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Loyola University Chicago School of Law

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

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Annals of Health Law
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Editor's Note

The *Annals of Health Law* is proud to present the Sixth Issue of our online counterpart, *Advance Directive*. Consistent with our goal of promoting student scholarship in the area of health law, this Issue features articles focusing on the sweeping changes in health care initiated by the Patient Protection and Affordable Care Act (PPACA), specifically the impact on access of care.

This Issue begins with exploring innovations in health care through a patient's perspective. First, it analyzes patient-centered medical homes and determines whether these community health programs provide comprehensive, high-quality health care. Next, our authors evaluate extending the role of the independent nurse practitioner in an effort to provide quality health care in a cost-efficient manner. Our authors also examine whether expanding access to health care necessarily involves the increase of health information technology and the prohibition on rescission of health insurance.

Next, the Issue discusses initiatives in the PPACA that attempt to regulate the high costs of care. Our authors propose establishing additional requirements for charitable hospitals to help balance the financial burdens charged to uninsured patients. They also explore whether the structure, payments, data collection, and involvement of the Federal government through the physician quality reporting

initiative will result in less expensive care for patients. With these and other initiatives to increase the affordability of health care, our authors propose the overuse of emergency care will decrease and subsequently improve both urgent and non-urgent care, while cutting overall health care costs. Additionally, the authors argue that these improvements will cause a decrease in medical bankruptcies attributed to staggering medical bills and the rising costs of prescription medication.

The Issue then transitions into examining the effects of the PPACA on Medicare and Medicaid services in order to provide health care to low-income and uninsured populations. First, our authors evaluate the effectiveness of the Independent Payment Advisory Board, which will develop and propose modifications to the payment system under Medicare to curb spending. Second, the authors analyze Medicare's proposed rules for a value-based purchasing program. Finally, our authors address the expansion of Medicaid eligibility to low income individuals and propose methods to ensure eligibility results in enrollment in the program.

We also address several provisions in the PPACA that promote research and development of pharmaceuticals. Our authors begin by analyzing the impact of the Biologics Act on the development of biologics and biosimilars. Specifically, they discuss whether this Act will encourage investment and development of innovative drugs. Our authors then compare these medical innovations with those in the United Kingdom.

Finally, the Issue analyzes the strengths and weaknesses of the PPACA. Our authors explore whether the PPACA will cause a long-term relief on the budget and taxpayers. Particularly, it reviews whether current estimates by the Congressional Budget Office present an accurate projection of the price of the legislation on the financial future of America.

We would like to thank Sara Zweig, our *Advance Directive* Senior Editor, Jonathon Brouk, our Editor-at-Large, and Christopher Carlson, our Technical Editor, for their invaluable contributions in launching this issue. We would like to specially thank our *Annals* Editor-in-Chief, Joseph Van Leer, for increasing access to *Advance Directive* via Westlaw. We are also grateful to our *Annals* Executive Board Members, Megan Stiarwalt, Drew McCormick, and Mallory Golas, for their editorial assistance. The Annals membership deserves particular recognition for writing timely, thoughtful articles and for editing the work for their peers. Finally, we extend our warmest appreciation to the Beazely Institute for Health Law & Policy and our faculty advisors, Professor Lawrence Singer, Professor John Blum, and Megan Bess for their continued support, encouragement, and mentorship. We hope you enjoy our Sixth Issue of *Advance Directive*.

Sincerely,

Leilani Ana-Maria Pino
Advance Directive Editor
Annals of Health Law
Loyola University Chicago School of Law

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There's No Place Like Home: Moving Towards Patient-Centered Medical Homes for Healthcare Reform

Alexandria A. Ottens

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

-Benjamin Disraeli

The Census Bureau revealed that more than 50 million people, approximately one in every six Americans, were uninsured in 2009.[1] Alarmingly, between the years 2008 and 2009, the percentage of uninsured individuals increased from 14.6 percent to 15.1 percent, meaning that 2.2 million more people were uninsured in 2009.[2] Many factors contributed to this decline of insured Americans, including jobs lost in the recession, companies no longer sustaining health insurance benefits for their employees, and the need for families to eliminate coverage in an effort to save money.[3]

The overwhelming increase in medical care costs precipitated the rise in the number of Americans without health insurance.[4] In 2009, employees paid 47 percent more than they did in 2005 for their family health coverage, while employers paid 20 percent more for family health coverage.[5] Individuals in low-income households were nearly three times as likely to be uninsured as those with incomes of $75,000 or more.[6] The Census Bureau's data reflects the pervasive healthcare problem Americans continue to face and

1. Richard Wolf, *Number of Uninsured Americans Rises to 50.7 Million*, USA TODAY (Sept. 17, 2010, 2:19 PM), http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm.
2. *Census Bureau Releases 2009 American Community Survey*, U.S. CENSUS BUREAU (Sept. 28, 2010), http://www.census.gov/newsroom/releases/archives/american_community_survey_acs/cb10-cn78.html.
3. Wolf, *supra* note 1.
4. *Id.*
5. *Id.*
6. *Id.*; *Income, Poverty and Health Insurance Coverage in the United States: 2009*, U.S. CENSUS BUREAU

highlights the very motivation for the passage and enactment of the PPACA of 2010.

I. INTRODUCTION

In response to the growing epidemic of uninsured Americans, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010.[7] The PPACA was designed to insure an additional 32 million individuals in both public and private programs.[8] Since its passage, the PPACA has been at the epicenter of contentious partisan debates.[9] To illustrate, the House of Representatives voted 245 to 189 in support of repealing the PPACA, led by the Republican majority opposed to its passage.[10] Despite the ongoing political clash with regard to the PPACA's passage, it has created a platform for serious discussions about how to remedy the healthcare crisis and ultimately create opportunities that would reach as many uninsured and insured Americans as possible.

One such proposed remedy that has garnered growing support is the Patient-Centered Medical Home (PCMH). The PCMH is a healthcare approach aimed towards "providing comprehensive primary care for children, youth, and adults."[11] Namely, it operates under the presumption that the patient's entire healthcare needs will be provided by the patient's individual physician.[12] This article will evaluate PCMHs as a viable solution for healthcare reform. Specifically, this article will: (1) explain how PCMHs relate to the PPACA; (2) explore the components and unique characteristics of PCMHs; (3) proffer reasons for their growing support; (4) assess the risks and concerns that members of varying communities have about PCMHs; and (5) show evidence that PCMHs can, in fact, operate successfully.

A healthcare system failing nearly one in six Americans is clearly an urgent matter.[13] With so many Americans struggling to afford their healthcare benefits in the current economic climate, it is no wonder that the community at large is currently engaging in

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(Sept. 16, 2010), http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html.

7. Wolf, *supra* note 1.

8. *Id.*

9. *See generally* David M. Herszenhorn & Robert Pear, *House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES (Jan. 19, 2011), http://www.nytimes.com/2011/01/20/health/policy/20cong.html.

10. *Id.*

11. *Joint Principles of the Patient Centered Medical Home*, PATIENT CENTERED PRIMARY CARE COLLABORATIVE (Feb. 2007), http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

12. *Id.*

13. Wolf, *supra* note 1.

discussions about how to remedy this problem. . .quickly.

A seemingly top contender, the PCMH, has received much attention after the passage of PPACA's Section 3502, which establishes community health teams to support the PCMH.[14] Significantly, PPACA provides $11 billion to support and expand community health centers over the next five years.[15] Section 3502 directs the Secretary of Health and Human Services to create a program that either provides grants or directly enters into contracts with "eligible entities" to establish health teams to provide primary care services.[16] These "eligible entities" are referred to as health teams in Section 3502 whose purpose will be "to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas" they serve.[17] Community health centers have existed for over 40 years, providing "comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay."[18] Throughout this time, community health centers have effectively become the PCMH for millions of Americans, including some of the country's most vulnerable populations.[19] The implementation of community health centers will, therefore, play a crucial role in testing the PPACA's overall success.[20]

II. WHAT ARE PCMHS?

The model home concept, while new in the wake of recent healthcare reform discussions, is actually not a novel idea.[21] In fact, the American Academy of Pediatrics (AAP) first introduced the term "medical home" in 1967.[22] The term, medical home,

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3502, 124 Stat. 119, 124 (2010) [hereinafter PPACA].

15. *Community Health Centers and the Affordable Care Act: Increasing Access to Affordable, Cost Effective, High Quality Care*, HEALTHCARE.GOV (last updated Aug. 6, 2010), http://www.healthcare.gov/news/factsheets/increasing_access_.html [hereinafter *Community Health Centers and the Affordable Care Act*].

16. PPACA, *supra* note 14.

17. *Id.* (noting that health teams are comprised of "community-based interdisciplinary, inter-professional teams").

18. *Community Health Centers and the Affordable Care Act*, *supra* note 15.

19. *Id.*

20. *Id.*

21. *Joint Principles of the Patient Centered Medical Home*, *supra* note 11.

22. *Id.*; ROBERT GRAHAM CENTER, THE PATIENT CENTERED MEDICAL HOME: HISTORY, SEVEN CORE FEATURES, EVIDENCE AND TRANSFORMATIONAL CHANGE (Nov. 2007), http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-medical-home.Par.0001.File.tmp/rgcmo-medical-home.pdf.

initially referred to a centralized location for archiving a child's medical record.[23] Since then, the AAP has expanded the medical home concept to include primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[24] In 2004, the Future of Family Medicine Project sought to expand the meaning of a medical home and promoted the idea that every American should have a personal medical home.[25] There are currently four primary care physician organizations that encourage the use of PCMHs: the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.[26] The practice of PCMHs has also been endorsed by many purchaser, labor and consumer organizations, including IBM, Merck and Company, the ERISA Industry Committee, and AARP.[27] In fact, major public and private health plans, including Medicare, United Health Care, Aetna, and certain Blue Cross and Blue Shield plans are testing PCMHs.[28]

PCMHs are defined by six characteristics which include: "(1) personal physician, (2) physician-directed medical practice, (3) whole-person orientation, (4) coordinated care, (5) quality and safety, and (6) enhanced access."[29] In the PCMH model, the personal physician's role is to ensure that his or her "patients have access to coordinated and managed care that is continuous, comprehensive, preventive, and evidence-based."[30] The PCMH model ensures that each patient is "assigned to a team of health care professionals who are responsible for that patient's ongoing care."[31] The personal physician directs and oversees the team, and specifically provides the patient with "acute, chronic, and preventive care."[32]

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23. *Joint Principles of the Patient Centered Medical Home*, *supra* note 11.
24. *Id.*
25. Gwendolyn Roberts Majette, *From Concierge Medicine To Patient-Centered Medical Homes: International Lessons & The Search For A Better Way To Deliver Primary Health Care In The U.S.*, 35 AM. J.L. & MED. 585, 593 (2009).
26. *Id.*
27. Robert A. Berenson et al., *A House Is Not A Home: Keeping Patients At The Center Of Practice Redesign*, 27 HEALTH AFF. 1219 (2008).
28. *Id.*
29. Majette, *supra* note 25, at 586.
30. *Id.*
31. *Id*. at 593.
32. *Id.*

III. PCMH MODEL BENEFITS

PCMHs offer myriad benefits, including improved coordination, broader access, and patient-centered care. In a 2005 survey, the Commonwealth Fund discovered that only thirty-six percent of primary care physicians systematically received patient survey data that would provide valuable feedback pertaining to patients' preferences, needs, and values.[33] The lack of communication between patient and physician is one of many reasons in support of adopting the PCMH model.

The core of the PCMH model is that it is patient-centered primary care. The PCMH model stresses the importance of primary care. Acknowledging that this kind of care is individualized for the patient, the patient is provided easier access to a physician who can offer a broad range of services.[34] This could potentially lead to greater success with respect to prevention and overall health.[35] Notably, patient-centered primary care is integral to a healthcare system that ensures that all of the patients have access to the kind of care that works for them.[36] The Picker Institute "has delineated eight dimensions of patient-centered care, including: (1) respect for the patient's values, preferences, and expressed needs; (2) information and education; (3) access to care; (4) emotional support to relieve fear and anxiety; (5) involvement of family and friends; (6) continuity and secure transition between health care settings; (7) physical comfort; and (8) coordination of care."[37] Much of what has been missing in our current system has been consistent and reliable communication and the PCMH is a direct response to that problem. In support, numerous studies have indicated that through a PCMH model, the overall healthcare costs are reduced.[38] Further, these studies simultaneously show that patients' overall care improves in situations where patients have continual access to preventative and maintenance care.[39]

Additionally, PCMH supporters contend that patients will benefit from integration and

33. Karen Davis et al., *A 2020 Vision of Patient-Centered Primary Care*, 20 J. GEN. INTERNAL MED. 953, 953 (Oct. 2005), http://onlinelibrary.wiley.com/doi/10.1111/j.1525-1497.2005.0178.x/pdf.

34. Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*, 7 ANNALS FAM. MED. 254, 259 (2009).

35. *Id.*

36. Davis et al., *supra* note 33, at 953.

37. *Id.*

38. JULIE E. KASS, ESQ. & JOSHUA J. FREEMIRE, ESQ., HEALTH L. HANDBOOK §3:16 (Alice G. Gosfield ed., 2009).

39. *Id.*

coordination of care.[40] Specifically, enhanced technology will create a system structured more efficiently.[41] By using enhanced technology, personal physicians anticipate that the integration of a patient's medical history, documentation, and testing will afford the physician more time to meet with his or her patients.[42] Care coordination would provide that specialist care providers communicate with primary care physicians to ensure that the patient receives prompt feedback so as to make appropriate and informed decisions regarding their care.[43] Essentially, this would require systems to be capable of monitoring whether recommended referrals actually occurred, ensuring that specialist consultation reports quickly reach the primary care physician, thus minimizing any delay in diagnosis and/or treatment.[44]

Another crucial characteristic and intended benefit of PCMHs is that patients would receive better access to care.[45] A more efficient and streamlined system, both with respect to infrastructure and general care provider coordination, would allow patients more flexibility in making appointments and generally having their primary care physicians readily accessible whenever needed.[46] Consequently, greater access would promote patient engagement in care.[47] Signs of patient engagement in care would include patients' receipt of information regarding their condition and subsequent treatment options.[48] Providing a system that encourages patients to participate in their care allows patients to have a greater chance for successful self-care.[49]

IV. RISKS AND CONCERNS REGARDING PCMH IMPLEMENTATION

While the PCMH model has garnered growing support as a powerful vehicle for healthcare reform efforts, it is a solution that concerns some healthcare professionals. The American Academy of Family Physicians commenced the National Demonstration Project (NDP) in 2006 to test the PCMH model.[50] After the NDP's conclusion in 2008,

40. *Id.*
41. *Id.*
42. *Id.*
43. Davis et al., *supra* note 33, at 954.
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. Nutting et al., *supra* note 34, at 254-55.

the independent evaluation team assessing the NDP's effectiveness in implementing the PCMH model reported several preliminary issues.[51] The team noted that there was a serious risk in underestimating the magnitude and time-frame that would be required to implement the required changes to reflect the PCMH model.[52] The team also raised concerns about the overestimation regarding the information technology sophistication necessary for successful implementation.[53] Further, the team was concerned with the severe undercapitalization to support and sustain PCMHs.[54] Raising these concerns early, the evaluation team aspired to caution the professional community against prematurely adopting unrealistic expectations surrounding PCMHs and their successful implementation.[55] Additionally, the goal in raising these concerns early was to avoid jeopardizing the evolution of the PCMH.[56]

As noted by the independent evaluation team for the NDP, becoming a PCMH requires transformation.[57] The changes that are required in adopting a PCMH model cannot occur incrementally, but instead, demand that participants wholly adopt an entirely new model of operation. Notably, "the NDP experience suggests that transformation to a PCMH requires a continuous, unrelenting process of change. It represents a fundamental reimagination and redesign of practice, replacing old patterns and processes with new ones."[58] As with any new venture, change from past practices and procedures takes time to successfully implement. Some fundamental changes required to successfully adopt the PCMH model would include:

> . . .new scheduling and access arrangements, new coordination arrangements with other parts of the health care system, group visits, new ways of bringing evidence to the point of care, quality improvement activities, institution of more point-of-care services, development of team-based care, changes in practice management, new strategies for patient engagement, and multiple new uses of information systems and technology.[59]

The team argues that each component cannot stand on its own, thus asserting that all of

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51. *Id.* at 255.
52. *Id.*
53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*

the abovementioned components of the PCMH model are interdependent.[60] Consequently, time becomes an important factor in the overall discussion surrounding PCMH adoption. The team opines that for legitimate PCMH implementation, everyone in the medical practice will have to be engaged in the process.[61] It is reasonable to expect that because of the need for mass PCMH support, it will inevitably take time before effective PCMH implementation can realistically be attained.

As part of the necessary transformation, PCMHs require more sophisticated technological programming than is currently in place. Some of the greatest weaknesses in implementing the PCMH model lie in the current absence of an infrastructure to support its ongoing existence.[62] Specifically, this means the systems currently used do not allow physicians to quickly document each patient's ongoing relationship with their primary care physician.[63] The system also fails to allow practitioners to document "that a personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."[64] Further, it is an impediment that the current system fails to allow physicians to document that "a personal physician is responsible for providing for all of the patient's health care needs or takes responsibility for appropriately arranging care with other qualified professionals."[65] Finally, the system as it exists today, does not document that the care a patient receives is coordinated and/or integrated in the context of the entire health care system and in the patient's community.[66] These current deficiencies are exactly what the independent evaluation team assessing the NDP noted: the lack of transformation when moving towards a PCMH model.[67] A medical home adhering to the core principles requires ". . .developing processes and systems (including IT) to support high levels of access and for communication with patients, coordination of patients' care within and outside the practice, capturing and using data for care of patients and populations and evaluation of

60. *Id.*
61. *Id.* at 258.
62. John C. Rogers, MD, MPH, MEd, Commentary, *The Patient-Centered Medical Home Movement – Promise and Peril for Family Medicine*, 21 J. AM. BD. FAM. MED. 370, 371 (2008).
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. Nutting et al., *supra* note 34, at 255.

performance, and support for evidence-based decision making."[68]

An additional concern regarding medical homes is the undercapitalization of the current model.[69] Fully integrating PCMHs requires a fundamental change in providing patient care and with this type of transformation in the system comes a cost. As mentioned above, information technology will play a vital role in the existence and sustainability of medical homes.[70] The cost of advanced health information and software technology concerns medical professionals.[71]

Despite genuine interest and commitment to incorporate PCMH standards into their practices, some physicians, namely solo and small group practices, may not have the ability to manage the recommended elements of a PCMH model.[72] One specific concern relates to the use of electronic medical records (EMR).[73] Although the use of an EMR is not an absolute requisite when adopting the PCMH model, many of the standards relating to PCMH implementation assume that practices have and will use an EMR.[74] The issue, though, is that patient costs of an EMR are higher for smaller practices than they are for larger practices.[75] Consequently, smaller practices may not be in a position to implement an EMR as their standard practice, thus potentially causing a barrier for smaller practices to satisfactorily fully adopt the PCMH model.[76] In fact, approximately thirty-three percent of physicians are in practices of one or two physicians, and approximately forty-two percent of physicians' groups are comprised of five or fewer, noting that there has only been a slight trend toward physicians joining larger groups.[77] An added concern for PCMH implementation is that by moving "so decisively to emphasize new responsibilities that implicitly assume reliance on various EMR functions [. . .], current PCMH recognition standards may leave behind crucial aspects of patient-centered care and the physicians who provide it."[78] Despite this concern, however, providers of Medicare and Medicaid could potentially benefit from the EHR incentives offered in the

68. Berenson et al., *supra* note 27, at 1227.
69. Nutting et al., *supra* note 34, at 255.
70. *Id.*
71. Berenson et al., *supra* note 27, at 1226.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*

HITECH Act.[79] By using the incentive payments allocated for satisfactory use of EHR technology, providers could potentially make progress towards a PCMH model.

An additional concern relates to the lack of a general consensus regarding the PCMH's objective.[80] Some advocates insist that the PCMH should focus on a commitment to formal shared patient-physician decision making.[81] Other advocates "see the medical home as better able to identify particular clinical areas that deserve greater attention, such as unexpressed depression or alcohol dependence."[82] Alternatively, others believe that the PCMH is an opportunity to address the need for greater attention to health literacy.[83] A further complication is that the role of hospitals in PCMHs has not yet been identified.[84]

Despite the various concerns related to mass acceptance and integration of the PCMH model, there are signs that such a model can work. Many fundamental characteristics of patient-centered primary care practices already exist in Denmark.[85] Each Danish primary care physician has an ongoing population of approximately 1,500 patients.[86] Danish primary care experts stress the importance of the ongoing relationship between patients and the primary care physicians because they opine that the contracts between them leads to better care as a result of both parties involved being aware of their rights and responsibilities.[87]

A primary care practice in Oregon, the Chehalem Medical Clinic, has implemented the medical home approach, whereby a team at the Clinic reviews patients' records before each visit to ensure that all necessary tests, immunizations and other preventive care is current.[88] Further, the Clinic staff communicates by secure e-mail and via phone in order

78. *Id.* at 1228.

79. Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 467 (2009) [hereinafter HITECH Act].

80. Berenson et al., *supra* note 27, at 1227.

81. *Id.*

82. *Id.*

83. *Id.*

84. AMERICAN HOSPITAL ASSOCIATION COMMITTEE ON RESEARCH, PATIENT-CENTERED MEDICAL HOME AHA RESEARCH SYNTHESIS REPORT 11 (Sept. 2008), http://www.hret.org/patientcentered/resources/patient-centered-medical-home.pdf.

85. Davis et al., *supra* note 33, at 955.

86. *Id.*

87. *Id.*

88. Joe Rojas-Burke, *'Medical Home' Strategy Aims to Boost Quality, Cut Costs with Better Primary Health Care*, OREGONLIVE.COM (Feb. 10, 2011, 11:26 AM), http://www.oregonlive.com/health/index.ssf/2011/02/medical_home_strategy_aims_to.html.

to ensure streamlined care.[89] The EMR tracks patients, which is particularly beneficial in situations where patients require multiple medications and follow-up care.[90] Other signs that Oregon is moving towards medical homes is that Kaiser Permanente, the largest managed care organization in the United States, "aims to convert all of its clinics in Oregon and southwest Washington to the medical home model" within the next year.[91] In addition to Kaiser Permanente's intended efforts, other leading PCMH advocates in Oregon "include the Oregon Primary Care Association and nonprofit health plan CareOregon, which helped [fifteen] community health centers and safety-net clinics across Oregon secure a grant from the Commonwealth Fund to establish medical homes."[92] Further, an Oregon House committee considered a bill which proposed that the committee would provide $400,000 to establish a PCMH research and training center at Oregon Health & Science University.[93]

V. CONCLUSION

The growing support for PCMHs arises from the need to implement a system that has greater accessibility to a wider population. With rising costs for healthcare and health insurance, the sense of urgency to find a solution to this impending problem becomes more prevalent the longer it is left unaddressed. Advocates of the PCMH model strongly assert that implementation would not only lead to a new healthcare identity, but would also combat the deficiencies in our current system. While advocates raise legitimate concerns pertaining to a sweeping adoption of the PCMH model, they still seem to trust that by carefully adhering to this model, by respecting the time it will take and the funding it will require, this model has the potential to sustain more than just a temporary existence. Perhaps, then, community health centers' continued and consistent success is appropriate indicia that PCMHs not only have the potential for similar national impact, but will, in fact, create a new healthcare identity for the U.S. that will have the greatest national reach thus far.

89. *Id.*
90. *Id.*
91. *Id.*
92. *Id.*
93. *Id.*

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Over Extended: The Role of the Independent Nurse Practitioner Practice in Addressing Problems with Affordability of U.S. Primary Care

*Daniel Marino**

I. INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[1] The Act contains many provisions intended to increase access to quality, affordable health care. With new regulations on pre-existing medical conditions, employer-provided medical benefits, and the expansion of Medicaid eligibility, it has been estimated that PPACA will effectively expand the provision of health insurance to an additional thirty-two million Americans by 2019.[2] It is difficult to argue with the altruistic intentions of the Act. Uninsured people are far more likely to forego necessary medical treatment because they simply cannot afford it.[3] What remains unclear, however, is how this new influx of potential patients will be funded.

The United States already spends more, per capita, on health care than any other country in the world.[4] Year after year, healthcare costs continue to increase at a rate far surpassing that of growth in national income.[5] In 2008, U.S. healthcare expenditures

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1. Pub. L. No. 111-148, § 1201, 124 Stat. 119 (2010).

2. John Geyman, *Will Health Care Reform 2010 Improve Access And Quality of Cancer Care?* PHYSICIANS NAT'L HEALTH PROGRAM OFFICIAL BLOG (Aug. 8, 2010), http://pnhp.org/blog/2010/08/08/will-health-care-reform-2010-improve-access-and-quality-of-cancer-care/.

3. HEALTH, UNITED STATES, 2009: WITH SPECIAL FEATURE ON MEDICAL TECHNOLOGY 69, (2010), http://www.cdc.gov/nchs/data/hus/hus09.pdf#080.

4. *Health Care Spending in the United States and OECD Countries*, KAISER FAMILY FOUNDATION (Jan. 2007), http://www.kff.org/insurance/snapshot/chcm010307oth.cfm.

5. *U.S. Health Care Costs*, KAISEREDU.ORG (Mar. 2010), http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#footnote1.

reached $2.3 trillion dollars, with physician and clinical services accounting for 21 percent of total costs.[6] A significant portion of these dollars were spent on primary care services. Not surprisingly, in 2006, a little more than half of all physician office visits were made to a primary care physician (PCP).[7] After all, "primary care deals with most health problems for most people most of the time."[8] Moreover, because PPACA emphasizes the importance of preventative care by making these services more affordable, the number of annual visits to PCPs can be expected to rise.[9]

Diminishing access to PCPs is adding to the skyrocketing cost of primary care services. Lack of access to primary care services has made emergency departments in local hospitals a main source of health care for an ever-growing number of Americans.[10] A 2006 survey by the Centers for Disease Control and Prevention "strongly suggest[s] that the growing use of emergency departments is directly related to [a] shortage of [PCPs]."[11] Nationally, there are just 88 PCPs per 100,000 people.[12] So, for those in need of primary care services, the wait to see a doctor can be thirty days or more.[13] The newly created Prevention and Public Health Fund will focus on increasing the number of PCPs.[14] However, more doctors, alone, may not be the best answer to more affordable care.

At least one scholar has suggested that the key to bending the cost curve for the provision of primary care services in America will largely include an increased reliance on lower-cost providers of care.[15] The nurse practitioner (NP) is one such provider.[16] "A

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6. *Id.*

7. *Ambulatory Care Use and Physician Visits*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 25 2010), http://www.cdc.gov/nchs/fastats/docvisit.htm.

8. Barbara Starfield, *The Primary Solution: Put doctors where they count*, BOS. REVIEW (Dec. 2005), http://bostonreview.net/BR30.6/starfield.php.

9. *Background: The Affordable Care Act's New Rules on Preventive Care*, HEALTHCARE.GOV (Jul. 14, 2010), http://www.healthcare.gov/law/about/provisions/services/background.html.

10. James Arvantes, *Emergency Room Visits Climb Amid Primary Care Shortages, Study Results Show*, AMERICAN ACADEMY OF FAMILY PHYSICIANS (Aug. 27, 2008), http://www.aafp.org/online/en/home/publications/news/news-now/health-of-the-public/20080827er-visits.html.

11. *Id.*

12. Ashley Halsey III, *Primary Care Doctor Shortage May Undermine Reform Efforts*, WASH. POST (Jun. 20, 2009), http://www.washingtonpost.com/wp-dyn/content/article/2009/06/19/AR2009061903583.html.

13. *Id.*

14. *Background: The Affordable Care Act's New Rules on Preventive Care, supra* note 9.

15. CLAYTON M. CHRISTENSEN ET AL., THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE 111-112 (McGraw Hill, 2009).

16. Unlike the Physician Assistant, or "PA," who is required to work under the supervision of a licensed physician in all fifty states, NPs already have independent provider status in eleven U.S. states. It seems

[NP] is a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses."[17] The NP works either independently or as a member of a healthcare team.[18]

Despite the growing prevalence of NPs, there remains a common uneasiness among our population about the provision of medical care by non-physicians. Many feel that NPs lack the proper training to justify increased roles as independent providers of primary care services.[19] This article will first provide a brief history of how doctors established themselves as the principal source of medical care for half a century, and the emergence of the NP as an important source of that care. Next, it will compare the NP's education, scope of practice, cost-effectiveness, and clinical efficacy to the PCP standard. This article will then explore ways in which the cost of delivering primary care services can be reduced through more widespread prevalence of independent NP practices, stressing the need for continued professional collaboration, a redefined role for the PCP, increased access to care, and more efficient regulation. Finally, this article will provide recommendations for future regulation intended to further shape the provision of primary care services while maximizing the nation's limited healthcare resources.

II. HISTORY OF PRIMARY CARE PHYSICIANS AND THE EMERGENCE OF NURSE PRACTIONERS

a. The Physician and the American Medical Association

Before physicians enjoyed the level of professional deference bestowed upon them by society, the practice of medicine was viewed more as common-sense and less as the scientific-based study that is associated with healthcare today.[20] Throughout the 19th century, citizens were free to provide healthcare services to the sick, regardless of whether the provision of those services was preceded by any amount of formalized

more likely that the NP will be considered, at least initially, as a more realistic choice for the role of lower-cost provider due to the regulatory inertia created by their demonstrated ability in these eleven states.

17. CAROLYN BUPPERT, NURSE PRACTITIONER'S BUSINESS PRACTICE AND LEGAL GUIDE 1 (1999).

18. *Id.*

19. Ginger Rough, *For Many, a nurse practitioner is The doctor*, ARIZ. REPUBLIC (Feb. 21, 2009), http://www.azcentral.com/news/articles/2009/02/21/20090221nursepractitioners0220.html (quoting Dr. Ted Epperly, then president of the American Academy of Family Physicians, "the [NP] replacing the family doctor is not good for America").

20. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 17 (1982).

training.[21] Even though the number of medical schools was increasing every year, little difference existed in the perceived expertise between those who received training and those who did not. This was due, at least in part, to the tremendous inconsistency in the quality of MD-granting institutions and the physicians that many fledging schools were producing.[22]

In 1846, a small group of physicians met in New York City to discuss the topic of medical educational reform.[23] The group would later become the leading organization in the medical profession, the American Medical Association (AMA).[24] The organization's agenda was clear. The AMA hoped to standardize medical education in an effort to confer superior authority on all who completed training from an accredited institution.[25] However, fierce competition for patients within the physician community, itself, limited AMA members' desire to work together.[26] Thus, the organization could not realize the collective strength it would need to attain the profound level of influence it was seeking.[27]

It was not until the late 19th century that competing physicians finally discovered something in which they could all believe: the need and importance of medical licensing.[28] Recognizing a strength in numbers, physicians from both well-respected medical schools and the less-respected commercial institutions teamed up to successfully lobby for statutes requiring medical licensing as a requisite to the legal practice of medicine.[29] However, establishing a statutory need for medical licensure was only half the battle. Because licensing requirements demanded little more than a medical diploma, without any ability to limit the number of institutions that could provide medical education, the amount of individuals who had access to the medical profession was virtually limitless.[30] As a result, the influence of the licensed physician, both

21. *Id.* at 47.
22. *Id.* at 116.
23. *Id.* at 90.
24. *Id.*
25. *Id.* at 91.
26. *See* STARR, *supra* note 20, at 92.
27. *See id.* at 93.
28. *Id.* at 102.
29. *Id.*
30. *Id.* at 116

professional and political, remained somewhat diluted.[31]

In 1910, the AMA teamed up with the Carnegie Foundation for the Advancement of Teaching, commissioning a young teacher named Abraham Flexner to individually assess every MD-granting institution in the country.[32] The Flexner Report, as it would later be known, revealed that most institutions were increasingly unable to keep pace with the advancements in medicine, which were being made in the areas of science and technology.[33] Public pressure following the Flexner Report forced a major reduction in the number of medical schools, and prompted the formation of state medical school accreditation boards which universally accepted Flexner's (and the AMA's) way of rating medical schools as authoritative.[34] Armed with new, standardized medical degrees which legitimized their professional authority, increased solidarity within their ranks, and the grant of a monopoly to practice medicine from the states, the cultural influence of physicians skyrocketed.[35] Furthermore, as decreased access to medical education limited the supply of doctors, the concentration of power embodied within the AMA made the organization a powerful political force with which to be reckoned.[36] Unfortunately, society would soon realize that doctors could be expected to behave in the same way as all pragmatic people in a capitalistic environment who seek to maximize profit. In 1920, biostatistician Raymond Pearl first demonstrated that the distribution of doctors throughout the U.S. was closely related to per capita income, leading Pearl to remark about doctors, "they do business where business is good and avoid places where it is bad."[37]

b. Emergence of the NP

The proliferation of the NP began in the 1960s, a decade that experienced shortages of physician-providers typical of the primary care profession today.[38] As physicians gravitated toward wealthier communities and higher-paying fields of specialization, the benefits of the NP's clinical and diagnostic abilities were considered particularly valuable

31. *Id.* at 102
32. STARR, *supra* note 20, at 118.
33. *Id.* at 120.
34. *Id.* at 120-21.
35. *Id*. at 15.
36. *See Id.*
37. *Id.* at 125.
38. BUPPERT, *supra* note 17, at 7.

in rural and underserved areas.[39] As the first NP educational programs began to pop up around the country, like physicians, NPs also lacked any standardized training program.[40] Following its creation in 1978, the National Council of State Boards of Nursing (NCSBN) defined the now-established minimum standard educational and licensure requirements for certification as a NP.[41] As a result, regulators began passing laws to shape NP licensure and scope of practice.[42] Despite any widespread ability to set up independent practice, and without a unified organization representing their interests, the number of NPs has steadily continued to increase to today's level of over 150,000 in the U.S. in 2009.[43]

As could be expected, the AMA vehemently protected its sovereign control over the practice of medicine. Physicians, in the name of public safety, objected to an expanded role of the NP so long as it involved activities outside the supervision of a licensed doctor.[44] So, though NPs, in general, possess both medical diagnosis and prescriptive privileges throughout the country, doctors have been successful in muddying the regulatory waters and clouding public perception[45] As a result, the NP's scope of practice varies significantly from state to state.[46] At one extreme, the NP can practice autonomously within a pre-defined scope of treatment; at the other, NP activities must always be within the supervision of a doctor.[47] Between these two extremes lies the question: do the disparities in education and clinical effectiveness of the PCP and the NP actually warrant the fragmented regulatory environment that currently prevents the NP from effectively filling an important societal and healthcare need?

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39. *Id.*

40. John Michael O'Brien, *How Nurse Practitioners Obtained Provider Status: A Lesson for Pharmacists,* 60 AM. J. HEALTH-SYS. PHARM. 2301-2307 (2003), *available at* MEDSCAPE (Dec. 17, 2003), http://www.medscape.com/viewarticle/464663_2.

41. *Id.*

42. BUPPERT, *supra* note 17, at 7.

43. Kaiser Family Found., *United States: Total Nurse Practitioners, 2009,* STATEHEALTHFACTS.ORG (Jan. 29, 2011), http://www.statehealthfacts.org/profileind.jsp?ind=773&cat=8&rgn=1.

44. O'Brien, *supra* note 40.

45. *See id.*

46. *Nurse Practitioner Scope of Practice*, AM. COLL. NURSING PRACTITIONERS, (Jan. 29, 2011) http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465.

47. *Id.*

III. A PROVIDER COMPARISON

a. Education

It should come as no surprise that physicians are among the most highly trained professionals. In addition to a four-year undergraduate degree, a PCP must obtain a four-year doctoral degree (M.D. or D.O.) and complete a three-year residency program.[48] The residency program is an opportunity for the inexperienced doctor to further hone medical judgment through continued hands-on, clinical training in the ambulatory, inpatient, and community setting.[49] Prior to being able to independently diagnose and treat patients, a PCP will have compiled over 15,000 hours of clinical experience.[50]

Of course, this process is no guarantee that the doctor will be able to practice medicine, at least in a legal sense. A PCP must be licensed by a state medical board.[51] In addition, licensed physicians are required to receive continuing medical education (CME); in some states, up to fifty hours of additional training per year are required.[52]

The NP also possesses a four-year undergraduate degree which is typically followed by state licensing as a registered nurse.[53] Next, the prospective NP will generally obtain a Masters of Science in Nursing (MSN) degree, also required by most states.[54] Hands-on, clinical experience is also a part of the NP curriculum. An NP will log between 500-1500 hours of clinical experience before meeting the licensure requirements of most states.[55] Likewise, licensed NPs are also required to receive continuing medical education. On average, NPs need fifteen hours of CME every year.[56]

Undergraduate studies being somewhat similar, an enormous disparity exists in the comparative cost between the education of PCPs and NPs. The total cost of tuition in 2009 to obtain a MSN for a NP specializing in family health averaged $16,624 and

48. PRIMARY CARE COALITION: TEX. ACAD. FAMILY PHYSICIANS, COMPARE THE EDUCATION GAPS BETWEEN PRIMARY CARE PHYSICIANS AND NURSE PRACTITIONERS, http://www.tafp.org/advocacy/resources/PCCIssueBriefScopeEdu.pdf (last visited Feb. 27, 2011) [hereinafter COMPARE THE EDUCATION GAPS],

49. *Training Requirements - 2010*, AM. ACAD. FAMILY PHYSICIANS, http://fmignet.aafp.org/online/fmig/index/family-medicine/training.html (last visited Feb. 27, 2011).

50. COMPARE THE EDUCATION GAPS, *supra* note 48.

51. *Id.*

52. *State Medical Licensure Requirements and Statistics*, AM. MED. ASS'N 54 (2010), http://www.ama-assn.org/ama1/pub/upload/mm/40/table16.pdf.

53. COMPARE THE EDUCATION GAPS, *supra* note 48.

54. *Id.*

55. *Id.*

$34,308 for resident and non-resident students attending public schools, respectively.[57] Standing in stark contrast to this figure is the annual tuition fees paid by a would-be PCP. According to a survey of average 2009 tuition costs of nearly all accredited medical schools, just one year of the MD program at a public medical school was $3,610 more than the tuition cost of a complete MSN education at a public university.[58] The total price for a PCP education, therefore, can be well into the six-figure range.[59] Most notably, as the average newly-licensed PCP seeks his or her first real paying job, they will be over $150,000 in educational debt which can take decades to pay off.[60]

b. Scope of Practice

Today, the majority of NPs provide primary care.[61] Nearly every medical dictionary, professional organization, and agency has attempted to define primary care. Although the many definitions vary to some degree, the words found most in common include "first-contact, continuous, comprehensive, and coordinated care."[62] Representing merely one level of healthcare, primary care is distinguished from secondary or tertiary care, which are commonly thought of as more consultative, shorter-term in nature, and available only as an option of last resort.[63] The PCP will consult with secondary and tertiary care providers to seek guidance regarding patients whose problems the PCP cannot definitively diagnose.[64] In fact, upwards of 85 percent of a given population will only require primary care services within a given year.[65] By implication then, the availability and efficient delivery of primary care services within any healthcare system is crucial.

At the apex of primary care services is the PCP. The PCP is responsible for a myriad

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56. BUPPERT, *supra* note 17, at 14.

57. AM. ACAD. NURSE PRACTITIONERS, NURSE PRACTITIONER MSN TUITION ANALYSIS: A COMPARISON WITH MEDICAL SCHOOL TUITION 1 (Jan. 2010), http://www.aanp.org/NR/rdonlyres/04789D96-F37C-4550-91BB-29E71BAEC57A/0/NursePractitionerMSNTuitionAnalysisAComparisonwithMedicalSchoolTuition.pdf.

58. *Id.* at 2.

59. *See id.*

60. *Medical Student Debt*, AM. MED. ASS'N (2009), http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt.shtml; *see also* Gail Morrison, *Mortgaging our Future- The Cost of Medical Education*, 352 NEW ENG. J. MED. 117, 117 (Jan. 13, 2005).

61. BUPPERT, *supra* note 17, at 7.

62. Barbara Starfield, *Is Primary Care Essential?*, 344 LANCET 1129 (1994).

63. *Id.*

64. *Id.*

of problems with which patients present. The health issues faced by the PCP are not limited to a single type, or restricted to a single organ system, and the PCP education will have trained the physician to manage a great number of these problems on his or her own.[66] The PCP is responsible for listening to patients, diagnosing illnesses, managing health-related problems, and screening for additional issues.[67] A large part of the PCP practice involves acting as patients' coordinator of care.[68] As the first contact, the PCP will often refer to other health professionals for further evaluation or treatment. For example, an endocrinologist might be consulted for greater specialization and expertise in the case of a patient whom the PCP has diagnosed as diabetic.[69] Even after referral to the specialist, the PCP shoulders the responsibility for ongoing follow up and continuing care of the patient, seeing to it that the delivered services are adequate.[70]

The NP also plays an important role in the delivery of primary care services. However, because the PCP's scope of practice was defined in general terms to include any phase of a patient's care, when NPs sought legal recognition to provide some primary services, they were seen as "claiming the ability to do tasks which were already included in the universal and implicitly exclusive authority of medicine."[71] As a result, the scope of the NP practice as dictated by local nurse-practice acts varies considerably from state to state.[72]

Eleven states, including Arizona, permit a NP to work independently without any physician involvement.[73] Some state laws allow NPs to set up their own practices, and work independent of physician supervision. NPs are only bound to seek collaboration with a physician when faced with a problem that exceeds their level of expertise.[74] Nevertheless, a majority of states limit the NP to working only in collaboration with a

65. *Id.*
66. COMM. ON THE FUTURE OF PRIMARY CARE, INST. OF MED., PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA 40 (Molla S. Donaldson et al. eds., Nat'l Acad. Press 1996).
67. *Id.*
68. *Id.*
69. *See id.* at 39.
70. *Id.* at 40.
71. NAT'L COUNCIL OF STATE BOARDS OF NURSING, CHANGES IN PROFESSIONS' SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS, 5 (2007), https://www.ncsbn.org/ScopeofPractice.pdf.
72. SHARON CHRISTIAN ET AL., OVERVIEW OF NURSE PRACTITIONER SCOPES OF PRACTICE IN THE UNITED STATES- DISCUSSION 6 (2007), http://www.acnpweb.org/files/public/UCSF_Discussion_2007.pdf.
73. *Id.*
74. Ariz. Rev. Stat. § 32-1601(15)(a)-(viii) (2010).

licensed physician.[75] For instance, in Missouri anytime a NP sees a new patient, the patient is required to be seen by a physician within two weeks of the NP visit.[76] Elsewhere, NPs are prohibited from ordering certain lab tests and prescribing physical therapy, or are required to have physicians co-sign patient charts.[77] Licensed NPs in each of the fifty states generally have some prescriptive rights, although these rights also vary between jurisdictions.[78]

Because more often than not the NP is limited to practicing under varying degrees of direct supervision by a licensed PCP, the most common role of the primary care NP is that of the "physician extender."[79] As the term implies, the NP is hired by the PCP practice to lighten the load of the PCP who is increasingly burdened with high patient volumes resulting from shrinking reimbursement.[80] The NP provides direct patient care, which can include examination and review of histories, as well as coordination of care, patient education, counseling, and prevention awareness.[81]

c. Cost effectiveness

Physician extenders are considered more than mere assistants to the PCP. At just one-third of the starting salary of a new PCP and substantially lower insurance premiums, a NP could be expected to generate three to four times their expense in revenues.[82] Moreover, this relationship can be exploited to increase the bottom line of the physician-employer's practice by freeing up time to see more patients per week.[83]

Other business models are also catching on to the cost-effectiveness of NP care. Retail medical clinics, like MinuteClinic, utilize NPs to deliver convenient, quality, affordable care to patients with common medical conditions. Typical clientele of retail clinics are seeking alternatives to PCPs, urgent care centers, and hospital emergency rooms.[84] MinuteClinic can quickly accommodate patients with illnesses ranging from coughs and

75. CHRISTIAN ET AL., *supra* note 72, at 6.
76. Nancy Rudner Lugo et al., *Ranking State NP Regulation: Practice Environment and Consumer Healthcare Choice*, 11 AM. J. NURSE PRACTITIONERS 8, 17 (April 2007).
77. *Id.*
78. CHRISTIAN ET AL., *supra* note 72, at 7.
79. Susan F. Dubow, *Adding a Physician Extender*, PHYSICIAN'S NEWS DIGEST (Jun. 1997), http://www.physiciansnews.com/business/697dubow.html.
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.*

sore throats to ear, sinus, and bladder infections.[85] Although patients cannot receive the full spectrum of care they might receive at their PCP's office, the scope of care offered at MinuteClinic represents 17 percent of all visits to the PCP.[86] Even more impressive, the costs of managing what amounts to almost eighty million visits to PCPs each year are between 32% to 47% lower when administered by a NP in the retail clinic setting.[87]

As independent clinicians, NPs are cost effective as well. Consider how healthcare providers are reimbursed for services provided in a given patient interaction. Current Procedural Terminology (CPT) is a set of codes that is maintained by the AMA which provides payers with an accurate description of medical and diagnostic services provided to the patient.[88] For example, if the evaluation of a new patient took twenty minutes, a provider would submit a charge to an insurance company for code 99202.[89] In Arizona, the non-hospital based PCP would receive reimbursement of around $68.00.[90] This figure represents a Medicare reimbursement rate, thus a private insurer will usually pay the provider more for the same service. Although the gap continues to narrow, many NPs are reimbursed at a rate of just 60% to 85% of the physician rate.[91]

d. Clinical effectiveness

NPs have been shown to be more than just cost-effective care providers. The clinical effectiveness of the NP has also been demonstrated on several fronts. In response to a request from the Senate Committee on Appropriations, the Office of Technology Assessment (OTA) undertook an extensive review of ten studies that compared the quality of care delivered by an NP and a PCP.[92] The OTA analysis concluded that the provision of care by a NP is as good as, and in some cases better than, care provided by a

84. MINUTECLINIC, http://www.minuteclinic.com (last visited Dec. 5, 2010).
85. *Id.*
86. CHRISTENSEN ET AL., *supra* note 15, at 119.
87. *Id.*
88. *About CPT*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.shtml (last visited Jan. 29, 2011).
89. *CPT Code Search*, AM. MED. ASS'N, https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (select Arizona in the State dropdown menu, select Arizona in the City dropdown menu, enter five digit CPT code 99202).
90. *Id.*
91. Rough, *supra* note 19.
92. OFFICE OF TECH. ASSESSMENT, UNITED STATES CONG., *Case study #37*, *in*, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 3 (Dec. 1986), http://www.fas.org/ota/reports/8615.pdf [hereinafter OTA].

PCP.[93] The review found that NPs cared for acutely ill patients as well as their PCP counterparts, finding no differences in their competence to prescribe medications or the functional outcomes of their patients.[94] Remarkably, the OTA did conclude that "NPs appear to have better communication, counseling, and interviewing skills than physicians," which investigators attributed to the NP's superior ability to listen to patients, as well as convey instructions regarding the plan of care.[95]

More recently, in 2000 JAMA published a study by Mundinger and colleagues, comparing primary care outcomes in patients treated by NPs or PCPs.[96] Although previous studies had demonstrated the quality of care provided by the NP to be equivalent to that of the PCP, this study was controlled and randomized in an environment where NP responsibilities, authority, and patient types were equal to the PCP.[97] Outcomes were measured by several parameters, including initial visit satisfaction, patient health status, long-term satisfaction, and services utilization within one year of the initial visit.[98] Enrollees presented with various primary care health issues, including diabetes, hypertension, and asthma.[99] Investigators found no significant differences between patients treated by a NP and patients treated by a PCP.[100]

III. BENDING THE COST CURVE

a. Collaboration vs. Competition

The way to increase affordability of primary care medical services is to increase the ability of the NP to provide independent and autonomous care. NPs are, in many cases, more economical than their PCP colleagues, and have demonstrated the ability to be effective providers of care. Despite these benefits, NPs are exceedingly limited from providing an even greater benefit to the U.S. healthcare system.

One reason is that NPs are embroiled in an unnecessary turf war with the AMA and its

93. *Id.* at 19.
94. *Id.*
95. *Id.*
96. Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 59 (2000).
97. *See, e.g.*, W. Spitzer et al., *The Burlington Randomized Trial of the Nurse Practitioner*, 290 NEW ENG. J. MED. 251 (1974).
98. Mundinger et al., *supra* note 96, at 61.
99. *Id.* at 60.
100. *Id*. at 62-66.

PCP members. It seems clear that the AMA is ardently trying to prevent NPs from infringing upon the economic interests of physicians and is using its political clout to achieve this goal. The organization made this clear in a 2006 resolution wherein the AMA explicitly opposed the independent practice of medicine by NPs and any other non-physician.[101] Of course, doctors always contend that their vocal support for restricting non-physician providers like NPs from treating patients outside the supervision of a licensed physician is only out of concern for public safety. Is this really the case?

After all, lawmakers and doctors, alike, seem to have little concern over allowing NPs to treat patients who, residing in impoverished and underserved areas, were victimized by physician maldistribution.[102] It is only when considered outside of the low-income, self-pay communities, that increased authority and autonomy of the NP suddenly becomes "[bad] for America."[103] Perhaps this is the force behind the fragmented regulations that, in thirty-nine states, keep NPs from being able to set up an independent practice.

Considering the cost of becoming a PCP, it is no wonder physicians are so intent on maintaining their monopoly over the practice of medicine. Unfortunately, the principles upon which that monopoly was granted are broken and outdated. No longer should the responsibility for repayment of medical education rest on the backs of the health care-requiring public. It is in this context that the PCP's true objections to increased autonomy for the NP come to light.

In an editorial published in JAMA, Dr. Harold Sox concedes that greater competition between NPs and PCPs can lead to a greater standard of care.[104] It is his next comment with which health care consumers should take exception. "That outcome is good for society," Sox continued, "but it comes at a very high price for the individuals who have invested time and money in becoming health professionals and who are not busy enough to sustain their skills and earn a reasonable living."[105] With healthcare spending spiraling out of control, should the interests of health professionals be held superior to those of society?

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101. *See e.g.*, RESOLUTION: 904 (I-06), AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES, *available at* http://www.acnpweb.org/files/public/AMA_Resolution_904_11_06.pdf.

102. OTA, *supra* note 92, at 3.

103. Rough, *supra* note 19.

104. Harold C. Sox, *Independent Primary Care Practice by Nurse Practitioners*, 283 JAMA 106, 107 (2000).

105. *Id.*

Contrary to Sox's implication, while the earning of a medical degree and license does grant one a right to be a doctor, it does not guarantee the right to earn a comfortable living. Sox may be correct in his contention that new regulations granting the NP more autonomy to treat common ailments historically reserved for physicians may reduce demand somewhat for PCPs. More accurately, as one of Sox's physician-colleagues correctly points out in her letter to the editor, "the public- as patients and taxpayers- is under no obligation to support whatever number of physicians is produced."[106]

There will always be an important role for the PCP in U.S. healthcare. Dr. Sox's comment incorrectly implies that allowing NPs to set up independent practices might eventually render the PCP obsolete. In fact, even with greater NP autonomy, PCPs will still play a prominent role in the provision of primary care services.

b. New Roles for Providers of Primary Care

i. The NP

Let us assume that NP independent practices will offer identical services to those provided at MinuteClinic. Ten common issues currently account for 90 percent of the patient visits to these clinics: upper respiratory infection, sinusitis, bronchitis, pharyngitis, need for immunization, middle-ear infection, outer-ear infection, conjunctivitis, urinary tract infection, and blood pressure or screening lab tests.[107] Despite their high percentage of total volume to MinuteClinic, the combined total of these types of patient ailments account for only 18 percent of visits to *physicians'* offices.[108] So, one can hardly argue that there will no longer be a need for the PCP.

The question here is not whether a NP is as qualified to practice medicine as the PCP. The answer, simply put, is that the NP is not. The real question is whether the PCP is overqualified to provide certain primary care services. Flexner remarked, in his historic report on medical education that "the training of the doctor is therefore more complex and more directly momentous than that of the technician."[109] While that may still be true today, the fact remains, modern technology has transformed the diagnosis and treatment

106. Caroline M. Poplin MD, JD, *Health Outcomes Among Patients Treated by Nurse Practitioners or Physicians*, 283 JAMA 2521, 2523 (2000).
107. CHRISTENSEN ET AL., *supra* note 15, at 120.
108. *Id.*
109. *Id.* at 354.

of many common illnesses into a technical endeavor as opposed to an artful one. Better diagnostic equipment, established evidence-based treatment protocols, and safe, effective pharmacotherapies have changed the way we approach certain illnesses. The identification and treatment of diseases like strep throat, ear infections, and bronchitis is essentially rules-based, and no longer requires significant expertise. As such, it is hard to argue that the PCP is somehow uniquely qualified to prescribe an antibiotic, administer a vaccination, or perform the many ministerial duties of the care coordinator.

