Access Through Cost: Improving Access to Quality Care Under The PPACA’s System Of Universal Coverage

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I. INTRODUCTION

Universal healthcare is about raising the standards of public health through the provision of universal access to quality health care. In the United States, this effort is embodied in the Patient Protection and Affordable Care Act (PPACA). However, the most notable features of this act are more narrowly focused on the issue of increasing access through the provision of universal coverage. These measures include an expansion of Medicaid, premium assistance for people in lower income brackets and an individual mandate to buy insurance. They have been well-documented

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1. In regards to coverage, the U.S. Census Bureau reported that 48.6 million people were without coverage in 2011. CARmEN DeNAVAS-WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011 21 (Francis Grailand Hall ed., 2012). To address this the PPACA 26 U.S.C. § 5000A(b) requires individuals who do not obtain minimum essential coverage to report this in their tax returns and take a penalty, thus encouraging the uninsured to buy insurance. Additionally, the PPACA, 42 U.S.C. § 18071, provides premium assistance for those between 100% and 400% of the federal poverty level. 42 U.S.C. § 1396A(a)(10)(A)(VIII)(2010), expands Medicaid coverage to include everyone up to 133% of the federal poverty level. Furthermore, there is a deduction of 5% of income that essentially expands this coverage to people living at up to 138% of the poverty level. THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND CHILDREN’S HEALTH INSURANCE PROGRAM PROVISIONS IN THE NEW HEALTH REFORM LAW 1 (Apr. 7, 2010), available at http://www.kff.org/healthreform/7952.cfm. However, because the Supreme Court made the Medicaid expansion optional it is estimated that 22.3 million people who would have been eligible for the expansion will live in states that will not adopt the expansion, and, of those 22.3 million, 17.8 million live below 100% of the poverty level and will therefore not qualify for premium assistance. Genevieve M. Kenney et al., Health Policy Ctr., Making the Medicaid Expansion and ACA Option: How Many Low-Income Americans Could Remain Uninsured, 1 (2012), See infra section II (explaining cost reduction).

2. See THE HENRY J. KAISER FAMILY FOUND., supra note1.
and thoroughly discussed in public discourse, particularly concerning the Supreme Court’s highly publicized ruling on the constitutionality of the individual mandate to purchase health insurance. But guaranteeing coverage to all Americans does not guarantee them access to quality care if the available care cannot help patients attain the highest possible level of health. An aspect of universal access to quality health care that has not received enough attention is the effect cost has on providing quality care in a system where everyone is covered. Cost reduction is critical to the success of universal healthcare in the United States because the PPACA was designed, in part, to respond to the per capita growth of health care costs, which gradually make care inaccessible to more Americans every year.

Costs address the issue of access to quality care by increasing the feasibility of paying for an expanded coverage pool.

This article will therefore focus on the PPACA’s provisions that attempt to reduce the overall costs of care. Section II will examine the provisions of the PPACA designed to foster innovation, because access under universal coverage means finding the best ways to provide care of the same or better quality for a lower price. Section III will analyze the key assumptions of strengths and weaknesses of the PPACA and how it reduces costs. Section IV will show that the PPACA’s main focus in the realm of cost reduction is innovation of payment and delivery models and will suggest a broader approach for future healthcare legislation. Ultimately, the next step on the path towards universal access to quality health care is maximizing the

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4. Id.
5. In 2008 the U.S. spent more on health care per capita than any other developed country and health care costs were growing at a faster rate than workers’ earnings, increasing the likelihood that more workers would be unable to afford the costs of care. Paul B. Ginsburg, High and Rising Health Care Costs: Demystifying U.S. Health Care Spending, in 16 RES. SYNTHESIS REPORT 1 (Alwyn Cass II ed. 2008).
6. See id., section II.
potential for cost reduction. This will be accomplished by identifying and removing remaining cost barriers. Increasing the scope of cost reduction efforts to include all aspects of care will provide stronger assurance of access to quality care under America’s system of universal coverage.

