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Gabriel A. Mancuso

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I. Introduction - Defining the Health Care Value Problem

The dramatic rise of spending on health care in the U.S., over the last thirty years, the forecast of the continued growth in the cost of health care services and products, over the long term, and the relatively substandard health outcomes achieved by the U.S. health care system, are arguably the most important policy issues faced by current and future generations of Americans.

The United States leads all member nations of the Organization for Economic Co-operation and Development in overall health spending.¹ Navy Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff, remarked, “the single, biggest threat to our national security is our debt”.² Subsumed within the larger United States debt problem is overall health care spending. According to the Bowles-Simpson commission on fiscal responsibility and reform, federal spending on health care represents the United States’ single largest fiscal challenge over the long-run.³

Health expenditures in the United States neared \$2.6 trillion in 2010, an increase of over ten times the \$256 billion spent in 1980.⁴ The United States spent 17.6% of its gross domestic product on health expenditures in 2010⁵; and such spending is anticipated to rise to about \$4.6 trillion, or 19.8 % of the GDP, by 2020.⁶ By 2025, it is estimated that, “one in every four dollars in our nation’s economy will be spent on health care”.⁷

¹ OECD Health Data 2012 Excel Spreadsheet, (Nov 23, 2012),

<http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012-frequentlyrequesteddata.htm>.

² Army Sgt. 1st Class Tyrone C. Marshall Jr., *Debt is Biggest Threat to National Security, Chairman Says*, U.S. Dept. of Defense, (Sept. 22, 2011), available at <http://www.defense.gov/news/newsarticle.aspx?id=65432>.

³ The Nat’l Comm’n on Fiscal Responsibility and Reform, *THE MOMENT OF TRUTH* 36 (2010).

⁴ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *NATIONAL HEALTH CARE EXPENDITURES DATA*, (January 2012).

⁵ OECD HEALTH DATA 2012 EXCEL SPREADSHEET, (Nov. 23, 2012),

<http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012-frequentlyrequesteddata.htm>.

⁶ HENRY J. KAISER FAMILY FOUNDATION, *HEALTHCARE COSTS: A PRIMER* (May 2012), available at <http://www.kff.org/insurance/upload/7670-03.pdf>; See also, *National Health Expenditures 2010 Highlights*, Ctr. for Medicare & Medicaid Serv., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>; *National Health Expenditure Projections 2010 –*

Over the long-term, federal health spending threatens to balloon as the baby boomers retire and overall health care costs continue to grow faster than the economy. Under its extended-baseline scenario, the Congressional Budget Office (CBO) projects that federal health care spending for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health insurance exchange subsidies will grow from nearly 6% of GDP in 2010 to about 10% in 2035, and continue to grow thereafter.⁸

These statistics just begin to illustrate the magnitude of the health care value problem. To say that spending on health care and the cost of health care products and services is large and growing does not properly frame the problem. The fact that the U.S. spends proportionally more on health care than other developed nations does not fully indicate the true nature of the problem because we are not getting healthier as a result of that additional spending.

Researchers have shown that the United States health system lacks quality, particularly in contrast to other industrialized countries.⁹ According to the Kaiser Family Foundation 63.3% of adults in the United States were overweight or obese in 2011.¹⁰ According to the Commonwealth Fund, the United States spends proportionally more on health care than any other advanced nation but ranks last on dimensions of performance such as access, patient safety, efficiency, and equity relative to Australia, Canada, Germany, New Zealand, the United Kingdom.¹¹ Particular

2020, Ctr. for Medicare & Medicaid Serv., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf>.

⁷ U.S. Dep't. of Health and Human Services, (Nov, 23 2012), <http://www.healthreform.gov/reports/index.html>.

⁸ The Nat'l Comm'n on Fiscal Responsibility and Reform, *supra* at note 3.

⁹ T.R. REID, THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE 31 (2009); *see also*, Harold D. Miller, FROM VOLUME TO VALUE: BETTER WAYS TO PAY FOR HEALTH CARE, 28 HEALTH AFF. 1418 (2009).

¹⁰ HENRY J. KAISER FAMILY FOUNDATION, Percent of Adults Who are Overweight or Obese, 2011, (Nov 27, 2012), <http://www.statehealthfacts.org/comparemaptable.jsp?ind=89&cat=2&sort=a>.

¹¹ KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: AN INTERNATIONAL UPDATE ON THE COMPARATIVE PERFORMANCE OF AMERICAN HEALTH CARE vii-x (Commonwealth Fund 2007), *available at* http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2007/May/Mirror%20Mirror%20on%20the%20Wall%20An%20International%20Update%20on%20the%20Comparative%20Performance%20of%20American%20Health/1027_Davis_mirror_mirror_international_update_v2.pdf.

note should be made of these rankings because the other five countries spend considerably less on health care per person and as a percent of gross domestic product than does the United States.¹²

Such high spending statistics would not be as troubling if the U.S. health care system achieved outcomes that indicated that the extra money that was spent resulted in healthier citizens. Considering the relatively poor outcomes associated with our higher levels of spending it is more accurate to say there is a value problem in the U.S. health care sector.

Another piece of the problem with the U.S. health care system is that, despite our outsized spending on healthcare services and products, the number of Americans without insurance in the United States grew to 49.9 million people in 2010.¹³ The Affordable Care Act was passed in 2010 in an effort to extend health insurance coverage, and by extension access to health care services and products, to more Americans.¹⁴

It has been estimated that if the ACA legislation was not enacted the “amount of uncompensated care provided w[ould] more than double in 45 states” and by 2019 “the number of uninsured people w[ould] grow by more than 30 percent in 29 states and by at least 10 percent in every state.”¹⁵ With the implementation of the ACA the Congressional Budget Office estimates that by 2019 the number of uninsured Americans will be reduced by 32 million people resulting in 92% of the U.S. population with insurance coverage.¹⁶

These increased coverage estimates are significant because the uninsured receive fewer preventative and diagnostic services, tend to be more severely ill when diagnosed, and receive

¹² Davis *supra* at note 11.

¹³ Carmen Denavas-Walt, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, 23 (U.S. Dep’t of Commerce, Economic Statistics Admin. U.S. Census Bureau Report 2011).

