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ADVANCE DIRECTIVE

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THE HEALTH POLICY AND LAW REVIEW OF
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ANNALS OF HEALTH LAW
Advance Directive

THE *STUDENT* HEALTH POLICY AND LAW REVIEW OF LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

Beazley Institute for Health Law and Policy

VOLUME 22, STUDENT ISSUE 1 FALL 2012

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ANNALS OF HEALTH LAW
Advance Directive

Editor's Note

The *Annals of Health Law* is proud to present the Ninth issue of our online, student-written publication, *Advance Directive.* As has become tradition over the past few years, this Issue features articles that correspond with our Sixth Annual Symposium on Access to Health Care presented by the Beazley Institute for Health Law and Policy: *Comparative Universal Coverage Efforts & Expanding Access to Health Care*. The authors examine a variety of issues related to universal coverage and expansion of access to health care, including challenges related to the continued implementation of the Patient Protection and Affordable Care Act (PPACA).

The Issue begins by looking at lessons the United States can learn from other countries, and even its own past. First, we examine how the United States can learn from China's attempts at expanding access to health care for individuals living in rural poverty. Second, we analyze Chile's efforts to treat and pay for chronic conditions and whether these efforts could be translated to the United States' health care system. Finally, we discuss President Nixon's proposals for health reform, and if Congress should have incorporated more of Nixon's proposal into the final version of the PPACA.

The Issue then addresses the role that the states will play in implementing the PPACA and expanding access to coverage. Since the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* allows each state to decide whether to expand Medicaid, our authors analyze the costs and benefits to a state that chooses to expand eligibility in its Medicaid program. Our authors then analyze the role that exchanges will play in expanding access to healthcare coverage and the efforts that California has already begun to build an effective exchange.

Our authors next address the effect that the PPACA implementation has on hospitals, a major player in the healthcare industry. First, our authors discuss the role of non-profit hospitals in providing care and the challenges that non-profit hospitals are currently facing. Specifically, our authors examine the reimbursement models and additional tax-exemption requirements imposed by the PPACA, and how non-profits will have to adapt to these changes. Second, we examine the consolidation that has occurred in the hospital industry since the passage of the PPACA, and the ways in which anti-trust enforcement has prohibited some hospitals from merging, and thus, prevented hospitals from fully preparing for the changes under the PPACA.

The Issue then addresses some of the legal questions that still remain regarding implementation of the PPACA, and those effects that are yet unclear. First, we examine the United States District Court for the District of Columbia's decision in *Wheaton College v. Sebelius* that the plaintiffs' challenge to the PPACA's contraceptive mandate lacked sufficient standing. Specifically, our authors address the ways in which this decision will affect pending lawsuits challenging the contraceptive mandate and the implementation of the PPACA. Then, our authors address the question of whether the PPACA will succeed in reducing costs, and examine changes in the future that could further reduce health care costs.

Finally, the Issue concludes by examining those areas of the health care system where major gaps still exist and that still require a comprehensive solution. Our authors begin by examining the failure to adequately treat and pay for long-term care in the United States. Next, we analyze the role that long-term care referral websites play in expanding access to long-term care, including examining the fraud and abuse rules with which these websites must comply. Then, we discuss the mental health care system and the need for the federal and state governments to pay greater attention to this sector.

We would like to thank Timothy Loveland, our *Advance Directive* Senior Editor and Brian Troutman, our Technical Editor because without their knowledge and commitment this issue would not have been possible. We would like to give special thanks to our *Annals* Editor-in-Chief, Ashley Leonard, for her leadership and support. The *Annals* Executive Board Members, Logan Parker, Karim Hussein, Alissa Bugh, and Kristin Peterson, provided invaluable editorial assistance with this Issue. The *Annals* members deserve recognition for writing thoughtful, topical articles and for editing the work of their peers. Lastly, we must thank the Beazley Institute for Health Law & Policy and our faculty advisors, Professor Lawrence Singer, Professor John Blum, and Megan Bess for their guidance and support.

We hope you enjoy your Ninth Issue of *Advance Directive*.

Sincerely,

Carrie S. Gilbert
Advance Directive Editor
Annals of Health Law
Loyola University Chicago School of Law

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Extending Universal Health Care Access to the Rural Poor: Has China Shown Us the Way?

*Grant Peoples**

I. INTRODUCTION

Access to quality and affordable health care for rural Americans is a growing issue. Today, more than twenty percent of Americans living in non-metropolitan areas do not have health insurance.[1] Lack of health insurance is a critical factor in treating disease; those without health insurance are less likely to have a regular health care provider, less likely to seek preventive care, and are less likely to obtain medical tests and prescriptions.[2] The millions of rural Americans without insurance lack adequate access to preventive care and often neglect to treat chronic conditions.[3] To make matters worse, rural areas experience higher poverty rates and earn lower wages, exacerbating the effects of relatively low levels of employer-based insurance coverage.[4] This effect has only been amplified by the recent economic downturn. The result is that rural areas rely more heavily on Medicaid and other public coverage than their urban counterparts.[5]

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1. Jane Bolin & Larry Gamm. *Access to Quality Health Services in Rural Areas – Insurance: A Literature Review*. RURAL HEALTHY PEOPLE 5, *available at* http://www.srph.tamhsc.edu/centers/rhp2010/03Volume2access-insurance.pdf

2. *Id.* at 10.

3. *Id.* at 5-8, 9.

4. *Id.* at 6; s*ee also* Dr. Joe Blankenau et al., *The Causes and Consequences of the Rural Uninsured and Underinsured, Health Care Reform*, 3 CNTR. FOR RURAL AFF. 1, 1 (Apr. 2009), a*vailable at* http://files.cfra.org/pdf/Causes-and-Consequences-of-Rural-Uninsured.pdf.

5. Bolin & Gamm, *supra* note 1, at 6. In 1997, employer-sponsored insurance in urban counties was found to be 70%, while only 55% of employer's in rural counties sponsored

The problem is not unique to the United States. After China moved to a market economy in the 1980's, millions of poor rural Chinese that previously enjoyed universal access to health insurance as part of the Cooperative Medical System lost their coverage.[6] As in the United States, the cost of care was rising rapidly, increasing at nearly sixteen percent per year.[7] Medical expenditures were causing rural poor to drop below the poverty line.[8] With the dissolution of the communes came "a medical free-fall for the rural population."[9] The rural medical system crumbled. One commentator notes that "while the Maoist era brought health to Chinese people, the reform era . . . almost liquidated its achievements for quick money."[10] By the early 1990's, fewer than ten percent of rural Chinese had medical insurance.[11]

In response to this crisis, the Chinese government launched the New Cooperative Medical System (NCMS) in 2003.[12] The past decade has seen a dramatic turnaround. By 2011, more than 836 million rural Chinese enrolled in the system, representing ninety-five percent of China's rural counties.[13] Coverage for poor rural Chinese was nearly universal by

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employee insurance. *Id.*

6. Winnie Yip & William C. Hsiao, *Non Evidence-Based Policy: How Effective is China's New Cooperative Medical Scheme in Reducing Medical Impoverishment?* 68 SOC. SCI. MED. 201, 204 (2009). *available at* http://www.hsph.harvard.edu/health-care-financing/files/yip_and_hsiao_2009_-_non-evidence_based_policy.pdf; Xiaoyun Sun et al., *Health Payment-Induced Poverty Under China's New Cooperative Medical Scheme in Rural Shandong*, 25 HEALTH POL'Y & PLAN. 419, 420 (2010).

7. Yip & Hsiao, *supra* note 6, at 205.

8. Sun et al., *supra* note 6, at 420. In one Chinese county, out-of-pocket medical expenses caused nearly forty-five percent of its population to drop below the poverty line. *Id.*

9. Dale Jiajun Wen, *China's Rural Reform: Crisis and Ongoing Debate*, 43 ECON. & POL. WKLY. 86, 89 (2009).

10. *Id.*

11. Sun et al., *supra* note 6, at 420.

12. *Id.*

13. Kimberly S. Babiarz et al., *China's New Cooperative Medical Scheme Improved Finances of Township Health Centers But Not the Number of Patients Served*, 31 HEALTH AFF. 1065, 1066 (2012).

2012— approximately ninety percent of the rural population had health insurance.[14] Nevertheless, it is unclear whether the achievement of nearly universal coverage through the NCMS has actually provided poor rural Chinese better access to quality and affordable health care. Given that the U.S. will soon expand Medicaid coverage to uninsured rural Americans through the Patient Protection and Affordable Care Act (PPACA), this article considers the extent to which the Chinese example sheds light on the potential impact the new law may have on rural Americans.

This article argues that universal care through expanded government insurance does not necessarily lead to greater health care access for the rural poor. First, it briefly examines the historical background from which the NCMS arose. Second, it outlines policy and strategies the new system implemented to achieve its goals. Next, the article examines some of the successes and shortcomings of the new system. Finally, the article considers whether American efforts to create universal care through the PPACA may experience some of the same shortcomings as the NCMS.

II. HISTORICAL BACKGROUND OF RURAL CHINESE HEALTHCARE

From the 1950's through the 1980's, China provided medical care to rural Chinese through the Cooperative Medical Scheme.[15] The program emphasized preventive and basic care and at its peak covered about ninety percent of China's rural population.[16] The program was so successful that it was featured as a model for the world at the 1978 World Health Organization conference "Health for Ally by the Year 2000."[17] In 1982, however, China abolished communes and began to privatize their

14. *Id.*
15. Yip & Hsiao, *supra* note 6, at 205.
16. *Id.*; Sun et al., *supra* note 6, at 420.
17. Babiarz et al., *supra* note 13 at 1066.

economy.[18] The Cooperative Medical Scheme collapsed as a result. Village doctors became private practitioners and earned income from patients on a fee-for-service basis.[19] Because government subsidies for health facilities fell to ten percent of the facilities' total revenues by the early 1990's, the government implemented strict price control and set prices for basic health care below cost.[20] To recover the difference, providers hiked up drug and diagnostic services cost.[21] The price of health care soared, growing at sixteen percent per year.[22] The 2003 National Health Survey confirmed this disturbing trend and found that forty-six percent of rural Chinese that were sick enough to need medical care chose not to do so, with forty percent of this group citing cost as the reason.[23] In less than twenty years, the Chinese rural health system went from being the world health model for economic development to a system in which poor people could not access basic health services because of cost.

III. THE NEW COOPERATIVE MEDICAL SYSTEM: A NEW DIRECTION FOR RURAL CARE

In 2003, the central Chinese government implemented the New Cooperative Medical System (NCMS) in response to these challenges.[24] The goal was to achieve universal care for the nation's entire rural population through health insurance.[25] The NCMS also aimed to reduce

18. Sun et al., *supra* note 6, at 420.
19. Yip & Hsiao, *supra* note 6, at 205.
20. *Id*.
21. *Id*.
22. *Id*.
23. Yip & Hsiao, *supra* note 6, at 205.
24. Sun et al., *supra* note 6, at 420.
25. Hongwek Xu & Susan E. Short, *Health Insurance Coverage Rates in 9 Provinces in China Doubled from 1997 to 2006, With a Dramatic Rural Upswing*, 30 HEALTH AFF. 12 2419, 2420 (2011).

illness-induced poverty in rural households.[26] To achieve this goal, policy-makers focused on reimbursing for impatient care as opposed to outpatient care, reasoning that outpatient care was less likely to reach poverty-inducing cost levels.[27] Thus, the NCMS has higher patient reimbursement for acute, inpatient care than outpatient care.[28] The insurance program has voluntary enrolment and is funded by a combination of household contribution and government-matched funds.[29] To enroll in the program, members pay a flat rate premium of twenty Yuan.[30] The central government provides an annual subsidy of forty Yuan for each enrollee and requires the local government to match the forty Yuan.[31] The government planned to increase the subsidy to 200 Yuan per beneficiary by the end of 2011.[32] To discourage adverse selection (for example, sicker people opt-in while those who are healthy opt-out), the scheme requires all persons living in one household to join NCMS together.[33]

Reimbursement procedures vary by region and are somewhat complex.[34]

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26. *Id.* Health payment-induced poverty is poverty attributable to health payments. It occurs when health payments in a given year push a household below the poverty line or further below the poverty line. *Id.* at 421.

27. Xiaoyun Liu & Shenglan Tang et al., *Can Rural Health Insurance Improve Equity in Health Care Utilization? A Comparison Between China and Vietnam*. 11 INT'L J. FOR EQUITY IN HEALTH 10, 7 (2012), *available at* http://www.equityhealthj.com/content/11/1/10.

28. Xiaoyan Lei & Wanchuan Lin, *The New Cooperative Medical Scheme in Rural China: Does More Coverage Mean More Service and Better Health?* 18 HEALTH ECON. 25, 26 (2009).

29. Xiaomei Pei & Gerald Bloom, *Balancing Efficiency and Legitimacy: Institutional Changes and Rural Health Organization in China*, 45 SOC. POL'Y & ADMIN. 662, 667 (2011).

30. Babiarz et al., *supra* note 13.

31. Lei & Lin, *supra* note 28, at 27.

32. Babiarz et al., *supra* note 13.

33. Sascha Kotzchücher and Peter Lässig, *Transformative State Capacity in Post-Collective China: The Introduction of the New Rural Cooperative Medical System in Two Counties of Western China, 2006*-2008, 8 EUR. J. E. ASIAN STUD. 61, 79 (2009).

34. Lei & Lin, *supra* note 28, at 28. The central government gives local government four choices for reimbursement models. In the first and most popular model (65% of rural counties implement this model), inpatient services are reimbursed according to formula, while outpatient services and preventive care are paid for through a medical savings account.

Reimbursement is significant because the rate at which rural Chinese are reimbursed for medical services affects whether the poor can or cannot afford treatment. The NCMS reimburses rural Chinese patients directly rather than reimbursing providers.[35] Inpatient services are generally reimbursed according to a formula, while outpatient services are reimbursed using either a medical savings account for each family, a formula, or not at all.[36] The models incorporate some type of reimbursement cap and a deductible at different rates.[37] What they share in common is low reimbursement for preventive care, including insurance coverage for physical examination and treatment of chronic diseases.[38] The reimbursement structure reflects the NCMS's desire to target hospitalization and other catastrophic care in order to alleviate financial hardship and help prevent illness-induced poverty.[39]

IV. WHERE THE NCMS HAS SUCCEEDED

The NCMS succeeded overwhelmingly in extending health insurance to rural poor. The program expanded rapidly after its implementation in 2003. By 2011, the program enrolled more than 836 million people representing ninety-five percent of China's rural counties.[40] By 2012, the NCMS

Id. There is a deductible and a reimbursement cap for using a medical savings account. *Id.* In the second model (6.7% participation) there is no medical savings account designated for outpatient or preventive care. Rather, services are reimbursed according to a formula. *Id.* There is no deductible and no reimbursement cap. *Id.* The third model (11.17% participation) reimburses inpatient and outpatient services for catastrophic diseases with separate deductibles and reimbursement caps. *Id.* [The study provides no definition for what is and is not a "catastrophic" disease.] The fourth and final model (16.87% participation) reimburses inpatient services only. *Id.*

35. *Id.* at 28; *id.* at 40; *see also* Babiarz et al., *supra* note 13 at 1066 (stating "the New Cooperative Medical Scheme reimburses patients . . . after patients satisfy a per visit copayment").

36. Lei & Lin, *supra* note 28, at 28.

37. *Id*.

38. *Id*.

39. Sun et al., *supra* note 6, at 420.

40. Babiarz et al., *supra* note 13.

provided nearly universal insurance coverage; approximately ninety percent of the rural population chose to enroll.[41] One study finds that overall utilization of both inpatient and outpatient services have increased since the new system was implemented.[42] Systemic studies indicate some evidence that the NCMS has succeeded in reducing healthcare costs for those needing inpatient care. "The program decreased patients' out of pocket spending for higher-cost health services . . . by more than [eighteen] percent."[43] Although the reimbursement structure focuses on inpatient care as opposed to outpatient care, participation in the NCMS increased the probability that a patient utilized preventive care by sixty to eighty-five percent.[44]

The program has also increased utilization of services provided by township health services. Township health centers provide health services in rural areas and act as an intermediary between village clinics and county-level hospitals.[45] These providers have expanded the scope of the services they offer under the NCMS.[46] For example, many township health centers are required to provide all beneficiaries with an annual medical check-up.[47]

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41. Liu & Tang et al., *supra* note 27, at 5.

42. Lei & Lin, *supra* note 28, at 29 citing Wagstaff et al., *Extending Health Insurance to the Rural Population: An Impact Evaluation of China's New Cooperative Medical Scheme*, 28 J. OF HEALTH ECON. 1 (2009). However, relatively wealthy households are more likely to utilize NCMS insurance than their poorer counterparts. *Id.* This supports some authors' hypothesis that because patient expenses are reimbursed after treatment, out-of-pocket costs remain prohibitively high. *See* Kotzchücher & Lässig, *supra* note 33, at 82. As a result, many poor rural Chinese choose not to seek treatment. *See id*.at 39.

43. Babiarz et al., *supra* note 13, at 1070.

44. Lei & Lin, *supra* note 28, at 36. Further analysis reveals that the "effect of NCMS on preventive care might be mainly due to coverage leading to eligibility for a general physical examination," *id.*, as many rural Chinese counties provide insurance coverage for an annual physical examination. *Id.* at 28.

45. The township health centers are owned by the state and provide public health and primary medical services to rural Chinese. Babiarz et al., *supra* note 13 at 1065. The centers also manage provision of public health services, train clinicians, and supervise local rural health systems. *Id.*

46. Pei & Bloom, *supra* note 29, at 668.

47. *Id.*

Since the program began, township health centers are assigned responsibility for administering the program and must collect household contributions, verify implementation of regulations on prices and procedures, review reimbursement requests, and arrange payment of reimbursements to patients.[48] A notable success from the provider perspective is that the implementation of the NCMS led to large increases in township health centers' annual revenues.[49] Finally, the system is an improvement over the old model because the NCMS creates a larger risk-sharing pool at the county level to help offset the costs of providing care.[50]

China's ability to implement such sweeping change in only a decade is a testament to their political efficiency and to their growing tax revenue generated by a thriving economy.[51] While the new system has undoubtedly increased the number of poor rural Chinese covered by health insurance, it is less clear whether the poor actually have better access to health care.

V. SHORTCOMINGS OF THE NCMS

Unfortunately, expansion of medical insurance to the rural poor has not necessarily reduced their actual cost of medical care.[52] As one author points out, "the strong support for universal public health insurance reflects the assumption that lack of insurance is responsible for poor health, which may in turn lead to medical debt and poverty."[53] While there is evidence that the NCMS improved utilization of preventive care, there is no evidence showing that NCMS participation has reduced financial burden on the rural

48. *Id.*
49. Babiarz et al., *supra* note 13, at 1069. However, "these were essentially offset by accompanying expense increases." *Id.* This may be a double-edged sword because it encourages rising costs.
50. *Id.*
51. Yip & Hsiao, *supra* note 6, at 207.
52. *See generally* Lei & Lin, *supra* note 28.
53. Lei & Lin, *supra* note 28, at 38.

poor.[54] This can be attributed to a failure to change the financial incentives for providers as well as high deductibles and low reimbursement rates for patients.

Despite nearly universal insurance coverage,[55] the cost of obtaining medical care is still not attainable for many rural Chinese. This shortcoming is attributable to low reimbursement rates, high deductibles and initial out-of-pocket costs, and complicated reimbursement procedures. While "NCMS policy states that it will cover up to 50% of medical expenses,"[56] patients reported that the actual reimbursement level was much lower.[57] This is likely the result of reimbursement caps that provide reimbursement only up to a certain cost.[58] One author suggests that high deductibles may have prevented people from using formal medical services.[59] Because the NCMS requires members to pre-pay expenses before they are reimbursed, many of the rural poor who cannot afford the up-front costs associated with medical treatment decide to forego treatment altogether.[60] Finally, NCMS participants have noted that reimbursement procedures are unnecessarily difficult and confusing.[61] To obtain reimbursement, participants need to show "the NCMS enrolment certificate, receipt for all medical expenses, proof of residence status, and sometimes a referral document,"[62] in addition to waiting in long lines and traveling long

54. *Id.* at 39.
55. Babiarz et al., *supra* note 13, at 1066, citing CHINA HEALTH STATISTICS YEARBOOK (Peking Union Medical College Press 2011).
56. Liu & Tang et al., *supra* note 27, at 5.
57. *Id.*
58. *Id.*
59. Lei & Lin, *supra* note 28, at 39.
60. *Id.*; s*ee also* Yip & Hsiao, *supra* note 6, at 221-222. Yip and Hsiao argue that an alternative, first-dollar-coverage approach for primary care will give poor Chinese better access to preventive care and reduce cost in the long-term.
61. Liu & Tang et al., *supra* note 27, at 5.
62. *Id.*

distances to government health centers.[63]

Given these obstacles, expansion of health insurance coverage does not necessarily mean that rural Chinese have universal access to and utilization of health services.[64] According to one commentator, "it is not necessarily true that insurance coverage focusing on expensive hospital care is the most effective in providing financial risk protection."[65] This suggests that focusing on preventive rather than acute care would have potentially been a better solution if the overall goal is to reduce the cost of healthcare.

Another significant issue is the failure of the NCMS to change provider financial incentives. Increasing insurance coverage is just one piece of the puzzle. While the NCMS has succeeded in extending insurance coverage to a large number of poor rural Chinese, it has failed to address the rising cost of providing care. Providers continue to operate on a fee-for-service basis.[66] As such, the "response of many individual health centers to economic incentives has led to an unintended change in the balance of activities in the overall rural health system."[67] The fee-for-service model encourages providers to deliver a high volume of service rather than high quality service.[68] The effect is that many poor rural Chinese cannot afford the high cost of treatment despite government-provided insurance.

Furthermore, implementation of the NCMS is "not associated with meaningful changes in the probability of sick people having sought care

63. *Id.*
64. *Id.* at 7.
65. Yip & Hsiao, *supra* note 6, at 221-222.
66. *See generally* Hong Wang et al., *An Experiment in Payment Reform for Doctors in Rural China Reduced Some Unnecessary Care but Did Not Lower Total Costs*, 30 HEALTH AFF. 2427 (2011). This study implemented an experiment with a mixed payment mechanism for providers based on a salary and bonus system in attempt to lower the cost of delivering care to rural Chinese. *Id.* The payment method was successful in reducing costs. *Id.* at 2432.
67. Pei & Bloom, *supra* note 29, at 672.
68. Hong Wang et al., *supra* note 66.

during the previous year."[69] While one study found that the NCMS has led to higher utilization of outpatient services,[70] another found there was no difference in utilization of outpatient services between those who enrolled in the NCMS and those who did not enroll in the NCMS.[71] This finding is consistent with the NCMS's focus on inpatient, acute care services and strongly evidences that despite having better access to health insurance, the insurance is not making treatment of chronic conditions or preventive care more affordable for rural Chinese citizens.

As one commentator notes, the "fundamental problem of the NCMS is that . . . policymakers did not recognize that in fact expenses incurred for treating chronic illnesses – not only hospitalizations – are a major factor in medical impoverishment."[72] While the NCMS reduces cost for rural Chinese when there is a need for hospitalization, the plan fails to provide adequate coverage for preventive treatment and treatment of chronic conditions. Additionally, extending insurance to millions of poor Chinese, though noble, has done nothing to change the incentives driving the increasing costs of healthcare.[73] While the NCMS has made incredible progress by coverage, it has failed to reduce the cost of health insurance to the rural poor because reimbursement rates are low and the cost of care continues to escalate.[74] The program's emphasis on providing insurance for acute inpatient care comes at the expense of lack of outpatient services. Thus, the increase in insurance coverage has not significantly increased health care access for poor rural Chinese. The cost of care remains

69. Babiarz et al., *supra* note 13, at 1069.
70. *See* note 33, *infra*. Lei & Lin hypothesize that the increased utilization of outpatient care was attributable to the requirement that the township health center provide an annual physical check-up to enrollees. Lei & Lin, *supra* note 28, at 36.
71. Liu & Tang et al., *supra* note 27, at 4.
72. Yip & Hsiao, *supra* note 6, at 220.
73. Hong Wang et al., *supra* note 66.
74. Liu & Tang et al., *supra* note 27.

prohibitively high for many poor rural Chinese.

VI. WILL THE PPACA EXPERIENCE THE SAME SHORTCOMINGS AS THE NCMS?

The United States faces similar health care access challenges for rural populations, as many rural Americans do not have health insurance and cannot otherwise afford access to quality care.[75] As such, a focus of the PPACA is to increase affordable access to health care for the rural poor. Where China has focused on improving individual affordability by increasing the width and depth of insurance coverage, the U.S. has geared its health insurance reform policies toward "social affordability," with an emphasis on driving the cost of delivering care down in order to reign in public spending.[76] In this very important respect, the PPACA fundamentally differs from the NCMS because a critical focus of the law is lowering the cost of providing health care.

One way the PPACA attempts to lower health care costs is through value-based-purchasing. Value-based purchasing intends to change incentives for providers by basing reimbursement on performance rather than volume of patients treated.[77] Reforms aimed at changing financial incentives for providers were absent from the NCMS, as providers continue to be reimbursed on a fee-for-service basis.[78] The PPACA attempts to address this concern through value-based purchasing. This provision may

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75. *See generally* Bolin & Gamm, *supra* note 1.

76. Yuanli Liu, *Increasing the Affordability of Health Care: Comparing Reforms in China and the United States in* Charles W. Freeman III & Xiaoqing Lu Boynton, *Implementing Health Care Reform Policies in China: Challenges and Opportunities*, CNTR. FOR STRATEGIC AND ITL'L. STUDIES, 12 (2011), *available at* http://csis.org/files/publication/111202_Freeman_ImplementingChinaHealthReform_Web.pdf.

77. KEITH J. MUELLER, *The Patient Protection and Affordable Care Act: A summary of Provisions Important to Rural Health Care Delivery* 22 (2010), *available at* http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06_08_10.pdf.

78. Hong Wang et al., *supra* note 66.

have a lesser impact in rural areas, however, because providers that do not have a minimum number of cases are excluded.[79] Thus, it is possible that rural providers treating a small number of patients will continue to be incentivized based on fee-for-service volume rather than treatment outcome. The impact value-based purchasing will have on cost reduction remains to be seen.

Another way in which the PPACA differs from the NCMS is an emphasis on improving rural health care infrastructure and resources. Congress included provisions to expand rural healthcare workforce, facilities, services, and insurance options,[80] as well as providing increased payments through Medicaid and Medicare to incentivize rural practice.[81] These supply-side reforms were largely absent from the NCMS. Indeed, the quality of physicians and health providers in rural China remains a concern.[82]

While one of the PPACA's goals is to attain universal coverage by extending Medicaid to cover thirty million more Americans,[83] China's example demonstrates that insurance coverage does not necessarily lead to better access or utilization of health services by the rural poor. Given the high number of the rural poor dependent on Medicaid,[84] the success or

79. *Id.* Special rules are established for small rural hospitals and Medicare dependent hospitals. *Id.*

80. Scott Lindstrom, Comment, *Health Care Reform and Rural America: The Effect of the Patient Protection and Affordable Care Act and Rural America: The Effect of the Patient Protection and Affordable Care Act on the Rural Economy and Rural* Health, 47 IDAHO L. REV. 639, 647 (2010).

81. Jon M. Bailey, *Health Care Reform, What's In It? Rural Communities and Rural Medical Care*, 9 CNTR. FOR RURAL AFFAIRS 1, 1 (July 2010), a*vailable at* http://files.cfra.org/pdf/Rural-Communities-and-Medical-Care-brief.pdf; *see also* Lindstrom, *supra* note 67, citing 42 U.S.C. §§ 292s, 297b, 295f, 295f-1, 295, 254q (2012).

82. In general, rural Chinese "barefoot doctors" have low levels of education and are unsophisticated. *See generally* Lidan Wang et al., *The Problems and Solutions to the Building of the New-type Rural Cooperative Medical Workforce*, 7 ASIAN SOC. SCI. 9 (2011).

83. Bailey, *supra* note 68.

84. Bolin & Gamm, *supra* note 1 at 6.

failure of the PPACA in the context of rural care may hinge on its proposed expansion. Although the Supreme Court upheld the law in its June 2012 decision, it struck down a key provision when it held that the withholding of Medicaid funds from states not in compliance with the law was unconstitutionally coercive.[85] The impact is that many poor rural Americans may face the same problem that rural Chinese are facing. Namely, in states that opt-out of the Medicaid expansion, the poorest rural Americans may not be able to afford treatment despite the extension of the subsidy; those assumed to be covered by Medicaid when the PPACA was drafted may fall into a new Medicaid "donut hole."[86] One commentator argues:

> Federal subsidies to purchase insurance through the newly created insurance exchanges are not extended to those below the federal poverty level. Those who fall between 100-133% FPL can access subsidies but are still responsible for covering premiums up to 2% of their income – which may prove untenable for this low-income population. Moreover, this population – faced with a "penalty" or a "tax" – may decide that it is cheaper to not purchase insurance. The result? If states opt-out of the Medicaid expansion, most Americans whose incomes fall below 133% of the poverty line are left without an affordable option for obtaining health

85. Nat'l Fed'n Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2594-2600, 2607 (2012). A divided Supreme Court upheld the constitutionality of the individual mandate as a tax but invalidated conditioning of federal Medicaid funds on state acceptance of Medicaid expansion. *Id.* The court held, "nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is penalize States that choose not to participate in that new program by taking away their existing Medicaid funding." *Id.* at 2607.

86. Leah Ralph. *Post Supreme Court Ruling, All Eyes on Medicaid*, BIPARTISAN BEAT BLOG (July 10, 2012), http://bipartisanpolicy.org/blog/2012/07/post-supreme-court-ruling-all-eyes-medicaid.

insurance.[87]

Despite the anticipated expansion of insurance through Medicaid, millions of poor rural Americans still may not be able to afford access to health care. Although in China it may be the case that "high population coverage doesn't automatically mean equal access to and utilization of health services,"[88] rural Americans are hoping that the PPACA does not come to realize the same shortcomings as the NCMS.

VII. CONCLUSION

As China's example indicates, universal insurance coverage does not necessarily lead to affordable access to high quality care for the rural poor. The NCMS has succeeded in extending insurance coverage to nearly all poor rural Chinese. Nevertheless, health care costs remain prohibitively high for many of the rural poor despite universal coverage. This can be attributed to low reimbursement rates, high deductibles and initial out-of-pocket costs, and complicated reimbursement procedures. Notably, the NCMS has failed to address perverse provider incentives that drive up the cost of care. The result is that many of the rural poor still cannot afford health care.

The PPACA, by contrast, attempts to reign in health care spending through value-based purchasing. However, the systemic impact these reforms will have on the rising cost of care is uncertain at best. It is also unclear how value-based purchasing reforms will play out in a rural provider context, as the PPACA excludes providers that do not have a minimum number of cases. The success or failure of the PPACA reforms in the context of the rural poor may depend on whether states choose to opt-

87. *Id.*
88. Liu & Tang et al., *supra* note 27, at 7.

out of the Medicaid expansion. A troubling possibility is that in opt-out states, the rural poor will face the same problem many poor Chinese are facing; despite subsidies and extended insurance coverage, high premiums may make health coverage financially unattainable. Whether the American health reform avoids this pitfall remains to be seen.

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A Comparative Look at the Success of the Chilean Universal Coverage Program with a Focus on Diabetes and Oral Health Treatment and Its Potential Application to the United States Healthcare System

*Marcus Morrow**

I. INTRODUCTION

Chronic diseases, such as diabetes and oral health diseases, are a growing problem worldwide and are responsible for fifty percent of the total worldwide burden of disease in 2005.[1] In order to combat chronic diseases, some countries, like Chile, have implemented universal health care,[2] while others, like the United States have attacked only certain chronic conditions through various health care initiatives.[3] Despite the fact that the United States has the most expensive health system in the world, the U.S. ranks thirty sixth for life expectancy, likely caused by the chronic diseases that plague many Americans.[4] In 2007, the diabetes and oral health burdens in the U.S. amounted for more than $116 billion in estimated annual direct

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1. Ricardo Bitran, et al., *After Chile's Health Reform: Increase in Coverage and Access, Decline in Hospitalization and Death Rates*, 29 HEALTH AFF. 2161 (2010).

2. *See generally id.*

3. *See generally* KAISER FAMILY FOUND., MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS, 1 (August 2012), *available at* http://www.kff.org/medicaid/upload/8340.pdf [hereinafter *Health Homes*]. The various health care initiatives in the U.S. include chronic disease prevention programs that focus on the individual's well being, policy promotion, health equity, research translation and workforce development. NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, THE POWER OF PREVENTION: CHRONIC DISEASE. . .THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY, 11-12 (2009), *available at* http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf [hereinafter *Power of Prevention*].

