

**UNFORTU-NATION: AMERICA'S
LIBERTARIAN ETHOS, AND THE
REJECTION OF COST-EFFECTIVE
RATIONING IN HEALTH CARE REFORM**

Daniel Cunix

Historically, Americans have rejected the idea of rationing health care. With increasing strain on health care costs and availability, however, recent reforms attempt to solve many of the system's greater problems. In this Note, Mr. Cunix examines the current issues regarding cost rationing in relation to the Patient Protection and Affordable Care Act. While discussing the limitations in the language of the Act, Mr. Cunix also analyzes foreign health care systems which focus on various forms of cost-effective rationing. Lastly, Mr. Cunix presents a possible solution of balancing the best cost-effective rationing with American's libertarian desire for self choice.

Daniel Cunix is an Associate Editor 2011–2012, Member 2010–2011, *The Elder Law Journal*; J.D. 2012, University of Illinois, Urbana-Champaign; B.A. 2007, University of Wisconsin-Madison.

This Note is dedicated to the late, unapologetic polemicist and public intellectual, Christopher Hitchens who provided the inspiration and courage to write so frankly and honestly about a controversial subject. I'd also like to give special thanks to Mita Lakhia, whose tireless efforts are the only reason this Note was finished by the publication date.

Resources should be used for interventions that are known to be effective, in accordance with national or local priorities. Because resources are limited, there will always be some form of rationing.

World Health Organization Report.¹

I. Introduction

Jack Rosser, a fifty-seven-year-old citizen of Britain, has advanced kidney cancer.² Britain's National Institute for Health and Clinical Excellence (NICE) set a maximum expenditure of \$45,000 to lengthen life for an additional year.³ A drug called Sutent can treat kidney cancer, but its use exceeds the \$45,000 maximum expenditure.⁴ For that reason alone, NICE recommended that the National Health Service (NHS) not provide the drug to dying cancer patients, including Jack Rosser.⁵ The media and the public responded with abhorrence, proclaiming NICE's policy as "immoral" and concluding that "[t]hey are sentencing him to die."⁶ Others state that Rosser is only "one of NICE's many victims," because NICE "regularly hands down death sentences . . ."⁷

Health care rationing inherently raises issues of morality such as "[w]hat price is life?" and whether we deserve a system where "soulless bureaucrats arbitrarily put a dollar value on our lives."⁸ NICE eventually issued a final ruling recommending that the NHS provide Sutent to cancer patients due to the press and extreme public pressure.⁹ In a societal context, however, was this the correct decision?

Upon first reading Jack Rosser's story, the decision to provide Sutent seems intuitive. Emotionally and ethically, there is no price to

1. WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000, HEALTH SYSTEMS: IMPROVING PERFORMANCE 47 (2000) [hereinafter WORLD HEALTH REPORT 2000], available at http://www.who.int/whr/2000/en/whr00_en.pdf.

2. Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES, July 19, 2009, (Magazine).

3. Eben Harrell, *Is Britain's Health-Care System Really That Bad?*, TIME, Aug. 18, 2009.

4. Singer, *supra* note 2.

5. *Id.*

6. *Id.*

7. *Id.* (citation omitted).

8. *Id.* (citations omitted).

9. *Id.*

be put on a person's life. Delving deeper into the realities of de facto and de jure health care rationing schemes, however, the issue becomes complex. Americans who balk at an institution that makes rationing determinations fail to understand that in a system of finite resources there will always be some level of rationing. Health care in the United States is full of de facto examples of rationing. The United States spends more money on health care than any other country in the world but fails to insure anywhere between forty-five and fifty-nine million Americans.¹⁰ Those without health care are entitled to emergency care under the Emergency Medical Treatment and Active Labor Act (EMTALA), but studies show that the uninsured receive twenty percent less care under EMTALA and have a death rate thirty-seven percent higher than the insured.¹¹ Additionally, an estimated 20,000 people per year die due to lack of insurance.¹² The United States may not be explicit in its use of cost-containment measures like the United Kingdom, but the human costs are statistically greater. Ironically, so are the financial costs.

Britain has managed to provide health insurance to every one of its citizens at one-third the cost per capita compared with the United States.¹³ Although Britain has implemented a de jure rationing system, it has higher life expectancies, lower infant mortality rates, and more acute-care hospital beds per capita.¹⁴ However, rationing has its drawbacks. Britain has higher cancer mortality rates than the United States because of limited access to cancer-fighting drugs.¹⁵ World Health Organization statistics show, however, that greater access to expensive drugs does not lead to greater longevity for Americans.¹⁶ The lesson to be learned can be summed up in one fact: the U.S. health care policy of no explicit rationing has garnered a ranking of thirty-seventh best in the world.¹⁷ The rationing system in Britain, with its

10. Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS INTERNAL MED. 485, 485 (2009); Maggie Fox, *Nearly 59 Million Lack Health Insurance: CDC*, REUTERS (Nov. 10, 2010, 9:33 A.M.), <http://www.reuters.com/article/idUSTRE6A905U20101110>.

11. Singer, *supra* note 2.

12. *Id.*

13. See WORLD HEALTH REPORT 2000, *supra* note 1, at 195 tbl.8. The United Kingdom spends \$1,303 per capita as opposed to the United States which spends \$4,187. See *id.*

14. Harrell, *supra* note 3.

15. See Michel P. Coleman et al., *Cancer Survival in Five Continents: A World-wide Population-Based Study (CONCORD)*, 9 LANCET ONCOLOGY 730, 751 (2008).

16. See WORLD HEALTH REPORT 2000, *supra* note 1, at 30 fig.2.3.

17. *Id.* at 155 tbl.1.

lower costs and more extensive coverage, received a ranking of eighteenth in the world.¹⁸

Health care looms as the single greatest threat to the United States' fiscal well-being, but resistance from powerful interests such as the insurance industry and the electorate at large have stifled most meaningful reform options, especially rationing.¹⁹ Instead of an open debate as to the best methods to cut costs, discussions of cost reduction generally focus on the health care providers who continuously face decreases in reimbursement rates from Medicaid and Medicare patients, and in turn, patients with private insurance.²⁰ It seems that the Obama administration's Patient Protection and Affordable Care Act (Affordable Care Act or ACA) will once again implement the same cost-reducing methods due to the language of the act, which specifically prohibits the use of rationing methods like those used by NICE.²¹

President Obama's legislation ignores the lesson from health care systems abroad—the best methods for controlling costs are rationing and regulations that place targets on spending for medical care.²² Examples of targets can be seen in health care systems around the world; some set fixed systemic costs for a period of time and others determine which services will be covered based on price and effectiveness. Within the United States, Oregon adopted a rationing system for its Medicaid program that uses a defined list of covered services based on effectiveness.²³ Each rationing program requires that difficult decisions be made while considering where each health care dollar receives the most utility. In programs such as Oregon's, the implication is that certain procedures must be given priority over

18. *Id.*

19. See Peter H. Schuck, *The Golden Age of Aging, and Its Discontents*, 18 *ELDER L.J.* 25, 40–41 (2010).

20. HEALTH LAW: CASES, MATERIALS AND PROBLEMS 768–69, 785–87 (Barry R. Furrow et al. eds., 6th ed. 2008).

21. Peter J. Neumann & Milton C. Weinstein, *Legislating Against Use of Cost-Effectiveness Information*, 363 *NEW ENG. J. MED.* 1495, 1495 (2010).

22. See Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 3403, 124 Stat. 119, 490 (2010) (to be codified at 42 U.S.C. § 1395kkk) (placing prohibitions on rationing for reform proposals); Marmor et al., *supra* note 10, at 488; Nancy K. Stade, Note, *The Use of Quality-of-Life Measures to Ration Health Care: Reviving a Rejected Proposal*, 93 *COLUM. L. REV.* 1985, 1986–88 (1993); Fox, *supra* note 10.

23. See Norman Daniels, *Is the Oregon Rationing Plan Fair?*, 265 *JAMA* 2232, 2232 (1991).

other procedures deemed less important.²⁴ Other programs, such as NICE, rely on Quality Adjusted Life Year (QALY) methods to determine which services are cost-effective enough to be included in the national plan.²⁵ The commonality between these programs is the willingness to allocate medical resources where they provide the greatest utility.

It is possible that the Obama administration neglected to use rationing methods in the reform bill as a tactical tool—utilized to quell the fears of Americans who believe in so-called bureaucratic “death panels,” a term made popular by Sarah Palin during the political battle over reform in 2009.²⁶ In particular, the elderly oppose any type of ration-based health care, and they constitute a highly effective voting bloc fully capable of protecting their own group interests.²⁷ Thus, in order to appease a powerful group of voters, reformers have taken reforms off the table that might achieve cost-containment levels unavailable through other methods.²⁸

It seems likely that the outcome of the ACA will be that younger and healthier workers will be subsidizing the elderly and the infirm through personal mandates and new premium structures.²⁹ Additionally, providers will receive less in reimbursements due to a new reimbursement structure designed to cut over \$100 billion in the first decade.³⁰ Lost among the reforms will be any type of de jure rationing.

This Note discusses the limitations on health care rationing explicitly located within the language of the ACA as well as the detrimental effect of those limitations on the Act’s ability to reduce per capita health care costs. Part II presents a brief history of the American health care system and the continued utilization of reduced reim-

24. *Id.*

25. Robert Coleman, *The Independent Medicare Advisory Committee: Death Panel or Smart Governing?*, 30 J. NAT’L ASS’N ADMIN. L. JUDICIARY 235, 279–81 (2010).

26. See Neumann & Weinstein, *supra* note 21, at 1495; Jim Rutenberg & Jackie Calmes, *False ‘Death Panel’ Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 13, 2009, <http://www.nytimes.com/2009/08/14/health/policy/14panel.html>.

27. Schuck, *supra* note 19, at 40. Perhaps one of the reasons AARP Vice President John Rother has stated his organization supports the health care proposals suggested by the Obama administration is the language included in the ACA that limits the ability to use QALY methods in determining where health resources will be spent. See *id.*

28. See *id.*

29. See *id.* at 41.

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

bursement to providers as a cost-saving mechanism. Part III examines current problems associated with rising costs of the American health care system and analyzes whether the ACA can decrease expenditures. It also explores the utilization of rationing strategies from the HMO era as well as foreign health care systems to further reduce costs. Part IV recommends that the American government take advantage of comparative effectiveness research by allowing the Independent Medicare Advisory Board to make ration-based cost-saving proposals and then use Accountable Care Organizations to administer health care provided by a single payer government insurer.

II. Background

The rising cost of providing health services in America is a problem likely to lead to Medicare and Medicaid insolvency by 2017.³¹ It is also estimated that the government spent \$1.25 trillion on health care in 2010, with private expenditures topping government spending at \$1.37 trillion in insurance payments and out-of-pocket expenses.³² These expenditures are expected to rise to \$2.23 trillion and \$2.12 trillion, respectively, by the year 2018.³³ In spite of this exploding financial burden caused by the inability to contain health care costs, the ACA has prohibited proven, ration-based policy reforms and instead looked to other avenues to contain costs.

The language of the Obama administration's ACA suggests that the provider will again shoulder the burden of any reduction in health care costs.³⁴ The ACA calls for the creation of an Independent Medicare Advisory Board (IMAB) that must submit proposals to "reduce the per capita rate of growth in Medicare spending."³⁵ It further states:

The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copay-

31. PATRICIA A. DAVIS, CONG. RESEARCH SERV., *MEDICARE: HISTORY OF PART A TRUST FUND INSOLVENCY PROJECTIONS 2* (2009).

32. U.S. CENSUS BUREAU, *NATIONAL HEALTH EXPENDITURES—SUMMARY, 1960 TO 2007, AND PROJECTIONS, 2008 TO 2018*, available at <http://www.census.gov/compendia/statab/2010/tables/10s0127.pdf> (last visited Mar. 9, 2012).

33. *Id.*

34. See ACA, Pub. L. No. 111-148, § 3403, 124 Stat. 119, 490 (2010) (to be codified at 42 U.S.C. § 1395kkk) (leaving little to no possibility for increased costs to Medicare or Medicaid beneficiaries).

35. *Id.*

ments), or otherwise restrict benefits or modify eligibility criteria.³⁶

This restrictive clause of the ACA prohibits IMAB from making any recommendation to lower costs that requires rationing of health care services, increasing the costs to beneficiaries, or reducing the number of beneficiaries to Medicare or Medicaid.³⁷

The ACA, in addition to creating the IMAB, creates the Patient-Centered Outcomes Research Institute (PORI), which is given the task of conducting comparative effectiveness research.³⁸ PORI is limited in its methods, however, by the language of the ACA, which states:

The Patient-Centered Outcomes Research Institute . . . shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.³⁹

Although the implications of this language are not entirely clear as to the manner in which PORI can utilize information to be gained through the use of QALYs, the clause certainly prohibits the board from using a cost-utility analysis as a standard for health care expenditure determinations and thresholds.⁴⁰ Additionally, this clause taken in conjunction with the clause referring to the IMAB restrictions discussed *supra*, suggests that the ACA mandates a broad restriction on any type of cost-utility or rationing method.⁴¹ Due to these restrictions, the American health care system must rely, once again, on the same cost cutting methods it has employed throughout its existence. To understand the cost-containment measures and the incentives therein, a brief history of the American health care system is appropriate.

