

## Reform of the United States health care system: an overview\*

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### Abstract

This essay, written for readers unfamiliar with the details of American health law and policy, portrays the essential features of the battle for health reform in the United States and of the law that survived the battle: the Patient Protection and Affordable Care Act (PPACA). The essay summarizes key aspects of the U.S. health care system and how it compares in terms of costs and results with other advanced nations' systems. The political and legal conflicts leading up to and following PPACA's enactment are described. The major features of the law, attempting to address problems of access to health care, quality, and cost, are explained. Issues remaining to be resolved in the law's implementation are set out: the expansion of Medicaid coverage for the low-income population; the formation of each state's health insurance exchanges; cost-control measures such as the establishment of the Independent Payment Advisory Board and the adoption of new payment models; coverage of contraceptives as part of the essential benefits package; and the role of the new Patient-Centered Outcomes Research Institute. The essay concludes that the law is poised to achieve genuine progress toward increased access to health care, but that the law's aims of improving quality and controlling costs are far less certain of accomplishment.

### Introduction

The story of America's historic health care reform, still unfolding, is a tale of polarized ideology, complex and brutal politics, perverse economics, and high-level legal battle against a background of a health care system in disarray. This essay portrays the essential features of that story and of the law that survived the battle: the Patient Protection and Affordable Care Act (PPACA).<sup>1</sup> The essay summarizes key aspects of

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\* Editor's note: This article is based in part on a series of presentations by Professor Leflar to the Health Care and Law Research Group (*Iryō to hō kenkyūkai*) founded by Professor Norio Higuchi at the University of Tokyo. Most figures illustrating this article are adapted from Leflar's November 6, 2012 presentation.

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<sup>1</sup> Pub. L. No. 111-148, 124 Stat. 119 (codified in scattered sections of 42 U.S.C.).

the U.S. health care system and how it compares in terms of costs and results with other advanced nations' systems. The political and legal conflicts leading up to and following PPACA's enactment are described. The major features of the law are explained, and the issues remaining to be addressed are set out.

The United States, like every nation seeking to better its health care system, faces a set of dilemmas known as the "iron triangle of health care." The three vertices of the triangle represent three dimensions of each health care system: access, cost, and quality. The dilemmas stem from the fact that attempts to improve any one of the three dimensions are likely to create pressure on one or both of the other two. PPACA ambitiously seeks to address all three simultaneously – while furthering principles of justice as well.

This essay concludes that the new law will increase access to care, covering most Americans who are now uninsured and making America a somewhat more just society. Quality improvements, some spurred by the law and others of independent origin, are also discernible on the horizon. Whether health care costs can be controlled in the face of pressures from both higher demand and quality improvement initiatives, however, depends on deft implementation of the law's provisions against a background of rapidly changing economic forces. Cost-control success cannot be predicted with confidence.

### **Background: U.S. health care in comparative perspective**

It is well known that the U.S. health care system (if the word "system" can properly be used to describe such a complex, disorderly set of arrangements) fails to provide timely and appropriate care for a substantial segment of the population, and that the care that the public does receive is far more expensive than care provided in any other nation. What is less well known is which segments of the population lack coverage, and how the high-cost care that does reach the public results in many respects in mediocre health outcomes. Myths about American health care are pervasive, and factual correctives are needed.

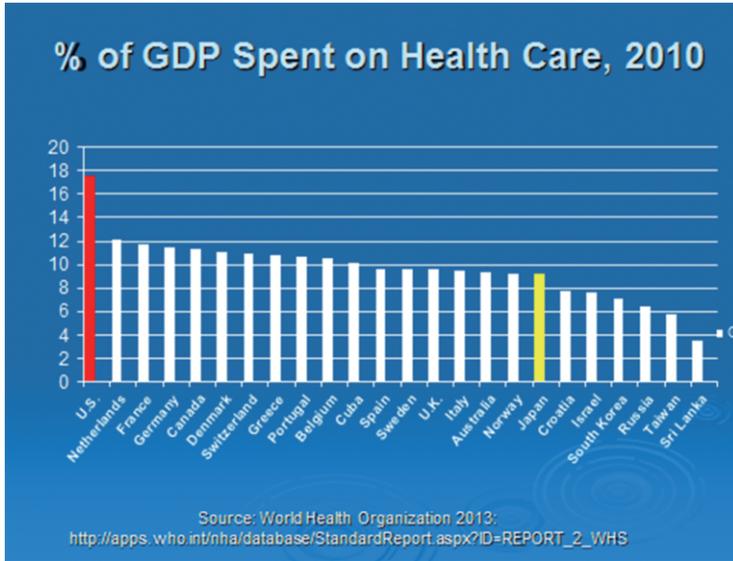
Most of the roughly 50 million uninsured are not unemployed or welfare recipients, as many believe. Rather, the majority are members of working families. Although adults under age 65 typically receive health insurance as an employment benefit, not all are so fortunate. Most small businesses, many medium-sized firms, and even some large firms do not offer health insurance to their employees.<sup>2</sup> Private health insurers' premiums for individuals are notoriously costly, beyond the