4. Everette James & Arthur S. Levin, *The Inevitability of Health Reform*, 50 DUQ. L. REV. 235, 237 (2012).

medical expenditures.[5] Driven by an aging population and a struggling economy, government-sponsored health care is expected to increase to more than fifty percent of all health spending in the U.S.[6] To combat the rising costs of health care, the U.S. Congress passed the Patient Protection and Affordable Care Act (PPACA), which, in part, focuses on reducing the cost of chronic condition treatment.[7]

This article seeks to compare Chile's universal care model and its impact on two specific chronic conditions, diabetes and oral health diseases, to the U.S. healthcare system. Within the list of Chile's prioritized conditions, two are of particular interest compared to the U.S.; one, diabetes, is frequently covered under U.S. health policy, while another, oral health diseases, gets far less attention.[8] This article also discusses what the U.S. can learn from Chile's universal care model as the Unite States moves forward to reduce the impact of chronic conditions on its' healthcare beneficiaries.

II. DISTINCT FEATURES OF CHILE'S HEALTH SYSTEM

Chile is one of South America's top economic performers, with an estimated GDP per capita of $16,100 for 2011.[9] In recent years, Chile has experienced a rise in life expectancy and a reduction in the number of

5. *Power of Prevention*, *supra* note 3, at 7.

6. James & Levin, *supra* note 4, at 237.

7. *Health Homes*¸ *supra* note 3, at 1 (explaining that the PPACA established a new state option in the Medicaid program to implement "health homes" for Medicaid beneficiaries with chronic conditions). The concept of health home builds on the patient-centered medical home model and seeks to foster a "whole person" orientation to care for persons with chronic conditions through enhanced integration and coordination or primary, acute, mental and health, and long-term services and supports across the lifespan. *Id.*

8. *Id*.; *see also* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, CHILDREN AND ORAL HEALTH: ASSESSING NEEDS, COVERAGE AND ACCESS 1 (2012) *available at* http://www.kff.org/medicaid/upload/7681-04.pdf [hereinafter *Children and Oral Health*].

9. S.A. Southbridge, *Health in Chile*, NZ TRADE AND ENTERPRISE, 3 (February 2012), *available at* http://www.nzte.govt.nz/explore-export-markets/market-research-by-industry/Services/Documents/Health%20Market%20Profile%20Chile%20Feb%202012.pdf [hereinafter *Exporter Guide Health in Chile*].

citizens afflicted with chronic conditions.[10] The large majority of Chile's health system beneficiaries receive care in public hospitals.[11] These beneficiaries use the *Fondo Nacional de Salud* (FONASA)[12], the government health insurance program that provides coverage for people who cannot afford private insurance, while approximately fourteen percent of the population uses Chile's well-developed private health insurance system known as the *Instituciones de Salud Provisional* (ISAPRES).[13] Chile continues to develop health reforms to ensure that every person afflicted with a chronic disease receives timely and high-quality care.[14]

After decades of bias in accessing health care and problems with organization and investment[15], in 2000, the Chilean government identified four main challenges in their health system: the population's progressive aging, the increasing cost of health services, the inequalities in the access of different socio-economic groups, and a gap in the health conditions of those groups.[16] Between 2000 and 2006, Chilean President Ricardo Lagos

10. Bitran et al., *supra* note 1, at 2162. In 2005, the average life expectancy for Chileans was 78.2 years, and infant mortality rate was 8 per 1,000 live births. *Id.* Chile's health indicators such as life expectancy and infant mortality rate are among the best in the region and are similar to those of highly industrialized countries. *Id.*

11. *Exporter Guide in Chile*, *supra* note 7, at 3.

12. Bitran et al., *supra* note 1, at 2161.

13. *Exporter Guide in Chile*, *supra* note 7, at 3- 4 (explaining that the remaining population is employed by the military and government and is covered under government provided insurance).

14. *Id.* at 11.

15. Eduardo Missoni and & Giorgio Solimano, WORLD HEALTH REPORT, TOWARDS UNIVERSAL HEALTH COVERAGE: THE CHILEAN EXPERIENCE 18 (2010) *available at* http://www.who.int/healthsystems/topics/financing/healthreport/4Chile.pdf [hereinafter *World Health Report*]. (discussing that the Inter-ministerial Committee on Health Sector Reform, representing various Chilean government entities further indentified four objectives for the 2000-2010 decade. They included (a) improving existing health indicators; (b) addressing the new demands derived from the ageing and the changing health profile of the population; (c) closing health gaps and inequities across socio economic groups; and (d) improving the scope, access to, and quality of services according to the expectations of the population. *Id.*

16. *Id.* at 18.

initiated a reform that aimed to address the country's four major challenges to its health system.[17] The reform intended to ensure universal access to care and financial protection against the most prevalent health problems that represented sixty to seventy percent of the Chilean population's disease burden.[18] By 2005, the Chilean Parliament approved a number of health reform laws including the Universal Access Plan with Explicit Guarantees (AUGE Plan).[19] The AUGE Plan includes both coverage and payment for pre-defined health conditions in order to provide better access to care.[20] The AUGE Plan's key elements include universal coverage for all citizens and a medical benefits package consisting of a prioritized list of diagnoses and treatments.[21] The AUGE Plan gradually increased the amount of health conditions prioritized under Chile's universal healthcare plan, and now there are over sixty-six covered conditions.[22] In addition, the AUGE Plan defines a maximum waiting period for receiving services; the set of activities, procedures, and technologies necessary for treating the covered conditions; and the maximum amount that a family can spend per year on health care.[23]

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17. *Id.* at 10.
18. *Id* at 11.
19. *Id.*
20. *Id.* at 11. The AUGE Plan also created the new Health Superintendence which took over the functions of the previous Superintendence of ISAPRES and also was in charge of the FONASA budget regarding the treatment and services of guaranteed list of conditions. *Id* at 16. Thus, the AUGE Plan was the first body in Chile to supervise public and private funds together. *Id.*
21. *Id.*
22. *Id* at 13-14 (stating that to allow for gradual introduction of prioritized health conditions, in 2005 AUGE was applied to twenty-five pathologies, which later increased to fifty-six by 2007, and sixty-six by 2010).
23. THE WORLD BANK GROUP, SOCIAL DEVELOPMENT DEP'T, REALIZING RIGHTS THROUGH SOCIAL GUARANTEES: AN ANALYSIS OF NEW APPROACHES TO SOCIAL POLICY IN LATIN AMERICA AND SOUTH AMERICA, (2008), *summarized in Chile: Regime Explicit Guarantees (Plan AUGE)* §12 *available at* http://siteresources.worldbank.org/EXTSOCIALDEV/Resources/3177394-1168615404141/3328201-1192042053459/Chile.pdf?resourceurlname=Chile.pdf

Both the national and international policy communities have praised the design of Chile's complex process for setting healthcare priorities.[24] The AUGE Plan's purpose was to introduce an element of continuity into the Chilean health system and to introduce prioritized lists of conditions aimed at guaranteeing equal access to care.[25] Within the list of prioritized conditions, diabetes and oral health are especially interesting for sake of comparison to the U.S. model.[26]

III. CHRONIC CONDITIONS: DIABETES

Both Chile and the U.S., through their government sponsored insurance plans, provide nearly-universal coverage for diabetes treatment (including dialysis therapy).[27] Within the prioritized lists of diagnoses and treatments covered under Chile's AUGE Plan, chronic renal insufficiency, diabetic retinopathy, diabetes types one and two, and prevention of renal disease are included.[28] It has been estimated that savings from using the AUGE Plan reaches up to $1,000 per year for diabetic patients,[29] which is nearly full

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[hereinafter *Plan AUGE*] (stating that "[t]hese maximums differ depending on the family's income, thus protecting the principles of equity, inclusion and redistribution").

24. Gabriel Bastias et al., *Health Care Reform in Chile*, 179 CANADIAN MED. ASSOC. J. 1289, 1291 (2008), *available at* http://www.cmaj.ca/content/179/12/1289.full.pdf [hereinafter *CMAJ]*

25. *World Health Report*, *supra* note 15, at 20.

26. *See id.; see also Children and Oral Health*, *supra* note 8.

27. *See* Roberto Pecoits-Filho et al., *Policies and Health Care Financing Issues For Dialysis in Latin America: Extracts From the Roundtable Discussion on the Economics of Dialysis and Chronic Kidney Disease*, 29 PERIT. DIAL. INT. S222, S225 (February 2009), *available at* http://www.pdiconnect.com/content/29/Supplement_2/S222.full.pdf+html [hereinafter *PDI*]. *See also Health Homes*, supra note 3, at 1.

28. *CMAJ*, *supra* note 24, at App'x 1: *see also World Health Report*, *supra* note 12 at 13. There are two major forms of diabetes; type one diabetes is characterized by a lack of insulin productions and type two diabetes results from the body's ineffective use of insulin. INTERNATIONAL DIABETES FEDERATION, http://www.idf.org/types-diabetes (last visited November 3, 2012).

29. Bitran et al., *supra* note 1, at 2164. Savings for type two diabetes was estimated to be $286, while savings for type one diabetes was estimated to be $1,255 for type one diabetes. *Id. See also World Health Report*, *supra* note 15, at 21. 500,000 pesos is

coverage as the average per capita cost of diabetes in 2000 was $703.[30] Also, twenty-eight percent of respondents to a recent survey concerning the AUGE Plan mentioned that at least one member of their household has been diagnosed with one of the guaranteed medical conditions[31] related to diabetes.[32] In 2007, hyperglycemia accounted for 2.3 percent of the total burden of disease in Chile and was considered one of the most important risk-factors to chronic disease prevention.[33] Chile is successfully helping to combat this risk-factor through the AUGE plan.[34] Under the plan, Chile's 350 municipalities are responsible for outpatient services, including stand-alone outpatient centers and general outpatient centers that both provide procedures for hemodialysis (HD) therapy and diagnosis.[35] Additionally, the AUGE Plan mandates coverage for a set of interventions for children and adults aimed at the prevention and early detection of types one and two diabetes.[36]

The AUGE Plan's impact has been significant; during the initial period that AUGE was implemented (2002-2007), there was a forty-eight percent increase in Chileans seeking treatment for type two diabetes.[37] This increase indicated that Chileans who had previously forgone treatment for diabetes were now able to afford it. Under Chile's public insurance system FONASA, type one diabetes cases nearly quadrupled and under the private

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approximately $1,000.

30. Alberto Barecelo et al., *The Cost of Diabetes in Latin American and the Caribbean*, 81 BULLETIN OF THE WORLD HEALTH ORG. 19, 24 (2003), *available at* http://www.who.int/bulletin/Barcelo0103.pdf.

31. *Plan AUGE*, *supra* note 23, at §21 (explaining that the most frequently mentioned medical conditions included both type one and type two diabetes).

32. *Id.*

33. Bitran et al., *supra* note 1, at 2162.

34. *Id.*

35. *Exporter Guide Health in Chile*, *supra* note 9, at 6. Municipalities are local government administrative divisions with defined territories and populations. *Id.*

36. Bitran et al., *supra* note 1, at 2163.

37. *Id.* at 2166.

ISAPRE plans, they nearly doubled.[38] During the same period, there was a seven percent drop in hospitalization from complications due to type one diabetes, especially among patients older than thirty.[39] There was also a thirteen percent increase in hospitalization for type two diabetes, especially among patients older than sixty-five.[40] The increase in hospitalization for type two diabetes was due to patients seeking out care more often because of the increase in access and treatment options.[41]

However, there are some limitations to the coverage of AUGE with regards to end stage renal disease, as the protocol for adult patients is guaranteed access to HD, but not peritoneal dialysis (PD).[42] Even if a patient and doctor agree on peritoneal dialysis, AUGE will not cover it.[43] Due to the priority setting, "non-AUGE" conditions, estimated at fifty-two percent of the total demand at any given time, may suffer delays in care.[44] The Jamie Guzmán Foundation, a private, non-profit foundation in Chile focused on public service, found that the AUGE Plan puts excessive emphasis on advanced or curative care and that fifty percent of its spending

38. *Id.* The large contrasts between the FONASA and ISAPRE plans may partly be the result of lower initial treatment rates in FONASA, where access to care was generally more restricted by waiting lists than ISAPRE plans. *Id.*

39. *Id.* at 2167-68.

40. *Id.*

41. *Id.* (stating that the 13percent increase could be explained because of better access to care or, to some extent, population aging). *Id.* There was also a 48percent drop in case fatality rate for type 1 diabetes, while the hospital death rate for type 2 diabetes in Chile dropped 5 percent. *Id.* This is an impressive finding given that this is an older, higher-risk population. *Id.* This may also be attributable to improved quality of care made possible through the implementation of standard treatment protocols. *Id.*

42. *World Health Report*, *supra* note 15, at 25. There are two main types of dialysis: hemodialysis and peritoneal dialysis. NATIONAL INSTITUTE OF HEALTH, http://www.nlm.nih.gov/medlineplus/dialysis.html (last accessed November 3, 2012). Both types filter blood to ride the body of harmful waste, extra salt and water. *Id*. Hemodialysis does that with a machine, while peritoneal dialysis uses the lining of a patient's abdomen, called the peritoneal membrane. *Id*.

43. *World Health Report*, *supra* note 15, at 25.

44. *Id*.

is focused on three preventable diseases including type two diabetes.[45] Furthermore, Chile's National Health Superintendency found that nearly one-third of all type one diabetes patients waited for treatment longer than the maximum time defined by the AUGE plan.[46]

On the other hand, the AUGE Plan has left space for continuous improvement and mandates regular protocol reviews to add new disorders and incorporate new evidence for treatment of covered conditions.[47] Recently, policymakers started an initiative to increase access and coverage to PD because PD has higher patient satisfaction ratings and lower global costs than HD.[48] As a whole, the AUGE Plan led to a considerable increase in the number of individuals seeking regular treatment for both type one and type two diabetes.[49]

In comparison, to address the nearly twenty-six million Americans with diabetes, the U.S. has specified under the PPACA a list of chronic conditions, including diabetes, that are to be covered by Medicaid.[50] Since 2010, people with diabetes have begun to benefit from the PPACA.[51] The treatment services for diabetes include: comprehensive care management; care coordination and health promotion; comprehensive transitional care

45. *Id.*
46. Bitran et al., *supra* note 1, at 2168.
47. *World Health Report*, *supra* note 15, at 25.
48. *PDI*, *supra* note 27, at S224. The HD and PD groups did not show differences in quality-of-life index, but annuals global costs for HD were $20,810, while PD cost $20,750. *Id.*
49. Bitran et al., *supra* note 1, at 2169. Since the adoption of the reform, there have been sizeable improvements in treatment of chronic conditions and disease detection has improved, thus allowing more timely treatment. *Id.*
50. *Health Homes*, *supra* note 3, at 1.
51. AM. DIABETES ASS'N., HOW HEALTH CARE REFORM IS HELPING PEOPLE WITH DIABETES ASSOC 1, *available at* http://www.diabetes.org/assets/pdfs/advocacy/aca-2nd-anniversary-brief.pdf [hereinafter *ADA Overview*]. Benefits that are currently enjoyed by diabetics under the PPACA include: new coverage options for individuals with pre-existing conditions; no pre-existing condition exclusions for children, free coverage of preventative care, and new program to prevent type 2 diabetes. *Id.*

from inpatient to other settings, including appropriate follow-up; patient and family support; referral to community support services; and use of health information technology.[52] By 2014, people with diabetes will no longer be denied insurance or forced to pay more for coverage simply because they have diabetes.[53] In addition, Medicare participants are now able to receive a free annual wellness visit to identify health risks such as diabetes or diabetes-related complications and to develop an individual prevention plan.[54] This wellness visit is noteworthy because it can help modify a diabetic's risky health behaviors such as lack of physical activity and poor nutrition.[55] Similarly, the National Diabetes Prevention Program (NDPP) was established to expand the reach of community-based programs which have a proven track record of preventing type two diabetes and recently received ten million dollars from the Prevention and Public Health Fund.[56] While the long-term impact of the PPACA in the U.S. is to be

52. *Health Homes*, *supra* note 3, at 1. These changes are significant considering that more than one in ten adult Medicaid enrollees have been diagnosed with diabetes, and diabetes costs in the United States grew greatly between 2002 and 2007 to more than $174 billion. *Id.* at 4*;* NAT'L CONF. OF STATE LEGISLATURES, FED. HEALTH REFORM PROVISIONS RELATED TO DIABETES 1 (2011), *available at* http://www.ncsl.org/portals/1/documents/health/DiabetesinHR511.pdf [hereinafter *Federal Health Reform Related to Diabetes*].

53. *ADA Overview*, *supra* note 51, at 2. Beginning January 1, 2014, the PPACA prohibits insurers in the individual and group markets from imposing preexisting condition exclusions. FOCUS ON HEALTH REFORM: HEALTH INSURANCE MARKET REFORMS: PRE-EXISTING CONDITION EXCLUSIONS 3 (September 2012) *available at* http://www.kff.org/healthreform/upload/8356.pdf. The PPACA's prohibition on pre-existing condition exclusions will enable diabetic patients to access necessary benefits and services, beginning from their first day of coverage. *Id.* The PPACA will also require insurance companies to guarantee issue health plans to any applicant regardless of their health status and impose limitations on how much insured can vary premiums based on an individual's health status. *Id.*

54. AM. DIABETES ASS'N., QUESTIONS AND ANSWERS ABOUT HEALTH REFORM AND DIABETES ASSOC. 2, *available at* http://www.diabetes.org/advocate/our-priorities/health-care/QA-Health-Reform-and-Diabetes.pdf.

55. *Id.* at 3. The Prevention and Public Health fund was established by the PPACA to address wellness and prevent and make some preventive services available for free. *Id.*

56. *Power of Prevention*, *supra* note 3, at 5-6. Physical activity has been shown to control type 2 diabetes while good nutrition can control a diabetic's insulin and blood sugar levels. *Id.*

determined, the universal coverage in Chile has dramatically improved the health of its diabetic citizens.[57]

IV. CHRONIC CONDITIONS: ORAL DISEASES

Oral diseases are some of the most common chronic diseases and constitute a major public health problem because of their high prevalence, impact on an individual's health, and high cost of preventative care and treatment.[58] In most rural localities around the world, populations have little access to dental care and have high rates of risk-factors, such as poor diet and the absence of prevention and educational programs.[59] In order to prevent the spread of oral health diseases such as cavities and gingivitis, educational programs should be established to promote oral health as well as to increase resources to treat patients and decrease the negative impact of oral diseases in the future.[60]

In Chile, the AUGE Plan covers comprehensive oral health of pregnant women and children, integrated adult oral health, and outpatient dental emergencies.[61] Within Chile's public healthcare sector, primary care services are relatively well organized, delivering free dental services at local health centers administered and owned by local municipalities.[62] The Chilean government prioritizes oral health to such a degree that, in 2008, it implemented a national health program that reviews the main barriers and

57. *See generally* Bitran et al, *supra* note 1. The case fatality rate among patients with type one diabetes dropped forty eight percent after the implementation of AUGE while the hospital death rate for type two diabetes dropped five percent – a noteworthy finding given that this is an older, higher risk population. *Id.* at 2167.

58. Cesar Andres Rivera Martinez, *Pre-school Child Oral Health in a Rural Chilean Community*, 5 INT. J. ODONTOSTOMAT. 83, 86 (2011), *available at* http:// www.ijodontostomat.com/2011_v5n1_013.pdf .

59. *Id.*

60. *Id.* at 85.

61. *Exporter Guide Health in Chile*, *supra* note 9, at 27-29.

62. *CMAJ*, *supra* note 24, at 1289.

social determinants that generate inequities in oral health provision and proposes solutions to address those issues.[63] Of the 2,290 public health facilities in Chile, twenty-one are Mobile Dental Clinics, capable of performing outreach work in rural areas and small towns.[64]

Furthermore, in order to promote dental health, the Chilean Health Ministry authorized a variety of health initiatives including the fluoridated milk program, a program that targets primary school children.[65] This program has seen a major decrease in the prevalence of cavities after three years, including a twenty four percent reduction in cavities amongst nine-year-olds[66] through twelve-year-olds.[67] The fluoridated milk program was a primary example of Chile using a public health approach to promote oral health benefits such as cavity prevention and overall dietary well-being.[68] The Ministry of Health also developed "An Integral Clinical Oral Health Guide for six-year-old children," which attempts to manage cavity development through a variety of less invasive techniques.[69] Chile uses non-invasive techniques at a significantly higher rate than the U.S.; Chile's

63. *Social Determinants of Health,* WORLD HEALTH ORG., http://www.who.int/social_determinants/thecommission/countrywork/within/chile/en/index.html.

64. *Exporter Guide Health in Chile*, *supra* note 9, at 5.

65. RODRIGO MARINO ET AL., MALMO UNIV., FLUORIDATED MILK PROGRAMME FOR RURAL PRIMARY SCHOOL CHILDREN IN CHILE (2006), *available at* http://www.mah.se/CAPP/Country-Oral-Health-Profiles/AMRO/Chile/Information-Relevant-to-Oral-Health-and-Care/Special-Projects-of-Interest/Fluoridated-Milk-Programme/.

66. *Id.* (explaining that the program targeted 35,000 primary school children between the ages of six to fourteen, living in twenty five municipalities of Chile). Under the program, each child drinks 200ml of prepared fluoridated milk for 200 days. *Id.* The program was repeated for three years and the results were a cavity reduction decrease twenty four percent for six year olds, and twenty six percent for twelve year olds. *Id.*

67. *Id.*

68. *Id.*

69. *See* Oswaldo Ruiz & Jo E. Frencken, *ART Integration in Oral Health Care Systems in Latin American Countries as Perceived by Directors of Oral Health*, 17 J. OF APPL .ORAL SCI. 106, 107 (2009) (explaining that the program manages cavity development and progression through sealing pits and fissures, using additional cavity control measures and ART restoration of tooth cavities). The restorative component of the ART approach is based on using only hand instruments to eliminate soft, pre-cavity tissue. *Id.*

dental programs use non-invasive techniques 31.6 percent of the time, while the U.S.' dental programs only do so five percent of the time.[70] Chile's greater use of non-invasive cavity management procedures compared to the U.S. illustrates how much more advanced Chile is in providing sufficient oral health care to its citizens, as non-invasive procedures are part of Chile's progressive dental health system.

Unlike Chile, tooth decay remains the most common chronic disease among children ages six through eighteen in the U.S.[71] About one in four non-elderly adults have untreated tooth decay in the U.S., about twenty-six percent of Medicare beneficiaries have no natural teeth due to poor oral health, and for every adult without health insurance, an estimated three lack dental coverage.[72] Furthermore, in 2010, one in five Medicare beneficiaries had not visited a dental provider in the prior five years, and a larger share delayed or did not get dental care due to cost concerns.[73] The PPACA specifically includes pediatric oral health care among the ten "essential health benefits" that all qualified health plans will be required to cover for children beginning in 2014, but adult benefits are not included.[74] Compared to children's oral health, the oral health of low-income adults is less widely recognized by government policies.[75] Hence, millions of adults without dependent children are left uninsured for the treatment of their oral health

70. *Id*. at 110.
71. *Children and Oral Health*, *supra* note 8, at 1.
72. KAISER FAMILY FOUND., ORAL HEALTH IN THE UNITED STATES: KEY FACTS 1 (2012), *available at* http://www.kff.org/uninsured/upload/8324.pdf; KAISER FAMILY FOUND., ORAL HEALTH AND MEDICARE BENEFICIARIES: COVERAGE, OUT OF POCKET SPENDING, AND UNMET NEED 1 (2012), *available at* http://www.kff.org/medicare/upload/8325.pdf [hereinafter *Oral Health Medicare Beneficiaries*].
73. *Oral Health Medicare Beneficiaries*, *supra* note 74, at 3-4.
74. *Children and Oral Health*, *supra* note 8, at 1.
75. *Id*.

needs.[76]

Despite the PPACA's expansion of publicly-funded insurance that now covers dental care for children, the U.S. still faces an important problem because private insurers are not required to provide oral health coverage.[77] Even with stand-alone private dental insurance, many adults will still be uninsured due to the high costs of private insurance.[78] In following the guidance of Chile's universal coverage along with the PPACA and its initial steps, the U.S. should expand its oral health coverage even further by mandating dental coverage for both private and public insurers of adults and children through the essential benefits package.[79]

V. LESSONS THE UNITED STATES CAN LEARN FROM CHILE

Overall, Chile has developed a comprehensive rights-based system that avoids solely judicial protections of health rights.[80] The system integrates those who require the most support into a universal system with the young and healthy, so the poor can access goods and services on equal terms with the rest of the population.[81] The United States can learn from Chile's focus on access and financial protection and can implement these targeted reform strategies when treating chronic conditions.[82] Yet, Chile's model for universal care has flaws that the U.S. can improve on. Unlike Chile, the U.S. should explicitly guarantee continuous care and make service options

76. *Id.*
77. *Id.*
78. *Id.* at 3.
79. *Id* at 6. Included within the PPACA's provisions are increased funding for health centers, public education to promote oral health, grants for school-based sealant programs and workforce training and development programs. *Id.*
80. *World Health Report*¸ *supra* note 15, at 29.
81. *Id.*
82. *Plan AUGE*, *supra* note 23, at Table 2.

well known to the public to increase awareness.[83] This increased awareness will ensure that these service options are fully utilized by the populations that need them. Also, the U.S. should continue to make it a priority to establish explicit quality standards, as done under the PPACA, and create functional systems for quality certification, accreditation and compliance, which is something Chile has yet to do in the implementation of the AUGE Plan.[84] One key impact measure that the U.S. should consider for chronic disease prevention is to reduce the rate of hospitalization from medically uncontrolled cases.[85] A successful "preventative" program minimizes chronic diseases' effects on a patient's health while averting costly hospitalizations.[86]

When comparing the universal health care of Chile with the health care in the U.S., one can see similarities between the programs. For example the coverage of diabetes-related health issues is similar, but one can also see stark differences, such as oral health coverage. The lesson learned from Chile's AUGE Plan model in regards to diabetes is for the U.S. to continue its extensive coverage, as the impact of diabetes will continue to decline as more patients seek treatment.[87] The lessons learned from the AUGE plan with respect to oral health should be even more apparent. Oral health diseases cause pain for millions of Americans each year and are some of the

83. *Id.* (explaining that although AUGE stipulates that treatment services should be provided for the time necessary for the recovery of health, only some services have precisely defined treatment durations). The United States should understand that explicit definition of duration will allow for ease and certainty. *Id.* Furthermore, despite the fact that the general Chilean population knows of the AUGE Plan, there are problems communication service options to the public. *Id.*

84. *Id.*

85. Bitran et al., *supra* note 1, at 2165.

86. *Id.*

87. *Power of Prevention*, *supra* note 3, at 3. Tremendous progress has been made in managing diabetes and its complications. *Id.* Because of public health efforts, higher percentages of people with diabetes are monitoring their blood sugar daily and receiving, through health professionals, annual foot exams, eye exams, and influenza. *Id.*

most under-covered chronic conditions in the Unites States health system.[88] As seen by Chile's success in preventative treatment in oral health care, the U.S. should extend its oral health coverage as well.[89]

Despite the importance of Chile's health reform and its universal care focused AUGE Plan, there has been a striking lack of evaluation.[90] Unlike Chile, the U.S. should maintain an evaluation system that regularly collects data and contrasts its health reform's achievement with the reform's cost.[91] Additionally, close monitoring and analysis of changes in coverage, access, and utilization for chronic conditions will be instrumental in tracking progress towards improved health for everyone in the U.S.[92] Unfortunately, while Chile has accepted the clear notion that health is a human right, the U.S. has yet to accept that viewpoint in the political arena.[93] The U.S. continues to debate on the proper system of health care and is divided on whether further expansion of health care is the best option for the Unites States.[94] Until a consensus is made, the hope for a universal care model in the U.S. will continue to remain only a hope, and not a reality.

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88. *Id.* at 5. More than ninety percent of adults aged twenty to sixty four have experienced tooth decay. *Id.*

89. Oswaldo Ruiz & Jo E. Frencken, *supra* note 71, at 110.

90. Bitran et al., *supra* note 1, at 2168.

91. *Id.*

92. *See Children and Oral Health*, *supra* note 8, at 6.

93. *Plan AUGE*, *supra* note 23, at §24. Minister of Health, Osvaldo Artaza, stated "a health system based merely on purchasing power or targeted and paternalist assistant programs generates inequity, inefficiency and quality discrepancies. On the contrary, a system that is able to offer universal (basic and modern) services in priority areas, defined through cost benefit analysis, can promote greatly the sustainable exercise of the human right to health. . .The guarantee of the right to health similar to other social guarantees, has meaning only in a democratic society. Democracy is increasingly conceived not only as a political but also a social and economic system that allows for simultaneously for growth and equity, for economic development and quality of life. . ." *Id.*

94. Saulny, Susan, *Few Minds are Changed by Arguments in Court*, NY TIMES, Mar. 28, 2012, *available at* http://www.nytimes.com/2012/03/29/us/health-care-debate-ripples-across-us-as-hearings-end.html?_r=0.

VI. CONCLUSION

Chronic diseases plague the wallets and spirits of citizens of the entire world, not just the United States. Furthermore, despite the recent improvement and innovation of Unites States' health reform, other countries have enjoyed even greater success at providing health care for their citizens. Chile's success with its universal healthcare system under the AUGE Plan in treating chronic diseases, such as diabetes and oral health diseases, can be a comparative model for future health reform in the U.S. The AUGE Plan can provide important insight, including what measures to take in providing universal care and which to avoid. Moreover, although Chile and the U.S. might differ politically and economically, if the U.S. seeks to improve the health of its population, it can do so effectively if they learn and adapt from Chile's established universal healthcare model.

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Nixon and the PPACA

*Michael Meyer**

I. INTRODUCTION

The late Senator Edward Kennedy often recalled his failure to make a deal with Richard Nixon on health care as his biggest legislative regret.[1] Nixon came closer than any president until Barack Obama to enacting universal health care.[2] But, Nixon's involvement in the infamous Watergate Scandal often overshadows his health reform efforts. In Section II, this article details Nixon's proposals, and Section III discusses why they failed. Section IV explores how his proposals impacted modern health reform efforts. Finally, Section V discusses why the Patient Protection and Affordable Care Act (PPACA) should have adopted more of Nixon's plan.

II. NIXON'S EFFORTS IN THE 1970S

Health care reform was a personal issue for Nixon.[3] He grew up poor and lost two brothers to tuberculosis.[4] As a California congressman, Nixon first proposed national health insurance in 1947[5] and continued his efforts after he became President in 1968.

Nixon offered his first proposal, as president, for national health

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1. Steven Pearlstein, *Kennedy Saw Health-Care Reform Fail in the '70s; Today's Lawmakers Don't Have To*, WASH POST, Aug. 28, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/08/27/AR2009082703919.html.

2. STUART ALTMAN & DAVID SHACTMAN, POWER, POLITICS, AND UNIVERSAL HEALTH CARE: THE INSIDE STORY OF A CENTURY-LONG BATTLE 33 (Prometheus Books 2011).

3. Kevin G. Hall, *Democrats' Health Plans Echo Nixon's Failed GOP Proposal*, MCCLATCHY Nov. 28, 2007, http://www.mcclatchydc.com/2007/11/28/22163/democrats-health-plans-echo-nixons.html.

4. *Id.*

5. *Id.*

insurance on February 18, 1971.[6] Although it never came to a committee vote in Congress, his proposed National Health Insurance Partners program (NHIP) would provide the groundwork for nearly every comprehensive universal health plan in the future, including his 1974 plan.[7] Noting America's soaring medical bills, Nixon explained that he built his strategy on four basic principles: assuring equal access, balancing supply and demand, organizing for efficiency, and building on strengths.[8] He proposed a National Health Insurance Standards Act, requiring employers to provide basic health insurance coverage for their employees.[9] He also proposed a Family Health Insurance Plan that would provide subsidized insurance to poor families, largely replacing Medicaid.[10] Medicaid would continue, however, for the aged poor, blind, and disabled.[11] Moreover, Nixon's plan required each State to establish insurance pools that would offer insurance to those who did not qualify for either program.[12] Nixon also noted the benefits of Health Maintenance Organizations (HMOs): providing more doctors and facilities in inner city and rural areas, producing more health professionals, researching issues concerning medical malpractice suits and insurance, and encouraging preventative care.[13]

The NHIP ultimately fell victim to what is known in health policy circles

6. President Richard Nixon, Special Message to the Congress Proposing a National Health Strategy (Feb. 18, 1971) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=3311).