Naturally, skeptics will argue that, once given the opportunity to treat patients independently from physician supervision, NPs will push the limits of their knowledge, placing patients in serious danger. However, like their PCP counterparts, NPs can be expected to ethically refer patients to more experienced specialists when a problem is outside their individual scope of expertise. Collaboration between healthcare professionals should always be the standard of the industry.

ii. The PCP

In reality, many diseases remain in the domain of intuitive medicine. That is to say, neither a diagnostic tool, nor established evidence-based rules exist to definitively diagnose and treat most illnesses. This represents the other 82% of primary care office visits, and should remain the dominion of the PCP. In focusing on treating the sickest patients needing primary care services, PCPs will be utilizing the full extent of their expertise. One could envision a situation where PCPs actually performed more like sub-specialists, relinquishing control over the less serious 18% of their practices, and remanding patients back to NPs for effective, less expensive care-coordination services. This scenario is not without precedent. Advances in new therapies have allowed PCPs to effectively treat conditions like allergies, hypertension, depression, conditions that were once far more commonly treated by a specialist. Plus, "as Internet-based decision tools bring the diagnostic capabilities of the world's best specialists in to the offices of [PCPs]"[110], greater numbers of these providers may still be required.

Of course, as technology continues to improve and more rules-based protocols for disease treatment are developed, PCPs will gain ever more patients that were once reserved for their specialist colleagues. All things considered equal, so long as a service

110. *Id.*

can be provided in a quality manner, it is in the best long-term financial interest of the system to encourage the provision of that service by the most economical provider wherever possible. Finding ways to reduce expenditures on routine and ordinary provisions of primary care will free up more economic resources that can be shifted toward the underserved and the higher risk members of our society.

c. Meeting the Demand for Primary Care

Sox's fear of decreased demand for the PCP fails to take into account another critical issue. The nation is experiencing a shortage of PCPs. The American Academy of Family Physicians predicts that the U.S. will need about 40,000 more PCPs in the next ten years.[111] Meanwhile, the Association of American Medical Colleges predicts this shortage to increase to a staggering 124,400 physicians by 2025.[112]

The reason so many newly-minted doctors are extending their residencies and seeking certification as specialists is simple. PCPs are reimbursed far less for evaluation and management of patients than for other services, like surgical procedures. This is the case even though the surgical procedure may be performed in less time than the in-office consultation. For example, while the PCP or Orthopedic surgeon (ORS) would be paid similar figures for the twenty-minute new patient office visit (around $68.00 as previously discussed), the ORS might receive as much as $1,100 for ninety minute surgical procedure; the PCP would need to see seventeen patients to earn that amount.[113]

The dwindling numbers of PCPs and the perceived inadequacy of reimbursement for their services are having a devastating financial impact on U.S. healthcare expenditures. Though praised as one of the most cost effective providers of healthcare in the country, The Mayo Clinic went so far as to stop accepting Medicare patients in its Glendale, Arizona primary care satellite clinic early in 2010.[114] Doctors, at an alarming rate, generally agree that it just does not make business sense to treat public pay patients.[115] Of the physicians that continue to see Medicare patients, some resort to a gaming of the

111. Halsey III, *supra* note 12.
112. *Id.*
113. James Rickert, *Primary Care-Lifelines and Shortages*, 361 NEW ENG. J. MED. 1413,1413 (2009).
114. David Olmos, *Mayo Clinic in Arizona to Stop Treating Some Medicare Patients*, BLOOMBERG (Dec. 31, 2009), http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0.
115. *Id.*

system; manipulating CPT codes to increase reimbursement for the same encounters.[116]

Consequently, many patients, Medicare and Medicaid patients in particular, are left without sufficient access to primary care services. Left with few options, more and more of these patients are turning to the hospital emergency room (ER) for basic care.[117] In fact, an analysis of ER utilization in New York State, determined that a PCP could have appropriately handled nearly half of all ER visits in 2009.[118] The difference in the cost for treating the same condition in an office, as opposed to a hospital, setting can be astronomical. It is estimated that had individuals who sought non-emergency treatment in an ER visited a PCP instead, patients and their insurance companies would have saved up to 90 percent of their expenditures.[119] Unfortunately, the dearth of available providers leaves many of these patients with little choice.

Some believe the answer to the shortage of PCPs is higher reimbursement rates for many of the services performed. These proponents of reimbursement equality argue that PCPs' services should be valued as much as the services provided by their specialist counterparts.[120] While this might provide an incentive for greater numbers of medical students to pursue primary care careers, the unfortunate reality for patients and taxpayers is higher reimbursement for the same services will only lead to even higher costs for health care, and even less access to this essential care.

i. Strength in Numbers

A better solution is to grant legal authority to the nearly 150,000 NPs in America to provide primary care services themselves. As previously mentioned, NP driven centers of care, like MinuteClinic, can provide billions in savings on insurance reimbursements and out-of pocket expenditures.[121] This may just be the beginning. Consider the differing financial incentives of the NP and PCP. Fair or not, it is increasingly clear that the licensed physician is unwilling to incur an enormous medical school debt obligation

116. *See, e.g.*, MEDICAL CODING CASH SECRETS, http://medicalcodingcashsecrets.com/ (last visited Dec. 4, 2010).

117. STEPHEN R. PITTS, MD ET AL., NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 2006 EMERGENCY DEPARTMENT SUMMARY, 3 NATIONAL HEALTH STATISTICS REPORTS (Number 7, 2008).

118. Josh Green, MD, *Potential Savings Through Reduction of Inappropriate ER Utilization in Hawaii*, HAWAII IPA (2010), http://hawaiiipa.com/media/Document_41.pdf.

119. *Id.*

120. *Id.*

121. CHRISTENSEN ET AL, supra note 15, at 120.

for what he perceives to be inadequate reimbursement of his time and service.

In contrast to the PCP, the NP historically has operated with much lower overhead. First, the NP has less educational debt with which to contend. Second, NPs generally earn a fraction of the salary that is paid to a PCP performing the same services. As a result, the NP is much more willing to take on Medicare and Medicaid patients, and can even provide self-pay patients the quality care they deserve at a price they are more likely able to afford. CMS recognizes this important resource and willingly reimburses the NP for services rendered, albeit at 85 percent of the physician level.[122] Still, this at least establishes the NP as a distinct provider of care in the eyes of the country's most influential payer. The more PCPs refuse to see public pay patients, the sooner CMS may be willing to reconsider its reimbursement levels of non-physician providers who will.

Moreover, in November 2010, a commercial insurer serving Maryland, Northern Virginia, and our nation's capital announced it will, for the first time, allow NPs to participate as "independent primary care providers in its network."[123] Additional sources of primary care services translates into fewer patients utilizing our nation's ERs, not to mention restored access to care for Medicare and Medicaid patients. Thus, NP services, in many instances, represent the most efficient use of our limited financial resources.

d. Loosening the Regulatory Reigns

Less regulation could lead to significant savings by eliminating needless oversight and duplication of efforts. In states like Missouri, where visits to an NP must be followed by a visit to a PCP, patients cannot benefit from access to a lower-cost provider of care. Instead, if a patient makes a cost-effective decision to see a NP, they are promptly faced with the additional cost of seeing a PCP, not including the potential hidden costs of travel, or time away from work or family. Elsewhere, in states where NPs are prohibited from ordering basic services, or obligated to have a physician co-sign their charts, costs are certain to rise as a result of requiring two trained professionals to do the job of one. For some reason, performing in the role of the physician extender remains acceptable; possibly because, as a physician extender, the NP continues to serve the economic

122. *Reimbursement Issues*, ILLINOIS SOCIETY FOR ADVANCED PRACTICE NURSING, (Feb. 16, 2011) http://www.isapn.org/?page=ReimbursementIssues.

123. Chris Huntemann, *Insurer Expands Primary Provider Status to Nurses*, MARYLAND COMMUNITY NEWSPAPERS ONLINE (Nov. 6, 2010), http://www.gazette.net/stories/11062010/businew85600_32552.php.

interests of physicians.

IV. FUTURE CONSIDERATIONS

Admittedly, any change in the level of independence under which the NP may operate will require the necessary regulatory background in order to have a significant effect. State legislative bodies possess the power to amend their respective Medical Practice Acts, and should take action to enhance the availability and effectiveness of primary care in this country. That is not to say that less regulation of the healthcare industry is required. Instead, lawmakers should carefully consider whether the current regulations limiting the ability of the NP to practice independently actually protect public safety, or simply further physician interests.

Regulations that are "barriers serve no useful purpose and contribute to our healthcare problems by preventing the full deployment of competent and cost effective providers who can meet the needs of a substantial number of consumers."[124] Requiring the NP to work under the supervision of a physician limits patients' access to providers and precludes capable caregivers from stepping up to address the growing shortage of PCPs. States that enforce such regulations do so despite overwhelming clinical evidence of NP competency and limited patient choice. In redefining the scope of practice of the NP, regulators will have the data that exists regarding the clinical effectiveness of NPs' diagnosis and treatment abilities that have been compiled to date. Regulations should limit the NP to practicing only within areas where competence has been clearly demonstrated, and mandate consultation with physician-providers when the NP is faced with a situation beyond their expertise. In short, NPs should continue working in the capacity that they currently serve, except with the ability to do so independently.

In addition, Medical Practice Acts should require NP governing bodies to develop one uniform educational and licensing program so that the public can feel confident in the requisite training and expertise of new providers. The standardization of MD-granting institutions resulting from the Flexner report has served both physicians and the American public well, and should operate as the basis upon which to produce consistently qualified and well-trained NPs.

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124. Lugo et al., *supra* note 76 at 9 (quoting B. Safriet, *Impediments to Progress in Health Care Workforce Policy: License and Practice Laws,* 31 INQUIRY 310 (1994)).

Above all, patient safety should be protected. Standardized measures should be developed for identifying and de-credentialing unscrupulous and unethical practitioners. Inherent in this goal is the concept that knowledgeable providers will refer to other providers when confronted with matters beyond his or her capabilities, or when specialty care is necessary for the patient.

V. CONCLUSION

Primary care has been called the "backbone of a rational health services system."[125] In fact, in the U.S., analysis has found a positive correlation between the availability of primary care services with health levels.[126] With national numbers totaling over 150,000 strong, NPs are the optimal solution to lowering the cost of receiving primary care services, and can exponentially increase public access to those services.

NPs have consistently demonstrated the ability to provide quality health care in a cost efficient manner. Unfortunately, when limited to working strictly under the supervision of a licensed physician, any realized benefits of lower cost of care either inure directly to the physician or are eviscerated by unneeded oversight. Either way, it is the practice that benefits and not the public.

As autonomous, independent providers of care, NPs could disperse throughout states providing additional centers of care. NPs are a trusted source of patient management within PCP offices now, and there is no reason to believe that they could not provide the same services on their own.

Health care is evolving, and as such, the delivery of health care must as well. Regulations and predispositions about who is qualified to deliver that care should be reexamined so that the needs of a changing population can be adequately served. Demographic changes, like the aging of the population and the addition of thirty-two million for whom insurance must be funded, have the potential to stretch the U.S. healthcare human and economic resources beyond their limits. Fortunately, advances in technology and evidence-based healthcare procedures have created an opportunity for a new business model of health care delivery- the independent NP practice.

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125. Starfield, *supra* note 62.
126. L. Shi, *Primary Care, Specialty Care, and Life Chances,* 24(3) INTERNAT'L J.HEALTH SERVICES

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Health Information Technology: Building the Foundation for the Reconstruction of Health Care Delivery

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) aims at increasing access to health care, while simultaneously improving the quality of care delivered and decreasing the costs of acquiring needed care.[1] Notably, the most significant provision of PPACA is the individual mandate, which requires United States citizens and legal residents to have health care coverage.[2] Those who do not purchase qualifying health coverage are assessed a tax penalty of the greater of $695 per year up to a maximum of three times that amount or 2.5 percent of household income.[3] The penalty will be phased-in until 2016, at which point the penalty will be annually adjusted to reflect the cost-of-living.[4] The mandate represents an attempt to significantly expand access to health care services for most Americans, however without the technological infrastructure to sustain such a marked expansion, fundamental changes in access to health care will not be possible.[5]

Expanding access to health care necessarily involves the increase of health information technology.[6] Health information technology (health IT) refers to the exchange of health

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1. CONGRESSIONAL RESEARCH SERVICE, *PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, at 1 (March 2, 2011).
2. KAISER FAMILY FOUNDATION, FOCUS ON HEALTH REFORM: SUMMARY OF NEW HEALTH REFORM LAW (March 26, 2010), http://www.kff.org/healthreform/upload/8061.pdf.
3. *Id*.
4. *Id*.
5. Melinda Beeuwkes Buntin et al., *Health Information Technology: Laying The Infrastructure For National Health Reform*, 29 HEALTH AFFAIRS 6, 1214, 1214 (2010).
6. *Id*.

information in an electronic environment.[7] As more health information is exchanged, proper and expedient processing and utilization of that information becomes essential.[8] Appropriate usage of health IT most notably requires that the privacy and security of such information be ensured.[9] Recognizing the importance of health IT to an expanding health care delivery system, PPACA incentivizes the increase of health IT infrastructure and its usage in the delivery of quality health care.[10] Specifically, PPACA provides funding from the American Recovery and Reinvestment Act of 2009 to accelerate the investment in and adoption of health IT, thereby simplifying administrative procedures and promoting efforts to develop and maintain quality of care measures.[11] Although idealistically, implementation of widespread health IT will make health care delivery more effective, there are significant roadblocks to such adoption.[12] These include costs,[13] disagreement as to methodology, and concerns about the complexities of appropriate installation and maintenance.[14] While these misgivings have merit, successful reconstruction of the existing health care delivery system necessitates a developed health IT infrastructure that does not exist today.[15]

II. PROVISIONS UNDER PPACA RELATED TO THE USE OF HEALTH IT

The utilization of health IT, such as electronic health records, is an extensive theme contained in PPACA.[16] While new initiatives focused exclusively on health IT are altogether absent from the legislation, PPACA itself contains more than forty references to the term "health information technology."[17]

The most significant provision under PPACA relating to health IT requires the

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7. U.S. DEP'T OF HEALTH & HUMAN SERVICES, *Health Information Technology*, http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/ (last visited Feb. 19, 2011).

8. Buntin et al., *supra* note 5, at 1216.

9. U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 7.

10. Buntin et al., *supra* note 5, at 1215.

11. Kurt Herzer and Meena Seshamani, *A Success Story in American Health Care: Using Health Information Technology to Improve Patient Care in a Community Health Center in Washington*, at 2-3 (last visited Feb. 18, 2011), HEALTHREFORM.GOV.

12. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *Health Information Technology: Federal Agencies' Experiences Demonstrate Challenges to Successful Implementation*, at 1 (Jan. 15, 2009).

13. David Blumenthal, *Perspectives on Health Reform*, 1230 COMMONWEALTH FUND 2, at 2 (Jan. 2009).

14. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *supra* note 12, at 1.

15. Blumenthal, *supra* note 13, at 5.

16. FOLEY & LARDNER LLP, LEGAL NEWS *ALERT* – PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, at 1 (May 2010) [hereinafter PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY].

17. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.

Secretary of the United States Department of Health and Human Services (HHS) to integrate the reporting mechanisms for the Physician Quality Reporting Initiative (PQRI) with the electronic health record "meaningful use" incentives established by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009.[18] In other words, PPACA will tie electronic health record (EHR) adoption and quality reporting together with incentives for both.[19] This provision is one of the most significant of PPACA with regard to health IT and electronic health records (EHRs).[20] Specifically, the Secretary must create a plan that will integrate reporting on quality measures pertaining to the meaningful use of EHRs under both PQRI reporting requirements and HITECH Act provisions.[21]

Furthermore, PPACA requires that the Secretary of HHS identify gaps where quality measures do not exist or are lacking and need improvement.[22] A quality measure is defined

as a standard for measuring the performance and improvement of population health or of

health plans, providers of services, and other clinicians in the delivery of health care services.[23] In an effort to incentivize the adoption and incorporation of appropriate quality measures, the Secretary is permitted to award grants and contracts to public and private entities so that they might develop quality measures or work on improving existing ones.[24]

Administrative simplification represents another effort under PPACA that incorporates the use of health IT.[25] Under Sections 1104,[26] 10109,[27] and 3021[28] of PPACA, some key

18. Pub. L. No. 111-148, § 3002, 124 Stat. 119, 365; FOLEY & LARDNER LLP, LEGAL NEWS *ALERT* – PPACA WILL DRIVE QUALITY HEALTH CARE REFORM, at 2 (May 2010) [hereinafter PPACA WILL DRIVE QUALITY HEALTH CARE REFORM].

19. Chad Mather et al., *Penalties coming under PPACA, PQRI*, AAOS NOW (Jan. 2011), http://www.aaos.org/news/aaosnow/jan11/advocacy2.asp.

20. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.

21. *Id.*; Mather et al., *supra* note 19.

22. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.

23. *Id.*

24. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.

25. *Id.*

26. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 1104, 124 Stat. 119, 147.

27. Pub. L. No. 111-148, § 10109, 124 Stat. 119, 915-17.

elements of Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions are amended and expanded.[29] PPACA first amends Section 1173 of the Social Security Act (SSA).[30] Sections 1171 through 1179 of the SSA, HIPAA's Administrative Simplification provisions, were created to encourage the growth of electronic record keeping and claims processing within the nation's health care system.[31] These provisions require the Secretary of HHS to adopt electronic format and data standards for nine specified administrative and financial transactions between health care providers and health plans, including patient eligibility inquiries and reimbursement claims.[32] Section 1173 of the SSA, as amended by Section 1104 of PPACA, establishes a timeline for the development, adoption and implementation of a single set of operating rules for each of the nine specified transactions.[33] The set of operating rules shall be adopted no later than July 1, 2011, in a manner that such rules become effective no later than January 1, 2013.[34] Further, the standards and associated operating rules must meet the following requirements: 1) enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care, 2) be comprehensive, and 3) provide for timely acknowledgment, response, and status reporting that support a transparent claims and denial management process.[35] PPACA also amends SSA Section 1173 to require the Secretary to regularly solicit input from the National Committee on Vital and Health Statistics (NCVHS), the Health Information Technology Policy and Standards Committees, and other stakeholders regarding whether standards and operating rules should be developed for other administrative and financial transactions.[36] Finally, PPACA adds a new Public Health Service Act (PHSA), Title XXX, Subtitle C, comprising Section 3021, which requires the Secretary to develop standards that facilitate enrollment of individuals in federal and state health and human

28. Pub. L. No. 111-148, § 3021, 124 Stat. 119, 262-63.
29. ERIN D. WILLIAMS & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., PUBLIC HEALTH, WORKFORCE QUALITY AND RELATED PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 80-82 (June 7, 2010).
30. *Id.* at 81.
31. *Id.* at 80.
32. *Id.*
33. *Id.* at 81.; Pub. L. No. 111-148, § 1104, 124 Stat. 119, 146-47 (2010).
34. Pub. L. No. 111-148, § 1104, 124 Stat. 119, 148 (2010).
35. WILLIAMS & REDHEAD, *supra* note 29, at 81*;* Pub. L. No. 111-148, § 1104, 124 Stat. 119, 147.
36. WILLIAMS & REDHEAD, *supra* note 29, at 82; Pub. L. No. 111-148, § 10109, 124 Stat. 119, 915-17.

service programs.[37] Specifically, the standards must allow for the following functions: 1) electronic matching against existing federal and state data that provide evidence of eligibility, 2) simplification and submission of electronic documentation, digitization of documents, and system verification of eligibility, 3) reuse of stored eligibility information, 4) capability of individuals to manage their eligibility information online, 5) ability to expand the enrollment system to integrate new programs, and 6) notification, including by e-mail and phone, of eligibility and recertification.[38]

Under PPACA, the Secretary is also charged with developing reporting requirements for use by health plans to address the plan's benefits and reimbursement structures.[39] These reporting requirements must implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health IT.[40] Plans are required to submit reports to the Secretary and plan members stating whether the benefits under the plan include the specified elements.[41] Moreover, PPACA requires that the Secretary develop similar reporting guidelines for application to the establishment of health benefit exchanges.[42]

Many of the other provisions under PPACA incentivize the use of health IT by requiring its usage in order to participate in a variety of new programs, many of which provide financial rewards for such participation and meaningful use of health IT.[43] For example, PPACA permits the Secretary to disperse grants to programs that establish themselves as "Community Health Teams," or community-based interdisciplinary, inter-professional teams designed to support primary care practices.[44] In order to establish themselves as such, the programs must demonstrate a capacity to implement and maintain health IT that meets the requirements of certified EHR technology.[45] Similarly, the Secretary is authorized to make grants to long-term care facilities in an effort to assist

37. WILLIAMS & REDHEAD, *supra* note 29, at 82.
38. WILLIAMS & REDHEAD, *supra* note 29, at 82; Pub. L. No. 111-148, § 3021, 124 Stat. 119, 262-63.
39. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.
40. *Id.*
41. PPACA EMPHASIZES USE OF HEALTH INFORMATION TECHNOLOGY, *supra* note 16, at 1.
42. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*

them in offsetting the costs related to acquiring certified EHR technology.[46]

Although most of the health IT-related provisions under PPACA do not exclusively concern health IT or EHRs, a large percentage of the new programs under PPACA make the appropriate use of health IT a qualifying factor for participation.[47] Inevitably, health care providers will undoubtedly be looking for ways to cut costs as they are required to provide health care services to many more Americans.[48] If providers can experience financial rewards as a result of investment in the establishment of a health IT infrastructure or the implementation of EHR programs, participation in programs, such as the establishment of community health teams, will become all the more attractive.[49] Furthermore, the expansion of health IT usage will make cost accounting more effective.[50] More rapid assessments of quality and value of health care will be available, decreasing the money wasted on fragmentation of care and the use of unnecessary services.[51] Moreover, simplification of the assemblage and exchange of health information will become essential as the number of potential consumers of health care increases substantially.

III. HEALTH IT ESSENTIAL TO THE EXPANSION OF ACCESS TO HEALTH CARE COVERAGE

Evidence indicates that health information liquidity can facilitate significant improvements in health care access, efficiency, and convenience.[52] Health IT is particularly important in ensuring that patient-centered care is provided.[53] Technology facilitates the portability of health information so that it follows patients across settings and providers.[54] Liquidity of health information additionally saves time – allowing prescriptions to be filled remotely and quickly, lab results to be viewed by the provider and patient immediately after they are processed, and patients to be reached for targeted

46. *Id.*
47. *Id.*
48. Buntin et al., *supra* note 5, at 1218.
49. Blumenthal, *supra* note 13, at 3.
50. Buntin et al., *supra* note 5, at 1216.
51. *Id.* at 1216-17.
52. SUSAN L. PENFIELD ET AL., TOWARD HEALTH INFORMATION LIQUIDITY: REALIZATION OF BETTER, MORE EFFICIENT CARE FROM THE FREE FLOW OF HEALTH INFORMATION 1 (Booz Allen Hamilton, 2009), http://www.boozallen.com/media/file/Toward_Health_Information_Liquidity.pdf.
53. *Id.*
54. *Id.* at 5.

prevention outreach.[55] Health IT also promotes equity and consistency in health care delivery, as clinical needs become the focus, rather than individual characteristics, such as socioeconomic status.[56] Finally, health IT will lessen the burden placed on patients, since health information will be readily available at the point of care and patients will have direct access to their own personal health records.[57]

Better methods of storing, analyzing and sharing health information will make possible the expansion of health care access to more Americans.[58] Using health IT to implement payment reform and simplify administrative processes is essential to achieving expectations of health insurance enrollment.[59] It is projected that approximately thirty-two million Americans will become newly insured as a result of the new health reform law.[60] Accommodating these new enrollees requires the use of health IT to not only streamline managerial processes, but also to effectively manage risk.[61] Data collected through EHRs could especially help insurers manage the care of new enrollees with pre-existing conditions.[62] The standardization and integration of clinical and administrative data through the development of health IT will also enable health care providers to achieve greater efficiencies in health care delivery.[63] This change in the way health care transactions take place will reduce both costs and hassle for patients, providers, and payers.[64]

Besides increasing efficiency and enabling equitable delivery of care, the growth of health IT will assist in laying the groundwork for further change to the existing health care system.[65] As many have argued, the transformation depends on better partnering between doctors and patients.[66] Health IT can play a vital role in making this partnership simpler and stronger.[67] As patient data becomes more accessible, physicians are better

55. *Id.*
56. *Id.* at 6.
57. *Id.*
58. Buntin, *supra* note 5, at 1214.
59. *Id.* at 1218.
60. *Id.*
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.*
65. *Id.* at 1214.
66. Michael Millenson, *Health IT: A Tale of Three Watsons*, FORBES, Feb. 14, 2011, at 2, *available at* http://blogs.forbes.com/sciencebiz/2011/02/14/health-it-a-tale-of-three-watsons/.
67. Penfield et al., *supra* note 52, at 5.

equipped to tailor care to the needs, preferences, and medical challenges of each individual.[68] Moreover, patients can be provided care in methods that are easier to access.[69] Just as health IT can afford health care providers opportunities to simplify the delivery of health care, so can these developments promote patient accountability with regard to health.[70] Patients can begin to understand their health history and plan future care accordingly.[71] In some instances, patients might even be able to control the input of data into a potential health IT system.[72] Although changing the relationship between patient and provider is an important step in restructuring the delivery of health care and ensuring that more Americans have access to health care services, health IT has become increasingly important in ensuring that policymakers have correct information on which to base their policy initiatives.[73] Just as health IT is crucial to changing clinicians' and hospital administrators' behaviors, health IT is absolutely necessary if policymakers are to effectively redirect policy priorities.[74]

The sustainable development of health IT will significantly impact access to health care in the United States.[75] The meaningful use of health IT and EHRs will promote patient-centered care, save time and resources, prevent waste of unnecessary medical services, strengthen the patient-physician relationship, and fuel policymakers with updated, relevant information.[76] Most importantly, health IT provides an important vehicle for change to the existing health care delivery system.[77]

IV. THE COMPLEXITIES OF IMPLEMENTING HEALTH IT

Recommending establishment of comprehensive health IT programs seems an obvious solution to a general lack of meaningful quality measures and readily accessible patient health information, however appropriate implementation of a health IT infrastructure is

68. Jerry Langley & Carol Beasley, DEP'T OF HEALTH & HUMAN SERVICES, HEALTH INFORMATION TECHNOLOGY FOR IMPROVING QUALITY OF CARE IN PRIMARY CARE SETTINGS, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY 5 (July 2007).

69. *Id.*

70. *Id.* at 11.

71. *Id.* at 10-11.

72. *Id.* at 11.

73. Kate Ackerman, *Blumenthal Looks Back at 2010, Offers Peek Into Plans for 2011*, iHealthBeat, at 2-3 (Jan. 3, 2011), http://www.ihealthbeat.org.

74. *Id.* at 2.

75. Buntin et al., *supra* note 5, at 1218.

76. Penfield et al., *supra* note 52, at 5-6.; Kate Ackerman, *Blumenthal Looks Back at 2010, Offers Peek Into Plans for 2011*, iHealthBeat, at 2-3 (Jan. 3, 2011), http://www.ihealthbeat.org.

maybe the most complicated endeavor in restructuring the current health care delivery system.[78] In fact, the federal government has been working to promote the nationwide use of health IT for years.[79] In the past three decades, the U.S. Department of Defense (DoD) and the Department of Veterans Affairs (VA) have made significant contributions to advances in technology by adopting robust, comprehensive EHR systems.[80] More recently, in 2001, the National Committee on Vital and Health Statistics proposed a national health information infrastructure.[81] Later, in 2004, the Office of National Coordinator for Health IT (ONC) was created by executive order, envisioning a nationwide interoperable health information technology infrastructure that would improve healthcare quality and safety, reduce costs, promote a more effective marketplace, and improve the coordination of care.[82] Unfortunately, accomplishing widespread adoption and implementation of health IT has proven difficult and there still exists much debate as far as the most effective method for achieving this transition.[83] Based on its past work on federal health IT activities, the General Accounting Office (GAO) provided testimony concerning the principal issues posed by a transition to nationwide health IT capability.[84]

Primarily, a productive transition will require the establishment of a foundation of clearly defined health IT standards that are agreed upon by all involved stakeholders.[85] Developing and implementing universal standards is crucial if health IT systems are to work together and provide the right people the access to the information they require.[86] Moreover, standards are needed to ensure data quality and consistency, so that exchange of health IT is interoperable.[87] A seamless transition to health IT capability will also require defining comprehensive plans that include milestones and measures.[88] Activities

77. Buntin et al., *supra* note 5, at 1219.
78. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *supra* note 12, at 1; Langley & Beasley, *supra* note 68, at 1.
79. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *supra* note 12, at 1.
80. Penfield et al., *supra* note 52, at 7.
81. *Id.*
82. *Id.*
83. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *supra* note 12, at 1.
84. GENERAL ACCOUNTING OFFICE REPORTS & TESTIMONY, *supra* note 12, at 1.
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*

must be coordinated, results monitored, and outcomes effectively integrated.[89] Thirdly, the GAO advises that successful implementation of nationwide health IT requires that personal privacy is protected such that public acceptance of health IT is achieved.[90] Public confidence in adoption of health IT is essential if standards are to be made universal.[91]

Not only is widespread adoption of health IT complex, it is also extremely costly.[92] Moreover, the greatest driver of healthcare cost inflation is new medical technology.[93] Considering the costs of implementing technological advances, convincing health care providers to adopt health IT is quite difficult.[94] Providers are concerned about both the costs of installing and maintaining the systems themselves, as well as the possibility that they might not realize any future financial gains from implementation of health IT and EHRs.[95] Many health IT experts contend that the EHRs currently available on the market are too expensive, too complicated, and will not guarantee better quality care.[96] These experts also argue that spending large amounts of money subsidizing currently available technology would encourage providers to adopt records that will soon be outdated.[97] Therefore, the adoption of new medical technology must be limited to technologies whose effectiveness and safety are based on sound scientific evidence.[98] Additionally, as health care coverage is expanded in 2014, the medical technology industry will see a significant increase in demand for its products.[99] Furthermore, health care coverage expansions will be partially financed by limits on the growth of Medicare payments.[100] Because medical technology pays providers for medical services delivered to beneficiaries, cuts to providers will essentially be passed on to medical technology manufacturers in the form of pricing pressure and deferred purchases of more expensive

89. *Id.*
90. *Id.*
91. *Id.*
92. Blumenthal, *supra* note 13, at 2.
93. Daniel J. Ullyot, *Healthcare Reform 2010 – A Surgeon's Perspective*, AM. HEART HOSPITAL J. 82 (2010).
94. Blumenthal, *supra* note 13, at 2.
95. Blumenthal, *supra* note 13, at 2.
96. *Id.* at 3.
97. *Id.* at 4
98. Ullyot, *supra* note 93, at 83.
99. David Nexon & Stephen J. Ubl, *Implications Of Health Reform For The Medical Technology Industry*, 29 HEALTH AFFAIRS 1324, 1326 (2010).
100. *Id*. at 1327.

equipment.[101] Most importantly, recent medical literature has not indicated that health IT improves human performance in the practice of medicine.[102] Very little research has been done on the topic, but of the studies performed, the results have shown little difference in quality between those medical practices that use electronic medical records (EMRs) and those with paper records.[103] Moreover, other countries have tried health IT, the United Kingdom in particular, and have been devastated, both economically and otherwise, by its adoption.[104]

Even considering the difficulties inherent to execution of health IT infrastructure, it seems unlikely that the existing health care system will stay current without taking advantage of the power of electronic technologies.[105] Not until widespread efforts are made to establish workable health IT programs will it be clear the advantages of implementing such efforts.

V. CONCLUSION

While the future of health IT usage in practice remains uncertain, it is clear that Congress foresees a restructured health care system facilitated by an improved network of health information and EHRs.[106] HHS has already taken substantial steps towards investment in health IT.[107] On February 9, 2011, HHS announced that it will make $750 million in federal funds available for disease prevention efforts, which specifically include data collection initiatives and IT infrastructure projects at local health departments.[108] This money will come from the Prevention and Public Health Fund created by PPACA.[109] HHS has also launched a Web portal, where health IT developers are able to access health data.[110] HHS hopes this portal will fuel development of innovative IT applications.[111]

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101. *Id.*
102. John V. Mackel, *Health Information Technology (HIT): For the Government, or for the Patient?*, 15 JOURNAL OF AMERICAN PHYSICIANS AND SURGEONS 113, 113 (2010), http://www.jpands.org/vol15no4/mackel.pdf.
103. *Id.*
104. Mackel, *supra* note 102, at 113.
105. Blumenthal, *supra* note 13, at 4.
106. *Id.* at 5.
107. *HHS to Allot $750M for Disease Prevention, IT Infrastructure*, iHealthBeat (Feb. 10, 2011).
108. *Id.*
109. *Id.*
110. *HHS Launches Health Data Site To Boost Industry Innovations*, iHealthBeat (Feb. 14, 2011).
111. *Id.*

As efforts to repeal PPACA threaten the derailing of new health IT, administrative agencies, like HHS, continue to move forward.[112] Although the consequences of investing in health IT could be devastating, change necessitates risk. New health IT has the potential to simplify the delivery of health care, curb costs, improve the patient-physician relationship, and stimulate patients to become active consumers.[113] Arguably, these investments in the future of health care are worth the plausible risks.

112. EMPLOYEE BENEFIT ADVISER, *PPACA repeal effort reenergizes reform conversation* (Jan. 11, 2011).
113. Penfield et al., *supra* note 52, at 5-6.

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The Regulation of Rescission: Is a National Standard Necessary?

*Sam Richardson**

I. INTRODUCTION

Current health care reform evolved out of a commitment to increase the quality, access, and security of health care for all Americans. The Patient Protection and Affordable Care Act (PPACA) addressed access concerns by promising to provide more health benefits for more Americans.[1] PPACA's flagship protections, often referred to as the "new Patient Bill of Rights", proposed several amendments aimed at protecting health insurance consumers. These consumer protections included, among other protections, a prohibition on preexisting condition exclusions, no lifetime or annual monetary limits on health insurance benefits, and a prohibition on health insurance rescission.[2] This article will focus on the practice of rescission in the individual health insurance market, which has been characterized as "one of the truly egregious practices occurring in the health insurance market".[3]

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1. Barack Obama, U.S. President, Address to Congress on Health Care (Sept. 9, 2009), *available at* http://millercenter.org/scripps/archive/speeches/detail/5548.

2. 42 C.F.R. §§ 144, 146, 147 (2010).

3. *Termination of Individual Health Policies by Insurance Companies: Hearing Before the Subcomm. on Oversight & Investigation of the H. Comm. on Energy & Commerce*, 111th Cong. 41 (2009), *available at* http://democrats.energycommerce.house.gov/Press_111/20090616/transcript_20090616_oi.pdf (statement of Rep. Schakowsky, Member, H. Comm. on Energy and Commerce) [hereinafter *Hearing Transcript*]; *see also* Gary Schuman, *Post-Claim Underwriting: A Life & Health Insurer's Right to Investigate or Bad Faith?*, 45 TORT TRIAL & INS. PRAC. L.J. 697, 697, 701 (2010) (specifying that those enrolled in employer-sponsored health plans are generally not the target of rescission since coverage is guaranteed regardless of health. Conversely, individual and small group insurance is not guaranteed and almost always is underwritten and thus subject to rescission actions.); s*ee also* Letter from Roger Sevigny et al., Nat'l Ass'n of Ins. Comm'rs, to Honorable Bart Stupak, U.S. House of Representatives & Honorable Greg Walden, U.S. House of

First, this article will explain the practice of rescission as it affects the average American. Second, this Article will analyze the arguments for and against restricting the use of rescission and how the issue has been previously addressed by states. Third, this article will discuss how Congress reconciled those arguments in the language of PPACA. Lastly, this article evaluates the PPACA prohibition on rescission in light of its goal to increase access. Ultimately, although the national standard will curtail the overall practice of rescission by insurers, diligent enforcement by state agencies is necessary for the prohibition to provide full protection to Americans.

II. THE HISTORICAL PRACTICE OF RESCISSION IN AMERICA

In August of 2003, Otto Raddatz, a fifty-nine-year-old restaurant owner from Illinois, purchased health insurance from Fortis Health.[4] Over a year later, Otto was diagnosed with an aggressive form of non-Hodgkin's lymphoma.[5] He immediately began chemotherapy and was informed that he would need a stem cell transplant to live.[6] Luckily, Otto's initial treatments were covered by his insurance.[7] As Otto's chemotherapy treatments intensified in preparation for the transplant, Fortis notified him that his insurance policy was being rescinded, canceling all of his coverage back to August of 2004.[8] For Otto, this meant that none of the cancer treatments he had received would be covered and the lifesaving stem cell transplant would be canceled.[9] Without the financial assistance afforded by insurance coverage, Otto could not afford the procedure.[10] Fortis told Otto that his coverage was being rescinded due to omissions in his application for coverage; Fortis had performed a routine review and discovered a CT scan from 2000 showing a minor aneurysm and some small gallstones that Otto failed to

Representatives (July 24, 2009), http://www.naic.org/documents/testimony_0907_rescissions_sevigny_vaughan_praeger_ario.pdf [hereinafter NAIC Letter] (echoing the sentiments of Rep. Schakowsky by stating "given the particularly harmful nature of rescissions, state regulators recognize that even one confirmed case of abuse is too many.").

4. STAFF OF COMM. ON ENERGY & COMMERCE, 111TH CONG., MEMORANDUM ON SUPPLEMENTAL INFORMATION REGARDING THE INDIVIDUAL HEALTH INSURANCE MARKET 10 (COMM. PRINT 2009), http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf [hereinafter HEARING SUPPLEMENT]; *Hearing Transcript*, *supra* note 3, at 4 (statement of Rep. Stupak, Member, H. Comm. on Energy and Commerce).

5. *Hearing Transcript*, *supra* note 3, at 4; HEARING SUPPLEMENT, *supra* note 4, at 10.

6. *Hearing Transcript*, *supra* note 3, at 4.

7. *Id.*

8. *Id.* at 58 (statement by Peggy Raddatz).

9. *Id.*

10. *Id.* at 4.

disclose on his insurance application.[11] In reality, Otto's doctor had never told him about these conditions; nor did Otto receive treatment for, or experience any symptoms from, either condition.[12] Most notably, these pre-existing conditions were not medically related to Otto's cancer.[13] With the window for his transplant closing, Otto's sister, herself an attorney, turned to the Illinois Attorney General for help.[14] Under pressure from the Illinois Attorney General, Fortis reversed the rescission decision, and Otto was able to receive the transplant that allowed him to live three more years.[15] The outcome of Otto Raddatz's story, however, is the exception rather than the norm. Most policyholders do not have the same access to an attorney, and without the benefit of an attorney for a sister and an active State Attorney General, insurance rescission would have easily left Otto bankrupt and cost him the last three years of his life.[16]

III. THE CONFLICTING ARGUMENTS ON RESCISSION

Ottis Raddatz's story was told before the House Committee on Energy and Commerce on June 16, 2009,[17] at a hearing entitled "Termination of Individual Health Policies by Insurance Companies." The hearing focused on a commonplace insurance practice known as rescission.[18] Rescission is the cancelation of a contract due to certain kinds of default by a party, declaring the contract void in its inception.[19] In an insurance context, a rescission occurs when an insurer retroactively cancels a customer's coverage based on misrepresentation in the application, even if the premiums are kept current.[20] A rescission nullifies a policy to the effect that it is as if a contract between the insured and the insurer was never formed.[21] As a health insurance practice, rescission is largely "limited to medically underwritten health insurance markets", which includes individual health insurance policies.[22] Rescission usually follows post-claim underwriting, which is

11. *Hearing Transcript*, *supra* note 3, at 58.
12. *Id.*
13. *Id.*
14. *Id.* at 59-60.
15. *Id.* at 5.
16. Hearing Transcript, *supra* note 3, at 59.
17. *Id.* at 4.
18. *Id.* at 1, 4.
19. BLACK'S LAW DICTIONARY 1306 (6th ed. 1991)
20. Bruce Japsen, *Rescinding Consumers' Insurance Coverage to End*, CHI. TRIB., July 6, 2010, at C1.
21. Schuman, *supra* note 3, at 705.
22. NAIC Letter, *supra* note 3, at 1; The U.S. Census Bureau estimates that approximately 27 million Americans, including approximately 17 million nonelderly individuals, have directly bought health insurance

the "process of retrospectively investigating an insured's application . . . only after the insured has made a claim" under their coverage.[23] The rescission of an insurance contract is the usual remedy given to insurers for misrepresentation by an individual on their insurance application.[24]

The typical health insurance rescission follows the same pattern as the story of Otto Raddatz: an insured patient files a major claim, the insurer scrutinizes the claimant's medical history and compares it with their application, looking for any misrepresentations or omissions. Any discrepancies found can be used as grounds for a rescission action.[25] Thus, whenever a policy is obtained based on incorrect material information communicated by the insured, the insurer is contractually guaranteed the right to rescind the policy.[26] Put simply, "when it comes to health care rescissions, hindsight is 20/20."[27]

Due to the fact that, in most cases, even an innocent misrepresentation on an application will provide the grounds for rescission, "a health plan seeking to rescind the coverage of an ill patient will almost certainly find a reason to do so."[28] An individual who relies on their health coverage only to have it rescinded is left in an extremely vulnerable position, it is likely he has ongoing treatment that he must then pay for out-of-pocket, leaving him with crippling medical debt, and making him virtually uninsurable in the future.[29] The rescission of health insurance effectively limits an individual's access

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each year between 2002 and 2009 *see generally Health Insurance Historical Tables: HIA-1 and HIA-6*, U.S. CENSUS BUREAU (2010), http://www.census.gov/hhes/www/hlthins/data/historical/index.html [hereinafter *Census Table HIA-1* and *Census Table HIA-6*] (estimating that approximately 27 million Americans, including an estimated 17 million non-elderly individuals, have purchased individual health insurance each year between 2002 and 2009); *but see* Gary Claxton & Janet Lundy, *How Private Health Coverage Works: A Primer*, THE HENRY J. KAISER FAMILY FOUNDATION, 1 (April 2008), http://www.kff.org/insurance/upload/7766.pdf (estimating that only 14 million non-elderly people bought health insurance directly in 2006).

23. Lori J. Parker, *Cause of Action for Wrongful Rescission of Health Insurance Policy When Fraud, Misrepresentation, or Misstatement Regarding Insured's State of Health is Raised as Defense*, 45 CAUSES OF ACTION 2D 1, §12 (2010). *See generally* Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000) (providing an extensive overview of the practice of post-claim underwriting in insurance).

24. Brian Barnes, *Against Insurance Rescission*, 120 YALE L.J. 328, 332 (2010).

25. Gerald S. Flanagan, Note and Comment, *A Healthy State of Mind: The Role of Intent in Health Care Service Plan Rescissions*, 43 LOY. L.A. L. REV. 291, 293 (2009); *see also* NAT'L ASS'N OF INS. COMM'RS, RESCISSION DATA CALL OF THE NAIC REGULATORY FRAMEWORK (B) TASK FORCE 11-12 (2009), http://www.insurance.illinois.gov /hiric/RescissionDataCall.pdf [hereinafter NAIC DATA CALL] (listing the sources of information insurers use for underwriting and sources of information used by insurers in considering rescission).

26. Schuman, *supra* note 3, at 705.

27. Flanagan, *supra* note 25, at 298.

28. *Id.*

29. *See* Barnes, *supra* note 24, at 332; *see* Lisa Girion, *Sick but Insured? Think Again*, L.A. TIMES, Sept.

to health care in the past (via its retroactive nature), present (in its ability to deny a present claim) and future (as the individual now has a condition that is "preexisting", making it more difficult to obtain new insurance).[30]

As a smaller percentage of Americans are obtaining health insurance through their employer and unemployment numbers remain high, more Americans are turning to individual health insurance plans for coverage.[31] Because rescissions typically occur in the individual insurance market, as the number of Americans covered by these plans increases, so does the likelihood of rescission abuse.[32] Until recently, any substantive data on the use of rescission was difficult to obtain since the only data tracking was done by insurance companies and they did not disclose this information.[33] This has changed in the last few years, when both the National Association of Insurance Commissioners (NAIC) and the U.S. House Committee on Energy and Commerce requested data on rescissions from the largest health insurers in the United States.[34] The NAIC report found the rescission rate to be 3.7 rescissions for every 1,000 polices and/or certificates written between 2004 and 2008.[35] The House Committee report found that WellPoint, Assurant, and UnitedHealth rescinded at least 19,776 policies between 2003 and 2007.[36] However, opponents of rescission stress that these numbers should be considered in light of the three following factors. First, both reports are based off of information provided by the industry they were investigating and planning on regulating.[37] Secondly, both reports

17, 2006, at B14.

30. While the preexisting condition issue might eventually be moot as PPACA includes a provision prohibiting preexisting condition exclusions by insurers, it does not go into effect for adults until 2014. Prohibition of Preexisting Condition Exclusions, 26 C.F.R. § 54.9815-2704T (2010).

31. CENSUS TABLE HIA-6, *supra* note 22; *Hearing Transcript*, *supra* note 3, at 104 (statement of Don Hamm, CEO, Assurant Health).

32. *See* Schuman, *supra* note 3, at 701; *see* Anna Wilde Mathews, *Going it Alone When Buying a Health Policy: Focusing on Premiums Risks a Nasty Surprise When the Bills Arrive*, WALL ST. J., June 24, 2009, at D1 (predicting the continued growth of individuals under individual policies to grow to 20 million in 2010); *see generally* NAIC DATA CALL, *supra* note 25, at 3 (charting the growth of individual major medical policies in force from 46 companies from 2.7 million in 2004 to roughly 4 million in 2008).

33. Girion, *supra* note 29.

34. *See* NAIC DATA CALL, *supra* note 25, at 2 (stating that the NAIC collected data submitted by 46 companies that wrote individual major medical policies, and the data collected represented a sample of 70% of the covered lives from 2004-2008); *see* HEARING SUPPLEMENT, *supra* note 4, at 7-8 (stating that the commission collected data submitted by the three insurance companies at the hearing from 2003-2007).

35. NAIC DATA CALL, *supra* note 25, at 1, 5.

36. HEARING SUPPLEMENT, *supra* note 4, at 7-8.

37. NAIC DATA CALL, *supra* note 25, at 2 ("[NAIC] asked each company for the total number of individual major
medical policies issued and in-force by state for each year, as well as the total number of rescissions by state per

commented on problems with data collection.[38] Finally, while the number of rescissions may seem small, their financial impact is not: the 19,776 rescissions in the House Committee report saved the three insurance companies at least $300 million.[39] Furthermore, although the number of people affected by the rescission process may be small, those affected are often the most vulnerable to the financial consequence.[40]

a. Insurer's Defense of Rescission

Even as rescission has become a controversial topic, insurers have consistently defended the practice.[41] The crux of their argument is that rescission is necessary to prevent fraudulent claims and keep premiums down for the honest consumer.[42] Insurers argue that without the option of rescission, the insured has no contractual burden of good faith to provide accurate information, and this loophole will effectually turn "health insurance" into "sick insurance", causing overall costs to skyrocket.[43] Proponents of rescission argue that restricting an insurer's right to investigate post-claim means that the insurer is forced to do all of their underwriting at the time of application.[44] Additionally, in doing their pre-claim underwriting, an insurer would be forced to always assume deception on the part of the applicant until investigation indicates otherwise, raising premiums and increasing the wait time between application and coverage.[45] Furthermore, insurers maintain that they are not fiduciaries, and therefore owe no special duty to their customers.[46] Even though the practice is severe, insurers repeatedly point out that rescission is extremely limited in its application.[47]

b. The Call for the Regulation of Rescission

Opponents of rescission have responded to these defenses in several ways. First, it has been argued that post claim underwriting, the practice which rescission is predicated on,

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year."); HEARING SUPPLEMENT, *supra* note 4, at 1 ("Committee sent document requests to 50 state insurance commissioners and three health insurance companies that provide individual health insurance policies, Assurant Health, WellPoint, Inc., and UnitedHealth Group.").

38. NAIC DATA CALL, *supra* note 25, at 2; HEARING SUPPLEMENT, *supra* note 4, at 7.
39. HEARING SUPPLEMENT, *supra* note 4, at 8.
40. Jaspen, *supra* note 20.
41. *Hearing Transcript*, *supra* note 3, at 106, 110, 113.
42. Schuman, *supra* note 3, at 704, 718.
43. *Id.* at 700, 704, 718.
44. *Id.* at 759.
45. *Id.*
46. *Id.* at 720.

"is a vehicle for opportunism in the insurance relationship" and per se bad faith on the part of the insurer.[48] In the practice of health insurance, it is alleged that insurers can "simply lie in wait, collecting premiums and earning interest until an insured becomes seriously ill" and subsequently rescind the contract and avoid a payout.[49] Furthermore, reformers argue that since the initiation of a rescission action is in the sole control of the insurer, "rescission systematically overcompensates the insurer by allowing it to retain the premiums paid by people it does not actually insure."[50] For example, there could be a large number of people with a condition similar to Otto Raddatz but the insurer will not employ rescission until they make a claim, thus making the insurance policies of those individuals illegal illusory contracts.[51]

Second, opponents contend that rescission is not used to combat fraud, but to increase the profitability of insurance companies by reducing payouts.[52] Furthermore, while it has been difficult to prove, opponents maintain that health insurers give bonuses based on successful rescissions.[53] Where courts have found the practice of rescission to be a means for cost containment, profit maximization, or the basis for bonuses, rescission has been uniformly punished.[54]

Finally, rescission "horror stories" have a substantial impact on the public's awareness and perception of rescission. Personal anecdotes such as Otto Raddatz's are numerous and are extremely effective tools for both opponents of rescission and lawmakers.[55] The President of the United States used Otto's story, among others, in his address to Congress

47. *Hearing Transcript*, *supra* note 3, at 106, 114.
48. Cady & Gates, *supra* note 23, at 810, 826-28.
49. Schuman, *supra* note 3, at 711.
50. Barnes, *supra* note 24, at 336.
51. *See also* William B. Maguire, Comment, *A Call for Minnesota to Prevent Health Insurance Rescissions Following Post-Claims Underwriting*, 33 HAMLINE L. REV. 137, 144-45 (2010) (explaining illusory contracts).
52. *See* Flanagan, *supra* note 25, at 306 n. 111 ("Since the rescission surge beginning in 2001, HMOs have experienced an explosion in profitability. Between 2001 and 2005, HMOs . . . [have] increased their first-quarter profits by 990 percent.").
53. Girion, *supra* note 29 (". . .according to the depositions of Blue Cross and Blue Shield employees, fraud has little to do with it [rescissions]."); HEARING SUPPLEMENT, *supra* note 4, at 18 (In 2008 case it was revealed that "Health Net paid bonuses in part based on meeting or exceeding annual targets for rescinding policies."); *but see Hearing Transcript*, *supra* note 3, at 116 (assuring the Committee "there is no WellPoint policy to either factor in the number of rescissions or the dollar amount of unpaid claims in the evaluation of employee performance or in calculating employees' salary or bonuses").
54. Schuman, *supra* note 3, at 733.
55. *See Hearing Transcript*, *supra* note 3; *see* Obama, *supra* note 1.

to garner support for health care reform.[56] These humanizing stories have provided a strong counterpoint for even the most logical pro-rescission arguments.[57]

IV. MOVEMENT TOWARDS REFORMING RESCISSION

a. Historical Regulation at the State Level

Traditionally, the regulation of insurance, including market conduct such as rescission, has been the responsibility of the state.[58] With no federal rule on rescission, states developed varying standards.[59] It was state law which limited the ability to rescind health insurance policies sold within its borders.[60] The three common standards are exemplified by California's "willful" standard[61], Minnesota's "material" standard[62], and Illinois' "willful or material" standard.[63] Common to all three standards is the insured's remedy to restore coverage after rescission is litigation.[64]

California's "willful" standard requires an insurer to show that a misrepresentation was voluntary and intentional in order to lawfully rescind the policy.[65] Additionally, pursuant to the California Health and Safety Code §1389.3, California prohibits post-claim underwriting, meaning that a health insurer must complete medical underwriting prior to granting coverage or else rescission will be illegal.[66] However, even with the strictest regulations in the nation, rescission remained a common practice in California.[67] Additional state regulatory efforts to further restrict the use of rescission in California have met a consistent gubernatorial veto.[68]

Minnesota's "material" standard bars a health insurer from rescinding a policy unless

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56. Obama, *supra* note 1.
57. *See* NAIC Letter, *supra* note 3, at 2 ("[G]iven the particularly harmful nature of rescission, state regulators recognize that even one confirmed case of abuse is too many.").
58. Claxton & Lundy, *supra* note 22, at 8.
59. HEARING SUPPLEMENT, *supra* note 4, at 6; *see* Jaspen, *supra* note 20.
60. Schuman, *supra* note 3, at 698 n. 6.
61. Maguire, *supra* note 50, at 150.
62. *Id.* at 147.
63. *Id.* at 155.
64. *Id.* at 148.
65. *Id.* at 150.
66. Flanagan, *supra* note 25, at 300-01.
67. *See* Maguire, *supra* note 50, at 138-39 ("Horton . . . [testified to the] Congressional Subcommittee, noting that despite it being against the law in California, her health insurance provider still practiced post-claims underwriting."); *see* HEARING SUPPLEMENT, *supra* note 4, at 17-18 (stating the fines levied against insurance companies for illegal rescission by California).
68. *See* Flanagan, *supra* note 25, at 294 n. 17; *see* Emily Berry, *Rescission Legislation Vetoed*, AM. MED.

it can show that the misrepresentations were material to the insurer's decision to accept the risk represented by the policy.[69] There is no requirement that there be a nexus between the misrepresentation on the application and the claim for treatment. To satisfy this standard, all an insurer must show is "that it never would have accepted the individual for coverage if it had known the truth about a misrepresentation made on the policy."[70]

Finally, Illinois' "willful or material" standard, as the name suggests, is a combination of the two, in that it is a more lenient standard that allows for rescission under either scenario described above.[71] With one of the most lenient standards in the nation, Illinois has the most rescissions in the country by volume and the second highest per capita.[72] In claims involving rescission of health insurance coverage due to alleged misrepresentations by the insured, "the majority rule allows rescission based on a showing that the insured provided incorrect information, regardless of whether intentionally, [or] innocently done."[73]

Even though differing state regulations can have the benefit of flexibility, this piecemeal approach to regulation had drawbacks in the regulation of rescission. Many state standards were unclear, in the words of the Illinois Insurance Director, "our law [on rescission] was ambiguous, vague and left wide latitude and discretion with the insurance industry."[74] Furthermore, it has been noted that "[c]ourts are reluctant to deploy such a harsh remedy against sympathetic policyholders, and the result is a body of case law that is difficult to reconcile with the legal rules it purports to apply", thus creating inconsistent application within a single state.[75]

Most importantly, Congress found that "[a]ccording to documents provided by the companies . . . it appears that insurance companies have taken advantage of the haphazard regulatory framework by engaging in a series of controversial practices

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NEWS (Oct. 26, 2009), http://www.ama-assn.org/amednews/2009/10/26/bisb1026.htm.