¹⁴ TIMOTHY S. JOST ET AL., HEALTH CARE REFORM SUPPLEMENT TO HEALTH LAW: CASES, MATERIAL AND PROBLEMS 83 (Thompson Reuters 2010).

¹⁵ *The Case for Change*, <http://www.healthreform.gov/reports/index.html>. (last accessed Nov. 23, 2012).

¹⁶ JOST ET AL., *supra* note 14, at 63.

less therapeutic care than insured patients.¹⁷ Without access to insurance people often either forgo needed preventative care or flock to emergency rooms where care is guaranteed to be provided, by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) statute.¹⁸ Such emergency care is incredibly expensive to provide relative to primary care services. About half of all emergency services go uncompensated, according to Centers for Medicare & Medicaid Services (CMS).¹⁹ Further, an overwhelming and steadily growing body of evidence shows a direct correlation between lack of insurance, lack of health care and poor health.²⁰

Finally, many Americans who do have insurance are “underinsured”, meaning that the insurance coverage that they have is not adequate; this can cause financial problems related to health care needs beyond what their insurance covers. Three-fifths of Americans who report health-care related financial problems had health insurance, while almost half of all bankruptcy filings have some medical cause.²¹

These facts indicate that the U.S. health care market is far from an efficient system for delivering health care or controlling costs. The above facts reinforce the need for systemic reforms and help illustrate why health care has come to the forefront of the national political consciousness as a “major policy priority”²². As a result, much of health care scholarship has turned to the questions of cost and cost containment.

¹⁷ *Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work and Income*, 60 *The Urban Institute Medical Care Research and Review*, 2 suppl, 3A-75S.

¹⁸ Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. §1395dd.

¹⁹ *Cost of Emergency Care*, Am. Coll. of Emergency Physicians, <http://www.acep.org/content.aspx?id=25902>. (Nov 23, 2012).

²⁰ TIMOTHY S. JOST ET AL., *HEALTH LAW: CASES, MATERIAL AND PROBLEMS* 562 (Thompson Reuters 2010).

²¹ Elizabeth Warren & Melissa Jacoby, *Insured But Not Protected: How Many Americans are Underinsured, and Beyond Hospital Misbehavior: An alternate Account of Medical Related Financial Distress*. 100 *NW. U. L. REV.* 535 (2006).

²² <http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#Background>, Nov 23, 2012.

This paper seeks to investigate and examine the problem of health care spending from a value perspective. The author argues that achieving lower spending targets involves both creating more efficient ways of delivering care and creating a new set of societal norms from which health care is provided and consumed. Only in a more efficient market can patients and doctors decide how to properly allocate resources to health care.

Part II of this paper will examine the nature and causes of health care cost and spending in the U.S. Part III will examine proposed mechanisms to either stabilize or bring down the cost of health care services and products. Part IV will provide a summation of the current policy arena and outline a recommended strategy.

II. Health Care Economics in an Inefficient Market

It is widely believed that the market for health care is distorted, and that the amount we, as a nation, spend on health care is not the amount we would freely choose to spend in a true competitive market.²³ Magnifying this problem is the fact that there is an inevitable trade-off between rising health care costs and other public goods, such as access to college and good wages for working Americans.²⁴

Among the myriad of factors determining spending on health care are biological need; medical decision making, which itself is a function of the prevailing standards of care in the medical and legal communities, the perceived value or efficacy of care, the actual value or efficacy of care, and the availability of a given service provider or product; overall cultural attitudes regarding both dying and the quality of life; advertising, technological change; and governmental regulation and tax policy.

²³ JOST *supra* note 20, at 565.

²⁴ Ezekiel J. Emanuel, *What We Give Up for Health Care*, N. Y. TIMES, Nov. 21, 2012, <http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care/?pagemode=print> (arguing that controlling health care costs is a necessary trade-off in order to maintain other public goods, such as education and national strength).

Monetary cost is one among these factors that will determine future spending on health care in the U.S. Monetary cost cannot be viewed in isolation from the other factors listed, however, since it is, at once, a reflection of the price the market will bear for a service/product and a value judgment about the necessity, efficacy and quality of that product or service. These societal value judgments are reflections of each of the other factors listed.

Monetary cost and spending preferences are each factors that interplay to determine total expenditures on health care. Past spending, unlike the idea of future cost, reflects a societal choice as to how resources have been allocated and is a fixed number. Future cost, is representative of choices that have yet to be made, by both the suppliers and consumers of health care products, and is open to manipulation.

a. Biological Need

Biological need is a factor associated with health care consumption decisions because virtually no person in the world makes it from cradle to grave without participating in the health care market. This fact was taken as “given” by the U.S. Supreme Court during oral arguments in National Federation of Independent Businesses v Sebelius, 567 U.S. ____ (2012), the landmark decision that upheld many parts of the ACA legislation. In analyzing the ability of Congress to regulate health insurance under the Commerce Clause, both petitioners and respondents conceded “the given is that virtually everyone, absent some intervention from above... will use health care”.²⁵

The idea that there is some intrinsic level of health care consumption that is baked into each human’s experience is significant and supports the idea that the system for providing care should

²⁵ Transcript of Oral Argument at 68:3-11, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, (2012) (Nos. 11–393, 11–398, 11–400).

be as efficient as possible. The fact that a particular market will affect all people is a major incentive to ensure that the market works effectively to allocate society's resources.

Simply because everyone uses the market for health care services does not mean that each consumer is well informed about the products or services that they buy. For example, in emergency situations or in cases of sudden serious illness, people often enter the market for health services involuntarily, without warning, and with little time to research courses of treatment. These scenarios can be a catalyst to overconsumption in health care products or services that do not lead to better health outcomes for the patient.

When you combine the fact that everyone will require health care over the course of their lifetime with the mandate, by the EMTALA statute, that care is to be provided regardless of ability to pay a seemingly bleak picture of growing health care spending seems to loom. This bleak picture does not necessarily need to be the case. Once we acknowledge that there is a minimum amount that will be spent on health care we can focus on optimizing that which is spent. For example, one way the ACA seeks to lower cost is by making preventative forms of care, such as primary care services, more widely available. The thinking goes that a greater access to preventative forms of care will lead to a healthier population who will, in turn, spend less on costly health care interventions as they age.

b. Medical Decision Making Processes

A free market generally works best to properly allocate resources when consumers have accurate and complete information about the characteristics of the market's products and prices. This requires, among other things, that information about products and services be easily obtained, without excessive search. Additionally, market efficiency requires that no single

vendor gain too much power over prices by having a large number of sellers compete with each other.