<sup>2</sup> AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), MEDICAL EXPENDITURE PANEL SURVEY (2010), *available at* <http://www.ahrq.gov/research/data/meps/index.html>.

budgets of many working families. As a result, 67% of the uninsured are members of families with at least one full-time worker.<sup>3</sup>

Although ethnicity is correlated with lack of health insurance, the ethnic group least likely to have insurance is not African-Americans, as many believe; it is Hispanics. More than one-third of Hispanic workers (33.8%) were uninsured in 2008, compared with 11.7% of African-Americans and 8.4% of Caucasians and others.<sup>4</sup>

**Figure 1. Comparative Health Care Expenditures (International)**

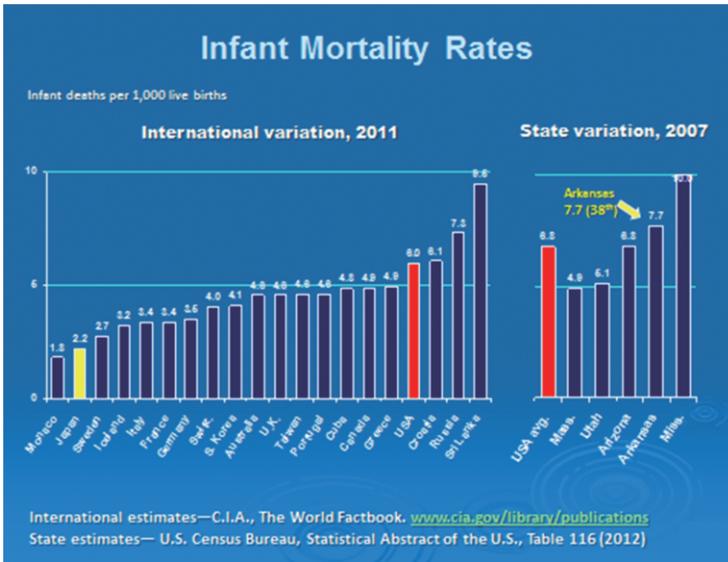


Health care costs in the U.S. comprise a far greater share of Gross Domestic Product than in other advanced nations (Figure 1). Yet by many measures, the health outcomes experienced by Americans fail to match those achieved by other countries. For example, infant mortality rates in the U.S. are significantly worse than rates in deficit-racked countries such as Greece and Portugal, and more than double those in Japan. Infant mortality in the lowest-ranked state, Mississippi, is on a par with rates in developing nations such as Sri Lanka (Figure 2). Age-standardized death rates from noncommunicable diseases likewise show the U.S. trailing most other advanced nations (Figure 3). To be sure, other factors besides the quality of health care systems enter into such mortality statistics; but health care plays an important role.

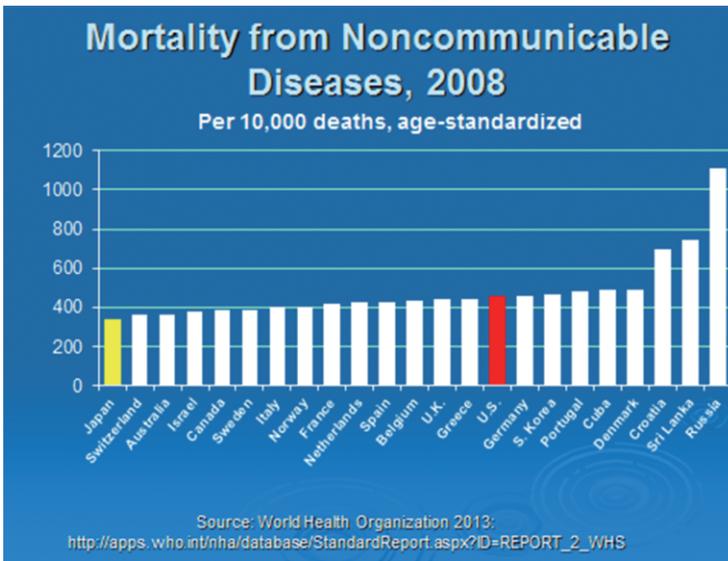
<sup>3</sup> SARA R. COLLINS, KAREN DAVIS, MICHELLE M. DOTY ET AL., GAPS IN HEALTH INSURANCE: AN ALL-AMERICAN PROBLEM (Commonwealth Fund 2006).