69. Maguire, *supra* note 50, at 147.

70. *Id.* at 149-50.

71. *Id.* at 155.

72. *Illinois Department of Insurance, Changes Resulting From National Health Insurance Reform*, ILL. DEPARTMENT OF INS., 2 (Mar. 22, 2010), http://www.insurance.illinois.gov/newsrls/2010/top10hcr2010.pdf; NAIC DATA CALL, *supra* note 25, at 8.

73. Parker, *supra* note 23, at §11.

74. Jaspen, *supra* note 20.

75. Barnes, *supra* note 24, at 331.

involving rescissions."[76] While there was some federally uniform rescission regulation under ERISA, it did not apply to individual health insurance plans.[77]

b. PPACA's New Federal Standard

As a result of these findings, Congress decided to address the problem federally and passed provisions in PPACA amending the Public Health Service Act (PHSA) to create a broad prohibition on rescission practices in most instances.[78] The section pertaining to rescission reads:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).[79]

With this language, PPACA created a uniform federal standard for the use of post-claim rescission.[80] The new protections apply to any plan year starting after September 23, 2010, including grandfathered plans. Under the new law, rescission is only permitted in cases of fraud and intentional misrepresentation of material fact when the insured is given thirty days notice of rescission action.[81]

Section 2712 combines Minnesota's material standard with California's willful standard. In doing so, the legislation is able to balance the needs of the insured with insurers; it greatly bolsters the protections for consumers while still allowing rescission in cases of outright fraud, the explicit reason given by insurers for their practice of

76. HEARING SUPPLEMENT, *supra* note 4, at 8.

77. Parker, *supra* note 23, at §16

78. Patient Protection and Affordable Care Act, 42 USCA § 300gg–12 (West 2010) (amending the Public Health Service Act to include §2712: Prohibition on Rescission).

79. 42 U.S.C.A. § 300gg–12.

80. Nat'l P'ship for Women & Families, PPACA Implementation: Consumer Recommendations for Regulators and Lawmakers, 35 (May 2010), http://www.naic.org/documents/committees_e_hrsi_comments_Consumer_Implemen tation_ Recommendations_5-7.pdf [hereinafter NPWF Report].

81. *Id.*; PPACA § 1001; Jaspen, *supra* note 20.

rescinding policies.[82] The new PPACA standard would have made the rescission of Otto Raddatz's insurance illegal as a matter of law, as his omission was clearly not intentional and willful or fraud.[83] Furthermore, even though the new federal standard does not incorporate California's practice of placing an obligation on the insurer to investigate the accuracy of medical information on its applications, Section 2712's focus on the state of mind of the insured in determining if rescission is proper encourages insurers to thoroughly underwrite a policy at the application stage.[84]

V. PPACA'S RESCISSION POLICY ACHIEVES ITS GOAL TO INCREASE ACCESS FOR AMERICANS

On January 8th, 2010, the Department of Health and Human Services, in conjunction with the Department of the Treasury and the Department of Labor, issued the interim final rule regarding rescission.[85] The rule specifically states that the protections of Section 2712 set a federal floor, leaving states free to pass laws that provide more protection for individuals.[86] As codified, the regulation defines rescission as any "cancellation or discontinuance of coverage that has a retroactive effect."[87] The regulations forbid the rescission of a covered individual unless that individual makes an intentional misrepresentation of a material fact or commits fraud.[88] Even if fraud has been committed, the issuer must give thirty-day advanced written notice to all individuals who will be affected by the rescission action.[89] With its wide application to both group and individual plans, it is likely that these protections will greatly curtail improper rescission actions.

Even before its effective date, the passing of PPACA has caused several large insurers to promise to fundamentally change their business practices and limit rescission to cases

82. Maguire, *supra* note 50, at 167.

83. *Id.*

84. Hilary Rowen, *California Court of Appeal Clarifies Standards for Rescission Based on Misrepresentation in Health Insurance Applications*, SEDGWICK LLP (Spring 2010), http://www.sdma.com/california-court-of-appeal-clarifies-standards-for-rescission-based-on-misrepresentation-in-health-insurance-applications-05-18-2010/ ("It is even possible that PPACA will cause carriers to undertake more thorough investigations of medical information in applications . . . A misstatement with respect to a broad question . . . is likely to be treated as inadvertent; a misrepresentation with respect to a detailed follow-up question looks a lot more like fraud.").

85. Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. at 37,192.

86. *Id.*

87. Rules Regarding Rescissions, 45 C.F.R. § 147.128 (2010).

88. *Id.*

of clear fraud, a promise these same insurers were unwilling to make less than a year earlier.[90] However, this quick change in position illustrates an important point: if PPACA is repealed, an expedited move by insurers back to practicing rescission is highly possible. At the time of this writing, two state court cases have declared the PPACA unconstitutional and will likely be decided by the U.S. Supreme Court.[91] Additionally, although an initial repeal effort failed to pass the U.S. Senate on February 2, 2011, subsequent attempts to overturn PPACA are probable.[92] Therefore, in order to guarantee that the practice of rescission is not resumed, it falls on the states to codify these protections.[93]

VI. CONCLUSION

The vast majority of scholarly work on health insurance rescission concludes that reform is needed. Only one academic article, written by the chief litigation counsel for an insurance company, has drawn the conclusion that post-claim underwriting and rescission of health insurance is valid legal practice.[94] Furthermore, experts with experience in rescission actions have largely supported nationally uniform rescission regulation; with state legislation being blocked, federal legislation provided the simplest avenue for providing such regulation.[95] As shown above, with enforcement, Section 2712 has the potential to end the abuse of rescission.

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89. *Id.*

90. Press Release, Health & Human Serv., Momentum Building on Sebelius' Challenge to Insurers to Ban Rescission Before Law Takes Effect in September (April 28, 2010), *available at* http://www.hhs.gov/news/press/2010pres/04/ 20100428a.html ("UnitedHealthcare [states] they will stop rescissions immediately"); Press Release, Health & Human Serv., HHS Secretary Kathleen Sebelius on WellPoint's Decision to Ban Rescissions in Advance of the Affordable Care Act's Requirement (April 27, 2010), *available at* http://www.hhs.gov/news/press/2010pres/04/20100427b.html ("WellPoint's announcement that it intends to end the practice of rescinding patients' coverage in advance of the Affordable Care Act's requirement"); *Hearing Transcript*, *supra* note 3, at 153-54 (recording the statements from the representatives of Wellpoint, UnitedHealth, and Assurant that they will not commit to a statement that their companies "will never rescind another policy unless there was intentional fraudulent misrepresentation in the application").

91. Bara Vaida, Scoreboard: Tracking Health Law Court Challenges, KAISER HEALTH NEWS (Mar. 23, 2011), http://www.kaiserhealthnews.org/Stories/2011/March/02/health-reform-law-court-case-status.aspx?P=1#overturned ; *see also* Brief for the Respondent in Opposition, Virginia ex rel. Cuccinelli v. Sebelius, 728 F.Supp.2d 768 (2011) (No. 10-1014), *available at* http://www.justice.gov/healthcare/docs/cuccinelli-v-sebelius-brief-respondent.pdf (opposing the motion for an expedited hearing by the Supreme Court).

92. David M. Herszenhorn, *Senate Rejects Repeal of Health Care Law*, N.Y. TIMES, Feb. 2, 2011, at A20 ("Republicans said after the votes that they would persist in their efforts to overturn the law.").

93. *See* A.B. 2470, 2009-2010 Gen. Assemb., Reg. Sess. (Ca. 2010) (California bill codifying the same protections provided by Section 2712 with certain additional protections for individuals).

94. Schuman, *supra* note 3, at 700-01.

95. NAIC letter, *supra* note 3, at 1; Jaspen, *supra* note 20.

There is some criticism that Section 2712 does not go far enough. Alleged gaps in the legislation include: no requirement of a nexus between the condition behind the claim and the condition allegedly misrepresented, no limit on when an accepted policy becomes incontestable, no independent third-party review of rescission actions, and no enforcement mechanism for ensuring compliance.[96] Yet, most of these problems will be moot or substantially limited in 2014, when PPACA will ban medical underwriting for elements that are not related to geographical location, age or tobacco use.[97] In the interim three years, the efficacy of the prohibition will have to rely on its enforcement by state agencies such as California's Department of Managed Care, State Attorney General Offices, and State Insurance Commissioners. Whatever the fate of the PPACA, the federal prohibition on rescission should be preserved or reinstated at a state level in order to provide the necessary protection to consumers. Otherwise, individuals such as Otto Raddtaz's will continue to be victimized and the promise that "no one should be treated that way in the United States of America"[98] will remain unfulfilled.

96. NPWF Report, *supra* note 80, at 36-37.
97. Prohibition of Preexisting Condition Exclusions, 26 C.F.R. § 54.9815-2704T (2010).
98. Obama, *supra* note 1.

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PPACA: Leveling the Payment Field

*Lizzy Magarian**

I. INTRODUCTION

In the last ten years, the American media has been replete with stories about nonprofit tax-exempt hospitals overcharging, aggressively billing, and even suing patients who are underinsured members of the working poor unable to pay their medical bills.[1] Alternatively, hospital executives report that their institutions have been victims of bad press and misinformation, suffering damage to their reputations despite the fact that they provide billions of dollars of unreimbursed care to patients every year.[2]

Section 9007 of the Patient Protection and Affordable Care Act (PPACA) entitled "Additional Requirements for Charitable Hospitals" may help balance the financial burdens perceived by tax-exempt hospitals that extend unreimbursed care every day with those felt by patients who receive and are billed for care they cannot live without, yet cannot afford.[3] By implementing nationally uniform charity care reporting requirements and limiting the rates charged to uninsured patients, PPACA may shed light on the levels of and types of charity care the tax-exempt hospitals provide to their communities and catalyze an increase in access to care.

Part One of this article discusses past litigation involving tax-exempt hospitals and both state tax exemptions and the Internal Revenue Code's Section 501(c)(3), which

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1. *See* Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Villains, No Heroes*, 51 VILL. L. REV. 95, 104 (2006); Jonathan Cohn, *Uncharitable?*, N.Y. TIMES MAGAZINE DESK, Dec. 12, 2004 at 51; Transcript from CBS Broadcast of 60 Minutes: Hospitals: Is the Price Right?, CBS NEWS, http:// www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml (last visited May 8, 2011) (detailing two uninsured families struggles to pay exorbitant bills incurred at nonprofit hospitals).

2. Cohn, *supra* note 1.

3. Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010).

exempts an organization from federal taxation if the organization has a "charitable purpose."[4] Part Two of this article describes the requirements set by the PPACA for nonprofit hospitals, explaining what hospitals have to do in order to comply with the new law, as well as some background on what led the provisions to come into effect. Part Three examines whether § 9007's requirements provide enough incentive to hospitals in order to increase access to affordable care for low-income patients.

II. 501(C)(3)'S FAILURE TO HOLD HOSPITALS ACCOUNTABLE FOR CHARITY CARE

Since 1969, the Internal Revenue Service has not required hospitals to provide charity care to receive a federal tax exemption rather, the IRS only requires that hospitals engage in "community benefit activities" in order to qualify for exemption.[5] Receipt of tax deductible contributions, the ability to issue tax-free bonds, and, most importantly, federal income tax exemption are among the financial advantages nonprofit hospitals enjoy as tax-exempt entities under the Federal Revenue Code.[6] In 2005, the House Tax Panel Chairman estimated that these federal benefits amounted to $50 billion annually.[7]

In 2005, the U.S. Government Accountability Office (GAO) reported that government hospitals provided significantly higher uncompensated care (bad debt and free care combined) than private nonprofit and investor-owned hospitals.[8] Beyond the comparison of hospitals across the profit spectrum, the report also brought to light the fact that only a small percentage of hospitals provided the majority of the private not-for-profit uncompensated care burden.[9] Ultimately, the GAO concluded that the 501(c)(3) tax exemption policy simply fails to hold tax-exempt nonprofit hospitals accountable for providing services of benefit to the public.[10]

Notably, some studies have found that most hospitals would not earn their tax exemption on the value of charity care alone—especially if the charity care is expressed

4. I.R.C. § 501(c)(3) (2006).

5. U.S. GAO, NONPROFIT HOSPITALS: VARIATIONS IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFITS REQUIREMENTS (2008). [hereinafter "GAO Report 2"].

6. Cecilia M. Jardon McGregor, *The Community Benefit Standard For Nonprofit Hospitals: Which Community, and For Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 310-11. (2007).

7. *Id.* at 310.

8. DAVID M. WALKER, U.S. GAO, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS, 19 (2005).

9. *Id.*

10. *Id.*

in terms of costs, rather than charges.[11] One 2007 survey found a broad range of charity-care practices among hospitals, while one in five spent ten percent of revenue on uncompensated care, the remaining nonprofit hospitals surveyed spent three percent or less.[12] The community benefit standard became subject to intense scrutiny in 2003, when the *Wall Street Journal* began a series of articles documenting abusive billings practices pursued by not-for-profit hospitals against indigent patients.[13] The articles reported that nonprofit hospitals fare better financially than their for-profit counterparts, with seventy-seven percent of nonprofit hospitals, as opposed to sixty-one percent of for-profit hospitals, earning profits.[14]

These studies emphasize the need for Section 9007 of PPACA as an attempt to balance the amount that hospitals are saving in tax exemptions versus the monetary value of the charity care they provide to their communities. Yet, the PPACA does not go so far as to mandate a minimum level of charity care for nonprofit hospitals, instead it requires them to implement new community needs assessments and reporting systems for their community benefits.

a. State Tax exemptions and Reporting Requirements Vary

The term "nonprofit" refers to the way that an organization is structured under state law, with the chief requirement being that such organizations are constrained with what they may do with their profits, particularly they cannot have equity owners entitled to receive distributions of revenue generated.[15] While nonprofit status is a requirement for state and federal tax exemption, it does not automatically confer tax-exempt status.[16] Nonprofit entities may apply for tax exemptions under the federal income tax, the state income tax, the state property tax, and the state sales/use tax.[17] Hospitals typically

11. Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility And How Should It Be Defined And Reported?*, 51 ST. LOUIS U. L.J. 459, 465 (2007)(citing studies by the Cong. Budget Off., the Gen. Acct. Off, and the Ctr. For Tax and Budget Accountability).

12. Theo Francis, *Politics & Economics: Lawmakers Question if Nonprofit Hospitals Help the Poor Enough*, WALL ST. J., July 20, 2007, at A5 (487 hospitals surveyed).

13. *See* Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients For Unpaid Bills*, 96 IOWA L. REV. 761, 771-72 n.62 (2011).

14. John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once For the Poor, Strike It Rich*, WALL ST. J., Apr. 4, 2008, at A1.

15. John D. Colombo, *Federal and State Tax exemption Policy, Medical Debt and Healthcare For the Poor* 51 St. Louis L.J. 433, 435-56 (2007).

16. *Id*. at 435.

17. *Id*. at 436.

organize themselves as nonprofit organizations under state law, and apply for federal income tax exemption as charitable organizations.[18]

Rather than waiting for federal laws to require hospitals to provide more charity care in return for federal income tax breaks, a number of states have either proposed legislation, pressured hospitals through their political branches, or passed laws that require a minimum charity benefit in return for state tax exemptions.[19] In 2008, the GAO reported that fifteen states have community benefits requirements, five of which (Alabama, Mississippi, Pennsylvania, Texas, and West Virginia) require a minimum amount of community benefits, while four of the fifteen (Illinois, Indiana, Maryland, and Texas) have penalties for hospitals that fail to comply with such requirements.[20] Even among states with minimum community benefit requirements, however, there is little congruity in level of detail or definition of community benefits.[21] Texas, for instance, requires that hospitals provide charity care at either five percent of net patient revenue, an amount equal to one hundred percent of the hospital's state tax exemption benefits, or a "reasonable level relative to community need, hospital resources, and tax-exempt benefit received."[22] Pennsylvania law differs in that it requires exempt hospitals to spend at least seventy-five percent of their net income, but not more than three percent of total operating costs on uncompensated care.[23]

With a minority of states requiring specific reporting of community benefits from nonprofit hospitals, it is unsurprising that no uniform national or multistate system extracts both qualitative and quantitative data from hospitals in order to determine a community benefit standard exists.[24] Thus, the "ambiguous state standards of community benefit, coupled with limited resources for monitoring and enforcement, have hampered state efforts to increase the provision of charity care by exempt hospitals."[25] One standard of community benefits reporting for a large number of hospitals was developed by the

18. *Id*.
19. *See* Lisa Kinny Helvin, *Caring For The Uninsured: Are Not-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 452-56 (2008).
20. GAO Report 2, *supra* note 5, at 16.
21. *Id*. at 17-18.
22. Lawrence E. Singer, *Leveraging Tax-exempt Status of Hospitals*, 29 J. Legal Med. 41, 52 (2008).
23. *Id*.
24. Helvin, *supra* note 19, at 455.
25. *Id*. (*citing Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways & Means*, 109th Cong. (2005) (statement of Nancy M. Kane, Professor of Mgmt., Harvard Sch. of Pub. Health).

VHA, formerly known as Voluntary Hospitals of America, an alliance which represents over 2,400 not-for-profit healthcare organizations, and the CHA, Catholic Health Association, the largest group of not-for-profit healthcare sponsors, systems, and facilities in the US, in a joint initiative to enhance community benefit reporting.[26] Its *Guide for Planning and Reporting Community Benefit* is perceived to be an excellent effort to standardize the reporting of community benefit, although controversial in its insistence to categorize bad debt and Medicare payment shortfalls as charity care.[27] The PPACA's new nationwide reporting standards may help alleviate this tension, as it requires hospitals to report bad debt and financial assistance and other community benefits at cost separately.[28]

b. Revocation of State Level Tax exemptions

Many states have requirements for tax exemption that are more stringent than federal 501(c)(3) standards.[29] Revocation of state tax exemptions may provide significant incentive to ensure that hospitals and other health care organizations make meaningful contributions to their communities in return for both state tax breaks. In a 1985 landmark case, the Supreme Court of Utah upheld a revocation of state tax exemptions because several hospitals in question used less than one percent of their revenues for free care for the poor.[30] In the same year, private nonprofit hospitals in Pennsylvania came under a high level of scrutiny when the Supreme Court held that Pennsylvania law required organizations to "donate or render gratuitously" a substantial portion of its services, in order to be considered charitable and thus eligible for state tax exemption.[31] By 1996, exemptions for 175 of the state's 220 private nonprofit hospitals had been challenged.[32] Following this increased scrutiny, however, few legislative or enforcement actions arose nationally, until recently, when the Illinois Supreme Court upheld the state property tax revocation of Provena Covenant Medical Center.[33] The Court ruled that the Medical

26. Singer, *supra* note 22, at 56.
27. *Id.*
28. IRS Form 990H instructions, available at http://www.irs.gov/pub/irs-pdf/i990sh.pdf.
29. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1144 (Ill. 2010)("tax exemption under federal law is not dispositive of whether real property is exempt from property tax in Illinois"); *Dialysis Clinic, Inc. v. Levin*, 938 N.E.2d 329 (Ohio 2010) (reconsideration denied).
30. *Utah County v. Intermountain Health Care Inc.*, 709 P.2d 265 (Utah 1985).
31. Hospital Utilization Project v. Commonwealth, 487 A.2d 1306 (Penn. 1985).
32. Colombo, *supra* note 15, at 442.
33. Singer, supra note 22, at 48; *Provena*, 925 N.E.2d at 1144 (Ill. 2010).

Center in Urbana, Illinois had not demonstrated that it provided sufficient charity care to justify the state property tax exemption, citing the hospital's lack of availability of charity care, contracts with for-profit doctors, and aggressive collection methods.[34]

c. Federal Litigation Unsuccessful

The practice of tax-exempt hospitals charging uninsured patients far more than insured patients is a practice many citizens and lawmakers find troubling. In 2004, a group of plaintiffs' lawyers filed over seventy federal cases against over 600 hospitals that pursued aggressive billing and collections policies against indigent patients, alleging that the health care providers had breached their charitable obligations mandated by their tax-exempt status.[35] Yet, plaintiffs have had little success challenging the tax-exempt status of hospitals and have found themselves without any standing to oppose the allegedly abusive billing practices of hospitals. The Panel on Multidistrict Litigation refused to centralize the 2004 federal class actions and various district courts dismissed nearly all of the plaintiffs EMTALA, FDCPA, and § 1983 claims.[36] In response to claims that hospitals were unjustly enriched by their tax exemptions when they did not provide affordable care, Judge Preska of the Southern District of New York stated that formulating federal health care policy is not a proper function of the court, and "[p]laintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."[37] Even a not-for-profit health group sued for allegedly charging uninsured patients four to five times more than it charged insured patients was not successfully litigated in court.[38]

Although the IRS has stripped health care organizations of tax-exempt status in the past, these types of administrative actions are not patient-driven, and only reach litigation stages when the organizations appeal the IRS decisions to federal courts.[39] These sporadic interventions from the federal government do not reflect that exemption from federal taxation plays a more prominent role in the affairs of nonprofit hospitals than state

34. *Provena*, *supra* note 29.
35. Helvin, *supra* note19, at 425.
36. Cohen, *supra* note 1, at 127-29.
37. Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 565-67 (S.D.N.Y. 2005).
38. *See* Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients For Unpaid Bills*, 96 Iowa L. Rev. 761, 775 (Jan. 2011).
39. *See* IHC Health Plans, Inc. v. Comm'r ., 325 F.3d 1188 (10th Cir. 2003) (finding that a corporate operator of health maintenance organizations (HMOs), did not qualify as charitable exempt organizations

tax exemption.[40] The greater relative importance of federal tax exemption in relation to state tax exemption is not because more money is at stake, but because federal tax law reaches into many aspects of hospitals operations, including governance, relationships with other providers, and charity care policies.[41] By requiring nonprofit hospitals to perform specific community benefits reporting to keep this vital federal tax exemption, Section 9007 should lead to more uniform and transparent standards and expansion of charity care.

III. PPACA'S NEW REQUIREMENTS FOR NONPROFIT HOSPITALS

The PPACA replaced I.R.C. 501(c)(3) with new I.R.C. § 501(r), which outlines additional requirements that hospitals must abide by in order to keep their federal tax exemption.[42] The new Internal Revenue Code provision replaces the old "community benefit activity" requirement with new, more detailed and varied requirements, including both action and reporting on the part of nonprofit hospitals and other healthcare providers.[43]

a. Community Health Needs Assessments

Starting on March 23, 2012, PPACA will require hospitals to perform a "community health needs assessment" (CHNA) every three years in order to keep their federal nonprofit status.[44] The CHNA reporting process will replace the community benefit standard, a standard which resulted in extremely varied charity practices among U.S. nonprofit hospitals and which left regulators unable to track hospital performance in order to recognize disparities in charity care and/or inflated charges.[45] Under the CHNA standard, each hospital must not only analyze their communities' needs in writing, they must also implement a strategic plan to meet these health needs.[46] The strategic plan must be publicly available, and a result of input from both public health experts and local

within the meaning of 501(c)(3)).

40. Barry R. Furrow et al., Health Law: Cases, Materials and Problems 997 (6th ed. 2008).
41. *Id.*
42. PPACA § 9007, *supra* note 3.
43. *Id.*
44. All § 9007 requirements other than CHNA apply to taxable years beginning after March 23, 2010. PPACA § 9007 (f), *supra* note 3.
45. Helvin, *supra* note 19, at 455.
46. PPACA § 9007 (a)(1)(3), *supra* note 3.

community members who represent interests in the area served by the hospital.[47]

As a follow-up to performing a CHNA, PPACA requires hospitals to include in their I.R.S. Form 990 not only a description of how the organization is addressing the needs identified in the CHNA, but also which needs are not being addressed and an explanation as to why they remain unaddressed.[48] These increased requirements for Form 990 may be a result of concern over abuse of tax-exempt status by hospitals, which may not provide many significant benefits to their communities. From 2000 to 2005, the number of nonprofit nongovernmental healthcare systems increased by nineteen percent, with the American Hospital Association reporting a fifty-six percent increase in the number of nonprofit hospitals associated with these health systems.[49] Through the CHNA requirement, PPACA requires this growing group of hospitals to collect meaningful input on what their communities need and execute a plan to address these needs. Consequently, when this information is publicized, it is likely to attract more quality dialogue between hospitals and the communities they serve. Hopefully, this process will enable hospital administrators to understand more clearly the needs of their communities, and better inform patients of the ways in which nonprofit hospitals intend to impact their communities.

b. Financial Assistance and Emergency Medical Care Policies

One prevalent issue that PPACA attempts to alleviate is patient billing, which many perceive as confusing and inequitable. The PPACA requires hospitals to establish a written financial assistance policy, to include:

The criteria for eligibility for financial assistance,

The method for applying for financial assistance,

The basis for calculating amounts charged to patients,

The action to be taken in the event of nonpayment, and

A description of the procedures to publicize the policy[50]

While most hospitals already have a financial aid policy in place, these requirements are an important step towards changing both the inner workings of hospitals, and the

47. *Id.*

48. *Id.* at § 9007(d).

49. Rummana Alam, *Not What The Doctors Ordered: Nonprofit Hospitals And The New Corporate Governance, Requirements Of The Form 990*, 2011 U. Ill. L. Rev. 229, 242 (2011).

external interaction between hospitals and the public.[51] By requiring hospitals to have a plan to publicize their financial assistance policies, PPACA makes it more likely that hospital employees will be familiar with their hospitals' policies and better able to identify who will qualify for aid, as well as more prepared to explain financial repercussions to patients.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals provide patients who present with emergency conditions a medical screening examination and stabilizing treatment, as appropriate, regardless of patients' ability to pay.[52] In a facially similar provision, PPACA requires hospitals to establish a written policy concerning emergency medical care, requiring the organization to provide care for emergency medical conditions regardless of the patient's ability to pay.[53]

c. Charge Caps and Billing Practices

Perhaps the most radical departure from past requirements for tax-exempt hospitals is PPACA's limit on the amount a hospital may charge for emergency or non-emergency medical care to patients eligible for financial assistance.[54] Hospital's collection efforts are often indicative of whether the care they provide is actually charitable: "aggressive collection efforts can have a chilling effect on indigent patients, preventing them from seeking care even though a hospital has an 'open admissions' policy."[55] PPACA caps the charges for these types of patients at not more than the amount generally billed to insurance companies with significant bargaining power, and prohibits the use of gross charges.[56] The Joint Committee on Taxation defined gross charges as follows:

A hospital facility may not use gross charges (i.e., "chargemaster" rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.[57]

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50. PPACA § 9007 (a)(4), *supra* note 3
51. Thai, *supra* note 38, at 778.
52. 42 U.S.C. § 1395dd (2000).
53. PPACA§ 9007(a)(1)(4)(b), *supra* note 3.
54. PPACA, *supra* note 3 (a)(1)(5), § 10903(a).
55. Helvin, *supra* note 19, at 455 *citing* Reply Brief for the Appellant, St. David's Health Care Sys. v. United States, 349 F.3d 232 (5th Cir. 2003) (Nos. 02-50959, 02-51312).
56. PPACA, *supra* note 3 (a)(1)(5)
57. JOINT COMMITTEE ON TAXATION, JCX-18-10), TECHNICAL EXPLANATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010) (hereinafter "JCT report").

Section 9007 also requires that hospitals refrain from engaging in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.[58] This provision is designed to prevent hospitals from pursuing overly aggressive billing practices such as lawsuits, liens on residences, arrests, body attachments, or other similar collection processes.[59] Congress intends the Secretary of the Treasury to issue guidance on what constitutes reasonable efforts to determine eligibility. Congress defines "reasonable efforts" as notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.[60]

Undoubtedly, PPACA's prohibition on hospitals engaging in extraordinary collections efforts is a direct response to the practices of some nonprofit hospitals such as putting liens on patient homes, garnishing wages, and even imprisoning debtors.[61] By defining what the government considers reasonable collection efforts and prohibiting gross charges, PPACA calls attention to the aggressive billing policies that some hospitals employ. The prohibition on hospitals charging exorbitant rates to those who can least afford may help the plight of those patients who cannot afford to advocate for themselves.

IV. HOW PPACA'S REQUIREMENTS MAY INCREASE PATIENT ACCESS

a. PPACA Requirements for the IRS

In addition to the new requirements for hospitals, PPACA also requires the IRS to take new action regarding the information they receive from CHNAs. It provides that the Secretary of the U.S. Treasury in consultation with the Secretary of Health and Human Services submit two reports to Congress.[62] Annually, Congress requires one report on the levels of charity care provided, bad debt expenses, and the unreimbursed costs of government programs with respect to both private tax-exempt, taxable, and government-

58. PPACA, *supra* note 3, at § 9007(a)(1)(6).
59. JCT Report, *supra* note 57, at 82.
60. *Id.*
61. Kane, *supra* note 11, at 462.
62. See PPACA, *supra* note 3, at § 9007(c).

owned hospitals, as well as the costs that private tax-exempt hospitals incur for community-benefit activities.[63] Additionally, the Secretaries must submit another report on trends within five years of the enactment of PPACA, which derives from reports submitted on levels of charity care in the annual reports.[64]

These reports will likely cause the IRS to allocate a significant amount of resources toward the evaluation of CHNAs and the analysis of the data presented by them. However, one major roadblock to this happening is the overall funding of the IRS. Without the resources to meaningfully evaluate the data PPACA requires of tax-exempt hospitals, IRS enforcement of the bill may exist largely in theory, leaving hospitals to comply on a largely voluntary basis. As federal tax exemption is so important to nonprofit hospitals, they may fully implement the policies PPACA requires of them without the looming threat of IRS audits of their actions. If properly executed, the IRS reports should include meaningful data on the broad levels of charity care hospitals provide their communities in return for their federal tax exemptions. If these reports are submitted to Congress as PPACA envisions them, the future may include even more legislation aimed at improving access in practical way for those who most need it, while also taking into account the financial constraints of hospitals.

b. Requirements of Hospitals: How Charge Caps May Benefit both Providers and Patients

Under PPACA, hospitals will be subject to review by the Department of Treasury at least once every three years.[65] Any hospital that fails to meet CHNA requirement for any taxable year will be subject to an excise tax of $50,000, which must be reported on the annual tax return, and may be faced with revocation of their federal tax-exempt status.[66] The broad changes that PPACA requires hospitals to make both internal/policy based and external/reporting based do call into question whether hospitals will be quick to make changes that will likely cost far more than the $50,000 fine.

"Bad debt" is a term used by hospitals to describe financial losses incurred from patient-pay balances.[67] A recent study illuminates how upfront discussions with patients

63. *Id*. at § 9007(e)(1)(A).
64. *Id*. at § 9007(e)(2).
65. PPACA § 9007(c) *supra* note 3.
66. *Id*. at § 9007(b).
67. Colombo, *supra* note 15, at 433 ("for-profits refer to [uncompensated care] as bad debt; nonprofits

and evaluations of their financial status may enable providers to decrease their bad debt levels.[68] It found that the value of the healthcare dollar decreases significantly once a patient leaves a facility without providing payment—with that dollar diminishing to thirty-three cents within six months, and plummeting to a paltry twelve cents in one year.[69]

The implementation and wide dissemination of financial aid policies required by PPACA may make significant strides in reducing both hospital "bad debt" and patient financial distress.[70] If hospitals consistently identify patients who require financial assistance at the point of service, verify their insurance status, and negotiate payment terms (including incentives such as prompt-payment discounts), patients will likely feel more comfortable and knowledgeable, enabling them to understand their financial responsibilities in return for services rendered. This is a stark contrast to current practices whereby uninsured or otherwise financially needy patients receive care, only to receive massive bills that they cannot pay, which may send them into bankruptcy, foreclosure, and prohibit them from seeking proper health care in the future, as well as increase the hospital's bad debt numbers.[71]

Capping the charges billed to patients who qualify for financial assistance is also likely to increase access, as well as increase the chances that a hospital will be repaid for services rendered to such patients. Ensuring that nonprofit tax-exempt hospitals do not charge uninsured and/or financially unstable patients premium prices for treatment is a key solution to both protecting such patients and making it possible for hospitals to receive payment for services they do render to them. PPACA addresses the fundamental issue that the least wealthy patients in the U.S. simply cannot afford to pay highest sticker price associated with different procedures, and capping the charges on these patients could help both the patients and hospitals alike.

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refer to it as charity care.")

68. *Patient Access and the PPACA*, 19 NO. 12 HEALTHCARE REGISTRATION 1, 8 (Sept. 2010) (this article also provides an excellent sample financial assistance policy and procedure).

69. *Id.*

70. McGregor, *supra* note 6, at 307 ("Since the average amount obtained through collection efforts is 'only seven cents on the dollar,' nonprofit health care organizations will recognize financial benefits to qualify these patients for charity instead.").

71. Kane, *supra* note 11, at 462.

V. CONCLUSION

The conflicting interpretations of the level of charity care that is appropriate for nonprofit tax-exempt hospitals to provide among hospitals themselves, regulators, and the media may be resolved through PPACA's new specific reporting standards, and leverage the benefits that hospitals receive in return for federal tax exemption into increased access to affordable care for needy patients. Hopefully, the transparency and consistency in charity care reporting required by Section 9007 of PPACA will enable IRS and Congress to better evaluate the clash between tax-exempt hospitals and those who feel that such hospitals do not "earn" their exemptions. Section 9007 provides for better communication between hospital, community, and patient than has typically existed in the past regarding the finance of healthcare. By catalyzing symbiosis rather than antagonism between low-income patients and nonprofit tax-exempt hospitals, the legislation may help resolve controversy surrounding the tax-exempt status of nonprofit hospitals and dramatically increase access to care.

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The Overuse of America's Emergency Rooms

*Alexandra Sternberg**

I. INTRODUCTION

A hospital emergency room can be a patient's one-stop-shop for an array of healthcare services, day or night, regardless of their ability to pay, or the severity of their condition.[1] As a result, not only is emergency room use growing in general, but a larger number of people are turning to emergency rooms for non-urgent care and for conditions that could be treated or prevented by primary care physicians. In fact, it is estimated that more than half of the 120 million annual emergency room visits are avoidable.[2] This inappropriate emergency room use creates major inefficiencies in both care and cost. First, those with non-urgent symptoms often receive better care from their primary healthcare providers.[3] Their use of the emergency room creates crowding, long waits, and added stress on hospital resources, thereby lowering the quality of care for those with true medical emergencies. Second, emergency room use costs vastly more than its alternative. Emergency room overuse is responsible for $38 billion in wasteful spending in the U.S. each year.[4] Therefore, reducing the overuse of emergency rooms will improve the care received by both urgent and non-urgent patients while cutting overall healthcare costs by billions of dollars each year. To do this the healthcare system must widen access to

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1. NEW ENGLAND HEALTHCARE INSTITUTE, A MATTER OF URGENCY: REDUCING EMERGENCY DEPARTMENT OVERUSE 2 (2010) http://www.nehi.net/uploads/full_report/pa_issue_brief__final.pdf [hereinafter NEHI].

2. NATIONAL PRIORITIES PARTNERSHIP, REDUCING EMERGENCY DEPARTMENT OVERUSE: A $38 BILLION OPPORTUNITY 1 (2010) http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=598.

3. Jeanne M. Lambrew et al., *The Effects of Having a Regular Doctor on Access to Primary Care*, 34 MEDICAL CARE 138, 143 (1996).

4. NEHI, *supra* note 1, at 1-2.

primary care and other alternatives to emergency room use, as well as create financial incentives to lower emergency room use for non-urgent conditions.

II. EMERGENCY ROOM USE IN THE UNITED STATES

The number of persons visiting the emergency room is increasing each year. From 1995 to 2005, the annual number of emergency room visits in the U.S. grew nearly 20 percent, from 96.5 million to 115.3 million.[5] More importantly, the use of emergency rooms for non-urgent care has also grown, from 9.7 percent of visits in 1997 to over 12 percent in 2006.[6] Shockingly, studies have shown that an estimated 56 percent of all emergency department visits are avoidable.[7] This is because a majority of patient's issues are non-urgent, treatable by primary care physicians, or are preventable.[8] This means that almost 67 million trips to the emergency room each year could be avoided.[9]

Although there is a widespread belief the poor and uninsured solely overuse the emergency room, research has shown that this is largely untrue.[10] The overuse of emergency rooms is widespread across the entire American population regardless of insurance status.[11] In fact, the insured are responsible for a disproportionate increase in emergency room visits.[12] However, statistics present that the more income people have, the less likely they are to ever visit an emergency room.[13] Also, African Americans and people over age seventy-five are most likely to visit emergency rooms.[14]

Those who do not have a regular doctor are more likely to use the emergency room for non-urgent medical needs, regardless of socioeconomic or health status.[15] Although research shows most American adults reported having a primary health care provider, many are still using the emergency room for issues that could be treated by their general

5. *Id.* at 2.
6. *Id.*
7. *Id.*
8. *Id.*
9. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 1.
10. NEHI, *supra* note 1, at 1-2; Maggie Fox, *Who's packing ERs? Not the uninsured*, RUETERS (May 19, 2010) http://www.reuters.com/article/2010/05/20/us-usa-health-emergencies-idUSTRE64I78X20100520.
11. NEIH, *supra* note 1, at 3.
12. *Id.*
13. Fox, *supra* note 10, at 1.
14. *Id.*
15. Laura A. Petersen et al., *Nonurgent Emergency Department Visits: The Effects of Having a Regular Doctor*, 36 MEDICAL CARE 1249, 1252 (Aug. 1998).

doctor.[16] This can be attributed to a lack of access to primary care physicians. A rise in patient demand due to the aging population and an increase in chronic diseases currently outpace the supply of primary care providers.[17] Long wait times in the physicians office, limited availability of appointments, or difficulty getting through to the physician on the telephone, all increase a patient's likelihood of turning to the emergency room despite having a primary doctor.[18]

III. COSTS TO THE HEALTHCARE SYSTEM DUE TO EMERGENCY ROOM OVERUSE

Inappropriate use of emergency rooms has significant financial and quality implications.[19] In terms of quality, the implications are two fold, affecting both the non-urgent and urgent patients' quality of care. Moreover, reducing emergency department overuse could lower overall healthcare costs by billions of dollars.

First, people who use a regular doctor for non-urgent care generally have better access to quality health care.[20] This is because emergency rooms are not optimal settings for the delivery of non-urgent care.[21] The episodic nature of emergency care lacks continuity and is rarely coordinated with care that occurs elsewhere.[22] Patients that receive continuous care by a regular healthcare provider benefit from enhanced clinical diagnostic accuracy and treatment, disease prevention, and higher rates of patient adherence to treatment regimens.[23] Higher continuity of care is also associated with decreased hospitalization due to better management of medical problems.[24] Regular doctors are also more likely to take preventative measures such as screening for cancer.[25] For instance, women with a regular source of care were approximately one-third more likely to have been screened for cancer than those without.[26] Additionally, individuals

16. George Rust et al., *Practical Barriers to Timely Primary Care Access*, 168 ARCHIVES INTERNAL MED. 1705, 1705 (2011).
17. NEIH, *supra* note 1, at 5.
18. Rust et al., *supra* note 16, at 1708.
19. Petersen et al., *supra* note 15, at 1252.
20. Lambrew, *supra* note 3, at 143.
21. NEHI, *supra* note 1, at 7.
22. *Id*.
23. *Id*.
24. *See* James M. Gill et al., *The Effect of Continuity of Care on Emergency Department Use*, 9 ARCHIVES FAM. MED. 333, 333 (2000).
25. Lambrew et al., *supra* note 3, at 143.
26. *Id.*

with poor to fair health are twice as likely to see a doctor if they have a regular doctor.[27]

Second, the increase in emergency room use for non-urgent care is overloading hospitals' resources, making it harder for those with urgent conditions to receive the care they require.

Treating an increased amount of non-urgent patients crowds hospital emergency rooms, creates longer wait times, and stresses hospital resources, lowering the quality of care for those truly in need of emergency care. Many hospitals cannot handle the increased number of emergency patients. A national survey in 2002 showed that 62 percent of all hospitals surveyed reported operating their emergency rooms at or beyond capacity.[28] Further, nearly one-third of all hospitals have experienced periods of "Emergency Department Diversion," having to divert some or all ambulances to other hospitals.[29] In 2003, emergency room overcrowding forced half a million ambulances to be diverted; averaging one ambulance rerouted every minute.[30] Some hospitals, like Chicago's Provident Hospital, have been forced to stop accepting ambulance runs to their emergency rooms.[31] Hospitals only have so many beds in their emergency departments and if non-urgent patients occupy them, they are unavailable for those with acute medical needs whom the emergency room was designed for in the first place.

Finally, researchers have estimated that the difference in costs between emergency departments and private physician's offices or similar locations account for billions of dollars nationwide.[32] In 2007, it was estimated that the average emergency room visit costs $767; $580 more than the cost of an office-based visit.[33] When multiplied by 67 million people who choose to use the emergency room instead of an office-based doctor, avoidable emergency department use results in $38 billion dollars of wasteful health care spending each year.[34]

If the American healthcare system is able to minimize the use of hospital emergency rooms for non-urgent, primary care physician treatable, and preventable healthcare needs,

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27. *Id.*
28. Rust et al., *supra* note 16, at 1705.
29. *Id.*
30. *Id.*
31. Monifa Thomas, *Provident to turn away emergency ambulances*, CHICAGO SUN-TIMES, Feb. 14, 2011, at 10.
32. Petersen et al., *supra* note 15, at 1252.
33. NEHI, *supra* note 1, at 6.
34. *Id.*

it will not only increase access and quality of care for millions of patients, but also save billions of healthcare dollars spent each year.

III. SOLUTIONS TO AVOIDABLE EMERGENCY ROOM USE

Barriers to timely access to primary care and a lack of alternatives create excess emergency department use.[35] This problem is so widespread that no one solution can prevent the 67 million unnecessary emergency room visits per year. The healthcare system must widen access to primary care, provide alternatives to the emergency room, and create financial incentives in order to lower emergency room overuse.

The first solution requires the healthcare system to provide better access to primary care physicians. This is especially important because those who do not have a regular doctor are more likely to use emergency care for non-urgent medical needs [36] and people who use a regular doctor for non-urgent care generally have better access to quality health care.[37]

Recognizing the need for expanded primary care, the Patient Protection and Affordable Care Act (PPACA) of 2010 has created several programs, which promote access to primary care providers. This includes programs to support workforce education and training and provide funding to expand primary care capacity.[38] The PPACA reauthorized programs that support residency training in primary care, provide need-based financial assistance for physicians in training and practicing primary care physicians, and supporting faculty and curriculum development.[39] Additionally, the PPACA requires residency programs to redistribute at least 65 percent of unfilled spots in non-primary care programs to primary care or general surgery residency programs.[40] Financial incentives for primary care physicians under the PPACA include a 10 percent increase in Medicare payments for primary care encounters starting in 2011.[41] The law also provides for the testing and implementing of new primary care delivery models and

35. Rust et al., *supra* note 16, at 1709.
36. Petersen et al., *supra* note 15, at 1252.
37. Lambrew et al., *supra* note 3, at 143.
38. John D. Goodson, *Patient Protection and Affordable Care Act: Promise and Peril for Primary Care*, ANNALS OF INTERNAL MED. 2 (2010) http://www.annals.org/content/early/2010/04/15/0003-4819-152-11-201006010-00249.full.
39. *Id.*
40. Robert B. Doherty, *The Certitudes and Uncertainties of Health Care Reform*, 152 ANNALS OF INTERNAL MED. 679, 680 (May 2010).
41. *Id.*

financial reimbursement methodologies to primary care physicians who improve outcomes for patients with chronic illnesses.[42] These programs may help to meet the increasing demand for primary care in the long term.[43]

However, due to barriers to primary care, many patients with a primary care physician still visit the emergency room for non-urgent care.[44] These barriers include long wait times in the physician's office, limited availability of appointments, or difficulty getting through to the physician on the telephone.[45] Luckily, most barriers are considered to be, at least partially, under the control of the primary care practice.[46]

Answering the telephone on time and the availability of timely and convenient appointments are just some of the ways primary care providers can break down barriers to care.[47] Further, providing patients with access to after-hours physicians or telephone consultations with nurses have been proven to reduce emergency room use.[48] One program showed that after implementing a call system, inappropriate emergency room visits were reduced from 41 percent to 8 percent.[49] Also, patients who receive care at primary care practices that offer evening and weekend hours are less likely to turn to the emergency room.[50]

Having a regular source of primary medical care is necessary but not sufficient to lower the risk of emergency room over usage. Primary care providers must provide continuity in their care. A continuous relationship with a physician allows a patient to develop trust in the physician's knowledge and medical judgment.[51] Therefore, whenever it is unclear whether a patient needs to go to the emergency room, they are more likely to defer to the physician's advice.[52] Further, patients under continuous primary care are less likely to be hospitalized because of better management of chronic issues, better screening for diseases, more comprehensive medical care and a higher

42. *Id.*
43. *Id.*
44. Rust et al., *supra* note 16, at 1705.
45. *Id.* at 1708.
46. *Id.* at 1709.
47. *Id.*
48. NEHI, *supra* note 1, at 8.
49. *Id.*
50. *Id.*
51. Gill, *supra* note 24, at 337.
52. *Id.*

likelihood of properly following treatment plans.[53] Therefore, not only will wider access to continuous primary care divert some emergency room use to doctor's office, it will also prevent future needs for the emergency room.

Secondly, the healthcare system needs to provide alternative sites for treatment of non-urgent conditions. Although they are small players in the health care arena,[54] retail-based clinics, like Walgreen's Take Care Clinic and CVS's MinuteClinic, present a great alternative to emergency room use. Retail based clinics are a straightforward model; they offer a limited menu of mainly acute and simple medical services on a walk-in basis, provide care through nurse practitioners or physicians assistants with lower salaries, and are located in small, relatively inexpensive retail spaces for easy consumer access.[55] Their inclusion in insurance coverage has allowed retail clinics to enter the mainstream healthcare system.[56] They also help alleviate emergency room overuse by those without a regular physician or insurance coverage. In one survey, thirty-three percent of respondents did not have a primary care provider and twenty-two percent reported being uninsured at the time they used the retail clinic.[57] Also, retail clinic visits cost one-fifth of emergency room visits.[58]

Hospitals themselves are also adding creative solutions to traditional emergency rooms to help relieve overcrowding. Some hospitals are using the InQuickER system to allow patients with issues that are not life threatening to sign-in online, wait at home, and come in at a specified time.[59] This is a viable option for hospitals without the ability to expand their emergency department in response to its ever-increasing use. Twenty-three emergency rooms in eight states have implemented this system.[60] Other hospitals have set aside nurses and doctors to treat patients with minor issues and non-urgent conditions.[61] Creating a separate track for patients who can be treated relatively quickly may reduce wait times and improve the overall flow of patients through the emergency

53. *See id.* at 333.
54. Margaret Laws & Mary Kate Scott, *The Emergency of Retail-Based Clinics in the United States: Early Observations*, 27 HEALTH AFFAIRS 1293, 1294 (2008).
55. *Id.*
56. *Id.* at 1294.
57. *Id.* at 1295.
58. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 2.
59. Brian Indrelunas, *ER patients can wait at home instead, for a price*, THE DESERT SUN, Feb. 10, 2011, at B5.
60. *Id.*
61. *Id.*

room.[62]

Finally, insurance companies can create monetary incentives for patients who use their primary care providers. Health insurance plans can include financial penalties in order to deter those who use the emergency room for non-urgent care. For example, several of Aetna's small-group HMO plans do not cover emergency room care that is deemed "non-urgent."[63] Insurance companies can also institute policies that encourage continuity of care, for example, offer lower co-payments for patients and higher reimbursements for physicians when visits are made to one's regular provider and higher copayments for non-urgent emergency room visits.[64]

IV. CONCLUSION

As the American population ages and the prevalence of chronic conditions rise, the barriers between primary care physicians and their patients increase. As a result, millions of people turn to hospital emergency rooms for non-urgent and primary care physician treatable and preventable illnesses each year. This has profound effects on our healthcare system. This increase in inappropriate emergency room use lowers the quality of care for both urgent and non-urgent patients, and wastes $38 billion healthcare dollars each year.[65] In order to solve the problem, the American healthcare system must widen access to continuous care by primary physicians and to emergency room alternatives like retail clinics must be widened, as well as create financial incentives by insurance companies. Lowering unnecessary emergency room use will not only save billions of dollars every year, but also, Americans will gain better access to quality health care.

62. NEHI, *supra* note 1, at 9.
63. Sarah Miller, *The Effect of Insurance on Outpatient Emergency Room Visits: An Analysis of the 2006 Massachusetts Health Reform* 5 (University of Illinois, 2010).
64. NATIONAL PRIORITIES PARTNERSHIP, *supra* note 2, at 1.
65. NEHI, *supra* note 1, at 1-2.

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The Patient Protection and Affordable Care Act: A Cure for Medical Bankruptcy?

Ashley Koenen[*]

I. INTRODUCTION

In 2009, an estimated 1.4 million Americans filed for bankruptcy.[1] Although bankruptcy was once largely attributable to job loss and family problems,[2] in recent years, medical-related costs have become its leading cause.[3] Bankruptcies due to medical costs, known as "medical bankruptcies," have risen by almost fifty percent over the past decade, and most bankruptcy filers are middle-class homeowners who have gone to college.[4] Few, it seems, are safe from the potentially devastating effects of staggering hospital bills and prescription drug costs. As Dr. Steffie Woolhander characterized the boundaries of medical bankruptcy, "Unless you're a Warren Buffett or Bill Gates, you're one illness away from financial ruin in this country."[5]

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1. ADMIN. OFFICE OF THE U.S. COURTS, 2009 REPORT OF STATISTICS REQUIRED BY THE BANKRUPTCY PREVENTION AND CONSUMER PROTECTION ACT OF 2005 5, *available at* http://www.uscourts.gov/uscourts/Statistics/BankruptcyStatistics/BAPCPA/2009/2009BAPCPA.pdf (last visited Mar. 28, 2011).

2. TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT 142 (Yale University Press 2000).

3. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 742 (2009).

4. *Id.* at 741 ("Using a conservative definition, 61.2% of all bankruptcies in 2007 were medical . . . Most medical debtors were well educated, owned homes, and had middle-class occupations."). The authors defined "medical bankruptcy" as including one of the following among debtors: $5,000 or at least 10 percent of income owed to uncovered medical bills; medical bills or illness as the reported reason for bankruptcy; two or more weeks of work-related income loss due to debtor illness or medical disability; two or more weeks of lost income due to a sick family member; a mortgaged home to pay off medical bills. *Id.; but see* David Dranove & Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. w74 (2006) (suggesting that medical bills are a contributing factor in just 17% of personal bankruptcies and that those affected tend to have incomes closer to poverty level than to middle class).

5. Theresa Tamkins, *Medical Bills prompt more than 60 percent of U.S. bankruptcies*, CNN HEALTH, (June 5, 2009), *available at* http://articles.cnn.com/2009-06-05/health/bankruptcy.medical.bills_1_medical-

In 2010, President Barack Obama passed the Patient Protection and Affordable Care Act (PPACA) to expand coverage for the uninsured, regulate out-of-pocket medical expenses, and prevent financial ruin over medical debt.[6] In an email to supporters following PPACA's passage, President Obama stated, "we'll finally start reducing the cost of care – creating millions of jobs, preventing families and businesses from plunging into bankruptcy, and removing over a trillion dollars of debt from the backs of our children."[7]

Despite the President's assurances, scholars have offered mixed reviews about whether the PPACA will ultimately produce a decline in medical bankruptcies.[8] PPACA proponents argue that it will prevent medical bankruptcy by limiting out-of-pocket medical costs and expanding medical coverage to people who did not previously have health insurance.[9] Others disagree, highlighting that most medical bankruptcy filers already have health insurance, approximately seventy-five percent,[10] and even after the full implementation of PPACA, families will continue to face significant out-of-pocket costs and obstacles in accessing health care.[11]

This article analyzes the dynamic ways the PPACA will affect U.S. bankruptcies and highlights its potential pitfalls. Part II provides a background to this analysis by exploring how medical debt contributes to a large and increasing share of U.S. bankruptcies and introduces the PPACA. Part III explains why scholars and politicians

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bills-bankruptcies-health-insurance?_s=PM:HEALTH.