36. *Id.*

37. *See id.*

38. Neumann & Weinstein, *supra* note 21, at 1495.

39. ACA, Pub. L. No. 111-148, § 1182, 124 Stat. 119, 741 (to be codified at 42 U.S.C. § 1320e-1).

40. Neumann & Weinstein, *supra* note 21, at 1495.

41. *See id.*

A. History: The Transforming Role of Health Care in America

1. THE EMPLOYER-PROVIDED HEALTH CARE SYSTEM

Although the era of modern medicine began with the historic discovery of penicillin in 1941,⁴² the modern era of insurance began two years later with an Internal Revenue Service (IRS) tax ruling that may not have seemed as important but the effects of which are just as far-reaching.⁴³ The ruling created the de facto rationing system that currently exists in the United States today. In 1943, the IRS ruled that group health insurance premiums paid for by an employer for the employees would be considered an “ordinary and necessary” business expense rather than income and therefore would not be taxable as income.⁴⁴ In terms of cost control, this tax benefit acts as a subsidy for the middle class and the wealthy; although employees as a group are the easiest to insure, they also receive tax breaks. On the other hand, individuals who are unemployed do not receive the tax subsidies.⁴⁵ Subsequently, in 1954 the IRS completed an extensive overhaul of the Internal Revenue Code, including a provision that explicitly excludes employer contributions into employee insurance from taxation.⁴⁶ Since the 1954 revision, the majority of insured people in the United States receive their insurance through their employer by means of tax-free contributions.⁴⁷ The benefit, then, is that insured employees are not taxed on the capital that pays for their health care premiums.

2. BRITAIN'S NATIONAL HEALTH SERVICES (NHS) AS A PRECURSOR TO MEDICARE AND MEDICAID

During the genesis of employer-provided health coverage, the idea of government involvement in health care gained legitimacy after

42. David Ho, *Bacteriologist Alexander Fleming*, TIME, Mar. 29, 1999, <http://www.time.com/time/magazine/article/0,9171,990612,00.html>.

43. David Gratzner, *What Ails Health Care*, 159 PUB. INT. 109, 111 (2005), available at http://www.manhattan-institute.org/pdf/PI_gratzer_spring05.pdf.

44. D. ANDREW AUSTIN & THOMAS L. HUNGERFORD, CONG. RESEARCH SERV., THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY 5 (2009), available at <http://www.fas.org/sgp/crs/misc/R40834.pdf>.

45. DAVID GRATZNER, THE CURE: HOW CAPITALISM CAN SAVE AMERICAN HEALTH CARE 26–28 (2006).

46. I.R.C. § 106 (2011) (regulating contributions by employers to accident and health plans).

47. Avik Roy, *Health Care and the Profit Motive*, NAT'L AFFAIRS, Spring 2010, <http://www.nationalaffairs.com/publications/detail/health-care-and-the-profit-motive>.

Lord Beveridge submitted a report to the Labour party in 1942, which outlined the creation of the government run NHS.⁴⁸ Soon after the report was made public, President Roosevelt gave the State of the Union address and told the American people that Social Security should cover beneficiaries from the “cradle to grave.”⁴⁹ In 1943, the Wagner-Murray-Dingell Bill was introduced in Congress, an attempt to amend Social Security to include health benefits and government-paid doctors.⁵⁰

The bill failed, but President Truman continued the campaign after the death of Roosevelt in 1949.⁵¹ The American Medical Association (AMA) mounted a successful counter-effort to Truman’s campaign and government involvement in health care when it linked the effort to socialism.⁵² The AMA also persuaded employers to continue to purchase private health insurance for their employees.⁵³ Over the next few years, support for a national health system fell significantly.⁵⁴ In 1945, seventy-five percent of the population supported the proposal, while in 1949 only twenty-one percent of Americans wanted the government to become involved in health care.⁵⁵

The notion of government-provided health care as a right, originally spurred by Lord Beveridge’s proposal for a free national health care system, motivated President Lyndon Johnson to continue support for government involvement in health care.⁵⁶ In 1965, President Johnson signed the Medicare bill into law as amendments to the Social Security Act of 1935.⁵⁷ Part A consisted of an entitlement to inpatient care that would be paid for by a payroll tax and Part B consisted of a voluntary additional insurance program to cover outpatient forms of care.⁵⁸ Medicaid covered qualifying people with disabilities, the blind, and the indigent as a form of welfare funded through general

48. GRATZER, *supra* note 45, at 29.

49. Coleman, *supra* note 25, at 249 (citations omitted).

50. Ellen M. Yacknin, *Helping the Voices of Poverty to be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143, 150 n.29 (1994).

51. Jacob S. Hacker & Theda Skocpol, *The New Politics of U.S. Health Policy*, 22 J. HEALTH POL. POL’Y & L. 315, 318–19 (1997).

52. *Id.* at 319.

53. Coleman, *supra* note 25, at 250.

54. *Id.* at 250–51.

55. *Id.*

56. See GRATZER, *supra* note 45, at 29–31.

57. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 et seq. (2006)).

58. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 777–78.

revenue dollars.⁵⁹ The structure of these programs continues in much the same fashion as it did during the 1960s,⁶⁰ including benefits beginning at age sixty-five.⁶¹ This creates a problem because health care inflation outpaces general inflation and the American population is living longer.⁶²

3. NIXON'S CREATION OF HEALTH MANAGEMENT ORGANIZATIONS (HMO) AS A RESPONSE TO COST RAISING INCENTIVES

During Nixon's first year in office, there was strong public dissatisfaction with the state of health care in America.⁶³ The President recognized the problems and referred to the issue as a "crisis," claiming that "[u]nless action is taken in the next 2 or 3 years . . . we will have a breakdown in our health care system."⁶⁴ In response, Nixon oversaw the passage of the HMO Act of 1967.⁶⁵ The Act created a new type of health insurance that created networks between health care providers who were to provide care at a capitated, flat rate.⁶⁶

The key element of HMOs is capitation, which is the essence of how managed care organizations (MCOs) reimburse providers.⁶⁷ Under the old fee-for-service system, payments were made for each service provided.⁶⁸ Under capitation, the purchaser pays a set amount to an insurer, and the MCO agrees to provide a range of services that are medically necessary.⁶⁹ In addition, HMOs contain a designated gatekeeper physician who acts as the point of contact between the patient

59. *Id.*

60. Cynthia E. Boyd, *Medicare: It's Time to Talk About Changing It*, 19 ANNALS HEALTH L. 79, 79 (2010).

61. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 57 (5th ed. 2010).

62. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., THE 2009 ANNUAL REPORT OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 11 (2009), available at <https://www.cms.gov/ReportsTrustFunds/downloads/tr2009.pdf>.

63. GRATZER, *supra* note 45, at 45.

64. *Id.* at 45–6. It has also been argued that Nixon placed such an emphasis on passage of the HMO Act because of strong pressure for a national health insurance. *Id.* Nixon preferred moving private insurance as well as Medicare and Medicaid into private HMOs as opposed to further government intervention into health care. *See id.* at 46 (explaining that this was Nixon's attempt to curb government expansion into health care).

65. Coleman, *supra* note 25, at 256–57.

66. *Id.*

67. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 640.

68. *Id.*

69. *Id.*

and the managed care organization.⁷⁰ In this system, the physician is a contractor working for the HMO and is incentivized to see more patients and provide fewer services.⁷¹ The cost-saving features consist of selective contracting of physicians and hospitals, limited visits to specialists, and the organization's ability to determine which services are "medically necessary."⁷² Even though the HMO system utilizes each of these de jure rationing techniques, there have been about 100 studies done on the quality of care provided by MCOs that have shown no discernible decrease in quality from fee-for-service systems.⁷³

Early academic and government responses to HMOs were very supportive. Studies show that initial expenditures in health care are important to the population's health but that subsequent spending does not necessarily link to increased population health.⁷⁴ The general public was slow to warm to HMOs. By the end of the 1970s, there were only ten million people enrolled in an HMO.⁷⁵ A turning point came as the cost of health care continued to increase, which placed a substantial burden on employers.⁷⁶ As a result, the seventy-five percent of Americans covered under a traditional indemnity plan in 1988 shrunk to only fourteen percent by the end of the 1990s.⁷⁷ Conversely, HMO enrollment grew by 800% in eighteen years to seventy-nine million.⁷⁸ HMOs became so popular that in the 1990s, Republicans and Democrats alike suggested that HMOs be used to help reduce the cost of Medicare.⁷⁹

Even the courts were supportive of the role of MCOs. The Supreme Court in 2000 held in *Pegram v. Herdrich* that an MCO is not a fiduciary to the extent that a physician in the network makes mixed eligibility or treatment decisions.⁸⁰ This case supports HMOs because

70. Erica Worth Harris, *The Regulation of Managed Care: Conquering Individualism and Cynicism in America*, 6 VA. J. SOC. POL'Y & L. 315, 323 (1999).

71. *Id.*

72. *Id.* at 322–23.

73. CONSUMER CHOICES: SOCIAL WELFARE & HEALTH POLICY 1, 4 (Robert F. Rich & Christopher T. Erb eds., 2005).

74. GRATZER, *supra* note 45, at 52–53.

75. *Id.* at 48.

76. *Id.*

77. *Id.* at 49.

78. *Id.*

79. *Id.*

80. *Pegram v. Herdrich*, 530 U.S. 211, 231–32 (2000); Robert F. Rich et al., *Judicial Interpretation of Managed Care Policy*, 13 ELDER L.J. 85, 142 (2005). Mixed eligibility decisions are those decisions made by the participating physicians of an HMO which involve an analysis of both the appropriate level of care required and whether or not the plan will cover such care. As a result of the holding in *Pegram*,

it does not hold them legally liable for coverage decisions that their in-network physicians make.⁸¹ Further, the holding reflects the Court's recognition that health care rationing is required if the HMO model is to be effective.⁸² To place liability on the HMO for making mixed eligibility decisions through its physicians would be in conflict with its purpose and congressional intent.⁸³ The HMOs' ability to contain costs was evident in the fact that expenditures did not increase above general inflation between 1993 and the end of the decade.⁸⁴

4. PUBLIC DISCONTENT WITH MANAGED CARE ORGANIZATIONS AND THEIR DECLINE

Despite the HMOs' ability to rein in costs, public sentiment turned against them.⁸⁵ Repulsed by policies that cut costs by limiting specialist visits, reduced consumer choices, and limited treatment to "medical necessity," the public urged politicians to regulate these practices.⁸⁶ This backlash led to the consideration of over one thousand pieces of anti-MCO state legislation, which ended the only period in the past three decades where the cost of health care decreased when adjusted for inflation.⁸⁷ As the number of regulations mounted, the efficiencies attributed to MCO cost containment dwindled.⁸⁸ The American people made it clear that they would not stand for any rationing of health services, at least not any type of rationing that restricts individual choice.⁸⁹

Statutes and case law began to reflect public sentiment. For example, the Supreme Court of California, in *Potvin v. Metropolitan Life*

these decisions are not subject to an ERISA fiduciary duty, allowing physicians to consider cost-saving incentives. Vedder, Price, Kaufman & Kammholz, *Mixed Eligibility-Treatment Decisions by HMO Physicians Are Not Subject to a Fiduciary Duty Under ERISA*, HEALTH CARE BULLETIN, July 2000, available at http://www.vedderprice.com/docs/pub/1e2d875c-8ad3-4bb5-8291-3cdb326e0220_document.pdf.

81. Rich, *supra* note 80, at 142.

82. *Id.* at 112.

83. *Id.*

84. Coleman, *supra* note 25, at 259.

85. *Id.* at 259-60.

86. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 660.

87. Harris, *supra* note 70, at 320-26. One thousand bills were considered in 1998 alone. *Id.*

88. *Id.* at 326.

89. *Id.* at 342-43. Although the public dislikes rationing, de facto rationing exists based on factors such as income level, employment, and age. See Marshall B. Kapp, *De Facto Health-Care Rationing by Age*, 19 J. LEGAL MED. 323, 331 (1998); Schuck, *supra* note 19, at 45 (explaining that rationing is inescapable and happens through bureaucracy, the market, or a hybrid process).