<sup>4</sup> WILLIAM A. CARROLL & G. EDWARD MILLER, HEALTH INSURANCE STATUS OF FULL-TIME WORKERS BY DEMOGRAPHIC AND EMPLOYER CHARACTERISTICS, 2008 (AHRQ MEDICAL EXPENDITURE PANEL SURVEY 2011), available at [http://meps.ahrq.gov/mepsweb/data\\_stats/Pub\\_ProdResults\\_Details.jsp?pt=StatisticalBrief&opt=2&id=992](http://meps.ahrq.gov/mepsweb/data_stats/Pub_ProdResults_Details.jsp?pt=StatisticalBrief&opt=2&id=992).

**Figure 2. Comparative Infant Mortality Rates (International; Selected U.S. States)**



**Figure 3. Comparative Mortality Rates from Noncommunicable Diseases**



Quite a lot of America’s relatively poor record on health benefit per dollar spent is due to inefficiencies built into the health care system. The percentage of total health care expenditures spent on administration and insurance in the U.S. (7.7% in 2006) is almost double that reported in Canada (4.1%), and more than triple the level in Japan (2.3%).<sup>5</sup>

<sup>5</sup> J. Cylus & G. F. Anderson, Multinational Comparisons of Health Systems Data, 2006 (Commonwealth Fund 2007).

The Institute of Medicine, a prestigious research entity, estimated that almost one-third of U.S. health care spending goes to waste on billing and excess administrative costs, duplicative x-rays and other diagnostic tests, and unnecessary or ill-advised procedures.<sup>6</sup> Counting as “waste” the additional procedures needed to repair previous mistakes adds an estimated \$17 billion annually to the inefficiency toll.<sup>7</sup>

Perhaps the most important structural reason contributing to America’s excessive health care costs is that the amount of payment providers receive for their services depends chiefly on quantity, not quality. Since physicians control most health care purchasing decisions, and they are not constrained in most health care settings by cost considerations, incentives for excessive diagnostic procedures are built into the system. These incentives are heightened by the fear of lawsuits – an exaggerated fear, perhaps, since the number of paid malpractice claims has been declining steadily for the past twenty years.<sup>8</sup> Still, professional impulses to do everything possible for the patient, united to considerations of litigation avoidance and financial gain, create intractable upward pressures on expenditures.

A second factor that has driven U.S. health insurance costs higher than costs in nations with universal coverage is our private health insurance companies’ practice of medical underwriting and risk selection. In the absence of rules requiring health insurers to accept all applicants, companies seeking to avoid high-risk customers have devoted considerable resources to investigating and screening applicants’ past health records, a practice that both is costly and results in denials of insurance to those most in need.

In the author’s view, for advanced, specialized treatments at selected hospitals, the U.S. offers health care of a quality second to none. But in terms of providing good health care to the nation as a whole, the U.S. falls far behind other advanced nations, and even behind some much poorer nations. For what Americans pay for their health care, too often they fail to get their money’s worth. And the unceasing growth of health care costs is unsustainable.

### **The brutal politics of health reform**

Barack Obama campaigned for president in 2008 on a platform of health reform. He scored a decisive electoral victory, and the Democrats

<sup>6</sup> BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 83-84 (Mark Smith et al. eds., Institute of Medicine 2012).

<sup>7</sup> Jill Van Den Bos et al., *The \$17.1 Billion Problem: The Annual Cost of Measurable Medical Errors*, 30(4) *Health Affairs* 596 (2011).

<sup>8</sup> Myungho Paik, Bernard Black & David A. Hyman. *The Receding Tide of Medical Malpractice Litigation*. <http://ssrn.com/abstract=2109679> (Feb. 2013).

gained a filibuster-proof 60-vote majority in the Senate<sup>9</sup> and increased their majority in the House of Representatives. In the early months of his presidency, Obama made overtures to congressional Republicans in an effort to reach agreement on the outlines of a bipartisan consensus health reform program. Those hopes vanished during the summer of 2009. Former Republican vice-presidential candidate Sarah Palin characterized the reform proposals as creating government “death panels” to determine whose life is worth saving and whose should be sacrificed to save money. At town hall meetings across the country, “tea party” activists<sup>10</sup> denounced health reform as a government scheme for “socialized medicine.” The health reform debate took on larger overtones symbolic of what some have called a “culture war” between proponents of different visions of America’s future. The criticisms had an effect on public perceptions, as the complex and poorly understood health reform proposals never commanded majority support in opinion polls.