II. THE PPACA’S COST SAVING MEASURES

Although there are other ways the PPACA combats rising costs besides encouraging innovation,7 this article will only examine two factors that contribute to rising cost: (1) waste8 and (2) the development and implementation of new technology.9 The focus of these inquiries is on efforts that seek to innovate the way care is delivered and technology is implemented. The provisions of the PPACA that will be specifically examined largely concern innovation in payment and delivery models: the Center for Medicare and Medicaid Innovation (CMI);10 the Medicare Shared Savings program;11 payment bundling;12 the Independent Payment Advisory Board (IPAB)13; and healthcare delivery systems research.)14 Additionally, there are three provisions that focus on encouraging third parties to independently research approaches to innovation: optimizing

7. Most notably the way the individual mandate combats the so-called “death spiral” by ensuring that insurers will not get stuck covering concentrated pools of high risk patients. Larry Levitt & Gary Claxton, Is a Death Spiral Inevitable if There is No Mandate?, KAISER FAMILY FOUND. (June 19, 2012), available at http://policyinsights.kff.org/en/2012/june/is-a-death-spiral-inevitable-if-there-is-no-mandate.aspx.
8. The Institute of Medicine estimates that $750 billion of health care costs in 2009 were waste. INST. OF MED., Best Care at Lower Cost: The Path to Continuously Learning Health Care in America Ab-2 (Mark Smith et al eds., 2012).
9. The Congressional Budget Office (CBO) estimates “roughly half of the increase in health care spending during the past several decades was associated with the expanded capabilities of medicine brought about by technological advances.” CONGR. BUDGET OFFICE, TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING PUB. NO. 2764 12 (2008), available at http://www.cbo.gov/publication/41665.
delivery of public health services,\textsuperscript{15} patient centered outcome research,\textsuperscript{16} and state waivers for innovation.\textsuperscript{17} After examining these provisions, it is clear how innovation under the PPACA is almost exclusively concerned with reducing costs at the physician level, with little attention to other forces affecting the cost of health care.

The first set of provisions encourages physicians to provide care in more cost efficient ways. The purpose of the CMI is to “test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care”\textsuperscript{18} by “transition[ing] primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment” and “[c]ontracting directly with groups of providers of services and suppliers to promote innovated care delivery models.”\textsuperscript{19} This provision is motivated by the concern that physicians are highly incentivized to provide unnecessary care under fee for service (FFS) models\textsuperscript{20} because the more they provide the more money they make.

The Medicare Shared Savings Program similarly takes aim at the FFS model through the establishment of Accountable Care Organizations (ACOs).\textsuperscript{21} ACOs make a group of providers responsible for a population of

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  \item \textsuperscript{15} PPACA, 42 U.S.C. § 300u–15 (2010).
  \item \textsuperscript{16} PPACA, 42 U.S.C. § 1320e (2010).
  \item \textsuperscript{17} PPACA, 42 U.S.C. § 18052 (2010).
  \item \textsuperscript{18} PPACA, 42 U.S.C. § 1315a(a)(1) (2010).
  \item \textsuperscript{19} PPACA, 42 U.S.C. § 1315(A)(b)(2)(B)(i)-(ii) (2010). The section further goes on to suggest features that a desirable model might include such as “utiliz[ing] technology… to coordinate care” and “maintain[ing] a close relationship” between providers. PPACA, 42 U.S.C. § 1315a (b)(2)(C)(iv)-(v).
  \item \textsuperscript{20} Under FFS payment schemes physicians are paid for each individual service they provide. MEDICAID.GOV, Fee For Service, (January 4, 2013, 10:57AM), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html. This incentivizes physicians to provide unnecessary additional services because the physician is additionally compensated for providing the additional services.
  \item \textsuperscript{21} PPACA, 42 U.S.C. § 1395jjj (a)(1)(A) (2010).
\end{itemize}
Medicare patients and pay them predetermined sums for achieving certain quality benchmarks. The program provides financial rewards for ACOs that exceed benchmarks and leave them financially accountable for the inability to meet them. The result is that a provider’s financial success is directly tied to their ability to improve the efficiency of care delivery. Similarly, the pilot program for bundled payments pays the entire cost of care for specific conditions in one lump sum. The provider’s profit is based entirely on their ability to provide care at a cheaper cost than the predetermined rate, again tying financial success to results instead of the post-hoc payment style of FFS. The section on health care delivery systems research provides for health care delivery system research intended to create “innovative methodologies. . . for quality improvement practices in the delivery of health care services.” Although this does not put pressure on physicians to improve efficiency, it is still focused on cost reduction through innovative care delivery.