One reason that the market for health care services is distorted is that consumers are often ill equipped to make decisions regarding spending because they lack key information about the quality and price of medical services.²⁶ Most consumers do not have the expertise needed to evaluate the recommendations of their health care providers or comparative information about prices.

As a result, consumers delegate a considerable amount of decision making authority to their physicians. This puts physicians in the peculiar position of being able to create a demand for their own services by acting both as the agents for patients and the suppliers of medical products/services to those patients.

Medicine operates largely as a fee for service payment scheme. This model pays providers on a per procedure or per treatment basis and gives doctors a financial incentive to administer more services a la carte. That is, providers “gain increased revenues and profits by delivering more services to more people, fueling inflation in health care costs without any corresponding improvement in outcomes.”²⁷ This volume-based system also penalizes providers financially for accomplishing the goals of keeping people healthy, reducing errors and complications, and avoiding unnecessary care.²⁸

Since the current payment system encourages volume-driven care, rather than value-driven care²⁹ and because physicians wield considerable influence over the demand for their services it

²⁶ Congress of the United States, Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, (1992).

²⁷ Harold D. Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFF. 1418 (2009).

²⁸ *Id.*

²⁹ *Id.*

is little wonder that the U.S. leads the world in health care spending, while simultaneously lagging in outcomes.

c. Increased Technology Costs

Many health economists believe that a primary reason why health care costs so much in the U.S., and why the cost of care is increasing so rapidly, is because of the widespread and rapid adoption of health care technology.³⁰ It is argued that the availability of more expensive, state-of-the-art medical technologies and drugs raise treatment costs and overall health care spending. This is so because new technologies may generate demand for more intense, costly services even if they do not necessarily deliver better patients outcomes or are not as cost-effective as older methods.³¹

These arguments are not accepted out of hand, however, as there are many in the policy arena that believe that technology, specifically health information technology (“Health IT”) and electronic medical records (“EMR”), will bring about major savings in health care spending over the long term. One estimate projects that universal transition to EHRs can lead to a potential efficiency savings averaging more than \$77 billion per year. This forecast is based on the potential reduction of costs associated with medication errors, communication and documentation of clinical care test results, staffing and paper storage.³²

I believe there is a stark difference between over-utilization of new treatment technologies, that needlessly increase spending, and technology targeted towards improving the efficiency of the logistics and management of health care. While I acknowledge the former as a real factor

³⁰ JOST *supra* note 20, at 574.

³¹ Congress of the United States, Congressional Budget Office, *Technological Change and the Growth of Health Care Spending*, (2008).

³² Hillestad, R., J. Bigelow, A. Bower, et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, HEALTH AFF., 24(5):1103–1117 (2005).

driving health care spending, I will discuss below the ways in which technology is seen as a solution to, rather than a cause of, our health care value problem.

d. Price Distortions

Price is another area where the economics of health care are distorted in the United States. A striking feature of the American health care system is that even though we spend more on health care than any other nation, we consume no more, or less, health care than most other nations.³³

The U.S. pays dramatically more per unit of health care consumed, more per health care worker and more for the same drugs than do most other nations.³⁴

These facts imply that the U.S. does not utilize more productive resources on health care than other nations, we simply spend more for the health care we receive. It follows that, theoretically, we could cut health care costs without diminishing the volume of care received if we could pay less to those who provide care.³⁵ Therein, however, lies the rub, one man's cost is another's income. If we are to achieve meaningful savings in the amount of money spent on health care it is very likely that doctors, nurses, and other workers in the health care industry will need to receive less income per unit of health care they provide.

Another problem regarding price in the United States is that the true cost, or full price, of a procedure or product is often not imposed fully on the parties that are making the consumption decisions. In many instances, assuming a patient is covered, insurance will pay the majority of costs, leaving the patient to pay a deductible or co-payment that is a fraction of the full price of the services or products consumed. The presence of third-party payers, such as an insurer, dulls the incentive for consumers to pay much attention to costs at the point of service. Additionally,

³³ Gerard F. Anderson, *It's the Prices Stupid: Why the United States is so Different from Other Countries*, 22 HEALTH AFF., May/June 2003 at 89.

³⁴ See Anderson *supra* note 33 at 89.

³⁵ Uwe Reinhardt, *Resource Allocation in Health Care: The Allocation of Lifestyles to Providers*, 65 MILBANK QUARTERLY 153 (1987).

the tax subsidy for employer provided insurance reduces the pressure on the insured individuals to pay close attention to cost of their insurance. Finally, the difficulty of patients in assessing the quality of care adds to the weakening of the incentive for consumers to seek out the lowest prices.³⁶

e. Primary Care Providers; Supply and Access

Primary care, characterized by continuity of care and an established relationship between patient and physicians, was once the central grounding of our healthcare system.³⁷ However, currently 60 million Americans, or nearly one in five, lack adequate access to primary care due to a shortage of primary care physicians in their communities.³⁸ People who are uninsured, low-income, members of racial and ethnic minority groups, or living in rural or inner-city areas are disproportionately likely to lack a usual source of primary care.³⁹ The future does not look much brighter, the Association of American Medical Colleges estimates, the United States will face a shortage of more than 45,000 primary care physicians by 2020 and a shortage of 64,800 primary care physicians by 2025.⁴⁰

These facts are significant from both a patient health perspective and a cost perspective because effective primary care can improve the quality of care and improve patient health

³⁶ Reinhardt *supra* note 35.

³⁷ KAISER FAMILY FOUNDATION, PRIMARY CARE SHORTAGE: BACKGROUND BRIEF available at <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx>.

³⁸ *Primary Care Access: An Essential Building Block of Health Reform*, Nat'l Ass'n of Cmty. Health Centers. (March 2009), available at <http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf>.