Nevertheless, Democratic majorities in the House and Senate passed differing versions of health reform in the autumn of 2009, opposed by almost all Republicans in the House and all in the Senate. It seemed as though a reconciled bill would soon reach the president’s desk. But Senator Edward Kennedy, a long-time health reform advocate, died in December and in the by-election to select his replacement, to widespread astonishment, Republican Scott Brown won Kennedy’s seat, depriving the Democrats of their 60-vote majority needed to break a filibuster. Hopes for reform dimmed. Nevertheless, deft parliamentary maneuvering employing a “budget reconciliation” procedure enabled the Democrats to bypass the filibuster threat and enact the legislation by a simple majority. President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010.

Controversy did not cease with the law’s enactment. Republicans continued to attack almost every aspect of PPACA, referring to the new programs disparagingly as “Obamacare.” Their particular targets were the “individual mandate” requiring U.S. residents to obtain health insurance from 2014 onward or pay a fine to the Treasury, and the Medicaid program’s expansion to provide insurance for low-income adults.<sup>11</sup> The law’s opponents argued that requiring the purchase of insurance infringed on personal liberty and was beyond Congress’s

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<sup>9</sup> Under Senate rules, opponents of a bill can debate it endlessly, blocking consideration of all other business, unless 60 of the 100 senators vote to cut off debate. The tactic of debating a bill to death is called a “filibuster.”

<sup>10</sup> A loose grass-roots anti-tax coalition with right-wing libertarian leanings, the “Tea Party” movement arose in resistance to the Obama Administration. The movement takes its name from a 1773 incident in which American protesters against colonial British tax imposts dumped tea cargoes into Boston harbor.

<sup>11</sup> The law also provides sliding-scale subsidies to many people with too much income to qualify for Medicaid.

power under the constitution's Commerce Clause.<sup>12</sup> Twenty-six states filed lawsuits in federal courts contending the law was unconstitutional; the lower courts' decisions split. Some states refused federal funding to implement the law's expansion of Medicaid coverage. Health reform was one of the major issues in the 2010 congressional election campaign. Republicans capitalized on the law's public unpopularity, seizing control of the House of Representatives and reducing the Democrats' Senate majority.

PPACA's fate then hung on two events of high significance: the Supreme Court's much-anticipated ruling on the law's constitutionality in July 2012, and the presidential and congressional election in November of that year. In both forums, PPACA won.

The Supreme Court, in *National Federation of Independent Businesses v. Sebelius*,<sup>13</sup> upheld the law's constitutionality by a 5-4 vote. The rationale for the decision was a surprise to many observers. In the arguments before the Court, most attention had focused on whether the Commerce Clause gave Congress authority to impose the "individual mandate" to purchase health insurance. Five justices held that the mandate exceeded the Commerce Clause's allowable scope: "The Framers gave Congress the power to *regulate* commerce, not to *compel* it."<sup>14</sup> But Chief Justice Roberts, writing for the Court, construed the fine imposed on non-purchasers as a "tax" and held that a different source of constitutional authority, the taxing power, legitimated the mandate.<sup>15</sup> In an opinion that seemed mindful of the ongoing political controversy, Roberts also concluded that the proper balance between federal and state power should allow any state to opt out of the law's expansion of the Medicaid health insurance program without suffering a cutoff of existing federal Medicaid funding.<sup>16</sup> In effect, the Court gave a go-ahead for the Obama Administration to proceed with implementation of PPACA, although individual states could choose to deny funding for care to the poor.

The Court's decision could have been overturned by the electorate in the November 2012 elections. However, Obama was re-elected by a substantial majority, defeating Mitt Romney by a margin of 332-206 in electoral votes (Figure 4). Democrats gained two Senate seats and eight

<sup>12</sup> The constitution gives Congress the power "to regulate Commerce . . . among the several States." U.S. Const. Art. I, § 8, clause 3.

<sup>13</sup> 132 S. Ct. 2566 (2012).

<sup>14</sup> 132 S. Ct. at 2589 (emphasis in original).

<sup>15</sup> 132 S. Ct. at 2593-2600. The taxing power is set out in Art. I, § 8, clause 1.

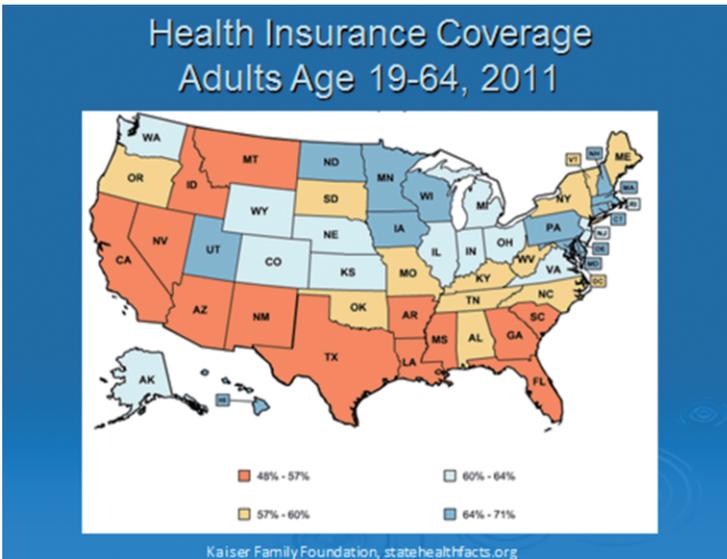
<sup>16</sup> 132 S. Ct. at 2603-08. Requiring states to expand coverage or lose all federal Medicaid funding would constitute federal coercion of the states in violation of the constitution's Spending Clause, which empowers Congress "to pay the Debts and provide for the . . . general Welfare of the United States." Art. I, § 8, clause 1.