7. ALTMAN & SHACTMAN, *supra* note 2, at 42.

8. Nixon, *supra* note 6.

9. Nixon noted that the Federal Government would pay nothing for this program, as the cost would be shared by employers and employees; the employee contribution would have a ceiling of thirty-five percent during the first two and one half years and twenty-five percent after. *Id.*

10. Single people and childless couples did not qualify. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

as "Altman's Law."[14] Aside from Nixon's proposal, Ted Kennedy introduced his "Health Security Plan,"[15] the AMA[16] proposed Medicredit,[17] Senator Russell Long and the insurance companies joined forces to formulate their own plan,[18] and by July of 1971, twenty-two health reform bills had been filed.[19] Everyone supported health reform, but only the reform that they put forth; consequently, none of the twenty-two health reform bills ever reported out of committee.[20] Nixon's failed proposal forced him to draft a new program.[21]

On February 6, 1974, Nixon introduced the Comprehensive Health Insurance Plan (CHIP).[22] In a message to Congress, Nixon noted that health reform was even more urgent than when he first proposed it in 1971.[23] He organized his plan around seven principles[24] and explained that

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14. "Nearly every major interest group favors universal coverage and health system reform, but, if the plan deviates from their preferred approach, they would rather retain the status quo." ALTMAN & SHACTMAN, *supra* note 2, at 44.

15. *Id.* at 43-44.

16. The American Medical Association (AMA) is the largest organization representing American physicians. *Id.* at 381-82.

17. *Id.* at 44.

18. *Id.*

19. *Id.*

20. *Id.*

21. Nixon sent another document to Congress on March 2, 1972 in an unsuccessful attempt to persuade Congress to pass the National Health Insurance Partnership Act. President Richard Nixon, Special Message to the Congress on Health Care (March 2, 1972) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=3757).

22. President Richard Nixon, Special Message to the Congress Proposing a Comprehensive Health Insurance Plan (Feb. 6, 1974) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=4337).

23. *Id.*

24. "First it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits; second, it will cost no American more than he can afford to pay; third it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system; fourth, it uses public funds only where needed and requires no new Federal taxes; fifth, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the Federal Government; sixth, it encourages more effective use of our health care resources; and finally, it is organized so that all parties would have a direct stake in making the system work – consumer, provider, insurer, State governments and Federal Government." *Id.*

it would offer every American the same protection through one of three programs: Employee Health Insurance, Assisted Health Insurance, or an improved Medicare Plan.[25] All three programs included identical benefits for all Americans and would not exclude anyone based on the nature of his or her illness.[26] Like the 1971 proposal, the CHIP required that all employers offer their employees health insurance; however, this time it made temporary Federal subsidies available for employers who faced significant cost increases.[27] Nixon once again introduced a government subsidized coverage program, Assisted Health Insurance, designed to replace Medicaid for most services.[28] This program, however, would cover *everyone* not offered coverage under Employee Health Insurance or Medicare, meaning childless individuals would be eligible as well.[29] Additionally, Nixon proposed to improve Medicare by covering outpatient drugs and limiting out-of-pocket costs.[30] Nixon also proposed creating Professional Standards Review Organizations tasked with reviewing health services provided under CHIP,[31] as well as state oversight over insurers and providers.[32] This comprehensive plan improved upon the 1971 proposal's

25. *Id.*

26. *Id.*

27. Employees would pay thirty-five percent of the premium for the first three years and twenty-five percent thereafter, similar to the requirements in the 1971 proposal. *Id.* Individuals would pay the first $150 in annual medical expenses, and a separate fifty-dollar deductible provision would apply for out-patient drugs. There would be a maximum of three medical deductibles per family. *Id.* After reaching the deductible limit, the individual would pay twenty-five percent of additional bills, but there was an annual catastrophic maximum expense of $1,500 per family. *Id.*

28. *Id.*

29. *Id.*

30. Individuals enrolled in Medicare would pay the first $100 for care received and the first $50 toward outpatient drugs. *Id.* Individuals would then pay twenty percent of any bills above the deductible limit, but capped out-of-pocket costs at $750. *Id.*

31. These organizations would be operated by private physicians and would be charged with "maintaining high standards of care and reducing needless hospitalization." *Id.*

32. In regards to insurers, states "would approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit, and take other appropriate measures." *Id.*

deficiencies and the country seemed to be on the verge of major health reform.

III. WHY THE CHIP FAILED

In February 1974, Senators Bob Packwood and Wilbur Mills, the influential chairman of the Ways and Means Committee, agreed to cosponsor Nixon's bill.[33] Nixon's rival, Ted Kennedy, however, began secretly meeting with Mills in hopes of forming a new health reform plan,[34] and by April 1974, Kennedy and Mills announced their own plan.[35] Meanwhile, Russell Long, the powerful chairman of the Senate Finance Committee, and Senator Abraham Ribicoff joined together with their own health reform bill.[36] Suddenly Nixon found himself in a situation similar to 1971: competing health reform plans threatened to cancel each other out.

In the late spring of 1974, Nixon, Kennedy, and Mills agreed to meet in order to craft a compromise,[37] but their efforts ultimately failed.[38] Kennedy was unwilling to support an employer mandate where employers purchased coverage from private insurance companies, something Nixon insisted on, and the potential deal fell through.[39] Kennedy later cited the failure to reach a deal as his biggest legislative regret.[40]

In the months following the failed compromise, health reform efforts

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Meanwhile, for providers, the state "would assure fair reimbursement for physician services, drugs, and institutional services, including a prospective reimbursement system for hospitals." *Id.*

33. ALTMAN & SHACTMAN, *supra* note 2, at 55.
34. *Id.*
35. *Id.*
36. *Id.* at 56-57.
37. *Id.* at 57.
38. *Id.* at 58.
39. *Id.*
40. Pearlstein, *supra* note 1.

made little progress.[41] The Watergate Scandal grew, and on August 8, 1974, Nixon became the first President in American history to resign.[42] Although Nixon's successor, Gerald Ford, addressed Congress days later and stated he would seek bipartisan effort to pass national health coverage, he soon turned his focus to other national issues.[43] Ford's distracted focus, coupled with the competing health reform bills, meant Nixon's plan for national health coverage never came to fruition.

IV. INFLUENCE ON THE PPACA

While Nixon failed to successfully implement his healthcare policies in the 1970's, his proposed plans laid the foundation for Obama's comprehensive health reform, the PPACA, signed into law on March 23, 2010.[44] Obama made health reform a core part of his election campaign in 2008,[45] and upon winning the election, health reform became a primary agenda item for his administration.[46]

The PPACA resembles the CHIP in many ways. First and foremost, it attempts to significantly expand health coverage.[47] Similar to Nixon's employer-mandated coverage, the PPACA requires employers with fifty or more full-time employees to offer their employees coverage, provided that

41. ALTMAN & SHACTMAN, *supra* note 2, at 58.

42. Carroll Kilpatrick, *Nixons Resigns*, WASH. POST, Aug. 9, 1974, http://www.washingtonpost.com/wp-srv/national/longterm/watergate/articles/080974-3.htm.

43. Hall, *supra* note 3.

44. KAISER FAM. FOUND., SUMMARY OF NEW HEALTH REFORM LAW 1 (2011), http://www.kff.org/healthreform/upload/8061.pdf.

45. After entering the 2008 presidential race, Obama stated, "I am absolutely determined that by the end of the first term of the next president, we should have universal health care in this country." Nedra Pickler, *Obama Calls for Universal Health Care*, USA TODAY, Jan. 1, 2007, http://www.usatoday.com/news/washington/2007-01-25-obama-health_x.htm.

46. Peter Nicholas et al., *Healthcare Reform Tops Agenda for Obama's Prime-Time News Conference*, L.A. TIMES, July 23, 2009, http://articles.latimes.com/2009/jul/23/nation/na-obama-healthcare23

47. KAISER FAM. FOUND., *supra* note 44.

at least one full-time employee receives a premium tax credit.[48] Employers with more than two hundred employees must automatically enroll their employees into health insurance plans offered by the employer,[49] while employers with up to fifty full-time employees are exempt from any penalties for failure to offer their employees coverage.[50] Much like Nixon's plan to offer temporary subsidies to employers who would have faced significant cost increases, the PPACA offers a tax credit to small businesses that do purchase health insurance for their employees.[51] Although the PPACA does not require an employer-mandate, it does include an individual mandate.[52]

The PPACA expands Medicaid, analogous to Nixon's plan regarding Assisted Health Insurance's goal of subsidizing those who could not afford coverage.[53] Similar to Nixon's proposal to enact a program dedicated to researching malpractice suits and insurance, the PPACA calls for awarding five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.[54] The PPACA even touches on workforce training and development,[55] which Nixon discussed during his

48. The premium tax credits are available to individuals and families with incomes between 100-400% of the Federal Poverty Level. *Id.* at 2. Those tax credits are available to purchase insurance through Health Insurance Exchanges. *Id.* Those employers who fit into this category but do not offer coverage to their employees will be assessed a fee of $2,000 per full time employee, excluding the first 30 employees from the assessment. *Id.* at 1.

49. Employees may opt out of coverage. *Id.* at 1.

50. *Id.*

51. This tax credit is available for employers with no more than twenty-five employees and average annual wages of less than $50,000. *Id.* at 3.

52. Requires U.S. citizens to have qualifying health coverage; failure to comply must pay a tax penalty each year. *Id.* at 1.

53. PPACA seeks to expand Medicaid to all non-Medicare individuals under the age of sixty-five with incomes up to 133% of the Federal Poverty Level based on modified adjusted gross income. *Id.*

54. *Id.* at 9.

55. PPACA will establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy, work to increase the number of Graduate Medical Education training positions, increase workforce supply and support training of health

proposals in the 1970's.

V. HOW THE PPACA COULD HAVE DONE MORE

Passing the PPACA, the largest health reform plan and one of the biggest legislative achievements in recent history, was a remarkable feat. However, Nixon proposed the core ideas from the PPACA nearly forty years prior to its passage. Some argue that Nixon's CHIP was stronger than the PPACA.[56] Perhaps Obama would have been wise to incorporate more of the CHIP into the PPACA.

Despite the PPACA's requirements for certain employers to provide their employees health insurance,[57] it falls far short of the employer mandate that Nixon included in the CHIP. While the PPACA does mandate that employers with over two hundred employees provide insurance, employers that have between fifty-one and one hundred ninety-nine employees may opt not to provide coverage, and instead pay a fee.[58] Some argue that employers may decide that it is more cost-efficient to not insure their employees and just pay the fee,[59] leaving their employees on their own to find coverage. Meanwhile, employers with fifty or less employees face no penalty if they fail to provide their employees with coverage.[60] This is a far cry from employer-mandated health coverage.

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professionals through scholarships and loans, address the projected shortage of nurses and retention of nurses, and support the development of training programs that focus on primary care models. *Id.* at 12.

56. "Nixon's proposal for health care reform looks a lot like Democratic proposals today. In fact, in some ways it was stronger." Paul Krugman, *Missing Richard Nixon*, N.Y. TIMES, Aug. 31, 2009, http://www.nytimes.com/2009/08/31/opinion/31krugman.html?_r=0.

57. KAISER FAM. FOUND., *supra* note 44.

58. *Id.*

59. Carolyn McClanahan, *Will Employers Dump Health Insurance Coverage?*, FORBES, May 30, 2012, http://www.forbes.com/sites/carolynmcclanahan/2012/05/30/will-employers-dump-health-insurance-coverage/.

60. KAISER FAM. FOUND., *supra* note 44.

Instead, the PPACA contains an *individual* mandate.[61] Those individuals who forego health insurance (and are not eligible for Medicaid or Medicare) will have to pay a tax each year.[62] The government will give a premium credit to those who cannot afford health insurance, but still do not qualify for Medicaid, to be used to purchase insurance through the Health Care Exchanges.[63] The Health Care Exchanges will be state-based, administered by a governmental agency or non-profit organization, and provide a marketplace for individuals to purchase insurance.[64] Instead of providing tax credits to individuals and setting up fifty separate, state-run insurance exchanges,[65] Obama and Congress should have followed Nixon's advice and created an employer-based mandate.

The majority of Americans already receive their health coverage from employers.[66] Employer-mandated coverage would just build onto an existing system, and in turn go a long way towards the goal of insuring every American.[67] Many oppose employer-mandated coverage, evidenced in part by the fact that it has been proposed and subsequently rejected multiple times.[68] Admittedly, it is expensive for small businesses to insure their employees;[69] consequently, small businesses, the Chamber of Commerce, and conservative and libertarian groups have opposed previous attempts to enact an employer mandate.[70]

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61. *Id.*
62. *Id.*
63. *Id.* at 2.
64. *Id.* at 4.
65. *Id.*
66. Mark Merlis, *Health Policy Brief: Employer Mandate*, HEALTH AFFAIRS 1, Jan. 15, 2010, http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_15.pdf.
67. *Id.* at 5.
68. ALTMAN & SHACTMAN, *supra* note 2, at 247.
69. HEALTHCARE.GOV, SMALL BUSINESSES AND THE AFFORDABLE CARE ACT, http://www.healthcarwww.e.gov/news/factsheets/2011/08/small-business.html.
70. ALTMAN & SHACTMAN, *supra* note 2, at 247.

Nixon offered a potential solution to the high costs that small businesses would incur if the government enforced an employer-mandate: temporary Federal subsidies.[71] The PPACA has a similar approach, as it offers small businesses tax credits if they choose to insure their employees.[72] If the PPACA implemented an employer-mandate, then it follows that significantly more small businesses would need some sort of assistance to comply. But, with an employer-mandate, significantly more individuals would no longer need a tax credit to use in the Health Insurance Exchanges because their employer would provide their insurance. Thus, the federal government could use the money originally intended as tax credits for individuals as tax credits for the small businesses now insuring those individuals.

Another way to offset the high costs that businesses incur from insuring their employees is to look to employee contributions. In 2010, the average insured employee contributed nineteen percent of their premium coverage.[73] Nixon's CHIP, on the other hand, required employees to contribute thirty-five percent of their premium for their first three years and twenty-five percent after that.[74] While employees would most likely be reluctant to contribute as much as thirty-five percent of their premium coverage, perhaps a middle ground between the CHIP's proposal and the 2010 average would have lessened the burden on employers if the PPACA had enforced an employer-mandate.

In addition to adopting the CHIP's employer-mandated health coverage,

71. Nixon, *supra* note 22.

72. Qualifying employers must have no more than twenty-five employees and average annual wages of less than $50,000. KAISER FAM. FOUND., *supra* note 44, at 3.

73. Gary Claxton et al., EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 70 (2010), http://ehbs.kff.org/pdf/2010/8085.pdf.

74. Nixon, *supra* note 22.

the PPACA should have also embraced the CHIP's strict oversight of insurance companies. The State role in the PPACA consists mainly of setting up the Health Care Exchanges, overseeing Medicaid expansion, and establishing a program to serve as an advocate for people with private coverage in the individual and small group markets.[75] The CHIP went further, requiring states to approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit, and take other appropriate measures.[76] Finally, the CHIP proposed that states would assure fair reimbursement for physician services, drugs, and institutional services.[77] Such strict oversight would theoretically help control costs by preventing insurance companies from manipulating the marketplace. The CHIP provided the foundation for much of the PPACA, but the PPACA could have expanded coverage even further, while effectively controlling costs, by incorporating more of Nixon's proposals.

VI. CONCLUSION

Nixon provided many of the ideas that laid the groundwork for modern health care reform.[78] Proposals such as employer-mandated health coverage, expansion of government-subsidized coverage, and a comprehensive benefit package, just to name a few, paved the way for Obama to sign the PPACA into law nearly forty years later. While PPACA marked a monumental step in health care reform, it could have done more by adhering more closely to Nixon's proposals from the 1970s. A full-fledged employer mandate would build upon a system that already covers the majority of Americans, guaranteeing coverage for millions of citizens.

75. KAISER FAM. FOUND., *supra* note 44, at 7.
76. Nixon, *supra* note 22.
77. *Id.*
78. ALTMAN & SHACTMAN, *supra* note 2, at 35.

Furthermore, adopting Nixon's strict regulations would help to keep insurance companies in check, helping to keep costs down for all insured individuals. Perhaps future health care reform efforts can continue to learn from Ted Kennedy's mistake.[79]

79. Pearlstein, *supra* note 1.

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Why States Will Likely "Opt Into" the Medicaid Expansion

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) depends heavily on Medicaid to reach the goal of near-universal health care. States' decisions as to whether or not to expand Medicaid will be an important step toward reaching universal health care nationwide. There are 11.5 million uninsured people in the United States with incomes below the poverty line that would be newly eligible for Medicaid under the expansion that would be at risk for remaining uninsured if their states do not expand Medicare.[1] Although Medicaid expansion is not the only step toward reaching universal coverage, it is a significant and vital step in the process.

On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the United States Supreme Court held that the expansion of Medicaid under the PPACA exceeded Congress's power under the Spending Clause.[2] Specifically, the Court found the statutory provision allowing the Secretary of Health and Human Services (HHS) to penalize states that choose not to participate in the PPACA's expansion of Medicaid by withholding all further federal funding for Medicaid to be unconstitutionally coercive. The Court's decision made the Medicaid

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1. Genevieve M. Kenney et al., *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not be Eligible for Medicaid?*, THE URBAN INST., 1 (2012), *available at* http:// www. urban.org/UploadedPDF/412605-Supreme-Court-Decision-on-the-Affordable-Care-Act.pdf.

2. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 U.S. 2566, 2607 (2012).

expansion now optional for states. After the decision, some state officials vowed to not participate in the Medicaid expansion when it goes into effect in 2014.[3] However, the Medicaid expansion will provide sources of savings for state governments, and "opting out" of the Medicaid expansion will likely have a negative financial consequence on states. Therefore, states may ultimately decide to opt into the Medicaid expansion.

Section II of this article will address the decision states must make regarding whether to expand Medicaid following the Supreme Court decision. Section III will examine the states' strongest arguments against the expansion. Finally, Section V of this article will examine reasons for which states are likely to accept the expansion: the financial benefits are ultimately too attractive and certainly outweigh many financial consequences.

II. U.S. SUPREME COURT'S EXPANSION OF MEDICAID WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Medicaid is a joint federal–state entitlement program funded both by the federal and state governments, but is administered by the states. Since the program began, the federal government and states share the financial responsibility for providing care to beneficiaries through a matching rate system.[4] In 2009, the program accounted for twenty-one percent of state spending nationwide, with the federal government paying roughly sixty percent of the bill.[5] Excluding federal dollars, Medicaid consumes twelve

3. *See generally* THE ADVISORY BD. CO., WHERE EACH STATE STANDS ON ACA'S MEDICAID EXPANSION A ROUNDUP OF WHAT STATE'S LEADERSHIP HAS SAID ABOUT THEIR MEDICAID PLANS, http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion (last visited December 22, 2012).

4. Martha Heberlein et al., *Financing New Medicaid Coverage Under Health Reform:The Role of the Federal Government and States*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1, 1 (2010), *available at* http://www.kff.org/healthreform/upload/8072.pdf.

5. Benjamin D. Sommers, *Why States Are So Miffed About Medicaid- Economics*,

percent of state-generated revenues – an amount that is typically second to a state's cost of education.[6]

Under the PPACA, participating states are required to extend Medicaid eligibility by January 1, 2014.[7] Eligibility would be extended to nearly all individuals under age sixty-five with incomes up to and including 133% of the federal poverty level (FPL) (or 138% after applying a standard five percent "income disregard").[8] For those newly eligible, the federal government will pay 100% of the costs from 2014 to 2016.[9] The federal contribution will then phase down to ninety percent by 2020, where it will remain.[10]

In *Sebelius*, the Court held that the individual mandate, one of the most controversial aspects of the law, was valid under Congress' taxing power.[11] Additionally, the Court found that the PPACA cannot force states to expand Medicaid coverage to uninsured citizens by withholding current federal Medicaid funding.[12] Although the federal government may offer generous financial incentives to the states for the expansion, including full federal funding for the first three years, the Court found that the real incentive for states to participate in the expansion was the threat that a noncompliant state would lose all federal funding for Medicaid.[13] The Court found the threat to withhold current federal Medicaid funding to be coercive and

Politics, and the "Woodwork Effect," 365 NEW ENG. J. MED. 100 (2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1104948.

6. *Id.*

7. Randall R. Bovbjerg et al., *State Budgets Under Fed. Health Reform: The Extent and Causes of Variations in Estimated Impacts*, KAISER COMM'N ON MEDICAID AND THE UNINSURED ii (2011), *available at* http://www.kff.org/healthreform/upload/8149_ES.pdf.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Sebelius*, 132 U.S. at 2608.

12. *Id.* at 2607.

13. *Id.*

unconstitutional. As a result of the decision, there is no obligation for states to expand Medicaid coverage under the PPACA.[14] Instead, states may decide to "opt out" and refuse the additional federal funds for the expansion, and they may do so without losing any current Medicaid funding.

Additionally, citizens without access to other coverage and with incomes between 133 and 400% of the FPL can qualify for new federal subsidies to buy private coverage through an Exchange.[15] Exchanges, in addition to Medicaid expansion, are another major step toward achieving universal health coverage. States are required to set up a state-based Exchange, but if they do not, the federal government will operate an Exchange for their citizens.[16] States can elect to build a fully state-based exchange, enter into a state-federal partnership exchange, or default into a federally-facilitated exchange.[17]

III. STATES' APPREHENSION TO EXPANDING MEDICAID

Immediately after the Supreme Court's ruling in *Sebelius*, some Republican state officials said they were inclined to reject the Medicaid expansion.[18] If a state decides not to implement the expansion, some of the people who would have received Medicaid could instead receive tax credits

14. Joseph Antos, *The Medicaid Expansion Is Not Such a Good Deal for States or the Poor*, 38 J. OF HEALTH POL., POL'Y & L. 179, 179 (2012), *available at* http://jhppl.dukejournals.org/content/early/2012/10/09/03616878-1898848.full.pdf.

15. *Id.*

16. *Id.*

17. *Establishing Health Insurance Exchanges: An Overview of State Efforts*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1 (2012), *available at* http://www.kff.org/healthreform/upload/8213-2.pdf.

18. Charles Ornstein, *Mystery After the Health Care Ruling: Which States Will Refuse Medicaid Expansion?* PROPUBLICA (June 28, 2012), http://www.propublica.org/article/mystery-after-the-health-care-ruling-which-states-will-refuse-medicaid-expa.

and other subsidies from the federal government.[19]

A. Budget Concerns

Some state officials have stated budget concerns as the top reason for hesitating to expand Medicaid. Many state officials are already struggling to pay for the entitlement program, which typically is the largest or second largest state expense.[20] Further, the Congressional Budget Office projects that states would pay approximately seventy-three billion, or seven percent of the cost of the Medicaid expansion between 2014 and 2022, whereas the federal government would pay $931 billion, or ninety-three percent.[21] These states argue that although their future share of the cost may sound small in comparison to the federal government's cost, it will still be a significant expenditure. Although states would pay for a small percentage of the expansion, this amount still represents billions in new spending that could require cutbacks of other more popular programs, such as education or transportation, or else raise taxes.[22] Furthermore, many state officials worry that a future, deficit-focused Congress will scale back the federal share and shift more costs of the program to the states as it seeks ways to reduce the federal budget deficit.[23]

Additionally, states are concerned with what may happen during an economic downturn, as Medicaid is designed to be "counter-cyclical."[24] States face increasing enrollment and Medicaid expense at a time when they

19. Kenney et al., *supra* note 1.

20. Phil Galewitz, *States Balk at Expanding Medicaid*, KAISER HEALTH NEWS (July 2, 2012), www.kaiserhealthnews.org/stories/2012/july/02/state-costs-medicaid-expansion.aspx.

21. *Id.*

22. *Id.*

23. Robert Pear, *Uncertainty Over States and Medicaid Expansion*, N.Y. TIMES, June 28, 2012, *available at* http://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html?_r=0.

24. Sommers, *supra* note 5.

have decreasing revenues.[25] This occurs because when the economy is poor, more people cannot afford insurance and have incomes low enough to make them eligible for benefits.[26] Whenever there are many newly unemployed individuals because of economic downturns, the ranks of those newly eligible for Medicaid surge as well.[27] Thus, a recession doubles the havoc on states: reduced tax revenue and increased Medicaid spending.[28] Therefore, states confront fundamental challenges to their budgetary stability.

B. The "Woodwork Effect"

Many state leaders have said they worry about the "woodwork effect" from the Medicaid expansion.[29] The woodwork effect is used to describe a possible phenomenon that will occur with people who are already eligible for Medicaid under current law but are not enrolled. State officials are worried that when the Medicaid expansion goes into effect in 2014, the law will bring out of the woodwork millions of people who are already eligible for Medicaid but are not already enrolled.[30] Whereas federal funds cover 100% of costs for newly eligible individuals starting in 2014, states will continue to receive the current, traditional federal contribution rate for any additional enrollment of people who were already eligible.[31] Currently, the federal government covers between fifty to seventy-six percent of the cost

25. *Id.*
26. *Id.*
27. *See generally* Shefali S. Kulkarni, *Puzzling Out How to Help States With Hard-Hit Medicaid Budgets*, KAISER HEALTH NEWS BLOG (November 8, 2011, 4:46 PM), http://capsules.kaiserhealthnews.org/index.php/2011/11/puzzling-out-how-to-help-states-with-hard-hit-medicaid-budgets.
28. Sommers, *supra* note 5.
29. *Will Medicaid Bring The Uninsured Out Of The Woodwork?*, NAT'L PUB. RADIO (July 11, 2012) (*available at* http://m.npr.org/news/U.S./156568678).
30. *Id.*
31. Sommers, *supra* note 5.

of care, with each state's "matching rate" (or "federal medical assistance percentage" (FMAP)) depending on the state's per capita income.[32] Therefore, these "woodwork" beneficiaries will not be federally funded as newly eligible beneficiaries, but rather as current Medicaid enrollees.

According to Benjamin D. Sommers, M.D. with the New England Journal of Medicine, "millions of low-income Americans are currently eligible for Medicaid but do not participate because of enrollment barriers, poor retention, or lack of information."[33] Sommers further explains, "states anticipate that many such uninsured individuals will come out of the woodwork and sign up for Medicaid under the PPACA, thanks to heavy media coverage, streamlined enrollment procedures required by the law, and the individual mandate to obtain insurance."[34] Additionally, states fear that when some people investigate whether they can receive health insurance through one of the Exchanges, they will discover that they qualify for Medicaid, further increasing enrollees.[35] These individuals may then sign up for Medicaid.[36]

C. Large Administrative Costs

Although typically lower than the cost of covering newly eligible individuals, a number of states argue that the administrative costs for new Medicaid enrollment will be the second largest cost that they face.[37] Some state officials have stated that although the federal government will fully fund the expansion for the first three years, in addition to eventually being

32. Heberlein et al., *supra* note 4.
33. Sommers, *supra* note 5.
34. *Id.*
35. *Will Medicaid Bring The Uninsured Out Of The Woodwork?*, NAT'L PUB. RADIO (July 11, 2012) (*available at* http://m.npr.org/news/U.S./156568678).
36. *Id.*
37. Bovbjerg et al., *supra* note 7, at vi.

responsible for ten percent of the cost of services, states will also have to cover one-half of all additional administrative costs.[38] Administrative costs include conducting eligibility determinations and enrolling beneficiaries, administering fair hearings to resolve disputes regarding eligibility or coverage, credentialing individual practitioners and surveying and certifying institutional providers, and detecting and prosecuting fraud and abuse.[39] Administration is often projected as a flat five to eight percent of all new spending on benefits or managed care organization premiums.[40] Additionally, some states fear the fiscal strain that would result from revamping administrative procedures necessary in order to accommodate the enrollment of millions of new beneficiaries.[41]

IV. REASONS STATES WILL LIKELY DECIDE TO EXPAND MEDICAID

A. Long-term Savings of Health Care Costs

States will see long-term healthcare cost savings as a result of the Medicaid expansion. In particular, expanding Medicaid and providing coverage to young uninsured individuals will decrease the amount states spend on lifetime health care costs. The newly eligible individuals include 7.8 million adults under the age of thirty-five.[42] Roughly twenty-six percent of uninsured individuals who would be eligible for coverage are between the ages of nineteen and twenty-four, another twenty-six percent are

38. Antos, *supra* note 15, at 180.

39. Andy Schneider et al., Chapter IV: Medicaid Administration, KAISER COMM'N ON MEDICAID AND THE UNINSURED 129, *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14262.

40. Bovbjerg et al., *supra* note 7, at vi.

41. Sommers, *supra* note 5.

42. Genevieve M. Kenney et al., *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? Timely Analysis of Immediate Health Policy Issues*, URBAN INST. 1, 2 (2012), *available at* http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

between the ages of twenty-five and thirty-four, and thirteen percent are between the ages of fifty-five and sixty-four.[43] Studies have shown uninsured individuals are more likely to use high-priced emergency care services or become hospitalized for reasons that could have been avoided with preventive care.[44] A significant consequence for those uninsured is worse overall health, as about twenty percent of adults who were uninsured for at least one year reported they were in fair or poor health, compared to about eleven percent with continuous health coverage.[45] Furthermore, since access to health care is essential for preventive care measures and early diagnoses, coverage for younger uninsured individuals may offset high health costs in the future.

Additionally, approximately two million uninsured adults between the ages of fifty-five and sixty-four would gain Medicaid coverage under the PPACA.[46] Research shows increased coverage for this age group could reduce future health care costs because lack of coverage before reaching Medicare age is associated with greater utilization and higher expenditures under Medicare.[47] Thus, although Medicare is entirely funded by the federal government, some of the high costs of Medicare would be offset when those individuals would receive health care coverage under Medicaid.

A study conducted by the Robert Wood Johnson Foundation used a Health Insurance Policy Stimulation Model (HIPSM) to produce a consistent set of estimates for federal and state spending and savings. The model found that while the federal government would spend $704 billion to

43. *Id.*
44. Nan L. Maxwell, *Health Care Coverage in the United States*, UPJOHN INST. FOR EMP'T RESEARCH 1, 3 (2012), *available at* http://research.upjohn.org/up_bookchapters/816.
45. *Id.* at 2.
46. Kenney et al., *supra* note 44, at 5.
47. *Id.*

$743 billion more under the PPACA, states would spend ninety-two billion dollars to $129 billion less with the expansion than without the expansion over the same time period, between 2014 and 2019.[48] The study found while state spending on additional enrollees will rise by eighty billion dollars, the costs would be offset by sixty billion dollars in new federal spending on existing enrollees under the PPACA.[49]

B. Reduction of Mental Health Costs

Moreover, the Robert Wood Johnson Foundation study found that another source of savings for states would be the reduction of current spending on individuals with mental illnesses.[50] These savings result because state and local governments currently use general funds to pay for a large portion of state mental health costs.[51] In fiscal year 2008, state mental health agencies spent an estimated $36.8 billion,[52] and of this amount, 45.4%, or $16.7 billion, represented state and local costs outside of Medicaid.[53] Medicaid paid for forty-six percent of state mental health services, or $16.9 billion.[54] Among the adults served by state mental health agencies, 79% are either unemployed or outside the labor force.[55] Nevertheless, forty-three percent of consumers served by these agencies

48. Matthew Buettgens, Stan Dorn & Caitlin Carroll, *Consider Savings as Well as Costs State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019*, URBAN INST. 1 (July 2011), *available at* http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.

49. *Id.*

50. *Id.*

51. *Id.*

52. Matthew Buettgens & Stan Dorn, *Net Effects of the Affordable Care Act on State Budgets*, URBAN INST. 1, 4 (2010), *available at* http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf.

