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I. THE PROBLEM

The Patient Protection and Affordable Care Act[1] ("ACA") has, as its primary goal, universal access to health insurance for all American citizens and legal residents. When fully implemented, the ACA will provide insurance to an additional 32 million people who are currently uninsured and to many millions of others who are underinsured. While universal health insurance is certainly a public health goal that this country has sought for many decades, the additional lives that will be added to the insurance rolls as well as new minimum coverage requirements mandated by the ACA will create fiscal burdens for the already expensive U.S. healthcare system. In 2009, Americans spent $2.5 trillion or 17.6 percent of gross domestic product ("GDP") on health care, a number that is predicted to continue to rise absent serious interventions.[2] The ever-escalating costs of health care as well as the anticipated costs of healthcare reform for the additional 32 million Americans who will be required to have health insurance by 2014 may well prove to be a crucial tipping point for an already fiscally overblown healthcare system.[3]

The imperative of cost containment for the entire American healthcare system has been well-documented for quite some time, but recently, spending on federal healthcare programs such as Medicare, Medicaid, and

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1. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified at 42 U.S.C. § 18001) [hereinafter ACA].

2. CTRS. FOR MEDICARE & MEDICAID SERVS, NATIONAL HEALTH EXPENDITURES AGGREGATE T1 (2011), *available at* http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

3. The CBO has estimated that health care reform will cost in excess of $1 trillion over the next decade but eventually reduce the budget deficit because of decreases in the costs of health insurance and other cost saving provisions of the legislation. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 Before the Subcomm. on Health & the H. Comm. on Energy & Commerce*, 112th Cong. 3 (Mar. 30, 2011), (statement of Douglas W. Elmendorf, Director, CBO), *available at* http://permanent.access.gpo.gov/gpo5690/03-30-HealthCareLegislation.pdf.

the Children's Health Insurance Program ("CHIP") has reached a more critical mass.[4] The larger picture is the specter of a growing and unsustainable federal debt. As of July 2011, the federal debt stood at approximately $14.342 trillion.[5] The unprecedented and continuing growth of the federal debt is currently the subject matter of a number of blue-ribbon commissions. One such commission, the bipartisan National Commission on Fiscal Responsibility and Reform ("Bipartisan Commission"), created by President Barack Obama by Executive Order,[6] is co-chaired by Erskine Bowles and former Senator Alan Simpson.[7] The Commission's concern is with the rise in federal debt held by the public over the last decade from 33 to 62 percent of GDP,[8] an increase driven by two wars, a number of fiscally irresponsible policies and a deep economic downturn all of which have contributed to a decade of deficit spending by Congress.[9] In addition to the Bipartisan Commission's efforts, there are a number of other deficit-reduction packages including one drafted by the Debt Reduction Task Force launched by the Bipartisan Policy Center in an effort to find a bipartisan solution to reduce the debt and place the United States on a sustainable

4. In 2009, the cost to the U.S. taxpayer of the three major public health insurance programs – Medicare, Medicaid, and CHIP – was $732 billion, which accounted for 21 pecent of total federal spending. Because they are entitlement programs, Medicare and Medicaid must cover all eligible beneficiaries. CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: WHERE DO OUR FUTURE TAX DOLLARS GO? 1 (2011), *available at* http://www.cbpp.org/files/4-14-08tax.pdf.

5. FINANCIAL MANAGEMENT SERVICE, DAILY TREASURY STATEMENT: FRIDAY, JULY 29, 2011 TIII-C (2011), *available at* https://www.fms.treas.gov/fmsweb/viewDTSFiles?dir=w&fname=11072900.pdf. The federal debt is comprised of approximately $9.6 trillion in public debt and $4.6 trillion in intragovernmental debt. The federal debt increases each fiscal year that the government cannot balance its budget, i.e. when expenses exceed revenue. This deficit forces the government to borrow money which adds to the federal debt. The federal government's borrowing may not exceed the federal debt ceiling which currently has been set by Congress at $14.3 trillion. Francis Symes, *Congress Q&A: Debt Ceiling*, CONGRESS.ORG, Apr. 25, 2011, http://origin-www.congress.org/news/2011/04 /25/ congress_qa_ debt_ceiling.

6. Exec. Order No. 13,531, 75 Fed. Reg. 7927 (Feb. 18, 2010).

7. FiscalCommission.gov, About the National Commission on Fiscal Responsibility and Reform (2011), http://www.fiscalcommission.gov/about.

8. NAT'L COMM'N ON FISCAL RESPONSIBILITY & REFORM, THE MOMENT OF TRUTH 10 (2010), *available at* http://www.fiscalcommission.gov /sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf. (The report was supported by 11 of its 18 members but did not win the supermajority of 14 needed to send the report to Congress for a vote). In 2010, U.S. gross domestic product, the total of goods and services produced in the U.S., equaled $14.6 trillion while federal debt held by the public equaled 62 percent of GDP. JONATHAN HUNTLEY, CBO, FEDERAL DEBT AND THE RISK OF A FISCAL CRISIS 1 (2010), *available at* http://permanent.access.gpo.gov/lps124972/07-27_Debt_FiscalCrisis_Brief.pdf; Cent. Intelligence Agency, The World Factbook: United States Economy (Jul. 12, 2011), https://www.cia.gov/library/publications/the-world-factbook/geos/us.html.