Insurance Co., held that an MCO cannot remove a physician from the network if there are only a handful of MCOs in the area, and the de-selection will significantly impair the physician's practice of medicine.⁹⁰ An even bigger hindrance to MCOs came in the form of any willing provider (AWP) laws, which forced HMOs to include any health care provider who is willing to meet network requirements.⁹¹ In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, the Supreme Court held that AWP laws are a matter of insurance.⁹² Therefore, even though these laws fall under ERISA preemption, they also fall under the savings clause and may be enacted by the states.⁹³ This holding effectively eliminated selective contracting by MCOs, which constituted possibly the best conduit for cost savings.⁹⁴

With the new limits imposed on MCOs' cost-containment measures came an increase in the cost of health care, new attitudes about consumer involvement in health care decisions, and an end to the era of decreasing costs. From 1993 until 2000, MCOs managed to keep costs steadily rising at two percent yearly.⁹⁵ But Americans' consumer-based attitudes ran contrary to the cost-saving mechanisms utilized by MCOs, and MCO participation peaked in 1998.⁹⁶ After the backlash, 2002 saw a 9.6% increase in health care spending as a percentage of GDP.⁹⁷

B. A History of Shortchanging the Provider: Utilizing Lower Reimbursement Rates to Decrease Costs

The history of Medicare reimbursement can be divided into five different eras.⁹⁸ The first era spanned from the beginning of Medicare in 1965 until 1972, during which each physician's individual reim-

90. *Potvin v. Metropolitan Life Ins. Co.*, 997 P.2d 1153, 1160 (Cal. 2000).

91. Anne Carroll & Jan M. Ambrose, *Any-Willing-Provider Laws: Their Financial Effect on HMOs*, 27 J. HEALTH POL. POL'Y & L. 927, 943 (2002).

92. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003).

93. *Id.* at 335-37. The ERISA preemption clause preempts any retirement plan regulations by the state, unless they pertain to the business of insurance, and then the regulation is saved by the savings clause. *Id.* at 342. In that case the states may enact the regulations. See HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 672.

94. See Carroll & Ambrose, *supra* note 91, at 928.

95. Coleman, *supra* note 25, at 259.

96. *Id.* at 258.

97. *Id.* at 259.

98. Miriam J. Laugesen, *Siren Song: Physicians, Congress, and Medicare Fees*, 34 J. HEALTH POL. POL'Y & L. 157, 160 (2009).

bursement policy was retained to encourage participation.⁹⁹ The Department of Health, Education and Welfare was concerned with physician boycott, and therefore determined that physicians receive their "usual and customary" fees.¹⁰⁰ This policy caused Medicare costs to nearly double between 1968 and 1971.¹⁰¹ In the second era beginning in 1973, Congress established a Medicare Economic Index that left the underlying payment system intact but limited fee increases to a "weighted average of the cost of physicians' office practice and general wage rates."¹⁰² The index slowed growth but still led to a sixteen percent rise in expenditures between 1970 and 1988.¹⁰³

Congress reacted to the continued increases in 1984 by reducing fees for procedures it considered "overvalued."¹⁰⁴ Additionally, Congress created the Prospective Payment System (PPS), wherein hospitals were reimbursed a set payment amount dependent on the diagnosis.¹⁰⁵ The fee-for-service payment system, however, was retained for physicians who were incentivized to make up for the loss of revenue by seeing more patients and ordering more hospital services.¹⁰⁶ This created a gap between the incentives of the physicians and the hospitals, which hospitals tried to bridge by implementing physician incentive plans.¹⁰⁷ Under these plans, physicians were paid by hospitals to order earlier discharge of patients and to demand fewer services.¹⁰⁸

The third era began in 1989, after regulators learned that they had to control not only the costs of services provided but also the volume of services provided.¹⁰⁹ To incentivize physicians to lower their costs, Congress passed the Omnibus Budget Reconciliation Act

99. *Id.* at 161.

100. Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 195-96 (1995).

101. *Id.* at 196.

102. Laugesen, *supra* note 98, at 161-62; Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 13 (1986).

103. Laugesen, *supra* note 98, at 162.

104. Miriam J. Laugesen & Thomas Rice, *Is the Doctor In? The Evolving Role of Organized Medicine in Health Policy*, 28 J. HEALTH POL. POL'Y & L. 289, 302 (2003).

105. Richard S. Saver, *Squandering the Gain: Gainsharing and the Continuing Dilemma of Physician Financial Incentives*, 98 NW. U. L. REV. 145, 156 (2003).

106. *Id.* at 157.

107. Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 419 (1996).

108. *See id.*

109. Laugesen, *supra* note 98, at 162.

(OBRA) in 1989.¹¹⁰ The purpose of the act was to introduce a “resource based” relative value scale for payment of services.¹¹¹ A payment scale instituted in each geographic area set the maximum price that any physician could charge for a service.¹¹² Additionally, the Act made fee levels dependent on whether Medicare expenditures were more or less than the amount budgeted for by Congress.¹¹³ Therefore, all physicians’ fees increased only if total system expenditures remained within budget.¹¹⁴ Evidence suggests that this approach was successful in slowing the growth of Medicare expenditures.¹¹⁵

In 1997, the fourth era began with a new payment system designed to reflect the income of the national economy.¹¹⁶ Included in the Balanced Budget Act of 1997, the new payment system required that Medicare fees reflect the overall changes in the gross domestic product, as well as the factors used in the OBRA.¹¹⁷ The name given to the reform is the Sustainable Growth Rate (SGR), and it consolidated the reimbursement rates for service-specific updates so that the increases in fees were the same regardless of the service provided.¹¹⁸ Additionally, Medicare reduced fees in the event that growth of costs outpaced target expenditures.¹¹⁹

Then in 2002, the fifth era began when Medicare expenditures on physician reimbursement first increased beyond the SGR target.¹²⁰ The statutory reaction to the problem was to cut reimbursement rates, and in 2002 there was a 4.8% cut.¹²¹ Since 2002, there has not been a single year when the cost of physician reimbursement has not exceeded the SGR target, and each year the system should automatically reduce the reimbursement rates in accordance with the SGR legislation.¹²² Congress found this outcome unacceptable, however, and

110. *Id.* at 163.

111. Phyllis G. Coleman & Ronald A. Shellow, *Privacy and Autonomy in the Physician-Patient Relationship*, 16 J. LEGAL MED. 509, 513 (1995).

112. *Id.*

113. Laugesen, *supra* note 98, at 163.

114. *Id.* at 163–64.

115. *Id.* at 164.

116. *Id.*

117. Laugesen & Rice, *supra* note 104, at 304.

118. *Id.*

119. *Id.*

120. Laugesen, *supra* note 98, at 165.

121. JIM HAHN, CONG. RESEARCH SERV., MEDICARE PHYSICIAN PAYMENT UPDATES AND THE SUSTAINABLE GROWTH RATE (SGR) SYSTEM 1 (2010), available at <http://aging.senate.gov/crs/medicare15.pdf>.

122. DENNIS M. BARRY ET AL., THE IMPACT OF HEALTH CARE REFORM LEGISLATION ON MEDICARE, MEDICAID AND CHIP 15 (2010), available at

began to pass a series of bills that override the mandatory SGR reductions, known as the “doc-fix.”¹²³ Since 2002, Congress has determined the increases in the fees manually by overriding the statutory increase through doc-fix.¹²⁴ As a result, physicians’ expenses have risen twenty-two percent since 2001, and reimbursement has also risen by about one percent.¹²⁵ Each year Congress continues to avoid giving physicians a huge cut in reimbursements by legislating around the cuts.¹²⁶ Reimbursement rates, however, still fail to increase with the rate of inflation.

MedPAC, the independent congressional agency charged with the task of making Medicare payment decisions,¹²⁷ explained that this system is flawed because it neither rewards physicians who control their volume of growth nor does it provide a remedy for physicians who prescribe unnecessary services.¹²⁸ Additionally, the system reimburses differently based on whether the service is provided at home or in a hospital setting, placing unnecessary focus on the location of treatment.¹²⁹ It was first thought that the SGR system would encourage national groups such as the AMA and state medical associations to encourage physicians to self-regulate, but it has failed to do so.¹³⁰

http://www.healthlawyers.org/Events/Prorams/Materials/Documents/HCR10/barry_luband_lutz.pdf.

123. Ezra Klein, *What to Do About the Doc Fix?*, WASH. POST, June 21, 2010, http://voices.washingtonpost.com/ezra-klein/2010/06/what_to_do_about_the_doc_fix.html.

124. BARRY ET AL., *supra* note 122, at 15. In 2003, there should have been a 4.4% cut, but instead Congress increased reimbursement by 1.6%. *Id.* In 2004, there should have been a 4.5% decrease, but Congress increased the rates 1.5%. *Id.* In 2005 a 3.3% cut was made, and Congress mandated a 1.5% increase. In both 2006 and 2007 the level was frozen. *Id.* In 2008, there should have been a 10.1% cut, but instead there was a .5% increase, and in 2009 there should have been a 15% cut, but instead Congress gave a 1.1% increase. *Id.* Today, there should be a 21% decrease in fees, but instead Congress froze the fees at the 2009 level. *Id.*

125. James B. Dolan, *Reimbursement Rates Threaten to Cut Access for Medicare Patients*, TAMPA BAY TIMES, Apr. 23, 2010, <http://www.tampabay.com/opinion/columns/reimbursement-rates-threaten-to-cut-access-for-medicare-patients/1089519>.

126. *Id.*

127. See generally MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2005), available at http://www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf.

128. Laugesen, *supra* note 98, at 166–67.

129. *Id.* at 167.

130. BARRY ET AL., *supra* note 122, at 15–16.

1. THE AFFORDABLE CARE ACT CONTINUES TO LOWER REIMBURSEMENT RATES

Several policies under the ACA are designed to lower costs by as much as \$300 billion over the next ten years by reducing reimbursement rates to providers.¹³¹ Initially, the ACA intends to bring payments of Medicare Advantage plans into parity with traditional Medicare plans.¹³² Medicare Advantage expenditures currently exceed traditional Medicare by fourteen percent.¹³³ To reduce the payments of Medicare Advantage plans by the \$138 billion necessary to equalize the plans, the ACA will reduce payments to Medicare Advantage providers.¹³⁴ Additionally, cuts to hospital reimbursement rates will apply to imaging services at a rate of fifteen to twenty-five percent depending upon the type of imaging being provided.¹³⁵

Further reductions to provider reimbursement rates will be based on variable factors outlined in the ACA. For example, reimbursement rates will be reduced based on a hospital's acquired condition rates.¹³⁶ The implication is that hospitals will not be reimbursed to the fullest amount if a patient leaves the hospital with a secondary diagnosis that could have been prevented.¹³⁷ In addition, the ACA institutes a rule where the worst twenty-five percent of hospitals in

131. Emily Jane Cook, *Healthcare Reform: Pay Back*, 33 L.A. LAW. 20, 20 (2010). These policies are intended to spread the savings among hospitals, doctors, and nursing homes. *Id.*

132. BARRY ET AL., *supra* note 122, at 18.

133. OFFICE OF HEALTH REFORM, DEPT. OF HEALTH & HUMAN SERVS., HEALTH INSURANCE REFORM AND MEDICARE: MAKING MEDICARE STRONGER FOR AMERICA'S SENIORS 1, *available at* <http://www.healthreform.gov/reports/medicare/medicare.pdf> (last visited Mar. 24, 2012).

134. BARRY ET AL., *supra* note 122, at 18.

135. *Id.* at 16.

The Health Reform Law increases payment reduction for Medicare advancement imaging services by increasing the practice expense units for imaging services from a presumed utilization rate of 50 percent to 65 percent for 2010 and 75 percent for 2011 However, certain low-tech imaging [services] . . . are excluded from this adjustment.

Id.

136. See Diane F. Paulson, Greater Bos. Legal Servs., What Every Estate Planner Needs to Know about Medicare, Presentation for the A.L.I.-A.B.A. Course of Study (Sept. 13-14, 2010). Hospital acquired conditions are "serious conditions that patients may get during an inpatient hospital stay," which are less likely to occur when a hospital follows proper procedures. *Glossary*, DEP'T HEALTH & HUM. SERVS., *available at* <http://www.hospitalcompare.hhs.gov/staticpages/help/hospital-glossary.aspx> (last visited Mar. 26, 2012). These conditions include, but are not limited to: air bubbles in the blood stream, mismatched blood types, and objects accidentally left in the body after surgery. *Id.*

137. BARRY ET AL., *supra* note 122, at 3.

terms of acquired condition rates will suffer an additional one percent reduction in reimbursement rates overall.¹³⁸ The Congressional Budget Office (CBO) projects that this policy will reduce Medicare spending by \$1.4 billion between 2015 and 2019.¹³⁹ A similar policy will be in place regarding excessive readmissions.¹⁴⁰ Hospitals will face a reduction in reimbursement if the number of readmissions exceeds the expected level.¹⁴¹

2. REIMBURSEMENT BASED ON QUALITY OF CARE

These policies are part of a larger system focusing on rewarding high quality and efficient care.¹⁴² The ultimate goal is cost containment, and therefore the system must focus more on reducing rates rather than increasing rates to those hospitals that increase efficiency.¹⁴³ The CBO estimates that ACA spending cuts to hospitals will total well over \$100 billion in the first decade.¹⁴⁴ Even so, the ACA will reward efficiency by making \$400 million in additional payments during 2011–2012 to extraordinary providers.¹⁴⁵ The ACA created a “modifier” to be added to bills dependent upon the quality of care that was provided.¹⁴⁶ The end result is a system that can reward efficiency but more commonly utilizes a broader policy of lower physician reimbursement.¹⁴⁷

III. Analysis

A. The American Ethos and Obstructions to Reform

American pride and nationalism have dominated reform rhetoric and obstructed the meaningful discourse that could potentially

138. *Id.* at 4. This policy has the effect of lowering Medicare reimbursement rates for twenty-five percent of all hospital-employed doctors. *See id.*

139. *Id.* The CMS Actuary projects that this policy can save Medicare \$3.2 billion in the same time period. *Id.*

140. *Id.* at 2.