³⁹ Ruddy, G. et al., *The family physician workforce: The special case of rural populations*, AM FAM PHYSICIAN July 2005, available at <http://www.aafp.org/afp/2005/0701/p147.html>. See also, Nat'l Ass'n of Cmty. Health Centers. *Access Denied: A Look At America's Medically Disenfranchised*. March 2007, available at http://www.graham-center.org/PreBuilt/Access_Denied.pdf.

⁴⁰ The Ass'n. of Am. Medical Colleges, *Physician Shortages to Worsen Without Increase In Residency Training*, available at https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_training.pdf.

outcomes and save money.⁴¹ Countries that are more oriented to primary care have residents in better health at lower costs. Health systems focused on primary care have been found to be associated with more effective, equitable, and efficient health services and residents of countries more oriented to primary care, such as the UK, Canada, Cuba, often report better health outcomes at lower costs.⁴²

Domestically, health is better in U.S. regions that have more primary care physicians, whereas several aspects of health are worse in areas with the greatest supply of specialists.⁴³ Further, a higher ratio of primary care physicians to population has been shown to correlate with better health.⁴⁴ One explanation for this correlation is that patients with a usual source of primary care tend to use more preventive health care and have health problems treated at earlier stages.⁴⁵

Various explanations have been put forward for the lack of primary care. A shortage of primary care providers is chief among those. Although 56% of patient visits in America are for primary care, only 37% of physicians practice primary care medicine, and only 8% of the nation's medical school graduates go into family medicine.⁴⁶

The shortage of primary care physicians is fostered by the payment system. The fee-for-service compensation system pays physicians based on the volume of care they deliver. This model results in a number of negative consequences for primary care physicians. Some of these consequences include poor reimbursements to primary care physicians, low comparative income,

⁴¹ Robert Steinbrook, *Easing the Shortage in Adult Primary Care — Is It All about Money?*, 360 NEW ENG. J. MED., 2696 (2009), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0903460>.

⁴² Starfield, B., L. Shi, and J. Macinko. 2005. *Contribution of primary care to health systems and health*. MILBANK QUARTERLY, 83:457-502.

⁴³ Starfield, B. *supra* note 42, at 457-502. See also, Starfield, B, Shi L, Grover A, Macinko J. *The effects of specialist supply on populations' health: assessing the evidence*, W5-97 HEALTH AFF. (2005).

⁴⁴ Hawkins, D., M. Proser, and R. Schwartz, *Health Reform and Healthcare Homes: The Role of Community Health Centers*. Harvard Health Policy Review, 8:2 (2007).

⁴⁵ Starfield, B., *Refocusing the System*, 359 NEW ENG. J. MED., 2087-91 (2008).

⁴⁶ Halsey, A. *Primary Care Shortage May Undermine Reform Efforts*, Washington Post (2009). See also, Health Resources and Services Admin., Bureau of Health Professions. *The physician work-force*, Rockville MD: HRSA (2008).

and poor quality of work life due to high patient loads These factors have contributed to more doctors choosing to train and practice in specialty medicine.⁴⁷

Many of the core primary care services, such as counseling, diagnosis, or dispensing prescriptions are difficult to have reimbursed relative to specialty areas of care that require more procedures, and thus more income. As a result, wide income disparities exist between family physicians, whose annual income by one estimate averages \$173,000, and those practicing specialties such as radiology, \$391,000, or cardiology, \$419,000.⁴⁸

Studies indicate that graduating medical students perceive the lifestyle associated with being a primary care physician as unfavorable, requiring more hours and less predictability than specialties.⁴⁹ Graduating medical students, who are frequently faced with repaying loans of over \$100,000 or more, are often inclined to enter a higher-paying medical specialty,⁵⁰ an inclination that perpetuates the undersupply of primary care providers in the United States.

III. Proposed Solutions

The value problem in health care is well known. Academics and government officials have been thinking about ways to make the health care market more efficient for many years.

One suggestion to make health care more a more efficient market has always been the implementation of a universal federal health care system. Starting with Theodore Roosevelt in 1912⁵¹, various American Presidents have urged Congress to pass legislation on universal healthcare. In 2010, almost 100 years after the idea was brought into the national conversation, comprehensive federal health care legislation was passed by Congress. The legislative

⁴⁷ Hauer, K. et al.. *Factors Associated With Medical Students' Career Choices Regarding Internal Medicine*, JOURNAL OF THE AM. MEDICAL ASS'N, 300:10 at 1154-1164 (2008).

⁴⁸ Halsey *supra* at note 46.

⁴⁹ Hauer *supra* at note 47

⁵⁰ *Id.*

⁵¹ Rich Barlow, *Claiming a Place in Health Care History*, available at <http://www.bu.edu/today/2012/claiming-a-place-in-health-care-history/> (2012).

embodiment of health reform was the Patient Protection and Affordable Care Act (ACA) which has three primary goals; improving quality, reducing costs, and increasing access and coverage.⁵²The ACA represented the most significant regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965.

The ACA is an ambitious effort, totaling some 2800 pages and touching almost every sector of the healthcare industry. Much of the Act is still in the process of being implemented and it remains to be seen whether the simultaneous goals of cost reduction and improved quality will be reached. The Congressional Budget Office (CBO) expressed concern that health care costs will remain high even after reform, however, CBO has also estimated that, on the other hand, the ACA will reduce the federal budget deficit by more than \$100 billion over the first decade and by more than \$1 trillion between 2020 and 2030.⁵³

One of the essential aspects of the ACA legislation is that, unlike previous legislative attempts to change health care, it does not rely on just one policy for effective cost control. Instead, it puts into place virtually every cost control reform proposed by physicians, economists, and health policy experts and includes the means for these reforms to be assessed quickly and scaled up if they are successful.⁵⁴ Accordingly, the author will use the ACA as a backdrop against which to report on some of the cost saving, quality promoting solutions that have been proposed throughout this policy debate.

a. Increased Supply of Primary Care Providers

As noted above, effective and ubiquitous primary care, specifically preventative care, can improve the health of patients, by helping prevent disease and illness, and reduce costs, by

⁵² Melinda Beeuwkes Buntin, et al., *Health Information Technology: Laying The Infrastructure For National Health Reform*, HEALTH AFF., 29:6 at 1219 (2010).

⁵³ Peter Orszag, Ezekiel Emanuel, *Health Care Reform and Cost Control*, NEW ENGLAND JOURNAL OF MEDICINE 363;7 (2010).