9. NAT'L COMM'N ON FISCAL RESPONSIBILITY & REFORM, *supra* note 8, at 10.

fiscal path,[10] as well as over one hundred suggestions for deficit reductions made by the Congressional Budget Office ("CBO"). Many of the suggestions from the various reports target the shaky sustainability of federal healthcare programs given the rising costs.

The CBO has projected that, without changes in spending, deficits will continue to rise and contribute to the growth of the federal debt, which by 2020 will have reached 90 percent of GDP.[11] By 2025, the CBO has projected that federal revenue will be able to finance only interest payments on Medicare, Medicaid, and Social Security with expenses from all other sectors financed with borrowed money.[12] The CBO, in an economic and budget issue brief, has described the effects of the continued growth in debt thusly:

> A growing portion of people's savings would go to purchase government debt rather than toward investments in productive capital goods . . . ; that "crowding out" of investment would lead to lower output and incomes . . . Moreover, rising debt would increasingly restrict the ability of policy-makers to use fiscal policy to respond to unexpected [economic] challenges . . . Beyond those gradual consequences, a growing level of federal debt would also increase the probability of sudden fiscal crisis, during which investors would lose confidence in the government's ability to manage its budget, and the government would thereby lose its ability to borrow at affordable rates. . . . [A]s other countries' experiences show, it is . . . possible that investors would lose confidence . . . and interest rates on government debt would rise sharply. The exact point at which such a crisis might occur for the United State is unknown. . . . [but] [w]hen fiscal crises do occur, they often happen during an economic downturn, which amplifies the difficulties of adjusting fiscal policy in response.[13]

The growing fiscal crisis in Greece is being hailed as a foretelling of what might happen in other debt-heavy countries, including the U.S. that cannot or will not solve their debt crises.[14] The immediate fear is that

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10. This commission, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici, released its report RESTORING AMERICA'S FUTURE on November 17, 2010. The Bipartisan Policy Center was founded by former Senate Majority Leaders Howard Baker (R-TN), Tom Daschle (D-SD), Bob Dole (R-KS), and George Mitchell (D-ME). *See generally* BIPARTISAN POLICY CTR., RESTORING AMERICA'S FUTURE (2010), http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf.

11. HUNTLEY, *supra* note 8, at 3.

12. BIPARTISAN POLICY CTR., *supra* note 10, at 12.

13. HUNTLEY, *supra* note 8, at 1.

14. A debt-heavy country is one where the percentage of federal debt to gross domestic product is high. Since both factors – growth of public debt relative to growth of GDP – are important in calculating debt weight, both persistent deficit spending and low levels of

Greece will default on its loans unless the more solvent EU countries led by Germany and France agree to subsidization that will allow Greece to regain some level of solvency. While the International Monetary Fund and the global finance world certainly fear the consequences of Greece's economic position, they are more fearful that a default in Greece will infect other debt-ridden countries such as Portugal and Ireland and even countries such as Spain and Italy leading to another global financial crisis. While the United States seems a long way from a similar scenario, it is certainly not unimaginable at the rate that debt is increasing relative to GDP.[15]

Although it is tempting to postpone drastic fixes to the budget because of the economic anomalies of 2009 and 2010 that are unlikely to recur, demands on the public fisc will inevitably continue to increase public spending. These demands are more likely to occur in the public healthcare sector, which continues to see costs unrelated to healthcare reform rising faster than in other public programs such as Social Security, where spending is more predictable.[16] The Centers for Medicare and Medicaid Services ("CMS") projects that health care expenditures will rise from $2.6 trillion in 2010 to $4.3 trillion by 2019.[17]

To further compound the effects of rising healthcare costs, the annual rate of growth of total health care and Medicare costs has been roughly 2.5 percentage points above the rate of GDP growth over each of the last several decades.[18] If this trend continues, an additional four percentage points of GDP will shift to Medicare over the next 15 years.[19] Professor Joseph Newhouse convincingly makes the case that, given the lack of appetite of the American electorate for a greater than 18 percent GDP allocation to federal spending, the irresistible force of healthcare cost growth will inevitably meet the immovable object of finite federal

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growth are important in the calculation. Some countries have lower debt weight because they engage in less deficit spending while others control their debt through more robust economies. AMY MEDEARIS & OGNIAN N. HISHOW, STIFTUNG WISSENSCHAFT UND POLITIK, NARROWING THE SUSTAINABILITY GAP OF EU AND US HEALTH CARE SPENDING 1 (2010), *available at* http://www.swp-berlin.org/fileadmin/contents/products/arbeitspapiere/Health Debt_EU_USA_formatiert_neu_KS.pdf.

15. The Congressional Budget Office has predicted that, absent change, U.S. debt level will grow from its current 62 percent of GDP to 90 percent of GDP by 2020. HUNTLEY, *supra* note 8, at 2-3.