141. *Id.* The level of readmissions will be based on a thirty-day readmission measure for heart failure, heart attack, and pneumonia. *Id.*

142. Cook, *supra* note 131, at 20.

143. *Id.*

144. Orszag & Emanuel, *supra* note 30, at 601.

145. Cook, *supra* note 131, at 25.

146. *Id.* at 26. The method involves accounting for quality by using risk-adjusted measures, including health outcome. *Id.* The cost measure is based on expenditures per individual adjusted for the geographic location. *Id.*

147. *Id.*

lead to meaningful reform.¹⁴⁸ Debates are often a platform for people to pontificate on the evils of foreign health systems and the dangers associated with rationing. During the Obama administration's campaign for the ACA, the Republicans' favorite message revolved around supposed "death panels."¹⁴⁹ Former Governor Sarah Palin claimed:

The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's "death panel" so his bureaucrats can decide, based on a subjective judgment of their "level of productivity in society," whether they¹³⁰ are worthy of health care. Such a system is downright evil.

Additionally, Congresswoman Michelle Bachmann of Minnesota adopted the position that the ACA would mean senior citizens and people with disabilities would be deprived of proper care.¹⁵¹ Each of these hyperbolic statements panders to the fear the American public has toward rationed care.

Ironically, the United States has long incorporated a de facto form of rationing into its own health care system. Since the 1943 IRS ruling for tax-free employer contributions to health plans, employers and employees have been incentivized to appropriate a portion of employee salaries for health insurance because it is not taxed.¹⁵² This incentive, in turn, has led to expanded health coverage for high-income employees who saw tax exclusion as a reason to demand more extensive health care plans.¹⁵³ As a result, the United States essentially adopted its first health care rationing system. Instead of being a right for all citizens, health care is tied to employment.¹⁵⁴ Without the tax benefits associated with employment, insurance is prohibitively expensive for unemployed or self-employed citizens.¹⁵⁵ Today, Americans accept that about fifty million people in the United States are

148. Harris, *supra* note 70, at 332.

149. Rutenberg & Calmes, *supra* note 26.

150. Sarah Palin, *Statement on the Current Health Care Debate*, FACEBOOK.COM (Aug. 7, 2009, 3:26 P.M.), http://www.facebook.com/note.php?note_id=113851103434 (last visited Mar. 9, 2012).

151. Paul Demko, *Bachmann: Prayer and Fasting Will Help Defeat Health Care Reform*, MINN. INDEP. (Aug. 24, 2009, 4:35 P.M.), <http://minnesotaindependent.com/42612/bachmann-prayer-and-fasting-will-help-defeat-health-care-reform>.

152. Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 AM. ECON. REV. 1373, 1373 (2003).

153. AUSTIN & HUNGERFORD, *supra* note 44, at 5.

154. Roy, *supra* note 47.

155. *See id.*

without health coverage, but they refuse to acknowledge this void as a form of rationing.¹⁵⁶

Industrialized democracies across the globe have demanded that health care be a guaranteed benefit of citizenship. Nations such as Australia, Germany, the United Kingdom, and Japan have determined that health care is so vital to freedom and prosperity that they have instituted universal coverage.¹⁵⁷ These countries do not have the problem of a large constituency of completely uninsured people.¹⁵⁸ Instead of trying to learn what those systems do right, however, the debate over health care reform tends to focus on those systems' deficiencies.¹⁵⁹ Even in the event that a foreign health system is accepted as successful, the detractors provide differences between the United States and the foreign country in an attempt to explain why the system cannot work in the United States.¹⁶⁰ For example, reformers have long looked to Canada as a viable single payer alternative to the current U.S. system.¹⁶¹ Although the system successfully controls costs, is substantially popular with Canadians, and is endorsed by physicians and academia, the debate is often framed as, "Canada is 'too different' from the United States to provide useable lessons for healthcare reform."¹⁶² These types of arguments are pervasive in the health care reform debate but are nothing more than stereotypes and weak assumptions made to pander to jingoistic American tendencies.

The Obama administration's unwillingness to place the burden of cost containment on Medicare and Medicaid beneficiaries is in line with a general public disapproval of using age as a measure for the distribution of health care.¹⁶³ A study by the Gerontological Society of America in 1993 found that nearly sixty-eight percent of people oppose age-based rationing while only about twenty-seven percent of

156. Uwe E. Reinhardt, *Health Care Crisis: Who's At Risk?*, PBS ONLINE, http://www.pbs.org/healthcarecrisis/Expts_intrvw/u_reinhardt.htm (last visited Mar. 9, 2012).

157. Theodore R. Marmor & Jonathan Oberlander, *A Citizen's Guide to the Health Care Reform Debate*, 11 YALE J. ON REG. 495, 502 (1994).

158. Adam Oliver, *The Single-Payer Option: A Reconsideration*, 34 J. HEALTH POL. POL'Y & L. 509, 510 (2009).

159. *Id.* at 514-15.

160. *Id.* at 526.

161. Marmor & Oberlander, *supra* note 157, at 502.

162. *Id.* at 503 (citations omitted).

163. See Nancy R. Zweibel et al., *Public Attitudes About the Use of Chronological Age as a Criterion for Allocating Health Care Resources*, 33 GERONTOLOGIST 74, 78 (1993).

people favor such methods.¹⁶⁴ The American aversion to rationing health care places increasing burdens on the industry and the economy in general due to the aging of the population and the fact that per capita expenditures on health care increase with age.¹⁶⁵ In fact, twenty-five percent of Medicare spending takes place within a patient's last six months of life.¹⁶⁶ This fact raises the question of why people are against such measures of cost control, even in the face of possible insolvency.

Not only are costs skyrocketing, but the current system also incentivizes patients to demand as many services as they can receive, causing costs to rise exponentially.¹⁶⁷ When the policies of employer-provided health insurance and government payor insurance programs such as Medicare and Medicaid are coupled with health care inflation, a high cost structure is inherent in the system.¹⁶⁸ Insurance plan holders and government plan beneficiaries have the incentive to demand the best and most extensive medical services available because they have paid a flat rate and must now only cover deductibles.¹⁶⁹ At the same time, the health care provider has the incentive to provide as many services as possible to raise the bill, which the third party will be forced to pay.¹⁷⁰ And finally, the third-party payor has an incentive to approve as few services as possible to keep costs down and profits high.¹⁷¹

Thus, the health care market does not behave as a normal market—that is, one where consumers spend their own money. Hospitals and physicians are not pressured into reducing their costs, health care payors are not privy to new expensive technologies and therefore approve their usage, and policyholders have no incentive to shop around for a lower price.¹⁷² Reform of the American health care system has been necessary for some time, and on March 23, 2010, the

164. *Id.* The question was whether “[l]ife-extending medical care should be withheld from older patients to save money to help pay for the medical care of younger patients,” and the results were that 6.2% of respondents strongly agreed, 21.2% agreed somewhat, 29.9% disagree somewhat, 37.8% strongly disagreed, and 4.9% said it depends or they are unsure. *Id.*

165. Henry J. Aaron, *Health Care Rationing: Inevitable But Impossible?*, 96 GEO. L.J. 539, 542 (2008).

166. Schuck, *supra* note 19, at 56.

167. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 568.

168. *Id.*

169. *Id.*

170. *Id.*

171. *See id.* at 567.

172. GRATZER, *supra* note 45, at 47.

ACA was signed into law and became the most comprehensive health care reform in decades.¹⁷³ Despite all the barriers to rationing embedded within the statute, it may be possible for the ACA to actually cut costs.

B. Can the Affordable Care Act Rein in Health Care Costs?

1. MEDICARE REFORMS

Richard S. Foster, the chief actuary of the Center for Medicare and Medicaid Services, has estimated that the ACA will reduce the costs of Medicare by more than half a trillion dollars from 2010–2019.¹⁷⁴ To attain this level of savings, there will necessarily be some negative effects felt by the program's beneficiaries.¹⁷⁵ Some areas of Medicare will actually be expanded by the ACA, however, improving the scope of benefits and services provided.¹⁷⁶ To determine where costs will either be saved or increased, financing must be examined in reference to reforms to Medicare Part D coverage, long-term care, and general Medicare coverage.¹⁷⁷

a. Part D Reforms The ACA reforms Medicare Part D prescription medication coverage by doing three things: (1) closing the existing gap in coverage known as the "doughnut-hole," (2) reducing the level of costs an employer can claim for tax benefits for its employee drug plans, and (3) increasing Medicare Part D premiums for high-income beneficiaries.¹⁷⁸ Although the intricacies of each of these reforms and the policies that precede them are beyond the scope of this Note, the effect on costs is important to the overall capability of the ACA to create health care savings.

As to the first reform, the ACA increases coverage by mandating that Part D plans cover seventy-five percent of all prescription drug

173. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 23, 2010, <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

174. Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 214 (2011). The estimated cost reduction is projected at \$575 billion. *Id.*

175. *Id.* at 215.

176. *Id.*

177. *Id.*

178. *Id.* at 218–19, 223, 225.

costs falling within the “doughnut hole” by 2020.¹⁷⁹ Prior to the reform, Medicare Part D did not cover any of the drug costs for a beneficiary between \$2,830 and \$6,440 of total yearly spending and then resumed coverage for “catastrophic” coverage above \$6,440.¹⁸⁰ Clearly then, covering seventy-five percent of the drugs that fall within that “doughnut hole” will result in significant savings for beneficiaries enrolled in Part D plans. Drug companies will take a major hit due to the reform, and the government is doing little to help cover the lost income.¹⁸¹ Whether or not this reform proves beneficial overall will depend on whether the drug companies respond with decreased advertising and lower executive compensation or decreased research and development investment.¹⁸² In terms of savings to beneficiaries, this reform will certainly lower the cost of Part D plans.

The other two reforms to Part D are less likely to reduce costs. Reducing the amount that an employer can claim as a cost of providing employee drug plans should save the government money, but only if employers continue to provide those benefits after the change in policy.¹⁸³ The twenty-eight percent reduction in the maximum claim amount was intended to end employer claims on expenditures that had already been subsidized by the government.¹⁸⁴ In theory the idea works, but unfortunately, the additional expense may cause employers to drop their employee drug coverage.¹⁸⁵ It is estimated that the government will lose money if twenty-four percent of retirees currently on private plans are moved to Part D.¹⁸⁶

179. *Health Reform and Medicare: Closing the Doughnut Hole*, MEDICARE RIGHTS CTR. 1 (Apr. 2, 2010), <http://www.medicarerights.org/pdf/closing-the-doughnut-hole-chart.pdf>. The “doughnut-hole” is the uninsured portion of a Medicare Part D plan that falls between \$2,830 and \$6,440 of total yearly spending. 42 U.S.C. § 1395w-102(b)(4)(B); Kaplan, *supra* note 174, at 217. All costs in the “doughnut-hole” must be paid entirely by the beneficiary with no coverage benefits from the Part D plan. Kaplan, *supra* note 174, at 217.

180. 42 U.S.C. § 1395w-102(b)(4)(B); Kaplan, *supra* note 174, at 217. The figures given are an example of a prototypical plan and do not necessarily reflect any particular Medicare Part D coverage structure. FROLIK & KAPLAN, *supra* note 61, at 89–90.

181. Kaplan, *supra* note 174, at 221.

182. *Id.* at 221–22.

183. *Id.* at 223–24.

184. *Id.* at 223.

185. *Id.* at 222.

186. AM. BENEFITS COUNCIL, EMPLOYER-SPONSORED RETIREE DRUG COVERAGE COST ANALYSIS AND FEDERAL REVENUE EFFECTS OF PROPOSED TAX ON RETIREE DRUG SUBSIDIES 1 (2009), available at http://www.appwp.org/documents/hcr_partd_reveffects.pdf.

