient care. *About Pittsburgh Regional Health Initiative*, PHRI, http://www.prhi.org/about_mission.php (last visited Feb. 29, 2012).

55. *What is PPC*, PHRI, http://www.prhi.org/ppc_what.php (last visited Feb. 29, 2012).

56. UPMC, UPMC 2010 ANNUAL REPORT 11 (2010), *available at* http://annualreport2010.upmc.com/_assets/pdf/UPMC_2010_Annual_Report.pdf.

dinated care.[57] One of the most promising pilots that both UPMC and Highmark are involved in, and which PRHI has history in, is something called a "medical home" model.[58]

Somewhat akin to the elusive ACO, but in reality more similar to HMOs, in a medical home model, the focus is on keeping individuals with chronic conditions healthy through the provision of coordinated care across the spectrum of providers.[59] Where an

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57. *See* Kris Mamula, *Pittsburgh Companies Become Proactive to Keep Healthcare Costs Down*, PITTSBURGH BUS. TIMES, June 28, 2010, http://www.bizjournals.com/pittsburgh/stories/2010/06/28/focus1.html?page=all; *Transforming Primary Care Practices*, EXECUTIVE SUMMARY (Pittsburgh Reg'l Health Initiative, Pittsburgh, PA), Dec. 2011, at 1, *available at* http://www.prhi.org/docs/Executive%20Summary%20Transforming%20Primary%20Care%20Practices%20December%202011.pdf; *UPMC Health Plan Introduces HealthyU*, HEALTHCARE FIN. NEWS, October 12 2011, http://www.healthcarefinancenews.com/press-release/upmc-health-plan-introduces-healthyu; *Employers: Wellness Programs*, UPMC HEALTH PLAN, http://www.upmchealthplan.com/employers/wellness.html (last visited Mar. 1, 2012); *Health & Wellness: Preventive and Immunization Guidelines*, UPMC HEALTH PLAN, http://www.upmchealthplan.com/health/preventive.html (last updated June 24, 2011); *UPMC HealthTrak Frequently Asked Questions*, UPMC HEALTHTRAK, https://myupmc.upmc.com/default.asp?mode=stdfile&option=faq#EQ_what (last visited Mar. 1, 2012); *Your Health*, HIGHMARK, https://www.highmarkbcbs.com/chmptl/chm/jsp/member.do?tab=3 (last visited Mar. 1, 2012). *See* UPMC, *supra* note 56; *Fact Sheet: Engaging Members in Their Healthcare*, HIGHMARK, https://www.highmark.com/hmk2/pdf/presskits/consumerism_fswellnessprograms.pdf (last visited Mar. 1, 2012); HIGHMARK, 2010 HIGHMARK INC. CORPORATE AND COMMUNITY REPORT (2010), *available at* http://www.nxtbook.com/nxtbooks/highmark/2010corpreport/index.php#/0.

58. Patricia L. Bricker et al., *Collaboration in Pennsylvania: Rapidly Spreading Improved Chronic Care for Patients to Practices*, 30 J. CONT'G EDUC. HEALTH PROFS. 114 (2010), *available at* http://acmd615.pbworks.com/f/Bricker-_IPIP_Penn.pdf; Kris Mamula, *Premier Medical Associates Begins Tracking Results of Proactive Care with Pilot Programs*, PITTSBURGH BUS. TIMES, Aug. 26, 2011, http://www.bizjournals.com/pittsburgh/print-edition/2011/08/26/premier-medical-assoc-proactive-care.html; Kris Mamula, *UPMC Expands Medical Home Model*, PITTSBURGH BUS. TIMES, May 20, 2011, http://www.bizjournals.com/pittsburgh/print-edition/2011/05/20/upmc-expands-medical-home-model.html?page=all; Press Release, Highmark, Highmark Inc. Beginning Patient-Centered Medical Home Pilot Program Designed to Improve Coordination of Care (Apr. 18, 2011), *available at* https://www.highmark.com/hmk2/about/newsroom/2011/pr041811.shtml; UPMC, *supra* note 56. *See Patient-Centered Care for the Safety Net System*, SAFETY NET MEDICAL HOME INITIATIVE, http://www.qhmedicalhome.org/safety-net/index.cfm (last visited Mar. 13, 2012).

While considered an "innovation," the concept of a medical home was introduced several years ago by the American Academy of Pediatrics ("AAP"). Am. Acad. of Family Physicians, et al., *Joint Principles of the Patient-Centered Medical Home*, AM. ACAD. PEDIATRICS (2010), http://practice.aap.org/content.aspx?aid=2063. In 2007, the AAP, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, issued guiding principles for medical homes. *Id.*

59. Howard J. Anderson, *The Medical Group Home*, HEALTH DATA MGMT., Nov. 1, 2009, *available at* http://www.healthdatamanagement.com/issues/2009_72/-39273-1.html; Harris Meyer, *Home Sweet Medical Home*, TRUSTEE, Nov. 2008, *available at*

ACO is most often envisioned as an alignment of hospitals and physicians, a medical home model is centered on the primary care physician.[60] It is the patient's primary care physician who serves as the patient's 'medical home,' overseeing both the delivery of acute healthcare services to patients and managing patients' overall health.[61] The primary care group helps to coordinate lab tests and specialist visits, but also makes sure patients are doing things like taking their medications.[62] They monitor a patient's health status on a routine basis.[63] By providing continual oversight, changes in a patient's condition are identified and managed quickly, before requiring critical intervention with attendant medical costs.[64]

The costs of implementing a medical home model generally include investment in information technology to manage and track patient care.[65] Additional payments to the primary care physician group are also likely to be necessary in order to compensate the group for the increased personnel and time commitments required in order to focus on patients' health on a routine, consistent, and frequent basis.[66] The costs are not extraordinary.