16. Jonathan Cohn, *Rick Foster and the Real Costs of Health Care Reform*, NEW REPUBLIC, (Feb. 7, 2011, 12:00 AM), http://www.tnr.com/blog/jonathan-cohn/82885/rick-foster-costs-health-care-reform.

17. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES PROJECTIONS 2010-2020 T1 (2011),
available at https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

18. Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans,* 29 HEALTH AFF. 1719, 1719 (2010).

19. *Id.*

revenue.[20] Maybe the federal healthcare cost overrun will be offset in other sectors or maybe it will be financed by additional taxes. More likely, Newhouse says, reductions in the rate of Medicare spending growth will have to be made.[21]

Recent legislative and non-legislative activities have been posited to consider the effects of earlier interventions into the problems of mounting federal debt. In April, 2011, House Republicans proposed "bending Medicare's cost curve" by transforming Medicare from a health insurance program for the elderly and disabled to a premium support system.[22] The changes envisioned by the GOP would achieve a federal budget surplus by 2040 by making substantial budget reductions to Medicare, Medicaid, the CHIP and the Health Insurance Exchange subsidies.

The various deficit commissions also envision policies to intervene before the inevitable Newhouse collision occurs. For example, the Bipartisan Commission's plan for a deficit reduction of almost $4 trillion through 2020 includes significant changes to a number of areas of high spending including a wholesale revision of the tax code as well as significant changes to Social Security and health policy. With regard to health care costs, the Commission report states:

> Federal health care spending represents our single largest fiscal challenge over the long-run. As the baby boomers retire and overall health care costs continue to grow faster than the economy, federal health spending threatens to balloon. Under its extended-baseline scenario, CBO projects that federal health care spending for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health insurance exchange subsidies will grow from nearly 6 percent of GDP in 2010 to about 10 percent in 2035, and continue to grow thereafter.[23]

Recognizing the crisis is one thing; implementing effective and fair changes to a very entrenched system is another. The Bipartisan Commission report sets out a series of recommendations to cut federal healthcare costs in both the near and medium terms including substituting for the current Medicare fee-for-service payment formula with costs controlled by the sustainable growth rate, "an improved physician payment formula that encourages care coordination across multiple providers and settings and pays doctors based on quality instead of quantity of services."[24] This shift

20. *Id.*

21. *Id.* at 1721.

22. *See generally* PAUL RYAN, H. COMM. ON THE BUDGET, 112TH CONG., THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE (2011), *available at* http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf.

23. NAT'L COMM'N ON FISCAL RESPONSIBILITY & REFORM, *supra* note 8, at 36.

24. *Id.* at 37.

from a fee-for-service reimbursement regime that demonstrably incentivizes volume to a system that encourages care coordination and pays providers based on quality rather than quantity of care is also the crux of Medicare reimbursement reform in the ACA. The so-called accountable care organization model ("ACO") of physician reimbursement found in the ACA has resulted in large health systems scrambling to design models for care and reimbursement that the government will reward under the new healthcare legislation. In the midst of cultural upheaval, the question remains whether providers, whose practice culture and income will no doubt be subject to a number of unwanted changes, will accommodate to make this new universal healthcare system sustainable by considering the cost of care in making decisions for their patients.

To the extent that changes in delivery and reimbursement policy articulated by healthcare reform legislation and the recent report of the National Commission on Fiscal Responsibility and Reform have the effect of taming overuse and containing costs, they must be pursued vigorously. Moreover, a crucial component of the solution to the inexorable increase in healthcare costs must also include efforts to change the culture of health care from one of mindless overutilization to one of mindful and appropriate utilization. This paradigm shift requires the active participation of all sectors – government, patients, providers, insurers, and drug and device manufacturers. Without such a cultural change, the "tragedy of the commons" prophecy of Garrett Hardin and Howard Hiatt is inevitable: "[r]uin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons."[25]

Having advocated changes in how health care should be appropriated, we must be mindful not to let the federal debt tail wag the health policy dog. Currently the driver of healthcare cost containment is both the fear and reality of excessive federal debt attributable in no small measure to rising healthcare costs. But rising healthcare costs account not only for the higher costs of public payers, but also rising costs in the commercial insurance arena. Targeting only public programs such as Medicare and Medicaid for cost containment could put at risk beneficiaries who are the most vulnerable: the elderly, the disabled, the poor, and the young, leaving intact richer coverage for the remainder of the American population. This consequence, although unintended, might well be the result of a rush to solve a debt crisis that has been accruing for some time. While bending the

25. In 1975, Howard H. Hiatt, a physician, wrote an article for *the New England Journal of Medicine* analogizing available medical resources to Garrett Hardin's tragedy of the commons. Dr. Hiatt analogized total medical resources to the grazing area arguing that individual and population health were locked in competition for these limited resources. Howard H. Hiatt, *Protecting the Medical Commons: Who is Responsible?,* 293 NEW ENG. J. MED. 235 (Jul. 31, 1975).

healthcare cost curve is an imperative to financial sustainability, its applicability must be universal not only to ensure a fair and equitable distribution of healthcare resources but also because focusing cost containment on only public programs has distorting consequences.