House seats, although Republicans retained control of the House. The election cemented “Obamacare” as a key feature of America’s future. Ironically, many of the states that stand to benefit most from PPACA’s expansion of insurance coverage – states with the lowest health insurance rates, mostly located in a swath through the South — supported Romney over Obama. (Compare Figures 4 and 5.)

**Figure 4. Presidential Election Results, 2012, by State**



**Figure 5. Health Insurance Coverage, 2011, by State**



**Key features of PPACA**

PPACA, a complex piece of legislation, aims at improving all three dimensions of the health care system – access, cost, and quality. Among

those three goals, increasing access to care is the law's highest priority. The law's major provisions are briefly summarized below.

Access: Of the roughly 50 million uninsured Americans, slightly more than half will likely receive health insurance coverage when the law is fully implemented, leaving the nation well short of universal coverage. The following provisions are designed to expand access to care:

- The “individual mandate” requires almost all U.S. residents<sup>17</sup> either to obtain health insurance—through employment, public programs such as Medicare, Medicaid, and veterans’ benefits, or by individual or group purchases – or pay a fine.
- The “guaranteed issue” rule bans insurers from refusing coverage based on applicants’ preexisting medical conditions, and from imposing lifetime or annual coverage limits. Nor may health status or gender be the basis for variations in premium prices; only family size, geographic area, age, and tobacco use may serve to stratify premiums.
- Health insurance “exchanges” (i.e., marketplaces) will be established in each state to assist individuals’ and small businesses’ insurance purchases. In the exchanges, private insurance firms will offer standardized plans meeting minimum criteria for adequate coverage, with choices simplified as “bronze,” “silver,” “gold,” and “platinum” depending on desired comprehensiveness and price. All plans must cover designated evidence-based preventive care services with no cost-sharing imposed on the public, and must provide protection from catastrophic medical costs. Consumers can compare and purchase plans online or in person. About half the states will operate their own exchanges, but the rest are refusing to do so; in those states, the exchanges will be operated by the federal government.
- The Medicaid program will be expanded to provide health insurance at minimal cost to people whose household income is less than 138% of the Federal Poverty Level (FPL) -- about \$32,000 yearly for a family of four.
- For those earning too much to qualify for Medicaid, premium subsidies will be available on a sliding scale to people with household incomes up to 400% of the FPL – about \$92,000 for a family of four.
- Adult dependents are covered on their parents’ insurance up to age 26.
- Medium and large employers must provide coverage for their employees, or pay penalties.
- Small employers are not required to provide coverage for employees, but will receive tax credits if they choose to do so.

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<sup>17</sup> Excluded from the individual mandate are native Americans, religious objectors, prisoners, and undocumented aliens.

## Quality and Cost

PPACA's provisions to improve quality and restrain costs center around the two largest federal health insurance programs, Medicare for adults over 65 and Medicaid for the poor and the disabled. The federal programs are so large and so many providers depend on them for payment that federal policies tend to have considerable impact even in the private sector. The most significant of the new law's quality improvement and cost control measures include:

- pay-for-performance programs that reward providers for good health outcomes and penalize them for the contrary, gradually moving away from the pay-for-volume basis prevalent in the past;
- pay-for-reporting programs to gather the data needed for accurate pay-for-performance programs;
- pilot programs to test integrated models of care, such as “medical homes” providing coordinated care for high-need patients and “accountable care organizations” that accept a degree of financial responsibility for health outcomes of patients assigned to them;
- community-based prevention and employee wellness programs;
- bonuses for doctors and other providers for doing primary care;
- calorie labeling requirements for chain restaurants;
- requirements that private insurers limit the percentage of premiums spent on administrative costs rather than medical costs, or else provide rebates to consumers;
- requirements that all payments be made by electronic billing;
- reductions in payments under the Medicare Advantage program; and
- creation of an Independent Payment Advisory Board (IPAB) to recommend specific cost-savings measures for the Medicare and Medicaid programs if cost increases surpass a set level.