6. Barack Obama, *Why We Need Healthcare Reform*, N.Y. TIMES, Aug. 15, 2009, at WK9 ("No one in America should go broke because they got sick."); *see* Sarah Rubenstein, *Obama Aims To Help Patients Wipe Away Medical Debts*, WALL ST. J. HEALTH BLOG, http://blogs.wsj.com/health/2009/01/07/obama-aims-to-help-patients-wipe-away-medical-debts/ (Jan. 7, 2009, 2:06 PM) (citing The Obama-Biden Plan, http://change.gov/agenda/economy_agenda ("Obama and Biden will create an exemption in bankruptcy law for individuals who can prove they filed for bankruptcy because of medical expenses. This exemption will create a process that forgives the debt and lets the individuals get back on their feet.").

7. Mark Silva, *President Obama marks healthcare victory: 'We did not fear our future – we shaped it'*, L.A. TIMES BLOG, (Mar. 22, 2010 6:05 AM), http://latimesblogs.latimes.com/dcnow/2010/03/president-obama-marks-healthcare-victory-we-did-not-fear-our-future-we-shaped-it-speech.html.

8. *See infra* Part IV.

9. *See, e.g.*, Cathy Sparkman, *An Objective Look At the Patient Protection and Affordable Care Act*, THE SURGICAL TECHNOLOGIST 208, 209 (May 2010), http://www.ast.org/publications/Journal%20Archive/2010/5_May_2010/LegUp.pdf ("Tax credits will apply to premiums and cost-sharing to ensure protection against bankruptcy due to medical expenses.").

10. Himmelstein et al., *supra* note 3, at 743 (noting that three quarters of medical debtors had health insurance when they filed for bankruptcy).

11. Claudia Chaufan, *A second opinion on U.S. health care reform*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM (July 2, 2010), http://pnhp.org/blog/2010/07/02/a-second-opinion-on-u-s-health-care-reform/ ("PPACA, by allowing the sale of premiums for policies that will cover only 60 percent of health expenses, will do predictably little to change this state of affairs.").

argue that the PPACA will significantly decrease medical bankruptcies. Part IV explores the alternative argument and observes that the PPACA, though a positive development, does not address many of the fundamental issues facing today's medical debtors. Ultimately, this article suggests that the PPACA will not produce a significant decline in medical bankruptcies throughout the United States.

II. MEDICAL BANKRUPTCY: AN OVERVIEW

Medical bankruptcy refers to a bankruptcy filing that was "significantly influenced by the medical problems facing someone in the family."[12] The largest contributing factors to medical bankruptcy include hospital bills, prescription drugs, doctor's bills, and other out-of-pocket medical expenses.[13]

Medical bankruptcies are on the rise.[14] As recently as twenty years ago, the aftermath of serious medical problems accounted for only eight percent of all bankruptcies.[15] However, a number of changes in the last twenty years—increasing health costs,[16] a surging number of uninsured and underinsured Americans,[17] and significant changes to the Bankruptcy Code[18]—have drastically changed the reasons Americans file for bankruptcy.[19] According to a 2007 Harvard study, medical problems accounted for 62 percent of all personal bankruptcies filed in the U.S.[20] Surprisingly, 78 percent of those filers already had medical insurance at the outset of their illness, and 60.3 percent of

12. *Working Families in Financial Crisis: Medical Debt and Bankruptcy: Hearing Before the Subcomm. On Commercial and Administrative Law of the H. of the Judiciary H.R.*, 110th Cong. 2-3 (2007) (statements of Elizabeth Warren, Leo Gottlieb Professor of Law, Harvard Law School).

13. *Id.* at 7.

14. Himmelstein et al., *supra* note 3, at 743.

15. *Id.*

16. G. CLAXTON ET AL., THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS ANNUAL SURVEY 1 (2009). Between 1999 and 2009, the family health insurance premiums increased by 131 percent. *Id.*

17. Annual Census Bureau estimates released in August show 47 million people, or 15.8 percent of the U.S. population, were without health insurance during 2006 — a 4.9 percent increase. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE BY SEX, RACE, AND HISPANIC ORIGIN: 1999-2009, Table HIA.1, *available at* http://www.census.gov/hhes/www/hlthins/data/historical/index.html. In 2005, census figures showed that 44.8 million people, or about 15.3 percent of the population, lacked health insurance coverage. *Id.*

18. In 2005, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act, which implement filing more difficult and expensive for some consumers. *See* Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. 109-8, 119 Stat. 23 (codified as amended in scattered sections of 11 U.S.C. (2005).

19. Bankruptcies due to medical bills increased by nearly 50 percent in a six-year period, from 46.2% in 2001 to 62.1% in 2007. Himmelstein et al., *supra* note 3, at 745-746.

20. Himmelstein et al., *supra* note 3, at 742.

those filers had private coverage.[21]

In an effort to address the rise of medical bankruptcy,[22] as well as other problems with the U.S. healthcare system, President Obama and the Democrats signed the PPACA into law on March 23, 2010.[23] The Act includes health-related provisions that will take effect over the next four years including: expanding Medicaid eligibility for people earning up to 133 percent of the federal poverty level, subsidizing insurance premiums for people earning up to 400 percent of the federal poverty level, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage and denial of claims based on pre-existing conditions, and providing support for medical research.[24] Significantly, these efforts will expand health care coverage to thirty-one million currently uninsured Americans through a combination of cost controls, subsidies, and mandates.[25]

III. IN SUPPORT OF PPACA: WHY REFORM SHOULD IMPACT MEDICAL BANKRUPTCIES

Politicians and scholars alike argue that the implementation of PPACA will produce a decline in medical bankruptcies.[26] They argue Americans are often driven to medical bankruptcy because they have little or no health insurance coverage and a significant health problem.[27] By expanding insurance coverage to include previously uninsured Americans and Americans with pre-existing conditions, and also guaranteeing that individual and family premiums are affordable, the PPACA will "end the cost-shifting and uninsurance that are the hallmarks of the current system," and effectively decrease the number of Americans that are driven to bankruptcy because of medical debt.[28]

PPACA supporters argued that these reforms would be particularly significant for

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21. *Id.*

22. Barack Obama, President of the United States, Address at the White House Forum on Health Reform Report (Mar. 5, 2009), transcript *available at* http://www.whitehouse.gov/assets/documents/White_House_Forum_on_Health_Reform_Report.pdf (when discussing why America needs healthcare reform, President Obama stated, "The cost of health care now causes a bankruptcy in America every 30 seconds.").

23. Patient Protection and Affordable Care Act (PPACA), Pub. L. No.111-148, 124 Stat. 119 (2010).

24. Jonathan Gruber, *The Cost Implications of Health Care Reform*, 22 N. ENGL. J. MED. 362, 2050, 2050 (2010).

25. *H.R.3590 - Patient Protection and Affordable Care Act: OpenCongress Summary*, OPENCONGRESS, http://www.opencongress.org/bill/111-h3590/show (last visited Apr. 3, 2011).

26. *See id.* at 8 ("The problems I have outlined in my testimony-families forced into bankruptcy . . . Congress can fix these problems."); *Hearing on Medical Debt: Is Our Healthcare System Bankrupting Americans? Before the Subcomm. on Commercial and Administrative Law Comm. of the Judiciary*, 111th Cong. 10 (2009) (statement of Elizabeth Edwards, Senior Fellow, Center for American Progress Action Fund).

27. *Id.*

28. *Id.* at 17.

people with disabilities and pre-existing conditions.[29] For patients with disabilities, the Democratic Policy Committee proclaimed that "[w]ithin a year of enactment, people who have health problems, but who lack access to health insurance, will be able to purchase a plan that protects them from medical bankruptcy."[30] Moreover, for patients with chronic illnesses and other pre-existing conditions, advocates contend that the PPACA will provide "greater financial stability and access to health care."[31] Effectively, PPACA supporters argue that healthcare reform will target those people most at risk for medical bankruptcy—those with inadequate health insurance—and that reform will "result in affordable, reliable insurance coverage for all Americans."[32]

IV. POTENTIAL PITFALLS: WHY INCREASED COVERAGE MAY NOT PREVENT MEDICAL BANKRUPTCIES

There is little disagreement that PPACA will dramatically expand health insurance coverage.[33] There is concern, however, about its implications for healthcare costs and for reducing the instance of medical bankruptcy.[34] Citing the failure of one state's health reform to significantly impact the number of medical bankruptcy filings and the PPACA's failure to eliminate high co-pays and out-of-pocket expenses, critics predict that medical debt will continue to plague Americans, long after the full implementation of PPACA.[35]

The PPACA was largely modeled after a landmark 2006 healthcare reform in Massachusetts, which required all adults in the Commonwealth to have health insurance coverage.[36] The mandate requires all uninsured adults in the state to purchase some kind

29. *How The Patient Protection and Affordable Care Act Will Help Americans with Disabilities*, DEMOCRATIC POLICY COMM., *available at* dpc.senate.gov/healthreformbill/healthbill36.pdf (last visited Apr. 3, 2011).

30. *Id.*

31. *Hearing on Medical Debt: Is Our Healthcare System Bankrupting Americans? Before the Subcomm. on Commercial and Administrative Law Comm. of the Judiciary*, 111th Cong. 17 (2009) (statement of Elizabeth Edwards, Senior Fellow, Center for American Progress Action Fund).

32. *Id.*at 7.

33. *See id.*

34. *See infra* Part IV.A-B.

35. *See,* Megan McArdle, *Will Health Care Reform Reduce Medical Bankruptcies?*, ATLANTIC (Dec. 20, 2010, 3:30 PM), http://www.theatlantic.com/business/archive/2010/12/will-health-care-reform-reduce-medical-bankruptcies/68304/.

36. Sharon K. Long & Karen Stockley, *Sustaining Health Reform in a Recession: An Updated ON Massachusetts As Of Fall 2009*, 29 HEALTH AFF. 1234, 1234 (June 2010).

of insurance policy or face a fine.[37] Their choices include a range of new and inexpensive policies—ranging from about $250 per month to nearly free—from private insurers subsidized by the state.[38]

The reform exceeded many expectations in terms of expanding insurance coverage to Massachusetts' residents.[39] In mid-2008, just 2.6 percent of Massachusetts state residents lacked insurance coverage, which was down from 9.8 percent in 2006.[40] Massachusetts now boasts the highest rate of coverage of any state in the nation, prompting Massachusetts Governor Deval Patrick to declare that, because of reform, "families [were] less likely to be forced into bankruptcy by medical costs."[41]

Unfortunately, increasing health insurance coverage did little to impact the medical bankruptcy rate.[42] According to recent a Harvard study, between mid-2000, prior to the reform, and early 2007, after the reform took effect, the share of medical bankruptcies in Massachusetts changed only slightly, from 59.3 percent to 52.9 percent.[43] Because there was a sharp rise in total bankruptcies during that period, the absolute number of medical bankruptcies actually *increased*, from 7,504 to 10,093 in 2009.[44]

Because the PPACA is largely patterned on the Massachusetts plan, the findings in Massachusetts cast doubt on the claim that the PPACA will ultimately reduce medical bankruptcies across America.[45] To explain why medical bankruptcies persist in Massachusetts—and may continue to persist after the implementation of national healthcare reform—the Harvard study's lead author, Dr. David Himmelstein stated, "Massachusetts' health reform, like the national law modeled after it, takes many of the uninsured and makes them underinsured, typically giving them a skimpy, defective private policy that's like an umbrella that melts in the rain: the protection's not there when you need it."[46] Effectively, even if Americans have healthcare insurance, if that

37. Robert Steinbrook, M.D., *Health Care Reform in Massachusetts — Expanding Coverage, Escalating Costs*, 26 N. ENGL. J. MED. 358, 2757, 2759 (June 2008).
38. *Id.*
39. Howard D. Larkin, *Mass. Appeal?* 83 HOSPITALS & HEALTH NETWORKS 26, 27 (May 2009).
40. *Id.*
41. Deval L. Patrick, *Massachusetts Is a Health-Reform Model*, WALL ST. J., Sept. 17, 2009, at A23.
42. David U. Himmelstein et al., *Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?* 124 AM. J. MED. 224, 227 (2011).
43. *Id.* at 225.
44. *Id.*
45. *See id.* at 228.
46. *Massachusetts Reform Hasn't Stopped Medical Bankruptcies: Harvard Study*, PHYSICIANS FOR A

insurance has too many co-pays, deductibles and loopholes, they will likely go bankrupt despite having coverage.[47]

The PPACA, which allows the sale of premiums for policies that will cover only sixty percent of health expenses, will do little to end medical bankruptcies.[48] Because most medical bankruptcies afflict middle-class families with health insurance, high premium costs and gaps that exist in most insurance coverage—co-payments, deductibles and uncovered services—will continue to leave families liable for substantial out-of-pocket costs.[49] Dr. Woolhandler, an advocate of a single-payer health-care system, reiterated Dr. Himmelstein's concerns, explaining that PPACA would do little to address America's increasing medical bankruptcy rate.[50] "Providing coverage is not enough. . . Reform also needs to help families *who already have insurance* by upgrading their coverage and assuring that they never lose it."[51]

V. CONCLUSION

At its core, PPACA is more focused on expanding insurance coverage and increasing access to health care than reducing healthcare costs. The Massachusetts model shows that merely providing insurance coverage to the majority of the population is not enough. Although Massachusetts was able to raise the rate of its insured population to the highest in the nation, insurance was not effective in reducing the rate of medical bankruptcies. This failure to produce a decline in medical bankruptcies is largely attributed to the Massachusetts' model failing to protect insured individuals from coverage gaps and high out-of-pocket expenses. In effect, the Massachusetts model overlooked the fact that the large majority of medical bankruptcy filers *already had* medical insurance at the outset of their illness. Thus, instead of targeting the adequacy of the insurance coverage that existed, reform focused expanding coverage to more people. If the Massachusetts model

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NAT'L HEALTH PROGRAM (Mar. 8, 2011, 12:01 AM), *available at* http://www.pnhp.org/news/2011/march/massachusetts-reform-hasnt-stopped-medical-bankruptcies-harvard-study.

47. Anne Underwood, *Insured, but Bankrupt Anyway*, N.Y. TIMES BLOG: PRESCRIPTIONS (Sept. 7, 2009, 11:30 AM) http://prescriptions.blogs.nytimes.com/2009/09/07/insured-but-bankrupted-anyway/.

48. *Id.*

49. *Mass. Health Reform Hasn't Halted Medical Bankruptcies*, U.S.NEWS (Mar. 8, 2011), http://health.usnews.com/health-news/managing-your-healthcare/insurance/articles/2011/03/08/mass-health-reform-hasnt-halted-medical-bankruptcies.

50. *Medical Debt: Is Our Healthcare System Bankrupting Americans? Hearing Before the Subcomm. on Commercial and Administrative Law Comm. of the Judiciary*, 111th Cong. 21 (2009) (testimony of Steffie Woolhandler, M.D., M.P.H., Harvard Medical School).

is any indication of what is to come, the PPACA will be insufficient in eliminating medical bankruptcies.

51. *Id.* at 24 (emphasis added).

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Loss of Financial Incentives for Physician Quality Reporting: Insult to Injury or a Step in the Right Direction?

*Elizabeth Ballek**

I. INTRODUCTION

In 2009, newly elected President Barack Obama told the nation, "we know that our families, our economy, and our nation itself will not succeed in the 21st century if we continue to be held down by the weight of rapidly rising health care costs and a broken health care system." [1] These costs are staggering with 2.5 trillion dollars spent on healthcare in 2009, equating to nearly eighteen percent of the gross domestic product of the United States.[2] Proportional quality outcomes related to these expenditures are not consistently seen however, as one author noted "[i]t is hard to ignore that in 2006, the United States was number 1 in terms of health care spending per capita but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for life expectancy.**"** [3]

These cost and quality issues affect all Americans, including the forty three million who are provided for each year as beneficiaries under Medicare.[4] The Medical Payment Advisory Commission recognized in 2008 that funding to the Medicare program was in

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1. Barak Obama, President, *Two Pillars of a New Foundation* (May 16, 2009), *available at* http://www.realclearpolitics.com/articles/2009/05/16/two_pillars_of_a_new_foundation_96530.html.

2. *Nat'l Health Expenditures Fact Sheet,* U.S. DEP'T OF HEALTH & HUMAN SERV. CMS. https://www.cms.gov/pf/printpage.asp?ref=http://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp (last visited Apr. 29, 2011)

3. Christopher J.L. Murray, et al., *Ranking 37th — Measuring the Performance of the U.S. Health Care System*, NEW ENGLAND JOURNAL OF MEDICINE, (Jan. 6, 2010), http://healthpolicyandreform.nejm.org/?p=2610.

4. *Medicare Coverage - General Information Overview*, U.S DEP'T OF HEALTH & HUMAN SERV. CMS http://www.cms.gov/CoverageGenInfo/ (last visited Feb. 14, 2011).

jeopardy and it is projected that the Medicare Part A Trust Fund will become insolvent by 2019.[5] In an effort to control costs, the Federal government has proposed cuts to physician and hospital funding for Medicare patients.[6] Though these proposed cuts have been close to passage in the legislature on several occasions, actual reductions were not implemented and the final decision on this issue has been postponed until late 2011.[7] In addition to the ongoing budget discussions, quality issues have also been reviewed, and in 2006, a quality reporting system was initiated through the Centers for Medicare and Medicaid Services (CMS).[8] Under the initial guidelines, reporting on quality data measures was voluntary.[9] In 2007, this changed to an incentive based program and participating physicians were paid a percentage return for reporting on quality measures for Medicare patients.[10] With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, additional changes were made to the system of quality reporting.[11] Though reporting remains "voluntary," physician incentives have been replaced by a negative incentives program.[12] This means that beginning in 2011, physicians who choose not to report data for their Medicare patients will lose the prior incentives on a tapering schedule, and will also see a decrease in their Medicare reimbursement rates.[13] This article will explore the possible reactions to and outcomes of these newest changes in the setting of an already stressed Medicare system and the potential effect of these changes on quality and access to care for America's growing Medicare population.

It is estimated that the United States total population, as of 2010, was roughly 310 million, with a little over forty million Americans being more than sixty-five years old. [14] By 2020, there will be nearly fifty-five million people over the age of sixty-five and

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5. *Report to the Congress: Reforming the Delivery System*, MED. PAYMENT ADVISORY COMM'N. (June 2008), *available at* www.medpac.gov/documents/jun08.; BARRY R. FURROW ET AL, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 768 (6th ed. 2006).

6. *Payment Action Kit - Medicare News and Resources.* AM. MED. ASS'N. http://www.ama-assn.org (last visited Feb. 19, 2011).[hereinafter *Payment Action Kit*]

7. *Id.*

8. DEP'T. OF HEALTH AND HUMAN SERVS., - CMS. CMS MANUAL SYSTEM, TRANSMITTAL 35, (2005), *available at* https://www.cms.gov/transmittals/downloads/R35DEMO.pdf.

9. *Id.*

10. U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, PHYSICIAN QUALITY REPORTING INITIATIVE - 2007 REPORTING EXPERIENCE, (Dec. 3, 2008) [hereinafter 2007 REPORTING EXPERIENCE].

11. Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148 § 3002 (2010)

12. *Id.* at (b)(8) (i-ii).

13. *Id.*

14. *U.S. Population Projections*, U.S. CENSUS BUREAU (Aug. 14, 2008), *available at*

eligible for Medicare coverage.[15] The President's estimated Medicare budget for 2010 was 447 billion dollars.[16] In Executive Summary of their June 2008 report, the Medicare Payment Advisory Commission stated that "[w]ithout change, the Medicare program is fiscally unsustainable over the long term and is not designed to produce high-quality care."[17] One of the Obama administration's stated goals is "to fundamentally reform our health care system, delivering quality care to more Americans while reducing costs for all."[18] Charged with a portion of this task, CMS has stated that they are attempting to become a purchaser of high quality health care by linking payment to the value of care provided.[19] To that end, they have initiated measures to assess the quality of care delivered.

II. PRIOR VERSIONS OF PHYSICIAN REPORTING

The first reporting program rolled out in 2005 by CMS, was the Physician Voluntary Reporting Program.[20] The program invited physicians to report data and identify the most effective ways to use the data in practice, with a goal of improving the delivery of care.[21] Some critics felt that while well intentioned, the lack of financial incentive did not foster interest.[22] In addition, the cost versus benefit of participating in this program was a potential deterrent.[23] The Tax Relief and Health Care Act of 2006, signed into law by former President George W. Bush, included a new provision for reporting of data on quality measures by physicians.[24] This new system, which had a start date of July 2007, was different in that while still voluntary, the reporting was linked to incentive payments for physicians.[25] CMS termed this new system, including the incentive payment

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http://www.census.gov/population/www/projections/summarytables.html.

15. *Id.*

16. Letter from Holly Stockdale, (May 20, 2009), *in* the CONG. RESEARCH SERV. REPORT FOR CONG. *available at* http://aging.senate.gov/crs/medicare4.pdf.

17. MED. PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: REFORMING THE DELIVERY SYSTEM, (2008), *available at* http://www.medpac.gov/documents/jun08_entirereport.pdf.

18. *A New Era of Responsibility: Renewing American Promise*, OFFICE OF MGMT. & BUDGET 1, 2 (2009) http://www.gpoaccess.gov/usbudget/fy10/pdf/fy10-newera.pdf

19. 2007 REPORTING EXPERIENCE, *supra* note 10 , at 22.

20. DEP'T. OF HEALTH AND HUMAN SERVS., *supra*, note 8 at 3.

21. *Id.*

22. Paul Stinson, *The PQRI catch-22: The CMS 1.5 percent reimbursement may incentivize IT adoption, but will it do so equally, and is it enough?* (Oct. 1, 2007)

23. *Id.*

24. 2007 REPORTING EXPERIENCE, *supra* note 10 , at 3.

25. *Id.* at 3,6.

structure, the Physician Quality Reporting Initiative (PQRI).[26] The new PQRI program, defined in the Tax Relief and Health Care Act, states that the physician who submits data on quality measures, as outlined in the CMS reporting system will, in addition to the amount otherwise paid, receive an additional amount equal to 1.5% of the allowed charges for all covered professional services.[27] To receive the additional payment, the physician must timely submit data selected from a list of seventy-four identified quality measures.[28] The list of reportable items includes a wide variety of high-volume disease and wellness categories over a broad reach of specialties including, for example, standard medication requirements for cardiac disease and stroke as well as the results of standard screening tools for cancer, cataracts, osteoporosis, diabetes and some childhood illnesses.[29] Data collection began in July 2007, and in the first six months, total incentive payments of $36,000,669 were made based on nearly 7.3 million valid quality data code submissions.[30]

CMS evaluated the first year of the program in a report in 2007 and concluded that while there were problems with the reporting mechanism itself, the program was successful "as more than half of all who participated in the program satisfied the statutory requirements for satisfactory reporting and thereby earned incentive payments." [31] In the final paragraph of the report, CMS was optimistic that participation would increase as the Medicare physician participation program had, and concluded that:

Medicare is rapidly transforming from a passive payer into an active purchaser of high-quality care by linking payment to the value of care provided. PQRI is an important first step toward establishing a value-based purchasing program for physicians. PQRI participation rates should increase over time, much like participation rates for the Medicare participating physician program, which began in 1984. . . . Initially, about 30 percent of physicians signed participation agreements, but the number increased to about

26. *Id.* at 3.
27. *Analysis and Payments* CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/PQRI/25_AnalysisAndPayment.asp#Topof Page (last visited Mar. 3, 2011).
28. 2007 REPORTING EXPERIENCE., *Supra* note 10, at 3.
29. Ctrs. for Medicare and Medicaid Servs. 2007 PQRI Quality Measures, Measures List http://www.cms.gov/PQRI/37_2007_PQRI_Program.asp#TopOfPage; U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, 2007 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) PHYSICIANS QUALITY MEASURES. (2007).
30. 2007 REPORTING EXPERIENCE, *supra* note 10, at 10.
31. 2007 Reporting Experience, *supra* note 10, at 17.

90 percent by the mid-1990s and was at 95 percent in 2007.[32]

The program continued into 2008 and 2009 after additions and corrections were made to the reporting system.[33] The incentive payment percentage remained 1.5 percent in 2008 and was increased to 2.0 percent in 2009.[34]

III. IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

In March 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. [35] Section 3002 of PPACA amended the Social Security Act to make changes to the existing PQRI system.[36] First, the program of incentivizing physicians for participation at a 2% rate was given an end date of 2014.[37] Incentive payments will phase-out on a tapering basis such that the rate will be 1% in 2011 and 0.5% for 2012 through 2014.[38] Following this, beginning in 2015, the fee schedule amount for services will be equal to the "applicable percent" of the fee that would otherwise apply to such services.[39] This means that the rate of reimbursement for services provided, for those physicians who do not satisfactorily submit data on quality measures will be reduced.[40] In 2015, the rate of reimbursement will be 98.5% of the regular fee amount and in 2016 and subsequent years, 98%. [41]

In addition, § 3002 of the Act states that by January 1, 2012, a plan will be in place to integrate the reporting of quality measures with the use of electronic health records (EHR).[42] Physician practice groups were already incentivized to show evidence that the professional was a "meaningful EHR user".[43] The new § 3002 language calls for integration, which consists of selection of reporting measures that demonstrate meaningful use of the EHR and the quality of care furnished to an individual.[44]

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32. 2007 REPORTING EXPERIENCE, *supra* note 6, at 22.
33. 2007 REPORTING EXPERIENCE, *supra* note 10, at 3.
34. *Analysis and Payments*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/PQRI/25_AnalysisAndPayment.asp#Topof Page (last visited Mar. 3, 2011).
35. PPACA, Pub. L. No. 111-148 § 3002 (2010).
36. *Id.*
37. 42 U.S.C.A. § 1395w–4(m)(1)(A) (2010).
38. *Id.* at (m)(1)(B)(i-iv).
39. *Id.* at § 1395w-4(a)(8)(A)(i).
40. 42 U.S.C.A. § 1395w-4(a)(8)(A)(ii)(I-II).
41. 42 U.S.C.A. § 1395w-4(a)(8)(A)(ii)(I-II).
42. Patient Protection and Affordable Care Act. Pub L. No. 111-148 § 3002(d).
43. 42 U.S.C.A. § 1395w-4(o)(1)(A)(B).
44. Patient Protection and Affordable Care Act. Pub L. No.111- 148 § 3002(d).

IV. PPACA CHANGES CONTEXTUALIZED

2010 saw an ongoing debate in both the house and senate regarding proposals to cut funding for Medicare up to twenty-five percent based on some estimates.[45] After multiple votes over the course of the calendar year, in December, President Obama signed the Medicare and Medicaid Extenders Act, postponed the debate on this issue to 2011.[46] This complex issue is not the subject of this article, however, the effect of PRQI changes must be considered in the context of the Medicare debate, as PRQI further affects physician reimbursement. The discussion of cutting Medicare funding is not new and the prospect of cutting reimbursement has been discussed and then postponed, multiple times over the last ten years. [47] In addition, a concept called Medicare opt-out began with the passage of the Balanced Budget Act of 1997, which included a provision allowing physicians and beneficiaries to privately contract for Medicare-covered services when certain requirements were met.[48] The ability to contract privately, allowed for physicians "opt out" of the Medicare program.[49] In 1998, CMS (then the Health Care Financing Administration), noted that there were benefits to opting-out, including a decreased chance for Medicare fraud and knowledge on the part of the beneficiary as to whether the services they sought under Medicare would be covered.[50] By 2005, the number of physicians opting-out was reportedly small with one source noting that that "very few" providers found opting-out attractive and the departure of this small group of providers did not appear to have created access problems for beneficiaries.[51] In 2007 however, the American Medical Association (AMA) noted that due to potential decreases in funding, "[m]any physicians may want to reconsider their current Medicare participation arrangements" and included opting-out as one of the possible options for

45. *Payment Action Kit*, *supra* note 6.

46. *Id.*

47. Markian Hawryluk, *CMS sticks to 4.2% Medicare pay cut: Physicians wait for Congress to act after proposed rule offers no relief.* Aug. 25, 2003. http://www.ama-assn.org/amednews/2003/08/25/gvsa0825.htm ; Mary Ellen Schneider, *Medicare Proposes 5.1% Physician Pay Cut in 2007*, INTERNAL MEDICINE NEWS, PRACTICE TRENDS 59 (Sep. 1 2006). http://imn.gcnpublishing.com/fileadmin/content_pdf/imn/archive_pdf/vol39iss17/74148_main.pdf.

48. *Testimony on Private Contracting in Medicare Before the Senate Fin. Comm.*(1998) (statement of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration).

49. *Id.*

50. *Id.*

51. William Buczko, *Provider Opt-Out Under Medicare Private Contracting*, HEALTH CARE FINANCING REV., /Winter 2004-2005, at 43.

change.[52] In 2009, a report of the Congressional Budget Office (CBO) found that a substantial reduction in payment rates could lead some physicians to stop accepting assignment of Medicare patients but also noted that it was difficult to evaluate the full extent of these reductions on access to care.[53] The report hypothesized that the reductions would affect physician participation variably by specialty with primary care physicians (PCPs) being the most likely to withdraw, as in many areas of the country, privately insured patients seek PCP services such as these physicians would not need to rely solely on Medicare as a source of reimbursement.[54] The CBO concluded that over time, the number of practicing PCPs would likely decrease. [55]

By 2011, The American Association of Physicians and Surgeons posted document examples, to facilitate Medicare opt-out including, "How to Opt Out of Medicare" and stated, "Thousands of physicians have already opted out."[56]

In February 2011, the House Ways and Means Committee heard testimony from CMS Administrator Dr. Donald Berwick, and Chief Actuary Richard Foster, regarding the impact of PPACA on senior citizens.[57] The Committee was dissatisfied with the answers of Dr. Berwick and was troubled by Mr. Foster's statement that "[i]f Medicare payment rates become lower than the current level for Medicaid, which would in fact happen over time under the Affordable Care Act, then it raises questions about the ability of beneficiaries to have access to care."[58] In a statement after the hearing, the Committee felt they had clear testimony from the CMS Administrator that "[S]eniors and other beneficiaries can expect higher costs and loss of access because of the Democrats' health care law." [59]

PRQI is inexorably linked to creation or maintenance of an electronic health record

52. *Payment Action Kit*, *supra* note 6; (last visited Mar. 30, 2011).

53. Letter from Douglas W. Elmendorf, Dir.**,** Cong. Budget Office to the Budget Comm. of the U.S. House of Representatives 1, 4 (Mar. 27, 2009).

54. *Id*. at 2.

55. *Id.*

56. *How to Opt Out of Medicare* ASS'N OF AM. PHYSICIANS & SURGEONS (Feb 1, 2011),http://www.aapsonline.org/medicare/optout.htm.

57. *See* Press Release, Committee on House Ways and Means, Medicare Chief Refuses to Answer Congressional Inquiries About the Health Care Laws' Impact on Seniors Would Not Change One Thing in the 2,200 Page Law, (Feb. 10, 2011), http://waysandmeans.house.gov/News/DocumentSingle.aspx?DocumentID=224603.

58. *Id.*

59. *Id.*

and § 3002 calls for an integration of quality reporting with EHR.[60] EHR has gained acceptance as a helpful and efficient method of keeping and culling data from the patient record, however, installation of such software can range from roughly $1,000.00 in a small practice to perhaps $15,000.00 in a larger group with considerable variation based upon the number of licensed users.[61] It is important to recall the statutory incentive program is in place to help defray costs in this area, but a survey by the Centers for Disease Control found that while approximately fifty percent of physician practices surveyed will be using EHR by 2010, only ten percent described use of fully functional systems. [62] To assist with the process, CMS published a document called PQRI Electronic Health Record Reporting Made Simple. [63] It is worthy of note however that in this document, the physician is counseled to "[c]ontact [their] EHR vendor to determine if [their] EHR system is qualified for use in PQRI EHR-based reporting." [64] The "qualified" language has sparked a market response to the EHR software need, such that a web-search for "[s]oftware installation, EHR" results in 180,000 hits.[65]

To add fuel to the fire for scrutinizing Medicare reimbursement, in early 2011, the Associated Press reported that 111 physicians, nurses, healthcare company owners and executives, and others had been charged with participating in Medicare fraud schemes involving more than $225 million in false billing, reportedly the largest healthcare fraud investigation ever in this county.[66] The allegations were widespread but included overcharging Medicare patients for procedures, which were unnecessary, or never completed at all.[67] It is into this tumultuous arena that the new PRQI changes have been brought.

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60. Patient Protection and Affordable Care Act. Pub. Law No. 111-148, at § 3002(d)(7).

61. EQUALITY HEALTHCARE INFORMATION FOR PHYSICIANS, http://eqhip.com/index.cfm/pageid/13 (last visited Fed. 11, 2011) ; Unicharts EMR, http://www.unicharts.com (last visited Feb. 21, 2011).

62. Chun-Ju Hsiao et al., Ctrs. For Disease Control and Prevention, Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates (Dec. 2010) *available at* http://www.cdc.gov/nchs/data/hestat/emr_ehr_09.

63. *2010 PQRI Electronic Health Record (EHR) Reporting Made Simple*, CTRS. FOR MEDICARE AND MEDICAID SERVS, Jan. 2010, *available at* https://www.cms.gov/PQRI/Downloads/2010EHRPQRIMadeSimpleFS032310f.pdf.

64. *Id.*

65. GOOGLE, http://www.google.com (last visited Feb. 11, 2011).

66. Kelly Kennedy, *111 charged in Medicare scams worth $225 million: A massive crackdown on Medicare fraud rounded up more suspects than any in history*, ASSOCIATED PRESS, Feb. 17, 2011, *available at* http://www.salon.com/news/healthcare_reform/?story=/news/2011/02/17/us_medicare_fraud_bust.

67. *Id.*

V. POSSIBLE EFFECT OF THE PPACA PHYSICIAN QUALITY REPORTING CHANGES

Given the current tenor of the healthcare debate in this county, the effect of the changes to the PQRI requirements and incentives may be perceived by physicians as another item on a list of wrongs under Medicare reform. For physicians, the last ten years have seen, among others, pending cuts to Medicare funding overall, loss of financial incentive and now decreased reimbursement for non-participation. From the perspective of the government, the PQRI changes may be seen as CMS taking logical action to become the "active purchaser of high-quality care" they had hoped to become as of 2007. Since 2005, the government has made a significant financial investment in the PQRI system including financial assistance for implementation of the EHR, four years of incentive payments and education while physician practices learned the PQRI system. Both sides may see the loss of incentive payments as being insignificant as in 2007, CMS reported the average payout to physicians was approximately $635.00 per individual provider and the mean payout for group providers was $4,713.00.[68]

IV. EFFECT OF THE PQRI CHANGES ON ACCESS TO CARE

The issue then becomes whether the changes in the PRQI will be the last-straw for physician practices and lead to a decrease in the number of Medicare patients physicians are willing to see. The answer may turn on whether the reporting actually improves the quality of care doctors can deliver to their patients. The pooling of the PQRI patient data can be likened to a disease registry, through which physicians are able to track their patients individually or by population, such that they can provide proactive care and treatment to individual patients or groups of similar patients.[69] The concept of pooling data to improve care is established and registries have been described as crucial in the management of patients with chronic diseases.[70] This is consistent with the goals of the PQRI program as the AMA reports that, after sorting of the data by CMS, PQRI results allow physicians to complete their own performance improvement activities.[71] Other

68. 2007 REPORTING EXPERIENCE, *supra* note 10, at 10.

69. IA DEP'T OF PUB. HEALTH, DISEASE REGISTRY ISSUE BRIEF, (Apr. 2010), http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/043010_executive_summary_draft.pdf.

70. *Id.*

71. *The AMA Practice Management Center. Physician Quality Reporting Initiative measured against AMA's Principles for Pay for Performance programs*, AMERICAN MEDICAL ASSOCIATION, Aug. 2008,

entities report that "PQRI is currently designed to encourage medical care providers to discuss quality care oriented questions during an office visit, as well as to encourage appropriate documentation of data in a patient's medical chart for follow up or reference at a later date and time. Reporting the requested data for PQRI incentive promotes awareness by providers and practices what data may or may not be fully or appropriately documented during their current patient process." [72] However, the Medical Group Management Association completed a survey regarding physician responses to PQRI in 2010.[73] This survey found continued dissatisfaction with accessing and use of feedback reports.[74] The survey included quotes from unidentified physicians with the negative responses clearly outweighing the positive. [75] One commenter felt that the process was working as "A couple of the measures for which we are reporting have actually proven to highlight areas where our physicians do need to pay attention to some clinical details."[76] Another however said "PQRI is a joke it has nothing to do with quality. Furthermore the reporting and feedback has been horrendous. . ." and a third "The PQRI is more trouble than it's worth but if penalties are put in effect we will have to participate." [77]

IV. CONCLUSION

CMS began to pave the path to this end in 2005 with the initiation of voluntary reporting. The incentivized reporting peaked interest and showed that it was possible for physician practices to participate in the PQRI data collection. The incentives for both PQRI and the installation of EHR facilitated participation. Participation in PQRI may be a good step for physician groups to take now, as it could be the basis for pay-for-performance programs of the future.[78] The setting is tumultuous and the end-of-the-day question is whether the structure, payments, data collection and involvement of the

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http://www.ama-assn.org/resources/doc/psa/CMS_pqri_chart.pdf

72. DocSite PQRI 2010 Frequently Asked Questions, COVISINT, DOCSITE PQRI http://www.docsite.com/products/pqri (last visited Apr. 30, 2011).

73. Press Release, MED. GRP. MGMT. ASS'N , Medical Practices Express Continued Frustration with PQRI Program. (Feb. 17, 2010), *available at* http://www.mgma.com/press/default.aspx?id=32798.

74. *Id.*

75. *Id.*

76. MED. GRP. MGMT. ASS'N, PHYSICIAN QUALITY REPORTING INITIATIVE LEARN 2010 MEMBER COMMENTS, (2010), *available at* http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=32797

77. *Id.*

78. Mary Ellen Schneider, *Medicare's PQRI Could be the Basis of Future P4P*, INTERNAL MEDICINE NEWS, PRACTICE TRENDS 50, (Apr. 15, 2010), *available at*

Federal government will result in higher quality, less expensive care for patients or will these measures drive already discouraged physicians away from Medicare beneficiaries. There may be enormous implications for the access to care, especially for seniors, as these events play out over the next several years.

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http://imn.gcnpublishing.com/fileadmin/content_pdf/imn/archive_pdf/vol43iss7/70397_main.pdf.

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Employee Wellness Programs: Improving Access to Healthcare or Legal Landmine?

*Eddie Young**

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, provides significant funding and rewards to improve the health status of the nation.[1] The Act is intended to combat America's downward spiraling health outlook by improving access to health care through efforts such as employee wellness initiatives.[2] While there are many advantages to these initiatives, employers must be cautious not to infringe upon discrimination laws and privacy rights when offering these programs.[3] Litigation based on this type of infringement will likely rise, as more employers implement these programs and federal and state employment laws become more complex.[4] Failing to take necessary precautions could cause such programs to do more harm than good.

I. WELLNESS PROGRAMS – AN EMPLOYER'S MECHANISM TO PROMOTE HEALTH

With movie seats expanding to accommodate increasingly larger patrons and airlines incurring rising fuel costs to transport heavier passengers, America needs help providing

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1. *Impact of the Health Care Reform Laws on Wellness Programs*, WELLSOURCE (last visited Feb. 28, 2011), http://www.wellsource.com/articles-wellnessrx/Impact-of-the-Health-Care-Reform-Laws-on-Wellness-Programs.html [hereinafter *Impact*].

2. *See id.*

3. Anne C. Bancroft, *Corporate Wellness: Is It Healthy For Employers?*, 55 PRAC. LAW. 39, 44-50 (2009).

4. Jennifer D. Thomas, *Mandatory Wellness Programs: A Plan To Reduce Health Care Costs Or A Subterfuge To Discriminate Against Overweight Employees?*, 53 How. L.J. 513, 554 (2010).

people with access to health care.[5] Even more troubling is the explosion of Americans who lack health insurance.[6] In 2010, estimates revealed that about fifty million Americans between the ages of eighteen and sixty-four did not have health insurance at some point in the twelve-month period preceding the study.[7] Additionally, about thirty-two percent of middle-income adults in this age bracket report being uninsured at some point in the same time period.[8] To further complicate things, health care expenditures are expected to nearly double from $2.4 trillion in 2008 to $4.3 trillion by 2018.[9] Of these expenditures, an estimated seventy-five percent of all healthcare costs stem from preventable chronic health conditions.[10]

To best counter this health crisis and its growing expenditures, many employers are turning to workplace wellness programs.[11] By definition, wellness programs are considered "any program designed to promote health or prevent disease."[12] These programs vary and often include: diagnostic testing for health problems, educational classes, or rewards for meeting certain weight, cholesterol, restraint from nicotine use or blood pressure targets.[13] While employees participate in these programs, employers also gain many benefits from having a healthy workforce such as lower absenteeism, greater productivity, better morale, and lower health insurance expenses.[14]

The early-established wellness initiatives often consisted of voluntary programs such as gym discounts, smoking cessation programs, and other preventative measures.[15] However, in light of the explosion of health care costs, employers are aggressively changing their wellness initiatives by charging higher health insurance premiums or deductibles to those employees who do not participate in wellness programs or choose to

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5. Bancroft, *supra* note 3, at 39.

6. *Access to Health Care*, CENTER FOR DISEASE CONTROL AND PREVENTION – VITAL SIGNS 1 (Nov. 9, 2010),*available at* http://www.cdc.gov/VitalSigns/pdf/2010-11-vitalsigns.pdf.

7. *Id.*

8. *Id.*

9. Daniel C. Rubenstein, *The Emergence Of Mandatory Wellness Programs In The United States: Welcoming, Or Worrisome?*, 12 J. HEALTH CARE L. & POL'Y 99, 99 (2009).

10. Elizabeth C. Ghandakly, *Employee Wellness Programs: A Cure For Employer Health Plans?*, 3 ENTREPRENEURIAL BUS. L.J. 37, 38 (2008).

11. Rubenstein, *supra* note 9, at 100.

12. Ann Hendrix & Josh Buck, *Employer-Sponsored Wellness Programs: Should Your Employer Be The Boss Of More Than Your Work?*, 38 Sw. L. Rev. 465, 468 (2009).

13. Sonja C. Rajki, *Workplace Wellness Programs: What's Legal, What's Not (and Why Your Company Should Have One)* (Aug., 2009), *available at* http://www.ssrl.com/library.html.

14. Bancroft, *supra* note 3, at 40.

15. Hendrix & Buck, *supra* note 12, at 469.

engage in unhealthy behavior.[16]

II. PPACA - SPREADING WELLNESS THROUGH FINANCIAL INCENTIVES

Beginning in 2011, provision § 10408 in the PPACA offers small businesses the opportunity to qualify for federal grants that help establish a wellness program in the workplace.[17] The provision offers financial incentives to employers with fewer than 100 employees who work twenty-five hours or more per week.[18] Additionally, to qualify for grant money, employers must not have had a workplace wellness program in place as of March 23, 2010.[19] To be eligible for the grant, the wellness program must contain health awareness initiatives, efforts to encourage employee participation such as financial incentives, initiatives to change unhealthy behaviors and lifestyle choices, and supportive environment efforts including workplace policies.[20]

Commencing, January 1, 2014, the PPACA will also allow employers to give reductions of up to thirty percent of the cost of insurance premiums to employees who participate in employee wellness programs.[21] Further rewards may be forthcoming, as discretion will be left to the regulatory agencies to increase this threshold to as much as fifty percent.[22]

Prior to the enactment of the PPACA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave employers the opportunity to lower the cost of health insurance premiums for employees participating in wellness programs.[23] HIPAA carries a strict non-discrimination rule that aims to prevent discrimination in health coverage as a result of a person's health status.[24] However, it offers an exception in the form of rewarding participation in a health wellness program.[25] While the HIPAA

16. *Id.* at 469-70 (some companies have implemented 'unhealthy behavior' fines for nicotine use).
17. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 10408 (2010).
18. PPACA, § 10408(b)(2)(A) (2010).
19. *Id.* at § 10408(b)(2)(B) (2010).
20. *Id.* at § 10408(c)(2) (2010).
21. HEALTH BENEFIT NEWS, WELLNESS AND PREVENTION PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 2 (last visited Feb. 28, 2011) http://healthbenefitsnews.com/wp-content/uploads/2010/05/WELLNESS_ppaca_Issue-Brief-May-2010.pdf [hereinafter WELLNESS].
22. *Id.*
23. *Id.*
24. BENEFIT ADVISOR, FINAL HIPPA NON-DISCRIMINATION RULES 1, (last visited May 2, 2011) http://www.mcgrawwentworth.com/Benefit_Advisor/2007/BA_Issue_1.pdf.
25. ERIN RIAN, LEAGUE OF MINNESOTA CITIES INSURANCE TRUST, WORKSITE WELLNESS PROGRAMS – THE GOOD, THE BAD & THE HEALTHY 3 (last visited Feb. 28, 2011), www.lmc.org/media/document/1/worksitewellnessprograms.pdf.

exception limits rewards to twenty percent of the cost of employee-only coverage under the plan, the PPACA expands the incentive to participate in an employee wellness program.[26]

III. IMPROVING ACCESS THROUGH INCENTIVES

Section 10408 and Section 2705 of the PPACA align to achieve the same goal of increasing participation in employee wellness plans. This comes as a relief considering many companies desperate to cut costs from their budget eliminated wellness programs during the height of the recent recession.[27] Section 10408 of the Act gives small employers who eliminated these programs prior to March 23, 2010, incentive to reinstate such programs.[28]

Several scholars have criticized the effectiveness of positive incentives, such as those outlined in Section 2705, in successfully increasing participation levels in wellness plans.[29] Suggestions have been made that penalties, such as charging employees higher insurance premiums for not participating in a wellness program, are more likely to increase participation.[30] For example, in 2008 PepsiCo introduced a $600 surcharge for smokers but also offered a smoking cessation program and nicotine replacement therapy.[31] As a result, PepsiCo saw a tenfold increase in participation in its wellness program coupled with a dramatic decline of employees who smoked.[32] While empirical evidence may suggest that such negative incentives may be more powerful, employers should be cautioned that such actions may trigger lifestyle discrimination claims or even disability claims.[33] Nevertheless, it is too soon to say whether the PPACA will persuade employers to shift towards offering positive incentives, and if so, whether this approach is the most effective means to increasing participation in a wellness program.

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26. WELLNESS, *supra* note 21, at 2.
27. Laura Petrecca, *Cost-Conscious Companies Re-Evaluate Wellness Programs*, USA TODAY (June 19, 2009), *available at http://www.usatoday.com/money/workplace/2009-06-16-wellness-programs-companies_N.htm.*
28. WELLNESS, *supra* note 21, at 2.
29. Thomas J. Parisi, *The Onus Is On You: Wellness Plans And Other Strategies Being Employed For Patients To Take Ownership Of Their Health*, 13 QUINNIPIAC HEALTH L.J. 243, 262 (2010).
30. *Id*. at 263.
31. Petrecca, *supra* note 27.
32. *Id.*
33. Parisi, *supra* note 29, at 263.

IV. LEGAL CAUTION FOR EMPLOYERS

While the PPACA may create strong incentives to encourage participation in a wellness program, employers should proceed with caution. Such programs implicate many federal laws including HIPAA, the Genetic Information Non-Discrimination Act of 2008 (GINA), Americans with Disabilities Act (ADA), and the Age Discrimination in Employment Act (ADEA).[34] For example, HIPAA requires that wellness programs meet a five-factor test if they are offering a reward based on satisfying a health factor.[35] Other laws such as GINA prohibit employers from collecting genetic information, such as family medical history, through a wellness program.[36] Similarly, the ADA prohibits employers from denying, on the basis of a disability, qualified individuals with a disability an equal opportunity to participate in the wellness programs.[37] As a result, employers must be prepared to offer a reasonable accommodation to an employee with a disability to ensure their participation.[38] Further, the ADA restricts employers from making medical inquiries or requiring medical exams unless they are job-related and a business necessity.[39] Additionally, the ADEA allows workers over the age of 40 to challenge their employer's wellness program on the basis of disparate impact.[40]

Restrictions imposed by these laws coupled with privacy rights of the employees often complicate the employer's desire to monitor employee health behavior.[41] Thus, it is often quite difficult to prove that an individual has achieved success in a wellness program, such as quitting smoking or changing eating habits.[42]

In addition to federal laws, many states also prohibit employers from engaging in "lifestyle discrimination."[43] For example, California has implemented off-duty conduct laws to protect employees from experiencing an adverse employment action for their

34. *Wellness Programs May Be Bad For Employers' Health*, LAWYERS.COM (last visited Apr. 3, 2011), http://labor-employment-law.lawyers.com/human-resources-law/Wellness-Programs-May-Be-Bad-For-Employers-Health.html.

35. Emily Noll, *Good-Intentioned Wellness Programs Need Rules Too*, CORPORATE WELLNESS MAGAZINE (July 8, 2010), *available at* http://www.corporatewellnessmagazine.com/article-detail.php?issue=issue-12&article=intentioned-wellness-programs.

36. *Id.*

37. *Workplace Wellness: Potential Legal Issues Associated With Workplace Wellness Plans* (last visited Apr. 3, 2011), http://www.hbbenefits.com/Workplace_Wellness_Potential_Legal_issues.pdf.

38. *Id.*

39. *Id.*

40. Noll, *supra* note 35.

41. Parisi, *supra* note 29, at 263.

42. *Id*. at 263-64.

participation in lawful conduct away from the workplace.[44] Meanwhile, other states protect the employee's use of lawful products but permit employers to discriminate in providing health insurance due to their negative health habits.[45]

Navigating the legal implications of wellness programs may be unsettling for many employers, especially small businesses who lack the resources for legal assistance. Section 4303 of the PCPAA provides some assistance in that it requires that the Center for Disease Control provide an educational campaign and technical assistance to promote the benefits of employee wellness programs, however, it is yet to be seen what net positive value this program will bring.[46]

V. CONCLUSION

The PPACA aims to rein in the growing expenditures of medical treatment through health and wellness promotion and prevention initiatives.[47] As recent as 2008, spending levels to treat preventable diseases had risen to approximately $303 billion to $493 billion annually.[48] While this cost seems astronomical, the detriment to the economy hurts most in terms of lost productivity and absenteeism in the workplace.[49] Understanding the costs associated with preventable diseases influences employers to take a proactive approach by investing in workplace wellness programs.[50]

Congress created the PPACA with certain mandates and incentives to promote wellness and healthier lifestyles, especially through workplace initiatives.[51] While employers often posses the best intention to utilize these programs to increase healthcare options for their employees, employees are not afraid to look to the judicial system to prevent employers from over-regulating their private lives.[52]

Only time will tell how successful the PPACA is in promoting access to health care. Although, the PPACA pushes employers to participate in wellness programs, it may end

43. Bancroft, *supra* note 3, at 48.
44. *Id.*
45. *Id.* at 48-49.
46. Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through The Affordable Care Act*, NEW ENG. J. MED. (Aug. 25, 2010), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1008560.
47. WELLNESS, *supra* note 21, at 1.
48. *Id.*
49. *Id.*
50. *See* Rajki, *supra* note 13.
51. WELLNESS, *supra* note 21, at 1.
52. Ghandakly, *supra* note 10, at 39.

up pushing employers right into the courtroom. Costly litigation in defending the employer from alleged violations of federal and state employment laws could ultimately hurt a company's bottom line and perhaps persuade them that wellness programs, while harmless on their face, are in actuality a legal land mine.

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Children's Health Insurance Program: Who Will Be Left Behind?

*Elizabeth Piekarz**

> We are not a nation that leaves struggling families to fend for themselves. No child in America should be receiving her primary care in the emergency room in the middle of the night. No child should be falling behind at school because he can't hear the teacher or see the blackboard. I refuse to accept that millions of our kids fail to reach their full potential because we fail to meet their basic needs. In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation—health care for our children is one of those obligations.[1] - President Barack Obama

I. INTRODUCTION

Although President Obama has said that ensuring the health and well-being of our nation's children is "one of the highest responsibilities we have," eight million American children remained uninsured in 2009.[2] That is not to say that the federal government has not tried to reduce this shocking statistic. In fact, large strides have been taken over the past fifteen years since the creation of the Children's Health Insurance Program (CHIP), which provides health care coverage to over five million uninsured children.[3]

The effect of a lack of access to insurance is clear—uninsured children are at a greater risk for preventable health problems because they are often likely to forego needed

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1. President Barack Obama, Remarks on Children's Health Insurance Program Bill Signing (Feb. 4, 2009), *available at* http://www.whitehouse.gov/the_press_office/RemarksbyPresidentBarackObamaOnChildrensHealthInsuranceProgramBillSigning/.