II. THE MYTH OF BIPARTISAN POLITICS AS TOLD BY LEGISLATIVE EFFORTS TO TAME HEALTH CARE COSTS

In November, 2010, the Republicans won a majority of seats in the House of Representatives.[26] With an additional forty-eight votes,[27] the Republicans have a clear majority in the House and have been able to advance their political agenda without too much interference.[28] Although the Democrats still have a majority of votes in the Senate (fifty-one Democrats, forty-seven Republicans, and two Independents who caucus with the Democrats), their majority consists of moderate Democrats who, on occasion, can be persuaded to vote with the Republicans. The political reality of a strong House Republican majority and a weaker Senate Democratic majority, in combination with an ever-more conservative Washington political agenda, makes the possibility of true and thoughtful bipartisan solutions to legitimately important issues like debt reduction seem almost impossible. The recent budget deal between Republicans and Democrats and the administration to fund the federal government for the remainder of the fiscal year in exchange for $38 billion in budget cuts demonstrates that the very conservative wing of the Republican majority in the House knows that in a game of fiscal chicken, the President and Democrats are likely to blink first.[29]

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26. The Republicans have 240 seats in the House of Representatives; the Democrats have 192 seats; there are 3 vacancies. Office of the Clerk of the U.S. House of Representatives (2011), http://clerk.house.gov/index.aspx

27. *Id.*

28. Although, as the above note indicates, the House Republicans have been able to successfully make demands on Democrats and the administration, there seems to be a limit to the ability of their majority to unilaterally govern policy decisions. For example, Paul Ryan (R-WI), chair of the House budget committee, recently proposed the so-called "Path to Prosperity" budget, which seeks to not only slash entitlement spending but also change the fundamental structure of Medicare, was defeated by the Senate in a vote joined by five Republican senators. This vote took place one day after a Democratic victory in a special election to replace an outgoing Republican representative in the traditionally Republican 26th Congressional district, a defeat where proposed changes to Medicare were the key issue. Felicia Sonmez, *Senate Rejects GOP Budget Plan that would Overhaul Medicare*, WASH. POST: POST POLITICS (May 25, 2010, 5:58 AM), http://www.washingtonpost.com/blogs/2chambers/post/on-heels-of-republican-special-election-defeat-senate-rejects-gop-budget-plan-that-would-overhaul-medicare/2011/05/AGacUTBH_blog.html.

29. *See* Jennifer Steinhauer, *Cantor Says House Won't Raise Debt Limit 'Without Serious Cuts,'* N.Y. TIMES: THE CAUCUS, (Jan. 18, 2011, 4:12 PM), http://thecaucus.blogs.nytimes.com/2011/01/18/cantor-says-house-wont-raise-debt-limit-

With respect to the next hurdle – raising the debt ceiling above its current $14.25 trillion cap so that Congress can pay its obligations and honor the full faith and credit of the United States – Republican leaders such as Paul Ryan, the chair of the House Budget Committee, and Eric Cantor, House Majority Leader, have threatened to vote against raising the debt ceiling unless the Democrats and the administration agree to long-term spending cuts calculated at $6 trillion in the next decade.[30] The majority of these cuts would be to popular entitlement programs such as Social Security, Medicare and Medicaid. If Republicans, as they have threatened to do, hold the federal debt hostage to their policy goals, the chance that these programs which provide health insurance for many vulnerable populations will be threatened is great.

While there is arguably unanimity about the need to control healthcare costs, there is substantial disagreement about how to most fairly and equitably accomplish this task. Rising healthcare costs pose an economic threat in all sectors, not just the public sector.[31] The conundrum of health care costs is illustrated by this year's seven percent plus rise in costs to $19,393 for a family of four covered by a preferred provider organization in an otherwise almost zero inflation economy.[32] The Milliman Medical Index ("MMI") reports that in 2002, American families had healthcare costs of $9,235, and those costs have now doubled in fewer than nine years.[33] Although the MMI tracks health care costs in the private sector, the same factors that drive costs in the private sector should be at play in the public sector as well.

According to Robert Pear, the health care analyst for the *New York Times*, there is not agreement about what drives costs. While Republicans continue to insist that it is federal health insurance reform – the ACA – the insurance industry argues that premiums are going up because of the underlying cost of care and a growing demand for it.[34] This, of course, comports with the MMI finding that healthcare costs for Americans in the private sector have doubled in less than nine years, a factor which accounts for extreme rises in private health insurance premium costs.[35]

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without-serious-cuts/.

30. Jackie Calmes, *Obama to Call for Broad Plan to Reduce Debt*, N.Y. TIMES, April 10, 2011, at A1.

31. *See* Robert Pear, *As Health Care Costs Soar, G.O.P and Insurers Differ on Cause*, N.Y TIMES, March 4, 2011, at A13.

32. MILLIMAN, 2011 MILLIMAN MEDICAL INDEX 1 (May 2011), *available at* http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2011.pdf.