As of this writing, action on the latter two measures has stalled. Under pressure from private health insurers and seniors, the Obama Administration scaled back the planned Medicare payment reductions.<sup>18</sup> And the Independent Payment Advisory Board, a target of Republican criticism, has not yet even been constituted.

Costs of the insurance coverage provisions of the health reform law over the eleven-year period 2012-2022 are projected at \$1,168 billion, which is an \$84 billion decrease following the Supreme Court's decision allowing states to opt out of the Medicaid expansion<sup>19</sup> but a

<sup>18</sup> *In Reversal, U.S. to Raise Medicare Advantage Payment Rate*. Reuters, April 2, 2013, available at <http://www.cnbc.com/id/100608355>.

<sup>19</sup> Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 24, 2012), available at <http://www.cbo.gov/publication/43472>.

considerable increase over pre-enactment estimates. These costs are covered by increased taxes and fees, so that the net effect is predicted to be a reduction in the federal budget deficit. The biggest source of additional tax revenues is higher-income taxpayers, who face a 0.9% increase in Medicare withholding and a 3.8% tax increase on unearned income such as investment income, rents, and royalties. The health care sector, which will benefit from tens of millions of new customers, is also subject to new taxes and fees directed at pharmaceutical manufacturers, medical device manufacturers, and health insurers (except for nonprofits covering the poor, elderly, or disabled). Other revenue will be raised from penalties on large and medium firms not offering coverage to their employees, from individuals choosing not to obtain qualified coverage, from tax shelters lacking economic substance, from comprehensive health plans offering upscale service, and from a tax on tanning beds.

### **Implementation issues**

Implementation of the new law has predictably sparked numerous controversies. Implementation involves complex sets of regulations and guidance issued by federal agencies such as the Departments of Health and Human Services, Labor, and the Treasury, as well as policy choices by the fifty states, a majority of which have Republican governors (30) or Republican-controlled legislatures (27) or both. Among the major implementation issues are expansion of the Medicaid program to cover more low-income people; formation of each state's "exchanges" (health insurance marketplaces); cost-control measures such as the establishment of the Independent Payment Advisory Board and the adoption of new payment models; coverage of contraceptives as part of the essential benefits package; and the role of the new Patient-Centered Outcomes Research Institute.

Medicaid Expansion: Expansion of the Medicaid program to cover more low-income adults is perhaps PPACA's most notable measure aimed at creating a more just society. Each state operates its own Medicaid program, under federal guidelines and with federal funding assistance ranging from 50% to 83% of program costs. Heretofore, each state has determined the income level that qualifies residents for Medicaid assistance. Some states, particularly in the south central part of the nation, have set the maximum income level so low that very few non-disabled adults without children qualify<sup>20</sup> — a chief reason for the

<sup>20</sup> For example, in Arkansas a working parent with an income of just one-quarter of the Federal Poverty Level would be too rich to qualify for Medicaid. In Texas, a working parent with an income of just one-third of the FPL would be too rich. See Sara Rosenbaum, *Medicaid and National Health Care Reform*, 361(21) NEW ENGLAND J. MED. 2009, 2010 (2009) (Figure 1). Medicaid does provide coverage for children in families above those income levels, and for blind and disabled adults and children.

tattered nature of America's health care safety net.

PPACA changed that unfair structure, raising the maximum household income for adult Medicaid qualification nationwide to 138% of the Federal Poverty Level and providing 100% federal funding to the states for the expanded coverage through 2017, decreasing to 90% from 2020 on. However, as noted above, the Supreme Court's decision allows each state to decide whether to opt out of the Medicaid expansion. A substantial number of states with Republican governors, legislatures, or both have indicated their intention to do so, either out of ideological opposition to "Obamacare" or for fear that, despite the sizeable federal subsidies, paying for part of the expanded program would overly burden future state finances.<sup>21</sup> One compromise approach initiated by Arkansas, a south central state with a Democratic governor and a Republican legislature, is to proceed with expanded coverage but to use the federal funding to purchase insurance for new recipients from private insurance firms rather than through a publicly run program, thereby quieting some of the ideological opposition to government program expansion.<sup>22</sup>

Health Insurance Exchanges: A second major implementation issue is the creation of insurance exchanges, or markets where individuals and small businesses can shop for health insurance plans. Modeled on Massachusetts's "Connector" program, developed when Mitt Romney was the state's governor, PPACA's exchanges require private insurers' plans to meet the law's standards banning discrimination against residents with pre-existing conditions and assuring that premiums fall within permitted ranges. The law's sponsors originally contemplated that each state or group of states would set up their own exchanges. But as of this writing, 26 states have indicated that they will refuse to do so. In those states, the federal Department of Health and Human Services will operate the exchanges.<sup>23</sup> They are required to be up and running by October 1, 2013, so that people can use them to purchase insurance policies in advance of the individual mandate's effective date of January

<sup>21</sup> Ironically, taxpayers in states refusing to implement the Medicaid expansion (such as Texas) will be subsidizing the expansions in other states (such as Arkansas), through a portion of their federal income taxes.