2. *Id.*

3. U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, NATIONAL CHIP POLICY OVERVIEW, http://www.cms.gov/NationalCHIPPolicy/ (last visited May 4, 2011) [hereinafter POLICY OVERVIEW].

medical care.[4] However, children who are enrolled in CHIP have reported much lower unmet health care needs, increased access to care, and better communication with providers than those who are uninsured.[5] Without the establishment of CHIP, it is likely that the number of uninsured children could be more than double what it is today.[6] Nevertheless, CHIP still leaves a gap in coverage. With the passage of the Patient Protection and Affordable Care Act (PPACA)[7], portions of CHIP were altered—some for the better and some without effectively increasing access to the program or access to health care for uninsured children at all. This article will address the sweeping changes brought by PPACA to CHIP and evaluate their potential successes or shortcomings.

II. HISTORY OF CHIP

CHIP began in 1997 when it was created as part of the Balanced Budget Act.[8] Written by the late Senator Edward Kennedy, a long time proponent of expanding health care to all Americans, the bill planned to increase the federal tax on tobacco products to help finance health care for children.[9] In its original form under Title XXI of the Social Security Act, it provided annual appropriations through fiscal year 2007.[10]

Like Medicaid, CHIP is jointly financed by the federal government and the states and

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4. KIDS AND HEALTH CARE: USING INSURANCE, CASH AND GOVERNMENT PROGRAMS TO MAKE SURE YOUR CHILDREN GET THE BEST DOCTORS, HOSPITALS AND TREATMENTS POSSIBLE 87 (Silver Lake Editors 2004) [hereinafter Silver Lake].

5. Jeanne M. Lambrew, *The Children's Health Insurance Program: Past, Present, and Future*, THE COMMONWEALTH FUND, vii (Jan. 2007), http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf (comparing 2 percent unmet needs to 11 percent unmet needs).

6. FAMILIES USA, IN PERSPECTIVE: A CLOSER LOOK AT HOW THE AFFORDABLE CARE ACT HELPS EVERYONE, 1 (Oct. 2010) http://www.familiesusa.org/assets/pdfs/health-reform/in-perspective/Reframing-the-Medicaid-Debate.pdf.

7. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. Silver Lake, *supra* note 4; *see* 42 U.S.C. § 1397aa (2006).

9. Robert Pear, *Hatch Joins Kennedy to Back a Health Program*, N.Y. TIMES, Mar. 13, 1997, http://query.nytimes.com/gst/fullpage.html?res=980CE4D81E39F937A25750C0A961958260. Senator Kennedy recognized that many Americans were essentially excluded from the health care system, and he devoted much of his time serving the state of Massachusetts to establishing universal access to health care. Mona Sarfaty, *Senator Kennedy's Legacy to U.S. Health and Health Care*, NEW ENG. J. MED. E31(1), Sept. 30, 2009,
http://www.nejm.org/doi/pdf/10.1056/NEJMp0908059. His tenure ran from just before Medicare and Medicaid
were voted into law, and ended with his death in August of 2009, just months before the Patient Protection and
Affordable Care Act was signed by President Obama. *Id.*

10. ELICIA J. HERZ , CHRIS L. PETERSON & EVELYNE P. BAUMRUCKER, CONG. RESEARCH SERV., STATE CHILDREN'S HEALTH INS. PROGRAM (CHIP): A BRIEF OVERVIEW 1 (2009) [hereinafter BRIEF OVERVIEW].

is administered by the states themselves.[11] However, CHIP was created for the purposes of filling in the gaps that Medicaid left in the health care system. Many families with children earn too much money to qualify for Medicaid, but do not earn enough to afford private health insurance.[12] Provided with the extra federal funds, states are given flexibility to design a program to fill in such gaps in coverage by: (1) expanding traditional Medicaid coverage; (2) creating new and separate programs aimed at kids; or (3) creating a combination of both a separate program and an expanded Medicaid program.[13]

In order to reach the targeted population, CHIP eligibility is usually limited to "low-income" children. To meet this "low-income" requirement, most states require that the child be less than 19 years of age, with no health insurance, who would not have been otherwise eligible for Medicaid under the rules in effect in the state on March 31, 1997.[14] Furthermore, states are able to set upper income limits up to 200 percent of the federal poverty line or 50 percentage points above the applicable pre-CHIP Medicaid income level.[15] Alternatively, a state may apply for a waiver to expand eligibility to all individuals under 19-years-old, no matter what their income level.[16] Yet, the state will not receive *unlimited* federal funding to maintain such a program.[17]

When funding was set to expire in 2007, Congress tried to expand the program only to face a veto from President George W. Bush, who feared it was a move towards the "federalization of health care."[18] While waiting for a new Presidential pen, Congress made an effort to alleviate some of CHIP's most obvious shortcomings. The result was

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11. POLICY OVERVIEW, *supra* note 3.
12. Silver Lake, *supra* note 4.
13. *Id.* at 88.
14. BRIEF OVERVIEW, *supra* note 10.
15. SENATE FIN. COMM., DESCRIPTION OF POLICY OPTIONS: EXPANDING HEALTH CARE COVERAGE: PROPOSALS TO PROVIDE AFFORDABLE COVERAGE TO ALL AMERICANS 19, May 14, 2009, http://finance.senate.gov/download/?id=1DD95955-E95D-4AC7-919D-DAA62490D249.
16. BRIEF OVERVIEW, *supra* note 10.
17. *Id.* One such program was implemented in Illinois, where in 2005 All Kids was created to build on Medicaid and CHIP to fill the need for children from families who earned too much for public support and not enough for private insurance. *Illinois All Kids Program: A First in Universal Health Care*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=14296 (last visited May 4, 2011). However, the idea that "all kids" would be eligible, even if paying small amounts on a sliding scale, came to a halt on January 25, 2011 when Governor Pat Quinn signed legislation that will re-introduce income limits to the program. *Quinn signs Medicaid reform bill*, WGN NEWS, Jan. 25, 2011, http://www.wgntv.com/wgntv-quinn-signs-medicaid-reform-jan25,0,801631.story.
18. David Stout, *Bush Vetoes Children's Health Bill*, N.Y. TIMES, Oct. 3, 2007, http://www.nytimes.com/2007/10/03/washington/03cnd-veto.html?_r=1.

the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).[19] Calling it a "down payment on [his] commitment to cover every single American," President Obama signed CHIPRA into law extending financing for CHIP through fiscal year 2013.[20]

CHIPRA made an effort to improve some of the flaws in CHIP's original design. Besides renewing funding for the program, CHIPRA added an optional state plan amendment to cover pregnant women.[21] Additionally, CHIPRA terminated the so-called five-year ban present under CHIP, which restricted access to the program for legal immigrants until they had resided in the United States for five years.[22] Under the new Act, states are permitted to waive the five-year bar for CHIP coverage to pregnant women and children who are lawfully residing in the United States and are otherwise eligible for such coverage.[23] However, the choice to remove the five-year requirement is optional, and remains in place in many states.[24] As a result, even after implementing CHIPRA, CHIP continues to be imperfect and millions of American children remained uninsured.

III. HEALTH REFORM ATTEMPTS NEW SOLUTIONS TO OLD PROBLEMS

In early 2010, President Obama signed yet another bill into law for the purposes of making health care and health care coverage available to all Americans, the Patient Protection and Affordable Care Act.[25] PPACA contains several provisions that bolster CHIP, building on the advances of CHIPRA and extending coverage to an estimated 7.3 million children.[26] While many of the provisions will likely prove to be an effective

19. Children's Health Insurance Reauthorization Act (CHIPRA), Pub. L. No. 111-3, 123 Stat. 8 (2009).

20. POLICY OVERVIEW, *supra* note 3.

21. BRIEF OVERVIEW, *supra* note 10, at 3.

22. KAISER COMMISSION ON MEDICAID & THE UNINSURED, CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 at 2 (Feb. 2009), http://www.kff.org/medicaid/upload/7863.pdf.

23. BRIEF OVERVIEW, *supra* note 10, at 4.

24. *See* NATIONAL IMMIGRATION LAW CENTER, MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, 1-4 (Jul. 2010), http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-07-28.pdf (providing a table of immigrant eligibility in each state). For example, Ohio goes so far as to deny Medicaid eligibility to a legal immigrant even after residing in the United States for the five-year period. *Id.* at 3.

25. FAMILIES USA, EXPRESS LANE ELIGIBILITY: EARLY STATE EXPERIENCES AND LESSONS FOR HEALTH REFORM, 1 (Jan. 2011), http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf; Sheryl Gay Stolberg, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 24, 2010, at A19, *available at* http://www.nytimes.com/2010/03/24/health/policy/24health.html.

26. FAMILIES USA, HOW HEALTH REFORM HELPS LOW-INCOME CHILDREN, 1 (2010), http://www.familiesusa.org/assets/pdfs/health-reform/Low-Income-Children.pdf [hereinafter HOW HEALTH

means of increasing access to the program, shortcomings remain.

a. Increased Federal Matching Funds

Without the help of the federal government, most states cannot carry the fiscal burden of increasing eligibility under CHIP on their own. PPACA begins by providing two additional years of federal funds for CHIP, thereby ensuring that the program continues to be available through the end of fiscal year 2015.[27] Yet, PPACA assumes that CHIP will continue even beyond 2015, calling for a twenty-three percent increase in each state's federal matching rate between 2016 and 2019.[28] Consequently, for the extended years, the federal matching rate will be *at least* eighty-eight percent in every state participating in the program.[29] Additionally, the PPACA requires that states maintain their current eligibility levels for children at the risk of losing *all* federal funding for *all* of the state's Medicaid programs.[30]

The bottom line is that the more money that is made available to the states, the more each is encouraged to utilize CHIP to supply health coverage to low-income children thereby preventing children from falling through the cracks and seeking medical care only after an emergency arises. In order to receive funds under PPACA, states are prohibited from enacting policies that would prevent additional children from enrolling, such as by increasing waiting lists, requiring more frequent renewals, or adding new eligibility criteria.[31] Additionally, the Act includes 40 million dollars solely for increasing promotional outreach in the community.[32]

So far, the financial incentives have had a positive effect on the number of children utilizing CHIP programming. In 2010, thirteen states expanded eligibility and fourteen states made improvements in enrollment and renewal procedures.[33] At the same time,

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REFORM HELPS LOW-INCOME CHILDREN].

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.* at 2. Such a threat proved effective in Arizona, when in early 2010 the Congress abandoned proposed legislation to eliminate its CHIP program entirely which would have left 47,000 low-income children without health coverage. *Id.*

31. *Id.* at 1.

32. *Id.* at 2.

33. MARTHA HEBERLEIN ET AL., HOLDING STEADY, LOOKING AHEAD: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST SHARING PRACTICES IN MEDICAID AND CHIP, 1 (Jan. 2011), http://www.kff.org/medicaid/upload/8130.pdf.

only two states have implemented restrictions in eligibility.[34] Such stability in CHIP can be directly attributed to supplying the states with fiscal relief.[35] The next hurdle will have to be faced in 2019, when the financial incentives disappear and states are left to their own devices.

b. Updated and Modernized Enrollment Procedures

Another of CHIP's biggest roadblocks since its inception has been finding a way to get all eligible children enrolled in the program. Almost seventy percent of all uninsured children are eligible, but not enrolled in CHIP (or some Medicaid equivalent).[36] PPACA works to make enrolling in CHIP easier than ever before.

First, PPACA mandates that the Secretary of the Department of Health and Human Services establish a system to allow families to apply for any form of assistance for which they are eligible.[37] The Secretary will provide each state with a single, simple application for three programs (the state exchange, Medicaid, and CHIP) and then applicants will be referred by the state's Medicaid department to the appropriate program for enrollment.[38] This ensures that children receive health coverage regardless of which program they initially apply through. To facilitate this process, PPACA requires that a secure, electronic interface be created to allow for determination of eligibility based on one application.[39] Finally, each state must establish a website to collect applications no later than 2014.[40]

As soon as enrollment is successfully simplified, the number of children with access to CHIP will increase dramatically.[41] At that point, the response must turn to outreach, because as the number of families who learn that CHIP is available for their children increases, so too will the utilization of services. Retention strategies will then become the

34. *Id.* at 9.
35. *Id.* at 1.
36. REACHING ELIGIBLE BUT UNINSURED CHILDREN IN MEDICAID AND CHIP, CTR. FOR CHILDREN & FAMILIES, 3 (Mar. 2009), http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy+center%2Feligibleuninsured%2Feligibleuninsuredccf.pdf [hereinafter REACHING].
37. ENROLLMENT POLICY PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, FAMILIES USA, 1 (Dec. 2010), http://www.familiesusa.org/assets/pdfs/health-reform/Enrollment-Policy-Provisions.pdf [hereinafter ENROLLMENT POLICY].
38. *Id.*
39. *Id.* at 2.
40. *Id.* at 3.
41. *See* REACHING, *supra* note 36, at 2.

key to success.[42] The fewer hoops that are required to jump through in order to remain in the system, the more likely a child will be to stay covered and have access to their health care provider without accumulating large bills in the meantime.

c. Addressing the Plight of Legal Immigrants

As previously mentioned, CHIPRA lifted the bar so that legally residing immigrant children and pregnant women could enroll in Medicaid and CHIP.[43] However, PPACA does not go far enough to ensure that all eligible, legal immigrants have access to the program. States are still not *required* to lift the five-year bar in their programs; rather they have the choice whether or not to do so.[44] In addition, they can choose to cover both legally residing immigrant children and pregnant women, just children, or just pregnant women.[45] Legally residing immigrants are not barred from receiving services, but the federal government does not mandate coverage either, because a state can still choose to restrict access to immigrant children until they have lived in the United States for five years.[46]

Under PPACA, states that do pick up the option to cover all legally residing children will receive a higher federal CHIP matching rate for providing that coverage.[47] As an extra incentive, the additional funds are only available for those children who would have been barred under the old five-year rule.[48] Unfortunately, as of July 2010, only 24 states had included some form of the option to cover children and/or pregnant women who were "legally residing" in their state.[49] If additional states do not feel compelled to change

42. *Id.*

43. EXPANDING COVERAGE FOR RECENT IMMIGRANTS: CHIPRA GIVES STATES NEW OPTIONS, FAMILIES USA, 1 (Aug. 2010), http://familiesusa2.org/assets/pdfs/chipra/immigrant-coverage.pdf [hereinafter EXPANDING COVERAGE].

44. ROBERT WOOD JOHNSON FOUNDATION, STATE OF THE STATES, 7.4-7.5 (Feb. 2011), http://www.statecoverage.org/files/u34/SOS%20chapter%207.pdf [hereinafter STATE OF THE STATES]. In practice, the harsh citizenship requirements imposed prior to the passage of CHIPRA had the effect of delaying benefits to a number of eligible United States citizens who did not have ready access to the paperwork to prove it. Donna Cohen Ross, *New Citizenship Documentation Option for Medicaid and CHIP is Up and Running*, CTR. ON BUDGET & POLICY PRIORITIES, 1 (Apr. 20, 2010), http://www.cbpp.org/files/4-20-10health.pdf.

45. EXPANDING COVERAGE, *supra* note 43, at 1.

46. *See* STATE OF THE STATES, *supra* note 44. However, a state electing to cover lawfully residing children must offer coverage to *all* children who meet the definition—not just a subgroup of this population. Memorandum from Cindy Mann to State Health Officials (Jul. 1, 2010) *available at* https://www.cms.gov/smdl/downloads/SHO10006.pdf.

47. EXPANDING COVERAGE, *supra* note 43, at 3.

48. *Id.*

49. Informational Bulletin from Cindy Mann, Dir., Cntr. for Medicaid, CHIP & Survey & Cert. (Jul. 9,

their enrollment criteria in response to the new financial incentives, then the federal government must find a different way to encourage the inclusion of these children in CHIP across the states—even if it means prohibiting the five-year ban in its entirety.

IV. CONCLUSION

Since its inception in 1997, CHIP has provided health care to millions of our nation's children. Still, eight million more children remain without health care and it is time for a solution. PPACA made some important changes to CHIP—including increased federal matching funds and simplifying enrollment procedures—but when it comes to opening access to CHIP for legal immigrants, a great deal of work remains to be done. Until states are required to open up access to all children legally residing in their state, far too many will be left without support during some of their most important years of development.

2010), *available at* https://www.cms.gov/CMCSBulletins/downloads/07-09-2010-CHIPRA-and-ACA.pdf.

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Soda Taxes: A Missed Opportunity or An Untested Tactic?

*April Schweitzer**

I. INTRODUCTION

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (PPACA), into law.[1] This Act aims to expand healthcare coverage, control costs, and improve healthcare delivery in the United States.[2] The Congressional Budget Office estimates the new law will cost approximately $938 billion over ten years.[3] Ultimately, the cost of the Act is being financed through savings from Medicare and Medicaid as well as new taxes and fees, including an excise tax on high-cost insurance.[4] However, the Senate Finance Committee held several roundtable discussions on financing comprehensive health care reform where they considered and ultimately rejected many other funding options, including a national soda tax.[5]

Proponents estimate that a new excise tax of one cent per twelve-ounce can of non-diet soft drinks, including both carbonated and non-carbonated beverages, would generate about $1.5 billion per year.[6] A tax of one cent per ounce, as suggested by former New York City Health Commissioner Tom Frieden and Yale obesity expert Kelly Brownell,

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of 42 U.S.C.).

2. KAISER FAMILY FOUNDATION, FOCUS ON HEALTH REFORM: SUMMARY OF THE NEW HEALTH REFORM LAW 1 (2010), www.kff.org/healthreform/upload/8061.pdf.

3. *Id.* at 13.

4. *Id*.

5. *See* MICHAEL F. JACOBSON, CENTER FOR SCIENCE IN THE PUBLIC INTEREST, HEALTH CARE REFORM: *PREVENTION* IS ESSENTIAL 1 (May 12, 2009). The use of the terms "soda," "sugar-sweetened beverage," and "soft drink" are used interchangeably throughout this article in reference to any tax on the following carbonated and non-carbonated beverages: non-diet sodas, fruit and vegetable drinks, energy and sports drinks, iced teas and coffees, and flavored milk.

6. *Id.* at 2.

would generate approximately sixteen billon dollars per year.[7] Additionally, proponents further estimate that each penny tax per can of soda would lower soft drink consumption by about one percent.[8]

The first part of this article explores the links between sugar-sweetened beverages and obesity. The article goes on to describe the circumstances surrounding the proposal of a national soda tax and what tactics are now being utilized in individual states to curb sugar-sweetened beverage consumption since a soft drink tax was not included in the PPACA. The last part of the article focuses on the effectiveness of soda taxes. Although no single intervention will solve the obesity problem, soda taxes may provide incremental benefits and thus should be considered as a viable public policy.

II. THE LINK BETWEEN SUGAR-SWEETENED BEVERAGES AND OBESITY

Obesity is regarded as an epidemic in the United States due to a drastic increase in the rate of adult obesity over the last three decades.[9] There are serious long-term health effects from obesity, including type II diabetes, coronary heart disease, stroke, and cancer.[10] Some studies suggest that the health costs associated with obesity are greater than those associated with both smoking and drinking.[11] Medical costs for overweight and obese patients alone are estimated to be $147 billion, which amounts to 9.1 percent of all health care costs in the United States.[12]

Based on a systematic review of cross-sectional and longitudinal studies, the consumption of sugar-sweetened soft drinks has been linked to higher rates of obesity.[13] Thus, a case can be made for the need to reduce consumption of such beverages. Sugar-sweetened soft drinks contain "added, naturally derived caloric sweeteners, such as sucrose, high-fructose corn syrup, or fruit-juice concentrates, all of which have similar

7. *Id.* at 6.
8. JACOBSON, *supra* note 5, at 6.
9. Jason Fletcher et al., *Can Soft Drink Taxes Reduce Population Weight?*, 28 CONTEMP. ECON. POL'Y 1, 1 (Jan. 2010).
10. *Id.*
11. *Id.* According to the Campaign for Tobacco-Free Kids the total annual health care expenditures caused by smoking are $96 billion. According to the Marin Institute the annual health care expenditures for alcohol-related problems are $22.5 billion.
12. Kelly D. Brownell et al., *The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages*, 361 NEW ENG. J. MED. 1599, 1602 (Oct. 15, 2009).
13. *Id.* at 1599.

metabolic effects."[14] Such beverages are marketed widely to adolescents, and during the last decade–children consumed more sugar-sweetened beverages than milk.[15] Currently, these beverages account for between ten and fifteen percent of a child's caloric consumption each day.[16] The probability of a child becoming obese, increases by sixty percent for each extra glass of sugared beverage consumed per day.[17]

In the United States, soft drink consumption has been labeled as one of the major factors in the exploding rates of obesity.[18] Over the last fifty years soft drink consumption has increased by almost 500 percent.[19] One study suggests that cutting 100 calories per day could prevent weight gain in over ninety percent of people.[20] Such a decrease in caloric consumption could be obtained by consuming one fewer twelve-ounce can of sugar-sweetened soft drink each day.[21] Similarly, one would need to walk an additional mile each day to offset the caloric intake from the extra twelve-ounce can of soda.[22] Most would agree that consuming one less twelve-ounce soft drink would be easier than walking an extra mile each day. That is why Michael Jacobson, Executive Director of the Center for Science in the Public Interest, testified in favor of a tax on soft drinks as a way to decrease consumption, fund health reform, and support programs to promote healthy diets.[23]

III. CONGRESS CONSIDERS A SOFT DRINK TAX TO FUND HEALTH CARE REFORM

The proposal for a national excise tax on soft drinks was raised in May 2009 as part of the Senate Finance Committee's negotiations on health care reform.[24] Then in July 2009, President Obama mentioned the possibility of a national soda tax as part of an interview with Men's Health Magazine.[25]

As a result of the Senate Finance Committee considering a soda tax as a way to help

14. Brownell et al., *supra* note 12, at 1599.
15. Kelly Brownell & Thomas Frieden, *Ounces of Prevention - The Public Policy Case for Taxes on Sugared Beverages*, 360 NEW ENG. J. MED. 1805, 1805 (Apr. 30 2009).
16. *Id.* at 1805-06.
17. *Id.* at 1806.
18. Fletcher et al., *supra* note 9, at 1.
19. *Id.*
20. *Id.* at 2.
21. *Id.*
22. *Id.*
23. *See* JACOBSON, *supra* note 5, at 6.
24. Christine Spolar & Jospeh Eaton, *Food Lobby Mobilizes, As Soda Tax Bubbles Up*, HUFFINGTON POST, Nov. 4, 2009, http://www.huffingtonpost.com/2009/11/04/soda-tax-mobilizes-food-l_n_345840.html.

fund health reform – soft drink makers, supermarket companies, agriculture and the fast food business began pouring millions of dollars into campaigns opposing such a tax.[26] According to a report filed with the Senate Office of Public Records, in the first nine months of 2009, industry groups spent more than twenty-four million dollars working against the idea of a national excise tax on sugar-sweetened beverages among other legislative and advocacy initiatives.[27] Some activities included organizing petitions drives, asking Hispanic and African-American interest groups to write letters to their legislators and generating e-mail blasts characterizing the tax as unfair to low income people.[28] Additionally, print ads ran in publications, such as Roll Call, The Hill, and Politico, targeting lawmakers directly.[29] Approximately five million of the twenty-four million dollars reported was spent on an advertising campaign targeting lawmakers and promoting a coalition called Americans Against Food Taxes.[30]

The Americans Against Food Taxes group defines itself as a coalition of "responsible individuals, financially-strapped families and small and large businesses," and the membership list appears to be dominated by Burger King Corporation, Coca Cola, Pepsico, Domino's Pizza, and other similar corporations.[31] In September 2009, the group took out a full-page ad in The Washington Post, which was written as an open letter to Congress saying, "Don't tax our groceries."[32] Additionally, Americans Against Food Taxes ran commercials on cable networks, such as CNN, MSNBC, and Fox News, in a further effort to target legislators.[33]

In the end, the opposition's money was well spent because the proposal "ran into a committee with a lot of farm members," who are sympathetic to the food industry, and who ultimately killed the proposal before it ever made it out of the Senate Finance Committee.[34] The overall perception was that a national soda tax would not have

25. *Id.*
26. *Id.*
27. *Id.*
28. *Id.*
29. Natalie Zmuda, *Beverage Lobby Launches Campaign Against Soda Tax*, ADVERTISING AGE, Sept. 25, 2009, http://adage.com/article?article_id=139281.
30. Spolar & Eaton, *supra* note 24.
31. *Id.*
32. William Neuman, *Coke CEO Versus Obama on Soda Tax Proposal*, N.Y. TIMES, Sept. 17, 2009, http://www.cnbc.com/id/32896454/Coke_CEO_Versus_Obama_on_Soda_Tax_Proposal.
33. *Id.*
34. *See* Spolar & Eaton, *supra* note 24. Some have pointed out that the members of the Senate Finance

generated the kind of revenue needed to truly fund health reform.[35] Representative Bill Pascrell Jr., from New Jersey said that House lawmakers also considered including a soda tax as part of their health reform bill but ultimately decided against it because "[it] didn't look like we had the votes."[36]

Consequently, by November 2009, there was no longer a proposal for a national excise tax on soda in any of the health care reform bills under consideration in Congress.[37] However, the issue had gained traction, and because there was ultimately no national soda tax included in the PPACA, it is now up to the states to enact sugar-sweetened beverage taxes if they so choose. In May 2010, a White House task force on childhood obesity invited the states to do just that by suggesting that states experiment with taxing sugar-sweetened beverages as a way to reduce consumption.[38]

IV. TO TAX OR NOT TO TAX SOFT DRINKS AT THE STATE LEVEL

State-level soda taxes currently exist in thirty-three states.[39] The primary goal of such taxes thus far has not necessarily been to curb consumption but rather to generate revenue.[40] While there are those who argue that the government should not interfere in the market and that products and prices will change when consumers demand more healthy options, most economists agree that government intervention is necessary when there are "market failures."[41] Several such market failures exist in the case of sugar-sweetened beverages, including a lack of public understanding about the link between soft drink consumption and health, shortsighted decision-making, and externality costs.[42]

First, since many people do not fully understand the link between consumption of soft drinks and health consequences, consumption decisions are made without adequate

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Committee are especially sympathetic to the food industry: Democratic Chairman Max Baucus is from Montana, a large producer of sugar beets, and ranking member Republican Chuck Grassley, comes from Iowa, the nation's largest producer of corn which is a key ingredient in high fructose corn syrup used in sugar-sweetened beverages.

35. *Id.*

36. Neuman, *supra* note 32.

37. Spolar & Eaton, *supra* note 24.

38. Sal Gentile, *As White House tackles obesity, lawmakers eye soda as culprit*, NEED TO KNOW ON PBS, May 11, 2010, http://www.pbs.org/wnet/need-to-know/health/as-white-house-tackles-obesity-lawmakers-eye-soda-as-culprit/566/.

39. Brownell et al., *supra* note 12, at 1599.

40. Fletcher et al., *supra* note 9, at 3.

41. Brownell et al., *supra* note 12, at 1601.

42. *Id.*

information.[43] Such decisions are further distorted due to extensive marketing and advertising campaigns that tout the benefits of consumption. For example, "the National Cancer Institute only spends about one million dollars annually on the media component of its 5-A-Day campaign to encourage people to consume more fruits and vegetables."[44] Conversely, each year the beverage industry spends more than six hundred times that amount solely on advertising.[45] Coke and Diet Coke alone spend approximately $154 million on advertising each year.[46]

A second failure is the result of shortsighted decisions, which provide short-term gratification and long-term harm.[47] The third market failure has to do with externality costs.[48] One such externality cost is the almost forty billion dollars spent annually on issues related to obesity by Medicare and Medicaid at the expense of taxpayers.[49]

V. WHY SOFT DRINK TAXES ARE BEING PROPOSED IN THE FIRST PLACE

Soft drink taxes have been proposed for several reasons. First, soft drinks are the single largest contributor of energy intake at over seven percent.[50] Additionally, soft drinks are high in free sugars, which ultimately reduce appetite control and lead to weight gain.[51] Further, "the increase in soft drink consumption has mirrored the increase in obesity rates."[52]

Currently, the financial crisis has sparked more interest from officials in the states who need to make up for lost tax revenues.[53] The Center for Science in the Public Interest released a study in which the results concluded states could raise an estimated ten billion dollars a year by adding a seven-cent tax to a twelve-ounce can of sugar-sweetened soft drinks.[54] For example, $139 million could be generated in Arkansas, New York could

43. *Id.*
44. Michael F. Jacobson & Kelly Brownell, *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, 90 AM. J. PUB. HEALTH 854, 854 (June 2000).
45. *Id*.
46. *Id.*
47. Brownell et al., *supra* note 12, at 1601.
48. *Id.* An externality is a cost to a party that is not directly part of the transaction.
49. Brownell & Frieden, *supra* note 15, at 1806.
50. Fletcher et al., *supra* note 9, at 1.
51. *Id.*
52. *Id.*
53. Spolar & Eaton, *supra* note 24.
54. *Id.*

raise $937 million, and $1.8 billion could be generated in California from such a tax.[55]

One objection to a tax on sugar-sweetened beverages is that it would be regressive.[56] Similar arguments were made about tobacco taxes, but proponents successfully argued that the "poor face a disproportionate burden of smoking-related illnesses, that nearly all smokers begin to smoke when they are teenagers, and that both groups are sensitive to price changes."[57] Similarly, the poor also suffer from illnesses that are a consequence of both unhealthy diets and brand loyalties for sugar-sweetened beverages engrained since childhood.[58] However, sugar-sweetened beverages are not necessary for survival, and an alternative (i.e., water) is available at little or no cost; hence, a tax that shifted intake from sugar-sweetened beverages to water would benefit the poor both by improving health and by lowering expenditures on beverages.[59]

Another objection is that imposing a tax on sugar-sweetened beverages fails to solve the obesity epidemic and will affect those people who consume even small amounts of such beverages.[60] While this may be true, reducing caloric intake by just one to two percent annually could potentially have a notable impact on health in all age groups, and there would be less financial burden on those who consumed small amounts of sugar-sweetened beverages.[61]

Given the possible effect on sales, the beverage industry has launched opposition campaigns in every state that has considered a sugar-sweetened beverage tax and can be expected to continue to do so just as the tobacco industry has continued to oppose tobacco taxes.[62] When an eighteen percent sales tax on sugar-sweetened beverages was being considered in New York, PepsiCo threatened to move its corporate headquarters.[63] Likewise, the tobacco industry has continually opposed policy changes by financing front groups with names that suggest grassroots community involvement just as the beverage

55. Brownell et al., *supra* note 12, at 1603.
56. Lisa M. Powell & Frank J. Chaloupka, *Food Prices and Obesity: Evidence and Policy Implications for Taxes and Subsidies*, 87 MILBANK Q 229, 247 (2009).
57. Brownell et al., *supra* note 12, at 1603.
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. Brownell et al., *supra* note 12, at 1603.
63. *Id.*

industry has done by creating the Americans Against Food Taxes coalition.[64] In this past election cycle, the American Beverage Association spent more than one million dollars gathering signatures to get Initiative 1107 to repeal the soda tax in Washington State.[65] Although the tactics differ from state to state, the message is typically the same: "Don't lay the blame for obesity solely on soda."[66]

Public support for food and beverage taxes to address obesity has increased steadily from "thirty-three percent in 2001 to forty-one percent in 2003 and then to fifty-four percent in 2004."[67]

VI. SALES TAXES V. EXCISE TAXES

The most common way soft drinks are currently taxed is through a sales tax that is added as a percentage of the retail cost.[68] Unfortunately, there are several disadvantages to solely applying a sales tax. For example, such taxes may encourage consumers to simply purchase cheaper brands thereby forfeiting any calorie reduction.[69] Additionally, since a sales tax is added at the register some consumers will only become aware of the tax after deciding to purchase the item and lastly, the sugary syrups used in fountain drinks continue to be untaxed.[70]

On the other hand, excise taxes are more likely to affect consumer-purchasing decisions because wholesalers and producers will pass the extra cost along to retailers and ultimately to consumers.[71] Additionally, taxes levied on producers and wholesalers are easier to enforce because of the smaller number of businesses that would be required to comply.[72]

Further, consumers may be unaware of state sales taxes given that they are typically not apparent on shelf prices, and sales receipts only list the total sales tax paid not the sales tax on individual products.[73] Recent evidence supports the contention that many

64. *Id.*
65. Joey Peters, *Soda Taxes Fizzle in the Wake of Industry Lobbying*, THE WASHINGTON POST, July 13, 2010, at A-Section.
66. *Id.*
67. Brownell et al., *supra* note 12, at 1603.
68. *Id.* at 1602.
69. *Id.*
70. *Id.*
71. Brownell et al., *supra* note 12, at 1602.
72. *Id.*
73. Jessica Todd & Chen Zhen, *Can Taxes on Calorically Sweetened Beverages Reduce Obesity?*, 25

customers may not be aware of sales taxes on items when the tax is not included in the shelf price, and that "the economic incidence of the tax may be dependent on whether the tax is imposed on the manufacturer, retailer, or consumer."[74] Moreover, research suggests that specific excise taxes levied based on particular units provide more incentive to producers to lessen the amount of sugar per unit than a sales tax.[75]

VII. WHAT EXACTLY IS A SUGAR-SWEETENED BEVERAGE?

Most state sales taxes apply to caloric and diet carbonated beverages, but exclude other calorically sweetened beverages, such as fruit drinks, flavored milk, or sweetened coffees.[76] Thus, the tax can be avoided by simply substituting the untaxed products for taxed carbonated beverages while still consuming the same amount of calories.[77] Under the proposal floated by the Senate, sugar-sweetened beverages would have included "a variety of carbonated and non-carbonated beverages, such as non-diet sodas, fruit and vegetable drinks, functional drinks such as energy and sports drinks, iced teas and iced coffees, and flavored milk and dairy drinks," but not beverages with non-caloric sweetener.[78]

One controversial issue among states stems from the use of non-caloric sweeteners. Even though no negative health effects have been consistently demonstrated, some are concerned that diet beverages will ultimately increase calorie consumption by justifying consumption of other foods.[79] Currently, most researchers do not support taxing beverages with non-caloric sweeteners, but instead recommend additional research to determine whether taxing such products might be good policy in the future.[80]

VIII. THE EFFECTIVENESS OF SOFT DRINK TAXES

According to the studies that have been conducted thus far, it appears as though soft drink taxes do help to curb obesity, yet whether this decrease is significant is still up for

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CHOICES THE MAGAZINE OF FOOD, FARM AND RESOURCE ISSUES (2010), http://www.farmdoc.illinois.edu/policy/choices/20103/2010307/2010307.html.

74. *Id.*

75. Brownell et al., *supra* note 12, at 1602.

76. Todd & Zhen, *supra* note 73.

77. *Id.*

78. Carrie Budoff Brown, *Smokers, Diet-Soda Drinkers Spared?*, POLITICO, May 18, 2009, http://www.politico.com/news/stories/0509/22675.html.

79. Brownell et al., *supra* note 12, at 1603.

80. *Id.*

debate. For example, one study found that an increase of one percentage point in the state soft drink tax rate would lead to a decrease in body mass index (BMI) of .003 points.[81] The same study also discovered, the eighteen percent increase proposed in New York in 2008, "may not have a substantial effect on population weight."[82] Such results suggest that taxes may influence behavior but that the changes are likely not drastic enough to translate into significant changes in population weight.[83]

However, those under the age of eighteen, those with lower-incomes, or those who already have elevated BMIs are more likely to respond to price changes than older, healthier-weight or higher-income individuals.[84] In particular, one study found that "the BMI of children living below the federal poverty level was about fifty percent more sensitive to fruit and vegetable pricing than was the BMI of higher-income children."[85] This is relatively consistent with an another study which found the effects of sales taxes have the greatest impact on children who are heavier, come from low income families, are African American or who watch a lot of television.[86] These results were particularly significant for children who attend schools where sugar-sweetened beverages are available.[87]

There a number of events that must take place in order to link soft drink taxes to a decrease in obesity. First, the tax increase must actually result in higher prices for consumers.[88] Second, the higher prices must truly reduce consumer consumption and third, the decrease in consumption needs to translate into a reduction in obesity.[89] There is some evidence of each effect individually, but there is little research about whether all of the effects actually work together to decrease obesity. One study found that "an increase in soft drink tax rates leads to an increase in the price of soft drinks."[90]

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81. Fletcher et al., *supra* note 9, at 7.
82. *Id.* at 2.
83. *Id.* at 8.
84. Frank J. Chaloupka et al., *Sugar-Sweetened Beverage Taxes and Public Health,* ROBERT WOOD JOHNSON FOUNDATION (July 2009), *http://www.healthyeatingresearch.org/images/stories/her_research_briefs/ssb_taxes_and_public_health_her research_brief_7.31.09_final.pdf.*
85. *Id.*
86. Roland Sturm et al., *Soda Taxes, Soft Drink Consumption, And Children's Body Mass Index*, 29 HEALTH AFF. 1052, 1057 (2010).
87. *Id.*
88. Fletcher et al., *supra* note 9, at 3.
89. *Id.*
90. *Id.*

Additionally, other studies have found that a ten percent tax increase will reduce the consumption by two percent.[91]

Taken together, it may be a fair assumption that if soft drink taxes reduce consumption and consumption is related to obesity then soft drink taxes may reduce obesity. However, the availability of substitutes may make the taxes less effective.[92] An increase in sugar-sweetened beverage taxes will be less effective in reducing consumption and thereby fighting obesity if there are close substitutes with similar caloric content readily available.[93] Additionally, other foods, such as cookies or chips could also fill the caloric void left from decreasing consumption of sugar-sweetened soft drinks.[94]

IX. CONCLUSION

Even though soft drinks are the single largest contributor of energy intake in the United States over the past decade, soft drinks only account for about seven percent of total energy intake.[95] Consequently, only modest changes in population weight can be expected due to decreases in consumption as a result of tax increases.[96] As one may guess, the higher the tax imposed, the higher the reduction in BMI, but even a fifty-eight percent increase in soft drink taxes would only decrease the mean BMI in the United States by 0.16 points.[97]

Undoubtedly, a tax on soft drinks will raise billions of dollars in tax revenue for the states. A tax levied per ounce would be easiest to administer, and although it is more complicated, it is possible to levy a tax based on sugar content.[98] Additionally, an excise tax that incorporates a higher price visible to consumers will be more effective than a sales tax which may not allow the consumer to see the true price until after the purchasing decision has been made.[99]

If the money generated from a tax is used to help fund additional obesity-reduction programs, such as nutrition education, the tax will likely be more effective than if used as

91. *Id.*
92. Fletcher et al., *supra* note 9, at 4.
93. *Id.*
94. Todd & Zhen, *supra* note 73.
95. Fletcher et al., *supra* note 9, at 9.
96. *Id.*
97. *Id.* at 10.
98. Sturm et al., *supra* note 86, at 1058.
99. *Id.*

a way to increase the monetary cost of consumption alone.[100] Any tax on a specific food or group of foods can only address one small aspect of the obesity epidemic. "Diet choices are the result of a complex set of household and individual decisions, reflecting not only economic factors but also social and cultural norms."[101] Americans currently consume about 250 to 300 additional calories each day than several decades ago with almost half of the additional calories coming from sugar-sweetened beverages.[102] Although no single intervention will solve the obesity epidemic, soda taxes may provide incremental benefits and thus should be considered as a viable public policy.

100. Todd & Zhen, *supra* note 73.
101. *Id.*
102. Brownell & Frieden, *supra* note 15, at 1806.

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The Independent Payment Advisory Board: Will it Effectively Curb the Medicare Growth Rate?

*Laura B. Morgan**

I. INTRODUCTION

The Medicare program is growing at an explosive rate. Today, Medicare provides access to vital healthcare services for forty-seven million disabled and elderly Americans.[1] By 2030, due to an aging population and increasing life expectancies, this number is expected to reach eighty million.[2] Because of this dramatic increase in Medicare enrollees—together with new technologies and increased use, volume, and prices of healthcare services—total Medicare spending is expected to rise from its current rate of $519 billion annually to $929 billion annually by 2020.[3]

The Patient Protection and Affordable Care Act (PPACA) addresses the widespread concerns over these rising healthcare costs and the growing federal budget deficit[4] through its numerous measures designed to curb the growth rate of Medicare spending.[5] Some of these measures include a tax on "Cadillac" insurance plans, increased coordination of care through the establishment of medical homes and accountable care

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1. KAISER FAMILY FOUND., MEDICARE SPENDING AND FINANCING 1 (Aug. 2010), http://www.kff.org/medicare/ upload/7305-05.pdf [hereinafter MEDICARE SPENDING AND FINANCING].

2. *Id.* at 2.

3. *Id.* at 1–2. Notably, this increase reflects the savings in Medicare spending enacted by PPACA. *Id.* at 2.

4. KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: MEDICARE AND THE NEW INDEPENDENT PAYMENT ADVISORY BOARD 2 (May 2010), http://www.kff.org/healthreform/upload/7961-02.pdf [hereinafter EXPLAINING HEALTH REFORM]. A consideration of the national deficit is appropriate for a discussion about Medicare, because, in 2010, Medicare comprised twelve percent of the entire federal budget. MEDICARE SPENDING AND FINANCING, *supra* note 1, at 1.

5. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. PERSP. 601, 601–02 (2010).

organizations (ACOs), and the creation of institutions such as the Patient-Centered Outcomes Research Institute (PCORI)[6] and the Innovation Center in the Centers for Medicare and Medicaid Services (Innovation Center).[7]

Perhaps the most important—and most controversial[8]—institutional creation for curbing Medicare cost growth, however, is the Independent Payment Advisory Board (IPAB),[9] established by Section 3403 of PPACA.[10] The IPAB will be a fifteen-member panel of medical experts, independent from Congress, charged with the difficult task of developing and proposing modifications to the payment system under Medicare in order to curb spending.[11] This Article discusses the multiple challenges that the IPAB faces in this task, which it must overcome in order to produce desired savings in the Medicare program. The Article begins with a discussion of the purpose, structure, and authority of the IPAB. Then, it analyzes varying opinions about whether the IPAB will be able to ultimately achieve its goal.

II. THE PURPOSE, STRUCTURE, AND AUTHORITY OF THE IPAB

The purpose of the IPAB, according to the PPACA statute, is to "reduce the per capita rate of growth in Medicare spending."[12] To do this, the legislation establishes strict target growth rates for Medicare spending and sets forth a process for the IPAB to keep rates within these limits[13]—the first mandated spending limits the Medicare program has ever seen.[14] In addition to submitting proposals to curb Medicare spending, the IPAB is also tasked with the more minor roles of submitting annual reports to Congress regarding

6. PCORI will assess new medical tests, drugs, and other treatments as they are developed, thereby providing continuously updated information for physicians and patients. *Id.* at 602–03.

7. *Id.* at 603.

8. AM. MED. ASS'N, INDEPENDENT PAYMENT ADVISORY BOARD 1, http://www.amaassn.org/ama1/pub/upload/mm/ 399/hsr-payment-advisory-board.pdf (last visited Feb. 19, 2011).

9. Orszag & Emanuel, *supra* note 5, at 603.

10. Patient Protection and Affordable Care Act (PPACA) § 3403, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 42 U.S.C.). The original name of the IPAB was the Independent *Medicare* Advisory Board, but this was later changed to the current name of the Independent *Payment* Advisory Board in the Health Care and Education Reconciliation Act of 2010 § 10320(b), Pub. L. No. 111-152, 124 Stat. 1029.

11. Orszag & Emanuel, *supra* note 5, at 603; James C. Capretta, *The Independent Payment Advisory Board and Health Care Price Controls*, KAISER HEALTH NEWS (May 6, 2010), http://www.kaiserhealthnews.org/Columns/ 2010/May/ 050610Capretta.aspx.

12. PPACA § 3403(b).

13. Timothy Stoltzfus Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. PERSP. 103, 103 (2010).

14. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

issues of cost, access, quality, and utilization of healthcare services for private payers and Medicare, as well as submitting non-binding recommendations to curb the growth of private national health care spending.[15]

The fifteen members of IPAB will be nationally recognized experts in the fields of health facility and health plan management, actuarial science, and health finance and payment. Three of the members will be officials from the Department of Health and Human Services (HHS).[16] Members will be appointed by the President and confirmed by the Senate for six-year terms, and will work for the IPAB full-time with an annual salary of approximately $165,000.00.[17] In addition to the fifteen-member board, PPACA also provides for a ten-member consumer advisory council.[18] The IPAB's independence from Congress is a key component of its structure.[19] As an independent panel of healthcare experts, the IPAB can make more knowledgeable determinations than Congress about the healthcare industry, and can ideally mitigate the influence of politics and special interests on Medicare payment decisions.[20]

Before the IPAB is required to submit a proposal to reduce Medicare spending, the Office of the Actuary (OACT) must first determine whether Medicare spending growth rates will exceed target levels in a given year.[21] Prior to 2018, these target levels will be based on a combination of general inflation and medical inflation.[22] In 2018 and thereafter, the target levels will be based on the rate of general inflation plus one percentage point.[23] If OACT projects that Medicare growth rates will exceed target levels in a given year, then the IPAB must submit proposals to reduce Medicare spending

15. *Id.* at 2; Jost, *supra* note 13, at 104.

16. Jost, *supra* note 13, at 104. For more information about the process for appointment and confirmation of IPAB members, as well as additional qualifications and requirements of members, see AM. MED. ASS'N, *supra* note 8, at 2–3.

17. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104.

18. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

19. *Id.* at 2. According to the Kaiser Family Foundation, this is the first time Congress has ceded authority of parts of the Medicare program since the program started in 1965. *Id.*

20. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 103.

21. Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603. To determine whether spending will exceed target levels, OACT will determine "whether the projected average Medicare growth rate for the 5-year period ending 2 years later will exceed the target growth rate for the year ending that period." Jost, *supra* note 13, at 104. OACT will first report on this determination on April 30, 2013. EXPLAINING HEALTH REFORM, *supra* note 4, at 4. For an excellent breakdown of this and every other key implementation date for the IPAB, see *id.*

22. Orszag & Emanuel, *supra* note 5, at 603. To be exact, these target levels will be "the projected 5-year average of the mean of the Consumer Price Index (CPI) and the medical care CPI . . . ." Jost, *supra* note 13, at 104.

by the lesser of the percentage set in the statute or the amount by which spending will exceed the target.[24]

On September 1 of each year, the IPAB must submit a draft of its proposal to the Secretary of HHS.[25] Then, on January 15 (beginning in 2014), the IPAB must submit its final proposal to Congress.[26] Once Congress receives the proposal, it must review it under an expedited procedure.[27] Congress cannot consider any amendments that do not achieve the same level of cost savings, unless this requirement is waived by a vote from both houses of Congress and three-fifths of the Senate.[28] Unless Congress adopts an alternative to the proposal that will produce equally effective cost savings, or the President vetoes the Congressional proposal and that veto is not overridden, the Secretary of HHS must implement the IPAB's proposals by August 15 of that year.[29] Significantly, the Secretary's implementation of the proposals is not subject to judicial or administrative review.[30]

Yet, the IPAB does have some significant limitations on the scope of its proposals. Namely, the IPAB cannot submit any proposals that would ration care, modify Medicare eligibility criteria, raise costs to beneficiaries, change cost-sharing for covered services, or restrict benefits in any way.[31] Prior to 2020, the IPAB's proposals cannot include recommendations for changes to rates for hospitals and hospices, which are already receiving a reduction in their payments in other provisions of PPACA.[32] There are no restrictions, however, on the IPAB's ability to cut Medicare payment rates for physicians.[33]

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23. Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603; Capretta, *supra* note 11.

24. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 104. A reduction by the percent set in the statute means the "total projected Medicare spending for the year multiplied by 0.5 percent in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and future years." EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

25. Jost, *supra* note 13, at 104.

26. *Id.* at 104. If IPAB fails to submit a proposal to Congress on time, then the Secretary of HHS must submit a proposal that will achieve the same level of spending reductions. *Id.*; *see also* EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

27. Jost, *supra* note 13, at 104.

28. *Id.*

29. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603.

30. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

31. *Id.*; Jost, *supra* note 13, at 104; Capretta, *supra* note 11.

32. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104.

33. Jost, *supra* note 13, at 104. The IPAB's ability to make payment cuts for physicians may be limited, however, "if a permanent fix for the sustainable growth rate—the formula that determines increases or

The IPAB has several similarities to the Center for Medicare and Medicaid Services' Innovation Center and the Medicare Payment Advisory Commission (MedPAC), but both of these programs can be distinguished from IPAB.[34] First, the Innovation Center, which was established by PPACA, will be evaluating Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and will test and expand various payment structures to reduce expenditures and increase quality in all of these programs.[35] The Innovation Center will not have the same independent authority of the IPAB, however. Second, MedPAC, which was in place before PPACA's enactment, prepares recommendations for Congress on many aspects of the Medicare program, and it will continue in this advisory role for Congress after the IPAB's establishment.[36] MedPAC differs from the IPAB in that it does not have budget targets or decision-making authority, and Congress is not bound by its recommendations.[37] As the IPAB and other PPACA programs are implemented, the relationships between these boards will need to be navigated carefully so that they can complement rather than duplicate each other's work.[38]

III. ANALYSIS: CAN THE IPAB CURB MEDICARE SPENDING?

With this overview of the purpose, structure, and authority of the IPAB in mind, this section turns to an analysis of the varying perspectives on whether the IPAB will be able to achieve its intended purpose. Proponents of the IPAB claim that it will be able to slow the growth rate of Medicare spending while protecting beneficiaries through the prohibition on reducing benefits and rationing care.[39] Peter Orszag, former Director of the White House Office of Management and Budget, claims that the IPAB (along with other PPACA reforms) will be able to stem the long-term growth in Medicare costs because its flexible structure is able to institute policies for cost savings in real time, rather than through a rigid bureaucratic structure.[40] It is possible that the IPAB could

decreases in Medicare's physician payments—is passed." *Id.*

34. *Id.* at 104–05.

35. KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW 8 (Mar. 2010), http://www.kff.org/healthreform/upload/8061.pdf; Orszag & Emanuel, *supra* note 5, at 603.

36. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

37. *Id.*; *see also* DAVID NEWMAN & CHRISTOPHER M. DAVIS, CONG. RESEARCH SERV., R41511, THE INDEPENDENT PAYMENT ADVISORY BOARD 30 (2010) (comparing and contrasting IPAB and MedPAC).

38. Jost, *supra* note 13, at 104–05. For instance, the IPAB and the Innovation Center could share some staff members. *Id.* at 105.

39. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

40. Orszag & Emanuel, *supra* note 5, at 601.

produce tremendous cost savings, assuming that Medicare spending growth rates exceed target levels each year, thereby triggering the IPAB proposal process.[41] The Congressional Budget Office (CBO) estimates that the IPAB could reduce Medicare spending by as much as $28 billion from 2015–2019[42] and would continue to produce savings thereafter.[43] OACT estimates that the IPAB could achieve up to $24 billion in Medicare savings from 2015–2019.[44]

It is questionable whether this level of savings is realistic, however.[45] Notably, the target growth rates delineated in PPACA were only met in four of the past twenty-five years.[46] In those years, the IPAB target growth rate would have been approximately the same as the Medicare sustainable growth rate, which legislators have frequently overridden in the past.[47] In the future, when changes to Medicare policy produce higher spending, the IPAB will need to make even larger spending reduction proposals to achieve target rates, which is certainly a formidable task.[48] Moreover, in order to achieve long-term spending solutions, the IPAB will need to do more than propose reductions in provider payments, but may also need to propose changes to Medicare payment methods.[49]

Additional challenges facing the IPAB may also prevent it from achieving optimal cost savings in the Medicare program. For instance, it will likely be difficult to staff the IPAB with fifteen nationally recognized experts who are willing to leave their current positions for six years in exchange for a fairly modest salary.[50] The success of the program will

41. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

42. Jost, *supra* note 13, at 104. *But see* EXPLAINING HEALTH REFORM, *supra* note 4, at 2 (citing a CBO report that estimated Medicare savings from the IPAB of only $15.5 billion between 2010 and 2019, with all savings realized between 2015 and 2019).

43. Jost, *supra* note 13, at 104. CBO estimates that the savings after 2019 from IPAB would be in addition to other savings realized in Medicare spending from other Medicare-related PPACA provisions. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

44. EXPLAINING HEALTH REFORM, *supra* note 4, at 2. "According to OACT, meeting the target growth rates specified in the law will require Medicare growth rates to be reduced by an additional 0.3 percent per year, on average, *even after taking into account all other savings* that can be expected to arise from [PPACA]." *Id.* (emphasis added).

45. *See, e.g.*, Capretta, *supra* note 11 (arguing that IPAB will not produce cost savings).

46. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 104.