Finally, increasing premiums for high-income beneficiaries makes sense as a natural progression from the means testing of Medicare Part B.¹⁸⁷ A possible result, however, is that high-income elderly may refuse to participate in Part D.¹⁸⁸ They may instead self-insure through a private plan if they determine Part D is no longer worth the cost.¹⁸⁹ Although fewer beneficiaries is generally good in terms of costs, losing the wealthy may have the opposite effect because they are generally healthier than average.¹⁹⁰ Therefore, their presence in Part D plans acts as a subsidy to cover those in worse health, and losing them would mean an increase in average cost per beneficiary.¹⁹¹

b. Other Medicare Reforms The ACA institutes several other changes to the Medicare system to reduce costs. Preventative care is finally taking precedence to traditional treatment in the form of “annual wellness visits” paid for by Medicare at no cost to the beneficiary.¹⁹² This service is an extensive annual physical¹⁹³ and can reduce costs to Medicare through prevention and early detection of illness. Another substantial reform affects Medicare Part C, the managed care portion of Medicare.¹⁹⁴ To reduce the fourteen percent premium in expenditures for Part C plans over traditional Medicare, extra benefits will be cut, such as vision and dental coverage.¹⁹⁵ Although scaling back benefits will reduce costs, many Part C enrollees may leave the plan, resulting in increasing “complexity of paying for their health care” and rising administrative costs.¹⁹⁶

The reforms that are to be implemented into Medicare over the next decade will likely initiate a decrease in health care costs, but their true effectiveness will only be known with time. What seems to be clear, however, is that the reforms to Medicare noted above are not enough to contain costs of the entire health care industry. That is why the ACA created the Independent Medicare Advisory Board (IMAB)

187. Kaplan, *supra* note 174, at 225–27.

188. *Id.* at 228.

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.* at 238–39.

193. *Id.*

194. *Id.* at 239.

195. *Id.* at 239–40.

196. *Id.* at 241.

to continue to create proposals to decrease the per capita cost of Medicare coverage.¹⁹⁷

2. THE INDEPENDENT MEDICARE ADVISORY BOARD

The ACA amends Title XVIII of the Social Security Act to establish IMAB with the purpose of “reduc[ing] the per capita rate of growth in Medicare spending.”¹⁹⁸ Due to surrounding controversy, there have been substantial limits placed on the methods that may be employed by IMAB to control costs.¹⁹⁹ Advocacy groups on behalf of the elderly and people with disabilities are apprehensive about the idea of a technocratic board making Medicare payment decisions.²⁰⁰ Specifically, if the board decides to use any type of effectiveness outcome information to make Medicare payment decisions, it will be difficult for Congress to quell any public outcry.²⁰¹ Additionally, IMAB is prohibited from using rationing or increases in cost to beneficiaries to reduce the cost of Medicare, and many changes to Medicare have already been proposed and implemented.²⁰² As Professor Richard L. Kaplan stated, “[o]ne is compelled to ask in this context, ‘What’s Left?’”²⁰³

IMAB is tasked with projecting Medicare per capita growth rates and determining whether the projection falls within an allowable target determined by a formula which takes into account growth rates, the Consumer Price Index, All Urban Consumers, and the medical care expenditure category of the Consumer Price Index.²⁰⁴ If the

197. ACA, Pub. L. No. 111-148, § 3403, 124 Stat. 119, 489 (2010) (to be codified at 42 U.S.C. § 1395 et seq.).

198. *Id.*

199. *Id.*

200. Robert Pear, *Obama Proposal to Create Medicare Panel Meets with Resistance*, N.Y. TIMES, Aug. 13, 2009, <http://www.nytimes.com/2009/08/14/health/policy/14medpac.html>.

201. *Id.*

202. See ACA, Pub. L. No. 111-148, § 3403, 124 Stat. 119, 490 (to be codified at 42 U.S.C. § 1395kkk).

203. Kaplan, *supra* note 174, at 244–45.

204. Michael H. Cook, *Independent Payment Advisory Board: Part of the Solution for Bending the Cost Curve?*, 4 J. HEALTH & LIFE SCI. L. 102, 106–07 (2010). “The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.” *Frequently Asked Questions: Consumer Price Index*, BUREAU LAB. STATS., available at <http://www.bls.gov/cpi/cpifaq.htm> (last visited Mar. 26, 2012). The index can be used as an economic indicator and as a means of adjusting dollar values. *Id.* This method will be followed through the 2017 determination year, but beginning in the 2018 determination year, the factor used will be the average growth rate over the past five years, plus one percent. Cook, *supra*, at 107.

growth rate exceeds the target, IMAB is tasked with submitting a proposal to Congress that will achieve the amount of cuts necessary to match the target rate.²⁰⁵ Proposals made by IMAB may include factors such as reducing direct payments to Medicare Parts C and D, an increase in integrated care and coordination, and reducing expenditures in the areas leading to excess growth.²⁰⁶ IMAB is limited, however, by the ACA which states that proposals may not ration care, raise beneficiary premiums, increase cost sharing, or otherwise restrict benefits or change eligibility criteria.²⁰⁷

Additionally, IMAB must submit proposals to slow the growth of national health expenditures overall.²⁰⁸ The inclusion of this separate language suggests that merely lowering the government's Medicare and Medicaid expenditures will not have an overarching effect on the health care industry.²⁰⁹ These proposals will include recommendations to the private sector, which may be implemented voluntarily.²¹⁰ These recommendations, however, will not affect the structure of the system as a whole. A third-party payor system is retained, and patients are still incentivized to demand the greatest number of high cost services they can receive.²¹¹

3. IMPROVED MEDICAL PRACTICES AND INSURANCE MARKET RESTRUCTURING

Doctors Ezekial Emanuel and Peter Orszag believe that the ACA will bring about an actual decline in the costs of health care through methods other than those described *supra* Parts III.B.1 and III.B.2.²¹² To begin, anti-fraud measures implemented in the Medicare and Medicaid programs can bring about seven billion dollars in savings over ten years.²¹³ Additionally, the ACA reduces unnecessary bureaucracy by streamlining the administrative process, creating projected savings

205. Cook, *supra* note 204, at 108.

206. *Id.* at 110.

207. ACA, Pub. L. No. 111-148, § 3403, 124 Stat. 119, 490 (to be codified at 42 U.S.C. § 1395 et seq.).

208. Pear, *supra* note 200.

209. *Id.*

210. *Id.*

211. See HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 567.

212. Orszag & Emanuel, *supra* note 30, at 601-02. Orszag and Emanuel describe \$100 billion in predicted savings oriented toward reducing health care costs to the federal government as well as tens of billions a year in savings to insurers, physicians, hospitals, and other providers. *Id.*

213. *Id.*

of \$20 billion over the next ten years.²¹⁴ More importantly, they estimate that \$135 billion will be saved in the first ten years by eliminating unjustified subsidies to Medicare Advantage.²¹⁵ As Emanuel and Orszag point out, these policies reduce the level of costs rather than the growth of costs.²¹⁶ Additionally, the ability of anti-fraud measures like unfounded subsidies to cut costs remains in dispute.²¹⁷

When it comes to slowing the growth of costs, the projections for the ACA become more theoretical.²¹⁸ The supposed cost-saving methods that will be integrated into the American health system fall within one of two categories. Within the first category are the new regulations that improve medical practices and health.²¹⁹ These reforms include research on comparative effectiveness of treatment options, better and more regularly maintained records of outcomes, management of chronic diseases, and payment that depends on the success of outcomes.²²⁰ Although these provisions are laudable, and certain measures such as the move toward electronically-kept medical records have the potential to save money, the true ability of these measures to control costs is unknown.²²¹ Likewise, although comparative effectiveness research is important, it cannot be fully utilized if there is a restriction on insurance companies using the data to make coverage decisions.²²² Unfortunately, such a restriction exists in the language of the ACA, and no policy may be suggested based on QALY research.²²³ Therefore, neither the public nor the private sector of health care is fully utilizing cost effectiveness research.

The second category of savings arises from the restructuring of the health insurance marketplace.²²⁴ Within this category are the new insurance exchanges, where individuals can group together to bargain for lower rates.²²⁵ Additionally, states may enter into joint insurance

214. *Id.* at 602.

215. *Id.*

216. *Id.*

217. *Id.*

218. *See id.* at 601. Orszag and Emanuel provide exact dollar amounts for projected savings that relate to cost cutting; however, they only speak of the potential of slowing the growth of costs and provide no monetary figures. *Id.* at 603.

219. Marmor et al., *supra* note 10, at 486.

220. *Id.*

221. *Id.*

222. *Id.*

223. ACA, Pub. L. No. 111-148, § 1182, 124 Stat. 119, 741 (2010) (to be codified at 42 U.S.C. § 1320e-1).

224. Marmor et al., *supra* note 10, at 487.

225. *Id.*

compacts so that individuals may purchase insurance from outside of their state.²²⁶ While these cost-saving programs will save money for the consumer, it is unlikely that they will lead to a decrease in the actual amount of money spent on health care generally.²²⁷ These programs may force insurance companies to create new ways to maintain the same level of profits, but this does not translate to lower costs to the industry as a whole.²²⁸

Other provisions in the ACA—such as eliminating limits on benefits, banning coverage based upon preexisting health conditions, allowing children to be covered by their parents' insurance policy, and other pro-consumer regulations—are likely to increase the costs of health care for Medicaid, Medicare, and insurers, who will then transmit these costs to the providers due to limits on premium costs.²²⁹ Additionally, increases in the beneficiary pool of Medicaid, as well as a twenty-three percent increase in the match rate for the State Children's Health Insurance Program, lead to increasing expenditures by the federal government.²³⁰

a. Problems with Using Quality of Care and Reimbursement Rates to Lower Costs Although the ACA is determined to use quality of care as a factor for determining reimbursement rates in order to reduce costs, there is no universally accepted measure of quality.²³¹ For example, the plaintiff in *Berry v. Cardiology Consultants* wanted the court to find that he had received poor quality of care based on the *outcome*

226. LINDA J. BLUMBERG, URBAN INST. & ROBERT WOOD JOHNSON FOUND., DOES THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PERMIT THE PURCHASE OF HEALTH INSURANCE ACROSS STATE LINES? 1 (2010), available at <http://www.urban.org/uploadedpdf/412195-Health-Insurance-Across-State-Lines.pdf>.

227. See Marmor et al., *supra* note 10, at 488.

228. See *id.* at 487.

229. See generally AM. MED. ASS'N, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: OVERVIEW OF MAJOR PROVISIONS RELATING TO COVERAGE (2010), available at <http://www.ama-assn.org/ama1/pub/upload/mm/399/hsr-health-insurance-coverage-reforms.pdf>.

230. TEX. HEALTH & HUMAN SERVS. COMM'N, CHAPTER 8: CHILDREN'S HEALTH INSURANCE PROGRAM 8-13, available at <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PDF/Chp-8.pdf> (2010); Sara R. Collins, *How the Affordable Care Act of 2010 Will Help Low- and Moderate-Income Families*, COMMONWEALTH FUND (July 13, 2010), <http://www.commonwealthfund.org/Blog/How-the-Affordable-Care-Act-of-2010.aspx>.

231. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 15–40.

of his physician's services.²³² The court, however, rejected this view in favor of reviewing the *process* that the doctor employed to evaluate quality of services.²³³ This brief example from *Berry* highlights the difficulty in determining the quality of care provided by a physician. One court may use outcomes, as was suggested by the plaintiff in *Berry* and another may use different indicators.²³⁴

There are several different indicators that may be used to determine the quality of care.²³⁵ These indicators are generally categorized as inputs, outputs, processes, and outcomes.²³⁶ Inputs, the most frequently used indicator, refer to physicians' degrees, certifications, and other qualifications.²³⁷ Outputs refer to the number of patients seen by a physician or a hospital.²³⁸ This measure is used by the ACA when it rewards hospitals based on efficiency, defined by a low cost per beneficiary.²³⁹ The third system for measuring quality is process, which the *Berry* court used in its decision.²⁴⁰ Finally, the fourth measure is outcome, which takes into account quality of life indicators, actual improvement, and patient satisfaction.²⁴¹

It is apparent that the ACA has chosen to use outcome measures in some of its reimbursement scheduling.²⁴² There is, however, difficulty in determining the usefulness of the outcomes measure.²⁴³ To conclude whether or not a service provided a quality outcome, one must determine the realistic hopes for treatment.²⁴⁴ Each individual case cannot be decided by the same criteria, because there are many hopeless cases where even the best care would not result in actual im-

232. *Berry v. Cardiology Consultants*, 909 A.2d 611, 614 (Del. Super. Ct. 2006). The plaintiff wanted a finding of negligence based on the prescription of Amiodarone, which led to a diagnosis of Amiodarone pneumonitis in the plaintiff. *Id.* Therefore the plaintiff's theory is based on the outcome of the prescription as opposed to the procedure that the physicians used to determine what to prescribe. *Id.*

233. *Id.* at 616–19.

234. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 21–26.