53. *Id.*

54. *Id.*

55. *Id.*

have no Medicaid coverage.[56] When the PPACA is fully implemented, Medicaid coverage is expected to increase from 12.4 to 23.3% of individuals with mental illness or substance abuse disorders, and Medicaid's mental health spending is projected to rise by 49.7%.[57] Using twenty-five to fifty percent of these federal dollars to substitute for state and local spending, states could collectively save between eleven billion dollars and twenty-two billion dollars from 2014-2019.[58]

C. Significant Federal Subsidies

Although states have the option to opt out of accepting the funds to expand Medicaid eligibility, studies indicate state officials who choose to opt out will suffer a loss of potential savings. A report prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured analyzing the potential savings states could achieve under the PPACA between 2014 and 2019 found savings could range from $40.6 billion to $131.9 billion.[59] These savings come from the following areas: elimination of optional Medicaid coverage for adults over 133% of FPL and thus shifting them to federally funded subsidies in the exchange, the replacement of state and local spending on uncompensated care with federal Medicaid dollars, and the replacement of state and local spending on mental health services with federal Medicaid dollars.[60] The study found the greatest savings would result from uncompensated care savings.[61] The study analyzed and estimated the spending of state and local governments from

56. *Id.*
57. *Id.*
58. *Id.* at 2.
59. Buettgens et al., *supra* note 54, at 1.
60. *Id.*
61. *Id.* at 2.

examining state general fund dollars.[62]

A study conducted by RAND Corporation Technical for the Council of State Governments, which undertook a preliminary analysis of the impact of the PPACA on five states, found in Connecticut, for example, that although state Medicaid spending will increase, total state government spending on health care would be ten percent lower for the combined 2011-2020 period.[63] The study recognized that the expansion will increase the state's spending since, in the long run, the state will be required to pay ten percent of Medicaid costs for the newly eligible population, and that although this is far less than the traditional state share of Medicaid funding (ranging from fifty to twenty percent, depending on state's per capita income), it is more than the states would spend if these individuals remained uninsured.[64] However, the study found the Medicaid expansion would amount to a $300 million reduction in state spending in 2016.[65] The savings would mostly result from the federal subsidies available to residents who would have been otherwise covered by Connecticut's state-run health insurance program, SAGA (State-Administered General Assistance).[66] The researchers conducted their analysis using a microsimulation model developed by RAND researchers for the Comprehensive Assessment of Reform Efforts (COMPARE) project.[67] The model produces estimates of the effects of various coverage expansion policy changes on the number of people who newly obtain insurance and/or change sources of insurance, the

62. *Id*. at 4.
63. David Auerbach et al., *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut*, RAND HEALTH CORP., 1-2 (2011).
64. *Id*. at 3.
65. *Id*. at 2.
66. *Id*.
67. *Id*. at 5.

types of plans in which they choose to enroll, and the changes in private and public-sector spending.[68]

V. ANALYSIS

Although the counter-cyclical nature of Medicaid causes legitimate concerns for states, some economists generally view countercyclical government spending as a good thing since it protects household income and promotes consumption that fuels economic recovery.[69] During an economic downturn, Medicaid plays an important role as a program that expands to meet rising needs when the economy is weak.[70] Additionally, although state concerns of high administrative costs are valid, this perspective is short-sighted, as the federally subsidized expansion of Medicaid would replace costs of uncompensated care that largely come from other parts of state budgets.[71] These costs include state-funded insurance programs, public state and county hospitals, and community health centers.[72] Additionally, states may receive some help in paying for the new administrative costs due to a federal regulation proposed by Centers for Medicare and Medicaid Services (CMS) in November 2010 that could pay a ninety percent match rate for new eligibility and enrollment systems.[73]

Ultimately, it is likely states will accept the Medicaid expansion because the federal funding is too significant to bypass. As the federal government

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68. *Id.*
69. Sommers, *supra* note 5.
70. Leighton Ku, *CDC Data Show Medicaid and SCHIP Played a Critical Counter-Cyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn*, CENTERS FOR DISEASE CONTROL & PREVENTION 2 (2003), *available at* http://www.cbpp.org/archiveSite/9-23-03health.pdf.
71. Sommers, *supra* note 5.
72. *Id.*
73. Bovbjerg et al., *supra* note 7, at vi.

will not fund partial Medicaid expansions but instead states must fully commit to expansion to receive any funds, the significant sum of funding will ultimately be too attractive for states to reject expansion. Medicaid expansion will extend health coverage to more than twenty million people.[74] Implementing the Medicaid expansion with other provisions will reduce the number of insured people. According to Stanford University health economist Dr. Jay Bhattacharya, "If enough states decide to deny the Medicaid expansion, this may substantially reduce the ability of the PPACA [] to expand insurance coverage."[75] Although not the only step, every state expanding Medicaid is an important step for universal health coverage.

Furthermore, the National Association of Public Hospitals and Health Services (NAPH) estimates that the United States will spend as much as $53.3 billion more on bills that go unpaid by the uninsured.[76] Using data from various nationally recognized sources, NAPH projects hospitals will see $53.3 billion more uncompensated care costs by 2019 than originally estimated when lawmakers approved the PPACA.[77]

Moreover, states should act promptly to expand Medicaid because to do otherwise would harm states. According to Cindy Mann, deputy administrator of CMS, while there is no deadline for expanding Medicaid, states would pay a price for delay.[78] She explains that the federal payment

74. John Holahan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1 (2011), *available at* http://www.kff.org/medicaid/upload/8384.pdf.

75. Ornstein, *supra* note 20.

76. *Need for a Sustainable Solution: Restoring the Balance in Safety Net Financing*, NAT'L ASS'N OF PUB. HOSPS. & HEALTH SERVS. 1 (2012), *available at* http://www.naph.org/Links/ADV/NAPHuncompensatedcareanalysis.aspx.

77. *Id*.

78. Robert Pear, *Administration Advises States to Expand Medicaid or Risk Losing Federal Money*, N.Y. TIMES, Oct. 2, 2012, at 1-2, *available at* http://www.nytimes.com/2012/10/02/us/us-advises-states-to-expand-medicaid-or-risk-losing-funds.html?ref=robertpear&_r=0.

rates "are tied by law to the specific calendar years noted" since under the new law the federal government will pay the entire cost of Medicaid coverage for newly eligible beneficiaries for three years, from 2014 to 2016 and the federal share will decline to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and later years.[79] Therefore, if a state defers the expansion of Medicaid to 2016, the federal government will pay 100% of the costs for only 1 year.[80] After 2016, the federal share will drop to the levels specified by Congress, and states will be responsible for the remainder.[81] Furthermore, states are also likely to accept the federal funding for the Medicaid expansion because of the freedom and flexibility to drop the coverage. According to Mann, "a state may choose whether and when to expand, and if a state covers the expansion group, it may decide later to drop the coverage."[82]

VI. CONCLUSION

There are many reasons for states to accept the federal government's funding to expand Medicaid. While there are many social benefits to health care reform, states are likely to benefit financially from deciding to expand Medicaid. As the U.S. Supreme Court recognized, the federal government cannot require states to expand Medicaid without Congress overstepping its powers. Nevertheless, the financial reasons for extending Medicaid coverage are significant. While health care reform may cost states down the road, states will also experience great savings in other state and locally funded expenditures. Overall, despite the costs of expansion state officials will likely not reject the expansion of Medicaid to its citizens.

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79. *Id.* at 2.
80. *Id.*
81. *Id.*
82. *Id.* at 1.

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The California Health Benefit Exchange: Will California Learn From Its Past Efforts To Create A HealthCare Exchange?

*Alex Cooper**

I. INTRODUCTION

There are currently over 48 million people in the United States who do not have health insurance, accounting for 15.7% of the U.S. population.[1] One of the mechanisms by which the Patient Protection and Affordable Care Act (the PPACA) plans to decrease the number of uninsured persons in the United States is the implementation of State healthcare exchanges (exchanges).

While universal healthcare proponents were disappointed by the lack of a public option in the PPACA, state healthcare exchanges will be either state or federal-run programs designed to provide health insurance to many uninsured persons, by increasing competition among insurers.[2] Exchanges will be online marketplaces where individuals and small businesses can find and compare private health insurance options.[3] Comparisons have been made to web sites like Travelocity or Amazon, which allow consumers to compare products and services in one location.[4] Exchanges will be designed

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1. Jason Kane, *More Americans Insured: What's Behind the Numbers?*, PBS NEWSHOUR (Sept. 12, 2012, 3:54 PM), http://www.pbs.org/newshour/rundown/2012/09/number-of-uninsured-americans-drops-for-first-time-in-four-years.html.

2. U.S. DEP'T OF HEALTH & HUMAN SERVS., CREATING A NEW COMPETITIVE MARKETPLACE: AFFORDABLE INSURANCE EXCHANGES 1 (2011), *available at* http://healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

3. *Id.*

4. Victoria Colliver, *Health Care Exchange Will Offer Policies*, S.F. CHRON., June 29, 2012, at 1, *available at:* http://www.sfgate.com/health/article/Health-care-exchange-will-

to bring a new level of transparency to the healthcare insurance market, allowing individuals to compare plans based on both price and quality.[5] Insurance prices could decrease by increasing competition among insurers as well as allowing individuals and small businesses to come together to purchase insurance.[6] An estimated twenty-two million individuals could enroll in exchange programs nationally by 2014.[7] In an attempt to bolster public confidence in the exchange programs, as well as to set an example for public use of the exchanges, members of Congress will even be required to get their health insurance through an exchange.[8]

While the PPACA in its entirety has been met with resistance from the public, due in large part to the individual mandate included in the law, commentators and the general public support many of the individual provisions, including state healthcare exchanges.[9] Recent polls show that even eighty percent of Republicans favor the creation of state healthcare exchanges.[10]

The PPACA gave the States the option to establish a State-based exchange, operate in a State partnership exchange, or allow the Secretary of the Department of Health and Human Services to operate a Federally-

offer-policies-3675063.php (quoting Peter Lee, executive director of the California Health Benefit Exchange).

5. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2

6. *Id.*

7. Sara R. Collins & Tracy Garber, *State Health Insurance Exchange Legislation: A Progress Report*, THE COMMONWEALTH FUND, May 30, 2012, http://www.commonwealthfund.org/Blog/2011/Jun/State-Health-Insurance-Exchange-Legislation.aspx

8. CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, AFFORDABLE INSURANCE EXCHANGES, http://cciio.cms.gov/programs/exchanges/index.html (last visited Oct. 1, 2012).

9. Greg Sargent, *Republicans Support Obama's Health Reforms – As Long as His Name Isn't On Them*, WASH. POST. (June 25, 2012 at 1:09 PM), *available at* http://www.washingtonpost.com/blogs/plum-line/post/republicans-support-obamas-health-reforms—as-long-as-his-name-isnt-on-them/2012/06/25/gJQAq7E51V_blog.html.

10. *Id.*

facilitated exchange.[11] States were required to submit plans for how they intend to operate their exchanges or whether they will be participating in a state partnership exchange by November 16, 2012, in order to have the exchanges fully operational by the deadline of January 2014.[12]

This paper will discuss the state of healthcare coverage specifically in the state of California, and the challenges the state faces in providing healthcare to its population. This paper will then discuss the progress made by the state of California in establishing a healthcare insurance exchange, and the structure of this exchange. This paper will also explore the past efforts by California to create an exchange, and whether the current effort to create an exchange will be more successful than previous efforts.

II. THE STATE OF HEALTHCARE COVERAGE IN CALIFORNIA

The attempt to create a successful and efficient exchange in California will likely be highly scrutinized.[13] California's healthcare troubles are a microcosm of issues prevalent throughout the U.S. healthcare system. California has the highest number of uninsured people in the United States, at over seven million, and one of the highest percentages of uninsured people in the United States, at sixteen percent.[14] Budgetary problems also

11. CTRS. FOR MEDICARE AND MEDICAID SERVS., AFFORDABLE INSURANCE EXCH. 1 (2012), *available at* http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf.

12. Collins, *supra* note 7; Nicole Lewis, *HHS Proposes Health Insurance Exchange Rules*, INFO.WEEK (July 12, 2011 at 1:54 PM), http://www.informationweek.com/healthcare/policy/hhs-proposes-health-insurance-exchange-r/231001432. If states are unable to demonstrate complete readiness to create a state-based exchange by January 2013, the federal government will "step in to establish a state exchange to meet the January 2014 deadline." *Id.*

13. Abby Goodnough, *California Tries to Guide the Way on Health Law*, N.Y. TIMES, Sep. 14, 2012, *available at* http://www.nytimes.com/2012/09/15/health/policy/california-tries-to-lead-way-on-health-law.html?pagewanted=all&_r=0.

14. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, *available at* http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=125&cat=3&sub=39.

make California an interesting case study.[15] Because of these problems, Anthony Wright, executive director of the advocacy group Health Access California believes that "If it can be done here, it can be done anywhere".[16]

California has been proactive when it comes to implementing its exchange.[17] In September of 2010, California became the first State to sign its exchange into law, creating the California Health Benefit Exchange (HBEX).[18] As of September 14, 2012, the HBEX has already hired fifty employees, and plans to hire at least fifty more.[19] California has also been proactive in acquiring federal grant money to establish the HBEX, receiving $236 million before the Court made its ruling on the constitutionality of the PPACA.[20]

Expectations for the HBEX are high. Estimates have put the number of uninsured individuals in California who will purchase health insurance through the HBEX at around five million.[21] Of this five million figure, three million are expected to do so with the help of federal subsidies, while two million are expected to do so without federal assistance.[22]

III. STRUCTURE OF THE CALIFORNIA HEALTH BENEFIT EXCHANGE

California chose to create its exchange as a freestanding governmental

15. Goodnough, *supra* note 13.

16. *Id*.

17. Victoria Colliver, *California is Most Prepared for Health Care Law*, S.F. CHRON., June 29, 2012, at 1, *available at* http://www.sfgate.com/health/article/California-is-most-prepared-for-health-care-law-3672109.php.

18. KAISER FAMILY FOUND., STATE EXCHANGE PROFILES: CALIFORNIA (2012), http://healthreform.kff.org/State-.Exchange-Profiles/California.

19. Goodnough, *supra* note 13.

20. Colliver, *supra* note 4

21. Colliver, *supra* note 17; *but see* CA. HEALTHCARE FOUND., BRIEFING FOR THE CALIFORNIA HEALTH BENEFIT EXCHANGE, Oct. 21, 2010, *available at* http://www.chcf.org/events/2010/briefing-california-health-benefit-exchange.

22. Colliver, *supra* note 17.

body, unaffiliated with any existing agency.[23] This type of formation may help to keep the HBEX free from political influence or interest group influence.[24] As is required by law, a governing board will oversee the HBEX.[25] All five of the initial board members are current or former government employees.[26] While some states have included representatives from large insurance providers, California prohibits any insurance representatives from serving on the board.[27] Although there will be no representation on the governing board, a significant portion of the HBEX will be implemented by the private sector. In June 2012, California awarded Accenture a contract to implement the eligibility and enrollment system of the HBEX.[28] California will use an active purchaser model in order to determine which insurance providers will be included in the HBEX.[29] This selective contracting model will be used in order to maximize consumer value and shape the healthcare delivery system by keeping low-quality providers out of the HBEX.[30] One concern with this type of contracting model is that it could cause the HBEX to be too exclusionary, minimizing the number of insurers and decreasing

23. Mark A. Hall & Katherine Swartz, *Establishing Health Insurance Exchanges: Three States' Progress*, COMMW. FUND PUB., July 2012, at 1, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Jul/1611_Hall_establishing_hlt_ins_exchanges_three_states_progress.pdf.

24. KAISER FAMILY FOUND. ESTABLISHING HEALTH INSURANCE EXCHANGES: AN OVERVIEW OF STATE EFFORTS 2 (2012), *available at* http://www.kff.org/healthreform/upload/8213-2.pdf.

25. Dep't of Health and Hum. Serv. Notice of Rulemaking, 45 C.F.R. 155 and 45 CFR 156.

26. Hall, *supra* note 23 at 2.

27. *Id.* Because California will be using an active purchaser model in order to select the health plans to be included in the exchange, there is no insurance company representation on the Board. *Id.* The active purchaser model is discussed further in note 29.

28. HEALTHCARE IT NEWS, *ACCENTURE SELECTED TO IMPLEMENT CALIFORNIA HEALTH INSURANCE EXCHANGE*, June 28, 2012. http://www.healthcareitnews.com/press-release/accenture-selected-implement-california-health-insurance-exchange.

29. KAISER FAMILY FOUND., *supra* note 24, at 3.

30. Hall, *supra* note 23, at 2.

competition within it.

While the HBEX will be able to actively include or exclude insurers from the exchange, federal law has established minimums for what an insurance plan must provide in order to be included in it.[31] The health insurance market can be complicated to most buyers, as insurers confuse buyers with a wide array of benefits, co-pays, deductibles, and premiums.[32] Under the PPACA, an insurance plan must provide ten essential benefits, including hospitalization, lab services, maternity care and prescription drugs.[33] In order to further simplify the insurance-purchasing experience for buyers, the PPACA requires participating insurers to offer plans at four levels: bronze, silver, gold, and platinum.[34] Mandates such as these are included in order to increase the transparency of insurance plans as well as insure that buyers are receiving quality care through the HBEX.

IV. THE HPIC/PACADVANTAGE AND LESSONS FOR THE FUTURE

The California HBEX will not be the first attempt to create a healthcare exchange. In 1992, California established the Health Insurance Plan of California (HIPC).[35] It was started with similar goals in mind as the current healthcare exchange provisions of the PPACA – to give small businesses in California the collective power to negotiate for lower insurance premiums.[36]

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31. Kevin Yamamura, *California Health Care Exchange Prepares for 2014 Launch*, SACRAMENTO BEE, JULY 17, 2012, at 2, *available at* http://laborcenter.berkeley.edu/press/sacbee_july12.shtml.

32. Michael Hiltzik, *Will U.S. Learn its Healthcare Reform Lesson From California?*, L.A. TIMES, Sept. 14, 2009, at 2, *available at* http://articles.latimes.com/2009/sep/14/business/fi-hiltzik14.

33. Yamamura, *supra* note 31.

34. Hall, *supra* note 23 at 6.

35. HIPC-PACADVANTAGE, CALIFORNIA'S PREVIOUS SMALL EMPLOYER EXCHANGE, http://Californiahealthbenefitadvisers.com/hipc_pacadvantage.htm.

36. Hiltzik, *supra* note 32, at 1.

It began as a state-operated health insurance purchasing pool.[37] In 1999, the HIPC was contracted out to the Pacific Business Group on Health, who renamed the project PacAdvantage.[38] The program was not successful. Although the initial plan of the HIPC was to enroll 250,000 individuals in the first two years, only 150,000 individuals enrolled within the first five years.[39] This lack of enrollment accounted for only two percent of the small-market group, the very group for which HIPC was intended to provide insurance.[40]

There were several problems that ultimately doomed the HIPC/PacAdvantage. The main problem was that the HIPC/PacAdvantage did not maintain the enrollment volume required to be effective, and, in turn, did not maintain enough interest from insurers.[41] The second major problem of the HIPC/PacAdvantage was that insurers began to use the exchange solely to appeal to high-risk buyers, a process known as "adverse selection".[42]

Changes in the healthcare landscape brought about by the PPACA, as well as changes in the structure and method of implementation by the California HBEX should alleviate these two major problems. One of the factors that limited the number of enrollees in the HIPC/PacAdvantage was that individuals were not required to purchase health insurance. The individual mandate, the provision that requires all individuals to purchase health insurance, becomes effective in 2014, the same year as the

37. *Id.*
38. Micah Weinberg & Bill Kramer, *Building Successful SHOP Exchanges: Lessons from the California Experience*, PACIFIC BUS. GROUP ON HEALTH (2011) 2, *available at* http://www.pbgh.org/storage/documents/PBGH_SHOP_05.pdf.
39. *Id.*
40. Hiltzik, *supra* note 32.
41. *Id.*
42. *Id.*

exchanges.[43] The other key provision of the PPACA that will increase the California HBEX's likelihood of success is the subsidies provided by the federal government.[44] These federal credits, which will assist low and moderate-income individuals in purchasing insurance, will only be accessible within an exchange.[45] The influx of several million new customers, many of whom will have their health insurance plans subsidized by the government, should make the HBEX attractive to insurers.[46]

Another key to maintaining enrollment in the Exchange is to increase awareness of the program. According to a California Field Poll, seventy-five percent of those surveyed who are currently uninsured and would be purchasing insurance through the private market expressed an interest in doing so through the HBEX.[47] However, only seventeen percent of those surveyed were even aware of the HBEX.[48] In order to increase awareness, the HBEX is beginning to market itself aggressively, and, given the great diversity within the state, creative strategies will have to be employed. Ogilvy Public Relations Worldwide was awarded a $900,000 contract to market the HBEX, and they have already begun to implement creative marketing strategies.[49] Strategies have ranged from advertising on coffee cup sleeves at community colleges in order to reach adult students to

43. Liz Goodwin, *Supreme Court Upholds Obamacare Individual Mandate as a Tax*, ABC NEWS, June 28, 2012, http://abcnews.go.com/Politics/OTUS/supreme-court-upholds-obamacare-individual-mandate-tax/story?id=16669186#.UJgA2445hE8.

44. Sarah Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection*, CTR. ON BUDGET & POL'Y PRIORITIES, Aug. 17, 2010, *available at* http://www.cbpp.org/cms/index.cfm?fa=view&id=3267.

45. *Id.*

46. Kathy Robertson, *California Health Care Reform Goes Into Overdrive*, SACRAMENTO BUS. J., August 29, 2012, (quoting Gary Cohen, General Counsel for the California Health Benefits Exchange).

47. Mark DiCamillo & Mervin Field, *Californians Strongly Support Nation's Health Reform Law but Believe More Changes are Needed to the Health Care System*, THE FIELD POLL, 2, *available at* http://field.com/fieldpollonline/subscribers/Rls2423.pdf.

48. *Id.*

49. Goodnough, *supra* note 13.

advertising at professional soccer matches to reach young Hispanic men.[50] There are even plans to incorporate the HBEX into mainstream television, through shows like "Modern Family" and "Grey's Anatomy".[51]

The other major problem that contributed to the end of the HIPC/PacAdvantage was adverse selection. As individuals who are in poorer health and who have higher health expenses begin to enroll in an exchange, and lower-cost individuals who have lower health expenses enroll outside of it, it becomes too expensive for insurers to participate in the exchange.[52] Insurers discontinue their participation in the exchange, decreasing competition within the exchange, and increasing the prices of premiums within the exchange.[53] A simplified way of putting it is that adverse selection occurs when purchasing or offering health insurance outside of an exchange becomes more attractive to purchasers and insurers than doing so within the exchange. In the HIPC/PacAdvantage, adverse selection caused the number of insurers offering health plans within the exchange to decrease from 24 to 3 from 1992 to 1996.[54]

There are several safeguards included in the California HBEX that are designed to lower the risk of adverse selection. California's decision to use an active purchaser model in selecting health plans to be included in the exchange will prevent the HBEX from becoming merely a dumping ground for high-risk plans. The active purchaser model will allow the HBEX to

50. *Id.*
51. *Id.*
52. Lueck, *supra* note 44.
53. Sharon Silow-Carroll et. al, *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection*, THE COMMW. FUND PUB., Feb./Mar. 2011, *available at* http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx#1.
54. Hiltzik, *supra* note 32.

maximize value for consumers by selecting high-performing plans.[55] California's requirement that insurers offer each of the PPACA's four metal levels will lower the risk of adverse selection taking place as well, as insurers will not be able to simply offer high-risk plans within the HBEX.[56] The other important provision in the HBEX legislation is the requirement that all products and plans offered within the exchange be consistent with those offered outside of the exchange.[57] This will prohibit insurers from offering vastly different plans within and outside of the HBEX, decreasing the likelihood of adverse selection taking place.

V. ADDITIONAL HURDLES

There are still significant obstacles to overcome in order for the California HBEX to be successful. The first, and most prevalent, is the cost to the state, whose budget is already being stretched significantly. Despite the fact that the federal government is financing a great deal of the exchange, California's contribution could exceed two billion dollars per year.[58] To help close a sixteen billion dollar deficit, Governor Brown has already cut over one billion dollars from Medicaid, and is now relying on voters to approve temporary tax increases in order to avoid more cuts.[59] If there is no improvement in the State's financial situation, the HBEX may fail. Political uncertainty also makes the future of the HBEX difficult to predict. Many Republicans have pledged to repeal the PPACA.[60] Even if attempts at a complete repeal are unsuccessful, there could be significant

55. Silow-Carroll, *supra* note 53.
56. Hall, *supra* note 23, at 6.
57. *Id.*
58. Goodnough, *supra* note 13.
59. Goodnough, *supra* note 13.
60. Mitt Romney, *Health Care – Repeal and Replace Obamacare*. http:// www.mittromney.com/issues/health-care, (last visited October 27, 2012).

changes to the exchanges that may require restructuring the way that the exchanges operate.

VI. CONCLUSION

Despite the failures of the HIPC/PacAdvantage, expectations for the California HBEX are high. With the chance to provide healthcare insurance to a large uninsured population, and to provide more affordable healthcare to those who already have insurance, California has been very proactive in their creation of the California HBEX. Many of the obstacles that doomed the HIPC/PacAdvantage have been removed by the PPACA, and others can be avoided through careful planning by the individuals charged with designing, implementing, and marketing the HBEX. The individual mandate, the requirement that insurance plans in the HBEX meet certain minimum requirements, and the requirement that the plans offered within the HBEX are similar to the plans offered outside of it will help to ensure that the California HBEX does not experience the adverse selection that doomed the HIPC/PacAdvantage and similar efforts in other states. The California HBEX could be a very valuable tool in curbing rising healthcare costs and helping to provide health insurance coverage to more people in a state with high healthcare costs and a large uninsured population.

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Changes to Reimbursement and Tax-Exempt Status Requirements May Raise Financial Concerns, But Non-profit Hospitals Stand to Benefit from HealthCare Reform

*Loukas N. Kalliantasis**

I. INTRODUCTION

The United States overhauled its approach to healthcare and moved towards universal coverage by enacting the Patient Protection and Affordable Care Act (PPACA). This approach to universal healthcare mandates individuals to acquire health insurance. Since healthcare is expensive, the government will assist its citizens with acquiring healthcare in three ways: (1) by expanding Medicaid coverage to anyone under 133% of the federal poverty level,[1] (2) offering premium assistance tax credits to Americans earning up to 400% of the federal poverty level,[2] and (3) implementing cost-sharing reductions.[3] Together, the mandate and Medicaid expansion seek to increase access to the forty-seven million uninsured Americans.[4] The increase in access to healthcare is good news

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1. Patient Protection and Affordable Care Act [hereinafter PPACA], 42 U.S.C. § 1396A(a)(7)(B) (2010)
(there is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty). *See* KAISER FAMILY FOUND., MEDICAID AND CHILDREN'S HEALTH INS. PROGRAM PROVISIONS IN THE NEW HEALTH REFORM LAW 3 (2010), *available at* http://www.kff.org/medicaid/upload/8349.pdf; KAISER FAMILY FOUND., A HISTORICAL REVIEW OF HOW STATES HAVE RESPONDED TO THE AVAILABILITY OF FED. FUNDS FOR HEALTH COVERAGE 1 (2012), http://www.kff.org/healthreform/upload/7952-03.pdf.

2. *See generally* PPACA, 26 U.S.C. §36B (2010).

3. *See generally* PPACA, 42 U.S.C. §18071 (2010).

4. GENEVIEVE M. KENNEY ET AL., MAKING THE MEDICAID EXPANSION AN ACA OPTION: HOW MANY LOW-INCOME AMERICANS COULD REMAIN UNINSURED 2 (The Urban Inst. Ed.,

for Americans. However, financial challenges may be created for some healthcare providers because the PPACA also changes funding and reimbursement methods for Medicaid and Medicare,[5] and includes additional requirements[6] for tax-exemptions.

These changes will impact the operations of a major player in the healthcare industry—non-profit hospitals. Non-profit hospitals make up slightly less than two-thirds of urban, general medical and surgical hospitals.[7] Specifically, non-profit hospitals make up 2,904 of the 4,985 registered United States Community hospitals.[8] These hospitals provide more charity care than for-profit hospitals,[9] provide many community benefits,[10] and are also more likely to provide unprofitable services.[11] In addition, non-profit hospitals are generally larger than for-profit hospitals, and are more likely to be teaching hospitals.[12]

Non-profit hospitals play a vital role in the United States because of their contribution to public health through these aforementioned benefits. Yet, certain changes to the healthcare industry, as a result of universal healthcare

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2012), http://www.urban.org/UploadedPDF/412606-Making-the-Medicaid-Expansion-an-ACA-Option.pdf.

5. *See generally* PPACA, 42 U.S.C. §1395ww (2010).

6. *See* Pamela C. Smith & Kelly Noe, *New Requirements for Hospitals to Maintain Tax-Exempt Status*, 38 J. OF HEALTH CARE FIN. 16, 18 (2012).

7. Jill R. Horwitz & Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28 J. OF HEALTH ECON. 924, 925 (2009).

8. AM. HOSP. ASS'N, FAST FACTS ON US HOSPITALS 1 (2012), *available at* http://www.aha.org/research/rc/stat-studies/fast-facts.shtml.

9. Horwitz & Nichols, *supra* note 7, at 925.

10. Kristine Principe et al., *The Impact of the Individual Mandate and Internal Rev. Serv. Form 990 Sch. H on Cmty. Benefits from Nonprofit Hosp.*, 102 AM. J. OF PUB. HEALTH 229, 234 (2012). Non-profits admit more mentally-ill patients in psychiatric emergency services, provide comprehensive services for substance abuse treatment, provide AIDS services, provide obstetrical care, and operate an emergency room and trauma center at rates higher than for-profit hospitals. *Id*.

11. *Id*.

12. CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 12 (2006), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf.

coverage from the PPACA, have raised concerns about the financial stability of these hospitals. Particularly, budget cuts and new methods of reimbursement will create financial concerns for non-profit hospitals. In addition, the resulting increase in insured individuals will force hospitals to approach their tax-exempt status differently. Hence, there are major hurdles associated with universal healthcare coverage for which non-profit hospitals must prepare.

Changes to reimbursement and tax-exemption requirements from the PPACA, along with Illinois' approach adopting similar changes, will have a profound impact on non-profit hospitals. However, non-profits can continue to survive, and perhaps even thrive, in the changing healthcare industry. Although there are challenges forthcoming, the new approach to healthcare in the United States will promote efficiency and drive down costs, helping non-profit hospitals reach their altruistic goals of serving the public's health needs.

II. CONCERNS TO OPERATING CONDITIONS FOR NON-PROFIT DUE TO MEDICAID EXPANSION AND CHANGES TO REIMBURSEMENT METHODS

The PPACA aims to increase healthcare coverage to the population of the United States by mandating citizens to purchase health insurance.[13] In order to assist individuals in purchasing health insurance, the PPACA provides premium assistance tax credits and cost-sharing reduction benefits.[14] Those below 138% of the federal poverty level are eligible for

13. *See* PPACA, 42 U.S.C. §18091 (2010).

14. *See* PPACA, 42 U.S.C. §18071 (2010); PPACA, 26 U.S.C. §36B (2010). Americans earning up to 400% of the federal poverty level are eligible for a tax credit if they purchase insurance through a government based health insurance exchange program. *See* PPACA, 42 U.S.C. §18071 (2010). The tax credit is calculated as the lesser of the following calculations: (1) the monthly premium cost for the plan that an individual or family is enrolled in, or (2) the excess from 1/12 of the product of the applicable percentage and the individual or family's income subtracted from the premium for the silver tier package that an

coverage under Medicaid expansion.[15] The PPACA also addresses the constantly expanding cost of healthcare by introducing sweeping reform to reimbursement from Medicaid and Medicare. The PPACA will require the secretary of Health and Human Services to establish a value-based payment program for hospitals, as opposed to performance based payments, thus, giving incentives for hospitals to provide care more efficiently.[16] Providers will also be subject to Medicare and Medicaid payment reductions for readmissions, payment linkages to quality measures, and a pilot program regarding bundled payments.[17] In addition, the PPACA encourages efficiency by incentivizing providers to form Accountable Care Organizations that will participate in the Medicare Shared Savings Program.[18]

The changes to the payment methods create concerns about how hospitals will be able to survive reform.[19] In 2012, for example, revenues from Medicare and Medicaid are expected to remain strained, leaving non-profit hospitals wondering how they will be adequately reimbursed under

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individual or family would be eligible for. *See* 26 U.S.C. §36B (2010). The applicable percentage is determined by an individual's or family's income expressed as a percentage of the federal poverty level. *See* 26 U.S.C. §36B (2010).

15. KAISER FAMILY FOUND., *See supra* note 1.

16. *See* PPACA, 42 U.S.C. §1395ww (2010).

17. Principe et al., s*upra* note 10, at 232. As an additional check on costs, the PPACA also establishes an Independent Payment Advisory Board, which has the purpose of reducing the per capita growth in Medicare. *See* PPACA, 42 U.S.C. §1395kkk

18. *See generally* AMERICAN ACAD. OF FAMILY PHYSICIANS, MEDICARE SHARED SAVINGS PROGRAM: ACCOUNTABLE CARE ORG.. FINAL RULE (2011), http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/background/medicare-aco-summary.Par.0001.File.dat/AAFPFinalMedicareACO.pdf [hereinafter AAFP]. An Accountable Care Organization in the Medicare Shared Savings program is a group of providers that will work together to provide coordinated care to Medicare beneficiaries. *Id.* at 3. These organizations will be eligible to share a portion of savings generated to the Medicare program. *Id.* at 5.

19. *See* STANDARD & POOR'S, THE U.S. NOT-FOR-PROFIT HEALTH CARE SECTOR'S RATING STABILITY IS VULNERABLE TO HEADWINDS AFTER 2012 (2012), http://www.standardandpoors.com/spf/upload/Events_US/US_FI_Event_hc6512art7.pdf (discussing the various challenges non-profit hospitals will face).

these new payment models.[20] Care provided to Medicare and Medicaid beneficiaries is often reimbursed at below-market rates, paying hospitals a substantially lower percentage of billed charges than most private insurers.[21] For example, Provena Covenant Medical Center was under-reimbursed by $7,418,150 from Medicare and $3,105,217 from Medicaid in 2002.[22] The Centers for Medicare and Medicaid Services (CMS) will continue to reduce inpatient payment rates in fiscal year 2013.[23] The Budget Control Act of 2011 also requires a two percent downward reduction to all lines of Medicare payment, set to take effect January 1, 2013.[24]

The potential insolvency of Medicare and Medicaid has already been felt by many states' budgets as well.[25] In fact, in 2012, thirteen states cut Medicaid funding to balance budgets.[26] Even with the reimbursement

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20. *See id.* at 3. Revenues from all insurance providers will remain strained. *Id*. Medicare provided small inpatient update factors of 1.1%, and Medicaid was cut in various states. *Id*.