IPAB is an independent board that is charged with controlling per capita growth in Medicare spending. IPAB’s job is to develop and submit a proposal to reduce Medicare growth when it projects growth will exceed pre-approved growth rates. Although there are limits on what a proposal

22. The act requires the program to “establish quality performance standards. . . over time [] specifying higher standards, new measures or both for purposes of assessing such quality of care.” PPACA, 42 U.S.C § 1395jjj (b)(3)(C) (2010).
24. See PPACA, 42 U.S.C. § 1395cc-4 (2010) (defining a bundled payment in general as a comprehensive payment for the costs of services, in part (c)(3)(C), and creating a list of quality measures for the Secretary of Health to use in setting costs, in part (c)(4), for applicable services, as defined in part (a)(2)(C))
25. Id.
28. Id.
may include,\textsuperscript{29} IPAB is instructed to consider recommendations that “improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement.”\textsuperscript{30} Potentially, IPAB could make the receipt of Medicare funds conditional on the implementation of new delivery models, implement a bundled or capitated payment system, or use other methods to put pressure on physicians to reduce costs. Because the provision is intended to allow IPAB to be creative, it is somewhat vague; thus it cannot be assumed that these options are off the table.\textsuperscript{31} To the contrary, given that the theme has been to put pressure on physicians to innovate delivery to reduce costs, it is probably safe to assume that these will be the first tools for which IPAB reaches.

There are three additional provisions of the PPACA designed to encourage innovation in delivery models. Rather than applying direct pressure, these programs simply encourage third parties to innovate and are therefore not as forceful as those previously mentioned. However, the theme of focusing on delivery models and finding ways physicians can reduce costs remains persistent. The provision for Patient-Centered Outcomes Research authorizes the establishment of a nonprofit corporation\textsuperscript{32} Although their priorities include disseminating findings regarding “health outcomes, clinical effectiveness, and appropriateness of . . . treatments,”\textsuperscript{33} which again focus on delivery models and placing value on physicians’ judgment of the medical necessity of certain

\textsuperscript{29} PPACA, 42 U.S.C. § 1395kkk(a)(2)(A) (2010). Notable among these restrictions is the recommendations may not include provisions to ration care, raise revenues or Medicare beneficiary premiums, increase Medicare costs, or otherwise restrict benefits or modify eligibility criteria. PPACA, 42 U.S.C. § 1395kkk(a)(2)(A)(ii) (2010).
\textsuperscript{31} See PPACA 42 U.S.C. § 1395kkk (2010).
\textsuperscript{32} PPACA, 42 USCA § 1320e(b)(1) (2010).
\textsuperscript{33} PPACA, 42 USCA § 1320e(c) (2010).
procedures, but does include “medical devices, diagnostic tools, [and] pharmaceuticals” in the list of medical treatments, services and items described.\(^{34}\) This seems to suggest that research may be expanded to include ways to make medical devices, diagnostic tools and pharmaceuticals cheaper. Because this provision is about “patient-centered outcomes” however, research would likely focus on finding ways for physicians to utilize these technologies in the most efficient way possible.\(^{35}\) This, again, is a delivery model approach.