33. *Id.*

34. Pear, *supra* note 31.

35. Press Release, Milliman, Milliman Medical Index Indicates Healthcare Costs for Typical American Family of Four Have Doubled in Fewer Than Nine Years (May 11, 2011),

In the private sector, the burden of the rising costs of health care falls on employers and employees since the majority of health insurance for the under-65 population is employment-based. In the public sector – Medicare, for example – the government has been shouldering the lion's share of the burden of healthcare costs rather than shifting the rising cost of care to Medicare beneficiaries. The result of such a policy is the burgeoning Medicare budget and its effect on the federal deficit and ultimately the federal debt.[36] The problem is quite clear and undisputed: healthcare costs are rising at a level that is simply unsustainable both in the private sector where employers and employees are being punished, and in the public sector where the taxpayers are being punished. The Republican budget proposal seeks to solve the federal problem by using the "policy" of the private market, i.e. shifting the burden of the rising costs of care from the federal government to Medicare beneficiaries. It is a key provision of the "Path to Prosperity," the Republican budget blueprint introduced by Representative Paul Ryan, chair of the House Budget Committee, on April 5, 2011.[37]

The "Path to Prosperity" proposal is "projected to achieve a federal budget surplus by 2040, and would substantially reduce federal spending on major health programs, including Medicare, Medicaid," CHIP, and health exchange subsidies by 2022.[38] Since Medicare alone currently accounts for approximately 15 percent of federal spending, it is most clearly in the crosshairs of the Republicans' budget reduction strategies.[39] The Republicans' budget proposal seeks to fundamentally change the structure of Medicare from a universal social insurance system where the cost of the insurance is, for the most part, delinked from the beneficiaries' ability to pay, to a premium support system. Starting in 2022, all newly-eligible Medicare beneficiaries would have access to health insurance through private insurance plans rather than through the current government-run Medicare program. Under this privatized Medicare, the federal government would provide beneficiaries a subsidy toward the purchase of a private health insurance plan through the states' Health Insurance Exchange. Any costs in excess of the premium support would be the responsibility of the

http://www.prnewswire.com/news-releases/milliman-medical-index-indicates-healthcare-costs-for-typical-american-family-of-four-have-doubled-in-fewer-than-nine-years-121627963.html.

36. In 2010, Medicare cost the federal government $452 billion out of a federal budget of approximately $3.5 trillion. CTR. ON BUDGET & POLICY PRIORITIES, supra note 4, at 1.

37. *See generally* RYAN, *supra* note 22.

38. KAISER FAMILY FOUND. PROGRAM ON MEDICARE POLICY, PROPOSED CHANGES TO MEDICARE IN THE "PATH TO PROSPERITY" 1 (2011), http://www.kff.org/medicare/upload/8179.pdf [hereinafter PROPOSED CHANGES TO MEDICARE IN THE "PATH TO PROSPERITY"].

39. *See* CTR. ON BUDGET & POLICY PRIORITIES, *supra* note 4, at 1.

beneficiary.

While a change from insurance to premium support benefits the taxpayer by essentially capping the government's liability for Medicare, it does nothing to reduce total Medicare spending. It simply shifts the variable and rising costs of Medicare from the general taxpayer more specifically to Medicare beneficiaries. Unless other measures are taken to reduce healthcare costs, they will continue to rise both in the private and public sectors with the obligation falling on whichever party is burdened with them. Individuals in the private sector have felt the burden of higher costs of health care as employers who are spending ever higher amounts on employment benefits continue to shift premium costs to employees.[40] The Republican budget proposes the same kind of cost shift to Medicare beneficiaries resulting in costs to Medicare beneficiaries that are more than two times the current costs.[41] In 2010, the median income for seniors on Medicare was $26,780 (ages 65 to 74), $20,926 (ages 75 to 84), and $17,237 (ages 85 or older),[42] well above the 2011 federal poverty guidelines.[43] Even assuming that median income, including social security income, will grow in the next decade, seniors in the 75 percent income quartile will have a difficult time paying the out-of-pocket Medicare costs of $12,500 projected by the CBO.[44]

The Republicans' proposal regarding Medicare addresses only one issue, albeit a very important one: solutions to the problem of federal over-spending. It does not deal with the more fundamental underlying issue of healthcare cost containment, not only in Medicare, but in all sectors of health care. Democrats seem to believe that the best way to cut the costs of Medicare is to contain healthcare costs more generally and, to that end, several cost containment provisions are included in the ACA.[45] It remains

40. Kate Pickert, *Employer-Based Insurance: Paying More, Getting Less*, TIME, Oct. 26, 2009, *available at* http://www.time.com/time/nation/article/0,8599,1932184,00.html.

41. The CBO estimates that average out-of-pocket costs for the typical 65-year old in a private plan in 2022 will be $20,500. PROPOSED CHANGES TO MEDICARE IN THE "PATH TO PROSPERITY", *supra* note 38, at 3-4.

42. KAISER FAMILY FOUND. PROGRAM ON MEDICARE POLICY, PROJECTING INCOME AND ASSETS: WHAT MIGHT THE FUTURE HOLD FOR THE NEXT GENERATION OF MEDICARE BENEFICIARIES? 1 (2011), *available at* http://www.kff.org/medicare/upload/8172-2.pdf [hereinafter PROJECTING INCOME AND ASSETS].