The benefits, however, can be extraordinary. In a study performed by Seattle's Group Health Cooperative, patients participating in a medical home program required 29% fewer emergency room visits and 6% fewer hospital admissions than those in conventional programs.[67] Patients in medical homes reported higher satisfaction.[68] Quality scores were also higher.[69] While primary and specialist physician costs were higher in the medical home model, these increased expenses were more than offset by savings achieved through lower emergency room and urgent care visits

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http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/Article/data/11NOV2008/0811TRU_FEA_MedHome&domain=TRUSTEEMAG.

60. Anderson, *supra* note 59; Meyer, *supra* note 59.

61. Anderson, *supra* note 59; Meyer, *supra* note 59.

62. Anderson, *supra* note 59; Meyer, *supra* note 59.

63. Anderson, *supra* note 59; Meyer, *supra* note 59.

64. Anderson, *supra* note 59; Meyer, *supra* note 59.

65. Anderson, *supra* note 59.

66. M. Bailit, et al., *Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net*, SAFETY NET MED. HOME INITIATIVE: POL'Y BRIEF (Commonwealth Fund, New York, N.Y.), Oct. 2010, at 1, *available at* http://www.qhmedicalhome.org/safety-net/policyresources.cfm _PolicyBrief_Issue1.

67. Robert J. Reid et al., *The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers*, 29 HEALTH AFFS. 835, 835 (2010).

68. *Id.*

69. *Id.*

and fewer hospital admissions.[70] Overall savings were $10.30 per member per month.[71]

CareFirst BlueCross BlueShield in Maryland/Washington D.C. has also implemented a medical home program, paying the physicians who voluntarily enroll a 12% increase in their insurance payments, as well as extra payments for developing and implementing patient treatment plans.[72] CareFirst sets a global budget for each patient based on the typical cost of care for patients with similar conditions.[73] Costs for services and specialists are paid out of the budget, and if there is an amount remaining at the end of the year, the doctor can share in the savings if quality and other metrics are satisfied.[74] If the doctor goes over the budget, there is no penalty.[75] The 'no penalty' rule seems to be designed to offset fears that doctors will not order necessary tests or send patients to specialists, which was a core criticism of the HMO model.[76]

Three additional pieces of information help to put into perspective the scope of the potential benefit of medical homes for patients with chronic diseases, beyond an individual's health. Some of the most expensive individuals to treat are those with chronic conditions. Twenty-five percent of the population has one or more of the following chronic conditions: asthma, diabetes, heart disease, hypertension, or a mental disorder.[77] While the cost of treating these conditions is expensive, people with chronic conditions tend to suffer from other ailments as well.[78] Expenses for people with one chronic condition were twice as great as for those without any chronic conditions.[79] Spending for those with five or more chronic conditions was about fourteen times greater than spending for people without any chronic conditions.[80] According to 1996 data, the costs of treating individuals with these five chronic con-

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70. *Id.*

71. *Id.*

72. CAREFIRST BLUECROSS BLUESHIELD, PATIENT CENTERED PRIMARY CARE MEDICAL HOME PROGRAM: PROGRAM DESCRIPTION AND GUIDELINES (2010), *available at* http://dhmh.maryland.gov/healthreform/pdf/BOK5423.pdf.

73. *Id.*

74. *Id.*

75. *Id.*

76. Robert Kane et al., *Ch. 2: The Basics of managed Care: Promises and Pitfalls of Managed Care*, *in* MANAGED CARE: HANDBOOK FOR THE AGING NETWORK (Louise Starr et al. eds. 1996), *available at* www.aspe.hhs.gov/Progsys/Forum/basics.htm.

77. Stanton, *supra* note 35, at 7.

78. *Id.*

79. *Id.*

80. *Id.*

ditions totaled 49% of total health care costs.[81] Exacerbating the problem is the fact that the prevalence of chronic diseases is on the rise.[82]

Secondly, high hospitalization rates and aggressive medical interventions have generally been found not to result in better quality of life or longer length of life for individuals with chronic conditions.[83] In fact, the reverse appears to be true.[84] Rather, coordinated, routine preventive and maintenance care tends to produce the best quality outcomes, meaning that the medical home model offers a better care model in terms of quality of life and longevity, and is less expensive than the current model of treating acute medical issues arising from a chronic condition.[85]

Third, hospitalization rates in the United States for persons with asthma and for individuals with acute complications from diabetes are among the highest of all of the OECD countries, reflecting a need to improve primary care for these individuals throughout the United States.[86] Equally concerning, based upon 2007 data, Medicare beneficiaries in the Pittsburgh region who suffered from chronic conditions were hospitalized at the highest rate among the forty major regions in the United States.[87] When risk, gender, race, and age were adjusted, data showed that Pitts-

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81. *Id.*

82. P'SHIP TO FIGHT CHRONIC DISEASE, THE GROWING CRISIS OF CHRONIC DISEASE IN THE UNITED STATES, *available at* http://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf.