21. Simone Rauscher & John R.C. Wheeler, *Hospital Revenue Cycle Mgmt. and Payer Mix: Do Medicare and Medicaid Undermine Hospitals' Ability to Generate and Collect Patient Care Revenue?*, 37 J. OF HEALTH CARE FIN. 81, 83 (2010).

22. Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d. 1131, 1137 (2010).

23. *See* FLA. HOSP. ASS'N, FINAL RULE SUMMARY: MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM FEDERAL FISCAL YEAR 2013 1 (2012) (summarizing the Centers for Medicare and Medicaid Services final ruling CMS-1588-F). CMS has set the PPACA mandated market reductions at -0.8%, including the -0.1% predetermined market reduction, and also provides a provides a predetermined coding adjustment reduction of -1.9%. *See id*. at 2. Hospitals may encounter a one percent payment reduction under the new Value-Based Purchasing program. *See id*. at 6. Hospitals that have high readmission rates mayn also encounter an additional one percent reimbursement reduction for inpatient services. *See id*. 7.

24. *See id*. at 2.

25. MOODY'S INVESTOR SERVICE, TRANSFORMING NOT-FOR-PROFIT HEALTHCARE IN THE ERA OF REFORM 2 (2010), http://content.hcpro.com/pdf/content/251210.pdf [hereinafter MOODY'S].

26. *See* PHIL GALEWITZ & MATTHEW FLEMING, THIRTEEN STATES CUT MEDICAID TO BALANCE BUDGETS (Kaiser Health News, 2012), *available at* http:// www.kaiserhealthnews.org/Stories/2012/July/25/medicaid-cuts.aspx. Illinois made some considerable cuts to Medicaid, limiting enrollees to four prescriptions a month, imposing a copay on non-pregnant adults, and raising eligibility requirements to eliminate 25,000 adults

problems associated with Medicare and Medicaid, these two programs account for approximately fifty-five percent of care provided by hospitals.[27] Hospitals cannot refuse such a large revenue stream, and, therefore, must learn to operate with these new reimbursement policies.

Some healthcare policymakers worry that stringent reimbursement policies will lead to "cost-shifting."[28] Under this strategy, a hospital charges one payer more because it has received less from another.[29] In the context of Medicare and Medicaid, some policymakers argue that if public payers are less generous, then hospitals will raise prices for private payers.[30] If a hospital charges private payers a higher price to recover Medicare and Medicaid shortfalls, then, in turn, insurance premiums from private payers would rise more quickly.[31] This would increase the cost of healthcare and put strain on the healthcare industry.

Another concern about Medicaid reimbursement stems from the decision of the United States Supreme Court in *National Federation of Independent Businesses v. Sebelius*. In *Sebelius*, the court dealt with the constitutionality of the individual mandate, and the penalties that would be imposed on states that fail to expand Medicaid coverage; the Court upheld the constitutionality of the individual mandate because the mandate is essentially a tax, stating that "[t]he Federal Government has the power to impose a tax on those without health insurance.[32]

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from Medicaid. *Id.* At 1.

27. Rauscher & Wheeler, *supra* note 21, at 81.

28. Austin B. Frakt, *How Much do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 91 (2011). This study found that approximately twenty-one percent of Medicare and Medicaid shortfalls were cost-shifted to private payers between 1996 and 2000. *Id*. at 113.

29. *Id*.

30. *Id*. at 92.

31. *Id*.

32. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2601 (2012).

The Court, however, found the imposition of penalties against states that failed to expand Medicaid was unconstitutional, stating "what Congress is not free to do is to penalize states that choose not to participate in that new program by taking away their existing Medicaid funding."[33] Therefore, the Court held that it was unconstitutional for the Secretary of the Department of Health and Human Services to have the ability to withdraw existing Medicaid funds for states that did not comply with Medicaid expansion.[34] Nonetheless, the Court held that the penalty sanction did not affect the constitutionality of the Medicaid expansion itself.[35] Thus, the state has the option to join and reap the benefits of such expansion. However, the government can withdraw funds provided to a state that chooses to participate in the Medicaid expansion, but fails to comply with the PPACA's requirements.[36]

The result in *Sebelius* may have a big impact on the financial stability of non-profit hospitals because it prompts concerns that some states will refuse to expand their Medicaid programs.[37] A portion of the 22.3 million people who are newly eligible for Medicaid under the PPACA's expansion could remain uninsured.[38] Additionally, these states would be unable to reap the benefits of accepting Medicaid expansion under the PPACA – namely that Medicaid expansion would be 100% federally funded for the first three

33. *Id.* at 2607.
34. *Id.*
35. *Id.*
36. *Id.*
37. As of December 12th, 2012, governors from 9 states (Alabama, Georgia, Louisiana, Maine, Mississippi, South Carolina, South Dakota, Oklahoma, and Texas) have expressly stated that they will not expand Medicaid in their state. *See Where each state stands on ACA's Medicaid expansion*, THE ADVISORY BOARD COMPANY, http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap (last updated Dec. 20, 2012).
38. *See* Kenney et al., *supra* note 4, at 1. Of the 22.3 million newly eligible individuals, 17.8 million would not be eligible for premium subsidies via insurance exchanged. *Id.*

years (2014-2016), and at least 90% federally funded after that.[39] Rejecting the expansion could mean less funding for Medicaid reimbursement to non-profit hospitals.

Non-profit hospitals that provide care for a disproportionate share[40] of Medicare and Medicaid beneficiaries will be at further financial risk because the PPACA will begin to remove Disproportionate Share Hospital (DSH) payments.[41] Charitable and safety-net hospitals have long provided uncompensated care to low-income and underserved individuals.[42] Medicaid DSH payments are the largest source of federal funding for such uncompensated care, totaling nearly $11.3 billion in 2011.[43] However, the PPACA will begin to reduce Medicaid DSH payments by $14.1 billion between the years 2014 to 2019.[44] Therefore, non-profit hospitals in states that do not expand Medicaid will see funding for uncompensated care fall, while likely seeing the amount of uninsured remain relatively stable.[45]

III. CONCERNS STEMMING FROM THE CHANGING REQUIREMENTS FOR FEDERAL TAX EXEMPT STATUS AND STATE RESTRICTIONS TO TAX EXEMPTIONS

In addition to these reimbursement issues, non-profit hospitals must also be concerned with maintaining their tax-exempt status. A non-profit

39. KAISER FAMILY FOUND., *supra* note 1, at 1.

40. Hospitals that qualify for Medicaid DSH payments must a Medicaid inpatient utilization rate one standard deviation above the mean, or have a low-income utilization rate higher than twenty-five percent. *See* COREY DAVIS, Q & A: DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AND THE MEDICAID EXPANSION 2 (Nat'l Health Law Program, 2012), http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf. Hospitals that qualify for Medicare DSH payments must have a ration of low-income patients treated by the hospital exceeding fifteen percent. *See id*. 3.

41. *Id*. at 1.

42. *Id*.

43. *Id*. at 2.

44. *Id*. at 4. Medicare DSH payments will also be reduced by twenty-five percent from its base level beginning in 2014. *Id*. at 5.

45. *Id*. at 6.

hospital must meet the requirements of the Internal Revenue Code (IRC) Section 501(c)(3) in order to be granted an exemption from federal income taxes.[46] Section 501(c)(3) requires that a non-profit organization (1) serves a common good, (2) is not a for-profit entity, (3) had no net earnings benefitting the owners, and (4) does not exert a political influence.[47] The organization must be organized and operated exclusively for religious, charitable, scientific, or educational purposes.[48] The code does not define charitable for purposes of the tax exemption.[49]

With the growing concern that non-profit hospitals are providing insufficient benefits to their communities, the IRS and the PPACA have introduced new requirements. The PPACA introduces four new requirements: (1) a community health needs assessment, (2) a documented financial assistance policy, (3) no gross charges, and (4) no extraordinary billing and collection practices.[50] The PPACA also creates the new IRC section 501(r), which mandates tax-exempt hospitals to justify and document their community impact.[51] The new requirements indicate that the government is now concerned with non-profit hospitals preserving their end of the tax-exempt status bargain by providing adequate charity care.[52] Federal tax exemptions for non-profit hospitals result in billions of dollars saved.[53] With such considerable savings, meeting the requirements tax-

46. Smith & Noe, *supra* note 6, at 16. The Internal Revenue Service (IRS) is responsible for granting tax-exempt status from federal taxes to non-profit entities that meet the requirements in IRC § 501(c)(3). *Id*.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id*. at 18.

51. *Id*. at 17.

52. *See id.*

53. CONG. BUDGET OFFICE, *supra* note 12, at 3. In 2002, for example, the value of tax exemptions for non-profit hospitals totaled $12.6 billion. *Id*. Federal tax exemptions and state tax exemptions each compromised about half of this value. *Id.*

exempt status must be continuously scrutinized by hospital management.

Revenue Ruling 56-185 ruled that charity care is care for the sick, as well as providing care regardless of ability to pay.[54] Nonetheless, there is no mandate on a specific level or amount of charity care to be provided.[55] Thus, the standard for charity care for federal tax-exemption purposes is vague. State law, on the other hand, tends to be stricter, requiring specific amounts of charity care in order to qualify for state tax exemptions.[56] Even when specific amounts are not expressly required, the courts are free to interpret charity care law based on the common law. For example, the Supreme Court of Illinois affirmed the withdrawal of Provena Covenant Medical Center from state property tax exemption, resulting in a tax liability of $1.1 million dollars.[57] The court in this case held that charity care under Illinois law was defined as a gift to be applied for the benefit of an indefinite number of persons, for their general-welfare, or in some way reducing the burdens of government.[58] By this definition, Provena had only provided $831,724 in charity care, or only .723% of the hospital's revenue, which is far less than $1.1 million tax exemption.[59] Illinois law now provides that a non-profit must provide charity care that matches the amount granted on tax-exemption.[60]

The new requirements for tax exemption under the PPACA, as well as strict requirements in Illinois law, could leave non-profit hospitals incurring new tax liability that was previously exempted. These tax issues, taken

54. Smith & Noe, *supra* note 6, at 17. Revenue rulings provide guidance for complying with the internal revenue code. *See id*.
55. *Id.*
56. *Id.*
57. Provena, s*upra* note 22, at 1156.
58. *Id*. at 1145.
59. *Id*. at 1140.
60. 35 ILL. COMP. STAT. 105/3-8(b) (2012).

with reimbursement issues, raise financial concerns for the non-profit hospitals. However, these disruptions to the status quo will force non-profit hospitals to provide care efficiently, resulting in efficient and cost-effective non-profit hospitals.

IV. ROOM FOR HOPE: WHY HEALTHCARE REFORM DOES NOT HAVE TO STRAIN THE FINANCIAL FUTURE OF NON-PROFIT HOSPITALS

The new law is a radically different system with new payment methods and different incentives. Understandably, these organizations should be concerned about the new landscape of healthcare. Yet, since the PPACA became law, and on the eve of the implementation of the mandate and tax credits, there is information indicating that non-profit hospitals are adapting well.

A. Non-profit hospitals can adapt to the changing reimbursement methods and become more efficient

Many non-profits have feared that the lessening of Medicare and Medicaid reimbursements, due to budget cuts or losses from participating in shared savings programs, may cause too much financial strain. Yet, the reimbursement methods (or lack thereof) from government payers are not a death sentence with adequate planning and financial strategies.

Many studies have countered the conventional wisdom that a high Medicare and Medicaid payer mix undermines a hospital's ability to generate revenues. One study found that hospitals with high profit margin from private payers based on strong market power had weaker cost controls and higher cost per unit of service, which led to narrower margin on Medicare profits.[61] Moreover, hospitals with high financial pressure were

61. Jeffrey Stensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFFAIRS 1045, 1048 (2010).

able to post a four percent Medicare margin due to the lower costs per case; this study ultimately suggests that high Medicare payer mix combined with low private payer mix can still result in profitable operations of a hospital.[62] Some of this margin may be due to payments to hospitals with a disproportionate share of Medicaid patients.[63] Nonetheless, a key reason for the difference in Medicare profits between hospitals is the difference in costs per case, as opposed to just reimbursement amount.[64]

Furthermore, some studies have failed to find evidence that government payers undermine a hospital's ability to generate and collect patient care revenue.[65] In fact, hospitals with higher Medicare and Medicaid payer mixes collected slightly higher average patient revenue.[66] One of the main reasons behind higher average patient revenue can be attributed to Medicare payments being collected at a faster rate than private payers.[67] For some hospitals, taking action to improve their revenue cycle by initiating a variety of organizational and managerial changes has resulted in higher patient revenue.[68]

History suggests that it is also unlikely that states will continue to opt out of the Medicaid expansion under the PPACA.[69] Over time, states have met new federal requirements to extend Medicaid, despite budget constraints.[70] In addition, several states have analyzed the potential impacts of opting out

62. *Id.* at 1049.
63. *Id.* at 1050.
64. *Id.*
65. Rauscher & Wheeler, *supra* note 21 at 82.
66. *Id.* at 91.
67. *Id.*
68. *Id.* at 92. Such managerial changes include requiring patients to pay up front for deductibles and copay and changing services to focus on more profitable procedures. *Id*. at 91-92.
69. *See* KAISER FAMILY FOUND., *supra* note 1, *passim*.
70. *Id*. at 2.

of the Medicaid program.[71] These states found significant coverage and fiscal impacts, including increased uncompensated care costs, revenue losses for providers and hospitals, cost-shifting to private insurers leading to higher premiums, and loss of federal revenues that support other state agencies, such as mental health departments.[72] These studies also mentioned broader economic impacts on jobs and businesses.[73] This, along with the near complete federal subsidy of Medicaid, should provide enough incentive for states to adopt the expansion.

Non-profit hospitals can also secure future financial success by joining or forming an Accountable Care Organization (ACO).[74] An ACO may consist of a group of physicians, one or more hospitals, and other providers that come together to provide coordinated care for Medicare beneficiaries.[75] The PPACA incentivizes the creation of ACOs through the creation of the Medicare shared savings program, in which a qualifying ACO is able to share from any savings that the ACO generates for Medicare.[76]

The shared savings program begins with first assigning a certain population of Medicare beneficiaries to an ACO.[77] At the beginning of the year, CMS calculates a benchmark dollar amount for the ACO based on the typical Part A and Part B expenditures fee-for-service expenditures of the assigned beneficiary population.[78]The ACO continues to file claims for reimbursement under a typical fee-for-service program throughout the

71. *Id.* at 4.
72. *Id.*
73. *Id*.
74. *See generally* AAFP, *supra* note 18.
75. *Id.* at 3.
76. *Id*. at 5.
77. *Id*.
78. *Id.* This, essentially, is what CMS expects to pay out in reimbursement in the upcoming year.

year.[79] If the ACO's expenditures fall below the benchmark amount, then Medicare has saved money, and the ACO may share a certain percentage of the savings.[80] This provides an opportunity for non-profit hospitals to increase their revenue.

ACOs provide an organizational structure in which non-profit hospitals can capitalize on savings via Medicare shared savings.[81] If non-profit hospitals join an ACO, these hospitals will share the financial risk of loss, but can also reap the benefits of being a part of a more integrated system that is thought to improve quality and slow spending growth.[82] The benefits from more coordinated care, and the shared savings that may result, helps secure financial stability in the future.

Non-profits can also take this ACO value-based methodology and apply it to private payer and Managed Care Organizations. Advocate Health Care of Illinois (Advocate) contracted with Blue Cross Blue Shield of Illinois using value-based payments and risk sharing.[83] Advocate's financial statement indicated that by March 2011, its cost-of-care increase was 6.1% lower than the control group.[84] This suggests that value-based payment methods helped lower costs, but also, and more importantly, increases the

79. *Id*.

80. *See id*. at 5-6. CMS calculates the expenditures of the beneficiaries as opposed to totaling the reimbursement claims from the ACO. *Id*. at 5. This means that the ACOs are responsible for all expenditures of the Medicare beneficiaries. Even if the assigned beneficiary receives care outside the ACO network, the expenditures still count toward the ACO benchmark. *See id*. If the amount exceeds the benchmark, the ACO will be responsible to pay a percentage of the losses. *See id*. at 6. This model holds these organizations accountable for their care by changing the typical fee-for-service model by including the risk/benefit of loss/gain.

81. *Id*. CMS also requires an ACO to create its own separate governance structure. *See id*. at 3-5.

82. *See* Elliott S. Fisher & Stephen M. Shortell, *Accountable Care Organization Accountable for What, to Whom, and How*, 304 J. AM. MED. ASS'N 1715, 1715 (2010).

83. KAUFMAN HALL, REPORT FROM THE FRONT: ADVOCATE'S EARLY RESULTS (2012), *available at* https://www.kaufmanhall.com/DocumentDetails.aspx?did=68a3942b-ccf6-4f86-b8a2-e497c25b0e64.

84. *Id*.

value of the care provided.

B. Tax-exempt status can still be maintained by non-profit hospitals

Another reason non-profit hospitals can remain financially profitable is due to maintaining tax-exempt status. Maintaining this status could easily be accomplished with proper management and planning. Although there are new requirements from the PPACA, meeting these requirements should not be difficult due to the lack of specificity regarding the charity care requirement.[85] Although the PPACA should decrease the pool of uninsured through the individual mandate, opportunities to provide charity care still exist because eight percent of the population will still lack meaningful coverage by 2019, amounting to an estimated $46.6 billion uncompensated care expenditure.[86] In addition, non-profits can also direct their charitable impulses by focusing on other methods of community benefits to secure their federal tax-exempt status.[87]

Non-profit hospitals in Illinois also have the opportunity to preserve their state tax-exemptions due to changes in Illinois law. The Illinois legislature addressed the strict standards set forth in *Provena* and responded by expanding the definition of charity care.[88] The legislature recognized that non-profits not only provide charity care, but also provide "substantial financial subsidization of the Illinois Medicaid program."[89] The broadened definition of charity care allows non-profit hospitals to include other forms

85. Smith & Noe, *supra* note 6, at 17.
86. Principe et al., *supra* note 10, at 233.
87. *Id.* at 234 (discussing how additional community benefits include: community health improvement, community building activities, community health operations, or subsidized health services).
88. 35 ILL. COMP. STAT. 105/3-8(b) (2012).
89. 35 ILL. COMP. STAT. 200/16-86(a)(4) (2012).

of services as charity care,[90] as opposed to simply "gifted care[91]," giving non-profits in Illinois more flexibility.

V. CONCLUSION

Even though healthcare reform will begin to grow beyond the walls of a hospital[92], there will still be a meaningful role for the non-profit hospitals because the "services available through community benefit programs are designed to respond to unmet public health needs[93]." Further, new value based payment methods have had a positive impact, as some studies have showed that hospitals that serve poor patients improved the quality of care after a pay-for-performance model was introduced.[94]

Changes caused by healthcare reform also stress the importance of sound financial strategies. The Moody's investor service suggests that hospitals should gain market share to create pricing leverage against private payers, integrate care by employing physicians to align incentives, and improve efficiency by creating a unified information technology platform to ensure that all hospitals, clinics, and physician offices are electronically connected.[95] These techniques can increase efficiency, and prepare non-profit hospitals for these new payment methods.[96] Financial and managerial ingenuity can help overcome the forthcoming challenges. This will create a

90. The definition now includes typical charity care, health services provided to underserved individuals, subsidy of state and local government, subsidies of state healthcare programs, and relief from any other burden related to healthcare. 35 ILL. COMP. STAT. 105/3-8(c) (2012).

91. *See* Provena, *supra* note 22, at 1145.

92. 35 ILL. COMP. STAT. 200/15-86(a)(3) (2012).

93. Principe et al., *supra* note 8, at 235 (quoting Julie Trocchio, *Does Cmty.-Oriented Mission Fit With Health Reform*, OCT.-SEPT. HEALTH PROGRESS, 11, 11 (2009)).

94. Ashish K. Jha et al., *The Effect of Financial Incentives on Hospitals that Serve Poor Patients*, 153 ANNALS OF INTERNAL MED. 299, 305 (2010).

95. MOODY'S, *supra* note 24, at 3, 4, 6.

96. *See id*. at 8.

more efficient healthcare system with stronger non-profit hospitals.

Moving towards universal coverage for healthcare is an expensive endeavor that will create challenges for providers to overcome. Federal and state budgets for Medicare and Medicaid will likely be tightened, and tax-exempt statuses will be scrutinized. The PPACA is a lengthy and complicated law that brings about a vast overhaul of the healthcare system in the United States. However, this does not create an impossible obstacle to achieving the goals of non-profit hospitals. When the initial obstacles are understood and defeated, a new and more efficient system will emerge. Non-profit hospitals that have quality management and the pulse on its community's necessities will be able to survive this transition and thrive in the future.

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Health Reform's Push Towards Hospital Mergers: Will Antitrust Laws Adapt to Reach Reform Goals?

*Jamie Levin**

I. INTRODUCTION

The health care landscape is drastically changing as the federal government pushes towards a higher quality, more efficient health care system.[1] With the adoption of the Patient Protection and Affordable Care Act ("PPACA"), discussion has been centered on the estimated thirty-two million Americans who will gain insurance coverage by 2019 and the massive budget deficit reduction the federal government hopes to achieve.[2] However, there has been little discussion on health reform's impact on the hospital industry.[3] As the federal government seeks to achieve a value-based system of care, hospitals will be required to play a lead role in improving efficiency while providing high-quality care.[4] To achieve these goals, health care providers must adopt new payment and delivery approaches that integrate clinical outcomes with effective cost containment.[5] Taking these actions required or encouraged under the

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1. *Health Care Consolidation and Competition after THE PPACA: Before the Subcomm. On Intellectual Prop., Competition & the Internet of the H. Comm. Judiciary*, 112th Cong. (2012) (statement of American Hospital Association)[hereinafter *AHA: Health Care Consolidation and Competition after THE PPACA*], *available at* http://www.aha.org/advocacy-issues/testimony/2012/120518-tes-the PPACA.pdf.

2. Paul Wierbicki & Jennifer Bisenius, COST PRESSURES COULD FORCE DISTRESSED M&AS IN U.S. HOSPITAL MARKET, 20 BNA HEALTH CARE POL'Y R. 14 (2012), *available at* http://www.kirkland.com/siteFiles/Publications/BloombergBNA%20_April%202012.pdf.

3. *Id.*

4. *See* Lisa Goldstein, *The New Wave of Hospital Consolidation*, HEALTHCARE FIN. MGMT. ASS'N, http://www.hfma.org/Templates/Print.aspx?id=31501 (last visited Oct. 15, 2012).

5. *Value In Health Care: Current State and Future Directions*, HEALTHCARE FIN. MFMT

PPACA places considerable cost pressures on hospitals to transform their systems to achieve the PPACA's initiatives.[6]

The reform agenda assumes that hospitals have the financial strength to invest large amounts of capital in restructuring their hospitals while simultaneously absorbing decreased revenues from payment reform.[7] However, at the intersection of an economic crisis and health reform[8], many hospitals, especially stand-alone hospitals, cannot maintain the necessary capital to survive.[9] In effect, hospitals faced with these unprecedented demands will close and patients will suffer as physicians leave for more hopeful opportunities.[10] Closures will result in reduced specialty services, overcrowding, and an overall decrease in access to care.[11] Thus, the PPACA's purpose to expand access to care will be depleted if hospitals cannot survive to treat their communities.[12]

As hospitals face tightening payment, rising bad debt, and increased investment demands hospitals are merging to ensure their stability and access essential capital.[13] Federal agencies, like the Centers for Medicare and Medicaid Services (CMS), look to mergers as a way to build the continuum of care by better aligning hospitals' economic incentives to

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ASS'N 1 (June 2011) http://www.hfma.org/HFMA-Initiatives/Value-Project/Value-Project-Report-One/ [hereinafter *Value In Health Care*].

6. Wierbicki & Bisenius, *supra* note 2.

7. Mark E. Grube & Kenneth Kaufman, *Positioning Your Organization For Success in the New Era*, HEALTHCARE FIN. MFMT ASS'N, Jan. 2010, http://www.hfma.org/Templates/Print.aspx?id=2158 (last visited Oct. 28, 2012).

8. *See Id*.

9. *See* Wierbicki & Bisenius, *supra* note 2.

10. Brief for Petitioner at 7, F.T.C. v. ProMedica Health Sys., Inc., 3:11 CV 47 (N.D. Ohio Mar. 29, 2011) (No. 12-3583).

11. *Id* at 24.

12. *See id* at 2.

13. *Id* at 25. *See also* Chris Myers & Jason Lineen, *Hospital Consolidation Outlook: Surviving in a Tough Economy*, HEALTHCARE FIN. MGMT. ASS'N (2009), http://www.hfma.org/Templates/InteriorMaster.aspx?id=2463 (last visited Oct. 15, 2012).

reduce costs and improve value.[14] However, the federal government's stance towards consolidation appears highly unharmonious as federal antitrust agencies remain aggressive in their efforts to prevent hospital mergers that impede competition.[15]

The conflict between health care policy and antitrust enforcement has played out in a series of federal challenges to hospital mergers.[16] The outcomes of these mergers demonstrate that even as the PPACA aims to increase value in health care, traditional antitrust measures of cost containment and market consolidation continue to guide the FTC's enforcement decisions.[17] With health care experiencing a drastic change, antitrust enforcement must coincide to reach a desired outcome and begin to place greater weight on other factors driving health reform, like quality and efficiency.

This article will begin by highlighting certain health reform efforts that are transforming the landscape of the American health care system. Next, this article will discuss how these market changes are directly and indirectly spurring an influx of hospital mergers. Following that discussion, this article will examine the legal barriers in place thwarting hospital consolidation. This article will conclude by proposing adjustments to the

14. *See* Thomas C. Brown, Jr. et al., *Current Trends in Hospital Mergers and Acquisitions*, HEALTHCARE FIN. MFMT ASS'N,, www.hfma.org/Templates/Print.aspx?id=31062 (last visited Sept. 28, 2012).

15. *See* Brent Kendall, *Regulators Seek to Cool Hospital-Deal Fever*, WALL ST. J., March 18, 2012, *available at* http://online.wsj.com/article/SB10001424052702303863404577286071837740832.html.

16. Kathleen Roney, *An Overview of Recent Challenges to Hospital Transactions: Is the FTC Really More Aggressive?*, BECKER'S HOSP. REV. (May 1, 2012), http://www.beckershospitalreview.com/hospital-transactions-and-valuation/an-overview-of-recent-challenges-to-hospital-transactions-is-the-ftc-really-more-aggressive.html (last visited Oct. 28, 2012).

17. *See Understanding Recent Developments in Hospital Merger Enforcement*, Foley & Lardner LLP (May 9, 2009), http://www.foley.com/understanding-recent-developments-in-hospital-merger-enforcement-05-09-2012 (last visited Sept. 28, 2012).

current antitrust analysis to achieve the goals of health reform.

II. CHANGING MARKET CONDITIONS

The American health system is transforming and challenging the platform upon which hospitals operate into the near future.[18] While some commentators have compared hospital consolidation today to the "merger mania" of the 1990's[19], the range and magnitude of forces confronting independent hospitals today are unprecedented.[20] Current consolidation participants have unique risks with quality improvements, adopting strategies to control costs, flat or declining volumes of reimbursement, clinical and operational IT spending, and increased capital demands related to physician affiliation and employment.[21] Adoption of the PPACA did not create these driving forces, but it did increase the momentum towards a different economic and market environment, to which hospitals must respond.[22]

A. Decrease In Revenues

Of the many forces transforming American health care, none is more significant than the shift towards a value-based purchasing system.[23] Currently, hospitals operate under a fee-for-service payment system.[24] Hospitals survive off Medicare and Medicaid payments, which account for

18. Grube & Kaufman, *supra* note 7.
19. The forces behind the current consolidation and the past wave of consolidation in the late 1990's include payment challenges, spiraling healthcare costs, and a slow economic recovery. Goldstein, *supra* note 4.
20. Molly Gamble, *12 Challenges and Opportunities for Hospitals in 2012*, BECKER'S HOSP. REV. (Dec. 13, 2011), http://www.beckershospitalreview.com/hospital-management-administration/12-challenges-and-opportunities-for-hospitals-in-2012.html (last visited Oct. 28, 2012).
21. *Id.*
22. *See* Thomas C. Brown, Jr. et al., *supra* note 14.
23. *Value In Health Care*, *supra* note 5.
24. Grube & Kaufman, *supra* note 7.

forty-three percent of a hospital's gross revenues.[25] Under the Medicare fee-for-service model, hospitals are reimbursed based on the volume of services provided.[26]

Beginning in fiscal year 2013, CMS will implement a national Medicare hospital value-based program[27] designed to pay hospitals a better Medicare rate conditional upon achieving a targeted threshold of clinical performance.[28] The new plan will displace the current fee-for-service volume based payment system[29], thus impacting hospitals significantly as reimbursement per unit of service and inpatient user rates are expected to drop.[30] Providers will no longer be compensated for high volumes of patient care, but rather incentivized to improve preventative care, and reduce readmissions and avoidable hospitalization.[31] These market changes will force hospitals to respond quickly, as those that do not meet certain quality thresholds will face penalties.[32] Hospitals will be hit hard as they

25. MOODY'S INVESTORS SERVICE, HOSPITAL REVENUES IN CRITICAL CONDITION; DOWNGRADES MAY FOLLOW ANNOUNCEMENT, at 1 (Aug. 9, 2011), *available at* www.hhnmag.com/hhnmag/PDFs/2011PDFs/moodys.pdf.

26. Grube & Kaufman, *supra* note 7.

27. *Medicare Delivery and Payment System Reforms*, PREMIER INC. at 1, (Mar. 2012), *available at* https://www.premierinc.com/about/advocacy/iss/Position%20Papers/Medicare-Reform-Premier-Policy-Paper-March2012.pdf. In 2013, the government will also establish a bundle payment program. *Id.* Bundled payment programs will pay hospitals a flat amount that must cover hospital, physician, and postacute care costs, driving the need for greater efficiencies. Goldstein, *supra* note 4.

28. Grube & Kaufman, *supra* note 7.

29. *Id.*

30. Martin D. Arrick et al., *The U.S. Not-For-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, STANDARD & POOR'S 4 (January 25, 2012), *available at* http://www.standardandpoors.com/spf/. . .US/US_FI_Event_hc6512art7.pdf.

31. Debra J. Lipson & Samuel Simon, *Quality's New Frontier: Reducing Hospitalizations and Improving Transitions in Long-Term Care*, MATHEMATICAL POL'Y RES., 3 Mar. 2010, *available at* http://www.mathematica-mpr.com/publications/pdfs/health/LTQA_brief.pdf. Implementation of value-based programs will demand significant facility-specific improvement to produce a financial reward, which is a burden many hospitals cannot bear. Wierbicki & Bisenius, *supra* note 2.