43. FPL for a single person family is $10,830; 150 percent of FPL is $16,245. For Medicare beneficiaries whose income falls below 150 percent of FPL, the federal government will provide premium assistance. CHILDREN'S DEF. FUND MINNESOTA, 2010-2011 FEDERAL POVERTY GUIDELINES & STATE MEDIAN INCOME (2011), http://mn.bridgetobenefits.org/sites/6a96db77-77ff-4db8-a8e9-e42dff2af30e/uploads/2010-2011_Federal_Povery_Guidelines___State_Median_Income.pdf.

44. *See* PROPOSED CHANGES TO MEDICARE IN THE "PATH TO PROSPERITY," *supra* note 38, at 41.

45. These initiatives include reforms to the delivery system, i.e. delivering health care in

to be seen whether these initiatives can be implemented on a large scale, and whether they will manage to contain costs and slow the growth of all health care including the cost to the federal government. The majority of the solutions contained in the ACA avoid confronting the difficult issues of overtreatment and mistreatment and focus instead on delivery system and payment reform as well as expanding the availability of information to aid providers in making effective and more efficient healthcare decisions.[46] The National Commission on Fiscal Responsibility and Reform, which looks to reforming only federal healthcare spending, makes a number of recommendations to cut costs similar to many of the ACA recommendations including, the establishment of a long-term global budget for total healthcare spending limiting growth to one percent of GDP or less.[47]

III. THE VULNERABILITY OF PUBLIC HEALTH INSURANCE PROGRAMS TO COST CONTAINMENT INITIATIVES

As described in detail above, federal health insurance programs such as Medicare, Medicaid, and CHIP are particularly vulnerable to cuts in spending because higher healthcare costs are the primary driver of long-term federal deficits.[48] So, although cost containment is and should be a priority for health care in all sectors, it is particularly imminent in the public sector, so imminent, in fact, that Republicans have made the change in Medicare from an insurance program to a premium support system the centerpiece of its "Path to Prosperity" budget proposal.[49] While this shift would mean a radical change to Medicare that does not really solve the problem of the continuing rise in Medicare costs, postponing changes to entitlement programs is not really a solution either and leaves Medicare vulnerable to similar assaults from the right and eventually as a necessity regardless of political affiliation.[50] The right answer is continuing efforts to bend the healthcare cost curve across all sectors in order to make health

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a coordinated, accountable manner; case management, i.e. focusing on the small percentage of patients who consume the vast majority of the health care; changes to the reimbursement system, particularly the Medicare reimbursement system that incentivizes volume rather than outcome; focus on information technology including electronic health records as well as information about what treatment modalities are most effective (comparative effectiveness data); focus on prevention in order to prevent disease rather than treat disease. *See* ACA, *supra* note 1.

46. The ACA authorizes the establishment of an Independent Payment Advisory Board with the authority to make payment and cost control decisions.

47. NAT'L COMM'N ON FISCAL RESPONSIBILITY & REFORM, *supra* note 8.

48. *Id.*

49. While this change has been suggested by others like The National Commission on Fiscal Responsibility and Reform, it is usually a last resort solution. *Id.*

50. *See* BIPARTISAN POLICY CTR., *supra* note 10.

care a sustainable asset not only for today's users but for future generations as well.[51] The six hundred and forty billion dollar question is whether the various reforms that have been proposed in the ACA can be put into effect, and if they will be effective in solving the problems of unsustainable costs.

To a large extent, the delivery and reimbursement reforms of the ACA are directed toward cutting the costs of Medicare by creating reimbursement policies that incent outcome and disincent volume. The cost plus profit reimbursement scheme that characterizes Medicare is substantially different from the risk schemes of managed care that have characterized the majority of reimbursement in the commercial health insurance sector.[52] Medicare is required by law to pay providers rates of reimbursement for all services that it considers "reasonable and necessary" regardless of effectiveness[53] and linked only to the underlying cost of providing such services.[54] Notwithstanding that Medicare reimbursement rates are lower than commercial rates, Medicare providers are incented to continue providing services to Medicare beneficiaries because of the volume of services that Medicare is required to pay for.[55]

While the ACA recognizes that reimbursing volume is a driver of costs in Medicare and has incorporated some "fixes" for the volume problem, it contains little if any tools to combat the price problem particularly in the commercial market. However, it is generally understood that prices are one of the primary drivers of cost in health care particularly in the commercial health insurance market where payers are often out-negotiated by providers with regard to the price of services and with little evidence that such services are comparatively effective much less cost-effective.[56] Although Medicare reimbursement rates are the result of administrative pricing by CMS, Medicare administrative pricing is set to compensate providers at a cost plus profit rate. Even if profits are regulated rather than a function of the private market, the cost of providing ever-increasingly expensive care

51. Hiatt, *supra* note 25.

52. Notwithstanding the volume of managed care in the health insurance market, Dr. Joseph White of Case Western Reserve University does not believe that it is responsible for holding down the cost of care in the commercial market. *See* Joseph White, Cost Control and Health Care Reform: The Case for All-Payer Regulation (May 12, 2009), http://www.ourfuture.org/files/JWhiteAllPayerCostControl.pdf.