<sup>22</sup> The Obama Administration granted Arkansas a waiver of the standard rules to permit this initiative. See Sarah Kliff, *Arkansas's Unusual Plan to Expand Medicaid*, WASHINGTON POST, Feb. 28, 2013, available at <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/28/arkansas-different-plan-to-expand-medicaid/>; John Reichard, "Arkansas Solution" May Be Game-Changer for Health Law, *Top Medicaid Lobbyist Says*, WASHINGTON HEALTH POLICY WEEK IN REVIEW, April 5, 2013, available at <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2013/Apr/Apr-8-2013/Arkansas-Solution-Game-Changer-for-Health-Law.aspx?omnicid=16>.

<sup>23</sup> *Federal Government to Run 26 State Exchanges*, INSURANCE J., Feb. 20, 2003, available at <http://www.insurancejournal.com/news/national/2013/02/20/281869.htm>.

1, 2014.

Cost Control Issues: Measures to control the cost of health care remain controversial. Although the rate of increase in the nation's health spending has recently diminished,<sup>24</sup> few doubt that "bending the cost curve downward" should be an important national priority for the foreseeable future. Yet spending restraints inevitably involve the goring of some people's oxen, generating political friction. Among the first to feel a financial sting will likely be younger men. The new law limits how much insurers can charge higher-risk individuals such as the elderly and the sick, and bans rate discrimination against women (who in the past have routinely been charged higher premiums than men for identical coverage in the market for individual insurance<sup>25</sup>). Insurance companies are expected to hedge against diminished revenue streams from groups such as the elderly, the sick, and women by raising premiums for previously advantaged groups such as younger men.<sup>26</sup>

Shifts in premium costs from one group to another, the topic of the paragraph above, merely redistribute the impact of health care cost increases, without doing anything to moderate the increases. An essential strategy for dampening cost inflation is reform of the nation's existing physician payment systems, with their misaligned fee-for-service-based incentives promoting overuse of high-paid diagnostic and therapeutic procedures while giving short shrift to evaluation, prevention, and management services.<sup>27</sup> PPACA takes a few tentative steps in that direction, funding pilot programs and demonstration projects involving pay-for-performance, financial risk sharing by providers, bundled payments, and other alternative delivery and payment mechanisms. These projects are under way at a number of the nation's leading facilities. But the vast majority of health care services are still provided on a fee-for-service basis.

The Independent Payment Advisory Board: PPACA provided for creation of a powerful new entity to restrain health care costs when they exceed a specified increase rate: the bipartisan Independent Payment

<sup>24</sup> Annie Lowrey, *Slower Growth of Health Costs Eases Budget Deficit*, N.Y. TIMES, Feb. 11, 2013 (reporting on recent Congressional Budget Office figures).

<sup>25</sup> National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act 18 (2012)* (Table 1), available at [http://www.nwlc.org/sites/default/files/pdfs/nwlc\\_2012\\_turningtofairness\\_report.pdf](http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf).

<sup>26</sup> See Jeff Mason & David Morgan, *Some Healthcare Costs May Rise When "Obamacare" Implemented: Official*, Reuters newswire, March 28, 2013 (remarks of Health and Human Services Secretary Sebelius), available at <http://www.reuters.com/article/2013/03/28/us-usa-healthcare-sebelius-idUSBRE92R0OR20130328>.

<sup>27</sup> See CHANGING THE WAY PHYSICIANS ARE PAID: REPORT OF THE NATIONAL COMMISSION ON PHYSICIAN PAYMENT REFORM (2013), available at <http://www.physicianpaymentcommission.org/report>.

Advisory Board (IPAB). Empowering the IPAB is a rule-approval procedure designed to insulate cost-cutting decisions somewhat from the tensions of partisan politics driven by interest-group pressures.<sup>28</sup> The new law provides that the IPAB's recommendations for specific health cost savings are to go into effect unless both houses of Congress reject them and replace them with equivalent savings from other sources. Obamacare opponents have painted the IPAB as the likely incarnation of Sarah Palin's "death panel" specter, foisting decisions by unelected bureaucrats on the public in ways undercutting the liberty of doctors and patients. In the face of intense political and rhetorical opposition, as of this writing the Obama Administration has not yet even nominated members of the IPAB, and its statutory functions remain unexercised. Since health care inflation has diminished, however, the absence of an effective IPAB has so far made little practical difference.