235. *Id.*

236. Robert Rich, Director, Inst. of Gov't and Pub. Affairs, Univ. Ill. Coll. of Law, Lecture on Health Law & Policy (Nov. 8, 2010).

237. *Id.*

238. *Id.*

239. Cook, *supra* note 131, at 25.

240. See *Berry v. Cardiology Consultants*, 909 A.2d 611, 616–19 (Del. Super. Ct. 2006).

241. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 22.

242. See BARRY ET AL., *supra* note 122, at 3.

243. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 23.

244. *Id.* at 24.

provement.²⁴⁵ Another problem comes from using patient satisfaction to determine quality based on outcomes.²⁴⁶ The University of Michigan has a policy of approaching patients who have been involved in “near misses” and fully disclosing the mistake.²⁴⁷ Research has shown that this policy results in an increase in patient satisfaction and a decrease in malpractice claims.²⁴⁸ Therefore, if outcomes are based on patient satisfaction, approaching the patient in different ways can sway the result, and therefore reimbursement.²⁴⁹

Aside from the difficulties inherent in the use of quality to determine reimbursement rates, there is the pragmatic issue of decreased access to care associated with lower physician reimbursement.²⁵⁰ As reimbursement levels drop, providers’ financial concerns can lead to unwanted results.²⁵¹ For example, physicians in Pennsylvania are leaving the state due to low private insurer reimbursement.²⁵² Additionally, physicians have the financial incentive to order more tests and provide the maximum amount of tests while spending little time with patients.²⁵³ Issues also arise with the added temptation for physicians to overuse injectable drugs to increase services rendered.²⁵⁴

These incentives are diametrically opposed to those promoted by an MCO system of health care.²⁵⁵ In the case of low reimbursement

245. *Id.*

246. Rich, *supra* note 236.

247. Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 142 (2009).

248. *Id.* at 143, 157.

249. *Id.* at 125.

250. Maxwell J. Mehlman & Karen A. Visocan, *Medicare and Medicaid: Are They Just Health Care Systems?*, 29 HOUS. L. REV. 835, 848 (1992).

251. *See id.* at 850–51.

252. *See* Christopher Guadagnino, *Physician Shortage in Pennsylvania?*, PHYSICIAN’S NEWS DIGEST, Aug. 23, 2003, <http://www.physiciansnews.com/2003/08/23/physician-shortage-in-pennsylvania/>.

253. John W. Hill et al., *Law and the Healthcare Crisis: The Impact of Medical Malpractice and Payment Systems on Physician Compensation and Workload as Antecedents of Physician Shortages—Analysis, Implications, and Reform Solutions*, 2010 U. ILL. J.L. TECH. & POL’Y 91, 117 (2010).

254. *Id.* at 118.

255. Robert F. Rich, *Introduction: Consumer Choice and Health Care Policy Challenges*, in CONSUMER CHOICES: SOCIAL WELFARE & HEALTH POLICY 1, 4 (Robert F. Rich & Christopher T. Erb eds., 2005). The incentive structure is very different in a fee-for-service system and in a managed care system. *Id.* In fee-for-service, a doctor is paid more if he or she provides more services as well as higher cost services. *Id.* at 3. Additionally, there is often little oversight into the decisions that are being made by the doctor. *Id.* MCOs place incentives on providers to limit the amount

rates for fee-for-service models, there is an incentive to overuse already limited resources, which is contradictory to reducing the overall cost of the industry.²⁵⁶ In practice then, lower reimbursement rates do not advance the goal of actual cost reduction.

Another extreme example of unwanted results stemming from low reimbursement rates occurs when doctors refuse to treat Medicaid patients.²⁵⁷ Not only will doctors refuse to see more than some set proportion of Medicaid patients, but they will also over-treat those Medicaid patients with a lower quality of care to increase the reimbursement amount and decrease costs.²⁵⁸ Therefore, lower reimbursement levels once again provide perverse incentives as compared to an MCO model.

4. ACCOUNTABLE CARE ORGANIZATIONS

A lot of the difficulty that surrounded health care reform stemmed from the ACA's reform of MedPAC.²⁵⁹ The reformation will create an executive branch body, not answerable to voters, that will be in charge of making Medicare payment decisions.²⁶⁰ Congressional concerns regarding the reform target the fact that the board now makes decisions instead of recommendations and is therefore open to increased lobbying and the influence of special interests.²⁶¹ Despite concerns, in June 2009, MedPAC recommended the use of Accountable Care Organizations (ACOs) "as an option for use as Medicare's health delivery system."²⁶² ACOs could potentially be a significant cost-saving tool for health care. Like MCOs, the purpose of the ACO is to reduce costs of health care delivery by assigning beneficiaries to a group of providers (like an MCO network) with management that de-

of services for each patient. *Id.* at 4. This stems from the set fee that the consumer pays to the HMO. Additionally, there is administrative oversight as to the physicians' treatment decisions. *Id.*

256. *Id.* at 3.

257. Walter L. Stiehm, *Poverty Law: Access to Health Care and Barriers to the Poor*, 4 QUINNIPIAC HEALTH L.J. 279, 295 (2001). The average reimbursement for Medicaid charges is forty-two percent. This level does not even come close to covering actual costs. Rich, *supra* note 236.

258. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 832.

259. Pear, *supra* note 200.

260. *Id.*

261. *Id.*

262. Glenn E. Solomon et al., *Future Models: The Formation of Affordable Care Organizations May Revolutionize the Concept of Managed Care*, 33 L.A. LAW. 34, 34 (2010).

termines necessary services.²⁶³ The process would bring costs below the current Medicare delivery system.²⁶⁴ Unlike MCOs, however, ACOs cannot require beneficiaries to use predetermined providers.²⁶⁵ Instead, cost reduction is obtained through a mix of patient recommendations and efficiency, as well as financial bonus incentives for the ACO network to reduce the cost of its particular pool of patients.²⁶⁶

The ACO system reinstates many of the incentives that existed in the MCO era and may successfully control costs.²⁶⁷ Though physicians will still be paid in a fee-for-service manner, they are eligible for a portion of the bonus given to ACOs that are successful in limiting costs.²⁶⁸ Therefore, physicians retain the incentive to order only necessary services for patients. Additionally, anti-kickback laws and the Civil Monetary Penalties statute address any remaining concerns related to over- and under-treatment by ACO physicians.²⁶⁹

C. Lessons from Rationing Systems in the United States and Abroad

1. LESSONS FROM THE HMO ERA

The closest the United States has ever had to a nationally implemented rationing system was in the early 1990s when the largest percentage of employed persons were receiving health care through HMOs.²⁷⁰ Consumer and media distrust of a paternalistic system that took away treatment options from patients led to legislative backlash in the form of forty-seven states passing some form of anti-HMO legislation.²⁷¹ This legislation ended the only era in recent health care history that saw no rise in expenditures.²⁷²

263. *Id.*

264. *Id.* at 34–36.

265. *Id.*

266. *Id.* at 36.

267. *See id.* at 34. Physicians and administrators of ACOs are incentivized to reduce costs to receive bonuses. *Id.* at 36.

268. *Id.*

269. *Id.* at 37.

270. Harris, *supra* note 70, at 328 (explaining that managed care controls cost by rationing services).

271. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 588; Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally*, 38 J.L. MED. & ETHICS 352, 358 (2010).

272. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 588.

American individualism was the force that destroyed managed care.²⁷³ Patients were dissatisfied with MCOs because their only choice was of primary care doctors; a choice inherently limited by plan enrollment.²⁷⁴ Decisions as to treatment options, specialist visits, hospital visits, and treatment coverage were made bureaucratically with no involvement from the individual.²⁷⁵ Patients were often concerned that the entire group of physicians within their plan was of low quality, effectively blocking them from obtaining high-quality care.²⁷⁶ Additionally, most enrollees could not maintain a relationship with their physician because of constant changes in employer plans.²⁷⁷ Those that did establish a relationship were often concerned that the physician did not have autonomy, and therefore could not provide every service he or she deemed necessary.²⁷⁸

Physician incentives also factored into declining public support for MCOs by leading to “[h]orror stories of patients being refused care that would have prevented serious injury or death.”²⁷⁹ Physicians who were part of MCO networks were financially incentivized to lower costs, which meant providing less care for the patients.²⁸⁰ These incentives created distrust between MCO administrators and the public who felt that MCOs could not resist the temptation to under-treat patients for financial gains.²⁸¹ Therefore, the public became wary and distrustful of doctors who were part of MCO networks.²⁸² Patients felt that doctors were more concerned with their own self-interest than the patients’ interests.²⁸³ Patients also disliked the fact that administrators who made treatment decisions could not be held liable for medical malpractice.²⁸⁴ This created a precarious situation for patients who had no recourse for improper treatment decisions.²⁸⁵

When reviewing each of the factors that led to the decline of the MCO system in the late 1990s, it becomes clear that the backlash was

273. Harris, *supra* note 70, at 332.

274. *Id.* at 343.

275. *Id.* at 344.

276. *Id.* at 343.

277. *Id.* at 343–44.

278. *Id.* at 344.

279. *Id.* at 346.

280. *Id.*

281. *See id.* at 349.

282. *Id.*

283. *Id.*

284. *See id.* at 350.

285. *See id.*

not only focused on the rationing aspects of the MCO system.²⁸⁶ Americans actually disliked the lack of individual autonomy over health care decisions, as well as the misaligned incentive systems that provided financial benefits to physicians who under-treated.²⁸⁷ Whether or not patient choice deserves its place in a health care system can be debated, but for the purpose of stability in the United States, the MCO era has taught us that it is necessary.²⁸⁸ The MCO era has also taught us that the primary purpose of a health system cannot be, at least outwardly, cost saving.²⁸⁹ It is arguable that the major purpose of the Oregon Medicaid system is cost saving, but it was established with the message of increasing accessibility,²⁹⁰ therefore limiting public backlash. Had the MCO system focused messaging on access it might not have suffered the same decline.

2. LESSONS FROM HEALTH CARE SYSTEMS ABROAD

In 2000, the World Health Organization (WHO) published an extensive report of the world's health care systems to determine which ones perform better than others.²⁹¹ Within the statistics are lessons that can help the United States increase fairness, financial efficiency, and the number of services, while reducing preventable deaths and disability.²⁹² Additionally, WHO provided a rank for each country based on eight measures: health level, health distribution, responsiveness level, responsiveness distribution, fairness in financial contribution, overall goal attainment, health expenditures per capita in international dollars, and performance on level of health.²⁹³ The United States ranked first in only two measures: (1) health expenditures per capita in international dollars and (2) responsiveness level.²⁹⁴ Moreover, despite having the highest per capita cost in the world, the United States ranked thirty-seventh in overall performance.²⁹⁵

The report also showed that the United States is twenty-fourth in longevity and thirty-second in infant survival rates, but the United

286. *Id.* at 349.

287. *Id.*

288. *See id.*

289. *See id.*

290. *See generally id.*

291. WORLD HEALTH REPORT 2000, *supra* note 1, at 192–95.

292. *Id.*

293. *Id.*

294. *Id.* at 195.

295. *Id.*

States still spends \$4,187 per capita while the second highest per capita expenditure is \$3,564 in Switzerland (ranked twentieth overall).²⁹⁶ Additionally, all citizens of Switzerland are covered by insurance, and the total costs come to 10.1% of the GDP, while the United States has around fifty million uninsured, and health care expenditures make up 13.7% of the GDP.²⁹⁷

3. EXAMPLES OF RATIONING SYSTEMS

WHO's opinion is that "rationing should take the form of excluding certain interventions from the benefit package, not leaving out any people."²⁹⁸ To determine if benefit rationing is better than the U.S. method of population rationing, a quick overview of the systems in the United Kingdom, Austria, and Oregon will provide a basis for comparison.

a. The United Kingdom and the British National Health Service The British National Health Service (NHS) is a single payer system of health care instituted in 1948.²⁹⁹ The system is financed by income taxes and covers all British citizens.³⁰⁰ Supplementary commercial insurance is available for purchase and accounts for only about ten percent of health care expenditures.³⁰¹ The cost to consumers in the form of a user charge only accounts for 3.5% of health care expenditures.³⁰² Although there is no rationing by affordability as exists in the United States, there is rationing by time and by cost effectiveness.³⁰³

The first type of rationing that exists within the NHS has to do with the amount of time it takes to receive treatment.³⁰⁴ Like HMOs, the NHS uses a gatekeeper system where users must see a primary care physician before being referred to a specialist.³⁰⁵ The purpose is

296. *Id.* at 192–95.

297. Julie Rovner, *All Things Considered: In Switzerland, a Health Care Model for America?*, NAT'L PUB. RADIO (July 31, 2008), available at <http://www.npr.org/templates/story/story.php?storyId=92106731>.