53. Steven D. Pearson & Peter B. Bach, *How Medicare Could Use Comparative Effectiveness Research in Deciding on New Coverage and Reimbursement,* 29 HEATH AFF. 1796, 1796 (2010).

54. *Id.*

55. Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER, June 1, 2009, *available at* http://www.newyorker.com/reporting /2009/06/01/090601fa_fact_gawande.

56. Alan M. Garber & Harold C. Sox, *The Role of Costs in Comparative Effectiveness Research,* 29 HEALTH AFF. 1805 (2010).

will continue to cause healthcare costs to rise, not only in the commercial sector, but also in the public sector increasing federal and state government spending.

How do other countries keep their health care costs in check? While not all countries ration by analyzing how much value specific services buy,[57] all countries control what is paid for those services through either a single-payer system or by negotiating standard fees with all providers.[58] In addition, the effect of high prices extends beyond the price per service. For example, excessive payment rates generate excessive supplies of some equipment and therefore inefficient use: "[w]ith prices very high, outpatient facilities in the United States can earn a profit despite underutilizing capacity."[59] The Medicare Payment Advisory Commission, charged with the responsibility of pricing various Medicare services, has argued that high prices can result in increased volume of services because of provider-induced demand for such services.[60]

In the U.S., rates paid to providers by private payers depend on the relative economic strength of the payer and the provider.[61] As chair of Gov. John Corzine's New Jersey Commission on Rationalizing Health Care Resources, Princeton health economist Uwe Reinhardt had the opportunity to compare data on how much insurers paid providers for providing the same service to patients. The variation was palpable and proved, at least to Professor Reinhardt, that the private market provided little rationality for the actual costs of the procedure. Medicare has always had huge economic leverage because it accounts for such a significant portion of national health expenditures.[62] As a result, Medicare always sets the price of services while, in the commercial market, the relative bargaining powers of the

57. It seems clear that Americans have little or no appetite for rationing by cost; indeed, the fear that services will be taken away from consumers is great, particularly among Medicare beneficiaries. *Id.*

58. JOSEPH WHITE, COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE 197 (1995).

59. PAUL B. GINSBURG, ROBERT WOOD JOHNSON FOUNDATION, HIGH AND RISING HEALTH CARE COSTS: DEMYSTIFYING U.S. HEALTH CARE SPENDING 10 (2008), *available at* http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf.

60. *Report to the Congress: Medicare Payment Policy Before the Subcomm. On Health and the H. Comm. On Ways and Means*, 111th Cong. 9 (2009) (statement of Glenn M. Hackbarth, J.D., Chairman, Medical Advisory Commission), *available at* http://www.medpac.gov/documents/Mar09_March%20report%20testimony_WM%20FINAL.pdf.

61. Uwe E. Reinhardt, *A Modest Proposal on Payment Reform,* HEALTH AFF. BLOG (Jul. 24, 2009, 8:50 AM), http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/.

62. In 2009, Medicare accounted for 20 percent of national health expenditures of $2.5 trillion. *See* CTRS. FOR MEDICARE & MEDICAID SERS., NATIONAL HEALTH EXPENDITURES FACT SHEET T3 (2011), *available at* https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

parties determines price.[63] The hospital industry has always subsidized losses from Medicare and Medicaid by demanding higher rates from commercial insurers. In 2008, the hospital industry's aggregate payment-to-cost ratio from Medicare was 90.9 percent, from Medicaid 88.7 percent, and from commercial payers, 128.3 percent.[64]

However, because of changes in payer mix in the next five years – more Medicare and Medicaid patients relative to private-pay patients – cross-subsidization as a solution to negative margins will become less feasible forcing hospitals to confront negative margins with alternative solutions.[65] One possibility is that hospitals will stop admitting Medicare and Medicaid patients, a solution that seems nigh unto impossible. A second possibility is that hospitals will have to become more efficient. A recent report from Milliman demonstrates that efficiencies are possible and that cost-shifting is not necessarily destiny.[66] The National Business Group on Health conducted hospital cost-shifting analysis that identified sixteen cities where, although there was little or no sign of cost shifting for inpatient care, hospitals in those cities had high hospital value – defined as delivering low per capita inpatient cost to both Medicare and commercial insurers – and positive hospital margins as well.[67] Although the study did not test for the efficiency hypothesis, the authors suggest that although high value hospitals may be cost-shifting in some other way – outpatient treatment, for example – the data support another hypothesis: that hospitals in some cities are managed in such a way that they prosper despite current Medicare inpatient payments and without charging disproportionately higher amounts to commercial payers.[68]

Providers and particularly hospitals face additional reimbursement challenges. Since the payer mix projections depend on reliable data – aging demographics and an increase in Medicaid enrollment due to the ACA – providers may begin to lose their bargaining leverage with commercial

63. " . . . Medicare spending per enrollee has risen, on average, by about one percentage point less per year than has private insurance spending over the period from 1970 to 2006. . . . Medicare certainly has not achieved this by reducing volume or managing care; it has relied mainly on paying lower prices per service, which is possible because few providers can afford to opt out of such a large plan. . . . " White, *supra* note 53, at 9.