Contraceptive Coverage: Contraceptives are among the preventive health services that PPACA regulations require insurance plans to cover without cost sharing. Religious groups such as the Catholic Church, which view the use of some or all contraceptives as sinful, strenuously object to this requirement. The rule as originally promulgated exempted religious employers such as churches from the contraceptive coverage requirement, but it did not exempt other kinds of religion-affiliated organizations such as hospitals, universities, and charities. Many of them have filed lawsuits contesting the rule as a violation of religious freedom. Federal agencies have proposed a revised rule in an attempt to accommodate the religious organizations' concerns,<sup>29</sup> but ultimately this issue must be resolved in the courts.

Comparative Effectiveness Research: As iconic research by Wennberg and colleagues<sup>30</sup> has demonstrated, wide variations in clinical practice exist for treatment of identical conditions. These variations persist in some cases because of the lack of good evidence for the superiority of

<sup>28</sup> The IPAB rule-approval procedure is patterned after the limited-congressional-veto system for implementing proposed military base closures. Plans to shut down bases always provoke opposition in states whose local economies would be adversely affected, and powerful legislators from those states can often block action. To defuse their power, Congress passed a law setting up a commission to recommend a list of base closures. If Congress does not disapprove the list by a short statutory deadline, the closures automatically take effect. See 10 U.S.C. § 2687.

<sup>29</sup> See Tim Jost, Implementing Health Reform: Contraceptive Coverage and Religious Accommodation, Health Affairs Blog, Feb. 2, 2013, available at <http://healthaffairs.org/blog/2013/02/02/implementing-health-reform-contraceptive-coverage-and-religious-accommodation/>. Professor Jost's extensive series of reports on the Health Affairs blog is one of the most valuable resources for details on the implementation of health reform.

<sup>30</sup> E.g., John E. Wennberg & Alan Gittelson, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102 (1973); THE DARTMOUTH ATLAS OF HEALTH CARE, available at <http://www.dartmouthatlas.org/>.

one treatment modality over alternative treatments, and in other cases despite clear evidence that one treatment is preferable. To address the problem of excessive practice variation, health reform advocates proposed creation of a Comparative Effectiveness Research Institute to clarify and publicize evidence about best clinical practices. The proposal generated a storm of controversy due to fears that such an entity would foist cookbook, “one-size-fits-all” medicine on the public; would shut off payments for treatment modalities preferred by doctors and patients but disfavored by cost-conscious bureaucrats; would undervalue the lives of the old, the disabled, and the terminally ill; and would arrive at these decisions through secretive processes.

Responding to such criticisms, PPACA drafters renamed the new entity as the Patient-Centered Outcomes Research Institute, re-cast it as a non-governmental organization, prohibited it from making determinations about insurance coverage, required its proceedings to be conducted with transparency and its research to be made available to the public, and barred the Secretary of Health and Human Services from using the new Institute’s research findings “in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, not disabled, or not terminally ill.”<sup>31</sup> Treatments’ clinical effectiveness is considered a proper subject for the Institute’s research; cost-effectiveness is not.<sup>32</sup> Barred from direct influence on government reimbursement policy, the new Institute must fulfill its more limited mission through the effective production, gathering, and dissemination of research results to the medical profession and the general public.

## Conclusion

America’s 2010 health reform law, the Patient Protection and Affordable Care Act, aimed at expanding access to health care, improving quality, and restraining costs. In 2012 the Supreme Court upheld the law’s constitutionality and the voting public gave the Obama Administration its electoral imprimatur. As the law’s implementation proceeds, it has become clear that the first of these goals – expanded access – will be met to a significant degree. This is Obamacare’s historic accomplishment. Progress on the second goal -- quality improvement – is discernible on the horizon but remains tenuous. Prospects for significant cost control, unfortunately, are speculative at best. Adam Zyglis’s superb cartoon, published in the *Buffalo News* shortly after Obama signed the new law, sums up the situation more clearly than these thousands of

<sup>31</sup> 42 U.S.C. § 1320e-1(c), added by PPACA, Pub. L. No. 11-148 § 6301(c), 124 Stat. 740. This provision is an attack on the concept of “Quality-Adjusted Life Years” frequently employed by health economists.

<sup>32</sup> See Douglas Kamerow, *PCORI: Odd Name, Important Job, Potential Trouble*, 342 BRIT. MED. J. d2635 (2011), available at <http://www.bmj.com/content/342/bmj.d2635?keytype=ref&ijkey=03N7509fzfQfB6p>.

words can possibly do (Figure 6).

**Figure 6. “Obama Slaying the Dragon”<sup>33</sup>**



<sup>33</sup> Adam Zyglis, “Obama Slaying the Dragon” *BUFFALO NEWS*, March 28, 2010, available at <http://editorialcartoonists.com/cartoon/display.cfm/83764/>.