32. *AHA: Health Care Consolidation and Competition after THE PPACA*, *supra* note 1, at 2.

face new Medicare payment eligible guidelines enacted by the PPACA and absorb the $155 billion in Medicare cuts.[33]

B. Increasing Costs

The cost to replace the current fragmented system of care comes at a price, especially for providers.[34] For example, the PPACA requires healthcare providers to adopt Electronic Health Record (EHR) systems that can be used to gauge the quality of care and assist in developing cost-effective treatment patterns.[35] This record keeping system is designed to reduce administrative burdens, cut costs, and reduce medical errors.[36] However, the initial financial burden rests on the hospital to incur the short-term implementation costs or face penalties in 2015.[37]

For a mid-size hospital, the cost of transitioning from paper records to EHRs could amount to over fifty million dollars.[38] The PPACA initially incentivizes hospitals to adopt EHRs by providing roughly six million dollars in Medicare subsides.[39] However, these subsidies cover only ten percent of the overall cost of the transition to EHRs.[40] Plus, hospitals must invest in dedicated staff to develop and sustain these systems.[41] One study projected roughly half of all U.S. hospitals will be unable to implement the

33. PREMIER INC., *supra* note 27.
34. *AHA: Health Care Consolidation and Competition after PPACA*, *supra* note 1, at 2.
35. *See generally* 45 C.F.R. § 164.308 (2010).
36. Wierbicki & Bisenius, *supra* note 2. Hospitals also must meet "meaningful use" targets for implementing patient and electronic medical systems to receive federal government rewards. *See id.*
37. *Hospitals: The Changing Landscape is Good for Patients & Health Care*, AM. HOSP. ASS'N 3 (2012), *available at* http://www.aha.org/content/12/12-03-02-landscape.pdf [hereinafter *Changing Landscape*].
38. *Id.*
39. Wierbicki & Bisenius, *supra* note 2.
40. *Id.*
41. *Id.*

required technology standards by 2015, thus incurring penalties.[42]

C. Encouraging Integration

Further, health care reform will directly reward greater clinical integration through the Accountable Care Organization (ACO) model promoted by the Medicare Share Saving Program (MSSP).[43] THE PPACA incentivizes hospitals and physician practices to participate in these programs by reimbursing ACOs that meet quality-of-care targets and reduce the costs of patients relative to a spending benchmark.[44] Clinical integration is defined as a structured collaboration among hospitals, physicians, and other providers to improve quality and efficiency, which employs vertical and horizontal consolidation in its very nature.[45]

III. HEALTH REFORM IS CREATING AN URGE FOR HOSPITALS TO MERGE

As hospitals are hard-pressed to invest in an array of initiatives to meet reform goals, many hospitals are being driven towards consolidation.[46] For many hospitals, particularly those with lower bond ratings[47], the best and perhaps only strategy to remain in the community is merging with another hospital that possesses the financial resources it lacks.[48] While many stand-alone hospitals believe cost-containing measures are an effective tactic

42. *Id.*
43. Thomas C. Brown, Jr. et al., *supra* note 14.
44. PREMIER INC., *supra* note 27.
45. *See* Grube & Kaufman, *supra* note 7. Integration will also be encouraged as ACO participation allows for the sharing of cost and payments between hospitals and physicians to achieve improved value. Thomas C. Brown, Jr. et al., *supra* note 14.
46. Goldstein, *supra* note 4. *See also* Karen Minich-Pourshadi, *Hospitals & Acquisitions: Opportunities and Challenges*, HEALTH LEADERS MEDIA, Nov. 2010, at 3, *available at* http://www.healthleadersmedia.com/intelligence/detail.cfm?archive=AR&year=2011&content_id=259008.
47. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on bonds to access capital at a lower price. Brief for Petitioner, *supra* note 10, at 14.
48. *Changing Landscape*, *supra* note 37.

amid health care reform,[49] managing costs is only an effective near-future strategy.[50] Its effectiveness is limited in the long term as it is hard to find new cost-cutting initiatives year after year.[51] However, merging with a larger hospital allows independent hospitals to spread fixed costs over a larger patient base and expand patient access to services, better managing costs and improving patient care.[52]

Even for hospitals not experiencing financial distress, merging into a larger health system creates greater efficiencies and drives waste and costs out of the delivery system.[53] A merger between two hospitals can also enable economies of scale, shared branding, improved access to capital, and limited consolidation of clinical programs.[54] Hospitals with a strong infrastructure and steady supply of capital are more able to take advantage of the opportunities the PPACA presents.[55] Hospitals who evaluate the options of a partnership before a experiencing a financial decline will be in a better position for success.[56]

IV. ANTITRUST ANALYSIS OF HOSPITAL MERGERS

As the landscape of the health industry transforms and drives hospitals to merge, an important question is raised: how will antitrust laws coincide with the changing market realities?[57] Whether hospitals faced with unprecedented market forces will be evaluated under a traditional antitrust

49. Wierbicki & Bisenius, *supra* note 2.
50. STANDARD & POOR'S, *supra* note 30.
51. *Id*.
52. Wierbicki & Bisenius, *supra* note 2.
53. Brief for Petitioner, *supra* note 10, at 26. Mergers also allow hospitals to eliminate duplicative services and technology. *Id.*
54. Myers & Lineen, *supra* note 13.
55. Thomas C. Brown, Jr. et al., *supra* note 14.
56. Myers & Lineen, *supra* note 13.
57. *See* Foley & Lardner LLP, *supra* note 17.

review, or whether other factors will be considered, is a key concern for the future of providers and the communities they serve.

The Federal Trade Commission ("FTC") and the United States Department of Justice ("DOJ") equally possess the regulatory right to intervene in a merger,[58] primarily through enforcement of the Clayton Act.[59] Under section seven of the Clayton Act, federal antitrust agencies restrict acquisitions that may have the effect of lessening competition, or to create a monopoly.[60] Although Congress does not provide a definite test to determine whether mergers may substantially lessen competition, it has indicated that a merger must be viewed in the context of its particular industry.[61] Federal agencies must also examine the structure, history, and future for determining the probable anticompetitive effect of the merger.[62]

In analyzing section seven Clayton Act cases, courts generally adopt the framework set out in the FTC and DOJ Merger Guidelines.[63] In 2010, the *Horizontal Merger Guidelines* were revised to emphasize the ways in which

58. Mark E. Rust, *From HCQIA to ACA*, 33 J. LEGAL MED. 21, 28 (2012).

59. *See* Richard A. Feinstein et al, *FTC Antitrust Actions In Health Care Services And Products*, AM. BAR. ASS'N 2 (2001).

60. Jamie Moffitt, *Merging in the Shadow of the Law: The Case for Consistent Judicial Efficiency Analysis*, 63 VAND. L. REV. 1697, 1747 (2010). When violation of antitrust laws leads to litigation, many of the FTC's adjudicative matters are conducted before an FTC Administrative Law judge. Feinstein et al, *supra* note 59. This provides complex legal and economic issues to be heard in a forum specially suited for dealing with such matters. *Id.* The FTC also has the authority to seek a preliminary injunction in federal district court when they have reason to believe a party is violating any provision of law enforced by the FTC. *Id.*

61. Brief for Petitioner, *supra* note 10, at 27.

62. *Id.*

63. Moffitt, *supra* note 60. *See generally*, U.S. Dep't of J. & Fed. Trade Comm'n, Horizontal Merger Guidelines 1 (2010), *available at* http://ftc.gov/os/2010/08/100819hmg.pdf (federal agencies' analysis of mergers and acquisitions). Although Courts often look to the merger guidelines as a framework for interpreting the law, the guidelines do not bind judges. Melanie Evans, *ProMedica to Test Merger Guidelines in Federal Court*, MODERNHEALTHCARE.COM, Mar. 2012, *available at* http://www.modernhealthcare.com/article/20120331/MAGAZINE/303319982 (last visited Oct. 28, 2012).

the federal antitrust agencies analyze mergers involving actual or potential competitors.[64] In doing so, they de-emphasized market definition and increased the threshold for market concentration.[65] The updated policy has a great effect on how future mergers will be analyzed as more organizations integrate within clinical, operational, and technological systems.[66]

After the revisions to the *Merger Guidelines* in 2010, the FTC "redoubled its efforts" to prevent hospital mergers that may level insufficient local options for inpatient services.[67] The FTC has since moved to challenge three hospital mergers in federal court.[68] In two of the three cases, the FTC succeeded, which indicates that their enforcement efforts will likely not decline, or even adjust, in the rapidly changing health care environment.

A. FTC v. ProMedica

The first transaction tested under the new merger guidelines in federal

64. *FERC Reaffirms Merger Policy; Does Not Adopt DOJ/FTC 2010 Horizontal Merger Guidelines*, McDermott Will & Emery (Feb. 27, 2012), http://www.mwe.com/FERC-Reaffirms-Merger-Policy-Does-Not-Adopt-DOJFTC-2010-Horizontal-Merger-Guidelines-02-27-2012/?PublicationTypes=d9093adb-e95d-4f19-819a-f0bb5170ab6d.

65. *Id.* Courts also look to whether any defense or exemptions apply. Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, L. & CONTEMP. PROBS., Spring 1988, at 163. A defense to an anticompetitive merger is the failing firm defense, which allows a merger if one of the firms is in poor financial condition in order to preserve the failing firm's assets as a competitive force. *Id.*

66. *See* Thomas C. Brown, Jr. et al., *supra* note 14.

67. FTC ANNUAL HIGHLIGHTS 2012, FTC.GOV at 4 (2012), *available at* ftc.gov/highlights (last visited Oct. 28, 2012).

68. Roney, *supra* note 16. The third challenged merger involves the acquisition of Palmyra Medical Center in Albany, Ga., by Phoebe Putney Health System. Mary K. Marks, *Hospital Consolidations: Facing Competing Pressures to Merge and Remain Independent*, NATIONAL L. REV. (June 2012), *available at* http://www.natlawreview.com/article/hospital-consolidations-facing-competing-pressures-to-merge-and-remain-independent (last visited Oct. 28, 2012). Similarly, the FTC argued the transaction would greatly enhance Phoebe Putney's bargaining position in negotiations with health plans. *See Id.* However, the district court dismissed the FTC's compliant on the ground that the hospital's actions were immune from antitrust liability as a state actor. *Id.* The FTC has requested the US. Supreme Court grants certiorari to review the state action ruling. *Id.*

court was the FTC's retrospective challenge to the merger of St. Luke's Hospital and ProMedica Health System.[69] In January 2011, the FTC and the state of Ohio filed a complaint challenging ProMedica Health System's acquisition of control over St. Luke's Hospital, claiming anticompetitive harm due to the merger.[70] According to the commission, the transaction would reduce the number of competitors in general acute-care inpatient hospital services in Lucas County from four to three, creating a sixty percent market share.[71] ProMedica reasoned the acquisition was necessary in order to create efficiencies.[72] Further, the entities pled a variation of the "failing firm" defense, claiming that St. Luke's was a "weakened competitor" and therefore should not be analyzed as a viable independent market participant.[73]

After a full administrative trial, the Administrative Law Judge (ALJ) found the reduction from four to three hospitals in the area, would increase ProMedica's bargaining power with commercial health plans, thus leading to higher reimbursement rates for customers.[74] The FTC upheld most of the ALJ's Initial Decision and rejected all of ProMedica's arguments of efficiencies gains.[75] Further, the court dismissed St. Luke's "failing firm" defense.[76] The FTC reasoned that St. Luke's existing focus on quality care would make for a smooth transition to health reform.[77] The FTC ordered ProMedica to divest St. Luke's either to a new purchaser or to a newly

69. *See* Evans, *supra* note 63.
70. F.T.C. v. ProMedica Health Sys., Inc., No. 3:11 CV 47, 2011 WL 1219281 (N.D. Ohio 2011). *See also* Roney, *supra* note 16.
71. *F.T.C. v. ProMedica Health Sys*., *supra* note 70.
72. *Id.*
73. Foley & Lardner LLP, *supra* note 17.
74. Marks, *supra* note 68.
75. *Id.*
76. Foley & Lardner LLP, *supra* note 17.
77. *Id.*

constituted St. Luke's.[78] However, a month after the FTC's final order, officials from ProMedica and St. Luke's decided to file an appeal in the 6th U.S. Circuit Court of Appeals in Cincinnati, expected to take place in 2013.[79]

B. FTC v. OSF

In *Federal Trade Commission v. OSF*, a U.S. District judge ordered OSF Healthcare System and Rockford Health System to suspend their planned merger, until the FTC could hold an administrative trial in Washington.[80] Again, high concentration of market activity became the decisive issue.[81] The FTC reached its conclusion of anticompetitive effects by measuring the combined current patient admissions and patient days of the merged hospitals.[82]

In response, the hospitals reasoned the substantial efficiencies outweighed any anticompetitive effects.[83] The entities claimed increased efficiencies both in terms of annual recurring savings and one-time capital avoidance, which would permit the parties to gain capital in order to improve and expand medical services.[84] By merging, the hospitals argued they could improve their ability to recruit and retain specialists and subspecialists, which would increase the scope of services offered locally.[85]

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78. Marks, *supra* note 68.

79. Kris Turner, *ProMedica: FTC gear up for next legal battle*, TOLEDOBLADE.COM, July 25, 2012, *available at* http://www.toledoblade.com/Courts/2012/07/26/ProMedica-FTC-gear-up-for-next-legal-battle.html (last visited Sept. 15, 2012).

80. Roney, *supra* note 16.

81. *Id*.

82. *F.T.C. v. OSF Healthcare Sys*., 852 F. Supp. 2d 1069, 1078 (N.D. Ill. 2012).

83. *Id at 1088.*

84. *Id*.

85. *Id* at 1093. *See also* Katherine A. Ambrogi, *Analysis in Merger Enforcement: Lessons from FTC v. OSF Healthcare, 26* ANTITRUST HEALTH CARE CHRONICLE 2 (Sept., 2012), http://www.americanbar.org/content/dam/aba/publications/antitrust_law/at301000_chronicle_201209.authcheckdam.pdf

The district court rejected the hospitals' efficiency and community benefits arguments,[86] and instead accepted the FTC's contention that the claimed efficiencies were speculative, unreliable, and not merger-specific.[87] The district court reasoned the anticompetitive effects resulting from the reduction of three to two general acute-care hospitals in Rockford was too compelling to rebut.[88] At the same time, the court commended the hospitals for having the desirable goals of increasing quality of care, but concluded it was unable to declare if these goals could only be realized with the proposed merger.[89] In the end, the two-year legal battle dissuaded the defendants from pursing an appeal and they dropped the deal.[90]

C. Analysis

The hospital merger case law and pronouncements by the federal enforcement agencies make clear that any hospital merger resulting in high market shares faces a steep uphill climb to win FTC approval. The traditional analysis applied to these mergers illustrates an important challenge for providers to come up with ways to deliver services more effectively while at the same time receiving strict antitrust scrutiny.

At issue in each of these challenges was the anticipated consolidation of inpatient general acute care services.[91] The FTC found both cases to include an increase in market concentration, which they concluded would result in an increase in costs, reduction in quality and range of choices for

86. *F.T.C. v. OSF Healthcare Sys*., 852 F. Supp. 2d 1069, 1078 (N.D. Ill. 2012).
87. *Id* at 1093.
88. *Id* at 1082.
89. *Id* at 1094.
90. Joe Carlson, *OSF Healthcare, Rockford Health drop Merger Plans*, MODERNHEALTHCARE.COM, (Apr. 12, 2012, 5:45 PM), http://www.modernhealthcare.com/article/20120412/NEWS/304129969# (last visited Oct. 28, 2012).
91. Marks, *supra* note 68.

local consumers.[92] Yet, the court in *FTC v. ProMedica*, broadly defined the relevant market in Locus County, failing to include distinguishing services that set the hospitals apart.[93] By excluding distinguishing services of the two hospitals, the FTC failed to encompass the actual anti-competitive effects on the community.

Further, the FTC placed great weight on past performance as an indicator for an unlawful merger in *FTC v. OSF*.[94] In determining the relevant market share of the merged entities, the FTC based its presumption of unlawful activity solely on a showing that the combined entity would have fifty-five percent of the market share in past patient admissions and past days spent in the hospital.[95] Yet, as health reform is incentivizing providers to decrease patient admission and days spent in the hospital, past performance cannot be a conclusive measure for determining a hospital's future ability to compete.[96]

Additionally, while the 2010 *Merger Guidelines* revisions placed more weight on market concentration, the FTC and DOJ framework still states it is necessary to balance these anticompetitive effects with precompetitive efficiencies.[97] Yet, the courts dismissed the potential efficiencies created through these mergers. The courts reasoned the improved quality of care was speculative and hard to quantify. However, efficiencies gained from better alignment are not speculative if the necessary systems are adopted to appropriately measure their effects, which requires great capital.[98] While it

92. *Id.*
93. Foley & Lardner LLP, *supra* note 17. This definition excluded tertiary services and OB services, which are key distinguishing factors in the community. *Id.*
94. *See F.T.C. v. OSF Healthcare Sys*., *supra* note 82.
95. *Id*.
96. *See* Brief for Petitioner, *supra* note 10.
97. Moffitt, *supra* note 60.
98. Wierbicki & Bisenius, *supra* note 2.

is necessary for these hospitals to provide sufficient evidence for quality projections, only once investments of the merged entities are made can real quality measures be displayed. The break-up of these two mergers signals a challenge for future hospital to establish precompetitive benefits from potential cost-savings and efficiencies.

V. WHAT SHOULD BE DONE?

To accomplish a new continuum of care, antitrust laws must adapt to meet the realities of the health care market. As the American health care system is becoming one that stresses wellness rather than sickness, past performance indicators will not reveal accurate projections for the future of a hospital's anticompetitive effects. It is imperative to incorporate potential quality measures instead of patient admissions in measuring future health care mergers.

Moreover, antitrust laws must recognize that hospitals today are faced with decreasing reimbursement rates, increases in costs, and encouragement to integrate. Stand-alone hospitals face increased pressures to respond to these market realities and must be evaluated as such. Antitrust enforcement should not only execpt a "failing firm defense," but also evaluate a hospital's weak status. As illustrated in *ProMedica*, the court found that St. Luke's existing display of quality measures implied its financial stability into the future.[99] However, past quality care performance does not indicate their future financial strength, as the PPACA requires extensive capital demands for new technological quality-measurement systems.[100]

Additionally, smaller cities cannot support as many hospitals as they

99. *See F.T.C. v. ProMedica Health Sys*., *supra* note 70.
100. *See* Brief for Petitioner, *supra* note 10.

once did.[101] The market concentration in rural areas is often higher than urban cities, but in order for these hospitals to take part in health reform, the financial implications must be more proportionately weighed. If ignored both patients and the community will suffer as hospital services slowly deteriorate.[102]

Moreover, antitrust analysis must begin to properly weigh efficiencies as gained efficiencies are the driving force behind health reform. However, the case law makes clear that judicial treatment of efficiencies is aggressive and easily dismissed. Better integration of hospitals and physicians can achieve these efficiencies. Meeting these expectations cannot be achieved overnight and thus the FTC must begin to accept evidence demonstrating how efficiencies can be created. Since decreased costs for patients is the ultimate goal of both reform and antitrust efforts, the FTC must place greater weight on approaches that cut costs. As hospital mergers are likely to continue into the future, courts must accept these reform efficiencies as they warrant proper precompetitive effects.

VI. CONCLUSION

The direction of antitrust enforcement must coincide with the accelerating pace of consolidation of the American health care system. The federal government and private sector are creating great incentives for hospitals to consolidate that have the potential to increase cost-savings and streamline our system into a more efficient continuum of care. However, hospitals are particularly sensitive to changes in the law and their progress can be easily deterred by over-restrictive legislation and regulations. Therefore, antitrust analysis must recognize the current market realties.

101. Kendall, *supra* note 15, at 2.
102. Brief for Petitioner, *supra* note 10.

Once these unprecedented realities facing the health care industry are properly factored into antitrust enforcement, providers can begin to transform the current fragmented system into a coordinated one that produces more affordable, more accessible, and higher-quality health services.

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An Empty Promise? *Wheaton College v. Sebelius* and its Policy Implications on Impending PPACA Litigation

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I. INTRODUCTION

Chief Justice Earl Warren wrote, "the 'many subtle pressures' which cause policy considerations to blend into the constitutional limitations of Article III make the justiciability doctrine one of uncertain and shifting contours."[1] Indeed, while the justiciability doctrine restricts federal adjudication, in part, to actual disputes between adverse litigants, recent litigation challenging the Department of Health and Human Services Mandate (HHS Mandate) under the Patient Protection and Affordable Care Act (PPACA) substantiates Justice Warren's conclusion policy considerations commonly influence Article III's justiciability doctrine.[2]

In *Wheaton College v. Sebelius*, the United States District Court for the District of Columbia considered policy in holding the federal government's commitment not to enforce the HHS Mandate sufficiently eradicated Wheaton College's standing.[3] Accordingly, *Wheaton College* has

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1. *Flast v. Cohen*, 392 U.S. 83, 97 (1968). Not every case before a federal district court is suitable for adjudication on the merits. *Id.* "Justicability" concerns case requirements for a federal court to adjudicate on the merits. *Id.* While Article III does not explicitly outline a "justiciability doctrine," judicial interpretation of Article III's case-and-controversy doctrine requires, *inter alia*, "justiciability" for federal adjudication. *Id.*

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1101, 124 Stat. 119, 124 (2010) [hereinafter PPACA]. PPACA Section 1101 provides regulatory authority for the HHS Mandate. *Id.; see also Wheaton Coll. v. Sebelius*, No. 1:12CV1169(ESH), 2012 WL 3637162, at 4 (D.D.C. Aug. 24, 2012).

3. *Wheaton Coll.*, 2012 WL 3637162, at 4, 7; *see also About HHS*, HHS.GOV, http://www.hhs.gov/about (last visited Oct. 27, 2012). The Department of Health and

significant policy implications for over 100 plaintiffs comprising thirty-six pending federal lawsuits challenging the HHS Mandate's constitutionality, as litigants must overcome both changing policy considerations, as well as Article III's constitutional limitations to reach a judgment on the merits.[4]

This article will explore *Wheaton College's* implications surrounding the federal government's commitment not to enforce the HHS Mandate. Section II will provide background to the HHS Mandate and Wheaton College's aforementioned complaint. Section III will discuss the court's judgment dismissing Wheaton's case for lack of standing and ripeness. Finally, section IV will analyze *Wheaton College's* policy implications for the thirty-six pending federal lawsuits challenging the HHS Mandate, and *Wheaton College's* effect on the PPACA's foundation for universal coverage in the United States.[5]

II. THE HHS MANDATE AND THE WHEATON COLLEGE COMPLAINT

PPACA Section 1001 appended Section 2713(a)(4) to the Public Health Service Act (PHS Act).[6] Concisely, Section 2713(a)(4) requires all non-

Human Services is the federal agency tasked with providing essential human services and protecting individual health throughout the United States. *Id.*

3. *Wheaton Coll.*, 2012 WL 3637162, at 4; *see also HHS Mandate Information Central*, BECKETFUND.ORG, http://www.becketfund.org/hhsinformation central (last visited Oct. 27, 2012) [hereinafter *HHS Mandate Information Central*] (listing the 36 pending HHS Mandate challenges by federal circuit).

4. *Wheaton Coll.*, 2012 WL 3637162, at 4; *see also HHS Mandate Information Central*, BECKETFUND.ORG, http://www.becketfund.org/hhsinformation central (last visited Oct. 27, 2012) [hereinafter *HHS Mandate Information Central*] (listing the 36 pending HHS Mandate challenges by federal circuit).

5. Madison Park, *Where in the World Can You Get Universal Health Care*, CNN.COM, http://www.cnn.com /2012/06/28/health/countries-health-care/index.html (last visited Oct. 25, 2012) [hereinafter *Where in the World*]. The PPACA did not provide universal coverage in the United States. *Id.* Instead, the PPACA established the underpinnings for future universal coverage legislation in the United States. *Id.*

6. CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, GUIDANCE ON THE TEMPORARY ENFORCEMENT SAFE HARBOR FOR CERTAIN EMPLOYERS, GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE ISSUERS WITH RESPECT TO THE REQUIREMENT TO COVER CONTRACEPTIVE SERVICES WITHOUT COST SHARING UNDER SECTION 2713 OF THE PUBLIC HEALTH SERVICE ACT, SECTIONS 715(A)(1) OF THE EMPLOYEE RETIREMENT INCOME ACT, AND SECTION

grandfathered group health plans, and issuers of group or individual plans, to provide "preventive care" and screening to women beneficiaries without cost sharing.[7] Section 2713(a)(4) provided regulatory authority to the Health Resources and Services Administration (HRSA) establishing comprehensive guidelines defining "preventive care" under the PHS Act.[8]

Accordingly, on August 1, 2011, after amending the guidelines to exempt religious employers, HRSA issued comprehensive guidelines, known as the HHS Mandate, defining "preventive care" as, "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[9] Thus, the HHS Mandate required all non-grandfathered, non-exempt health insurance issuers provide contraceptive coverage in compliance with HRSA guidelines for plan years beginning on or after August 1, 2012.[10]

9815(1)(1) OF THE INTERNAL REVENUE CODE 1 (2012) [hereinafter GUIDANCE ON TEMPORARY ENFORCEMENT], http://cciio.cms.gov/resources/files/prev-services-guidance-08152012.pdf.

7. *Id.*; Bernadette Fernandez, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)* CONG. RESEARCH SERV. 1 (2011), http://www.ncsl.org/documents/health/grandfatheredplans.pdf. Under the HHS Mandate, a health insurance plan is considered "grandfathered" if the beneficiary was enrolled in the existing plan before March 23, 2010. *Id.*

8. 42 U.S.C. § 300gg-13(a)(1)-(4) (2012); GUIDANCE ON TEMPORARY ENFORCEMENT, *supra* note 6.

9. *Women's Preventive Services: Required Health Plan Coverage Guidelines*, U.S. DEP'T OF HEALTH & HUMAN SERVS. HEALTH RES. & SERVS. ADMIN., http://www.hrsa.gov/womensguidelines/ (last visited Oct. 5, 2012) [hereinafter *Women's Preventive Services Guidelines*]. "The Health Resources and Services agency (HRSA) of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable." *Id.* HRSA affirmed the regulatory objective of the guideline was "developed by the Institute of Medicine (IOM) [to] help ensure that women receive a comprehensive set of preventive services without having to pay a co-payment, co-insurance or a deductible." *Id.*

10. *Id.* On July 19, 2010, the Department of Health and Human Services released interim final regulations without an exemption for religious employers. GUIDANCE ON TEMPORARY ENFORCEMENT, *supra* note 6. However, in response to comments, HRSA amended the interim final regulations to provide an exemption for religious employers objecting coverage of contraceptive services on religious grounds. *Id.* A religious employer: "(1) has the inculcation of religious values as its purpose; (2) primarily employs persons who

On January 20, 2012, HHS reaffirmed the religious employer exemption, but outlined a temporary enforcement safe-harbor for all non-grandfathered, non-exempt health insurance issuers of group plans objecting to HRSA guidelines on religious grounds.[11] The safe-harbor provided objecting institutions one additional year for its group health plans to comply with HRSA guidelines.[12] In the interim, HHS promised to amend the HRSA guidelines to both "provid[e] contraceptive coverage without cost-sharing to individuals who want it and accommodat[e] non-exempted, non-profit organizations' religious objections to covering contraceptive services".[13] In other words, HHS promised to void HHS Mandate enforcement until August 1, 2013 and amend the HHS Mandate in the interim.[14]

After the safe-harbor announcement, Wheaton College declared it qualified for and would self-certify under the temporary safe-harbor.[15] As a qualified institution, Wheaton College would not be subject to HHS Mandate enforcement until the first plan year beginning on or after August 1, 2013.[16] Nonetheless, Wheaton filed suit against HHS in the United States District Court for the District of Columbia challenging the HHS Mandate's constitutionality.[17] Wheaton's complaint declared, "Wheaton's

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share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order." *Id.*

11. GUIDANCE ON TEMPORARY ENFORCEMENT, *supra* note 6. In order to qualify for an objection, each religious institution must not have covered HRSA approved contraceptives from February 10, 2012 onward. *Id.*

12. *Id.*

13. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,727 (Feb. 15, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590 & 45 C.F.R. pt. 147).

14. *Id.*

15. *Wheaton Coll.*, 2012 WL 3637162, at 2.

16. *Id.*

17. *Id.*

religious beliefs forbid it from participating in, providing access to, paying for, training other to engage in, or otherwise supporting abortion."[18] Wheaton asserted violations of the Religious Freedom Restoration Act, the First Amendment of the United States Constitution, and the Administrative Procedure Act.[19]

III. THE DISTRICT COURT'S JUDGMENT

On August 24, 2012, the United States District Court for the District of Columbia granted HHS's motion to dismiss on each of Wheaton College's claims for lack of standing and ripeness.[20] To establish standing, the court stated Wheaton College needed to prove the HHS Mandate caused it a "concrete and particularized" and "actual or imminent" injury in fact.[21] The court determined Wheaton failed to demonstrate injury because: (1) Wheaton qualified for and self-certified under the temporary "safe-harbor" voiding HHS Mandate enforcement for one additional year; and (2) HHS vowed to amend the HHS Mandate precisely in order to accommodate Wheaton's concerns.[22] Moreover, the court denied Wheaton's claim potential ERISA lawsuits attempting to enforce the preventive services regulations were "certainly impending" injuries.[23] Thus, the court

18. Complaint at 1, Wheaton Coll. v. Sebelius, No. 1:12CV1169(ESH), 2012 WL 3637162, at 4 (D.D.C. Aug. 24, 2012). *Wheaton Coll.*, 2012 WL 3637162 (No. 1:12CV1169(ESH)).

19. *Id.*

20. *Wheaton Coll.*, 2012 WL 3637162, at 9.

21. *Id.* at 4.

22. *Id.* at 6, 9. The court further stated, "Wheaton College may therefore continue to offer its current health plans, which do not cover Plan B and Ella, for the upcoming plan year without fear of government interference." *Id.* at 9.

23. *Id.*; *See* 29 USCS § 1002; *See also The Employee Retirement Income Security Act (ERISA)*, DOL.GOV, http://www.dol.gov/compliance/laws/comp-erisa.htm#.UIwmscWHKSo (last visited Oct. 27, 2012) [hereinafter ERISA]. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law setting minimum standards for pension plans. *Id.* ERISA requires plans to regularly provide participants with information about the plan including information about plan features and funding; sets minimum standards for participation, vesting, benefit accrual and funding. *Id.* ERISA also guarantees payment of

concluded Wheaton College lacked standing because it failed to establish a "concrete and particularized. . . certainly impending" injury in fact.[24]

To establish ripeness, the court stated Wheaton College needed to prove: (1) the fitness of each issue for judicial review; and (2) the extent to which withholding a decision would cause it hardship.[25] The court determined because the federal government would not enforce the HHS Mandate for one additional year while the HHS Mandate was amended, the preventive services regulations were, by definition, a "tentative agency position" unfit for judicial review.[26] Further, the court dismissed Wheaton's undue hardship assertion stating undue hardship "will rarely overcome the finality and fitness problems inherent in attempts to review tentative positions."[27] Consequently, the district court granted HHS's motion to dismiss on each of Wheaton College's claims.[28]

IV. WHEATON COLLEGE'S IMPLICATIONS FOR CURRENT HHS LITIGANTS

Wheaton College substantiates Justice Warren's conclusion federal courts commonly take policy into consideration when adjudicating on the merits.[29] Particularly, *Wheaton College* has considerable implications for over 100 plaintiffs comprising 36 pending federal lawsuits challenging the HHS Mandate's constitutionality because when government "deliberation" becomes a "promise" not to enforce remains ambiguous. Further, a government "promise" not to enforce does not eradicate the statute's

certain benefits through the Pension Benefit Guaranty Corporation, a federally chartered corporation, if a defined plan is terminated. *Id.*

24. *Wheaton Coll.*, 2012 WL 3637162, at 7.
25. *Id.*
26. *Id.* at 8.
27. *Id.*
28. *Id.* at 9.
29. *Flast*, 392 U.S. at 95 (1968); *compare Wheaton Coll.*, 2012 WL 3637162, at 9.

binding nature, exposing businesses to potential civil liabilities.[30] Such implications are particularly important for the PPACA's foundation for universal coverage in the United States.[31]

A. When "Deliberation" Becomes "Promise" is Problematic for Pending Litigants

Wheaton College is problematic for pending complainants challenging the HHS Mandate because exactly when government "deliberation" voiding statutory enforcement becomes a "promise" to govern accordingly remains unclear, yet is imperative in establishing standing in federal court.[32] In this case, the district court held Wheaton did not face "certainly impending" injury because it self-certified under the temporary safe-harbor such that the government "promised" not to enforce the HHS Mandate until the first plan year beginning on or after August 1, 2013.[33] Thus, since the government's vow not to enforce the HHS Mandate was the product of "a final decision," Wheaton failed to allege a "concrete and particularized. . .certainly impending" injury.[34]

However, *Wheaton College* did not address precisely *when* government "deliberation" becomes a "promise" of "sustained agency. . . represent[ing] a final decision," resulting in a problematic judgment for pending HHS Mandate litigants.[35] In this case, HHS publicly agreed not to enforce the Mandate on two occasions.[36] Yet, whether public deliberation is necessary, or merely sufficient, for a government "promise" to become a product of a

30. *HHS Mandate Information Central*, *supra* note 4; *see also Wheaton Coll.*, 2012 WL 3637162, at 9.

31. *Where in the Word*, *supra* note 5.

32. *Wheaton Coll.*, 2012 WL 3637162, at 4.

33. *Id.* The court further reasoned, "Wheaton College may therefore continue to offer its current health plans, which do not cover Plan B and Ella, for the upcoming plan year without fear of government interference." *Id.*

34. *Id.*

35. *Id.*

36. *Id.*; *see also* GUIDANCE ON TEMPORARY ENFORCEMENT, *supra* note 6.