⁵⁴ *Id.*

ensuring all Americans, regardless of where they live, have access to high quality care throughout their lifetimes.

The success of the ACA's attempts to lower health care spending will likely depend as much on the availability of primary care physicians as on the specifics of the reform measures themselves. Access to health insurance, which the ACA seeks to provide, does not necessarily ensure access to timely medical care, particularly in places where doctors are in short supply, are not accepting new patients, or are not accepting patients with some types of insurance. For example, across the country, in 2008, fewer than half of primary care clinicians were accepting new Medicaid patients, making it hard for the poor to find care even when they were eligible for Medicaid.⁵⁵

With the enactment of the ACA, providers say they are bracing for the surge of the newly insured into an already strained system.⁵⁶ Various health experts, including many who support the ACA, say there is little that the government or the medical profession will be able to do to close the doctor shortage gap by 2014, when the law begins extending coverage to about 30 million Americans because it typically takes a decade to train a doctor.⁵⁷

In some ways the shortage of primary care doctors, and doctors generally, is a problem that is only solved over an extended timeline and the ACA, to its credit, realizes that the problem will not be solved overnight and puts in place a number of strategies that invest in training over the next few years. It is important to note, to the extent that easing the shortage of primary care

⁵⁵ Annie Lowrey and Robert Pear, *Doctor Shortage Likely to Worsen With Health Law*, NY TIMES, JULY, 28 2012, available at <http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html>.

⁵⁶ Lowrey *supra* note 55.

⁵⁷ *Id.*

physicians will require additional funds, the initial costs of reform, such as training new personnel to fill the supply-demand gap, will increase.⁵⁸

In response to these concerns, the ACA includes a comprehensive strategy to strengthen and grow the nation's primary care workforce by investing in a new generation of primary care providers. Specific efforts of the ACA include increased resources for training, new incentives for physicians to supply primary care for patients, and support for providers who choose to enter primary care in underserved areas.⁵⁹

The ACA makes available \$250 million in new funding, for example, to grow the primary care workforce, which will support the training, development, and placement of an estimated 16,000 new primary care providers over the next five years.⁶⁰ Over half of this money, \$168 million, will be used to increase the availability, to medical students, of primary care residency slots. This measure is estimated to train only 500 new primary care physicians by 2015, a relatively small dent in the 45,000 primary care doctor shortage that is projected in 2020 by the Association of American Medical Colleges.

The Obama Administration's estimates make it clear that it is expensive, over \$330,000 per person, to support the training of new doctors. As such, the ACA grants \$1.5 Billion over five years to expand the National Health Service Corps (NHSC).⁶¹ The NHSC seeks to encourage already trained primary care physicians, physicians' assistants and nurse practitioners to practice in underserved areas by offering repayment of educational loans and scholarships to primary care providers who serve the people who live in areas of the country that have too few health care professionals.

⁵⁸ See Steinbrook *supra* note 41, at *Id.*

⁵⁹ U.S. Dept. of Health and Human Services, Fact Sheet: Creating Jobs and Increasing the Number of Primary Care Providers, *available at* <http://www.healthreform.gov/newsroom/primarycareworkforce.html/>

⁶⁰ See U.S. Dept. of HHS Fact Sheet *supra* note 59.

⁶¹ *Id.*

These are just two elements of a multi-faceted strategy to increase the forecasted shortage of primary care providers. The ACA's response to the forecasted shortage of 45,000 primary care physicians by 2020, however multi-faceted it may be, seems inadequate relative to the forecasted shortage, even the most generous of the Obama Administration's estimates, 16,000 new primary care providers total, including doctors, nurses, physicians' assistants, over the next five years, will still leave the system with a sizeable short fall.

Beyond the ACA there are other strategies that may increase the incentives for medical students to enter a primary care field. Princeton University economist Uwe Reinhardt points out that primary care doctors rank comfortably in the top 5 percent of the U.S. income distribution, however, he questions why, despite their acknowledged shortage, primary care doctors remain the lowest paid of all medical specialties. Dr. Reinhardt suggests one solution to the shortage is to change the economic incentives for primary care doctors.⁶²

Reinhardt acknowledges that there are many nonpecuniary factors that influence a medical student's career decisions, including personal characteristics, socioeconomic background, whether they grew up in rural or urban settings, the professional prestige that faculty advisers and society at large appear to accord different specialties and, of increasing importance recently, the life styles that different specialties imply, namely, the leisure time available for family and personal control over work hours.⁶³ Reinhardt suggests that public policy can play a limited role, at best, in influencing these factors and argues that changing

⁶² Uwe Reinhardt, *If Primary-Care Doctors Were Taxed Like Hedge-Fund Managers*, NY TIMES, OCT. 26, 2012, Available at <http://economix.blogs.nytimes.com/2012/10/26/if-primary-care-doctors-were-taxed-like-hedge-fund-managers/>.

⁶³ E. Ray Dorsey et al, Influence of Controllable Lifestyle on Recent Trends in Specialty Choice by US Medical Students, JOURNAL OF THE AM. MEDICAL ASSN., 290:9 (2003), available at <http://jama.jamanetwork.com/article.aspx?articleid=197211>.

financial incentives is an effective way for policy to influence a major factor in a future doctor's decision making.⁶⁴

Public policy can attempt to influence a new graduate's choice of medical field through the economics of that choice either by reducing the cost of investing to enter that field or by enhancing the future income stream from practice in that field.⁶⁵ On the cost side of the incentive equation, medical schools could charge less to students who commit to train and work as primary care doctors. Alternatively, the credentialing required to become a primary care doctor could be decreased, relative to that required to become a specialist, so that less education would be required of, and less money spent by, medical students seeking to work in primary care. A backdoor variation on this theme, namely debt forgiveness in exchange for primary care practice in an underserved community, is already seen in the incentives given by the National Health Services Corp that were outlined above and expanded by the ACA.