83. Dartmouth Atlas of Healthcare, *FAQ*, DARTMOUTH INST. FOR HEALTH POL'Y AND CLINICAL PRAC., www.dartmouthatlas.org/tools/faq (last visited Nov. 4, 2011).

84. *Id.*

85. One issue not addressed in this essay is the role of personal responsibility in healthcare from a prevention and maintenance perspective, as well as from a cost perspective (e.g. should individuals who smoke or do not exercise pay more for healthcare?). The Robert Wood Johnson Foundation is sponsoring a campaign, "Care about your Care," designed to encourage people to take an active role in their healthcare. *See* Laura Landro, *Informed Patient: Getting Patients to Care About Their Care*, WALL ST. J. HEALTH BLOG (Sept. 12, 2011, 9:27 AM), http://blogs.wsj.com/health/2011/09/12/getting-patients-to-care-about-their-care/.

86. Pearson, *supra* note 25, at 5. *See also* ORG. FOR ECON. CO-OPERATION AND DEV., *supra* note 26, at 104-07 (noting that uncontrolled diabetes hospital admissions rates appear to have improved for the United States, as compared with the OECD 2009 data reflected in Pearson's presentation relating to diabetes acute complications admission rates).

87. Harold D. Miller, *Regional Insights: Less Health Care Could Be Better for Us*, PITTSBURGH POST-GAZETTE, Aug. 7, 2011, http://www.post-gazette.com/pg/11219/1165512-432-0.stm; Steve Twedt, *Pittsburgh Hospitals' Care Costs Are Highest in Country*, PITTSBURGH POST-GAZETTE, Feb. 12, 2012, http://www.post-gazette.com/pg/12043/1209745-455.stm.

burgh ranked highest in the country for Medicare spending for hospitals and skilled nursing facilities.[88]

The pilot programs demonstrate that medical homes have the ability to impact the quality and cost of care for individuals with chronic conditions in a significant manner. For patients, this means better quality of life. For the economy and employers, it means more productive workers and lower healthcare costs.

The medical home model is just one of many ideas being piloted. The American Recovery and Investment Act of 2009 earmarked nearly $400 million for grants to communities to develop programs to prevent chronic disease and promote wellness.[89] For example, Nashville was awarded $7.5 million in federal grants to implement healthier lifestyles to combat obesity.[90] With the United States leading the world in obesity and obesity contributing to a variety of health concerns, including type 2 diabetes and heart disease, slowing or halting the increase in obesity seems like a worthwhile endeavor.[91] To the extent Pittsburgh can lead the nation in innovative health care delivery and payment reform, we should be doing so. Further, as Nashville and the rest of the country learns what works, we should benefit by implementing the most successful experiments.

V. CONCLUSION

While UPMC and Highmark are piloting new programs and funding research into integrated medicine, there is room for improvement and reason to want that improvement to come at a faster pace. We have come to expect sophisticated, "best in class" healthcare in western Pennsylvania. We should also expect our

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88. Miller, *supra* note 87.

89. *HHS Communities Putting Prevention to Work Initiative*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/recovery/programs/cppw/factsheet.html (last visited Mar. 1, 2012).

90. Joey Garrison, *Stimulus Grant Drawing Millions to Fight Obesity in Nashville*, CITY PAPER, Mar. 19, 2010, http://nashvillecitypaper.com/content/city-news/stimulus-grant-drawing-millions-fight-obesity-nashville.

91. *Obesity and the Economics of Prevention: Fit not Fat—United States Key Facts*, ORG. FOR ECON. CO-OPERATION AND DEV., http://www.oecd.org/document/57/0,3746,en_2649_33929_46038969_1_1_1_1,00.html (last visited Mar. 1, 2012) (soaring obesity rates make the United States the fattest country in the OECD). *See also* CTRS. FOR DISEASE CONTROL AND PREVENTION, NAT'L CTR. FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, AT A GLANCE 2011: OBESITY: HALTING THE EPIDEMIC BY MAKING HEALTH EASIER 2 (2011), *available at* http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Obesity_AAG_WEB_508.pdf.

healthcare institutions to be not just thought leaders, but action leaders in healthcare reform. Given the level of provider/insurer integration, Pittsburgh is perhaps better positioned than any other region in the country to be on the cutting edge of healthcare reform. UPMC and Highmark are both financially strong institutions with deep Pittsburgh roots. They are both nonprofit community organizations whose missions—their very purpose for existing—are to make this region healthier. We are looking forward to a new chapter in Pittsburgh's history, as it leads the nation in healthcare reform.