The waivers for state innovation allow states to waive particular requirements if they can show they will provide comparable coverage without creating excessive out-of-pocket costs.\(^{36}\) The provision for Research on Optimizing Delivery of care involves providing funding for research that “identify[ies] effective strategies for organizing, financing, or delivering public health services.”\(^{37}\) Because states will still have to provide coverage that is at least as comprehensive and affordable, any innovation implicated by this section will invariably involve reimbursement; and therefore, will likely involve delivery model reform.\(^{38}\) Similarly, research on optimizing the delivery of care will not create any requirements. But, any positive findings will likely be incorporated into publicly-funded physician reimbursement.\(^{39}\)

By looking at these provisions, it is apparent that the PPACA’s cost-saving innovations are targeted largely at the models by which physicians provide care. As demonstrated, it focuses quite specifically on affecting the

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34. PPACA, 42 USCA § 1320e(a)(2)(B) (2010).
35. Particularly considering the language that state “the purpose of the Institute is to assist patients, clinicians, purchasers and policy-makers in making informed health decisions.” PPACA, 42 USCA § 1320e(c) (2010) (emphasis added).
38. PPACA, 42 USCA § 18052(b)(1)(B) (2010).
ways physicians utilize treatments and finding new ways to reimburse physicians so as to align their personal economic concerns with the public’s economic concerns regarding care implementation. Surprisingly, other players in health care—such as pharmaceutical companies, medical device manufactures and medical information technology providers—receive decidedly less attention.\textsuperscript{40} Although not completely absent, these players, who have at least some ability to affect the costs of care, are not approached with the same financial incentives or deterrents as physicians.\textsuperscript{41} Providing access to the full range of necessary care means addressing the costs of these factors in addition to those already addressed by the PPACA.

III. STRENGTHS AND WEAKNESSES OF THE PPACA’S INNOVATIVE MEASURES

Physician and hospital fees were a major concern for the drafters of the PPACA. This is not surprising because physician and hospital fees make up the largest percentage of health care costs.\textsuperscript{42} However, this approach is problematic because delivery models are not the only elements that affect cost and therefore affect access.\textsuperscript{43} To demonstrate the need to broaden the focus of cost-saving innovations, this section will examine the strengths and weakness of focusing on delivery models, and examine other factors that affect costs.

First, these provisions appear to operate under the assumption that physicians have the ability to substantially affect the cost of care and that

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\item \textsuperscript{40} See \textit{e.g.}, PACCA, 42 USCA § 1320e(a)(2)(B) (2010), (mentioning medical technologies but not developers of these technologies directly).
\item \textsuperscript{41} \textit{Id}.
\item \textsuperscript{43} \textit{Id}.
\end{itemize}
these financial incentives and deterrents are sufficient motivation make those changes.44 There is reason to speculate that some ACOs will fail to reduce costs because the economic incentives from shared savings programs are insufficient to encourage substantial change.45 Others argue that the utilization of unnecessary care often has nothing to do with a physician increasing their own revenues; and therefore, influencing physicians fails to address the true problems with cost.46 Even if these predictions turn out to be correct, the failure of ACOs to foster innovation will not affect the chances that other measures of the PPACA will.47

44. Of the overall $750 billion in estimated wasteful spending in the health care system, $210 billion is attributed to unnecessary services, $130 billion to insufficiently delivered services and $55 billion to missed prevention opportunities. Inst. of Med., supra note 8, at S-7. However $105 billion are attributed to prices that are simply too high and remaining estimation of waste is attribute to fraud and excess administrative costs. Id. The fact so much of these estimated costs have been attributed to factors that would seemingly fall entirely within a physician’s judgment provides at least one explanation for why the PPACA works so hard to create a system where physicians are highly motivated to find ways to improve delivery.

45. In addition to speculation that shared savings won’t be enough to offset loss, smaller practices may simply lack the structure required to reduce costs. Mark Merlis, Health Affairs, Accountable Care Organizations, in Health Policy Brief 3-4 (Robert A. Berenson ed., 2010). Alternatively, ACOs may run into legal problems such as antitrust or, instead of lowering costs, large ACOs that take up substantial market share could use their bargaining power against private payers. Id.