64. NATHAN S. KAUFMAN, KAUFMAN STRATEGIC ADVISORS, LLC, CHANGING ECONOMICS IN AN ERA OF HEALTHCARE REFORM 9 (2010), *available at* http://www.kaufmansa.com/pdf/publication.pdf.

65. DOUG PROEBSTING, WHY HOSPITAL COST SHIFTING IS NO LONGER A VIABLE STRATEGY 1 (2010), *available at* http://publications.milliman.com/publications /healthreform/pdfs/why-hospital-cost-shifting.pdf.

66. *Id.*

67. BRUCE PYENSON ET. AL., HIGH VALUE FOR HOSPITAL CARE: HIGH VALUE FOR ALL 1-2 (2010), *available at* http://publications.milliman.com/research/health-rr/pdfs/high-value-hospital-care.pdf.

68. *See generally id.*

payers resulting in lower and less variable reimbursement rates. The inability to continue to subsidize lower public reimbursement rates with higher commercial insurance rates means that hospitals must seriously explore alternative methods of controlling costs or face ever-growing negative margins and possibly financial default particularly in situations where facilities are underused.

Whether providers, particularly providers who are economically advantaged by price discrimination, will agree to all-payer rates may be a hard sell notwithstanding the data about the upcoming changes in patient mix. However, there is substantial evidence that discriminatory pricing of health care results in substantially higher costs, even to providers who benefit from it, because of the administrative expense of having to negotiate those price-discriminatory prices with every provider every year.[69] According to Michael E. Porter and Elizabeth Olmstead Teisberg:

> [t]he administrative complexity of dealing with multiple prices adds cost with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts. The lesson is simple: skewed incentives motivate activities that push costs higher. All these incentives and distortions reinforce zero-sum competition and work against value creation.[70]

Since Medicare is a single-payer system, it already pays uniform rates to all providers for the same service, rates which are generally lower than commercial rates.[71] Professor Joseph Newhouse has posited that if none of the potential fixes for Medicare's cost growth is successful in curbing Medicare spending, it will fall inevitably because the irresistible force – the inexorable rise in Medicare spending – will finally meet an immovable object – the American voters' historic disinclination to allocate more than eighteen percent of GDP to government spending.[72] Assuming that other solutions to a deficit budget such as borrowing or increasing taxes are not in play, the rising Medicare spending will be forced to slow down. "One way

69. Reinhardt, *supra* note 61.

70. MICHAEL E. PORTER & ELIZABETH OLMSTEAD TEISBERG, REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS 66 (2006).

71. In 2007, Medicare paid physicians 11 percent less than the overall average rate, Medicaid 40 percent less than the average rate and commercial payers, 14 percent more than the average rate. WILL FOX & JOHN PICKERING, HOSPITAL & PHYSICIAN COST SHIFT: PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS 7 (2008), *available at* http://publications.milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf.

72. Newhouse, *supra* note 18, at 1719.

or another, the steady-state growth rate will fall; the curve will be bent."[73]

But, says Newhouse, it is hard to imagine cutting only Medicare spending while spending by the commercially insured under age sixty-five continues to grow at historic rates. Such a phenomenon would lead to a marked divergence between what providers are paid for treating the commercially insured relative to what they are paid for Medicare beneficiaries. "This gap could jeopardize Medicare beneficiaries' access to mainstream medical care."[74] Medicare would start to look like what Medicaid has looked like for a long time – a payer that providers prefer to avoid. As Professor Newhouse notes, this phenomenon has already started to occur with the emergence of concierge medicine for the wealthy elderly. Physicians who practice concierge medicine request from their patients a lump-sum amount intended to cover those services that Medicare does not reimburse.[75] Clearly, concierge medicine is intended to price discriminate by cross-subsidizing lower Medicare rates with lump-sum payments made by individual Medicare beneficiaries rather than commercial payers.[76]

The kind of divergence between the public and private sector payment systems that Newhouse is talking about has not been envisioned as a likely scenario; in fact, part of the reluctance of Congress to implement the sustainable growth rate as a method of controlling Medicare costs has been the perceived need to keep Medicare rates within striking distance of commercial rates in order to avoid the "physician flight" risk that Medicaid has experienced. The irony of focusing just on Medicare cuts to control the growth of federal debt is a solution – like the House Republican "Path to Prosperity" plan – that is likely to result in harm to Medicare beneficiaries. While it is difficult to argue that rising healthcare costs are not a serious problem that must be dealt with, the effort to do so needs to be broader than just government health insurance programs like Medicare. It must be sufficiently broad in its reach in order to sustain affordable universal access to decent health care, certainly the goal of the recent hard-fought health reform legislation.

73. *Id.* at 1721.

74. *Id.*

75. *Id.*

76. Ricardo Alonso-Zaldivar, *Spread of Concierge Medicine Prompts Medicare Worries,* HUFFPOST POLITICS (Apr. 2, 2011, 10:14 AM), http://www.huffingtonpost.com/2011/04/02/concierge-medicine-medicare-health care_n_844042.html?view=screen.