47. Jost, *supra* note 13, at 104. The Medicare sustainable growth rate is the formula by which Congress updates Medicare's physician fee schedule. *Id.*

48. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

49. Jost, *supra* note 13, at 105.

50. *Id.* at 104.

also be contingent on Congress' response to IPAB's proposals.[51] Although both houses of Congress and a three-fifths Senate vote are required to override payment cuts, Congress can propose independent legislation to increase Medicare funding, in the same way that Congress has evaded the Medicare sustainable growth rate in the past.[52]

Another major concern that the IPAB's critics express is that its imposed spending limits are not attainable due to the continual rise of overall healthcare costs in the United States.[53] Given these rising costs, if Medicare provider payment rates are cut but *private* payers' rates remain relatively unregulated, many healthcare providers may abandon the Medicare program because they are not able to remain profitable when serving Medicare beneficiaries[54] (much like many providers have abandoned the Medicaid program). This, in turn, would certainly jeopardize Medicare beneficiaries' ability to access healthcare services.[55] Although the IPAB is charged with making recommendations to Congress to curb the growth of private national health care spending, these recommendations are advisory only.[56] Thus, it is likely that "Congress may not be able to cap Medicare expenditures without addressing private expenditures as well."[57]

One would expect that a measure such as the IPAB, which is intended to cap spending on a federal entitlement program, would encounter support from Republicans and opposition from Democrats.[58] The reality, however, has been the opposite. Democrats included the IPAB legislation in PPACA out of a belief that stronger federal payment controls will cut healthcare costs, somewhat like "government-driven managed care."[59] Republicans, on the other hand, have vehemently opposed implementation of the IPAB. In fact, in July 2010, a group of Republican Senators introduced the "Health Care Bureaucrats Elimination Act," which has as its sole intention the repeal of the IPAB

51. *Id.* at 105.

52. *Id.* The fact that Congress regularly evades the Medicare sustainable growth rate has been cited as a reason why Congress cannot effectively cut costs in the Medicare program. *Id.*

53. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

54. *Id.*; Jost, *supra* note 13, at 104–05. It is not clear, however, that healthcare providers would abandon Medicare beneficiaries on a widespread basis when faced with reductions in Medicare payment rates, due to the fact that Medicare comprises a significant portion (twenty-three percent) of total national healthcare spending. MEDICARE SPENDING AND FINANCING, *supra* note 1, at 1.

55. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

56. *See id.*

57. Jost, *supra* note 13, at 105.

58. Capretta, *supra* note 11.

59. *Id.*

legislation.[60] Section two of this bill argues that the IPAB's repeal is necessary in order to remove "unelected, unaccountable bureaucrats from seniors' personal health decisions . . . ."[61] In a press release supporting the bill, Republican Senators criticized the IPAB for "punt[ing] tough decisions to a bunch of bureaucrats with no accountability to the American people" and even described it as "the definition of a government takeover."[62] The Republican claim that attracted the greatest media attention, however, was that the IPAB would result in rationing of health care, because it would have the power to decide whether certain treatments and tests were too expensive and could not be covered by Medicare.[63]

The IPAB provision in PPACA has also drawn nearly universal criticism from major players in the healthcare industry, including the American Medical Association (AMA), American Hospital Association (AHA), and Pharmaceutical Research and Manufacturers' Association (PhRMA).[64] The AMA calls the IPAB "one of the most controversial provisions of PPACA" and declared that modifying IPAB's framework and authority "is one of [its] highest legislative priorities."[65] The AHA went even further and wrote a letter to Senator John Cornyn, one of the sponsors of the Health Care Bureaucrats Elimination Act, expressing its support for the bill.[66] In this letter, the AHA explained that U.S. hospitals support repealing the IPAB because

its existence permanently removes Congress from the decision-making process, and threatens the long-time, open and important dialogue between hospitals and their elected officials about the needs of local hospitals and how to provide the highest quality care to their patients and communities.

Already, America's hospitals are paid less than the cost of treating Medicare patients,

60. S. 3653, 111th Congr. (2010); Ezra Klein, *A Prescription for Ruin*, NEWSWEEK.COM (Aug. 13, 2010), http://www.newsweek.com/2010/08/13/a_prescription_forruin.html. The Healthcare Bureaucrats Elimination Act was still pending at the time of this Article's writing.

61. S. 3653 § 2.

62. Press Release, Sen. Orrin Hatch, Hatch, Group of Sens. Introduce Health Care Bureaucrats Elimination Act (July 27, 2010), *available at* http://hatch.senate.gov/public/index.cfm?FuseAction=PressReleases.Print&PressRelease_id= 15babd06-1b78-be3e-e064-18242ae805bb&suppresslayouts=true.

63. *Id.*

64. Duff Wilson, *Industry Aims at Medicare Board*, N.Y. TIMES PRESCRIPTIONS (Nov. 4, 2010, 1:23 PM), http://prescriptions.blogs.nytimes.com/2010/11/04/industry-targets-medicare-board/.

65. AM. MED. ASS'N, *supra* note 8, at 1.

66. Letter from Rick Pollack, Exec. Vice President, Am. Hosp. Ass'n, to Senator John Cornyn (Oct. 26, 2010), *available at* http://www.aha.org/aha/main-story/2010/101026-ms-ipab.html (follow "letter" hyperlink).

and although hospitals will not be subject to IPAB decisions until 2020, we are deeply concerned that removing elected officials from the decision-making process could result in even deeper cuts to the Medicare program in the future.[67]

These concerns are even more pressing for physicians, because there are no temporary restrictions on the IPAB's ability to cut Medicare payment rates for physicians, as there are for hospitals.[68]

Although many of these concerns are legitimate, there are also many reasons to be optimistic about the IPAB's potential. First, while Republicans fear that the IPAB will lead to the rationing of health care, the legislation specifically prohibits the IPAB from submitting any proposals that would ration care, restrict benefits, modify eligibility criteria, raise costs to beneficiaries, or change cost-sharing for covered services.[69] Furthermore, the fear of a "government takeover" through the IPAB is not substantiated because Medicare itself is a federal government program, and the IPAB's recommendations are only binding on issues related to Medicare spending.[70]

While it is true that the IPAB shifts the balance of power from the legislative branch to the executive branch,[71] this is a necessary component of the IPAB. Congress has been unable to make major Medicare cost reform in the past due to special interests and the political unpopularity of making cuts to the Medicare program.[72] Moreover, there are numerous safeguards in place to keep the IPAB accountable to voters. The Senate must confirm all IPAB members, and a consumer council will be in place to advise the IPAB.[73] Once the IPAB submits a proposal, if Congress disagrees with the proposed cost-cutting measures, it can propose alternative measures that achieve the same level of cost savings, and can even waive the requirement to achieve equal cost savings by a vote from both houses of Congress and three-fifths of the Senate.[74] Even though this is a difficult hurdle,

67. *Id.*

68. *See supra* note 33 and accompanying text (explaining the fact that there are no restrictions in the legislation on the IPAB's ability to cut Medicare payment rates for physicians).

69. *See supra* note 31 and accompanying text (describing these restrictions on the IPAB's authority).

70. Klein, *supra* note 60.

71. *Republicans Take On Cost-Cutting Panel Backed by Budget Chief Orszag*, KAISER HEALTH NEWS (July 29, 2010), http://www.kaiserhealthnews.org/Daily-Reports/2010/July/29/IPAB.aspx.

72. Klein, *supra* note 60; *see also supra* notes 19–20 and accompanying text (discussing the influence of politics and special interests on Medicare cost reform).

73. *See supra* notes 17–18 and accompanying text (explaining these safeguards).

74. *See supra* text accompanying note 28 (describing the process set forth in the IPAB legislation by which Congress reviews the IPAB's proposals).

it is an important safeguard to keep the IPAB accountable to Congress, and subsequently to voters.

Perhaps the most legitimate concern expressed by the IPAB's critics is that many healthcare providers will abandon the Medicare program if the gap continues to widen between private payment rates and Medicare rates.[75] As AHA explained, Medicare payment rates to hospitals today are less than the cost of treating patients.[76] With the IPAB's additional downward pressure on Medicare payment rates in the years to come, hospitals and physicians will be faced with greater challenges in treating Medicare patients. As the IPAB proposes and HHS implements significant changes under PPACA, both entities will need to be mindful of financial pressures on providers to ensure that the millions of Americans on Medicare can continue to access vital healthcare services.

IV. CONCLUSION

Clearly, the explosive growth rate in Medicare spending must be curbed. Inevitably, reductions in Medicare payment levels and changes in payment methods are a politically contentious issue because of the growing ranks of constituents who will be impacted by such measures. Perhaps, the best solution to achieve needed reform in Medicare spending is to remove Medicare payment decisions from the realm of politics. It remains to be seen whether the IPAB, by doing just that, will be able to effectively rein in Medicare spending.

75. *See supra* notes 53–55 and accompanying text (discussing the challenges facing providers due to reductions in Medicare payment rates).

76. *See supra* notes 66–67 and accompanying text (explaining the contents of the AHA letter).

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Value-Based Purchasing As a Bridge Between Value and Access

*Erin Lau**

I. INTRODUCTION

By definition, the words "value" and "access" seem to have little correlation. Value quantifies monetary cost by considering the worth of the service or product without regard for accessibility to that service or product.[1] Similarly, "access" by its definition is unconcerned with value. Access is "the freedom or ability to make use of something."[2] The words "freedom or ability" connote two dimensions of health care access: potential access and actual access.[3] Potential access is the health care that is available to the patient-consumer.[4] Actual access is the health care that is obtained.[5] Neither dimension of access addresses the cost concern fundamental to the definition of "value." Despite this apparent dichotomy between value and access, recent reform efforts propose the notion that value can increase access in the realm of health care.

The purpose of this article is to explore the effect of value on access to health care by examining Medicare's proposed rules for a value-based purchasing program (VBP

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1. *Value Definition*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/value (last visited Feb. 21, 2011).

2. *Access Definition*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/access (last visited Feb. 21, 2011).

3. *See* LU ANN ADAY ET AL., EVALUATING THE MEDICAL CARE SYSTEM: EFFECTIVENESS, EFFICIENCY, AND EQUITY 126 (1993). "Actual access" and "potential access" have also been described in health care literature as "utilization" or "revealed access" and "accessibility" respectively. *Id. See also* Lin, Swu-Jane, *et al.*, *Potential Access and Revealed Access to Pain Management Medications*, 60 SOC. SCIENCE & MED. 1881, 1881 (2005).

4. *Id.*

5. *Id.*

program).[6] First, this article will summarize the proposed rules for the implementation of the VBP program.[7] Next, this article explores how the VBP program may increase actual and potential access to health care.[8] Finally, this article discusses a criticism that the VBP program may actually decrease access to health care.[9] Ultimately, this article concludes that the VBP program will likely increase access to health care.[10] Please note that although CMS released the Final Rule for the VBP program at the time this article was published, it was not at the I initially wrote the article. Due to time constraints, this article will not focus on the Final Rule, but only the Proposed Rule and its specifics.

II. THE VBP PROGRAM FIXES PAYMENT ON PERFORMANCE MEASURES

On January 13, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposal for the implementation of the VBP program for hospital inpatient services.[11] The VBP program was authorized by Section 3001(a) of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).[12] Hospitals eligible to participate in the VBP program include those hospitals in the fifty states and the District of Columbia that are currently reimbursed under the Acute Care Inpatient Prospective Payment System (IPPS).[13]

The purpose of the VBP program is to reorient CMS' method of reimbursement from paying for volume to paying for value, results, and innovation.[14] The VBP program achieves this objective by giving incentive payments for achievement and improvement based on a performance score.[15] These incentive payments will apply to discharges on or after October 1, 2012.[16] Participating hospitals are further motivated to receive a high

6. Medicare Program; Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454 (proposed Jan. 11, 2011) (to be codified at 42 CFR pts. 422, 480).
7. *See* discussion *infra* Part II.
8. *See* discussion *infra* Part III.
9. *See* discussion *infra* Part IV.
10. *See* discussion *infra* Part V.
11. Medicare Program; Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454, 2454 (proposed Jan. 11, 2011) (to be codified at 42 CFR pts. 422, 480).
12. *Id.* at 2454, 2457.
13. *Id.* at 2479.
14. *Id.* at 2455.
15. *Id.* at 2457.
16. *Id.* at 2454.

performance score because Section 5001(a) of the Deficit Reduction Act of 2005 further decreased the annual percentage a participating hospital received by two percentage points.[17] The VBP program is based upon the Medicare Hospital Quality Reporting Program (Hospital IQR Program), which provides financial incentives to report specific quality measures.[18] Under the proposed rules, eighteen quality measures from the Hospital IQR Program are used to determine a hospital's performance score.[19]

In general, the eighteen quality measures are categorized into two domains: clinical process of care and patient experience of care.[20] Clinical processes of care measures include: the treatment of heart failure, pneumonia, acute myocardial infarction, and healthcare-associated infections.[21] Measures of patient experience of care are based on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey.[22] Each domain has a separate calculation for an achievement and improvement score.[23] After the domain score is calculated, the domain is weighted by an equation, first the clinical process domain score is multiplied by .7, then the patient experience of care domain is multiplied by .3.[24] Finally, the sum of all of the weighted domain scores results in the hospital's performance score.[25] The performance score is then translated using a linear exchange function that will determine the percentage of the VBP incentive payment the hospital earned.[26]

III. EFFECTS ON INCREASED POTENTIAL AND ACTUAL ACCESS

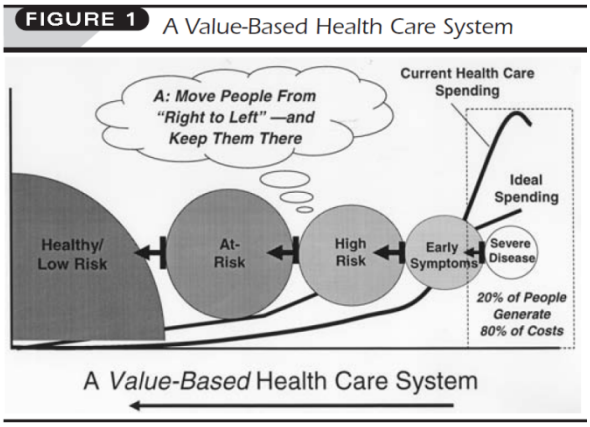
The VBP program may increase actual access and potential access to health care in at least three different ways. First, the value-based health care theory of health care

17. *Id.* at 2456.
18. *See id.* at 2457 (The results of the Hospital IQR program can be found at www.hospitalcompare.hhs.gov).
19. *Id.* at 2457.
20. *Id.* However, in 2013 a third domain "outcome measures" will be taken into account. *Id.* at 2466. The measures for this domain have yet to be determined. *Id.*
21. *Id.* at 2462.
22. *Id.* HCAHPS is a national standardized survey and data collection developed by CMS, the Agency for Healthcare Research and Quality (AHRQ) and the Department of Healthcare and Human Services to measure patient experience. HCAHPS: PATIENTS' PERSPECTIVES OF CARE SURVEY, https://www.cms.gov/HospitalQualityInits/30_HospitalHCAHPS.asp (last visited May 13, 2011).
23. *Id.* at 2467, 2472.
24. *Id.* at 2457.
25. *Id.*
26. *Id.* at 2466.

delivery encourages the majority of beneficiaries to utilize services because the theory seeks to create a more equitable distribution of services.[27] Second, those services will be more accessible to those beneficiaries because participating hospitals are incentivized to improve and provide those services.[28] Finally, the VBP program increases potential access by encouraging beneficiaries to become informed on the treatments they should seek through the discharge instruction measure.[29]

a. VBP increases actual access based on the Value-based health care theory

The value-based health care theory of health care delivery generally promotes a more equitable distribution of resources, [30] which increases access to health care because more services can be provided the majority of those who require preventative services.[31] Currently, only twenty percent of people generate eighty percent of healthcare spending.[32] Figure 1 depicts this disparity by showing the populations of patients based on their risk for severe disease.[33] The steep "Current Health Care Spending" slope represents where the most spending occurs; the higher the line the more is being spent on that population.[34] This creates a steep slope that illustrates the disparity of the spending distribution within the different patient populations − the more severe the disease, the smaller the population, and the greater the expense.[35] Value-based health care seeks an equitable distribution of resources by spending across all patient groups through incentivizing



27. *See* discussion *infra* Part III A.
28. *See* discussion *infra* Part III B.
29. *See* discussion *infra* Part III C.
30. Margaret E. O'Kane, *Performance-Based Measures: The Early Results Are In,* 13 J. MANAGED CARE PHARMACY S3, S4 (March 2007).
31. *See Id.*
32. *Id.*
33. *Id.* at S3.
34. *Id.*
35. *Id.* at S4, Fig. 1.

quality care and innovation for all patients and not just the seriously ill.[36] In sum, value-based health care seeks to decrease the slope of the spending distribution, as illustrated by the "Ideal Spending" line, thereby increasing access to health care across all populations.[37] Similarly, the VBP purchasing program will be evaluated to determine whether it affects access to care for Medicare beneficiaries.[38] Yet, based on the proposed rules, the slope of the ideal spending line may not result in a drastic decrease.

In Figure 1, the slope of the Ideal Spending Line is a gradual slope that reflects uniform spending based on the severity of the disease.[39] Although the Ideal Spending Line displays a significant decrease in spending for severe diseases from the Current Health Care Spending line, [40] the VBP program may not achieve the Ideal Spending Line in Figure 1 due to its source of funding. While value-based purchasing theory's Ideal Spending Line achieved through reducing spending on patients with severe disease and increasing spending on the majority of patients, which are those patients with less severe diseases, the VBP program will be funded by a reduction in the base operating Diagnosis Related Groups' (DRG) payment for each hospital.[41]

Base operating DRG is the payment operating costs of inpatient hospital discharge services,[42] which is predicted to be reduced to create $850 million in funds for the VBP program.[43] Therefore, under the VBP program the difference between ideal spending and current health care spending will be influenced by the population of patients that use the most inpatient hospital discharge services because they are the patients creating the base operating DRG payments. If the base operating DRG payments are mostly used by the eighty percent patient population, then the difference between ideal spending and current health care spending may not change much from Figure 1. However, if the base

36. *Id.* at S3.
37. *Id.*
38. *See* Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2485.
39. O'Kane, *supra* note 30, at S4.
40. *Id.*, Fig. 1.
41. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2487. Diagnosis Related Groups is a reimbursement system that pays hospitals at a predetermined rate based on the patient's diagnosis. Rick Mayes, *The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System*, 62 J. OF THE HIST. OF MED. AND ALLIED SCI. 1, 1 (2006).
42. 42 U.S.C. 1395ww (d) (2011).
43. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2490. PPACA defines base operating DRG as the payment made under 42 U.S.C. 1395ww subsection (d). Patient

operating DRG payments are mostly utilized by the twenty percent that use the most resources, then the disparity between ideal spending and current health care spending would decrease in accordance with the value-based purchasing theory lines because it would shift funds to remaining eighty percent of the population.[44] Subsequently, actual access would increase because the eighty percent of patients who do not use most of the resources would receive services they previously did not receives because the resources were spent on the twenty percent with severe diseases.[45] Access is further increased because hospitals are incentivized to provide those services under the VBP program.

b. The VBP Program increases access by improving and providing more services

The VBP program increases actual access to health care services by financially incentivizing hospitals to provide and improve certain medical services.[46] Under the proposed rules, if a participating hospital fails to achieve a certain threshold for a quality measure or improve their performance for a quality measure, then will not earn achievement or improvement points.[47] If the hospital doesn't earn achievement or improvement points, then it will not be able to add to that measures' domain.[48] Therefore, if a participating hospital fails to earn achievement points or improvement points, then the hospital will not be able to receive the VBP financial incentive payment because the domain amount determines the payment amount.[49]

For example, if a participating hospital fails to achieve the threshold improvement score for providing a pneumococcal vaccination, it would receive zero points for that quality measure.[50] Receiving zero points for a quality measure would drastically affect a hospital's incentive payment because the incentive payment is based on the hospital's performance score, which is the sum of the weighted achievement scores.[51] Simply put, the VBP program incentivizes participating hospitals to improve overall quality or

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Protection and Affordable Care Act, Pub. L. No. 111-148 & 111-152, § 3001 (2010).

44. *See* O'Kane, *supra* note 30, at S4.
45. *Id.*
46. *See* Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2457.
47. *Id.* at 2467, 2472.
48. *Id.*
49. *See id.* at 2457.
50. *Id.* at 2469.
51. *Id.* at 2457.

maintain high performance in the areas measured by the VBP program because its incentive payment is based on all applicable scores.[52] A hospital cannot game the system by only improving one measure to the detriment of other measures because the financial incentive will be determined based on the aggregate scores of the services that hospital provides.[53] Furthermore, because the financial incentive is based on an aggregate score, a hospital can spread the risk of not receiving payment by providing several of the services that are measured. A hospital would be further incentivized to being to provide services that were previously not provided because the improvement score would be great.[54] Therefore, the VBP program encourages hospitals to improve or provide the services that the VBP program measures to receive or increase incentive payments. These increases in quality and services will subsequently lead to an increase in access to health care.

c. Discharge instructions would increase potential access to health care

Finally, the VBP program increases access to health care through the provision of discharge instructions for heart failure. Discharge instructions are directions and information for patients to manage their own care after leaving the hospital.[55] The provision of discharge instructions for heart failure is one of the eighteen quality measures that determine a hospital's performance score and subsequently its financial payment.[56] Incentivizing the provision of discharge instructions for heart failure increases potential access to self-care and preventative care for those patients and open beds for others because studies show a positive relationship between the provision of discharge instructions and a reduction in readmission rates.[57]

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52. *See id.*

53. *See id* at 2470 (describing the calculation of the domain score based on the aggregate of applicable measure scores).

54. *See id* at 2467 (describing the calculation for the improvement score. A hospital performance period score would not be reduced by the baseline period score because the hospital that started providing a new quality measure would not have a baseline period score).

55. Zeng-Treitler, Qing, et al., Improving Patient Comprehension and Recall of Discharge Instructions by
Supplementing Free Texts with Pictographs 849 (2008) (paper presented at the 2008 American Medical Informatics Association Annual Symposium), *available at* PubMed PMC2656019.

56. *Id.* at 2462.

57. *See generally* Monica VanSuch, et al., *Effect of Discharge Instructions on Readmission of Hospitalized Patients With Heart Failure: Do All of the Joint Commission on Accreditation of Healthcare Organizations Heart Failure Core Measures Reflect Better Care?*, 15 QUALITY SAFETY OF HEALTH CARE 414, 414-17 (2006); Ashish Jha, et al., *Public Reporting of Discharge Planning and Rates of Readmission*, NEW ENG. J. MED. 361, 2637-45 (2009).

In one particular study, there was a statistically significant relationship between readmission rates for heart failure and the discharge instructions based on the patient-reported measures from the HCAHPS survey.[58] This study is particularly relevant to the VBP program because the eighteenth quality measure relies on the HCAHPS survey.[59] The study postulated that 4,700 fewer readmissions could occur if hospitals could improve their performance on the HCAHPS discharge quality measure to the 90th percentile.[60] For example, the quality measure could be improved if the patient receives full and complete discharge instructions.[61]

In another study, the results showed a statistically significant difference between readmissions for heart failure when patients are given complete versus incomplete discharge instructions.[62] The study found that heart failure patients that were provided complete discharge instructions were less likely to be readmitted for any cause compared to patients who were only provided minimal instructions.[63] Patients who were not provided instructions for activity, drugs, or follow-up appointments were the most likely to be readmitted.[64] These studies indicate that the inclusion of discharge instructions for heart failure as a quality measure under the VBP program would increase access to health care.

By using a discharge instruction as a quality measure, the VBP program financially incentivizes hospitals to provide patients with discharge information for heart failure.[65] When patients receive discharge instructions, they are statistically more likely to not be readmitted to the hospital.[66] Therefore, the VBP program will reduce readmission rates by incentivizing the receipt of instructions. A reduction in readmission rates would, in

58. Ashish, *supra* note 57, at 2637 (The report concludes that there is a "very modest association" between readmission rates and the HCAHPS survey. *Id.* However, the data shows a difference of 2.3 patients with congestive heart failure and 2 patients with pneumonia between the scores on a HCAHPS discharge instruction survey in the lowest quartile and highest quartile. *Id.* at 2644. 2.3 and 2 are statistically significant numbers because the p value is only <.001. *Id.*).

59. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2462.

60. Ashish, *supra* note 57, at 2642.

61. VanSuch, *supra* note 57, at 416.

62. *Id.*

63. *Id.*

64. *Id.*

65. *See* Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2457.

66. *See* Donald Williams, et al., *Emergency Department Discharge Instructions and Patient Literacy: A Problem of Disparity*, 14 AM. J. EMERGENCY MED. 19, 19 (1996).

turn, increase access to health care because less services, beds, and funds would be used to treat those patients whose readmission could have been prevented. Furthermore, it increases potential access to self-care and preventative services because patients will be better informed about their health. This conforms to CMS' effort to transform Medicare into an active purchaser of quality health care and increase access.[67]

IV. ADVERSE EFFECT ON ACCESS

Although Part III discussed potential improvement in access to health care for those patients who utilize the least funds for services, some express concern for those high cost patients.[68] This Part addresses the specific concern that there could be a fundamental flaw in the application of the definition of value to access with regard to those high cost patients.[69]

In Part I, "value" was described in a literary form. However, "value" can also be defined mathematically as a ratio of quality divided by cost over time.[70] Therefore, value cannot be determined in cases where a standard for the quality numerator is difficult to determine.[71] Standards of quality are particularly complicated in cases of patients with multiple complex health issues because those patients are most likely to experience errors in care and require quicker treatment.[72] If the quality numerator in the equation for value cannot be determined, then a value-based purchasing system would be inherently flawed for those patients who need treatment most.[73]

As previously mentioned, the premise of value-based purchasing is to shift the Current Health Care Spending from those who need treatment most, to the majority of beneficiaries.[74] The VBP program would be based on a more utilitarian view of access to health care rather than actual need. Therefore, pursuing a reimbursement system that seeks to increase value may decrease access for those patients with costly, multiple

67. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2455.
68. *See* Brent Asplin, *Value-Based Purchasing and Hospital Admissions: Doing the Right Thing Isn't Easy* 56 ANNALS EMERGENCY MED. 258, 259 (2010).
69. *See id.* at 259.
70. *Id.*
71. *See id.*
72. *See id.*
73. *See id.*
74. *See* discussion *supra* Part III.

complex problems, particularly those who require the most care.[75] Although the VBP program may adversely affect access for those with multiple complex problems, the underlying issue is the failure to properly treat their condition rather than reimburse for that condition. Instead, PPACA addresses this issue by encouraging the development of new patient care models for the high cost and proper treatment of patients with multiple complex problems.[76]

V. CONCLUSION

Although value and access are often thought of as disparate concepts, the VBP program connects value to actual and potential access. The VBP program will likely increase actual and potential access to health care services for three reasons. First, more funds will be available for more Medicare beneficiaries.[77] Secondly, beneficiaries will have access to more services because the VBP program incentivizes participating hospitals to provide services that they might not have otherwise provided.[78] Finally, the use of discharge instructions increases potential access to health care by helping beneficiaries become active participants in their own care.[79] Still, there are concerns that the VBP program may have a utilitarian perspective on access to health care and decrease access for those with multiple complex problems that desperately need medical attention.[80] However, multiple complex problems may be better remedied by innovative treatment of the underlying diseases. By valuing the accessibility of services, the VBP program will demonstrate that value can increase access to health care.

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75. Asplin, *supra* note 68, at 259.

76. Patient Protection and Affordable Care Act, s*upra* note 43, at § 3021. PPACA authorizes the creation of the Center for Medicare and Medicaid Innovation (Center). *Id.* The purpose of the Center is to test new payment and service delivery models including a model for the care of individuals with multiple chronic conditions. *Id.*

77. *See* discussion *supra* Part III.

78. *Id.*

79. *Id.*

80. *See* discussion *supra* Part IV.

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Piling It On DSH Providers' Plate: Why PPACA's Eyes Are Bigger Than Its Stomach

*Caitlin Podbielski**

I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (PPACA) is the most comprehensive reform of the American healthcare system since the enactment of Medicare in 1965.[1] Passed in the midst of rising unemployment rates and unprecedented bankruptcies from medical debt, the PPACA aims to provide more Americans with access to health care by expanding public and private health insurance coverage eligibility, especially to low-income individuals. Historically, this population has been served by a system of healthcare providers known as the "safety-net" that often undertake substantial financial losses to provide free or deeply discounted care to these deserving, yet underserved communities.[2] This essential element of the healthcare infrastructure already struggles to meet the current needs of the uninsured and low-income populations it serves and after full implementation of PPACA in 2014, that mission may very well become impossible due to financial constraints affecting the states, the federal government, and the facilities themselves.[3]

On its face, the PPACA tries to relieve some of the safety-net's burden by enabling these individuals to access health insurance through government sponsored and private

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1. *See generally* Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (consolidated with the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Tit. X (2010)).
2. *See Infra* Part II (discussing the role of the safety-net).
3. *See Infra* Part II (highlighting the financial problems safety-net provided are facing).

options.[4] Viewed singularly, the provisions that expand Medicaid and create an individual mandate are commendable ideas, at least in theory.[5] When viewed in conjunction with the reimbursement reductions and supplemental funding cuts, however, the provisions that expand insurance coverage fail to create a financially sustainable trajectory for the hospitals and physicians that are expected to serve as the point of access for the remaining uninsured, the newly insured, and those still left in the safety-net. Under an intense resources strain, these facilities will be forced to make difficult decisions with harsh consequences for their communities. In light of these conflicting provisions, the PPACA may ultimately harm the populations the legislation meant to protect.

This article looks at the role of safety-net hospitals within the current health care system, and argues that certain conflicting provisions of PPACA threaten their long-term viability. First, this article will look at the importance of the Medicare and Medicaid Disproportionate Share (DSH) payments as a resource for safety-net hospitals to help supplement the cost of providing health care to low-income and uninsured populations.[6] Second, this article explains how PPACA intends to scale back or essentially eliminate those payments.[7] Third, it examines this funding reduction in tandem with the Medicaid eligibility expansion, individual mandate, and provider reimbursement rate adjustments to expose the gaps and resource constraints created by PPACA.[8] Lastly, this article concludes that once the reform is fully implemented, safety-net systems will become financially unsustainable, despite a pervasive residual need for such providers.[9]

II. DEFINING THE SAFETY-NET AND THE ROLE OF HOSPITALS

Safety-net hospitals by definition provide a large proportion of the inpatient care delivered to the uninsured.[10] By organizational structure, most safety-net hospitals are either not-for-profit corporations or public entities, operated either directly by the state or local government or by a separate government entity, such as a board of directors,

4. *See Infra* Part V (explaining the Medicaid expansion and Individual mandate provisions).
5. *Id.*
6. *Infra* Part II.
7. *Infra* Part III.
8. *Infra* Part IV.
9. *Infra* Part V & VI.
10. Michael Spivey & Arthur L. Kellermann, *Rescuing the Safety Net*, 360 NEW ENGL. J. MED. 2598, 2598 (Jun. 18, 2009), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp0900728.

entrusted with full governance authority.[11] Most are also eligible for exemption from federal income taxes, conditioned upon the provision of "community benefits," and serving patients regardless of ability to pay, especially Medicare and Medicaid beneficiaries, is one such example of a community benefit.[12]

Safety-net providers' contribution is typically quantified as a financial burden measured by the amount of uncompensated care incurred by treating the uninsured.[13] Consequently, these facilities are typically located where the uninsured reside, in depressed rural communities and inner cities.[14] Due to the skyrocketing healthcare costs and growing numbers of uninsured Americans as a result of rising unemployment rates, safety-net hospitals face mounting pressure to provide more for their communities despite falling reimbursement rates and revenue shortages.[15] Nationally, the unemployment rate is nine percent,[16] an unprecedented 50.7 million Americans are uninsured,[17] and the percentage of people living in poverty is currently 14.3 percent and rising.[18] Traditionally, the Medicaid program has been the mechanism for insuring low-income populations.[19] Unfortunately, this mechanism is riddled with coverage gaps and most

11. *Id*. Of the 3,900 nonfederal, short-term, acute-care general hospitals in the United States in 2003, approximately 62% were not-for-profit and 20% were public, government-owned. Statement of David M. Walker, Comptroller General of the United States before the House Committee on Ways and Means, United States Government Accountability Office, *Nonprofit, For-Profit, And Government Hospitals* (May 26, 2005).

12. While not explicitly required, the Internal Revenue Services considers treating Medicare and Medicaid patients as a form of community benefits for federal income tax exemption purposes. *See* Rev. Rul. 69-545, 1969-2 C.B. 117 *and* Rev. Rul. 83-157, 1982-2 C.B. 94 (stressing the significance of serving Medicare and Medicaid beneficiaries as evidence that a hospital is operated exclusively for the benefit of the community). But *see* Brief for Illinois Hospital Association Amici Curiae Supporting Appellants at 10, Provena Covenant Med. Ctr. v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (No. 107328) [herein after IHA *Provena* Brief] (discussing how the average Illinois hospital depends on Medicare and Medicaid for more than half of its revenue from patient care, but highlights the fact that both programs reimburse for less than the cost of services which creates what is known as the Medicare/Medicaid "shortfall").

13. Calculated as the sum of free care, for which the hospital does not expect payment, and bad debt, or uncollectable outstanding patient charges. Joel Weissman, *The Trouble with Uncompensated Hospital Care*, 352 NEW ENGL. J. MED. 1171, 1171 (Mar. 24, 2005).

14. Spivey & Kellermann, *supra* note 10, at 2598.

15. *See infra* notes 78-82 (discussing recently stayed Medicare reimbursement cuts and PPACA provisions to reduce reimbursement to fund itself).

16. U.S. DEP'T OF LABOR - BUREAU OF LABOR STATISTICS, *Labor Force Statistics from the Current Population Survey - Series ID: LNS14000000: Seasonal Unemployment Rate*, (Feb. 21, 2011), http://data.bls.gov/cgi-bin/surveymost.

17. Richard Wolf, *Number of Uninsured Americans Rises to 50.7 Million*, USA TODAY, Sept. 17, 2010, http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm (citing to data from the U.S. Census Bureau).

18. *Id.*

19. Sara Rosenbaum, *A "Customary and Necessary" Program—Medicaid and Health Reform*, 362 NEW ENGL. J. MED. 1952, 1952 (May 27, 2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1003890 (describing the eligibility requirements before reform as "tied to both low income and demographic characteristics that are vestiges of federal cash-welfare

unemployed or low-income individuals remain uninsured.[20] As a result, most rely on uncompensated care via hospitals' emergency departments, a costlier point of access, as their primary provider of health care.[21] Tax-exempt hospitals, specifically, have historically offered some of these services to eligible individuals free of charge as charity care, but in an era of negative operating budgets, charity care has become a controversial and arguably waning practice.[22]

Beyond serving populations severely limited in the ability to pay for medical services, safety-net hospitals are facing all of the same financial burdens present in the healthcare system at large. First, the vast majority of the paying patients at safety-net hospitals are Medicaid and Medicare beneficiaries—programs that reimburse hospitals at less than the

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programs designed to benefit the disabled, the aged, and extremely poor "dependent" minor children and their parents"). In Fiscal Year 2009, the US government's total Medicaid spending equaled $366,471,017,061. Kaiser Family Found., *Illinois: Medicaid Spending*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/profileind.jsp?sub=47&rgn=15&cat=4 (last visited May 2, 2011).

20. *See* SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID AND THE UNINSURED, KEY FACTS: WHERE ARE STATES TODAY?, PUBL'N NO. 7993, 1 (Dec. 2009), http://www.kff.org/medicaid/upload/7993.pdf (discussing that the states are only mandated to cover children, pregnant women, elderly and disabled, and parents of eligible children, but that nondisabled, nonparents can be covered at the discretion of the state). Illinois currently extends coverage to parents through 191% of the federal poverty level, beyond federal requirements, but does not offer coverage or premium assistance for nondisabled, nonparent individuals. Kaiser Family Found., *Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package, January 2011*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/profileind.jsp?rep=54&cat=4&rgn=15 (last visited May 2, 2011).

21. Weissman, *supra* note 13, at 1172; STEVEN R. MACHLIN, MED. EXPENDITURE PANEL SURVEY STATISTICAL BRIEF NO. 111: EXPENSES FOR A HOSPITAL EMERGENCY ROOM VISIT, 2003 (Jan. 2006), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st111/stat111.pdf (calculating that the average expenditure for an emergency room visit was $560 in 2003, and generally emergency room visits were more expensive than other ambulatory visits for outpatient services or services rendered in an office-based setting). For more information on the dynamic between the uninsured and hospital emergency departments, see JULIE PARADISE & CEDRIC DARK, KAISER COMM'N ON MEDICAID AND THE UNINSURED, POLICY BRIEF: EMERGENCY DEPARTMENTS UNDER GROWING PRESSURES, PUB. NO. 7960 (Aug. 2009), http://www.kff.org/uninsured/upload/7960.pdf [hereinafter EMERGENCY DEPARTMENT POLICY BRIEF].

22. State and Federal governments have increased focus on these organizations, questioning the merit of granting tax exemptions when limited free care is being provided in return. *See e.g.*, Provena Med. Ctr. v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (Illinois Supreme Court upheld the Department's decision to deny a property tax exemption, but only a plurality reasoned that the hospital's total charity care in 2002, which equaled less than one percent of patient revenues, was *de minimus* and thus did not constitute charitable use of the property) *and* Pub. L. No. 111-148, § 9007 (2010) (PPACA's requirements for hospitals seeking tax exemptions: 1) perform a community assessment every three years which is to be used to develop and adopt an implementation strategy to meet the needs of the community as highlighted by the study 2) develop financial assistance and emergency care policies that clearly explain the eligibility criteria, characterization of care as free or discounted, calculation procedures for charges, method of applying aid, measures to make the community aware of the financial assistance policy, and the hospital's plan in the event of nonpayment including collection processes, and 3) submit audited financial statements and Form 990 Schedule H, which now includes information regarding community benefits and charity care.) *See also*, Kris A. Moussette & Matthew O. Page, *President Signs PPACA—New § 501(c)(3) Requirements for Charitable Hospital*, EDWARDS ANGELL PALMER & DODGE, (Apr. 20, 2010) http://www.eapdhealthcarereform.com/presidentsignsppaca/ (describing PPACA new requirements on not for profit, tax-exempt hospitals).

cost of the services provided.[23] Not including losses incurred due to unpaid patient bills and charity care, this means the hospital's expenses exceed revenues for a vast majority of services rendered, resulting in a negative operating margin.[24] Second, due to a larger and less healthy aging population,[25] hospitals are experiencing increased acuity levels.[26] Lastly, the unstable financial market and uncertainty surrounding health care reform has driven many healthcare lenders from the market, leaving capital for facility improvements and equipment replacements scarce.[27] In the face of all these financial restraints, disproportionate share payments have been an important resource to supplement the bottom line of hospitals that bear a heavier burden of costs from treating higher numbers of Medicare, Medicaid, and uninsured patients.

III. MEDICARE AND MEDICAID DISPROPORTIONATE SHARE PAYMENTS

The Social Security Act, out of necessity, authorized Disproportionate Share (DSH) payments in the early 1980's.[28] In 1981, Congress allowed states to decouple Medicare

23. Reimbursement data from 2007 that shows that for every dollar spent on Medicare and Medicaid patients, .91¢ and .88¢, respectively, were recovered. This translated into a shortfall of $21.5 billion for Medicare patients and $10.4 billion for Medicaid patients in one year. Brief of the American Hospital Association Amici Curiae Supporting Provena Covenant Medical Center at 7, Provena Covenant Medical Center v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (No. 107328) [hereinafter AHA *Provena* Brief].

24. Spivey & Kellermann, *supra* note 10, at 2598 (explaining that the average operating margin for safety-net hospitals is -3.0%).

25. The US Census Bureau reports that in 2009, approximately twenty-four percent of the population or 72 million people, were older than fifty-five years old. US CENSUS BUREAU, CURRENT POPULATION SURVEY: ANNUAL SOCIAL ECONOMIC SUPPLEMENT 2009, POPULATION BY AGE AND SEX: 2009, BOTH SEXES, Table 1 (Dec. 2010), *available at* http://www.census.gov/population/socdemo/age/2009_older_table1.csv. *See also* John Pletz, *The Graying of Chicago*, 34 CRAIN'S CHIC. BUS., no. 6, Feb. 7, 2011, *available at* http://www.chicagobusiness.com/article/20110205/ISSUE01/302059982/crains-special-report-the-graying-of-chicago#axzz1EcwpccJK (describing the effect of the aging baby boomer generation on Chicago, and predicting more than 2 million Chicagoans begin turning sixty-five this year).

26. Scott B. David & Phillip J. Robinson, *Health Care Providers Under Pressure: Making the Most of Challenging Times*, 37 HEALTH CARE FIN., no. 2, 2010, at 49, 49. Higher acuity levels increase the demand for hospital staff, increasing labor costs, in addition to the fact that services to patients with a high acuity are costlier. *See generally*, Mark W. Stanton, *Hospital Nursing Staff and Quality of Care*, RES. IN ACTION (Agency for Healthcare Research and Quality) Mar. 2004, *available at* http://www.ahrq.gov/research/nursestaffing/nursestaff.pdf (discussing how increased patient acuity is demanding a more qualified nursing staff, within the greater focus of the nurse shortage situation).

27. David & Robinson, *supra* note 26, at 53 (noting that financially strong systems can access tax-exempt bonds, but weaker ones cannot, and traditional lending—which does not have the benefit of tax-free interest rates—is an option, but banks are mandating very strict terms and covenants). *See e.g.*, Mary A. Clark, *Rebuilding The Past: Health Care Reform In Post-Katrina Louisiana*, 35 J. HEALTH POL. POL'Y & L. 743, 747-48 (Oct. 2010) (describing the dilapidated condition of Charity Hospital, Louisiana's second largest safety-net (the largest in New Orleans) hospital in the state, before it was completely destroyed by Hurricane Katrina. Also explains the city's scramble for capital and deliberations to decide whether to refurbish it or demolish and rebuild the facility all together both before and after the hurricane).

28. *See generally* 42 U.S.C. §§ 1395ww *et seq*., 1396r-4 (setting forth the definition and formulas for Medicare and Medicaid DSH Payments, respectively). For a comprehendible overview of how these two

and Medicaid payments and recognizing the consequences this would have on facilities providing care to larger Medicaid populations, encouraged states to make supplemental payments to those facilities.[29] The Omnibus Budget Reconciliation Act of 1985 explicitly created an additional payment for hospitals that served a "significantly disproportionate share of low-income patients" through October 1, 1988.[30] In 1987, Congress increased the DSH percentage adjustment and extended the payments through 1990.[31] Under this regulatory scheme, states had to put up the money for the payments first, and the federal government would then match that amount.[32] Unfortunately in 1991, because of state abuse of the DSH payments,[33] Congress capped federal DSH funds at twelve percent of annual expenditures, based on published state allotments for 1992.[34] States responded by making payouts to select hospitals in excess of the cost of uncompensated care, instead of an equitable distribution, and managed to recover most of the money from the federal government.[35] Since then Congress restricts states from making DSH payments in excess of unreimbursed costs, and allows the Centers for Medicare and Medicaid (CMS) to scrutinize the DSH system on a state-by-state basis.[36] The way DSH payments functions today, states have a lot of discretion over which

different payments relate to each other and the aforementioned statutes, see Cooper Univ. Hosp. v. Sebelius, 686 F. Supp. 2d 483, 484-487 (D.N.J. 2009).

29. Spivey & Kellermann, *supra* note 10, at 2598-99.

30. Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9105(a), 100 Stat. 158 (1986) (amending 42 U.S.C. 1395ww(d)(5) adding paragraph (F)(i)).

31. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4003(b), 101 Stat. 1330-46 (1987) (amending 42 U.S.C. 1395ww(d)(5)(B)); the adjustment to the Prospective Payment System (PPS), through which CMS reimburses providers for Medicaid services, basically self-funded the DSH payments by lowering the diagnosis related group ("DRG") rate paid to all hospitals. Recognizing that most teaching hospitals would qualify as DSH providers, the indirect medical education adjustment was also decreased. Ass'n of Am. Med. Colleges, *Medicare Disproportionate Share (DSH) Payments*, AAMC.ORG, https://www.aamc.org/advocacy/medicare/155102/dsh.html (last visited May 2, 2011). For actual statutory language amending the PPS, see Pub. L. No. 100-203, § 4003(a) (amending 42 U.S.C. 1395ww(d)(5)(B)(ii)).

32. Spivey & Kellermann, *supra* note 10, at 2599.

33. Budget experts figured out that if states required the DSH hospitals to contribute to the state's required share, the state could draw down a larger federal matching payment. The hospitals were reimbursed at least their contributions, but states kept most of the federal funds, sometimes even turning around and using them to draw down a larger federal Medicaid payment. Spivey & Kellermann, *supra* note 10, at 2599; *see also* CHRISTIE PROVOST PETERS, NAT. HEALTH POL'Y FORUM, THE BASICS: MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS 4-5 (2009) http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf [hereinafter THE BASICS] As an effect of this abuse, Federal DSH payments increased from $1.4 billion to $15 billion between 1990 and 1996. Spivey & Kellermann, *supra* note 10, at 2599.

34. THE BASICS, *supra* note 33, at 5 (explaining that the problem with this cap is that basing the state allotments—above which federal funding was not available—was inadequate for future years, and also resulted in a system that favored states that had been taking advantage of the system prior to the new cap).

35. Spivey & Kellermann, *supra* note 10, at 2599.

36. *Id*. at 2600 (noting CMS has concluded that "recycling," the practice of drawing excessive federal funds, has essentially stopped as of 2006).

facilities qualify as DSH providers,[37] but the actual amount of the payment is calculated with a formula dictated by the statute.

Medicare and Medicaid DSH payments are calculated separately, but there is some overlap. Medicare DSH payments can be calculated in one of two ways. The first determines eligibility based on a disproportionate patient percentage (DPP) threshold.[38] CMS uses a complex formula, taking into account the DPP figure to determine the states DSH adjustment for the fiscal year.[39] Alternatively, an exception applies to hospitals known as "pickle hospitals" that meet certain statutory criteria[40] where the statute specifically provides the amount of the adjustment for those "exception" facilities.[41] Medicaid DSH payments are subject to more state discretion, provided the statutory minimum criteria for eligibility is met.[42] States are required to provide at least the amount calculated under the Medicare DSH formula, or can apply a distribution method that calculates an amount proportional to increases in the hospital's low-income utilization rate.[43] In recent years, DSH caps have been put in place to reduce federal

37. Subject to the federal threshold of a 1% Medicaid utilization rate. Spivey & Kellermann, *supra* note 10, at 2600; THE BASICS, *supra* note 33, at 3. Of some concern, thirty-seven states have chosen to make DSH payments to hospitals providing Medicaid and charity care below the federal threshold since 1993. Spivey & Kellermann, *supra* note 10, at 2600.

38. The DDP is the sum of two percentages. The first percentage divides Medicare/Medicare Advantage inpatient days (attributable to patients entitled to both Medicare Part A and Supplemental Security Income) by Total Medicare Days. The second percentage divides the total number of Medicaid, Non-Medicare Days by total patient days. CTRS. FOR MEDICARE & MEDICAID SERVICES, FACT SHEET: MEDICARE DISPROPORTIONATE SHARE HOSPITAL, 1 (Jul. 2009) http://146.123.140.205/MLNProducts/downloads/2009_mdsh.pdf [hereinafter CMS FACT SHEET].

39. The application of the formula is contestable and subject to judicial review under certain circumstances, and the issue has recently been before the courts. *See e.g.*, Baystate Med. Ctr. v. Leavitt, 587 F. Supp. 2d 37 (D.D.C. 2008) (holding in Baystate's favor in part, ordering Leavitt, the Secretary of Health and Human Services, to recalculate the SSI fraction [a component of the Medicare DSH formula] and to pay Baystate any monies due in accordance with the new calculation) *and* Auburn Regional Med. Ctr. v. Sebelius, 686 F. Supp. 2d 55 (D.D.C. 2010) (holding the court did not have jurisdiction to review a Provider Reimbursement Review Board's decision to dismiss seventeen Medicare provider's untimely administrative appeals, requesting recalculation of DSH payments).

40. CMS FACT SHEET, *supra* note 38, at 2-3. The exemption applies to hospitals located in urban areas, with at least one hundred beds that can demonstrate that more than 30% of total net inpatient care revenues come from state and local government sources for indigent care, other than Medicare and Medicaid. Omnibus Budget Reconciliation Act of 1985, § 9105. However, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended the criteria to allow urban hospitals with fewer than one hundred bed and rural hospitals with fewer than five hundred beds to be eligible. *Id.*

41. Pickle hospitals receive a thirty-five percent increase in Medicaid operating payments, and a capital DSH adjustment of 14.16%. H.R. REP. NO. 108-391, at 663 (2003) (Comm. Report to Accompany H.R. 1).

42. THE BASICS, *supra* note 33, at 3. Medicaid Inpatient Utilization rate is at least one standard deviation in excess of the mean for all hospitals in the state or the facility's low-income utilization rate exceeds twenty-five percent. All eligible facilities must have a Medicaid utilization rate of *at least* one percent. For example, Wisconsin only designates hospitals meeting the federal minimum criteria as DSH providers, while New York designates nearly all hospitals. *Id.*

43. *Id.* The amount cannot exceed the total cost of providing inpatient and outpatient services to

spending, with exceptions for certain rural and urban hospitals.[44]

Under certain conditions, states have used DSH payments to expand Medicaid coverage rather than directly reimburse for uncompensated care.[45] Generally, most facilities still rely on DSH payments to supplement financial losses resulting from providing care to the uninsured and low-income populations. In terms of bottom-lines, the National Association of Public Hospitals and Health Systems found that without the stabilizing effects of DSH payments, safety-net hospitals' operating margins would have been -5.6 percent in 2006.[46] In fact, as part of the American Recovery and Reinvestment Act of 2009, the federal government infused DSH payments to mitigate some of the effects of the global recession, recognizing the vital role these facilities play in providing essential health care to Americans, especially in the hardest of economic times.[47] From any perspective, these payments are vital to keeping safety-net hospitals financially afloat.

Medicaid and uninsured patient. As an oversight measure, states must submit to the Secretary of Health and Human Services a detailed annual report and an independent, certified audit of DSH payments to hospitals.

44. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 402 places a 12% cap on DSH payments to hospitals, except urban hospitals with more than one hundred beds, rural hospitals with more than five hundred beds, and Rural Referral Centers and Medicare Dependent Hospitals (per § 5003 of the Deficit Reduction of 2005, starting Oct. 1, 2006). Pub. L. No. 108-173, § 402, 117 Stat. 2066 (2003). *See also* CENTERS FOR MEDICARE AND MEDICAID, CMS LEGISLATIVE SUMMARY OF H.R. 1 MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 PUB. L. 108-173, 54-55 (Ap. 15, 2004) (summarizing the 12% cap, and noting that it does not apply to Pickle hospitals) and CMS FACT SHEET, *supra* note 38, at 2. For an example of how the DPP is calculated and the 12% cap is applied, see *Id.* at 2.

45. *See e.g.*, *Medicaid Waivers and Demonstrations List: Details for Massachusetts MassHealth 1115*, CENTERS FOR MEDICAID AND MEDICARE SERVICES (last updated Feb. 23, 2010), http://www.cms.gov/medicaidstwaivprogdemopgi/mwdl/itemdetail.asp?itemid=CMS042959 (and accompanying pdf's) (describing the state sponsored universal coverage plan implemented in Massachusetts, for which DSH funds were diverted in an effort to fund the coverage expansion). *But see*, Spivey & Kellermann, *supra* note 10, at 2600 (describing how Tennessee redirected DSH funds to expand Medicaid, and within months safety-net hospitals curtailed or virtually eliminated vital programs, causing Tennessee to reinstate the DSH program).

46. Nat. Ass'n of Pub. Hops. & Health Sys., *Medicaid DSH Funds: Essential Support for the Nation's Health Safety Net*, ISSUE BRIEF Mar. 2009, at 2, *available at* http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/Medicaid-DSH-Funds.aspx?FT=.pdf.
Compare supra note 24 (stating that the average operating margin for safety-net hospitals (with the DSH payments) is -3.0%).

47. Illinois received an increase of approximately $5,265,333 in DSH allotment under the Act. *Disproportionate Share Hospitals (DSH) Allotments for Fiscal Year 2009*, HHS.GOV (last revised Mar. 17, 2009), http://www.hhs.gov/recovery/cms/dshstates.html; Kaiser Family Found., *Illinois: Disproportionate Share Hospitals (DSH) Allotments under the American Recovery and Reinvestment Act (ARRA) FY 2010*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.kff.org/profileind.jsp?ind=678&cat=4&rgn=15 (last visited May 2, 2011) (calculates Illinois' increase at $10,703,308).