46. Some argue that doctors caught between the competing forces of pressure to reduce costs and the threat of medical malpractice lawsuits will provide care they may feel is unnecessary if they think a jury would find that failing to provide the service constitutes malpractice. See Christopher Smith, Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations, 20 Annals Health L. 165, 170-74 (2012). Not only are costs not a factor in determining whether a physician has committed malpractice, but the implication that a physician failed to provide a service simply as a matter of cost actually enhances the likelihood that a jury will find medical malpractice. Id.

47. The CMI and Patient Oriented Outcomes Research Institute (PCORI) have already started work on developing new payment and delivery models and have established websites that keep the public informed about their progress and invite anyone to provide comments or recommendations. PCORI, The PCORI Blog, (January 4, 2013, 10:57AM), available at http://www.pcori.org/blog/ (featuring blogs discussing PCORI’s most recent strategies in improving patient outcomes); Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation, What We’re Doing, (January 4, 2013, 10:57AM), available at http://www.innovations.cms.gov/initiatives/index.html (at most recent posting explaining and sharing feedback on current plans for the implementation of ACOs and other innovative programs).
Therefore any possible shortcomings of ACOs should not be interpreted as a sign of the overall ineffectiveness of the PPACA.48

However, there is research that suggests other factors, such as the high cost of medical technology, also contribute to overall increases in cost.49 Although, as a gross percentage of costs, these appear to pale in comparison to physician and hospital fees.50 On the other hand, physician use of medical technologies invokes all of these costs and any inflation of any of these costs will carry through to the cost of the physician’s services.51 Additionally, innovations in these types of medical technologies can sometimes bring patient care out of the context of the hospital or physicians’ office and more under the patient’s control, significantly reducing physician and hospital fees. In either case, for some patients, quality care will require the utilization of these technologies and the ability to access them will be highly affected by cost.

Instead of attacking what is contained in the PPACA, public discussion should turn to what it does not do to lower costs, which is arguably the PPACA’s biggest weakness. The PPACA should supplement existing cost-reducing measures aimed at physicians and delivery models with stronger measures addressing the other sources of medical costs, such as the costs of medical devices, diagnostic tools, pharmaceuticals and medical research. Policy that broadly targets the full range of factors that contribute to

48. Furthermore, the Congressional Budget Office projects that the PPACA will not increase the deficit and that it will actually yield a net reduction in deficits between the years 2010-2019. CONG. BUDGET OFFICE, H.R. 3590 - PATIENT PROTECTION AND AFFORDABLE CARE ACT: COST ESTIMATE FOR THE BILL AS PASSED BY THE SENATE ON DECEMBER 24, 2009, at 1 (2010), available at http://www.cbo.gov/publication/21279 (hereinafter ACA COST ESTIMATE). The report breaks down cost savings of PPACA by provision, estimating that CMI will reduce spending by $1.3 billion and Medicare shared savings will reduce spending by $4.9 billion. Id. at Table 4, pp. 6.

49. See CONG. BUDGET OFFICE, supra note 9.

50. Beamesderfer & Ranj supra note 42.

51. See id. (demonstrating that physician and hospital fees make up fifty-one percent of costs, listing technology and prescription drugs as one possible driving factor).
healthcare costs maximizes the potential for overall price reduction, thus increasing the value of our medical dollars and making quality care increasingly available to lower income Americans.

IV. WHAT UNIVERSAL COVERAGE CAN MEAN IN THE PPACA ERA

As we enter the next stages of the PPACA implementation, the effectiveness of these programs will become clearer and the public debate will continue. No matter how successful the PPACA will be at reducing costs, the desire to further reduce costs will persist and the next step will be to develop plans that address the role non-physicians play in health care costs.