On the other side of the incentive equation, the income stream earned by practicing in primary care could be enhanced through the federal income tax code by taxing the practice income of full-time primary care physicians at the same low rate now accorded certain portions of the incomes of the managers of private equity and hedge funds.⁶⁶ However viable this strategy may be from a policy standpoint it will likely remain, politically, a hotly contested one. All manner of Wall St. Occupiers and academics currently decry American income inequality and cite the tax preference for financiers as a chief concern. Giving primary care doctors beneficial tax treatment is probably an easier sell than the same for bankers, however, moving more high-income individuals into lower marginal rate brackets will still be politically fraught.

b. Standardization of Medical Practices

⁶⁴ Reinhardt *supra* at note 62.

⁶⁵ *Id.*

⁶⁶ *Id.*

Efficient use of medical resources requires consumers and providers to weigh the cost and benefits of alternative medical treatments. This is tough to do since patients lack the professional knowledge to evaluate which, out of a variety of courses of treatment, is the most effective and efficient approach to treating a particular condition. Moreover, providers seldom agree to a standardized treatment approach, “[e]very clinician has his or her own way of doing things, and the rates of failure and complication (not to mention the costs) for a given service routinely vary by a factor of two or three, even within the same hospital.”⁶⁷ Even within an institution surgeons take strikingly different approaches, they use different types of prostheses, different kinds of anesthesia, and different regimens for post-surgical pain control and physical therapy.

Accordingly, some physicians have argued that standardizing more health care procedures is a major way to reduce the money spent on health services overall. Orthopedic surgeon Dr. John Wright agrees that “[c]ustomization should be five per cent, not ninety-five per cent, of what we do”.⁶⁸ Wright worked to standardize knee replacements at Brigham and Women’s Hospital in Boston, MA. Dr. Wright and his team studied what the best professionals were doing, figured out how to standardize those practices and attempted to convince other physicians to follow suit.

As a result, the surgeons at Brigham and Women’s now use a single manufacturer for seventy-five per cent of their implants. This sort of uniform standard has given the hospital a greater bargaining power that has helped slash its knee-implant costs by half and has led to vastly better patient outcomes. The distance patients can walk two days after surgery has increased from fifty-three to eighty-five feet, nine out of ten patients could stand, walk, and climb at least a few stairs independently by the time of discharge. Perhaps most significantly, the amount of

⁶⁷ Atul Gawande, *Big Med: Restaurant chains have managed to combine quality control, cost control, and innovation. Can health care?*, NEW YORKER, August 13, 2012, available at http://www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande?currentPage=all.

⁶⁸ *Id.*

narcotic pain medications patients required fell by a third and they could also leave the hospital nearly a full day earlier on average, which saved some two thousand dollars per patient.⁶⁹

John Wright isn't alone in trying to design and implement this kind of systematically standardized care. The Virginia Mason Medical Center, in Seattle, has taken similar approaches for knee surgery and cancer care; the Geisinger Health Center, in Pennsylvania, has done it for cardiac surgery and primary care.⁷⁰ The University of Michigan Health System standardized how its doctors give blood transfusions to patients, thus reducing the need for transfusions by thirty-one per cent and expenses by two hundred thousand dollars a month.⁷¹

Such experiences provide small hints of the benefits of standardization, however, unless such strategies are implemented on a more broad nationwide scale and in other areas of medicine, the isolated strategies of Dr. Wright and others, are not going to do much to improve health care outcomes for most people or reduce the explosive growth of health care costs.

A major obstacle to the standardization movement is that in medicine new methods and ideas take quite a long time to trickle from innovative providers to others.⁷²

c. Health Care Technology as a Cost Saver

The advance of technology assisting in the delivery of health care services is thought by some to be a trend that will help reduce costs by improving efficiencies. Various strategies have been proposed to take advantage of technology for cost savings in health care. Two among those strategies are using health information technology (“Health IT”) services for the processing and management of patients’ electronic health records (“EHR”), and the establishment of online health care exchanges that serve as electronic marketplaces for obtaining coverage.

⁶⁹ Gawande *supra* note 67.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

Generally, Health IT refers to computer applications that assist in the practice of medicine. For example, computerized entry systems for physicians' ordering of tests or medications, support systems for clinical decision making, or electronic prescribing of medications. Some or all of those components are contained in an EHR, which has the capacity to send and receive data electronically and is ideally interoperable with other Health IT systems.⁷³

Health IT recognizes that information plays a key role in delivering health care. Providers, such as physicians and hospitals, generate and process information as they provide care to patients. Managing that information and using it productively poses a continuing challenge, particularly in light of the complexity of the U.S. healthcare market, with its many different types of providers, services, and settings for care.

Health IT has the potential to significantly increase the efficiency of the healthcare market by helping providers better manage information. Electronic health records are supposed to supply providers with more accurate and real-time data on their patients. More efficient information management may also lead to better outcomes for patients. Some examples cited are, reduced need for duplicate diagnostic tests, identification of harmful drug interactions and reminders to physicians about harmful drug interactions.⁷⁴

One problem with the Health IT "revolution" is that implementation has not occurred in very large numbers. It is estimated that only 20% of doctors and 10% of hospitals currently use

⁷³ Congress of the United States, Congressional Budget Office, *Evidence on the Costs and Benefits of Health Information Technology*, (2008).

⁷⁴ *Id.*

EHRs.⁷⁵ However, it is forecasted that the spread of EHRs will be jump-started by the American Recovery and Reinvestment Act's \$26 billion investment in Health IT.⁷⁶

The American Recovery and Reinvestment Act was passed in 2009. This Act contained Health Information Technology for Economic and Clinical Health (HITECH) provisions. The HITECH provisions have been alternately described narrowly, as legislation simply aimed at stimulating the adoption of health information technology, and broadly, as an essential foundation for the broader efforts to restructure health care delivery.⁷⁷

In furtherance of the goal of Health IT utilization, the Department of Health and Human Services issued rules that reward doctors and hospitals for the "meaningful use" of EHRs. Under the HHS rules, doctors and hospitals could receive as much as \$27 billion over the next 10 years to buy equipment to computerize patients' medical records. A doctor can receive up to \$44,000 under Medicare and \$63,750 under Medicaid, while a hospital can receive millions of dollars, depending on its size.⁷⁸ Beginning in 2015, hospitals and doctors will be subject to financial penalties under Medicare if they are not using electronic health records.⁷⁹

To meet the "meaningful use" standard under HHS rules, doctors will have to meet 15 specific requirements, plus 5 chosen from a list of 10 objectives. Hospitals will have to meet 14 requirements, plus 5 chosen from a menu of 10 goals. Doctors, for example, will have to use electronic systems to record patients' demographic data (sex, race, date of birth); their height, weight and blood pressure; their medications; and their smoking behavior. Additionally, to meet the new standards, doctors will have to transmit 40 percent of prescriptions electronically. The

⁷⁵ Jha AK.. *A progress report on electronic health records in US hospitals*, HEALTH AFF. (2010).