298. WORLD HEALTH REPORT 2000, *supra* note 1, at 137.

299. See Steve Ainsworth, *History Repeating Itself*, 40 PRACTICE NURSE 9, 10 (2010).

300. Adam Oliver, *The Single-Payer Option: A Reconsideration*, 34 J. HEALTH POL. POL'Y & LAW 509, 518 (2009).

301. *Id.*

302. *Id.*

303. See generally Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J.L. MED. 78 (2010).

304. *Id.* at 98.

305. Oliver, *supra* note 300, at 518–19.

the same in either system—to prevent unnecessary demand for specialists so that limited resources are used efficiently. In 1995, the NHS instituted a guaranteed maximum wait of eighteen months between the time a patient is referred to a hospital and the time he or she is actually admitted.³⁰⁶ A study done by the United Kingdom Department of Health, however, shows that wait times are not necessarily a result of the single payer system in the United Kingdom but rather a result of lower funding levels.³⁰⁷ Even so, at the 2007 level of funding for the NHS, far below the funding of the U.S. system, eighty-five percent of patients waited less than three months, and every patient had been seen within six months.³⁰⁸

The National Institute for Health and Clinical Excellence (NICE) controls cost effectiveness, the second type of rationing.³⁰⁹ NICE was created to “ensure that every treatment, operation, or medicine used is proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere.”³¹⁰ To fulfill the mission statement, NICE evaluates whether benefits associated with a particular intervention, measured by health outcomes, justify the costs of the intervention.³¹¹ Once NICE has ruled on a particular benefit, NHS decides whether to provide the intervention.³¹² This system prioritizes treatments according to the amount of “quality adjusted life years” (QALYs) a patient receives in return for the cost of intervention.³¹³ As explained by the chairman of NICE:

A QALY scores your health on a scale from zero to one: zero if you're dead and one if you're in perfect health. You find out as a result of a treatment where a patient would move up the scale. If you do a hip replacement, the patient might start at .5 and go up to .7, improving by .2. You can assume patients live for an average of 15 years following hip replacements. And .2 times 15 equals three quality-adjusted life years. If the hip replacement costs 10,000 GBP [about \$15,000] to do, it's 10,000 divided by three, which equals 3,333 GBP [about \$5,000]. That figure is the cost per QALY.³¹⁴

306. *Id.* at 519.

307. *Id.* at 519–20.

308. *Id.* at 519.

309. Katz, *supra* note 303, at 100.

310. *Of NICE and Men*, WALL ST. J., July 7, 2009, <http://online.wsj.com/article/SB124692973435303415.html>.

311. Oliver, *supra* note 300, at 521–22.

312. Eben Harrell, *How Much Is a Year of Life Worth?*, TIME, Mar. 27, 2009, <http://www.time.com/time/health/article/0,8599,1888006,00.html>.

313. *Id.*

314. *Id.*

The NHS uses a QALY measurement to determine the value NICE places on an additional year of added life based on a treatment.³¹⁵ As a general rule, the health economists working for NICE have determined that the threshold for a cost per QALY is between 20,000 to 30,000 GBP.³¹⁶ Treatments that yield a cost per QALY greater than that amount are not recommended by NICE to the NHS, and British citizens will only have access to the treatment in special circumstances.³¹⁷

A paternalistic health care system like the NHS is politically difficult to sell in the United States because Americans like to have choice.³¹⁸ This was seen in the backlash against HMOs in the 1990s.³¹⁹ A change in the NHS model shows that the British were not happy with such a paternalistic system either, and in 2006 the government introduced patient choice.³²⁰ Since then, gatekeeper physicians have been required to ask patients their choice of hospital.³²¹ Although British citizens do not have their choice of insurer, they still may exercise patient choice as to their provider.³²²

b. Austria Austria was ranked as the ninth best health care system in the world according to the 2000 WHO report.³²³ Additionally, it is sixth in total health expenditure per capita, at \$2,277, with only \$536 coming out of the consumer's pocket.³²⁴ Nearly all health care responsibilities lie with the federal government as outlined in the Austrian Constitution.³²⁵ Although the federal government has the task of generating health care law, the Lander (states) have to determine implementation policy and then create legislation to carry it out.³²⁶ The

315. *Id.*

316. *See id.*

317. *See id.*

318. Harris, *supra* note 70, at 345.

319. George J. Church, *Backlash Against HMOs: Doctors, Patients, Unions, Legislators Are Fed Up and Say They Won't Take it Anymore*, TIME, Apr. 14, 1997, at 32, available at <http://www.cnn.com/ALLPOLITICS/1997/04/07/time/hmo.html>.

320. Oliver, *supra* note 300, at 526.

321. *Id.*

322. *Id.*

323. WORLD HEALTH REPORT 2000, *supra* note 1, at 200.

324. *Id.*

325. MARIA M. HOFMARCHER & HERTA RACK, EUR. OBSERVATORY ON HEALTH CARE SYS., HEALTH CARE SYSTEMS IN TRANSITION: AUSTRIA 9 (Anna Dixon ed. 2001), available at http://www.euro.who.int/__data/assets/pdf_file/0003/96438/E72787.pdf.

326. *Id.* at 14.

people of Austria do not get to choose their health insurance fund but instead are automatically assigned to insurers based on their occupation; the unemployed are automatically insured as well.³²⁷ Each individual's contribution to one of the twenty-four social insurance institutions is determined by a percentage of income and varies between funds.³²⁸ These contributions comprise fifty percent of all health spending, and the rest is taken care of by general taxation.³²⁹

Although the health care system is government run, there are still private players in Austria's system, including optional private health insurance, private hospitals, welfare organizations, and self-help groups.³³⁰ Austrian health insurance funds are related to these providers in one of three ways: Integrated, Semi-Integrated, and Contracted.³³¹ The fully integrated relationship indicates that the health insurance funds fully fund the providers.³³² In the case of a contracted relationship, agreements are negotiated between the fund and the providers.³³³ Regardless of the provider, as long as payment is being made by social health insurance, there are particular benefits covered by the plan.³³⁴ The benefits are extensive, including medical home care, dental, drugs, and medical aid, but they are not exhaustive.³³⁵ Benefits that have not yet been included in the range of benefits covered must be applied for and then approved by a "head doctor" who is an employee of the health insurance fund.³³⁶

Before a particular benefit will be added to a social insurance plan, there must be discussion of access to the service, regional distribution of providers, reimbursement rates, and quality assurance.³³⁷ Although some in Austria consider this process to be an unnecessary delay in the distribution of care, others contend that it "is a necessary prerequisite to ensure balanced supply (horizontal equity), uniform fees and observance of quality criteria."³³⁸ The process to include particular benefits in the Austrian system has many parallels in process

327. *Id.* at 32.

328. *Id.* at 33-34.

329. *Id.* at 34.

330. *Id.* at 12.

331. *Id.* at 20.

332. *Id.*

333. *Id.*

334. *Id.* at 32.

335. *Id.* at 39.

336. *Id.*

337. *Id.*

338. *Id.*

and reasoning to coverage determinations made by MCOs in the United States and NICE in the United Kingdom.³³⁹

c. *Oregon* In the 1980s, rising Medicaid costs placed a great burden on state budgets, and the states looked for ways to reduce costs by reducing funding for certain medical treatments.³⁴⁰ In Oregon, the 1989 legislature determined that the \$1,100,000 it would spend on thirty-four transplants was better spent on prenatal care for fifteen hundred women, so it passed legislation to stop Medicaid funding of soft-tissue transplants.³⁴¹ This decision started the process of installing a prioritized health care system in Oregon called the Oregon Basic Health Services Act (OBHSA).³⁴² The purpose of the OBHSA was to provide extended access to basic health services while containing rising levels of the Medicaid budget.³⁴³ At the time OBHSA was created, sixteen percent of Oregonians lacked any form of health care, most of them poor or children.³⁴⁴ To increase Medicaid enrollment to all people without exploding the budget, the Oregon legislature determined that the services available through Medicaid should be what the “political, medical and social consensus deemed a fiscally and clinically acceptable package of basic health services.”³⁴⁵

To determine which treatments to cover, the Health Services Commission (HSC) creates a biennial list of condition and treatment pairings.³⁴⁶ The legislature then determines how much funding each of the benefits included in the list receives.³⁴⁷ Additionally, the HSC “actively solicits public involvement in a community meeting process to build consensus on the values to be used to guide health resource allocation decisions.”³⁴⁸ The commission employs several methods to

339. Cf. Martin Sipkoff, *Comparative Effectiveness: An Idea Whose Time Has Finally Come*, MANAGED CARE, Apr. 2009, <http://www.managedcaremag.com/archives/0904/0904.comparative.html>.

340. See Eric Lamond Robinson, *The Oregon Basic Health Services Act: A Model for State Reform?*, 45 VAND. L. REV. 977, 988 (1992).

341. *Id.* at 988–89.

342. See *id.* at 989.

343. *Id.*

344. *Id.*

345. Howard M. Leichter, *Oregon's Bold Experiment: Whatever Happened to Rationing?*, 24 J. HEALTH POL. POL'Y & L. 147, 149 (1999).

346. *Id.* at 149–50.

347. David L. Weigert, *Tragic Choices: State Discretion Over Organ Transplant Funding for Medicaid Recipients*, 89 NW. U. L. REV. 268, 310 (1994).

348. OR. REV. STAT. § 414.720(2) (2009).

ensure widespread public involvement in coverage determinations.³⁴⁹ As for patients who need treatments that are not provided within the benefits package, they are told that the treatment is not covered.³⁵⁰ Moreover, they are told that there is no cause for concern because the treatments that are not covered “have little effectiveness” and are not lifesaving.³⁵¹

Institution of the Oregon Medicaid rationing system had a substantial effect on increasing health care access to the poor. By 1994, only five years after the creation of the OBHSA, Oregon was “provid[ing] Medicaid benefits to forty-two percent more of the State’s poor population.”³⁵² In turn, the benefits package was substantially smaller than the one provided before the reform, and in 1991, the state legislature only approved funding for 587 of the 709 services on the commission’s priority list.³⁵³ Like the NHS, Oregon’s Medicaid system requires difficult decisions.³⁵⁴

Regardless of the difficulty of decisions that Oregon has to make, the system’s decisions are justly made.³⁵⁵ Oregon instituted a model of “rationing by democratic consensus,” in that they make a concerted effort to include the public in decisions regarding the way that medical services are going to be rationed.³⁵⁶ The system provides universal accessibility to those who qualify.³⁵⁷ Even though certain life saving and other high cost treatments are no longer covered, the likelihood of needing those treatments is minimal, or the marginal utility is not great enough to make it onto the prioritized list.³⁵⁸ Therefore, it is rational and just to determine that expansion of access to Medicaid coverage outweighs the diminished robustness of the overall package.³⁵⁹

349. Weigert, *supra* note 347, at 310.

350. Leichter, *supra* note 345, at 149–50.

351. *Id.* (quoting Thomas Bodenheimer, *The Oregon Health Plan—Lessons for the Nation*, 337 NEW ENG. J. MED. 651, 651–56 (1997)).

352. Weigert, *supra* note 347, at 310.

353. *Id.*

354. See Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1629 (1992).

355. See *id.* at 1627.

356. *Id.*

357. *Id.*

358. *Id.* at 1629.

359. See *id.* at 1629–30.

D. A Step in the Right Direction: Comparative Effectiveness Research

As it turns out, the federal government has a bureaucratic body similar to Oregon's Health Services Commission, the United Kingdom's NICE, and Austria's service determinations, except its recommendations are not used to make treatment decisions.³⁶⁰ President Obama, following the precedent set by the British QALY system and OBHSA, "signed into law an initiative providing \$1.1 billion to support research on the comparative effectiveness of drugs, medical devices, surgical procedures, and other treatments for various conditions."³⁶¹ The American Recovery and Reinvestment Act created a new council that conducts comparative effectiveness research (CER) to provide information and develop guidelines for providers on the effectiveness of medical procedures.³⁶² The research is defined as "evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition."³⁶³

CER could be an effective way to reduce the cost of health care in the United States by requiring a level of effectiveness for treatments that government health care plans provide. It can be used to justify the cost of a particular treatment and the denial of another. It can also ensure that "the most relevant and valid information" is being used when deciding the course of a medical intervention.³⁶⁴ The language of the ACA, however, limits the effectiveness of CER in America. The current form of the CER council only allows it to publish findings, but it may not make policy recommendations of any kind.³⁶⁵ Additionally, the language in the ACA does not allow IMAB to submit any proposal that includes rationing.³⁶⁶

360. See Paul H. Keckley & Barbara B. Frink, *Comparative Effectiveness: A Strategic Perspective on What It Is and What It May Mean for the United States*, 3 J. HEALTH & LIFE SCI. L. 53, 59 (2009).

361. Aanand D. Naik & Laura A. Petersen, *The Neglected Purpose of Comparative-Effectiveness Research*, 360 NEW ENG. J. MED. 1929, 1929 (2009).