When this time comes, the big targets should be providers of medical technologies, including pharmaceuticals, devices, and research itself.\(^{52}\) There is an argument that modifying delivery models will include physicians making more limited use of available technologies.\(^{53}\) Theoretically, if a physician was more judicious about the drugs they prescribed, the devices they used or the information systems they implement (or outsource to) costs could be reduced.\(^{54}\) However, this brings us back to the concern about whether pressures on delivery models will be sufficient to significantly reduce costs.\(^{55}\) More importantly, even assuming these pressures are sufficient, there is no reason not to take on these costs at the source and reduce the cost of care from multiple angles. Doing so would allow physicians to share the burden of lowering these costs, maximizing

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53. See Mark V. Pauly, Competition and New Technology, 24 Health Affairs 1523 (2005) (arguing that fighting rising medical costs is going to involve addressing limiting the use of beneficial new medical technologies).
54. Id.
55. See Smith, supra note 46; See Merlis, supra note 45.
the potential of finding the lowest cost for the best care.\textsuperscript{56} Using the PPACA as a model, the government should find ways to put pressure on these other players the way it has been doing with physicians and insurers.\textsuperscript{57} For example, if the government negotiated directly with companies that develop and sell medical technologies, it could use its buying power as leverage to put pressure on them to lower costs.\textsuperscript{58} The government can act as the purchaser of technologies for certain providers, for example for ACOs created under the PPACA. The government, or some other entity, could represent a large pool of providers to purchase technological goods and services wholesale, and set its own price, leaving the providers to find more efficient ways to develop their goods and services, similar to bundled payments and ACO reimbursement.\textsuperscript{59} Regardless, the government wants to affect cost through the newly $624 billion dollars of spending; thus, there needs to be a more holistic approach.\textsuperscript{60}

\section*{V. CONCLUSION}

Access to healthcare is as much about cost as it is about coverage. The

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\textsuperscript{56} See Pauly, supra note 53 at 1528 (arguing consumer understanding, or lack of understanding, of health motivates insurers and providers to avoid giving any impression that they are rationing the use of the newest technologies). By creating a system that addresses costs of technology by confronting developers directly regulation could bypass obstacles in the marketplace that affect providers ability to leverage costs.

\textsuperscript{57} See id., section II (discussing how PPACA creates pressures for providers to reduce costs of care); See 42 U.S.C. § 18091(2)(I) (justifying how PPACA requires insurers to provide coverage for pre-existing conditions by mandating coverage for all, thus preventing individuals from waiting to purchase health insurance until they need care and increasing the cost of health insurance premiums by creating an increasingly concentrated pool of high risk patients).

\textsuperscript{58} See discussion supra section II (regarding payment bundling, Medicare and Medicaid reimbursement under CMI and ACOs under Medicare Shared Savings as examples of how government can negotiate directly with a provider to reduce costs).


\textsuperscript{60} However, these $624 billion in costs are projected to be offset by a $478 change in outlays and a $264 increase in revenues to bring the net impact on the deficit to a $118 billion reduction from for the period 2010 to 2019. See CONG. BUDGET OFFICE, supra note 48, at 3.
PPACA has arguably taken care of coverage. But, for the aforementioned reasons, universal healthcare can expand access by further reducing costs. The next step in achieving truly universal healthcare is therefore finding ways to directly address those areas the PPACA leaves open. Ultimately, this means devising ways to create incentives for the providers of medical technologies to create ever more cost effective services and reduce unnecessary spending, before these technologies even reach a doctor’s office. By expanding coverage to all Americans, we have guaranteed that everyone in American has access to some level of medical care. By reducing costs, we ensure that they have access to quality care.

61. Starting in 2014, the mandate will require all Americans to purchase insurance and although several states have vowed to reject the expansion, within four years of establishing Medicaid, forty-eight states had adopted the program. Kaiser Family Found., A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage 6 (2012), available at http://www.kff.org/medicaid/8349.cfm. Federal funding for Medicaid was significantly smaller than is being offered under the expansion and therefore it is likely that states that opt not to adopt initially will adopt the expansion eventually. Id. (stating that Alaska took 6 years and Arizona took 16).

62. As opposed to indirectly, as is the case with Patient-Centered Outcomes Research, which includes “medical devices, diagnostic tools, [and] pharmaceuticals” as factors to consider when researching the clinical effectiveness, and appropriateness of . . . treatments.” PPACA, 42 U.S.C. § 1320e(a)(2)(B) (2012).