⁷⁶ Orszag *supra* note 53.

⁷⁷ Melinda Beeuwkes Buntin, Sachin H. Jain and David Blumenthal, *Health Information Technology: Laying The Infrastructure For National Health Reform* HEALTH AFF., 29:6 at 1214 (2010).

⁷⁸ Robert Pear, *Standards Issued for Electronic Health Records*, NY TIMES. July 13, 2010 available at <https://www.nytimes.com/2010/07/14/health/policy/14health.html>.

⁷⁹ *Id.*

final HHS rules did not mandate that doctors and hospitals be able to electronically exchange clinical information on patients but did require health care providers to work toward that goal.⁸⁰

Not everyone is convinced that the widespread adoption of Health IT will deliver on its promises to reduce costs or improve patient care. For example, there are problems cited with EHRs and the ease of copying and pasting of information. Dr. Leora Horwitz, an associate professor at Yale School of Medicine, remarked that while “[t]he advent of electronic medical records has been a boon to patient safety and physician efficiency in many ways... it has also brought with it a slew of ‘timesaving’ tricks that ... make it so easy for doctors to document the results of standard exams and conversations with patients that it appears more and more of [those exams or conversations] are being documented without ever having happened in the first place.”⁸¹

Dr. Horwitz has seen her own written assessment of a patient’s health appear in another doctor’s notes. Dr. Horwitz also reports having seen “patient is on day two of antibiotics” appear for five days in a row on one patient’s chart. Moreover, a 2009 study found that 90 percent of physicians reported copying and pasting when writing daily notes.⁸²

The time saving techniques of Health IT, it seems in some instances, are having the unintended consequence of making a doctor’s job too easy. A doctor used to have to fill out a checklist for every step while performing a physical exam. With an EHR, they can click one button that automatically places a comprehensive normal physical exam in a patient’s record.⁸³ It is not difficult to imagine a harried doctor, in the midst of a sixteen-hour workday, rushing through a physical exam by clicking an automatic entry button. The fee for service model gives

⁸⁰ Pear *supra* note 78.

⁸¹ Leora Horwitz, *A Short Cut to Wasted Time*, NY TIMES Nov. 23, 2012, available at http://www.nytimes.com/2012/11/23/opinion/shortcuts-in-medical-documentation.html?_r=0.

⁸² *Id.*

⁸³ *Id.*

this hypothetical doctor two major incentives, first he may earn the full income from such an exam without spending the full time needed to perform that exam and second such time saving techniques may allow him to rush off to a more complex and costly patient.

Hospitals received \$1 billion more from Medicare in 2010 than they did in 2005.⁸⁴ Some say this is largely because electronic medical records have made it easier for doctors to document and be reimbursed for the real work that they do. To a certain extent this is probably true, however, I find it difficult to believe that such growth in Medicare is attributable only to the ability of doctors to document previously undocumented real work. This fall, the United States' Attorney General and Secretary of Health and Human Services warned the five major hospital associations that abuses of the kind mentioned above would not be tolerated.⁸⁵ It follows that some portion of the \$1 billion dollar increase in Medicare reimbursement is surely abuse of Health IT.

The above issues undergird not only the shortcomings with Health IT but more so the shortcomings of the current fee for service provider payment model. No matter how efficient technology makes the management of care, if a provider makes more money as he or she provides a greater quantity of, or more costly, services and products that person has a large incentive to maximize the amount and cost of products or services provided per day, per patient, and even per hour.

d. Accountable Care Organizations

Meaningful costs savings cannot be achieved without reform of the fee for service payment model. Among the proposed changes in the way healthcare providers are compensated is the accountable care movement. The accountable care model, which is embodied by the formation of

⁸⁴ Horowitz *supra* note 81.

⁸⁵ U.S. Dept. of Health and Human Services, *Letter to CEOs of Five Major Hospitals*, Sept. 24, 2012, available at <http://assets.fiercemarkets.com/public/newsletter/fiercehealthit/obamaadminletter.pdf>

individual Accountable Care Organizations (“ACO”), matches payment for care with performance-based measures and seeks to change the way providers are compensated by moving away from fee for service compensation.⁸⁶

According to the American Hospital Association, the ACO concept seeks to remove existing barriers to improve the value of care.⁸⁷ Others have defined accountable care organizations as “affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending.”⁸⁸

The most significant barrier that the ACO concept seeks to remove is a payment system that rewards the volume and intensity of provided services instead of quality and cost performance.⁸⁹ Another substantial barrier that the ACO system seeks to remove is the widely held assumption, by both patients and providers, that more medical care is equivalent to higher quality care.⁹⁰

ACOs seek to achieve their goals by linking provider payment to outcomes and by providing bonus payments based on the amount of money saved relative to a pre-set benchmark. ACOs reward physicians by giving financial incentives to collaborate to increase prevention and the quality of care, “while discouraging overtreatment, undertreatment, and sheer profiteering.”⁹¹ ACOs can take a variety of organizational forms, such as integrated delivery systems, primary

⁸⁶ Thomas L. Greaney, *Accountable Care Organizations – The Fork in the Road*, 364 N. ENGL. J. MED. e1(1) (2011), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1013404>.

⁸⁷ Elliott Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, HEALTH AFF. (2009), available at <http://content.healthaffairs.org/cgi/reprint/28/2/w219>.

⁸⁸ Greaney *supra* note 86.