362. Alan M. Garber & Sean R. Tunis, *Does Comparative-Effectiveness Research Threaten Personalized Medicine?*, 360 NEW ENG. J. MED. 1925, 1925 (2009).

363. Robert M. Centor et al., *Comparative Effectiveness Research and the Medical Home—Made for Each Other?*, MEDSCAPE TODAY, Sept. 23, 2009, <http://www.medscape.com/viewarticle/709197>.

364. Garber & Tunis, *supra* note 362, at 1927.

365. See Keckley & Frink, *supra* note 360, at 58.

366. See ACA, Pub. L. No. 111-148, 124 Stat. 119, 490 (2010).

IV. Resolution

A. The Coexistence of Choice and Rationing

The Affordable Care Act is the most extensive reform of the health care industry in forty-five years, and a number of its policies are going to reduce the costs of health care in the coming decade. Some of these policies have been utilized previously, such as lower reimbursement rates, and have led to mixed results. Others are brand new, such as the institution of insurance exchanges, and the effectiveness of those will not be known for a number of years. One thing is certain, however: the inherent values of individuality and liberty have framed the boundaries of the reform effort. Americans have not accepted any system that entails paternalistic values or overtly rationed care, and the reformers took notice. The drafters made a significant effort when writing the legislation to guarantee the ACA could not be seen as government-run health care. Although a libertarian ethos lives within most Americans, the associated value set is not beneficial for health care reformers, whose principal focus needs to be cost reduction.

History proves that health care costs can be contained when choices are limited and cost efficiency is emphasized. When most Americans were insured with a generic indemnity plan prior to the institution of MCOs, health care costs skyrocketed as patients were incentivized to receive as many services as possible from any provider of their choosing.³⁶⁷ The fee-for-service model provided the utmost choice to the consumer, and employers paid heavily for that choice. In response, President Nixon created MCOs, which had a significant cost-saving effect on the industry.³⁶⁸ By substituting the choices of individual enrollees for the choices of HMO administrators with cost containment as a priority, MCOs forged the only period in recent history where health care inflation did not outpace overall inflation.³⁶⁹ Americans vehemently opposed the lack of choice associated with MCOs and demanded that legislators draft regulations to prevent MCOs from making decisions that limit care.³⁷⁰ Legislatures listened,

367. See Gratzner, *supra* note 43.

368. See *supra* text accompanying notes 63–65.

369. See Coleman, *supra* note 25, at 259.

370. See *supra* Part II.A.4.

and a river of legislation was passed that drowned the MCOs' ability to manage care efficiently.³⁷¹

Perhaps American cynicism toward health care is a relic of the MCO era when patients believed that their welfare played second fiddle to the financial welfare of the MCOs. Perhaps Americans fundamentally distrust limited choice and rationing strategies in an industry like health care, where they believe that cost containment should not be top priority. The former is likely the case; Americans could adopt a system that rations as long as it incorporates the values of individualism and choice that Americans hold so dearly. Although most Americans do not have a wealth of knowledge pertaining to the health care system, they probably understand the de facto rationing that exists within the current American system which has not created any great public backlash.³⁷²

The current system rations by cost. It also rations by employment. It is a daunting task for an unemployed individual to purchase affordable health care on the open market. More importantly, nearly fifty million people are uninsured with no access to health care other than required by the Emergency Medical Treatment and Active Labor Act.³⁷³ At the same time, the wealthy are enrolled in Cadillac plans that place specialist visits and the latest medical technology at their beck and call. The concept of de facto rationing is simple. Even more importantly, the American people accept it. The reason people accept this form of rationing over more explicit rationing, such as QALY, is that it does not run contradictory to their values. Even though health care is rationed, most people believe that unemployed people have the "choice" of working and therefore receiving coverage. Although procuring insurance as a single person on the market is difficult, the "choice" of purchasing does exist. Finally, wealthy Americans do have plans covering the best medical care in the world, and why not? The message is that the wealthy work hard and deserve to choose the best plan they can afford, even if it is an inefficient burden on the system.

371. See Harris, *supra* note 70, at 326.

372. This is not to say that people have not complained about the fifty million uninsured, but rather, that they do not complain because it is de facto rationing.

373. Richard Wolf, *Number of Uninsured Americans Rises to 50.7 Million*, USA TODAY, Sept. 17, 2010, http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm.

B. The ACA and the Existence of Necessary Institutions Required for Meaningful Reform

The direction of health care reform needs to be rethought. Some reforms included in the ACA will be beneficial, but the extent of cost containment is unknown.³⁷⁴ For Medicare, bringing Part C Advantage plans into parity with traditional Medicare will reduce costs, but it will also reduce services provided and make it more difficult for the elderly to pay their bills. Lowering reimbursement rates for providers with "lower quality care" will also lower costs to Medicare but at the risk of reducing access to services. Finally, the changes to Medicare Part D will lower the costs of prescription drugs to consumers at an unknown cost to the manufacturers.

In the private market, establishing insurance exchanges benefits the private uninsured or unemployed consumer. Whether this new marketplace will save the industry any money is unclear. Other reforms such as anti-fraud protections, streamlining administration, and electronic medical records will lower costs as well.³⁷⁵ Upon analyzing other health care systems that both keep down costs and provide a high level of services, however, it seems the ACA did not reform enough systemic ills to be truly successful.

Austria, Britain, and the Medicare system in Oregon, have utilized rationing to control costs.³⁷⁶ The United States has the necessary institutions to achieve the same results, yet they remain under-utilized. Each of the aforementioned systems uses efficiency outcomes of particular services to define benefit plans that cover all citizens.³⁷⁷ The governments do not cover the services that are determined cost-ineffective for any of its beneficiaries.³⁷⁸ By doing so, each of these systems is able to cover all citizens and retain a high level of care. Certain services will not be covered, but the odds of needing the particular uncovered service are low and the effectiveness of the services are not likely to be great or they would have been included in the coverage.³⁷⁹ An important part of each of these systems, as is the case in the majority of industrialized countries, is full coverage to all citizens as a right. Health care in America, however, has never been

374. See *supra* Part II.B.2.

375. See *supra* Part III.B.3.

376. See *supra* Part III.C.3.

377. See *id.*

378. See *supra* notes 317, 336–37, 345.

379. See, e.g., *supra* note 358.

considered a right for most American citizens.³⁸⁰ Coverage has been a benefit associated with employment and wealth.

C. Medicare for All

The United States has the necessary institutions in place to enact a system of health care that insures every citizen and contains cost through rationing services. Medicare, Medicaid, and SCHIP are all forms of government insurance; the government is the third-party payor, so it already has experience in health care insuring.³⁸¹ These systems are particularly expensive because they are effectively islands, separate from the rest of the covered population, full of elderly, people with disabilities, and other high cost enrollees. Instead of separating this population from other citizens, a government payor program should be extended to all people. It could be branded as Medicare for All, and as a result, cost containment possibilities abound. MCOs traditionally control enrollment so that the population has a mix of healthy as well as sick enrollees, with the sicker subsidized by the healthy.³⁸² This is impossible in Medicare, which is available to only the elderly,³⁸³ and in Medicaid or SCHIP, which are need-based programs for the poor.³⁸⁴ To make matters worse, the poor and elderly are generally in worse health, with nobody to subsidize their care in any of these programs. If every citizen of the United States were a member of a single insurance program, the mix of beneficiaries would be diverse enough that the young and healthy citizens could subsidize the elderly and sick, lowering the average cost of coverage per beneficiary.

1. BENEFITS AND PLANS

The benefit package for beneficiaries of Medicare for All should be determined based on a model comparable to the QALY system. There need not be any particular maximum cost for any service, as any beneficial service should be covered. This would ensure that the

380. See *supra* notes 152–55. With the exception of the elderly, veterans, Native Americans, and people with disabilities, Americans do not have the right to health care. *Id.*

381. HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 20, at 768.

382. Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 1012 (2010).

383. See *supra* note 61.

384. See *supra* note 59.

American system avoids the problem that the British system has with low cancer survivorship.³⁸⁵ It would also quell the fears of Americans who might believe a diagnosis of certain diseases would be a death sentence. In terms of institutions to carry out this program, the United States already has a body, the CER council, that conducts comparative effectiveness research and would be tasked with researching services to cover.³⁸⁶ Once research is compiled, IMAB could provide rationing suggestions to reduce the costs of Medicare. These two organizations could work together—the CER council providing data to IMAB, and IMAB suggesting the benefits that should be covered to regulators. The framework already exists, but legislation is prohibiting any movement toward realizing this system. It would require little additional financing for the CER council and IMAB to become effective cost-reducing entities, but it would require the repeal of prohibiting language within the ACA.³⁸⁷ With these changes, however, IMAB and the CER council could become America's version of NICE.

Additionally, there must be a number of plans from which individuals can choose. The Austrian health system provides universal coverage, but not every citizen is a member of the same plan.³⁸⁸ Instead, citizens are assigned to a plan as a member of their occupation.³⁸⁹ The organization of these types of plans can exist in the recommended system, but instead of delegation based on employment, each person should choose depending on which benefits he or she desires. Each plan would be tailored to fit certain age groups or health levels based on the additional services beyond those in the guaranteed coverage plan provided by IMAB recommendations. To determine other benefits included, each plan administrator (ACOs in this proposal) can conduct surveys and polls of their enrollees much like the HSC did when the Oregon plan was instituted.³⁹⁰ This ensures that public choice is part of defining the plans.

385. See Coleman et al., *supra* note 15.

386. See Neumann & Weinstein, *supra* note 21, at 1495.

387. See ACA, Pub. L. No. 111-148, § 3403, 124 Stat. 119, 490 (2010) (to be codified at 42 U.S.C. § 1395kkk).

388. See HOFMARCHER & RACK, *supra* note 325.

389. *Id.*

390. Weigert, *supra* note 347, at 310.

2. ADMINISTRATION

Each plan would be government insured but not administered. ACOs should have the job of managing care for many reasons, the first is that MCOs have acquired a bad name and require rebranding to gain support. ACOs are more desirable than MCOs in this system because much of the efficiency work will be done by the CER council and IMAB. Therefore, there is not a necessity for purely financial strategy from plan administrators. Instead, as discussed *supra*, ACOs will conduct research to efficiently provide for enrollees and then make treatment suggestions.³⁹¹ Patients do not have to accept but can be incentivized to do so through cost sharing programs. If an ACO meets cost efficiency benchmarks, portions of the bonus should be extended to beneficiaries through tax refunds the following year.

ACOs are preferable to MCOs because they can circumvent the existing legislation and judicial decisions regarding MCOs. It is crucial that there is some form of malpractice liability for ACOs in order to gain public support, which is currently not the case for MCOs. This should not pose a problem to the financial welfare of ACOs because they will not be making decisions that are overtly cost-oriented, and the decisions will only be suggested to the patients to determine the most efficient form of treatment.

D. American Acceptance of a Rationing Health Care Model

The American people may support a system arranged this way for a number of reasons. First, the public retains choice. They are able to choose their providers and the services they receive as long as they have been approved by the CER council and IMAB. Enrollees retain choice of provider as well, because, as discussed *supra*, ACOs cannot limit provider choice.³⁹² Additionally, people have the choice of several plans in which to enroll. Some plans may provide a wide range of services but limited intensive care, such as Medicare Part C. This type of plan would be attractive to younger people who do not need intensive care but prefer a plan that includes wide coverage of dental, vision, and possibly health club memberships. For the elderly and people with disabilities, there will be plans that include long-term care, nursing homes, and hospice care. These plans will not have the range of normal benefits that other plans include but instead would be

391. See *supra* Part III.B.4.

392. Solomon et al., *supra* note 262, at 34.

tailored to elderly people with more advanced illnesses. The exact make-up of each plan is unimportant. The point is that this system begins with choices for the individual and continues to provide choices throughout the coverage relationship.

Second, rationing is a vital component to this system, providing much-needed cost containment. The American people will accept it, though, because enough care has gone into preserving consumer choice that rationing should not be a barrier to incorporation. Certain services will not be provided to beneficiaries of certain plans, but the public will have played a part in making that decision. Just as the Oregon plan did in 1984,³⁹³ this system will ensure that rationing is done as democratically as possible with many avenues for citizens to provide input. If a system is able to incorporate rationing principles in cooperation with the public, while retaining consumer choice throughout the process, rationing can be embraced as the savior of the American health care system, rather than a socialist plot to kill our elderly and deny health care for profit.

V. Conclusion

The ACA is a beneficial piece of legislation because of its potential for cost containment in the health care industry. It has not, however, significantly reformed the structural ills of the American health care system and has therefore kept in place much cost inefficiency. The successes of the HMO era as well as foreign systems prove that cost-effectiveness rationing is essential to successfully providing a high level of care at a sustainable cost. Legislators need to amend the language of the ACA to allow IMAB to make suggestions that ration care. A system that incorporates rationing principles is politically possible in the United States as long as it retains choice for the individual.

393. Weigert, *supra* note 347, at 310.