IV. PPACA'S MEDICARE AND MEDICAID DISPROPORTIONATE SHARE PAYMENT REDUCTIONS

Despite the importance of DSH payments to safety-net facilities, the PPACA actually reduces both Medicare and Medicaid DSH payments starting in 2014.[48] As a starting point, in 2009, the federal government paid out approximately eleven million dollars in Medicaid DSH payments and ten million dollars in Medicare DSH payments.[49] Medicare DSH payments will experience the most dramatic reduction, dropping by seventy-five percent for fiscal year 2014.[50] Subsequent payments are based on three statutory factors relating to the size of the uninsured population under age sixty-five, as well as the amount of uncompensated care provided and the amount the hospital would have received had PPACA not reduced payments.[51] These factors are determined by the Secretary of Health and Human Services, and not subject to judicial or administrative review.[52] Medicaid DSH payments, on the other hand, will experience less dramatic cuts in an attempt to equitably distribute these reductions.[53] State allotments are decreased based on a new formula that imposes the largest reduction on the states with the smallest uninsured populations, and takes into account the importance of DSH payments to neutralize states' budget calculations for expanding Medicaid coverage.[54] Medicaid DSH payments are reduced by five hundred million dollars in 2014, with the maximum reduction of $5.6 billion occurring in fiscal year 2019.[55] The reduction in Medicaid DSH

48. Pub. L. No. 111-148, §§ 2551, 3133 (2010) (assuming its own success, future DSH payments cut by prescribed percentages, and then recalculated based on the size of the uninsured population post-2014 when the Medicaid expansion and Individual mandate take effect). *See infra* Section V (discussing why other provisions will actually still create a need for the safety net).

49. HEALTH & MED. POL'Y RES. GROUP, *Health Care Reform Impact in Illinois: Safety Net Hospitals*, May 2010, http://hmprg.org/wp-content/uploads/2010/05/Health-Reform-Workforce-factsheet-Final1.pdf [hereinafter *Illinois Impact*]. Illinois received approximately two hundred and fifteen million dollars for seventy-one hospitals in thirty cities. *Id.*

50. Pub. L. No. 111-148 § 3133(2) (as revised by Pub. L. No. 111-152, § 1104). The Congressional Research Service actually hails the Medicare DSH payment reduction as one of the largest cost savings provisions, citing to Congressional Budget Office predictions that it will decrease federal expenditures by $22 billion. PATRICIA A. DAVIS, ET. AL., CONG. RES. SERVICE, R41196, MEDICARE PROVISIONS IN PPACA (P.L. 111-148) at 3 (2010), *available at* http://opencrs.com/document/11-148/2010-04-21/ (click to download report for pdf).

51. Pub. L. No. 111-148 § 3133(2)(A)-(C).

52. *Compare* § 3133(c) (limiting judicial and administrative review) *with supra* note 39 (discussing cases where facilities have challenged the calculation of DSH payments).

53. Pub. L. No. 111-148 §2551(a)(2) (as replaced by Pub. L. No. 111-152 §1203(2)).

54. *Id.*; *Illinois Impact*, *supra* note 49 (pointing out that HHS must still develop a method for executing this provision, and ensuring the neediest states get the most funds). *See supra* note 34 (explaining the abuse before state allotments were put into place, and why equitable distribution of the reductions is even an issue).

55. Pub. L. No. 111-148 §2551 (as replaced by Pub. L. No. 111-152 §1203(2)); *Illinois Impact*, *supra* note 49.

payments are supposed to be offset by increased reimbursements to Medicare levels,[56] and indirectly countered by reducing the number of uninsured through the Medicaid expansion.[57] The idea behind reducing DSH payments is that covering an additional thirty-two million and effectively insuring ninety-five percent of Americans will dramatically reduce uncompensated care costs to a level undeserving of supplemental funding; however, other provisions of PPACA thwart this goal, rendering the safety-net anything but obsolete.[58]

V. OTHER PROVISIONS OF PPACA STRETCHING THE SAFETY-NET BEYOND SUSTAINABILITY

If PPACA went according to plan, then the DSH payment reductions may be a justified and fiscally efficient decision. Realistically speaking, the debate surrounding funding highlights the potential consequences of PPACA when limited state and federal resources are stretched too thin. The following subsections examine three PPACA provisions that will consume large amounts of federal and state dollars, but could end up costing the safety-net even more.

Coverage Gaps Created By Expanding Medicaid Eligibility and the Individual Mandate

One of the provisions of PPACA having the most impact on the safety-net is Section 2001, which brings all Americans under age sixty-five with income below 133 percent of the federal poverty level underneath the Medicaid umbrella starting January 1, 2014.[59]

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56. *Illinois Impact*, *supra* note 49.

57. *But see e.g.*, *Illinois Impact*, *supra* note 49 (discussing how Massachusetts' state sponsored universal health insurance program still left 2.6% of the population uninsured, but DSH payments were used to fund the coverage expansion, leaving hospitals with less revenue to care for the uninsured).

58. *See also*, Mark A. Hall, *Rethinking the Safety Net Access for The Uninsured*, 364 NEW ENGL. J. MED. 7, 8-9 (Dec. 29, 2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1011502 (arguing that the new uninsured population that will arise post-reform is evidence of the need to sustain the safety-net and describing the new uninsured population as: those falling into short term coverage gaps, those not subject to the individual mandate penalty because insurance is still unaffordable, in excess of eight percent of income, and the unaccounted for undocumented immigrant populations).

59. Pub. L. No. 111-148, § 2001(a) (2010). While the statute dictates 133%, new income counting rules for determining Medicaid eligibility specify a reduction of 5% of FPL from individuals income, which effectively raises new income eligibility threshold to 138% FPL. EVELYNE BAUMRUCKER & BERNADETTE FERNANDEZ, CONG. RES. SERVICE, 7-5700, GENERAL DISTRIBUTION MEMORANDUM: VARIATION IN ANALYSES OF PPACA'S FISCAL IMPACT ON STATES 8 n.11 (2010), *available at* http://healthreform.kff.org/~/media/Files/KHS/Scan/CRS%20State%20Impact%20of%20PPACA.pdf [herein after CRS MEMO]. Brian Blase, *Obamacare and Medicaid: Expanding a Broken Entitlement and Busting State Budgets*, WEBMEMO BY HERITAGE FOUND.,1, (Jan. 19, 2011), http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Medicaid-Expanding-a-Broken-Entitlement-and-Busting-State-Budgets (last visited May 2, 2011) [hereinafter WEBMEMO] (translating the

Most notably, this expansion applies to all individuals, including non-disabled, non-parents, that traditionally have been excluded from the program. For the safety-net system, this ideally translates into less uninsured patients, and guarantees at least some nominal reimbursement for services. Yet, a closer look at this provision and its application in conjunction with the individual minimum coverage mandate[60] reveals how the ideal might not become the reality.

First, newly eligible Medicaid beneficiaries will only be entitled to minimum essential benefits as defined by Section 1302(b) of PPACA, not full Medicaid benefits.[61] The federal government will pay for one hundred percent of the cost of these services provided to the "new eligibles" until 2016, then the federal share will decrease to ninety percent by 2020, leaving states to determine how to fund the remaining ten percent.[62] Second, before the expansion takes effect, states are prohibited from constricting current Medicaid eligibility requirements to save money,[63] with one major exception. If the state reports a budget deficit, the eligibility requirements for non-pregnant, nondisabled individuals above 133 percent of the federal poverty line, currently covered by a state program, can be restricted.[64] Considering that the vast majority of states are experiencing budget deficits, or at least tremendous strain, these individuals are most at risk of being uninsured until 2014,[65] if PPACA is fully implemented.[66] These individuals, as

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percentage into dollar value income: 138% FPL is the equivalent of $33,000 for a family of four, excluding any welfare benefits).

60. Pub. L. No. 111-148, § 1501(b) (2010).

61. These benefits are to be defined by the Secretary of Health and Human Services, but must include at least: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services, including oral and vision care. Pub. L. No. 111-148, § 1302(b) (2010) (emphasis added).

62. Pub. L. No. 111-148, § 2001(a) (as replaced by § 1201(1)(B) of Pub. L. No. 111-152).

63. § 2001(b)(1); WEBMEMO, *supra* note 59, at 1 (explaining that the maintenance of effort ("MOE") requirement is a condition of receiving federal funds, and the current eligibility levels are actually frozen at July 1, 2008 levels as a condition of receiving funds under the American Recovery and Reinvestment Act of 2009).

64. § 2001(b)(3) (entitled nonapplication); WEBMEMO, *supra* note 59, at 3 n.12. Some predict that states will scale back eligibility for individual over the expanded 133% federal threshold once the MOE expires in 2014, and instead shift this population into the state exchange for coverage where federal subsidies are available to them. CRS MEMO, *supra* note 59, at 5.

65. There are currently forty-four states and the District of Columbia reporting budget shortfalls for the 2012 fiscal year. Elizabeth McNichol et. al, *States Continue to Feel Recession's Impact*, CTR. ON BUDGET & POL'Y PRIORITIES, http://www.cbpp.org/files/9-8-08sfp.pdf.

66. Constitutional challenges to PPACA have already arisen. The Medicaid expansion has been challenged as a "customary and necessary" feature of state governments, and because the bill offers no alternative to participation as prescribed, the states argue that Congress "converts what [has] been a voluntary

discussed above, are already largely excluded from safety-net coverage, relying on the emergency room as a "primary care provider" because it is the most available point of access for individuals without coverage.

The third issue speaks to an existing system failure that is neither solved by PPACA nor will cease to be a problem: determining who is eligible and for which programs. The individuals targeted by the Medicaid expansion, could already be eligible in several states for Medicaid, but because of poor identification and recruitment mechanisms, are not actually enrolled. State participation rates nationwide vary, but no state has enrolled more than eighty percent of their citizens eligible for government-sponsored health insurance.[67] In fact, the national average is 61.7 percent for eligible individuals enrolled.[68] The PPACA assumes that sixteen million people in the current coverage gap will become enrolled automatically.[69] Yet, it fails to take into account the twelve million people currently eligible, but not in Medicaid, who will likely apply or face a penalty once PPACA's individual mandate takes effect.[70] This leads to the second part of the problem: who is eligible for which program. The portion of the population on the cusp between Medicaid eligibility and federal subsidies to purchase individual coverage poses

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federal-state partnership into a compulsory top-down federal program in which the discretion of [states] has been removed." Rosenbaum, *supra* note 19, at 1954. *See also* Commonwealth of Virginia *ex rel* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va., 2010) (holding that the Commonwealth had standing and the issue was ripe for judicial review, and denied a motion to dismiss because the Commonwealth's claim that the individual mandate, § 1501, exceeds Congress' constitutional power under the Commerce Clause, the Necessary and Proper Clause, and the General Welfare Clause had merit); *13 Attorney Generals Sue on Health Care Bill*, BOSTON GLOBE (Mar. 24, 2010), *available at* http://www.boston.com/news/health/articles/2010/03/24/13_attorneys_general_sue_on_health_care_bill/?rss_id=%20Boston.com+—+Health+news (detailing the lawsuit was filed in Pensacola ten minutes after President Obama signed PPACA into law, challenging the constitutionality of the individual mandate).

67. Massachusetts, with a state-sponsored universal health insurance program, is the only state with an eighty percent participation rate, but the District of Columbia does boast an eight-eight percent enrollment rate. Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion—The Soft Underbelly of Health Reform*, 363 NEW ENGL. J. MED. 2085, 2086 (Nov. 25 ,2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1010866.

68. Sommers & Epstein, *supra* note 67, at 2085. Varying participation rates among states is one of the more prominent factors in determining PPACA's impact on state budgets. PPACA encourages states to "improve outreach, streamline enrollment, and coordinate with exchanges" but each state's financial situation will dictates its ability and willingness to maximize Medicaid enrollment. CRS MEMO, *supra* note 59, at 8.

69. PPACA proposes another thirty-two million Americans will gain access to coverage because of the reform: sixteen million from the Medicaid expansion and sixteen million from the individual mandate and access to coverage through state exchanges. Health Care, CONGRESSIONAL BUDGET OFFICE, http://www.cbo.gov/publications/collections/health.cfm (last visited May 2, 2011) and Sommers & Epstein, *supra* note 67, at 2085.

70. WEBMEMO, 59, at 1. Sommers and Epstein hypothesize that for CBO estimates to be correct, and sixteen million more people be enrolled in Medicaid, participation rates among eligible individuals (without private insurance) will need to be at eighty percent, as opposed to this 61.7% national average. Sommers & Epstein, *supra* note 67, at 2086. For select states' Medicaid enrollment increase predictions, see CRS MEMO,

a conflict of interest between the state and federal governments. The states want to render these individuals eligible for federal subsidies to stay those costs,[71] while the federal government would prefer to see these individuals enrolled in the Medicaid program, of which states share some of the costs.[72] Either way, the fact that eligible individuals are not currently enrolled in the appropriate program, easily draws the conclusion that this borderline population will end up caught in the political crosshairs instead of having health insurance, as PPACA intended.[73] This reality alone speaks to the ongoing necessity of a safety-net system post-reform.

Reimbursement Rate Increased and Decreased

In an effort to make the Medicaid program more appealing for providers, the PPACA increased reimbursement rates for 2013 and 2014, to Medicare levels, for primary care services.[74] The federal government will pay this increase until January 1, 2015, after which states must fund the increase or cut rates.[75] If state budgets cannot sustain the increased reimbursement rates, states may have to potentially contend with an exodus of many primary care service physicians from the ranks of the Medicaid program if rates are ultimately reduced.[76] Financially, reimbursement rates, along with benefit scale-backs, are the most logical way for states to sustain the level of coverage mandated by PPACA, but the logical consequence is decreased access to primary care services for beneficiaries and increased presentation to the emergency room.[77]

Aside from the Medicaid reimbursement dilemma PPACA creates, safety-net facilities and Medicare providers recently dodged a twenty-three percent Medicare reimbursement rate cut when Congress renewed the wage index set under the Medicare Drug, Improvement, and Modernization Act of 2003.[78] The rate cut, intended to be a cost

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supra note 59, at Appendix.

71. For one such prediction, see *supra* note 64 and accompanying text.

72. WEBMEMO, 59, at 3.

73. *But see* Hall, *supra* note 58, at 9 (suggesting safety-net facilities can serve as points of origin to determine eligibility status).

74. Pub. L. No. 111-148 § 1202(a)(1) (2010).

75. Rosenbaum, *supra* note 19, at 1953; WEBMEMO, *supra* note 59, at 2.

76. WEBMEMO, *supra* note 59, at 3.

77. *Id.*

78. Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309 § 102, 124 Stat. 3285 (2010). *See also* Physician Payment and Therapy Relief Act of 2010, H.R. 5712, 111th Cong. (2nd Sess. 2010) *available at* http://www.gpo.gov/fdsys/pkg/BILLS-111hr5712enr/pdf/BILLS-111hr5712enr.pdf (initially staying the rate cuts for one month and providing a 2.2% increase for physicians) *and* David Loder & Mitchell Goldman, *U.S. Healthcare Reform Updates*, MONDAQ (Feb. 10, 2011).

savings mechanism, is only stayed through the end of 2011, at which point legislative action is required for any further extension.[79] Such action is unlikely given that the PPACA authorizes more than five hundred billion dollars in Medicare funding and reimbursement cuts in order to finance the law.[80] These reimbursement reductions alone, some predict, will cause more than seven hundred hospitals to become unprofitable.[81] If providers pull out of these programs, as is predicted, even those covered by the safety-net programs will be left with hospitals' emergency rooms as their only access point for care.[82]

VI. CONCLUSION

With all of the exceptional strides made to increase access and insure more Americans under the PPACA, it is quite alarming to realize that once the program expansions and reimbursement fluctuations start drawing from the same limited pool of state and federal resources those strides may be a lot smaller and less effective than anyone had hoped. As explained above, state are likely to scale back coverage and benefits, leaving the safety-net as the "health care of last resort" for those individuals marginalized by the system through political pushback[83] or intentional statutory omission.[84] When hospitals are

79. *House Could Delay Medicare Rate Cuts,* CNN, Nov. 29, 2010, *available at* http://www.cnn.com/2010/POLITICS/11/29/medicare.doctor.payments/index.html (explaining rate cuts have been blocked eight time in the last ten years).

80. *Camp Opening Statement: Hearing on the Health Care Law's Impact on the Medicare Program and its Beneficiaries*, COMMITTEE ON WAYS AND MEANS (Feb. 10, 2011) [hereinafter *Camp Opening Statement*] (""". . .there are more than one half-trillion dollars in cuts to Medicare that have been made in an effort to finance the law. Those changes include massive cuts to hospitals, cuts to home health agencies, cuts to skilled nursing facilities, and cuts to hospice providers. The concern of many on the committee is the impact of this law and the potential to either lose access to health care services or be forced to pay more for the services they need.").

81. *Camp Opening Statement*, *supra* note 80 (citing to Medicare actuaries predictions).

82. *See Emergency Department Policy Brief, supra* note **Error! Bookmark not defined.** (observing the effects of the recession and uninsured-ness on safety-net hospital emergency departments). *See generally,* Judith S. Gavaler & David H. Van Thiel, *The Non-Emergency in the Emergency Room*, 72 No.1 J. NAT. MED. ASS'N 33, 33 (1980), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2537390/pdf/jnma00033-0035.pdf (already identifying that low-income and uninsured as using the emergency room for nonemergency medical care because of the lack of a personal physician).

83. *See supra* Part V (discussing how states will try to shift individuals to the exchanges where federal subsidies are available and less state resources are necessary). *See, e.g., The Fiscal Consequences of the Health Care Law: Hearing Before the H. Comm. on the Budget*, (Jan, 26, 2011) (statement of Dennis G. Smith, Secretary of Wisconsin Dep't of Health Services, (transcript available at http://budget.house.gov/UploadedFiles/dsmith012611.pdf) (explaining that Wisconsin can save $579.4 million between 2014 and 2019 by shifting individuals out of Medicaid to the state exchange with federal tax credits).

84. The bill specifically prohibits undocumented aliens from purchasing coverage on the state exchanges, regardless of whether they can afford coverage with or without a federal subsidy. CHRIS L. PETERSON & THOMAS GABE' CONG. RES. SERVICE, R41137, HEALTH INSURANCE PREMIUM CREDITS UNDER PPACA (P.L. 111-148) 1-2 (2010),

faced with financial struggle and no means of increasing revenue, their only option is to cutback on services, facilities, or staff.[85] The community then suffers because the unprofitable, yet vital services are usually the most at risk to be scaled back or eliminated.[86]

Understandably, the impact of PPACA is yet to be seen,[87] but a more appropriate course of action may be to delay the scale back of vital resources to these entities currently partnering with the government to provide for the most vulnerable Americans. Too many "what if's?" remain unanswered to compromise an already fragile network of health care providers for the poor, yet the government's resolve is to ask for "even more, for even less."

available at http://healthreform.kff.org/~/media/Files/KHS/docfinder/crspremiumcredits.pdf.

85. *See* Julie Appleby, *Hospitals Hurt by Slumping Economy Put Off Projects*, USA TODAY, Jan. 22, 2009 *available at* http://www.usatoday.com/news/health/2009-01-22-hospitals_N.htm?POE=click-refer ("As a result of the economic crunch, 45% of hospitals have postponed upcoming improvement projects and 13% have halted expansions already underway" as reported by a survey of 639 hospitals.").

86. For examples, see AHA *Provena* Brief, *supra* note 23, at 30 (referencing "subsidized health service" such as emergency and trauma care, neonatal intensive care units, community health clinics and immunization programs) and IHA *Provena* Brief, *supra* note 12, at 6 (providing examples of unprofitable, yet vital community services, such as emergency departments, trauma and burn centers, neonatal intensive care units, and community care units).

87. Even the Congressional Budget Office predicts "limited" success, citing wasteful spending and fundamental reorganization as impediments to PPACA's fully effectuated success. Douglas W. Elmendorf, Director of the Cong. Budget Office, Economic Effects of the March Legislation, Presentation at the Schaeffer Center of the University of Southern California (Oct. 22, 2010), *available at* http://www.cbo.gov/ftpdocs/119xx/doc11945/USC10-22-10.pdf.

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Expanding Medicaid to Low-Income Individuals: Action Must Be Taken to Ensure Eligibility Results in Enrollment

*William VanMeter**

I. INTRODUCTION

Uninsured adults are more likely to forgo needed medical treatment than adults with private insurance coverage.[1] However, Medicaid insurance increases the chance that a low-income person will have access to health care.[2] In an effort to improve low-income adults ability to access health care, the Patient Protection and Affordable Care Act (PPACA) expands Medicaid eligibility to all people at or below 133 percent of the Federal Poverty Line (FPL).[3] While eligibility for insurance is the first step to improving access to health care for low-income individuals, obstacles may still prevent them from receiving care. Even after eligibility is extended, the newly eligible must enroll to obtain Medicaid insurance.[4]

This article examines the difficulty low-income individuals face when obtaining Medicaid insurance under new PPACA policies. Part II of this article briefly describes general Medicaid enrollment procedures. Next, Part III examines several of the problems associated with Medicaid enrollment. Part IV discusses solutions to Medicaid enrollment

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1. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 10 (Dec. 2010), http://www.kff.org/uninsured/upload/7451-06.pdf [hereinafter UNINSURED KEY FACTS].

2. *See id*. at 10 (stating that "The uninsured are far more likely than those with insurance to report problems getting needed medical care.").

3. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-146, § 2001, 124 Stat. 271, 271-73 (2010).

4. ELIZABETH CUSICK & KEN NIBALI, NAT'L ACAD. OF SOC. INS. STUDY PANEL ON MEDICARE/MEDICAID DUEL ELIGIBLES, CURRENT PROCESSES FOR ENROLLING MEDICARE/MEDICAID DUAL ELIGIBLES IN MEDICARE SAVINGS PROGRAMS AND EFFORTS TO INCREASE ENROLLMENT 5 (2005),

problems and specific state initiatives aimed at increasing Medicaid enrollment. Finally, this article concludes by analyzing the merits of the identified solutions.

II. APPLYING FOR MEDICAID

Individuals must apply to enroll in Medicaid; however, enrollment procedures vary, sometimes drastically, from state-to-state.[5] Generally, the procedure consists of completing a multi-page application and providing documentation of income, assets, and residency.[6] Many states also require in-person application at either a welfare or social security office.[7] For instance, in Illinois, applicants must visit the Department of Human Services (DHS) office.[8] Applicants with health problems that are unable to visit the office may request to have an application mailed to them.[9] These applicants must complete and return the application, and then are subject to a phone interview by a DHS staff member.[10] Additionally, some states even call for periodic verification of eligibility after initial enrollment.[11]

III. PROBLEMS WITH ENROLLMENT

For Medicaid expansion under the PPACA to be successful, newly eligible, low-income individuals must enroll in Medicaid.[12] Yet, eligibility for Medicaid does not necessarily translate into enrollment, as evidenced by the millions of individuals currently eligible for Medicaid that remain uninsured.[13] As recently as 2009, seventy percent of children eligible for Medicaid or Children's Health Insurance Program (CHIP) were uninsured.[14] Historically, eligible children do not remain uninsured because of their

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www.nasi.org/usr_doc/Current_Process.doc.

5. *Id.* at 5.

6. *Id.*; Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion – The Soft Underbelly of Health Care Reform*, 363 NEW ENG. J. MED. 2085, 2085 (Nov. 25, 2010).

7. CUSICK & NIBALI, *supra* note 4, at 5

8. *How to Apply for Medicaid*, ILL. DEP'T OF HEALTHCARE AND FAMILY SERVICES, http://www.hfs.illinois.gov/medical/apply.html (last visited May 5, 2011).

9. *Id.*

10. *Id.*

11. CUSICK & NIBALI, *supra* note 4, at 5 (verification of eligibility requires the enrollee to go through a similar process as the initial application and may require an additional visit to a government office.)

12. *See* Sommers & Epstein, *supra* note 6, at 2087 (commenting on enrollment being the key to successful health insurance expansion).

13. *Id.* at 2085.

14. AM. ACAD. OF PEDIATRICS, ACCESS: MEDICAID, CHIP, AND STATE MEDICAL HOME EFFORTS 1 (2011),

parents' failure to apply for Medicaid enrollment, but instead due to other administrative issues.[15]

Enrollment problems also extend to adults that are already eligible for coverage.[16] The average participation in Medicaid from 2007 to 2009 for eligible adults without any other health insurance alternative was 61.7 percent and enrollment among states varied from 44 percent to 88 percent.[17] Medicaid expansion may exacerbate enrollment problems, as states with the largest number of newly eligible adults under the PPACA are historically the worst at initial enrollment and maintaining enrollment for eligible adults.[18]

An eligible individual's failure to enroll in Medicaid often stems from perceived barriers to enrollment.[19] Barriers include difficulty completing the Medicaid application and lack of access to transportation, when in-person registration is required.[20] Parents of eligible children that started but failed to complete the enrollment processes reportedly withdrew because of the "difficulty of getting all the required papers (72%), overall hassle of the enrollment process (66%), and belief that the process was complicated and confusing (62%)."[21] In order for low-income individuals to benefit from Medicaid expansion, the enrollment process must be simplified and the perceived barriers to enrollment must be overcome.[22]

A 2005 survey on perceived enrollment barriers[23] found that forty percent of respondents interviewed at both urban and rural community health centers thought that

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http://www.aap.org/advocacy/access_slr.pdf.

15. MICHAEL PERRY ET AL., KAISER FAMILY FOUND., MEDICAID AND CHILDREN: OVERCOMING BARRIERS TO ENROLLMENT: FINDINGS FROM A NATIONAL SURVEY 8 (Jan. 2000), http://www.kff.org/medicaid/upload/Medicaid-and-Children-Overcoming-Barriers-to-Enrollment-Report.pdf [hereinafter OVERCOMING BARRIERS] (finding that twenty-one person of parents tried but could not complete the application process, twenty-one percent were denied coverage, and fifteen percent tried to enroll multiple times and had problems completing the process and gaining approval).

16. *See* Sommers & Epstein, *supra* note 6, at 2085 (discussing the Medicaid participation rates for eligible adults).

17. *Id.*

18. *Id.* (finding that the states that will have the most newly eligible adults are historically the worst at enrolling and keeping eligible adults enrolled in Medicaid, but not significantly worse).

19. Jennifer Stuber & Elizabeth Bradley, *Barriers to Medicaid Enrollment: Who is at Risk?*, 95 AM. J. PUB. HEALTH 292, 292 (2005).

20. *Id.*

21. OVERCOMING BARRIERS, *supra* note 15, at 9 (finding that seventy-two percent of parents had difficult getting the required documents, sixty-six percent found the process to be a hassle, and sixty-two percent thought the process was complicated and confusing).

22. *See* Stuber & Bradley, *supra* note 19, at 296 (finding that increased paperwork may make it more difficult to enroll in public insurance programs resulting in reduced enrollment).

23. *See id.* at 292-98 (identifying factors associated with perceived Medicaid enrollment barriers).

the Medicaid application was too long and complicated.[24] The respondents specifically identified several other enrollment barriers, specifically: difficulties accessing a translator, finding transportation to apply, and finding the documents required to apply.[25]

A prime example of a seemingly simple application requirement that negatively impacted enrollment is proof of United States citizenship.[26] After implementing the new requirement of presenting proof of citizenship, Medicaid enrollment declined.[27] Although the goal of demanding proof of citizenship was to prevent non-citizens from enrolling in Medicaid is laudable, U.S. citizens are often those burdened by the adverse affects.[28]

The citizenship requirement is evidence that enrollment procedures must be tailored towards simplification in order for the newly eligible to fully benefit from expanded Medicaid eligibility.[29] In fact, those newly eligible for Medicaid via the PPACA are primarily working-age adults without prior Medicaid experience.[30] Thus, because of the lack of experience with Medicaid enrollment procedures, enrollment procedures must be user friendly to help facilitate completion and ensure enrollment.[31]

A trend exists here for those already eligible and those that will be newly eligible from healthcare reform – enrollment is too difficult and actually prevents effective utilization of the services Medicaid is meant to provide. Despite a lack of effective utilization, or services where providers would receive payment, reduced Medicaid enrollment does not

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24. *Id.* at 294.

25. *Id.* (reporting that forty-one percent of respondents said it was difficult to find assistance from a translator, thirty-four percent agreed or strongly agreed they had difficulty finding transportation, and thirty percent agreed or strongly agreed that it was difficult to obtain the required documents).

26. Donna Cohen Ross, *New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up*, CTR. ON BUDGET AND POLICY PRIORITIES, 1 (rev. 2007).

27. *Id.* at 1, 4-7 (discussing the negative impact citizen require had on state Medicaid enrollment including: Wisconsin denying two-third of applications for lacking identify verification and 19.9 percent for not providing citizenship documents, Iowa experiencing a decline in Medicaid for three consecutive months for the first time in five years, Louisiana experiencing a net loss of nearly 15,000 children from its Medicaid program, and New Hampshire receiving half as many applications with all necessary documents).

28. *Id.* at 1, 4 (pointing to Wisconsin denying two-thirds of applications for failure to verify identity opposed to 19.9 percent for failure to provide citizenship documents as evidence that most people denied Medicaid were citizens).

29. *See* JULIA PARADISE, KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND. & MICHAEL PERRY, LAKE RESEARCH PARTNERS, OPTIMIZING MEDICAID ENROLLMENT: PERSPECTIVES ON STRENGTHENING MEDICAID'S REACH UNDER HEALTH CARE REFORM, 1 (Apr. 2010) (commenting on the need for easy enrollment processes to ensure Medicaid covers eligible individuals).

30. *Id.*

31. *See generally id.* at 1 (stating that individuals newly eligible for Medicaid do not have experience in

limit uninsured visits to emergency departments.[32] This burdens hospitals providing essential services and is not something we can accept, given available resources.[33]

IV. POSSIBLE SOLUTIONS TO ENROLLMENT PROBLEMS

Improving the enrollment rate among Medicaid eligible individuals will require the simplification of eligibility requirements so that applicants can easily ascertain their status before engaging in the enrollment process.[34] Additionally, the enrollment and renewal processes must pursue more streamlined avenues.[35] While these strategies will take time, introducing the public to Medicaid expansion in ways that encourage participation can operate as a quick approach to increasing enrollment.[36]

Methods to increase awareness, encourage participation, and simplify enrollment include: new outreach programs, use of automation and technology, diverse modes for enrollment, and partnering with community organizations.[37] Outreach programs may include using the media for public awareness.[38] At a most basic level, a change in organizational culture at state Medicaid agencies must occur in order for its expansion to be successful.[39] States originally took the roll of "gatekeepers" to reduce Medicaid fraud;[40] however, the hardship created by stringent enrollment procedures is in stark conflict with the goals of expanded coverage.[41] State Medicaid organizations must shift from their role as "gatekeepers," aimed at keeping non-eligible applicants out, to pro-coverage agents for eligible participants.[42]

Several states have already implemented programs to ease enrollment procedures and increase overall enrollment in Medicaid.[43] Specifically, Wisconsin has developed

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the program and commenting on the need for easy enrollment procedures).

32. *See Communities Matter*, COVER THE UNINSURED, http://covertheuninsured.org/content/communities-matter (last visited May 8, 2011) (commenting on the over crowding of emergency departments in both urban and rural areas).

33. Reed Abelson, *Uninsured Put a Strain on Hospitals*, N.Y. TIMES, Dec. 9, 2008, at B0.

34. *See* Sommers & Epstein, *supra* note 6, at 2086.

35. PARADISE & PERRY, *supra* note 29, at 1.

36. *Id.* at 1.

37. PARADISE & PERRY, *supra* note 29, at 1.

38. Sommers & Epstein, *supra* note 6, at 2086.

39. *Id.* at 7-8.

40. *Id.* at 7-8.

41. *Id.* at 7.

42. *Id.* at 7-8.

43. *See generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND.,

ACCESS, a web-based tool that assists in public benefits enrollment.[44] Oklahoma implemented a feature into SoonerCare that automatically enrolls newborn babies.[45] Additionally, Louisiana has utilized a strategy called Express Lane Eligibility (ELE) to simply enrollment.[46] ELE, as discussed below, is an effort to increase enrollment by individuals eligible for public benefits by allowing programs or agencies to use information that was previously provided to another agency. These programs offer viable solutions to improve enrollment of Medicaid-eligible participants.

Wisconsin's ACCESS is a web-based tool that allows residents to determine if they are eligible for benefits, apply for benefits, check benefits status, renew benefits, or report changes to eligibility for public benefits, including Medicaid.[47] Wisconsin provides numerous locations for assistance with and use of ACCESS, as it is aware that many low-income residents that receive benefits do not have Internet access.[48] These locations include: public libraries, county and tribunal agencies, health centers, and food pantries.[49] Additionally, ACCESS is written at a forth grade level to ensure that residents can understand and work through the application, and is available in both English and Spanish.[50] Furthermore, specialists are trained to help people that need assistance with the application process.[51]

Oklahoma implemented a feature into SoonerCare[52] that automatically enrolls

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OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: WISCONSIN'S ACCESS INTERNET PORTAL, 1 (2010) [hereinafter WISCONSIN ACCESS]; *see generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: LOUISIANA'S EXPRESS LANE ELIGIBILTY, 1 (2010) [hereinafter LOUISIANA EXPRESS LANE]; *see generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., OPTIMIZING MEDICAID ENROLLMENT: SPOTLIGHT ON TECHNOLOGY: OKLAHOMA'S AUTOMATIC NEWBORN ENROLLMENT SYSTEM, 1 (2010) [hereinafter OKLAHOMA AUTOMATIC ENROLLMENT].

44. WISCONSIN ACCESS, *supra* note 43, at 1.

45. OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1 (SoonerCare is Oklahoma's Medicaid program).

46. *See* NAT'L COUNCIL ON AGING, EXPRESS LANE ELIGIBILITY: NEW STRATEGIES FOR INCREASING ENROLLMENT 2-4 (June 2009), http://www.centerforbenefits.org/NCBOE_ELE_Issue_Brief_FINAL.pdf [hereinafter ELE ENROLLMENT] (Defining ELE and discussing methods to ensure ELE is successful. ELE is used to describe the processes of identifying a person in one public program that may be eligible for benefits in another public program, information sharing among public benefit programs, and auto-enrolling a person in a public benefit program when he is found eligible for another program.).

47. WISCONSIN ACCESS, *supra* note 43, at 1.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *See* OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1 (SoonerCare is Oklahoma's Medicaid program).

newborns if the baby's mother was enrolled in Medicaid at the time of birth.[53] This feature increased enrollment efficiency in the Medicaid program as SoonerCare now covers over sixty percent of births.[54] The previous system for enrollment was a paper-based system that was both time-consuming and error prone.[55] In addition to increasing enrollment efficiency, the automatic enrollment system also ensures that eligibility rules are applied consistently.[56]

Louisiana has developed an ELE program to determine eligibility, enroll, and verify eligibility for Medicaid.[57] ELE generally refers to identification of eligible people, information sharing between programs, and auto-enrollment of a person based on enrollment in another benefit program.[58] For an ELE program to be successful, the benefit programs should have similar eligibility rules.[59] Existing eligibility rules should be aligned to make eligibility determination as uniform as possible.[60] In Louisiana's case, sharing information among agencies made the enrollment process more efficient.[61] The agency does not have to reassess eligibility and look at factors that were already examined by another state agency to determine eligibility for other public benefits.[62] However, consent of the individual is required for agencies to share information and to permit automatic enrollment in Medicaid, if the person is eligible.[63] In its first month, Louisiana enrolled 10,000 children in Medicaid, despite reducing the Medicaid workforce by twelve percent in the pervious two years.[64]

The efforts in Wisconsin, Oklahoma, and Louisiana confirm the need to simplify Medicaid enrollment procedures to ensure that eligibility results in enrollment. These programs aim to improve enrollment by eliminating or reducing barriers to enrollment.

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53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.* at 2.
57. LOUISIANA EXPRESS LANE, *supra* note 43, at 1 (Louisiana's ELE program uses data elements from the state's Supplemental Nutrition Assistance Program (SNAP) to automatically enroll children in the states Medicaid program when their parents qualify for SNAP benefits).
58. *Id.*
59. *Id.* at 2-3.
60. *See Id.* at 3 (discussing states that have already modified eligibility rules).
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.* at 2.

V. ANALYSIS OF EFFORTS TO IMPROVE MEDICAID ENROLLMENT

The three main barriers to enrollment discussed above include complicated. applications, lack of transportation, and difficulty obtaining documents. These have been addressed in different ways by Wisconsin, Louisiana, and Oklahoma.[65]

Two ways that Wisconsin addressed the problem of the complicated applications was by providing access to assistance and limiting the language used in the application to a fourth grade reading level.[66] In using a web-based system it is important for people to have access to assistance; many low-income people do not have access to or experience using the internet. Since implementing the ACCESS program, over eighty percent of childless adults enrolled in state insurance programs have used ACCESS.[67]

Louisiana took note and moved a step further by proactively enrolling eligible-but-not-enrolled children.[68] However, Louisiana's system is still problematic as the person must authorize information sharing and be enrolled in another public program to be enrolled.[69] SoonerCare, in Oklahoma, has a similar problem in that enrollment only applies to newborn children when the mother is enrolled in Medicaid[70] The automatic enrollment feature, however, is a good base to build on and shows the development of a pro-enrollment mind-set.[71]

All of the programs discussed address the problem of transportation. Wisconsin established numerous locations that residents can visit to receive help with the application.[72] Automatic enrollment systems, like Louisiana and Oklahoma's, essentially eliminate the need for transportation to enroll; however, transportation may be needed to apply for the benefits that Medicaid eligibility is based.

The state programs do not specifically address the problem with obtaining documents.

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65. *See infra* Part IV.
66. WISCONSIN ACCESS, *supra* note 43, at 1.
67. *Id.* at 3.
68. LOUISIANA EXPRESS LANE, *supra* note 43, at 1.
69. *Id.* (stating that family consent is required for agencies to share date). The problem with consent is that, as described *infa* Part II, seemingly simple requirements can have a negative impact on the ability for a qualified individual to enroll in Medicaid.
70. OKLAHOMA AUTOMATIC ENROLLMENT, *supra* note 43, at 1.
71. *See generally Id.* at 1-3 (describing how auto-enrollment in SoonerCare works and explaining that the program was needed to fix the time consuming error prone enrollment procedures that prevented or delayed eligible childrens' enrollment).
72. WISCONSIN ACCESS, *supra* note 43, at 1.

Because the criterion for eligibility under the PPACA, which is income below 133 percent of the FPL,[73] is simplified, the requirements to prove eligibility should be reduced. The expansion of Medicaid to the newly eligible "establishes an expectation that everyone should be insured;"[74] however, as evidenced by the impact of proof of citizenship, simple requirements can have a negative impact on enrollment of eligible individuals.[75]

Even if the state programs address barriers to enrollment, the programs must actually result in higher enrollment to be successful. In Wisconsin, the percent of applicants that use the ACCESS system who are determined to be eligible for state health insurance is lower than other methods of applying.[76] The reason for the discrepancy is unclear; ACCESS applicants may be less likely to be actually eligible or the procedure of ACCESS may impede eligibility recognition.[77] ACCESS is utilized more in metropolitan areas and by applicants above 150 percent of the FPL.[78] The newly eligible will be below 133 percent of the FLP;[79] therefore, Wisconsin must consider whether additional procedures will be necessary to ensure that the newly eligible will enroll in Medicaid.

In addition, states that have implemented ELE initiatives have also experienced some setbacks.[80] While ELE makes enrollment easier for the benefit recipient, caseworkers used to a complex determination system may not easily adopt to the pro-enrollment

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73. PPACA § 2001, 124 Stat. at 271-73.

74. PARADISE & PERRY, *supra* note 29, at 1.

75. LAURA SUMMER, GEORGETOWN UNIV. HEALTH POLICY INST., GETTING AND KEEPING COVERAGE: STATES' EXPERIENCE WITH CITIZENSHIP DOCUMENTATION RULES 2 (Jan. 2009) (finding that enrollment in all seven states analyzed declined in the six month period following the implementation of the proof of citizenship requirement).

76. ROBERT WOOD JOHNSON FOUND., THE TARGET EFFICIENCY OF ONLINE MEDICAID/CHIP ENROLLMENT: AN EVALUATION OF WISCONSIN'S ACCESS INTERNET PORTAL 4 (Feb. 2011), http://www.rwjf.org/files/research/71923.pdf [hereinafter EVALUATION OF ACCESS] (finding that walk-in, mail-in, and phone applicants are more likely to be found eligible for health insurance).

77. *Id.*

78. *Id.* at 3 (finding that eighty percent of applications submitted by applicants above 150 percent of the FLP were submitted through ACCESS and fifty-six percent of applications submitted by applicants below 150 percent of the FLP and applicants in metropolitan areas used ACCESS sixth-five percent of the time opposed to sixty-percent for applicants from rural areas).

79. PPACA § 2001, 124 Stat. at 271-73.

80. *See* KAISER FAMILY FOUND. & CHILDREN'S PARTNERSHIP, EXPRESS LANE ELIGIBILITY EFFORTS: LESSONS LEARNED FROM EARLY STATE CROSS-PROGRAM ENROLLMENT INITIATIVES 1-8 (Aug. 2009), http://www.kff.org/medicaid/upload/7956.pdf (discussing the ELE programs in Alabama, Iowa, Louisiana, and New Jersey and identifying initial problems the states encountered) [hereinafter LESSONS LEARNED]; *see* JENNIFER SULLIVAN & LAURA PARISI, FAMILIES USA, EXPRESS LANE ELIGIBILITY: EARLY STATE EXPERIENCES AND LESSONS FOR HEALTH REFORM 3-14 (Jan. 2011), http://www.familiesusa.org/assets/pdfs/chipra/Express-Lane-Eligibility-State-Experiences.pdf (identifying lessons learned by states that have ELE programs).

environment.[81] Problems may also arise when agency information is mismatched; for example, last names may not be spelled the same.[82] Enrollment can also be stymied if the enrollment process, despite sharing of information between agencies, has multiple steps.[83] Enrollment significantly drops-off if the application process involves more than one form or visit to an agency.[84]

States are moving in the right direction to ensure that individuals newly eligible for Medicaid actually enroll. However, to achieve the goal of health insurance and access to healthcare for all low-income people, a default or retroactive system is needed for Medicaid enrollment. While the PPACA addresses access to health care by providing for the expansion of Community Health Centers (CHCs),[85] health centers that provide care regardless of a person's ability to pay,[86] uninsured are still more likely than those with insurance to have a regular access to health care.[87]

Currently, individuals must apply to be enrolled. Even ELE programs that automatically enroll eligible people have problems.[88] If an eligible person does not apply, and then receives medical treatment, the health provider bears the cost when the person is unable to pay. Hospitals and private organizations offer Medicaid application assistance to help low-income, uninsured individuals apply for Medicaid,[89] but for the true objective of Medicaid expansion to be realized, Medicaid enrollment procedures must be simplified and a default payment system for medical providers that provide treatment to Medicaid eligible individuals must be in place.

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81. SULLIVAN & PARISI, *supra* note 80, at 5 (discussing Alabama's problem with caseworkers used to a complex determination system).

82. *Id.* at 8 (discussing Louisiana's problem with mismatched enrollees, specifically, problems because the agencies use different identification numbers for beneficiaries and discrepancies in applications, such as different name spellings).

83. LESSONS LEARNED, *supra* note 80, at 4.

84. *Id.*

85. PPACA § 10503, 124 Stat. at 886.

86. Eli Y. Adashi, M.D. et al, *Health Care Reform and Primary Care – The Growing Importance of Community Health Centers*, 362 NEW ENG. J. MED. 2047, 2047 (2010).

87. UNINSURED KEY FACTS, *supra* note **Error! Bookmark not defined.**, at 10 (stating that "half of uninsured adults do not have a regular place to go when they are sick or need medical advice").

88. *See infra* Part V.

89. Examples of organization that offer Medicaid application assistance are the Health Justice Project at Loyola University of Chicago School of Law and Northwestern University Medical Center.

VI. CONCLUSION

Extending Medicaid to low-income individuals at or below 133 percent of the FPL is a step in the right direction to ensuring that low-income people have access to adequate health care.[90] Additional steps need to be taken to establish a default enrollment system for low-income individuals that do not actively apply for Medicaid. While granting eligibility is necessary for enrollment to take place, eligibility alone is not sufficient to ensure that the newly eligible will enroll and, therefore, receive benefits. By improving enrollment rates, states will be able to realize some of the intended benefits associated with Medicaid, including reducing the burden on hospital emergency departments. This could come with a cost to state budgets, an issue addressed by several states in 2011. Nevertheless, as long as eligibility requirements remain the same, states should strive to enroll those individuals.

90. PPACA § 2001, 124 Stat. at 271-73.

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The Biologics Act: Hopes for Access to Generic Biologics May Instead Be a Catalyst for New Innovation

*Brenda Flores Gehani**

I. INTRODUCTION

Recent advances in life sciences and biotechnology offer enormous potential for improving health. Biotechnology has led to major breakthroughs and produced new biologically derived treatments for many types of cancer, cardiovascular disorders, diabetes, and other debilitating or life-threatening diseases.[1] These treatments, referred to as "biologics," are drugs that are created using biotechnological processes derived from living organisms and will continue to revolutionize the pharmaceutical industry.[2] Biologics include medicines like the breast cancer drug Herceptin and the arthritis drug Humira, as well as vaccines such as those that prevent HPV and cervical cancer.[3]

However, the potential for biologics is curbed by their prohibitive costs.[4] Because biologics are significantly larger and more complex molecules than small-molecule pharmaceuticals, they are much more costly to develop.[5] Patients and healthcare payers and providers pick up this cost – and it is a considerable cost. For example, the cost for

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1. Matthew J. Seamon, *Antitrust and the Biopharmaceutical industry: Lessons from the Hatch-Waxman and an Early Evaluation of the Biologics Price Competition and Innovation Act of 2009*, 34 NOVA L. REV. 629, 631 (2010).

2. U.S. Food and Drug Administration - Center for Biologics Evaluation and Research, *What are "Biologics" Questions and Answers*, http://www.fda.gov/AboutFDA/CentersOffices/CBER/ucm133077.htm (last visited March. 29, 2011); Alfred B. Engelberg et al., *Balancing Innovation, Access, and Profits – Market Exclusivity for Biologics*, 361 NEW ENG. J. MED. 1917, 1917 (Nov. 12, 2009).

3. Anthony D. So & Samuel L. Katz, Op-Ed., *Biologics Boondoggle*, N.Y. TIMES, Mar. 8, 2010, at A0.

4. Engelberg et al., *supra* note 2, at 1917.

5. U.S. Food and Drug Administration, *supra* note 2.

an average biologic is more than 20 times that of a small-molecule drug.[6] Many biologics cost thousands of dollars for a course of treatment that can last months or years – costs that are far in excess of those for small-molecule pharmaceuticals.[7] These costs average between $10,000 to $20,000 or more per patient, per year.[8] Still, biologics are gaining ground in the pharmaceutical market. In 2008, biologics accounted for about thirty percent of sales of pharmaceutical products and are expected to account for fifty percent of all pharmaceutical sales by 2014.[9]

As biologics continue to grow, lower-cost alternatives to biologic therapies are necessary. After more than a decade of debate and mounting demand for lower-cost "generic" versions of biotechnology products, Congress passed the Biologics Price Competition and Innovation Act (Biologics Act).[10] The Biologics Act is included as Title VII of the Patient Protection and Affordable Care Act.[11] The Biologics Act creates a streamlined FDA approval pathway for generic versions of already-marketed biologic drug products. The purpose of the Biologics Act is to encourage innovation while making generic biologic drugs (biosimilars) accessible and less cost-prohibitive to the public. While the Biologics Act's impact on innovation and access remains to be seen, it may nonetheless encourage innovation of new biologics. These innovative biologics may not be the intended outcome of the Act, which are more competition in the form of introduction of generic biologics. Instead, it will encourage investment and development of new innovative drugs.

II. BACKGROUND

a. Biologics

Biologics "represent the cutting-edge of biomedical research."[12] Biologics are markedly different from small-molecule pharmaceuticals in various ways. While small-

6. Ian Evans, *Follow-on Biologics: A New Play for Big Pharma*, 83 YALE J. BIOL. & MED. 97 (2010).

7. Jeremiah J. Kelly & Michael David, *No Longer "If," But "When": The Coming Abbreviated Approval Pathway for Follow-on Biologics*, 64 Food Drug L.J. 115, 115 (2009). Throughout this article, the term "small-molecule pharmaceutical" is used to represent the class of chemically, as opposed to biologically, synthesized pharmaceutical products.

8. *Id.*

9. So & Katz, *supra* note 3.

10. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 7001-7003, 124 Stat. 119 (2010).

11. *Id.*

12. U.S. Food and Drug Administration, *supra* note 2.

molecule pharmaceuticals are composed of chemicals, biologics are composed of sugars, proteins, nucleic acids or complex combinations of these substances.[13] Biologics are created using biotechnological processes that stimulate biological molecules, often in living entities such as cells and tissues, as opposed to small-molecule drugs that are synthesized with chemicals.[14] Most biologics are complex mixtures that are not easily identified or characterized. The process of manufacture for biologics differs extensively from small-molecule compounds.[15] Synthesis of biologics requires living organisms such as bacteria or cell culture and requires hundreds of isolation and purification steps.[16]

Due to the complexity of biologics, an exact copy of a biologic is impossible, since changes to the compound itself occur during the manufacturing process.[17] Thus, generic biologics are not identical to the innovator drug, in contrast with small-molecule generic drugs, which must be chemically identical to the innovator drug. Instead, generic biologics are often called "follow-on biologics" or "biosimilars."[18] This name underscores the fact that follow-on biologics are similar, but not identical to the innovator, biological product.

b. Generics

Generic pharmaceuticals are a cheaper alternative for consumers. Similarly, generic biologics have been proposed as a possible solution for the continuing skyrocketing pharmaceutical costs. U.S. confidence in and acceptance of this idea is the basis for the fact that approval of generic drugs has been allowed for over twenty-five years. The Hatch-Waxman Act of 1984[19] aimed to strike a balance between incentives for drug innovation and the need for lower drug prices through increased competition.[20] The Hatch-Waxman Act created a growth in the generic industry as a response to the increased demand for lower-cost pharmaceuticals.[21] Generic alternatives facilitated by

13. *Id*; A. Taylor Corbitt, *The Pharmaceutical Frontier: Extending Generic Possibilities to Biologic Therapies in the Biologics Price Competition And Innovation Act Of 2007,* 18 DEPAUL J. ART TECH. & INTELL. PROP. L. 365, 376-7 (2008).
14. *Id.*
15. Corbitt, *supra* note 13, at 377.
16. *Id.*
17. *Id.* at 378.
18. Corbitt, *supra* note 13, at 367.
19. Pub. L. No. 98-417, 98 Stat. 1585 (1984) (codified as amended at 15 U.S.C. §§ 68b-68c, 70b (2006)).
20. Corbitt, *supra* note 13, at 371.
21. *Id.* at 366.

the Hatch-Waxman Act saved consumers billions of dollars in retail pharmacies alone on prescription drugs by purchasing generic drugs instead of brand name drugs.[22] As a compromise to competing interests from brand name drug manufacturers, new generic pharmaceutical companies and the need for public access to affordable medication, the Hatch-Waxman Act specifically authorizes "Abbreviated New Drug Applications" (ANDAs).[23] ANDAs allow a manufacturer that produces "a generic version of a patented drug to bypass the FDA's requirement of proving that the drug is safe and effective," so long as the formula is identical to the brand-name drug.[24]

Similar to ANDAs, an abbreviated pathway for the approval of biosimilars exists in the Biologics Act and is expected to reduce drug costs.[25] The Congressional Budget Office (CBO) estimates that the federal government could save $5.9 billion over ten years by establishing an abbreviated pathway for the FDA approval of biosimilars, not counting the savings to private purchasers.[26] Additionally, it is estimated that an abbreviated pathway will reduce total expenditures on biologics in the U.S. by about $25 billion over the same period.[27]

III. IMPACT OF THE BIOLOGICS ACT

Similar to the Hatch-Waxman act, the Biologics Act provides an expedited FDA approval procedure and is intended to promote the development of lower-cost alternatives to biologics.[28] The Hatch-Waxman Act facilitated the introduction of generics and has succeeded in creating access to significantly lower cost generic drugs for the consumer.[29] Similarly, the Biologics Act attempts to encourage the introduction of biosimilars by

22. CONGRESSIONAL BUDGET OFFICE, HOW INCREASED COMPETITION FROM GENERIC DRUGS HAS AFFECTED PRICES AND RETURNS IN THE PHARMACEUTICAL INDUSTRY ix (1998), *available at* http://www.cbo.gov/ftpdocs/6xx/doc655/pharm.pdf (in one year alone (1994), consumers of generic drugs saved between $8 billion and $10 billion in retail pharmacies alone on prescriptions drugs by purchasing generic drugs instead of brand name drugs).

23. Corbitt, *supra* note 13, at 372.

24. *Id.*

25. CONG. BUDGET OFFICE, COST ESTIMATE, S. 1695, BIOLOGICS PRICE COMPETITION AND INNOVATION ACT OF 2007 1 (2008), available *at* http://www.cbo.gov/ftpdocs/94xx/doc9496/s1695.pdf. The Biologics Act is substantially identical to the S.1695 Biologics Price Competition and Innovation Act of 2007, a biosimilars bill introduced in the 110th Congress. *See* Biologics Price Competition and Innovation Act of 2007, S. 1695, 110th Cong. (2007).