⁸⁹ AMERICAN HOSPITAL ASSOCIATION, ACCOUNTABLE CARE ORGANIZATIONS: AHA RESEARCH SYNTHESIS REPORT 3 (2010), available at http://www.aha.org/research/cor/content/aco_cp.pdf [hereinafter, AHA RESEARCH SYNTHESIS REPORT]

⁹⁰ *Id.*

⁹¹ Atul Gawande, *The Cost Conundrum: What a Texas Town can Teach us About Health Care*, NEW YORKER 1, 12, June 1, 2009, available at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all.

care or multispecialty medical groups, hospital-based systems, and contractual or virtual networks of physicians, such as independent practice associations.⁹²

On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to outline the incentive structures for ACOs and to help doctors, hospitals, and other providers better coordinate care for Medicare patients through ACOs.⁹³ Under the rule, the Center for Medicare and Medicaid Services (CMS) develops a benchmark for each ACO against which that ACO's performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses. The amount of shared savings depends on whether an ACO meets or exceeds its quality performance standards. These changes do not wholly replace the existing Medicare payment system, however, Medicare will continue to pay individual health care providers and suppliers for specific items and services as it currently does.⁹⁴

The HHS rule links the amount of shared savings an ACO may receive to its performance on quality standards. The proposed quality measures span five key areas that affect patient care: Patient/caregiver experience of care; Care coordination; Patient safety; Preventive health; and At-risk population/frail elderly health. The proposed rule sets out performance standards for each of these measures and a scoring methodology, including rules to prevent providers in ACOs from being penalized for treating patients with more complex conditions.⁹⁵

There are, of course, skeptics of the ACO movement. Some critics are concerned that under accountable care, providers will not be able to meet the levels of required cost saving without

⁹² See 42 U.S.C. § 1395jjj(b); see also Greaney, *supra* note 86.

⁹³ 76 Fed. Reg. 67802, 67803

⁹⁴ U.S. Dept. of Health and Human Services, *Accountable Care Organizations: Improving Care Coordination for People with Medicare*, March 31, 2012 available at <http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html>.

⁹⁵ *Id.*

ultimately being forced to compromise quality of care.⁹⁶ Additionally, consumers may fear that ACOs will ration care, to meet financial incentives, by denying patients access to needed services. Such fears could undermine individual ACOs or the accountable care movement generally, whether those fears are actually valid, or simply perceived as so by the public. Similar such fears led to a consumer backlash and the eventual failure of the managed care movement during the 1990s.⁹⁷

Current ACO reformers have learned from the managed care experience that support of the movement from patients is essential for changing the delivery of medical care.⁹⁸ The accountable care reformers are aware of the skepticism about patient involvement that remains from the previous efforts.⁹⁹ As such the criteria that are used to evaluate an ACO, requires population-based accountability, coordinated care, quality health care, and efficiency.¹⁰⁰

The ACO movement relates directly to the rethinking of the role of the patient and other stakeholders, such as employers, insurers, and other community members, in the delivery of healthcare.¹⁰¹ Patient-centered care generally improves outcomes by enhancing patient compliance with plans of care¹⁰², improving patient satisfaction and reducing length of stay, readmissions, and emergency department visits as well.¹⁰³

The Medicare Shared Savings Program (MSSP) model of accountable care, for example, contains thirty-three quality performance standards that ACOs must meet before obtaining shared savings. Of the thirty-three quality measures selected for the MSSP, seven are related to

⁹⁶ Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 81 (1998), available at <http://content.healthaffairs.org/content/17/4/80.full.pdf+html>.

⁹⁷ Louise Trubek et al., *Adopting Accountable Care Through The Medicare Framework*, Working Paper 16 (2012).

⁹⁸ THOMAS S. BODENHEIMER & KEVIN GRUMBACH, *UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH* 199 (5th ed. 2009).

⁹⁹ *Id.*

¹⁰⁰ 42 U.S.C. § 1395jjj(b) (2006 & Supp. IV 2010), added by § 3022 of ACA.

¹⁰¹ Trubek *supra* note 97 at 24.

¹⁰² Barbara Cliff, *The Evolution of Patient-Centered Care*, 57 J. HEALTHCARE MGMT. 86, 88 (2012).

¹⁰³ *Id.*

the patient's or caregiver's experience of care, to which the final rules give equal weight with measures relating to care coordination and patient safety, preventive health, and at-risk populations.¹⁰⁴

The three broad categories of MSSP patient-centered criteria are a direct response to the lessons learned from the managed care backlash.¹⁰⁵ The comments to the MSSP rules indicate that CMS sees patient-centeredness as a crucial aspect to achieve its goals of better care, better health, and lower costs.¹⁰⁶ The rule defines "patient engagement" as "the active participation of patients and their families in the process of making medical decisions.

Other doubters of the ACO approach, such as Commissioner J. Thomas Rosch of the Federal Trade Commission (FTC), cite the concern that ACOs will lead to provider consolidation, resulting in more consolidated market power and higher health care costs as a result.¹⁰⁷ These critics argue that greater collaboration from ACOs may bring with it a greater potential for market manipulation and antitrust concerns.¹⁰⁸ If market power is consolidated in a few national ACO holding companies those companies may manipulate market prices in their favor.

To dispel fears such as these there needs to be close oversight by regulators of large networks of ACOs and the care they provide.

IV. Conclusion

In sum, achieving lower cost and spending goals involves both creating more efficient ways of delivering care and creating a new set of societal norms from which health care is provided and consumed. Only in a more efficient market can patients and doctors decide how to properly

¹⁰⁴ 42 U.S.C. 1395jjj (2010).

¹⁰⁵ Trubek *supra* 97 at 27.

¹⁰⁶ MSSP Final Rule, 76 Fed. Reg. at 67826.

¹⁰⁶ *Id.*

¹⁰⁷ J. Thomas Rosch, Commissioner, Fed. Trade Comm'n., Speech at the Am. Bar Assoc. Section of Antitrust Law Fall Forum: Accountable Care Organizations: What Exactly are We Getting?, at 15 (Nov. 17, 2011), *available at* <http://www.ftc.gov/speeches/rosch.shtm>.

¹⁰⁸ *Id.*

allocate resources to health care. No single measure mentioned here will be a panacea for the nation's health care value problem. Making the health care market more efficient will require utilizing a comprehensive set of varied policies, testing the efficacy of those policies, at improving patient outcomes and reducing costs, and finally scaling up those policies which work best. We are optimistic that since the ACA follows roughly this approach we, as a nation, will learn how to better maximize the dollars we spend on health care over the coming years.