"final decision" remains ambiguous.[37] Therefore, while *Wheaton College* held the government "promise" not to enforce the HHS Mandate sufficiently eradicated Wheaton College's standing, the district court's judgment is problematic for over 100 pending litigants challenging the HHS Mandate because precisely when "deliberation" becomes a product of "sustained agency and public deliberation. . . represent[ing] a final decision" remains unclear, yet is imperative to establish "certainly impending" injury in fact.[38] In the absence of such impending injury, *Wheaton College* indicates pending complainants will lack standing in federal court.[39]

B. A "Promise" Voiding Enforcement does not Eradicate the Statute's Binding Nature and is also Problematic for Pending Litigants

Wheaton College indicates the government's vow not to enforce a given statute does not eradicate the statute's binding nature on those under the statute's jurisdiction.[40] This is problematic for pending litigants because even with an established government "promise" not to enforce, individuals and businesses are subject to civil liabilities without the ability to challenge the statute in federal court.[41] Wheaton College alleged even if the court found the government's pledge not to enforce the HHS Mandate a product of "sustained agency and public deliberation," it still faced "certainly impending" injury from the possibility of ERISA lawsuits attempting enforcement of the HHS Mandate's preventive services regulations.[42] However, the court stated, "Even crediting Wheaton's assertion that it is 'completely exposed' to such actions, it is well-established that the

37. *Wheaton Coll.*, 2012 WL 3637162, at 6.
38. *Id.* at 4.
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.; see also* ERISA, *supra* note 23.

theoretical possibility of harm from current litigation does not, without more, confer standing."[43] Thus, *Wheaton College* indicates a government "promise" voiding statutory enforcement does *not* eradicate the statute's binding nature, yet, litigants must establish more than the "theoretical possibility" of harm to establish standing.[44]

On one hand, it is reasonable for federal courts to restrict organizations from raising legal challenges before the statute becomes the product of "sustained agency and public deliberation."[45] By allowing litigants to challenge statutes not yet the product of a "final decision," civil lawsuits in the United States district courts would increase.[46] In fact, in 2011, alone, civil filings in the United States district courts increased to 289,252, or two percent.[47] Allowing the federal courts to render a decision on a statute not yet a product of a "final decision" would likely increase civil litigation further in federal courts and permit the federal judiciary to interfere with the legislative process or even encourage federal adjudication on claims not fit for judicial review under Article III.[48]

Conversely, because *Wheaton College* indicates a "promise" not to enforce, but does not eradicate a statute's binding nature, its implications are problematic because it puts businesses directly at risk of civil liabilities without the ability to challenge the statute in federal court.[49] In other words, under the court's reasoning, a government "promise" voiding

43. *Wheaton Coll.*, 2012 WL 3637162, at 4.
44. *Id.*
45. SUPREME COURT OF THE UNITED STATES, 2011 YEAR-END REPORT ON THE FEDERAL JUDICIARY 14 (2011), http://www.supremecourt.gov/publicinfo/year-end/2011year-endreport.pdf.
46. *Id.*
47. *Id.*
48. *Flast*, 392 U.S. at 95 (1968). Adjudicating on the merits of a case involving a statute not yet defined would present a number of justiciability issues including a lack of ripeness and the inability of the federal courts to render advisory opinions to other branches of government. *Id.*
49. *Wheaton Coll.*, 2012 WL 3637162, at 4.

statutory enforcement provides businesses with peace of mind the federal government will not carry out the statute, but since the "promise" does not eradicate the statute's binding nature, businesses may be exposed to civil liabilities by those challenging the business' compliance with the statute.[50] Under *Wheaton College*, such businesses will *not* have an applicable legal remedy in federal court until the statute becomes a product of "sustained agency and public deliberation."[51] In essence, the peace of mind the government "promise" not to enforce bestows to businesses is nullified by the fear of civil liabilities from lawsuits demanding statutory compliance.[52]

C. Wheaton College's Implications on the PPACA'S Foundation for Universal Coverage in the United States

Wheaton College's implications have particular importance regarding the PPACA's foundation for universal coverage in the United States because the PPACA has numerous employee mandates rendering businesses susceptible to future liabilities.[53] Since its enactment on March 23, 2010, PPACA initiates comprehensive health care reform on a 'roll-out' basis through 2014.[54] Meaning, while a particular PPACA requirement may not be in effect presently, the provision is still the product of binding statute.[55]

For example, in March 2012, the PPACA required any ongoing or new federal health programs to report racial, ethnic, and language data to HHS to reduce health care disparities.[56] Under the *Wheaton College* reasoning, if the government renders a "promise" voiding enforcement of this provision until March 2014 with the "promise" of amending said requirement in the

50. *Id.*
51. *Id.*
52. *Id.*
53. *What's Changing and When*, U.S. DEP'T HEALTH & HUMAN SERVS., http:// www.healthcare.gov/law/timeline/ index.html (last visited Oct. 5, 2012).
54. *Id.*
55. *Id.*
56. *Id.*

interim, businesses offering either new or existing health programs are obligated to abide by the statute's requirements; they are subject to civil liability for non-compliance, but are not provided a legal remedy to challenge the statute in federal court until the statute becomes the product of "final decision" in 2014.[57] Even in the presence of a government "promise" not to enforce, parties under the statute's jurisdiction are obligated to comply without the ability to challenge the statute in federal court.[58]

Accordingly, because *Wheaton College* indicates a "promise" does not eradicate the statute's binding nature, its implications are problematic for over 100 plaintiffs challenging the HHS Mandate, as litigants are obligated to abide by the HHS Mandate, are subject to civil liabilities for non-compliance, and are devoid ability to challenge the Mandate in federal court until it becomes the product of a "final decision."[59] Therefore, *Wheaton College* is problematic for current litigants because: (1) when government "deliberation" becomes a "promise" not to enforce remains unclear; and (2) a government "promise" not to enforce does not eradicate the statute's binding nature thus exposing businesses to potential civil liabilities.[60] Such implications are particularly important for the PPACA's foundation for universal coverage in the United States.[61]

V. CONCLUSION

As Justice Warren affirmed, "[j]usticiability is itself a concept of

57. *Id.*; *see also Wheaton Coll.*, 2012 WL 3637162, at 4.

58. *Wheaton Coll.*, 2012 WL 3637162, at 4; *see also* Kyle Duncan, *Not-So-Safe-Harbor*, NAT. REV. ONLINE (Sept. 6, 2012, 4:00 AM), http://www.nationalreview.com/articles/315995/not-so-safe-harbor-interview [hereinafter *Not-So-Safe-Harbor*]. "It's as if the government said, 'This law binds you, but we are not going to enforce the law's penalties against you for the time being.'" *Id.*

59. *Wheaton Coll.*, 2012 WL 3637162, at 4.

60. *Id.*

61. *Id.*

uncertain meaning and scope."[62] While the justiciability doctrine constitutionally restricts adjudication to cases asserting actual disputes between adverse litigants, Wheaton College's challenges to the HHS Mandate under the PPACA substantiates Justice Warren's notion policy considerations frequently enhance Article III's constitutional limitations for federal adjudication on the merits.[63] Therefore, *Wheaton College* has considerable implications for over 100 plaintiffs comprising 36 pending federal suits challenging the HHS Mandate and the PPACA's foundation for universal coverage in the United States.[64]

62. *Flast*, 392 U.S. at 95 (1968).
63. *Id.*; *see also Wheaton Coll.*, 2012 WL 3637162, at 4.
64. *Where in the World*, *supra* note 5.

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

*Matthew Newman**

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.[1] These measure include an expansion of Medicaid, premium assistance for people in lower income brackets and an individual mandate to buy insurance.[2] 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)(i)(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.[3] 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.[4] 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.[5] Costs address the issue of access to quality care by increasing the feasibility of paying for an expanded coverage pool.[6]

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

3. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

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 Cassll 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) waste[8] 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.

10. PPACA, 42 U.S.C. § 1315a (2012).

11. PPACA, 42 U.S.C. § 1395jjj (2010).

12. PPACA, 42 U.S.C. § 1395cc-4 (2010).

13. PPACA, 42 U.S.C. § 1395kkk (2010).

14. PPACA, 42 U.S.C. § 299b–33 (2010).

delivery of public health services,[15] patient centered outcome research,[16] and state waivers for innovation.[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"[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."[19] This provision is motivated by the concern that physicians are highly incentivized to provide unnecessary care under fee for service (FFS) models[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).[21] ACOs make a group of providers responsible for a population of

15. PPACA, 42 U.S.C. § 300u–15 (2010).
16. PPACA, 42 U.S.C. § 1320e (2010).
17. PPACA, 42 U.S.C. § 18052 (2010).
18. PPACA, 42 U.S.C. § 1315a(a)(1) (2010).
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).
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.
21. PPACA, 42 U.S.C. § 1395jjj (a)(1)(A) (2010).

Medicare patients and pay them predetermined sums for achieving certain quality benchmarks.[22] The program provides financial rewards for ACOs that exceed benchmarks and leave them financially accountable for the inability to meet them.[23] 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.[24] 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.[25] 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."[26] 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. [27] IPAB's job is to develop and submit a proposal to reduce Medicare growth when it projects growth will exceed pre-approved growth rates.[28] 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).

23. PPACA, 42 U.S.C. § 1395jjj (d)(1)-(2) (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*.

26. PPACA, 42 U.S.C. § 299b–33 (a)(1) (2010). The provision focuses on researching improvements to patient safety, reducing medical errors, delivering consistent care, and developing "tools, methodologies and interventions that can successfully reduce variations in the delivery of care"). PPACA, 42 U.S.C. § 299b–33 (b)(2)(B), (b)(6) (2010).

27. PPACA, 42 U.S.C. § 1395kkk(b) (2010).

28. *Id*.

may include,[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."[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.[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.[32] Although their priorities include disseminating findings regarding "health outcomes, clinical effectiveness, and appropriateness of . . . treatments,"[33] which again focus on delivery models and placing value on physicians' judgment of the medical necessity of certain

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).

30. PPACA 42 U.S.C. § 1395kkk(c)(2)(B)(i)(I) (2010).

31. *See* PPACA 42 U.S.C. § 1395kkk (2010).

32. PPACA, 42 USCA § 1320e(b)(1) (2010).

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

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).
36. PPACA, 42 USCA § 18052(b)(1)(B) (2010).
37. PPACA, 42 USCA § 300u–15(b)(3) (2010) (emphasis added).
38. PPACA, 42 USCA § 18052(b)(1)(B) (2010).
39. *See* PPACA, 42 USCA § 18052 (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.[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.[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.[42] However, this approach is problematic because delivery models are not the only elements that affect cost and therefore affect access.[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 effect costs.

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

40. *See e.g.,* PACCA, 42 USCA § 1320e(a)(2)(B) (2010), (mentioning medical technologies but not developers of these technologies directly).

41. *Id*.

42. Hospital care takes up an estimated thirty-one percent of all healthcare costs and physician and clinical services make up approximately twenty percent, combining to account for fifty-one percent of all medical costs. Adara Beamesderfer & Usha Ranj, *U.S. Health Care Costs*, KAISER EDU (Feb. 2012), *available at* http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#footnote6.

43. *Id*.

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]

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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 outsources 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

52. *See* CONG. BUDGET OFFICE, *supra* note 9.

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.[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.[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.[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.[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.[60]

V. CONCLUSION

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

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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.

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).

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).

59. *See* PPACA, 42 U.S.C. § 1315a (2012); PPACA, 42 U.S.C. § 1395jjj (2012).

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.[61] 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.[62] 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).

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The Effect of Medicaid Reform and Expansion on the Future of Long-Term Service and Supports in Illinois

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I. INTRODUCTION

The Unites States has seen a dramatic shift towards universal healthcare as evidenced by individual state healthcare reform initiatives,[1] the enactment of the Patient Protection and Affordable Care Act (PPACA), and the recent Supreme Court decision upholding the majority of the PPACA as constitutional.[2] While the nation moves towards a model of universal and comprehensive care, the elderly and disabled population continues to be overlooked, suggesting that the trend towards universal care is not as inclusive as it may seem.

Medicaid is the health insurance program that pays for a large portion of healthcare services consumed by the elderly and disabled populations.[3] One of the most expensive services provided under the Medicaid program is

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1. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, STATES MOVING TOWARD COMPREHENSIVE HEALTH CARE REFORM 1 (July 2009) *available at* http://www.kff.org/uninsured/upload/State-Health-Reform1.pdf ("Maine, Massachusetts and Vermont, have enacted and are implementing reform plans that seek to achieve near universal coverage of state residents. Many other governors and legislators have announced comprehensive reform proposals or have established commissions charged with developing recommendations on how to expand coverage.").

2. *See generally* KAISER FAMILY FOUND., A GUIDE TO THE SUPREME COURT'S AFFORDABLE CARE ACT DECISION 2-6 (July 2012) *available at* http://www.kff.org/healthreform/upload/8332.pdf [hereinafter A GUIDE TO THE SUPREME COURT'S DECISION].

3. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM CARE SERVICES AND SUPPORTS 1 (June 2012) *available at* http://www.kff.org/medicaid/upload/2186-09.pdf [hereinafter LONG-TERM CARE SERVICES AND SUPPORTS] (stating that Medicaid pays for 43 percent of spending on long-term care in the United States).

long-term support and services (LTSS).[4] The elderly and disabled population makes up the majority of LTSS users,[5] and, despite recent reform movements, this population continues to face challenges in accessing and affording care. This article will explore the relationship between LTSS and Medicaid, how recent reform efforts may affect LTSS in Illinois, and the challenges that lie ahead for Illinoisans' who require LTSS.

II. MEDICAID OVERVIEW

A. Structure of Medicaid

Medicaid was established in 1965 and is an insurance program operated jointly by the Federal government and state governments.[6] Congress created Medicaid to help low-income Americans pay for health care and remains one of the largest health insurance programs in the nation, covering approximately sixty-eight million low-income Americans in 2010 alone.[7] Under the Medicaid program, payment for services that enrollees receive is made jointly by the federal government and state governments. The share of the Medicaid payment that the Federal government is responsible for is determined by the federal medical assistance percentage (FMAP).[8]

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4. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID'S LONG-TERM CARE USERS: SPENDING PATTERNS ACROSS INSTITUTIONAL AND COMMUNITY-BASED SETTINGS 1 (Oct. 2011) *available at* http://www.kff.org/medicaid/upload/7576-02.pdf [hereinafter MEDICAID'S LONG TERM CARE USERS].

5. *Id.* at 2 ("Medicaid long-term care users were mostly elderly (52%), with persons with disabilities (40%) and other adults and children . . . making up the remainder of long term care users.").

6. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 27 (Mar. 2011) *available at* http://healthreform.kff.org/~/media/Files/KHS/docfinder/MACPAC_March2011_web.pdf, [hereinafter MACPAC REPORT].

7. *See id.*

8. *Id.* at 38 (stating that the federal share for Medicaid costs is determined by the federal medical assistance percentage (FMAP), a formula based on states' per capita income, and that FMAPs must be at least 50% but no more than 83%).

B. Medicaid in Illinois

In 2008, approximately 2.4 billion individuals were enrolled in Illinois' Medicaid program.[9] The program cost a total of nearly $15 billion to operate in 2010 and the state of Illinois was responsible for approximately $6.3 billion with the Federal government responsible for the remaining approximately $9.7 billion.[10]

III. THE RELATIONSHIP BETWEEN MEDICAID AND LONG-TERM SERVICES AND SUPPORTS

Medicaid covers a diverse group of low-income individuals, many of whom are battling complex health problems.[11] Low-income seniors and individuals with disabilities are included in the Medicaid population, and in Illinois these groups make up sixteen percent of the state's Medicaid enrollees.[12] Although seniors and individuals with disabilities make up a small percentage of total Illinois Medicaid enrollees, these groups account for nearly fifty-five percent of total Medicaid spending in Illinois.[13] Part of the reason that seniors and individuals with disabilities make up such a large portion of Medicaid spending is because these groups are the primary users of LTSS.[14]

Long-term services and supports (LTSS) refers to a multitude of services designed to assist individuals with daily activities and can include institutional nursing home care, community based services, and home

9. *Id.* at 78.
10. *Id.* at 86.
11. *Id.* at 2 ("The populations enrolled in Medicaid and CHIP are diverse, by definition low-income, but also may have chronic and complex health needs resulting in substantial spending.").
12. *Medicaid 101*, ILL. DEP'T OF HEALTHCARE AND FAMILY SERVS. 2 http://www2.illinois.gov/hfs/agency/Documents/Medicaid101.pdf (last visited Nov. 1, 2012).
13. *Id*.
14. *See* MEDICAID'S LONG TERM CARE USERS, *supra* note 4, at 2.

health services.[15] Private insurance benefits that include LTSS are typically limited in scope and LTSS are often not covered by traditional private health insurance.[16] LTSS are expensive[17] and private insurance policies rarely include such benefits,[18] because of these factors, many people who need LTSS spend down their assets in order to become eligible for Medicaid.[19] Due to the expense and limited availability of insurance that offers LTSS benefits, Medicaid has become one of the most prominent payers of LTSS.[20] In 2010, LTSS cost the Illinois Medicaid program nearly $4 billion.[21]

IV. HOW EFFORTS TO REFORM HEALTHCARE MAY AFFECT LTSS IN ILLINOIS

A. Illinois Smart Act

On June 14, 2012, Illinois Governor Quinn signed multiple Medicaid reforms with the intention of saving the state's Medicaid system from collapse and increasing the programs sustainability.[22] The new laws include

15. MACPAC REPORT, *supra* note 6, at 34; s*ee generally* LONG-TERM CARE SERVICES AND SUPPORTS *supra* note 2 (discussing the services Medicaid provides for LTSS populations).

16. MACPAC REPORT, *supra* note 6, at 32.

17. *See* LONG-TERM CARE SERVICES AND SUPPORTS, *supra* note 3, at 2 ("Paying for long-term services is expensive and can quickly exhaust lifetime savings. Nursing home care averages $74,800 per year, assisted living facilities average $39,500 per year, and home health services average $21 per hour.").

18. *See* MACPAC REPORT, *supra* note 6, at 32.

19. *See* ILL. DEP'T OF HEALTHCARE AND FAMILY SERVS., HFS 591SP MEDICAID SPENDDOWN, http://www2.illinois.gov/hfs/MedicalPrograms/Brochures/Pages/HFS591SP.aspx (last visited Nov. 1, 2012). The spenddown program is a way for some individuals who do not meet the low-income requirements of HFS programs to become eligible. *Id.*

20. *See* LONG-TERM CARE SERVICES AND SUPPORTS, *supra* note 3, at 1 (stating that Medicaid pays for 43 percent of spending on long-term care in the United States).

21. MACPAC REPORT, *supra* note 6, at 88.

22. ILL. GOV. NEWS NETWORK, GOVERNOR QUINN SIGNS LAWS TO SAVE MEDICAID, RESTRUCTURING PACKAGE STABILIZES MEDICAID AND PRESERVES CARE FOR MOST VULNERABLE, (Jun. 14, 2012), http://www.illinois.gov/PressReleases/

the Save Medicaid Access and Resources Together Act (SMART Act) and an increase on the price of cigarettes with the dual purpose of creating state funds for Medicaid and discouraging smoking throughout the state.[23] The SMART Act, which took effect July 1, 2012, includes revisions for Medicaid coverage.[24] The SMART Act contains specific coverage changes for treatment at long-term care facilities, including "an average 2.7% rate decrease," restructured financial requirements for spouses of patients at long-term care facilities, limited prescriptions for pharmaceuticals, and an increased "look back period for review."[25]

The revised financial requirements result in stricter regulation regarding who can become eligible for Medicaid and long term care assistance, and the length of time it will take individuals to become eligible.[26] For example, the extended "look-back" period of sixty months, which had previously been thirty-six months, means that it will take longer for many seniors to become eligible for Medicaid and long-term care coverage.[27] Similarly, categories of income and assets, such as spousal income and money spent on legal assistance before applying for Medicaid, have become stricter.[28]

ShowPressRelease.cfm?SubjectID=2&RecNum=10307.

23. *Id.*

24. *Coverage Changes Resulting from the Save Medicaid Access and Resources Together (SMART) Act*, ILL. DEP'T OF HEALTHCARE AND FAMILY SERVS. http://www.hfs.illinois.gov/html/062912n1.html (last visited on Nov. 1, 2012) [hereinafter *Coverage Changes*].

25. *Id*.

26. *See* JOINT COMM. ON ADMIN. RULES ILL. GEN. ASSEMB., *The Flinn Report*, Vol. 36 Iss. 28, 2 (July 13, 2012), *available at* http://www.ilga.gov/commission/jcar/flinn/20120713_July%2013,%202012%20-%20Issue%2028.pdf [hereinafter *The Flinn Report*].

27. *Coverage Changes*, *supra* note 23 (stating that the look back period for review increased from thirty-six months to sixty months, and applies to transfers as of January 1, 2001).

28. *See The Flinn Report*, *supra* note 25 ("The rulemaking imposes stricter limits on certain assets and asset transfers for persons seeking Medicaid assistance for long-term

B. Money Follows the Person: Pathways to Community Living

The Deficit Reduction Act (DRA) of 2005 changed Medicaid policies nation-wide regarding long-term care services and created the Money Follows the Person Rebalancing Demonstration program (MFP Program).[29] The MFP program is administered by the federal Centers for Medicare and Medicaid Services (CMS) and awarded original grants to thirty states.[30] Illinois received a grant totaling $55,703,078 to implement its own MFP program:[31] Pathways to Community Living.[32] Section 2403 of the PPACA extended the program through 2016 and provided an increase in funding for the MFP program.[33]

Illinois' MFP program, Pathways to Community Living, focuses on decreasing the number of individuals using institution-based services by increasing the use of Home and Community Based Services (HCBS).[34] In other words, the goal of the program is to decrease spending on institutional LTSS, such as costly nursing homes, and shift spending towards community services so individuals requiring LTSS can receive care at home or within their communities.[35]

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care.").

29. MATHEMATICA POLICY RESEARCH, INC., MONEY FOLLOWS THE PERSON DEMONSTRATION GRANTS: SUMMARY OF STATE MFP PROGRAM APPLICATIONS 1 (Aug. 21, 2007) *available at* http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/StateMFPGrantSummaries-All.pdf [hereinafter MONEY FOLLOWS THE PERSON] (stating that the DRA created the MFP program and authorized $1.75 billion to help states move people in institutional settings back home to their community, and to help states reorganize their LTSS systems in a way that emphasizes HCBS over institutional placement).

30. *Id.*

31. *Id.*at 45.

32. *Pathways to Community Living*, MONEY FOLLOWS THE PERSON, http://www.mfp.illinois.gov/ (last visited Nov. 1, 2012) [hereinafter *Pathways*].

33. *Money Follows the Person (MFP)*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html (last visited Nov. 1, 2012).

34. *Pathways*, *supra* note 32.

35. *See* MONEY FOLLOWS THE PERSON, *supra* note 29, at 45-47. Examples of

In 2008, operational protocol was approved for Illinois' Pathways to Community Living and transitions began in 2009.[36] While the program is only a few years old, the outcomes have already failed to meet the targets set forth in Illinois' original program proposal.[37] Furthermore, the program is very limited because it only focuses on individuals who seek to leave an institutional setting, and does little to improve existing HCBS in communities.[38]

C. PPACA Changes to LTSS

Following the Supreme Court decision on the PPACA, some of the mystery surrounding the future of Medicaid has been lifted; however, there are still questions left unanswered. The PPACA expands Medicaid access in all states by requiring that each state cover all individuals under 133% of the federal poverty level (FPL), in addition to those who may qualify under a specific category of eligibility.[39] Under the PPACA, the federal government would fund the total cost of the expansion for two years, and states would gradually become responsible for 10% of the funding for the expansion as it progresses.[40] Under the PPACA as originally drafted by Congress, the Secretary of Health and Human Services would retain the authority to withhold all of a state's federal funds for Medicaid for failure to

community based care include personal assistant and medication management services for the elderly, peer training for physically disabled individuals, and skills training in community living environments for mentally ill individuals. *Id.*

36. *Presentation from MFP Meeting, February 29, 2012*, MONEY FOLLOWS THE PERSON, http://mfp.illinois.gov/stakeholder/022912_presentation.html (last visited Nov. 1, 2012) [hereinafter *Presentation from MFP Meeting*].

37. *See* MONEY FOLLOWS THE PERSON, *supra* note 29, at 46. Illinois' original MFP proposal identified annual transition targets of 720 individuals in 2009; 765 individuals in 2010; and 815 individuals in 2011. *Id.* However, the actual transitions that occurred were 57 in 2009; 184 in 2010; and 237 in 2011. *See Presentation from MFP Meeting, supra* note 36.

38. *See generally* MONEY FOLLOWS THE PERSON, *supra* note 29, at 45-49.

39. A GUIDE TO THE SUPREME COURT'S DECISION, *supra* note 2, at 3.

40. *Id.*

comply.[41]

The Supreme Court held that the statute, as drafted, was unconstitutionally coercive because states would essentially have no choice but to comply.[42] The Court held that the remedy to this dilemma is to simply adjust the authority of the Secretary to only withhold expansion funds.[43] In effect, this means that the Medicaid expansion proposed under the PPACA is optional for states, though there is an incentive for states to comply in order to receive the additional federal funds.[44]

The PPACA focuses on utilizing HBCB services as opposed to the alternative—costly institutional care.[45] For example, the Community First Choice Option under the PPACA attempts to encourage more use of home-based treatment. The provision "provides states choosing to participate in this option a six percentage point increase in federal Medicaid matching funds for providing community-based attendant services and supports to beneficiaries who would otherwise be confined to a nursing home or other institution."[46]

Another provision in the PPACA, which has since been abandoned,[47] is the Community Living Assistance Services and Supports (CLASS) Act.[48]

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41. *See id.* at 5.
42. *See id.*
43. *Id.*
44. *Id*. at 7.
45. *See* Tammy Worth, *Helping Seniors Live at Home Longer: The New Patient Protection and Affordable Care Act Aims to Provide At-Home Alternatives to Nursing Home* Care, L.A. TIMES, Jun. 19, 2011, *available at* http://articles.latimes.com/print/2011/jun/19/health/la-he-long-term-care-20110612.
46. U.S. DEP'T OF HEALTH AND HUMAN SERVS, *HHS announces new Affordable Care Act options for community-based care*, HHS.GOV (Apr. 26, 2012), http://www.hhs.gov/news/press/2012pres/04/20120426a.html.
47. *See* MEDICAID'S LONG TERM CARE USERS, *supra* note 4, at 5.
48. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, HEALTH CARE REFORM AND THE CLASS ACT 1 (Apr. 2010) *available at* http://www.kff.org/healthreform/upload/8069.pdf [hereinafter CLASS ACT].

"CLASS is a national, voluntary insurance program that offers working individuals some protection against the cost of paying for long-term services and supports."[49] This innovative program illustrated an attempt to spread the responsibility of paying for long-term care between multiple payers, instead of relying primarily on Medicaid, and could have created an option for adults to plan for their long-term care needs.[50] Had the CLASS Act remained and implemented by the states, it could have addressed the issue of providing and expanding access to long-term care, which has historically been expensive and difficult to obtain for most Americans.[51] Instead, Secretary Sebelius released a report that the program would not be implemented following a determination that no benefit plan existed that would be both actuarially sound for seventy-five years and meet the statutory requirements under the PPACA.[52] The abandonment of the CLASS Act provided yet another example of how the elderly and disabled population, specifically those who require LTSS, continued to be overlooked within the movement towards universal healthcare.

IV. CONCERNS MOVING FORWARD

As the population of elderly people in the United States continues to grow, so does the demand for LTSS.[53] One thing that has remained consistent, however, is the ease with which LTSS are overlooked. Even in the midst of national healthcare reform and a movement towards universal healthcare, the difficulty in affording and accessing LTSS for elderly and

49. *Id.* at 2.
50. *See id.* at 3 (stating that CLASS would work together with other LTSS programs, including Medicaid, and that an individual eligible for CLASS benefits and benefits under Medicaid, the CLASS benefits would be used to offset Medicaid costs).
51. *See id.*
52. MEDICAID'S LONG TERM CARE USERS, *supra* note 4, at 5.
53. *See id.*

disabled individuals remains problematic. Although there have been minor recognitions of the need to address the problem of accessing and receiving LTSS, both nationally and in Illinois specifically, little progress has been made. The ease at which the CLASS act of the PPACA was abandoned exemplifies how LTSS remains a low priority with regards to overall healthcare reform. Further, the limited reform of LTSS in Illinois, coupled with the unremarkable results of programs already implemented, suggests that the accessibility and funding of LTSS for elderly and disabled populations will continue to be a challenge. In order to actually achieve a universal model, legislators on both the state and federal level will need to recognize how problematic the LTSS system is, and commit to reform that will increase the accessibility, quality, and cost-efficiency of LTSS.

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Online Long-Term Care Referral Sites: Increasing Access to Health Care or Violation of Federal Anti-Kickback Statutes?

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I. INTRODUCTION

As the baby boomers age, access to long-term care is increasingly important.[1] Historically, individuals seeking care relied on their medical provider to direct them toward the care provider best suited to meet their individual needs.[2] However, the Internet now allows patients to assume greater responsibility and freedom in finding care by increasing access to medical information, medical advice, and online support groups.[3] The expansion of the Internet led to the creation of online referral service sites.[4] These websites use patient needs assessments to connect patients seeking care with providers that best suit their needs.[5]

Free online referral services allow patients to identify and locate care providers that can meet their needs.[6] Online referral services assist patients seeking long-term care by conducting needs assessments in order to determine the level of care a patient needs and the patient's budget for

1. Susan D. James, *Baby Boomers Fuel Thriving Health Industry*, ABC NEWS (July 17, 2008), http://abcnews.go.com/Business/story?id=5389800&page=1#.UGDNEsWTZI6 (last visited Sept. 24, 2012).

2. Pearl Jacobson, *Empowering the Physician-Patient Relationship: The Effect of the Internet*, 2 PARTNERSHIP: THE CANADIAN J. OF LIBR. & INFO. PRAC. & RES., May 2007 at 3.

3. *Id*.

4. *See, e.g.*, CARE PATHWAYS, http://www.carepathways.com/LTC-match.cfm (last visited Oct. 28, 2012).

5. *See, e.g.*, YEARS AHEAD, http://www.yearsahead.com/content/provider/ (last visited Sep. 24, 2012).

6. *See, e.g.*, A PLACE FOR MOM, http://www.aplaceformom.com/ (last visited 11/1/2012).

medical expenses.[7] After the needs assessment the patient is presented with qualified care provider options that meet the patient's needs and then the care provider is connected with the patient.[8] However, problems arise as some patients who use online referral services may also rely on the government to subsidize their long-term care costs through either Medicare or Medicaid.[9] While these services may be increasing patients' access to health care options, these services may also violate the federal Anti-Kickback Statute (AKS) and potentially be at risk for imposition of administrative sanctions by the Office of the Inspector General ("OIG").[10] However, if online referral services follow certain safeguards, the OIG is not likely to take enforcement action in certain factual circumstances as evidenced by previous advisory opinions, allowing the online services to continue to expand access to health care services which is essential in the pursuit for universal health coverage.

This paper will begin with a discussion of AKS and the referral safe harbor provisions. Next, this paper will provide an overview of various OIG advisory opinions relating to online referral service providers. Furthermore, this paper will discuss what online referral services can do in order to protect themselves from OIG enforcement. Lastly, this paper will address how online referral services drive down health care costs and increase health care quality while expanding access to long-term care in addition to arguing that the OIG should not take enforcement action when

7. *Id.*
8. *Id.*
9. David Nardolillo, *HHS OIG Finds Potential Anti-Kickback Violations in Online Referral Service*, THE HEALTH L. SIDEBAR, http://healthlawsidebar.com/?p=366 (last visited Sept 25, 2012) (noting the use of Medicare and Medicaid by patients who use online referral services poses the question of whether online referral services violate the federal Anti-Kickback Statute.).
10. Advisory Op., Off. Inspector Gen., HHS No. 11-06, 6 (May 13, 2011) [hereinafter Advisory Op. 11-06].

the online referral sources follow certain safeguards.