26. CONG. BUDGET OFFICE, *supra* note 25, at 1.

27. *Id.*

28. Corbitt, *supra* note 13, at 366.

29. *Id.* at 371.

providing innovator biologics manufacturers with market exclusivity.[30]

The real impact of the Biologics Act on the development of biologics and biosimilars is still uncertain. One possible outcome is the development of more biosimilars, which the Act intended to spur. The Biologics Act will serve its intended purpose and encourage a new market of biosimilars, akin to the Hatch-Waxman Act. Incentivizing the development of biosimilars by creating an abbreviated approval pathway for biosimilars will allow for the development of more biologics in the form of biosimilars. The development of more biosimilars in the market will likely create discounted costs for biologics. As a result, there will be savings in both the private and public expenditures of drugs.[31] In other words, both commercial and government payers will save money by reducing their spending on specialty drugs.

Furthermore, more biosimilars will continue to increase because investment and production of biosimilars is attractive for pharmaceutical companies.[32] Biosimilars still have the potential of bringing in a large profit for pharmaceutical companies, despite the drop in price due to the generic classification.[33] Additionally, because they are just copies of pioneer drugs, the development of biosimilars poses a lower risk than developing an innovator biologic.[34]

Another possible outcome of the Biologics Act could actually be slowing the development of biosimilars and biologics. The Biologics Act incorporates some high hurdles that biosimilars must overcome in order to obtain FDA approval.[35] Because of the high costs and high standards for generic biologics, manufacturers may be slower to develop biosimilars compared to generic small-molecule drugs.[36]

Biologics have also not been subject to generic competition because they are more complex than chemical drugs, making it much more difficult, and expensive, to prove

30. Joanna T. Brougher, *The Biosimilars Act: Promoting or Discouraging the Development of Generic Biologics?*
A tug-of-war between generic and innovator biologics seems to be where drug developers are headed, 22 BIOTECHNOLOGY HEALTHCARE, Winter 2010, at 22, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008392/pdf/bth07_4_p022.pdf. *See* 42 U.S.C. § 262(k)(7).

31. CONG. BUDGET OFFICE, *supra* note 25, at 1.

32. Heidi Ledford, *'Biosimilar' Drugs Poised to Penetrate Market*, 468 NATURE 18, 19 (2010), *available at* http://www.nature.com/news/2010/101103/full/468018a.html

33. *Id.*

34. *Id.*

35. Brougher, *supra* note 30, at 22.

36. Steven A. Nash & Rebecca Workman, *A New Pathway for Follow-On Biologics*, 20 FED. CIR. B.J. 193, 198 (2010).

that a copy is identical to the original drug.[37] Additionally, the production process of biologics made from living organisms is riskier than that of chemical-based drugs and presents safety concerns.[38] Some argue that the Act may hinder innovation of biologics altogether.[39]

Yet another possible outcome is that the Biologics Act may encourage research and development of innovator biologics instead of biosimilars. Since replicating an innovator biologic may be too costly and may take a long period of time to enter the market, a biologic manufacturer may instead develop its own innovative biologic. By potentially discouraging generic competition, the Biologics Act may encourage the development of new biologic products. Rather than assuming costs of replicating biologics already in the market, manufacturers may be more willing to develop new products that target different diseases, resulting in more treatment options.

The Biologics Act provides innovator biologics manufacturers with market exclusivity and delays market entry for manufacturers of generic biologics.[40] Innovators have a lot to gain from developing new biologics. For example, innovator biologics manufacturers are 'rewarded' for their research and development with a twelve-year FDA exclusivity period.[41] This exclusivity period is much longer than the exclusivity period allowed by the Hatch-Waxman Act, which allows five years of market exclusivity.[42] The exclusivity period will certainly enhance investment incentives and innovation.[43] The twelve-year data exclusivity period for new biologics is an appropriate approach to balance innovation and lower costs of biosimilars.[44]

Even if the innovator biologic is not granted patent protection, the Act provides a separate way to obtain market exclusivity for twelve years.[45] Considering the long wait period required to obtain a patent and the uncertainty of the patent protection, the

37. Corbitt, *supra* note 13, at 378.

38. John Alan Little, Jr., *10th Annual Legal Ethics and Professionalism Symposium: Drawing the Ethical Line: Controversial Cases, Zealous Advocacy, and the Public Good*, 44 GA. L. REV. 1097, 1102 (2010).

39. *See* Melissa Levin, *Follow-On Biologics: Is The Incentive For Development Still Present?* 20 ANN. HEALTH LAW ADVANCE DIRECTIVE 49 (2010).

40. Nash & Workman, *supra* note 36, at 196-97.

41. Katherine N. Addison, *The Impact of the Biosimilars Provision of the Health Care Reform Bill on Innovation Investments*, 10 J. MARSHALL REV. INTELL. PROP. L. 553, 565 (2011).

42. Brougher, *supra* note 30, at 23.

43. Addison, *supra* note 41.

44. Henry Grabowski et al., *Data Exclusivity for Biologics*, 10 NATURE REV. DRUG DISCOVERY 15, 16 (2011).

guaranteed exclusivity period provides an incentive to research and development, since investors will be sure that the costs of development will be recovered due to the FDA approval of the biologic and its resulting exclusivity period.[46]

Thus, the FDA exclusivity period granted by the Biologics Act offers a major opportunity to develop more biologics. The exclusivity period favors innovation rather than copying pioneer drugs to create biosimilars. The opportunities and economic value for innovative biologic manufactures may incentivize the development of innovator biologics, rather than biosimilars as was intended in the Biologics Act.

IV. CONCLUSION

The Biologics Act's impact on innovation and access to biosimilars remains to be seen, and much debate about its potential impact continues. While the purpose of the Act to encourage generic competition is yet to be determined, the Act may in fact serve as a catalyst for innovation of new biologics. The costs of biologics may not be reduced as soon as expected, but the promise of new biologics therapies that target a variety of diseases will at least provide the availability of more life-saving treatments.

45. *Id.*
46. Addison, *supra* note 41.

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Incentivizing Innovation: Pharmaceutical Pricing in the United States and the United Kingdom

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I. INTRODUCTION

The United States and the United Kingdom differ greatly in the amount of government control involved in pharmaceutical pricing. Historically, the U.S. has favored a system where pharmaceutical prices are largely unregulated.[1] This has caused the U.S. to be the world's primary profit center for new medical innovations.[2] Conversely, the U.K. has employed a system where drug prices have been set by government agencies to decrease the price of drugs in order for the National Health Service plan to support the greatest number of patients.[3] As a result, there is a gap between new medical innovations being offered and what the government system will reimburse, leaving U.K. residents without the latest medical technology.[4]

Prior to the passage of the Patient Protection and Affordable Care Act (PPACA), there was concern that healthcare reform would have a negative effect on medical innovation in the U.S. as the threat of price controls similar to those of the U.K. loomed.[5] This

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1. John. A. Vernon, *Drug Research and Price Controls*, REG.22, Winter 2002-2003, http://www.cato.org/pubs/regulation/regv25n4/v25n4-7.pdf.

2. THE BATTELLE TECHNOLOGY PARTNERSHIP PRACTICE, GONE TOMORROW? A CALL TO PROMOTE MEDICAL INNOVATION, CREATE JOBS, AND FIND CURES IN AMERICA 5 (Battelle Memorial Institute, June 10, 2010), http://www.americanmedicalinnovation.org/sites/default/files/Gone_Tomorrow.pdf, [hereinafter *Gone Tomorrow*].

3. Ed Silverman, *UK's NICE Loses Decision-Making Powers*, PHARMALOT.COM (Nov. 2, 2010), http://www.pharmalot.com/2010/11/uks-nice-loses-decision-making-powers/.

4. Peter W. Huber, *Cherry Garcia and the End of Socialized Medicine*, CITY J., Autumn 2007, *available at* http://www.city-journal.org/printable.php?id=2382.

5. *See* John A. Calfee, *Limiting Drug Prices Means Limiting Future Cures*, AM. ENTERPRISE INST. FOR PUB. POL'Y RES. (October 10, 2009), http://www.aei.org/article/101153.

article will address how government cost controls impact pharmaceutical innovation, and how cost controls affect patient access to new medicines. First, this article will outline the current market-driven system in the U.S. Secondly, it will describe the government-run pricing system in the U.K. Finally, this article will analyze whether the recent reforms in health care will have a negative affect on pharmaceutical innovation.

II. U.S. PHARMACEUTICAL INNOVATION

To begin, the U.S. has historically maintained a relatively free market system in the pharmaceutical industry. However, regulations to ensure safety and effectiveness exist.[6] Beginning in 1962, pharmaceutical manufacturers have been required to obtain regulatory approval by the Food and Drug Administration (FDA) before beginning clinical testing.[7] Clinical testing usually continues through three successive phases.[8] The cost of getting a drug through this regulatory process is enormous. A study by Joseph DiMasi, an economist at the Tufts Center for the Study of Drug Development, found that the total research and development cost per new drug is $802 million in year 2000 valuation.[9] Moreover, it can take around twelve years for a company to obtain market approval on a new drug.[10] Typical patent protection for a pharmaceutical drug is twenty years, with ten to fifteen of those years committed to the testing and approval process.[11] The high cost of research and development, coupled with the length of time for FDA approval, leaves limited time for patent protection at the time of marketing.[12] Several provisions have been employed by the FDA to extend the time during which companies can market their drugs free of generic competition, which will allow pharmaceutical companies to recoup their investment in drug research.[13]

Such a provision was formed in 1984 through the Drug Competition and Patent Term

6. Stephen J. Ceccoli, *Divergent Paths to Drug Regulation in the United States and the United Kingdom*, 14 J. POL'Y HIST., no. 2, 2002 at 135, 156.

7. *Id*.

8. Joseph A. DiMasi et al., *The price of innovation: new estimates of drug development costs*, 22 J. HEALTH ECON. 151, 155 (2003).

9. *Id*. at 180.

10. Carolyne Hathaway et al., *Exclusivity Strategies in the United States and European Union*, 3 FOOD & DRUG L. INST. UPDATE 34, 34 (2009), http://www.lw.com/upload/pubContent/_pdf/pub2655_1.pdf.

11. Charles L. Hooper, *Pharmaceuticals: Economics and Regulation*, THE CONCISE ENCYCLOPEDIA OF ECONOMICS, *available at* http://www.econlib.org/library/Enc/PharmaceuticalsEconomicsandRegulations.html.

12. Hathaway, *supra* note 10, at 34.

13. *Id*.

Restoration Act, otherwise known as the Hatch-Waxman Act.[14] This Act provides up to five years market exclusivity to companies introducing a new chemical entity to the market and up to three years market exclusivity for conducting clinical trials to support changes to products already on the market.[15] These exclusivity provisions allow the innovating companies to generate profits on their drugs before generic competitors can undercut their prices.

The huge investment of time and money required to develop a drug and obtain approval by the FDA raised concerns that pharmaceutical companies would forego developing drugs to treat rare or unusual conditions because they would not see a return on their investment due to a limited market.[16] In response, Congress passed the Orphan Drug Act in 1983.[17] This Act provides manufacturers with seven years of market exclusivity after the FDA's approval of the drug, as well as grants and tax credits for each new orphan drug developed.[18] This provides an incentive for pharmaceutical companies to research and develop innovative and effective drugs for the orphan drug market.[19]

Next, after a drug is approved, it enters the market to be sold. The U.S. healthcare system consists of both private and public payers that utilize various reimbursement policies.[20] In contrast with many other countries, the U.S. does not utilize a form of drug price regulation to control spending due to concern that regulatory controls drive down profits and discourage flow of capital to support the development of new drugs.[21] The U.S. is regarded as the global leader of pharmaceutical innovation, and government officials have stated that the U.S. is covering most of the global cost for developing new drugs.[22]

The lack of price regulation in the U.S. has been criticized for causing excessively

14. *Id*. at 35.
15. *Id.*
16. *Id*. at 37.
17. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, OEI 09-00-00380, THE ORPHAN DRUG ACT: IMPLEMENTATION AND IMPACT 1 (May 2001).
18. *Id*. Orphan drugs are defined as those intended to treat diseases and conditions that affect 200,000 or fewer Americans, or for which the sales in the United States are not reasonably expected to cover the drug manufacturer's cost of research and development for the drug.
19. Hathaway, *supra* note 10, at 37.
20. Gretchen A. Jacobson, *Pharmaceuticals Pricing: U.S. and European Strategies*, EUR. INST. (Summer/Fall 2007), http://www.europeaninstitute.org/20070602115/Summer/Fall-2007/pharmaceuticals-pricing-us-and-european-strategies.html.
21. Salomeh Keyhani et al., *U.S. Pharmaceutical Innovation in an International Context*, 100 AM. J. PUB. HEALTH 1075, 1075 (June 2010).

high prices for medicines compared to other countries.[23] Researchers have repeatedly found that people in the U.S. pay more for pharmaceuticals than people in Western European countries.[24] One study compared the average prices of the thirty drugs with the greatest total U.S. spending in 2003 to the prices of the same drugs in the U.K. and France.[25] The authors concluded that the U.S. paid more for these drugs than the U.K., and the U.K. paid more than France.[26] Manufacturer sales prices for most new drugs in countries within the Organization for Economic Co-operation and Development (OECD) have sales prices for most new drugs that are forty to fifty percent below U.S. prices.[27] Patient advocates and researchers have expressed concern that this cost burden has been increasing costs of health care, thereby reducing access to medications for uninsured populations, and threatening general public health.[28]

Proponents of the relatively free-market system in the U.S. emphasize the advantages of using the latest and most innovative medical solutions. One study found that the availability of new drugs was responsible for forty percent of the increase in life expectancy over a fourteen year time period from 1986-2000.[29] Another study from Columbia University and the National Bureau of Economic Research found that life expectancy increased in states where access to newer drugs in Medicare and Medicaid programs were highest in demand.[30]

A study by the Pardee RAND Graduate School examined the effects that new drugs have on the medical system.[31] There are two main effects: the substituting effect and the access effect.[32] The substituting effect is when treated patients might switch from an old

22. *Id*.
23. *See* Vernon, *supra* note 1, at 22.
24. Jacobson, *supra* note 20.
25. *Id*.
26. *Id*.
27. CHARLES-ANDRÉ BROUWERS ET AL., ADVERSE CONSEQUENCES OF OECD GOVERNMENT INTERVENTIONS IN PHARMACEUTICAL MARKETS ON THE U.S. ECONOMY AND CONSUMER – WHITE PAPER 11 (The Boston Consulting Group, Inc., 2004).
28. Keyhani, *supra* note 21, at 1075.
29. BROUWERS, *supra* note 27, at 16.
30. FRANK R. LICHTENBERG, *WHY HAS LONGEVITY INCREASED MORE IN SOME STATES THAN IN OTHERS? THE ROLE OF MEDICAL INNOVATION AND OTHER FACTORS* 4 MED. PROGRESS REP., 16 (July 2007), http://www.manhattan-institute.org/pdf/mpr_04.pdf.
31. ZE CONG, VALUE OF PHARMACEUTICAL INNOVATION 5 (2009) (published Ph.D. dissertation, Pardee RAND Graduate School), *available at* http://www.rand.org/pubs/rgs_dissertations/RGSD242.html.
32. *Id*. at 5.

drug to the new one and benefit from advantages in the clinical effects of the new drug.[33] The access effect is when untreated patients might derive treatment from the new drug due to its possibly fewer side effects, better safety portfolios, more patient subgroups, more competition to give a greater number of patients access to treatments, or more advertising efforts from pharmaceutical companies.[34] This study found statistically significant access effects of new drugs, in terms of increasing the number of drugs prescribed.[35] In particular, the study found that more creative drugs (i.e., new chemical entities) tend to have larger, more significant access effects, whereas less creative drugs (i.e., generic drugs) contribute smaller or even negative access effects.[36] For example, when a new chemical entity was introduced to a drug class, "prescriptions in [that] drug class increased an average of 7% in the first three months, 18.3%. . . by months four to six, and 24.5% by months seven to twelve."[37] The findings of this study confirmed the hypothesis that new drugs can impact population health by changing the clinical effectiveness on existing treatments and changing the quantity of prescriptions written and/or people treated.[38]

Having access to innovative drugs also has economic benefits. To illustrate, economic studies have shown that newer, more expensive drugs are worth their price.[39] One study demonstrated that for each dollar spent on newer drugs, $6.17 was saved.[40] Another study estimated that a ten percent reduction in mortality due to heart disease could yield a present value of as much as $5.5 trillion to current and future generations.[41]

Additionally, it has been argued that to get innovative medications first and rock bottom prices later, pharmaceutical companies must participate in a delicate "choreography" of patent-protected monopoly and aggressive competition.[42] Drug companies introduce most new drugs in the U.S. first, and affluent Americans pay high

33. *Id*.
34. *Id*.
35. *Id*. at 20.
36. *Id*.
37. CONG., *supra* note 31, at 73.
38. *Id*. at 20.
39. Hooper, *supra* note 11.
40. *Id*.
41. BROUWERS, *supra* note 27, at 37. "A similar reduction in mortality due to cancer is estimated to have a present value of $4.4 trillion."
42. Huber, *supra* note 4.

prices while the patents last.[43] Subsequently, less affluent Americans, along with public and private insurers in the U.S., U.K., Canada, and the rest of the developed world, get a drastically discounted ride on their economic coattails.[44] Stated simply, three-dollar drugs in New York in 1996 are purchased in London for thirty-cents and then are offered for three-cents ten years later in Kuala Lumpur.[45] Unless pharmaceutical innovations are sold to the wealthy first, they will never become inexpensive.[46] Price-depressing strategies makes the pursuit of new drugs unprofitable and lowers the incentive for continued research and development.[47] A decline in innovation could compromise long-term global health.[48]

III. BRITISH PHARMACEUTICAL REGULATION

The British government has a vastly different view than the U.S. about controlling costs for pharmaceuticals. The one area where the two countries are similar is in the testing and approval process. Drug approval in the U.K. is nearly identical to that of the U.S. system under the FDA, where there is a three-phase clinical trial regimen.[49] After a product makes it through the approval process, the National Institute for Health and Clinical Experience (NICE) determines the cost-effectiveness of the new drug and provides guidance on treatments for patients using the National Health Service (NHS), without giving any deference to drug manufacturers.[50] Essentially, a new drug does not just have to be effective to be approved by NICE for use in the U.K., it must also offer value for the money.[51] Even if a new drug is innovative and life saving, it will not be approved by NICE if it does not offer a certain level of economic value.[52]

The evaluation system that NICE uses is called the "quality-adjusted life year" (QALY), which determines whether the increment in the cost of that treatment is worth

43. *Id*.
44. *Id*.
45. *Id*.
46. *Id*.
47. *Id*.
48. Huber, *supra* note 4.
49. THE MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AGENCY, MEDICINES AND MEDICAL DEVICES REGULATION: WHAT YOU NEED TO KNOW 9 (2008), *available at* http://www.mhra.gsi.gov.uk [hereinafter *MHRA*].
50. Jacobson, *supra* note 21.
51. Eben Harrell, *How Much Is a Year of Life Worth?*, TIME, Mar. 27, 2009, *available at* http://www.time.com/time/health/article/0,8599,1888006,00.html.
52. *Id*.

the increment in the health gain.[53] A QALY scores a person's health on a scale from zero to one: zero if you are dead and one if you are in perfect health.[54] Using the zero-to-one increments and average life spans after a given treatment, NICE determines a person's quality-adjusted life years.[55] Then, the cost of a treatment or procedure is divided by the quality-adjusted life year to arrive at the cost per QALY, which is the ceiling on how much will be spent for that person.[56] NICE cannot refuse treatments to patients who need them, and an expensive drug may still receive a positive NICE rating if it provides enough benefit to produce a favorable ratio.[57]

Currently, NICE is on the verge of losing some of its power to reject new drugs for inclusion on the NHS plan.[58] It was announced in November, 2010, that NICE will continue to give advice about which drugs are deemed effective, but will no longer decide whether patients should be given treatments that doctors recommend, as those decisions are being made only by doctors now.[59] The decision-making by doctors will be made under a value-based system, where local doctor groups will decide which drugs to purchase for patients.[60] Pharmaceutical companies such as Eli Lilly & Co. have warned that using a value-based pricing system may lead to delays in products entering the market.[61] The ultimate goal of this new system seeks to improve access to drugs, but some within the industry fear that introducing a new pricing system will actually cause delays in access to new drugs.[62]

The British government has established itself as a monopsony purchaser of drugs, thus enabling a variety of profit controls on the pharmaceutical industry organized through the Pharmaceutical Price Regulation Scheme (PPRS).[63] The PPRS has drawn criticism in the

53. *Id*.
54. *Id*.
55. *Id.*
56. *Id*. For example, if a person receives a hip replacement, the patient might start at .5 and go up to .7, improving by .2. Patients live for an average of fifteen years following hip replacements, and .2 multiplied by fifteen equals three quality-adjusted life years. The hip replacement costs $15,000, so it's 15,000 divided by three to arrive at a $5,000 cost per QALY.
57. Jacobson, *supra* note 20.
58. Silverman, *supra* note 3.
59. *Id*.
60. Chris Kay, *Drugmakers Negotiating with U.K. Over Pricing Changes*, BLOOMBERG NEWS, Dec. 1, 2010, http://www.bloomberg.com/news/2010-12-01/drugmakers-in-war-dance-with-u-k-government-over-value-based-pricing.html.
61. *Id*.
62. *Id*.
63. "Monopsony" is defined as monopoly power on the buyer's side. *See* Ceccoli, *supra* note 6, at 160.

U.K. On the patient level, it has been argued that when prices are out of line with value, the NHS is not making the best use of available resources to improve patient health.[64] Patients feel this through reduced access to drugs.[65] For example, if too much money is spent on an existing drug, doctors may have to balance their budgets by restricting access to new, innovative drugs.[66] In the case of Herceptin and Gleevec, two breakthrough first-in-class drugs to treat cancer, OECD countries experienced launch delays of twenty-three months and six months, respectively, compared to the U.S.[67] Furthermore, the weighted average age of diabetes drugs in the U.S. is five years, while it is seven to eight years in the U.K.[68]

Another criticism of the PPRS is that it is driving down international funding for pharmaceutical research and development.[69] Many countries control pharmaceutical profits through international reference pricing, where countries link the pricing of their pharmaceutical products to the pricing of another country.[70] The U.K. acts as a reference pricing country to other countries such as France, Italy, Canada, Belgium, Switzerland, Poland, Netherlands, Finland, Hungary, Norway, Ireland, and Japan.[71] Together, these markets account for about twenty-five percent of world pharmaceutical sales.[72] Thus, the profit control and pricing in the U.K. is not only reducing resources for research and development in its own country, but also for every country that uses its pricing as a reference point. Without OECD cost controls, estimates suggest that revenues for innovative drugs would increase by thirty-five to forty-five percent.[73] Moreover, if the OECD controls had been absent in the past, the incentives for research and development investment would have led to as many as a hundred and ten to one hundred and forty more innovative drugs available in the U.S. today.[74]

Today, the U.S. accounts for half of pharmaceutical research and development

64. OFFICE OF FAIR TRADING, THE PHARMACEUTICAL PRICE REGULATION SCHEME: AN OFT MARKET STUDY 1, 4 (2007) [hereinafter *OFT*].
65. *Id*.
66. *Id*.
67. BROUWERS, *supra* note 27, at 13.
68. *Id*. at 15.
69. *Id*. at 24.
70. OFT, *supra* note 64, at 42.
71. *Id*.
72. *Id.*
73. BROUWERS, *supra* note 27, at 31.
74. *Id*. at 36.

spending, while Europe accounts for only a third.[75] "U.S. prescription drug costs grew at annual rate of ten percent between 1992 and 2001. . . driven mainly by higher volumes and shifting the mix toward newer, more innovative medicines."[76] The U.K. saw slower growth around four to five percent.[77] Since the pharmaceutical industry has maintained a close correlation between its research and development investment and its free cash flow, patients in OECD countries typically gain access to innovative medicines, if at all, only after a substantial delay and at a level of availability well below that offered to U.S. patients.[78] Therefore, while drug costs are lower in the U.K., patients pay the cost of not having access to innovative medicines.

IV. U.S. HEALTHCARE REFORM

Prior to the signing into law of the PPACA, there was much debate about how healthcare reform would impact pharmaceutical innovation and access to newer drugs.[79] Some experts believed that price controls were imminent, and feared that the short-term benefit to consumers of reducing costs would lead to a long-term negative impact on social welfare by reducing the number of new drugs being brought to the market.[80]

Concerns about whether healthcare reform would weaken the pharmaceutical industry were warranted based on lessons from recent history. The Clinton Administration's Health Security Act (HSA) of 1993 had a negative impact on the industry, despite never being passed by Congress.[81] While this legislation was being drafted, stories about the high probability of price controls were leaked, causing anxiety for pharmaceutical companies.[82] The industry believed that the HSA would be so damaging that twenty-one large companies guaranteed to keep their prices below consumer inflation starting in

75. *See id*. at 22-23.
76. *Id*. at 10-11.
77. *Id*. at 10.
78. *Id*. at 12, 33.
79. Tomas J. Philipson, *Should U.S. import U.K. model for Medicare and Medicaid?*, FORBES, Oct. 5, 2010, http://www.forbes.com/2010/10/05/medicare-medicaid-innovation-opinions-contributors-tomas-j-philipson_print.html.
80. David R. Francis, *The Effect of Price Controls on Pharmaceutical Research*, NBER DIGEST, 4, 4-5 (May 2005).
81. JOSEPH GOLEC ET AL., PHARMACEUTICAL R&D SPENDING AND THREATS OF PRICE REGULATION, 3 (Nat'l Bureau of Econ. Research, Paper, 2008) *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1106963.
82. *Id*. at 10. The first event causing anxiety was the appointment of Hillary Clinton to lead the group writing the HSA, and she was known to favor price controls. The second event was a speech by President Clinton that stated that pharmaceutical prices were too high. *Id.* at 11.

1993, in order to convince Congress that legislation was not necessary.[83]

The HSA was ultimately defeated in Congress and the industry experienced a rally for a few months afterwards, but evidence "show[s] that pharmaceutical company stocks sustained significant price declines [from then] until late 1993."[84] Furthermore, research and development concentrated companies experienced much greater losses on average.[85] The negative effects of the HSA on the industry are indicative of the fact that threats of price regulation will reduce research and development assets and spending.[86]

Unlike the HSA in the 1990s, the PPACA of 2010 will actually benefit the U.S. pharmaceutical industry.[87] The industry was able to thwart price controls and tighter federal regulations, but also ensure that millions of uninsured Americans receive coverage.[88] The industry as a whole agreed to contribute eighty-five billion dollars over the next decade in the form of industry surcharges and lower prices they will receive from government programs.[89] Moreover, a new influx of covered Americans will now have access to prescription drug coverage, thereby increasing the number of customers for pharmaceutical companies.[90]

In addition to the eighty-five billion dollar contribution by the industry, the PPACA imposes an annual fee on any "covered entity engaged in the business of manufacturing or importing branded prescription drugs" beginning in 2011.[91] In determining the annual fee, government programs such as Medicare will provide a yearly report to the Department of Treasury, disclosing the prior year's sales for each branded drug for all manufacturers covered by the program.[92] Then, "the Secretary of Treasury will calculate the annual fee for each pharmaceutical manufacturer or importer based on reports from other specified federal government agencies based on a ratio of its branded drug sales to

83. *Id*. at 12.
84. *Id*. at 32.
85. *Id*.
86. GOLEC ET AL., *supra* note 81, at 31.
87. *Insurance and Pharmaceutical Companies May Weather Reform, but Some Have Concerns*, NJ.COM (Mar. 23, 2010), http://www.nj.com/business/index.ssf/2010/03/insurance_and_pharmaceutical_c.html.
88. *Id*.
89. *Id*.
90. *Id*.
91. Kathleen M. Sanzo, *Healthcare Reform Law: Impact on Pharmaceutical Manufacturers*, MORGAN LEWIS LAWFLASH, Apr. 15, 2010, *available at* http://www.morganlewis.com/pubs/WashGRPP_ImpactOnPharmaManufacturers_LF_15apr10.pdf.
"Covered entity" includes "any manufacturer or importer with gross receipts from branded prescription drug sales."

the branded drug sales of all covered entities for the prior year (i.e., market share)."[93] The annual fee will increase to a maximum of $4.1 billion in 2018, and then decrease to $2.8 billion in 2019 and subsequent years.[94]

Furthermore, the PPACA includes several important provisions to continue encouraging pharmaceutical companies to invest in research and development. First, Section 9023 provides a tax credit to small companies of 250 employees or fewer to encourage new therapies.[95] These credits will assist in "qualified investments," which include projects to conduct preclinical or clinical research to support marketing approval for a new drug; projects that develop molecular diagnostics; and the development of drug-delivery technologies.[96]

Second, Section 10409 of the PPACA establishes the Cures Acceleration Network (CAN), which is administered by the National Institutes of Health (NIH).[97] CAN will reward grants and contracts for "revolutionary advances in basic research" and "the development of high need cures, including through the development of medical products and behavioral therapies."[98] CAN will also support private, institutional, and governmental agencies in development efforts, and with facilitating the review of "high need cures" by the FDA.[99]

Additionally, Section 2709 of the PPACA prohibits health plans from denying coverage of certain routine patient costs associated with participation in "approved clinical trials."[100] This provision will likely encourage participation in clinical research, as medical costs for doing so will not fall directly on the researcher or participant.[101]

Another advantage for the pharmaceutical industry in the PPACA involves greater patent protection for some products.[102] A provision exists that grants manufacturers

92. *Id*. at 1-2.
93. *Id*.
94. *Id*.
95. Patient Protection and Affordable Care Act (PPACA), 42 U.S.C.A § 9023 (2010).
96. *Id*.
97. 42 U.S.C.A § 10409.
98. *Id*. NIH will deem a product to provide a "high need cure" if it "is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition," and if it is a product "for which the incentives of the commercial market are unlikely to result in its adequate or timely development."
99. *Id*.
100. 42 U.S.C.A § 2709. "Approved clinical trials" are clinical trials for the prevention, detection, or treatment of cancer or other life-threatening disease or condition.
101. *See id*.
102. THE HENRY J. KAISER FAMILY FOUNDATION, SUMMARY OF NEW HEALTH REFORM LAW 9, June 18,

twelve years to sell biologics – expensive new therapies made of human proteins and cells – before generics can be developed.[103] This provision will help incentivize manufacturers to continue researching and developing expensive new therapies, because the PPACA has retained the ability to recoup the investment dollars spent on such innovations.

As demonstrated above, the PPACA contains several beneficial provisions that, along with a lack of profit control, will continue to incentivize pharmaceutical companies to research and develop new medical innovations. One similarity between the U.K. regulatory system and the PPACA is the annual fee imposed on pharmaceutical manufacturers, where the amount owed to the government is based on each manufacturer's respective market share.[104] This is marginally similar to the U.K. profit repayment system, where manufacturers are required to repay profits that exceed the target forecast for that year.[105] Both systems are centered on the philosophy that companies that strive to innovate and continue to grow will be expected to pay higher fees for such successes. However, the PPACA limits the amount it forces companies to pay, while the U.K. system has no limit on how much they require companies to repay.[106] This is a key difference that will be crucial to maintaining competition and innovation amongst U.S. pharmaceutical manufacturers.

Another similarity between the PPACA and the U.K. system involves a newly created agency in the U.S., the Independent Payment Advisory Board.[107] This entity will have substantial authority to force changes in policies under Medicare, Medicaid, and the Children's Health Insurance Program to meet mandated cost reduction targets.[108] For example, changes in Medicare Part D could be included, which would significantly decrease the prices for drugs.[109] This advisory board is similar to the PPRS in the U.K., which administers the profit control policies to ensure that the British government is

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2010 [hereinafter *Kaiser*].

103. *Id*.

104. Sanzo, *supra* note 91, at 2.

105. THE ASSOCIATION OF THE BRITISH PHARMACEUTICAL INDUSTRY, THE PHARMACEUTICAL PRICE REGULATION SCHEME, 16, (November 2004) [hereinafter *PPRS*].

106. *See* Sanzo, *supra* note 91; PPRS, *supra* note 105.

107. Ian D. Spatz, *Health Reform Accelerates Changes in the Pharmaceutical Industry*, 29:7 HEALTH AFFAIRS 1331, 1334 (2010).

108. *Id*.

109. *Id*.

receiving value for what they spend on pharmaceutical products.[110]

It is difficult to assess the impact that the PPACA will directly have on pharmaceutical research and development.[111] Brand-name companies use revenue to pay for research and development, so any provision that reduces revenue or profits will impact innovation.[112] The abovementioned provisions that bear similarities to the U.K. regulatory system are two such provisions that could negatively impact the revenue of companies, leading to reductions in research and development.[113] Yet, most of the impact that the PPACA will have on research and development comes from the increased Medicaid rebates and the net cost of providing discounts in the Medicare drug coverage gap.[114] The number of newly covered patients resulting from the PPACA may counteract those discounts, but it is still an issue that pharmaceutical manufacturers must take into account when determining research and development budgets.[115]

In the foreseeable future, the PPACA will likely have little impact on U.S. pharmaceutical innovation. The relatively free-market of the U.S. is not compromised by the legislation, despite new challenges in handling greater government regulation. Pharmaceutical companies in the U.S. succeeded in staving off price and profit controls, which have negatively affected drug innovation in the U.K. For the time being, the U.S. will remain the epicenter of research and development for pharmaceutical manufacturers around the world, and patients here will continue to enjoy having first access to the latest medicines.

V. CONCLUSION

The U.S. pharmaceutical industry has historically been characterized as the market-driven pharmaceutical system of the world. Despite government regulations in the quality of products, manufacturers have long avoided price and profit controls by the federal government, leaving the door open for enormous profits to be invested in research and development. On the other hand, companies in the U.K. have endured profit controls and determinations about the value of their products from the British government. These

110. Jacobson, *supra* note 20.
111. Spatz, *supra* note 107, at 1334.
112. *Id*.
113. *Id*.
114. *Id*.
115. *Id*. at 1334-35.

differing cost control policies has led to vast differences in the advancement of pharmaceutical innovation and to significant disparities in patient access to medicines.

The PPACA does not impose price or profit controls on pharmaceutical companies in the U.S., and contains several provisions to promote research and development. Companies will likely see a decrease in drug prices due to Medicare and Medicaid rebates, but the PPACA will be providing drug coverage to millions of new Americans, who were previously unable to afford prescriptions. Thus, there appears to be a positive outlook for the U.S. to remain the world's leader in pharmaceutical innovation. As scientists are on the verge of major medical advances, policymakers must maintain incentives to fund such breakthroughs in order to keep innovative medicines in the hands of U.S. patients.

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The PPACA and the Federal Deficit: What is the True Effect of the Legislation?

*Dan Palermo**

I. INTRODUCTION

For years the United States has faced the predicament as to how to bring about health care reform that improves citizens' accessibility to affordable health insurance, protects families from potentially daunting healthcare expenses, and improves the incentive for providers to offer cost-effective care. After a seemingly interminable health care debate spanning much of 2009 and 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, as the federal government's attempt to achieve the reform.[1] Nevertheless, in the aftermath of the 2010 Congressional elections when the Republican Party took control of the House of Representatives, it became clear that the health care reform debate relating to the PPACA was far from a final resolution.

Aside from the obvious partisan disagreements over the scope of the government's role in health care, the PPACA is under the microscope for its effect on this country's growing deficit. According to the Congressional Budget Office (CBO) the PPACA will reduce the deficit by $143 billion over the first ten years after its enactment,[2] and by another $1.2 trillion the following decade.[3] Critics of the Act have raised concerns

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1. Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152).

2. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Former Speaker, U.S. House of Representatives at 2 (Mar. 20, 2010) *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf [hereinafter *Pelosi*].

3. *Where Does Health Care Reform Stand?*, CNN (Mar. 18, 2010), http://www.cnn.com/2010/POLITICS/03/18/health.care.latest/index.html.

regarding the accounting practices used by the CBO and legislators, stating that these numbers are not a true reflection of the impact the Act will have on the deficit due to intentional exclusions, double counting, and false sets of assumptions.[4]

The PPACA has somewhat of an identity crisis because, unlike a single program such as Social Security, the Act is a collection of mandates, subsidies, and regulations that will be applied to numerous groups of Americans in distinct ways and at different points in time.[5] Threats of a repeal of the Act prior to the 2012 congressional elections are more symbolic in nature than realistic due to the Democratic control of the Senate and the President's power of veto.[6] However, it is important to analyze the effect the PPACA will have on the federal government given its current and growing deficit. Ideally, the United States will provide all citizens with effective health care, but at what expense on current and future generations is this proposition reasonable? While it is important to achieve health care reform and legislative goals, it is equally important to do so in a fiscally responsible manner.

II. DEFENDING THE EFFECTS OF THE PPACA

The PPACA extends coverage to millions of people who would otherwise not have access to health care, and allows access to new benefit programs that were previously unavailable to those who have existing insurance.[7] Despite a divide in opinion on the legislation, the CBO reports that the PPACA will reduce the deficit over the course of its lifetime and that there is a risk of significant financial fallout if the legislation is repealed.[8]

a. Risks of Overturning the PPACA

If the Senate majority were to switch from Democrat to Republican control in 2012, attempting to repeal the Act altogether would be a risky strategic move. Although it

4. James C. Capretta & Kathryn Nix, *Obabamcare and the Budget: Playing Games with Numbers*, THE HERITAGE FOUND., 1-2 (Jan. 21, 2011), *available at* http://www.heritage.org/research/reports/2011/01/obamacare-and-the-budget-playing-games-with-numbers.

5. Jonathan Oberlander, *Beyond Repeal - The Future of Health Care Reform*, 363 NEW ENG. J. MED. 2277, 2278 (Dec. 9, 2010).

6. *Id* at 2277.

7. Pelosi, *supra* note 2, at 9.

8. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Honorable John Boehner, Speaker, U.S. House of Representatives, 8 (Jan. 6, 2011) *available at* http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf [hereinafter *Boehner*].

would allow conservative members of Congress to appease their constituents, it would effectively de-insure thirty-two million Americans who are predicted to gain coverage by the law.[9] In addition, several facets of the PPACA have already gone into effect, including allowing children under the age of twenty-six to remain under their parents' coverage, and reforms that incentivize preventive care and prohibit lifetime limits on coverage.[10] Furthermore, repealing the PPACA would deregulate the insurance industry, deprive persons currently utilizing the coverage provided by the Act that is already in effect, and increase the federal budget deficit.[11] According to the CBO, a repeal would cost the U.S. $145 billion by 2019 and $230 billion by 2021, and would continue to proliferate going forward due to disbanded revenue-raising provisions.[12] Following a repeal, the Republican Party would be challenged with the task of replacing the PPACA with a plausible alternative bill that would reduce the deficit, control costs, and expand access to insurance at the same time.

b. How the PPACA reduces the Federal Deficit

The PPACA will reduce the long-term federal budget deficit through a wide range of strategies designed to deliver improved health care at a lower cost.[13] According to the CBO, the net cost of the expanded insurance coverage provisions will be $788 billion.[14] The CBO also states that the PPACA will reduce federal healthcare spending via procedural regulations, such as prohibiting insurance companies that raise costs over certain thresholds from partaking in insurance exchanges and making the procedures health workers use to collect statistics more efficient.[15] The PPACA will also adjust bio-fuel regulations and assign the resulting revenues towards reducing the cost of the reform. At the same time, it will decrease the number of participants in nursing homes by increasing the support given by Medicaid to home care and it will increase funding for

9. Oblerlander, *supra*, note 5,. at 2277.

10. Amy Goldstein, *CBO says health care repeal would deepen deficit*, WASH. POST, Jan. 7, 2011, http://www.washingtonpost.com/wp-dyn/content/article/2011/01/06/AR2011010606159.html.

11. Oberlander, *supra* note 5, at 2277.

12. Goldstein, *supra* note 10.

13. U.S. DEP'T OF HEALTH & HUMAN SERV., PROPOSED BUDGET FOR THE FISCAL YEAR OF 2012, 80 (2011).

14. Pelosi, *supra* note 2, at 5.

15. *Will Healthcare Reform Reduce the Federal Deficit?*, THE HEALTH FOUND. OF GREATER CINCINNATI, (2010), http://reform.healthfoundation.org/is-what-i-hear-true/i-heard-that-the-bill-will-reduce-the-deficit-is-that-true.

preventive care − including providing added preemptive services for mental health and substance abuse disorders.[16]

Additionally, the CBO estimates that $420 billion in revenue will be produced by the PPACA from tax provisions and other revenues resulting from several regulations affecting programs such as Medicare and Medicaid.[17] Thus, the overall effect of the PPACA, with $788 billion in costs for coverage countered by a $511 billion reduction in federal spending and $420 billion in new revenue, could result in a net reduction of $143 million in the federal deficit from 2010 to 2019.[18]

III. CRITICS QUESTION THE CBO'S CALCULATIONS

Despite the reports by the CBO regarding the effects of the PPACA on the federal deficit, critics of the legislation believe that the numbers are inaccurate and do not paint a complete picture of the true cost of the Act on the federal government.[19] They believe that the projections from the legislation have been manipulated and that the accounting by the CBO only reveals a fragment of the PPACA's full cost.[20]

a. Excluding the "Doc Fix"

According to the critics, one of the primary ways the CBO projections fall short is the Medicare "doc fix." The PPACA includes legislation intending to reduce payments to many Medicare providing physicians.[21] This is not new legislation, as it originated in 1997 health care budget reforms by Congress.[22] The reforms mandated fee cuts based on a "sustainable growth rate," where once the volume of services performed by physicians exceeded a designated threshold, relief was granted to Medicare patients.[23] Despite this, every year since 2002, and as recently as December of 2010, these mandated fee cuts have been delayed by Congressional action. This legislation was nicknamed the "doc fix" based on the fear of physicians refusing care and elderly patients losing access to the

16. *Id.*
17. Pelosi, *supra* note 2, at 6.
18. *Id.* at 5.
19. Michael F. Cannon, *Do the Math- Obamacare Would Increase Deficits by $59 Billion*, CATO INST. (Mar. 22, 2010), *available at* http://www.cato.org/pub_display.php?pub_id=11591.
20. *Id.*
21. Boehner, *supra* note 8, at 2.
22. Ken Terry, *Nobody Likes Obama's "Doc Fix," but a Real Solution Is Anything But Easy*, CBS BUSINESS NETWORK (Feb. 18, 2011) http://www.bnet.com/blog/healthcare-business/nobody-likes-obama-8217s-8220doc-fix-8221-but-a-real-solution-is-anything-but-easy/2596.

medical services.[24] As a result, criticism centers on the fact that non-existent deductions in pay for the physicians are included as savings in the PPACA budget. Yet, neither the doc fix, nor any offsetting reductions are included in the law.[25] The Obama Administration has sought to permanently eradicate the mandated pay reduction, which would cost the government a projected $208 billion over the next decade, and would nullify the total deficit savings proposed by the CBO.[26] Thus, critics claim that the costs of covering care for Medicare patients are being addressed in separate legislation and are being shielded from the deficit calculations of the PPACA.

b. Double Counting Entitlement Program Figures

Additionally, critics assert that when accounting for the net effect of both Medicare and the newly created Community Living Assistance Services and Support (CLASS), some figures are either counted twice or not properly designated. [27] First with Medicare, the PPACA requires an increase in Medicare taxes and institutes cuts in the program.[28] The resulting revenue, however, is being double counted as both offsets to new programs created by the Act and as relief to extend the solvency of Medicare.[29] Thus, the reforms are being counted as both funding the expansion of other programs in the PPACA and financing future Medicare benefits.

The CLASS program is being instituted to make long-term care insurance available to anyone for programs such as home care, assisted living, and nursing home care, provided that they have been enrolled and paying premiums for the previous five years.[30] The CBO projects $70 billion in revenue from premium payments generated by CLASS over the next ten years.[31] Since beneficiaries must pay premiums for the initial five years without the government responsible for any outlays, critics' state that the $70 billion

23. *Id*.
24. *Id*.
25. James C. Capretta, *Obamacare: Impact on Future Generations*, THE HERITAGE FOUND (June 1, 2010), http://www.heritage.org/Research/Reports/2010/06/ObamaCare-Impact-on-Future-Generations.
26. Cannon, *supra* note 19.
27. Capretta & Nix, *supra* note 4.
28. *Id*.
29. *Id* at 3.
30. Lori Montgomery, *Proposed Long-Term Insurance Program Raises Questions*, THE WASHINGTON POST, Oct. 27, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html.
31. Scott Harrington, *Obamacare Deficit Debate is a Red Herring*, FORBES (Jan. 10, 2011), http://blogs.forbes.com/sciencebiz/2011/01/10/obamacare-deficit-debate-is-a-red-herring.

generated is being inaccurately counted as a frontload surplus for new spending.[32] After five years when the benefits are paid, the surplus will decline, since the premiums need to be paid out to beneficiaries.[33] By 2025, the participants' projected benefits are expected to exceed premium revenues, which will result in a shortcoming for funding for the program by the government.[34] Thus, detractors claim that premiums being generated by the PPACA cannot be counted as contributing towards a deficit reduction because they will be needed to pay the claims of the beneficiaries.

c. Employers Dropping Coverage

Critics of the PPACA also point out a potential scenario, one in which an unexpectedly high number of employers elect to drop the mandated coverage they provide to the employees in favor of a penalty fee, and allow employees to purchase the government option.[35] The CBO predicts that 19 million Americans will benefit from purchasing tax-subsidized insurance, which is included in the PPACA projections as a $460 million expense by 2019.[36] Since the penalty for dropping coverage is only $2,000 per employee, this gives incentive to an employer and a consenting employee to have the employer drop their mandated coverage, raise the employee's wages to make up for the lost benefit, pay the PPACA penalty, have the employee purchase the government option, and have both parties land in a stronger financial position.[37] This could be especially beneficial for large corporations and Fortune 500 companies who have to outlay billions of dollars annually to provide healthcare coverage to employees. AT&T employs over 300,000 people and spends $2.4 billion each year on healthcare insurance; their obligation could potentially be reduced to $600 million if they paid the penalty option and allowed their employees to purchase the government option.[38] Another market

32. Capretta & Nix, *supra* note 4.

33. Memorandum from the Chief Actuary of the Dept' of Health & Human Services- Ctr. for Medicare & Medicaid Services on The Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended. (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf.

34. *Id*.

35. Capretta & Nix, *supra* note 4, at 3.

36. *Id*.

37. Douglas Holtz-Eakin & Cameron Smith, *Labor Marketis and Health Care Reform: New Results*, AMERICAN ACTION FORUM (May 2010), http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf [hereinafter Holtz-Eakin].

38. Shawn Tully, *Documents Reveal AT&T, Verizon, other, Thought About Dropping Employer-Sponsored Benefits*, CNN MONEY (MAY 6, 2010),

leader, Caterpillar, would see its cost of employee coverage reduced by over seventy percent.[39] In fact, former CBO director Douglas Holtz-Eakin predicts as many as thirty-five million Americans will be utilizing government subsidized health care solely as a result of their employers dropping their coverage.[40] Thus, critics are concerned that the cost of the subsidized healthcare program will greatly exceed the $460 million projection if companies, specifically large corporations with high employee counts, take advantage of the fiscal opportunity the PPACA potentially provides for them.

d. Effect at the State Level

Critics also assert that the PPACA will also have deleterious effects at the state level of government. The PPACA would bring 16 million new Americans into Medicaid, an entitlement program that already utilizes 20 percent of state budgets.[41] From 2014 when the law goes into effect until 2019, states will face $21 billion in new Medicaid costs.[42] Additionally, the states will be responsible for just under $12 billion in administrative costs, which will exceed $100 million per year in the most populous states of California, Florida, New York, and Texas.[43] Forty-four states, including the four states already mentioned, and the District of Columbia all project a budget deficit for 2012 ranging from $3.6 billion to $25.4 billion.[44] Granted, the $33 billion ($21 billion for new Medicaid costs + $12 billion for administrative costs) in state level costs is a small expense relative to the federal burden, yet many states are clearly in very poor financial condition and are in desperate need to cut spending, and cannot afford significant outlays.[45]

IV. FUTURE FINANCIAL IMPACT

The potential omissions and future expenses that are not accounted for in the CBO's

http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/.

39. *Id*.

40. Holtz-Eakin & Smith, *supra* note 37, at 6.

41. Paul Howard, *The Impact of the Affordable Care Act on the Economcy, Employers, and the Workforce*, CENTER FOR MEDICAL PROGRESS AT THE MANHATTAN INSTITUTE (Feb. 9, 2011), http://www.manhattan-institute.org/pdf/testimony_02092011PH.pdf.

42. *Health Reform Issues: Key Issues About State Financing and Medicaid*, THE KAISER FAMILY FOUNDATION (May 2010), http://www.kff.org/healthreform/upload/8005-02.pdf.

43. Edmund F. Haislmaier & Brian C. Blasé, *Obamacare: Impact on States*, THE HERITAGE FOUNDATION (July 1, 2010), http://www.heritage.org/Research/Reports/2010/07/ Obamacare-Impact-on-States.

44. Elizabeth McNichol et al., *States Continue to Feel Recession's Impact*, CENTER ON BUDGET AND POLICY PRIORITIES (Feb. 10, 2011), http://www.cbpp.org/cms/?fa=view&id=711.

calculation of the impact of the PPACA could significantly affect the prospective financial outlook of the U.S. government. First and foremost, it will increase the federal deficit rather than reduce it. In 2010, the federal deficit was $1.3 trillion.[46] Historically, the average deficit is 2.9 percent of the Gross Domestic Product (GDP), but by 2050 the budget gap is projected to be in excess of 20 percent.[47] As the baby boomer generation retires, the cost of entitlement programs already in place such as Medicare, Medicaid, and Social Security will continue to escalate.[48] Adding the expense of the entitlements provided by the PPACA will only increase the burden and continue to cause the gap between the GDP and the deficit to close.

Also, history indicates that the costs of healthcare bills consistently exceed the estimates at enactment. Massachusetts Commonwealth Health Insurance cost twenty percent more than projected; Britain's National Health Service cost thirty percent more than forecasted; and in 1965 Medicare was projected to cost $12 billion by 1990− instead it was $110 billion.[49] While these ratios cannot be precisely applied to the PPACA, they give reason to be wary for the future expense of the legislation.

Additionally, the increased deficit created by the PPACA will delay the progress towards repairing the existing entitlement programs of Medicare, Medicaid, and Social Security. These programs do not have the discretion to decide how much they spend each year; rather they pay out what is demanded based on the covenants set out in the law.[50] Since these programs already take up about half of the federal budget, with the baby boomer generation retiring, the costs of these entitlement programs will continue to soar and occupy massive amounts of the annual budget.[51] Increased entitlement programs under the PPACA only exacerbate this problem, and takes away physical and intellectual resources from the reducing deficit spending at its core.

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45. Howard, *supra* note 41.

46. Capretta & Nix, *supra* note 4, at 3.

47. Nicola Moore et al., *Federal Budget Deficits Will Reach Levels Never Seen Before in the U.S.*, THE HERITAGE FOUNDATION (2010), http://www.heritage.org/budgetchartbook/federal-budget-deficits.

48. Richard Wolf, *Social Security Hits First Wave of Boomers*, USA TODAY, Oct. 9, 2007, http://www.usatoday.com/news/washington/2007-10-08-boomers_N.htm.

49. Dean Clancy, *5 Reasons Why Repealing Obamacare Will Not Increase the Deficit*, FOX NEWS (Jan. 7, 2011), http://www.foxnews.com/opinion/2011/01/07/reasons-repealing-obamacare-increase-deficit.

50. Jim Angle, *Entitlement Evolution Poses Threat to America's Finances*, FOX NEWS (Feb. 18, 2011), http://www.foxnews.com/politics/2011/02/17/entitlement-evolution-poses-threat-americas-finances/#ixzz1ELgoyUat.

51. *Id.*

Finally, the weight and responsibility of the unaccounted expenses in the PPACA falls on the shoulders of future generations. As soon as the new subsidies are put into place and actively relied upon by the American populace, it will be extremely difficult to ever eradicate them. In order to finance the added expenses of the PPACA, Congress will either have to raise taxes on future generations, reduce spending on other critical initiatives, or continue the cycle of adding to the deficit.[52]

V. CONCLUSION

The PPACA provides a substantial benefit to a projected thirty-two million people, many of whom have never had insurance before, nor would have had any potential of receiving coverage in the future. However, with all benefits come costs, and the current estimates by the CBO do not present an accurate projection of the price of the legislation on the financial future of America. Interpreting the ten-year deficit projections of the PPACA as the alpha and omega of the fiscal impact of the bill would be naïve. The projections have been manipulated to represent the PPACA as providing a significant deduction to the federal deficit in the immediate and distant future. Even Bill Elmendorf, the current director of the CBO, said that the PPACA would "maintain and put into effect a number of policies that might be difficult to sustain over a long period of time."[53] Although a primary benefit of the PPACA is believed to be long-term relief on the budget and future taxpayers, when omissions, double counting, unrealistic assumptions, and state level deficits are factored in, it becomes clear that the legislation amplifies the burden rather than reduces it.

52. Capretta & Nix, *supra* note 4, at 4.
53. Pelosi, *supra* note 2, at 14.