II. ANTI-KICKBACK AND REFERRAL SERVICE SAFE HARBOR

The federal AKS is a criminal, intent-based statute that states anyone who knowingly and willfully receives or pays anything of value to influence the referral of a federal health care program is guilty of a felony.[11] Violators of the law are subject to up to five years in prison, criminal fines of $25,000, and exclusion from participation in federal health care programs.[12] According to this rule, online referral services and care providers featured on online referral websites may be subject to penalties if Medicare and Medicaid beneficiaries use online referral services to find care providers.[13]

With respect to the AKS provisions, the OIG has established a safe harbor which address referral services.[14] Safe harbor provisions permit certain payment and business practices that may otherwise be implicated by the AKS.[15] A major element of the referral safe harbor provision requires that payment to the online referring service be based only on the cost of operating the referral service and not on the volume or value of any referrals for which payment is made under Medicare or Medicaid.[16] This safe harbor is violated by pay-per-lead online referral services when an individual on Medicare or Medicaid uses the online referral service to find a care provider.[17] Pay-per-lead transactions occur when an online referral service is paid money by a care provider on a per lead basis for potential

11. Pub. L. No. 92-603, 86 Stat. 1329 (codified as amended at 42 U.S.C.A. § 1320(a)-27(b) (2000)); *see also* 73 Fed. Reg. 56841 (Sept. 30, 2008).
12. *See* Pub. L. No. 92-603, *supra* note 11.
13. Nardolillo, *supra* note 9.
14. 42 C.F.R. § 1001.952 (2007).
15. *See id.*
16. *See id.*
17. *See, e.g.*, 73 Fed. Reg. 56841 (Sept. 30, 2008).

patients.[18] Because the online referral service receives remuneration for each lead it generates, pay-per-lead online referral services may violate this element of the safe harbor.[19]

III. OIG ADVISORY OPINIONS ON ONLINE REFERRAL SERVICES

A service's failure to fit within the safe harbor provisions does not necessarily mean violation of the AKS and it is the responsibility of the OIG to bring enforcement action.[20] The OIG usually focuses on the following factors in determining whether to take action against the parties involved: (1) whether the arrangement has potential to interfere with clinical decision-making; (2) whether the arrangement has the potential to increase costs to Federal Health Care Programs; (3) whether the arrangement has the potential to increase the risk of overutilization or inappropriate utilization; and (4) whether the arrangement raises patient safety or quality of care concerns.[21] The OIG has not stated whether pay-per-lead online referral service providers violate AKS, but OIG advisory opinions give some guidance as to how the OIG might apply AKS.[22] Advisory opinions are only binding on the parties requesting the opinion, but can provide advice on OIG sanctions and the application of AKS.[23]

In 2008 the OIG approved a pay-per-lead arrangement through an Internet advertiser for chiropractor services.[24] When potential patients visited the advertiser's website, patients provided a zip code and received a

18. Advisory Op., Off. Inspector Gen., HHS No. 08-19, 1, (October 29, 2008) [hereinafter Advisory Op. 08-19].
19. *See id*.
20. Advisory Op. 11-06, *supra* note 10, at 5.
21. *See, e.g.*, 73 Fed. Reg. 56841 (Sept. 30, 2008).
22. *See* 42 C.F.R. § 1008.1.
23. *See* 42 C.F.R. § 1008.53.; *see also* OFFICE OF INSPECTOR GEN., *Advisory Opinions*, https://oig.hhs.gov/compliance/advisory-opinions/index.asp (last visited 11/1/2012).
24. Advisory Op. 08-19, *supra* note 18 at 2.

list of subscribing chiropractors in the area.[25] Each chiropractor who subscribed to the Internet advertiser paid the Internet advertiser on a pay-per-lead basis.[26] The OIG analyzed the case as an advertising arrangement instead of a referral service and concluded that despite concerns with the pay-per-lead model, certain reasons minimized the risk of abuse.[27] The reasons that minimized risk included that the Internet advertiser was not a health care provider, was not affiliated with the health care industry, and did not collect healthcare information such as payer information and medical history.[28] The Internet advertiser's service was available to the general public, did not target federal health care programs, and the referral fees were charged regardless of whether the patient utilized the chiropractor's services.[29] Furthermore, the arrangement did not encourage the Internet advertiser to steer patients to particular chiropractors because the service used a patient's zip code to dictate where to send the patient.[30] Consequently, the OIG decided not to seek sanctions under the AKS.[31]

Some online referral services function in a similar way to the pay-per-lead arrangement approved by the OIG in the 2008 opinion.[32] However, other online referral services are distinguishable from the advisory opinion because the usual online referral services play a more significant role in determining which facilities receive referrals for potential patients.[33] Online referral services typically conduct a needs assessment to determine

25. *Id.*
26. *Id.* at 3.
27. *Id.* at 5.
28. *Id.* at 6.
29. *Id.*
30. *Id.* at 7.
31. *Id.*
32. *A Place For Mom*, *supra* note 6.
33. *Id.*

the level of care a patient needs and their budget.[34] The online model is different from the arrangement in the advisory opinion where the referral service company's role was limited to providing the patient with contact information and did not collect patient health-related information.[35]

Contrary to the 2008 OIG opinion, a May 2011 opinion by the OIG condemned an arrangement in which an online referral service was used by hospitals to identify post-acute care providers for the hospital's patients.[36] The hospital paid a fee to the online referral service, but the amount paid was not tied to the value or volume of referrals and the revenue generated by the online referral service exceeded the cost of providing the service.[37] Post- acute care providers who do not choose to pay a fee were listed on the online system, but received hospital referral requests via fax as opposed to electronically.[38] Hospitals referred patients to post-acute care providers on a first-come basis and those post-acute care providers who were paying for electronic access were at a significant advantage due to a quicker response time.[39] The OIG concluded that because acute-care providers paying for electronic access were more likely to get patients due to their payments and not due to superior care, the arrangement violated AKS. Additionally, the OIG found that because providers could face pressure to recoup the electronic access fees by ordering unnecessary services (which would increase costs to federal health care programs) the arrangement could also violate AKS in this respect.[40]

Similar to the May 2011 advisory opinion, some believe that online

34. *Id.*
35. Advisory Op. 08-19, *supra* note 18, at 3.
36. Advisory Op. 11-06, *supra* note 10, at 5.
37. *Id.*
38. *Id.* at 3.
39. *Id.* at 5.
40. *Id.*

referral services give preference to those care providers that pay a fee to be listed on the website because the online referral services revenue model is based on care providers paying a fee to be connected with individuals seeking care.[41] However, the May 2011 advisory opinion deals with a hospital dictating which service provider patients used based on the referral service recommendation and those care providers subscribing to the service had a significant competitive advantage.[42] The May 2011 arrangement is unlike general online referral services, which are not affiliated with the health care industry and allow patients to decide which care provider to use. Some believe online referral services are used as a place to start one's search for a care provider.[43] Since the patient is in total control of which service provider to use, the care provider is not chosen based solely on payments to the online referral service.

The most recent advisory opinion where the OIG found the arrangement to potentially violate AKS, but did not impose sanctions was issued in November of 2011.[44] In this case, an Internet service provider wanted to electronically prepare and transmit referral orders between health care practitioners to assist them with tracking their patients' services with other health professionals on a pay-per-click basis.[45] The OIG concluded it would not impose administrative sanctions under AKS, even though the

41. Paula Span, *A Helping Hand, Paid on Commission*, THE NEW OLD AGE N.Y. TIMES BLOG (Sep. 2, 2011), http://newoldage.blogs.nytimes.com/2011/09/02/a-helping-hand-paid-on-commission/ (last visited Sept. 24, 2012).

42. Advisory Op. 11-06, *supra* note 10, at 5.

43. Span, *supra* note 41.

44. *See generally* Advisory Op., Off. Inspector Gen., HHS No. 11-18, 2, (November 30, 2011) [hereinafter Advisory Op. 11-18].

45. *Id.* at 3 The internet service provider would assist healthcare providers in making referrals to other providers by: (1) sending the demographic, medical record, insurance, and billing information of a patient when the patient is seen by other providers; (2) issuing appropriate referral reminders; (3) tracking communications with other healthcare providers; and (4) exchanging information about orders, order results, and healthcare recommendations. *Id.*

proposed arrangement to provide the online service could generate prohibited remuneration under AKS if there was the requisite intent to induce or reward referrals of patients in federal healthcare programs.[46] According to the OIG, the per-click basis did not rely on whether the patient actually followed through with the referral, but the fees reflected the fair market value of the services and the services being available to anyone protected patient and provider freedom of choice, so the OIG did not impose sanctions.[47]

Like the arrangement in the November 2011 advisory opinion, some online referral providers allow all individuals seeking care to access the service.[48] Additionally, some believe the online referral services do not limit the patient or provider's freedom of choice, because patients can choose to use the care provider they prefer.[49] This freedom of choice separates online referral services from more traditional referral services that violate the AKS.

IV. ONLINE SERVICE PROVIDER ANTI-KICKBACK ENFORCEMENT ACTIONS

The OIG and the Department of Justice are responsible for enforcing the AKS, yet neither of these agencies has brought enforcement action against an online service provider utilizing pay-per-lead models. However, the OIG did settle with a health company that utilized a pay per patient model with a marketing company.[50] The government has also taken action in AKS

46. *Id*. at 12.
47. *Id*. at 10-12.
48. CARE PATHWAYS, *supra* note 5.
49. *See*, *e.g.*, Span, *supra* note 41.
50. *See* "OIG Settles Largest Ever Civil Monetary Penalty Case: Lincare Pays $10 Million and Signs 5-Year CIA to Resolve Allegations of Kickbacks and Self-Referral Violations," United States Department of Health and Human Services Office of Inspector General (May 15, 2006).

cases involving criminal and abusive pay per patient referral agreements.[51] In *United States v. Starks*, employees of a state agency that counseled pregnant women about drug use were paid a fee by an owner of a drug treatment program for every patient referred to the program.[52] The per-patient fees were exchanged in secret, were not based on a legitimate service, and the state employees would on occasion threaten the patients if the patients did not go to the specific drug treatment program.[53] The employees were convicted of violating the AKS and sentenced to varying prison sentences.[54]

Similarly, the court in *Nursing Home Consultants, Inc. v. Quantum Health Servs., Inc.* held that volume-based commissions paid to third party marketers by care providers were in violation of the AKS.[55] This case is distinguishable because it involved a private contract dispute between the parties involved when one party sought to avoid contractual obligations by claiming that the contract violated the AKS.[56] Despite the existence of specific anti-kickback enforcement action against online referral service providers, there are several safeguards that online referral service providers should use.

V. SAFEGUARDS TO ENFORCEMENT ACTION

Based on the foregoing advisory opinions, the OIG should not take enforcement action against pay-per-lead arrangements when online referral services adhere to three specific safeguards. First, online referral services

51. *See* U.S v. Starks, 157 F.3d 833, 835 (11th Cir. 1998).
52. *Id.* at 837.
53. *Id.*
54. *Id*. at 842.
55. *See* Nursing Home Consultants, Inc. v. Quantum Health Servs., Inc., 926 F. Supp. 835, 850 (E.D. Ark. 1996).
56. *Id.* at 839.

referral fees should reflect the fair market value of the services provided to the participating care provider.[57] The independent value of these services distinguishes fees from payments for referrals.[58] Some online referral services use independent valuation experts to establish the price for referral services which assures fair market value is used.[59] Second, the referral fees charged by the online service provider should be fixed and assessed to all participating care providers.[60] Variable rate structures should be avoided because they can give the impression that the online service provider has an incentive to recommend certain care providers over others based on the amount paid in the referral fee, rather than on a needs basis.[61] Third, the online service provider should base referral fees on the number of leads it creates, as opposed to the number of referred individuals who actually become patients of a participating care provider.[62] This type of referral fee structure is distinguished from the fee structure that correlates compensation to a federally payable business.[63]

Additionally, there are a few other actions that online referral services can take to avoid scrutiny under the AKS. The lower the referral fee charged by the online referral service, the better.[64] OIG is weary of higher fees because higher fees could lead to care providers charging higher service costs to patients in order to recoup the referral service costs.[65] Also, in order to eliminate the risk of claims of patient influence or steering, online referral service providers should not convey that it has any special

57. Advisory Op. 11-18, *supra* note 44, at 10.
58. *Id.*
59. YEARS AHEAD, *supra* note 5.
60. Advisory Op. 08-19, *supra* note 18, at 6.
61. Advisory Op. 11-06, *supra* note 10, at 5.
62. Advisory Op. 08-19, *supra* note 18, at 6.
63. *Id.*
64. Advisory Op. 11-06, *supra* note 10, at 5.
65. *Id.*

knowledge as to what makes a quality care provider.[66] Online referral services should also include disclaimers stating that care providers pay a fee to be included in the online referral services database.[67] The online referral service should disclose to patients using the referral service the way in which the online referral service selects its care providers, whether the patient will end up paying a fee to the care provider for using the online referral service, the relationship between the online referral service and care providers, and any restrictions that would not allow a patient seeking care to use the online referral service.[68] Following these safeguards, online referral service providers should not face risk of liability under the AKS.

These safe guards will help online referral services manage risk because the OIG should not bring enforcement against these services if these guidelines are followed. These guidelines ensure that online referral services are not inflating health care costs because prices are fixed and placed at fair market value. By having care providers pay on a per lead basis and not pay for the amount of individuals that actually become patients, potential patients have freedom to choose their care freely and online referral services lack an incentive to lead the patient to the most lucrative care provider. Also, the pay-per-lead approach ensures that quality of care is not sacrificed because patients make the decision of which care provider to use, creating an incentive for care providers to administer quality care. Finally, many online referral services are not health care providers and are not in any position to exert undue influence over patients. Online referral services are simply suggesting available options of care providers to patients.

66. Advisory Op. 08-19, *supra* note 18, at 6.
67. 42 C.F.R. § 1001.952.
68. *Id.*

Allowing online referral services to continue without OIG intrusion will lower health care costs and expand access to health care services, which is essential in the pursuit of universal health care. If the OIG allows online referral services to utilize these safeguards to avoid liability under the AKS, online referral services will serve a valuable role in expanding access to health care. Providing long-term care in an efficient manner is essential for universal health care. Finding long-term care can be difficult and the need for long-term care is only going to increase as people live longer. Online referral services grant patients greater access to choosing their own care options. Also, online referral services allow individuals who traditionally could not afford a variety of long-term care options to assess their individual needs, and find the long-term care option that best suits them. Giving patients access to more care provider options will create competition among long-term care providers, ultimately driving down long-term care costs while increasing the quality of care that is provided. Lowering health care costs, expanding access to care and improving the quality of care delivered is essential when pursuing universal health care.

VI. CONCLUSION

Online referral services make access to long-term care easier, more affordable, and more efficient. The online referral services allow individuals to access a greater amount of long-term care options that best serves the individual's need. Though it is unlikely that online referral services violate the AKS, in the interest of universal health care and creating a more efficient health system, it would be wise for the OIG to revise the referral safe harbor to protect online referral services because these services are providing tremendous benefit to the health care system. However, until action is taken to ensure protection of the online referral

services, specific safeguards should be utilized by the online services in order to establish the best defenses should enforcement action be brought.

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Efforts at Mental Healthcare and Substance Abuse Treatment Reform

*Megan Honingford**

I. INTRODUCTION

Often lost in the healthcare debate is the treatment and long-term care of mentally ill individuals or individuals with substance abuse. As general healthcare reform has been proposed and typically defeated and forgotten, mental healthcare reform has been tied to its fate. Given the impacts of mental illness on physical health, work productivity, public safety, and quality of life, mental healthcare deserves to be seen as an integral part of our overall health and a necessary part of our healthcare considerations. Mental illness can often be chronic and treatment can be costly, so universal coverage is imperative in the mission to provide care for all those who need it. Previous administrations and legislatures have made various efforts to reform healthcare, as well as mental healthcare, with varying success and failure. The Patient Protection and Affordable Care Act (the PPACA)[1] offers the most significant reform since the creation of Medicare. However, while the PPACA largely provides for mental healthcare under the same provisions as traditional healthcare, there are still practical barriers to access that must be overcome. But like traditional healthcare, there are paths available for moving toward universal coverage of mental healthcare.

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

II. IMPORTANCE OF MENTAL HEALTH

Although at times mental illness seems invisible or disconnected from most people's realities, it touches a great portion of society. A 2005 study found that more than one in four Americans will experience a mental disorder in a given year.[2] In addition, while the correlation is not defined, it is clear that one's mental health often affects his physical state.[3] Mental illness has a high comorbidity with physical illnesses and greater mortality rates.[4] In a study of 600 patients admitted to Ohio public mental health hospitals who had died in a year, the mean age at death was just 47.7 years, and the leading cause of death was heart disease.[5] Those suffering from bipolar disorder and schizophrenia are also at a higher risk for cancer.[6] In addition to physical ailments, those suffering from mental illness are at a much higher risk of injury than the general population.[7] These higher risks and comorbidities translate into more care and a larger burden on our hospitals, emergency rooms, and insurance systems. As such, mental healthcare should be considered an integral part of our overall healthcare system.

In a given year, 26.2% of American adults will suffer from a diagnosable mental illness.[8] While not all of these disorders are severe,[9] the loss in

2. Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication,* 62 ARCHIVE OF GEN. PSYCHIATRY 617, 620 (2005).

3. *See generally* WORLD FED'N FOR MENTAL HEALTH, MENTAL HEALTH AND CHRONIC PHYSICAL ILLNESS: THE NEED FOR CONTINUED AND INTEGRATED CARE 15 (2010), *available at* http://www.wfmh.org/2010DOCS/WMHDAY2010.pdf.

4. Brian J. Miller et al., *Mortality and Medical Comorbidity Among Patients With Serious Mental Illness*, 57 PSYCHIATRIC SERV. 1482, 1484 (2006).

5. *Id.*

6. WORLD FED'N FOR MENTAL HEALTH, *supra* note 3.

7. Emma E. McGinty et al., *Injury Risk and Severity in a Sample of Maryland Residents with Serious Mental Illness*, INJURY PREVENTION (June 2, 2012).

8. Ramya Sundararaman, *The U.S. Mental Health Delivery System Infrastructure: A Primer*, CONGR. RES. SERV., 2 (2009), *available at* http://www.fas.org/sgp/crs/misc/R40536.pdf.

productivity that even mild cases cause is reason enough to consider mental healthcare an essential part of our healthcare system.[10] While mental healthcare has been a consideration in almost all the efforts to reform healthcare in the 20th century, it must be made a priority in the goal of universal coverage.

III. EFFORTS TO REFORM HEALTHCARE AND EXPAND ACCESS

The push for universal healthcare coverage began with Teddy Roosevelt, who campaigned for workers' health insurance in 1912.[11] Three years later, Progressive party reformers campaigned for mandatory health insurance in the form of a state-based plan.[12] Even as far back as both of these unsuccessful attempts at reform, people generally supported the idea of universal coverage, but did not support any proposed plan for how to achieve it,[13] a conundrum still seen in public polling today.[14] The next major push for healthcare reform took place under Franklin Roosevelt's administration in the midst of the Depression when sickness first became a leading cause of poverty.[15] Though Social Security and unemployment insurance were passed into law, universal healthcare was not.[16] After the Depression, efforts under Truman's administration diverged from state-based plans towards national plans, but Congress failed to implement these

9. Kessler, *supra* note 2, at 625.

10. Debbie Lim et al., *Lost Productivity Among Full-Time Workers with Mental Disorders*, J. OF MENTAL HEALTH POL'Y. AND ECON. 139, 145 (2000).

11. Catherine Hoffman, *National Health Insurance – A Brief History of Reform Efforts in the U.S*, KAISER FAMILY FOUND., 1 (2009), *available at* http://www.kff.org/healthreform/upload/7871.pdf (last visited September 25, 2012).

12. *Id*.

13. *Id*.

14. Patricia Zengerle, *Most Americans Oppose Health Law but Like Provisions*, REUTERS (June 24, 2012) http://www.reuters.com/article/2012/06/25/us-usa-campaign-healthcare-idUSBRE85N01M20120625 (last visited Sept. 25, 2012).

15. Hoffman, *supra* note 11, at 2.

16. *Id.*

as well.[17]

Alongside the early 20th century efforts at universal healthcare, the field of mental health made significant strides in treatment, understanding of disorders, patient rights, and technology.[18] Social reformers fought for better conditions in mental institutions, and more extreme practices, like lobotomies, were phased out.[19] Until the 1960s, virtually all mental healthcare was provided by either private hospitals, which were paid for with private insurance or cash, or by state-run and state-funded inpatient institutions.[20] The 1946 National Mental Health Act provided some federal money for the states to implement their mental healthcare systems, but these hospitals were still largely state-funded.[21]

As the post-war economy boomed, employer health benefits were deemed non-taxable, and more and more people began to be covered by group health plans offered by their employers.[22] The push for national healthcare lost steam and reform efforts focused mainly on providing coverage for the elderly and poor.[23] President Kennedy's efforts to provide coverage for seniors[24] were realized under Johnson's administration with the passing of Medicare for the elderly, along with Medicaid for the poor.[25]

Meanwhile, the Eisenhower-commissioned Joint Commission on Mental

17. *Id.*at 3.

18. *See generally* Allison M. Foerschner, *The History of Mental Illness: From "Skull Drills" to "Happy Pills,"* STUDENT PULSE 3 (2010), http://www.studentpulse.com/articles/283/the-history-of-mental-illness-from-skull-drills-to-happy-pills (last visited October 29, 2012).

19. *Id.*

20. Milton F. Shore, *Community Mental Health: Corpse or Phoenix? Personal Reflections on an Era*, 23 PROF. PSYCHOL. - RES. & PRAC. 257, 257 (2006).

21. BOB SMUCKER, PROMISE, PROGRESS, AND PAIN: A CASE STUDY OF AMERICA'S COMMUNITY MENTAL HEALTH MOVEMENT FROM 1960 TO 1980 13, http://mentalhealthhistory.org/Promise_Progress_Pain.pdf.

22. Hoffman, *supra* note 11, at 3.

23. *Id.* at 3.

24. *Id.* at 5.

25. *Id.* at 4.

Health submitted its final report in 1961.[26] The report made two major recommendations: that care for the severely mentally ill should become the major priority in mental healthcare and that community mental healthcare centers should be established.[27] Federal efforts focused on the latter, which led to the Community Mental Health Act, providing federal money to the states with mandates to create community-based treatment centers, an action that has been largely credited with the widespread deinstitutionalization of the mentally ill.[28] While the Community Mental Health Act was aimed at moving the country towards a national mental healthcare system, it inadvertently led to cuts in state mental healthcare budgets[29] and the demise of inpatient treatment in favor of community-based outpatient services that were not yet fully established or funded. In 1968, the Act was amended to mandate treatment of substance abuse at community centers.[30]

Healthcare reform efforts continued, and under President Nixon, legislators generated broad support for reform and Congress came closer than it ever had to passing universal healthcare coverage, but competing proposals, political interference, and the Watergate scandal slowed the process to an eventual halt.[31] President Carter proposed a plan that would allow for private insurance through employers, expand coverage of the aged and poor, and create a public corporation that would provide for everyone else, but this failed in the face of recession.[32]

The mental healthcare system created under the Community Mental

26. Shore, *supra* note 20, at 258.
27. SMUCKER, *supra* note 21, at 7.
28. Shore, *supra* note 20, at 259.
29. SMUCKER, *supra* note 21, at 9.
30. *Id*. at 17
31. Hoffman, *supra* note 11, at 5-6.
32. *Id.* at 6.

Health Act remained largely in place until President Reagan's Omnibus Budget Reconciliation Act converted funding for mental health services into block grants to states and essentially ended any further federal involvement in the system.[33] Reagan did attempt to normalize drug-free workplaces and employer-based support for addiction by issuing an executive order to implement Employee Assistance Programs for rehabilitation of any federal employee found to be using illegal drugs.[34]

Later, President George H.W. Bush fielded several proposals for reform and he himself supported tax credits and purchasing pools.[35] The Clinton administration made the biggest push for reform to that point and succeeded in expanding Medicaid coverage for children but not in achieving significant reform.[36]

From the time of Reagan's changes through the 1990s, private mental health insurance was largely unregulated and mental health coverage was generally not as comprehensive as traditional healthcare coverage.[37] Mental health plans typical included an arbitrary lifetime limit on care.[38] Lifetime limits on mental healthcare were required to be equitable with those on medical treatment by the Mental Healthcare Parity Act of 1996.[39] Further integration of the two, and inclusion of addiction care, was achieved through the Paul Wellstone and Pete Domenici Mental Health Parity and

33. SMUCKER, *supra* note 21, at 18.
34. Exec. Order No. 12.564, 3 C.F.R.-224 (Sept. 15, 1986).
35. Hoffman, *supra* note 11, at 7.
36. *Id.* at 7.
37. Chris Koyanagi, *Can We Learn From History? Mental Health in Healthcare Reform, Revisited*, 60 PSYCHIATRIC SERV. 17, 18 (2009).
38. *Id.*
39. NATIONAL ALLIANCE ON MENTAL ILLNESS, THE MENTAL HEALTH PARITY ACT OF 1996, http://www.nami.org/Content/ContentGroups/E-News/1996/The_Mental_Health_Parity_Act_of_1996.htm (last visited Sept. 25, 2012) (summarizing Mental Healthcare Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (1996)).

Addiction Equity Act of 2008.[40]

These efforts were largely accepted by both the public and mental healthcare providers, but universal coverage was still not realized due to the fact that these measures applied only to those who already received employer-based coverage. While Medicaid and Medicare offered coverage to their subscribers, those who were not eligible for coverage through either of these pathways were left uncovered, an issue common among those with severe mental illness who were employable, but only in part-time positions that did not offer health insurance.[41] In addition, many individuals who may have been eligible to receive mental healthcare through either program fell through the cracks and remained outside the system because of the isolating nature of their conditions.[42] Many sufferers of severe mental illnesses like schizophrenia simply do not have the mental faculties or the family or social support network to find care.[43]

IV. MENTAL HEALTHCARE UNDER THE PPACA

The PPACA proves to be the most meaningful healthcare reform since the creation of Medicare and Medicaid, and these reforms encompass the world of mental healthcare. Under the PPACA, mental illnesses and addictions will be considered pre-existing conditions that cannot constitute a basis for denying coverage.[44] Mental healthcare will also be considered an

40. *See generally* Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 STAT. 3881 (2008).

41. Su Liu & Sarah Croake, *How are the Experiences of Individuals with Severe Mental Illness Different from Those of Other Medicaid Buy-In Participants?*, MATHEMATICA POL'Y RES., INC. 1 (2010).

42. SCI. AM., *The Neglect of Mental Illness Exacts a Huge Toll, Human and Economic*, (Feb. 23, 2012), http://www.scientificamerican.com/article.cfm?id=a-neglect-of-mental-illness.

43. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, 424 (1999), *available at* http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf (last visited October 29, 2012).

44. Richard A. Friedman, *Good News for Mental Illness in Health Law*, N.Y. TIMES,

essential benefit, which means most private plans will be required to offer at least some coverage,[45] a provision that was not part of either the 1996 or 2007 legislation. Additionally, the allowance for children up to age twenty-six to remain on a parent's insurance plan is a boon for mental healthcare, considering that nearly seventy-five percent of serious psychiatric disorders emerge by age twenty-five.[46]

The greatest proportion of mental healthcare expenditures comes from private insurers, with out-of-pocket payments accounting for just 2.7% less.[47] Together, these two sources account for 52.5% of mental healthcare spending.[48] Two ideas can be inferred from this fact: that the people who consume the bulk of mental healthcare (those with employee benefits or the ability to pay cash for care) are not who our society typically thinks of as the mentally ill, and that at least some of those who we typically think of as severely mentally ill[49] (those with disorders so severe they cannot be employed and are destitute) are not getting the care they likely need.

Assuming that those who use private insurance or pay out-of-pocket for their mental healthcare are not destitute, it is likely that this treatment is for illnesses such as anxiety, depression, eating disorders, ADHD in children, and some addictions. Care for these disorders, especially in less severe and debilitating cases, is often centered on outpatient therapy and medication.[50] Under new the PPACA provisions, those patients with private insurance

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July 9, 2012, at D6, *available at* http://www.nytimes.com/2012/07/10/health/policy/health-care-law-offers-wider-benefits-for-treating-mental-illness.html?_r=2.

45. U.S. DEP'T OF HEALTH AND HUMAN SERVS., GLOSSARY: ESSENTIAL BENEFITS, http://www.healthcare.gov/glossary/e/essential.html (last visited Sept. 25, 2012).

46. Friedman, *supra* note 44.

47. SUNDARARAMAN, *supra* note 8, at 9.

48. *Id*. at 9.

49. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 43, at 7.

50. MAYO CLINIC, MENTAL ILLNESS TREATMENT AND DRUGS, (Sept. 15, 2012) *available at* http://www.mayoclinic.com/health/mental-illness/DS01104/DSECTION=treatments-and-drugs (last visited Jan. 2, 2013).

will likely be able to continue their care and will not be denied benefits if they switch insurers.

V. CONTINUED OBSTACLES TO CARE

Currently, the most common obstacles to universal access to mental healthcare are lack of enrollment, continued disparity resulting in inadequate coverage, and practicality in rural and other areas underserved by mental health professionals and facilities.[51] Furthermore, although the Mental Healthcare Parity Act and the Mental Health and Addiction Equity Act required lifetime limits on mental healthcare to be equitable with those on physical healthcare, costs for mental healthcare can often far exceed limits imposed by private insurance plans, leaving those who pass their limits but do not qualify for Medicaid or Medicare essentially uninsured. This is largely due to fundamental differences in mental and medical care and the difficulty for regulators to establish parity between the two.[52]

Given the often highly publicized but not necessarily widely-held[53] opposition facing the PPACA and universal healthcare in general,[54] efforts to expand mental healthcare coverage will likely be met with similar opposition. The President and legislators would be wise to emphasize the importance of mental healthcare coverage for those in the community who use private insurance and encourage people to ask their employers for insurance plans that include comprehensive mental healthcare. From an employer's viewpoint, providing employees with access to mental

51. SUNDARARAMAN, *supra* note 8, at 13.
52. *Id.* at 15.
53. Zengerle, *supra* note 14.
54. Thomas Szasz, *Universal Healthcare Isn't Worth Our Freedom.* Wall Street Journal (July 15, 2009) http://online.wsj.com/article/SB124761945269242551.html (last visited January 2, 2013).

healthcare will likely boost productivity and decrease turnover.[55]

Furthermore, with the consistently growing number of Americans taking psychiatric prescription drugs,[56] along with growing controversy surrounding the possibility of over-prescription,[57] patients and mental health professionals alike may push towards more psychosocial therapy and less medication. This approach, while perhaps more effective and beneficial to patients' health, would be more costly[58] and would necessitate the need for more comprehensive coverage.[59] The mental healthcare community is in a position to make this fact known and to lobby on behalf of comprehensive coverage through employee benefit plans.

Turning to those patients who pay for mental healthcare through Medicare and Medicaid,[60] studies show that severe mental illness is more prevalent in those with lower socioeconomic status, many of whom are presumably on Medicaid.[61] Given the nature of severe diseases like bipolar disorder and schizophrenia, sufferers can go years without employment and, consequently, without insurance coverage.[62] Medicaid and Medicare under

55. Leah Carlson Shephard, *Mental Health Parity can Boost Productivity and Retention*, 21 EMPLOYEE BENEFIT NEWS 36, 37 (2007).

56. Brendan L. Smith, *Inappropriate Prescribing*, 43 MONITOR ON PSYCHOL. 36, 36 (2012).

57. *Id.* at 38.

58. *Id.* at 36 (Many patients on antidepressants are prescribed them by their primary care physician and never see a mental health professional, so the only cost associated is the prescription itself). *Id.*

59. As the number of people taking prescription psychiatric medicine climbs, the stigma of common mental illnesses such as depression and anxiety lessens, and comprehensive coverage likely will become more expected among those who receive benefits from their employers.

60. SUNDARARAMAN, *supra* note 8, at 9. (Medicaid and Medicare account for 32.6% of mental healthcare expenditures). *Id.*

61. THE COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, FACILITATING MEDICAID ENROLLMENT FOR PEOPLE WITH SERIOUS MENTAL ILLNESSES LEAVING JAIL OR PRISON: KEY QUESTIONS FOR POLICYMAKERS COMMITTED TO IMPROVING HEALTH AND PUBLIC SAFETY, 3 (2011). http://consensusproject.org/documents/0000/1141/Key_Questions_final.pdf (last visited Oct. 29, 2012).

62. Liu & Croake, *supra* note 40.

the PPACA will continue to provide mental healthcare to these patients,[63] but the Supreme Court's ruling that the federal government cannot require states to adopt new Medicaid provisions[64] may result in many patients not being eligible for Medicaid in states that choose not to adopt the new standards.[65] Even more sufferers of severe mental illness, who likely would have been Medicaid-eligible had the Supreme Court held the provisions mandatory, would then be isolated from the mental health system entirely.

To expand access to isolated patients and those who find themselves excluded from Medicaid under the new provisions, legislators and mental healthcare reformers must reach out to the public to raise awareness of the importance of comprehensive mental healthcare and ask for voter support to encourage their states to adopt the Medicaid expansion.

VI. CONCLUSION

The complex connections between mental illness and physical well-being, as well as societal ills like poverty and violence, are often overlooked in our debate over healthcare reform, but mental health is critically important to the efforts to expand health coverage. Many voters may favor measures that expand access to rehabilitative mental healthcare rather than the current system that pushes the non-violent homeless, poor, and addicted into the prison system and eventually back to the street.[66] Indeed, the apparent rise in incidents of mass violence by perpetrators who often have

63. CENTERS FOR MEDICARE AND MEDICAID SERVS., MEDICARE & YOUR MENTAL HEALTH BENEFITS, http://www.medicare.gov/Publications/Pubs/pdf/10184.pdf (last visited on Sept. 25, 2012).

64. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 3 (2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (last visited September 25, 2012).

65. Friedman, *supra* note 44.

66. J. Steven Lamberti et al., *The Mentally Ill in Jails and Prisons: Towards an Integrated Model of Prevention*, 72 PSYCHIATRIC Q. 63, 64-65 (2001).

had a history of mental health issues has prompted the beginnings of a cultural discussion on improving access to mental healthcare.[67]

With the PPACA likely to stay in place, the stigma of mental illness dissipating, and the need to provide a more efficient alternative for treating the severely mentally ill growing, the time is ripe for universal mental healthcare coverage to be realized.

67. SUNDARARAMAN, *supra* note 8, at 1.