Healthcare Reform: Let's Act Locally

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Healthcare Reform: Let’s Act Locally

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I. HEALTHCARE REFORM: WHERE WE STAND

Following heated debate and stark partisanship, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("Act"). It is the most significant health care reform legislation since the enactment of Medicare and Medicaid in 1965.

The discourse has not quieted since passage of the Act. If anything, the rhetoric has escalated. Healthcare reform remains a polarizing, emotional, and heavily politicized issue that raises a host of issues, including whether basic healthcare is a right, whether we should be forced to obtain health insurance coverage, whether the current healthcare system is effective, and whether it is sustainable.

As portrayed by the various factions, the Act will either end the abuses of the insurance industry and expand access to affordable

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coverage, or serve as a job killing, expensive piece of legislation that creates an unprecedented infringement of government on private citizens.

The law has spawned over twenty lawsuits and legislation has been proposed in at least forty-five states that would restrict or modify portions of the Act. The lawsuits challenge various provisions of the Act, including the requirement that states expand their Medicaid coverage and the minimum contribution requirements for employers that either do not offer employees insurance coverage or offer inadequate coverage. The core issue in these lawsuits, however, is the requirement that virtually all Americans maintain health insurance, or the so-called “individual mandate.” Similarly, it is the individual mandate that has generated the most public passion and dissension.


As of November 2011, three federal district judges have held that the individual mandate is constitutional and three federal district judges have held it to be unconstitutional. There are two federal appellate court decisions upholding the constitutionality of the individual mandate and one federal appellate court decision finding that the mandate is unconstitutional. A fourth federal appellate court found that the insurance mandate penalties are a tax and, therefore, can only be challenged once collected, so the action was not ripe. In November 2011, the Supreme Court agreed to hear appeals from the decision of the Eleventh Circuit Court of Appeals, arising out of Florida. The Supreme Court will review four aspects of the Act, including whether the individual mandate is constitutional and, if it is not, whether the remainder of the Act also is void.


11. Seven-Sky v. Holder, No. 11-5047, 2011 WL 1113489 (D.C. Cir. Mar. 17, 2011) (circuit court affirmed the district court decision, finding the individual mandate to be within Congress' authority); Thomas More Law Ctr., 651 F.3d at 534 (upholding constitutionality, finding that the individual mandate is an appropriate exercise of Congress' authority under the Commerce Clause); Florida II, 648 F.3d at 1322 (holding that the individual mandate represented an unconstitutional exercise of congressional power, but upholding the remainder of the Act). Florida II is, perhaps, a case of heightened significance because the plaintiffs were the attorney generals and governors of twenty-six states.

12. Liberty Univ., 2011 WL 3962915, at *16 (holding that the challenge was premature because the individual mandate constitutes a tax that could not be challenged prior to becoming effective).

13. Jennifer Haberkorn, Supreme Court to Review Health Care Reform Law, POLITICO (Nov. 14, 2011, 10:22 AM), http://www.politico.com/news/stories/1111/68300.html. Other questions before the Supreme Court include whether Congress can require states to expand Medicaid coverage, and whether the suit is ripe or whether a decision needs to wait until
The basic legal question raised by the individual mandate is whether the Commerce Clause of the Constitution permits the federal government to require individuals to purchase health insurance.14 A determination that the individual mandate is unconstitutional, even if coupled with a finding that the individual mandate could be severed, leaving the remainder of the Act in place, could jeopardize the entire Act. Without the funds generated through the individual mandate, it is not clear that sufficient revenue to implement the other reforms will be available.15 If the individual mandate is gone, but insurers are required to cover pre-existing conditions, there is little incentive for young, healthy individuals to purchase coverage. After all, they can just wait until they get sick and then purchase insurance, since the insurer cannot refuse to cover preexisting conditions. If that phenomenon occurs, the insurance pool will be too heavily weighted with high utilizers of medical care, causing overall premiums to increase and coverage to become unaffordable.16

II. THE CASE FOR PAYMENT REFORM

While the challenges and discussions have overwhelmingly focused on the individual mandate, it is actually the payment reforms contained in the Act that will likely determine the long-term effectiveness of the Act and, moreover, the viability of our entire health system.17 Without a material change in the way healthcare
is delivered and financed, it is difficult to see how our system can be sustained.

In 2009, health care spending in the United States reached $2.5 trillion, accounting for over 17% of the Gross Domestic Product ("GDP"), or $8,086 per person. Over one sixth of the nation's economy supports health care. By 2018, healthcare spending is projected to rise to nearly $4.3 trillion, which is approximately 20% of GDP. This percentage is projected to reach 34% by 2040, if costs continue to grow at historic rates.

Not only are healthcare expenditures high, they are higher in the United States than in other countries. Healthcare spending in the United States is approximately 50% more per person than the next most costly nation and is approximately double the average spending of other developed countries. Whether that equates to the best health care in the world is debatable. A recent study conducted by the Organization for Economic Co-Operation...
and Development ("OECD") indicated that the United States delivers terrific medical care for cancer diagnoses. For other metrics, however, the United States does not fare so well. For all of the money we spend on healthcare—more than any other nation in the world—the life expectancy in the United States ranks twenty-seventh of forty reported OECD and non-OECD countries.

The real mandate in healthcare reform is this: we have to change the way we deliver healthcare. President Obama, in an address to the American Medical Association, styled the issue this way: "[m]ake no mistake: [t]he cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America."

There are a multitude of reasons behind our high and escalating costs. Perhaps most notably, our payment system rewards medical utilization—we pay for procedures and tests. We pay for acute episodic care, rather than paying for outcomes, prevention, and wellness. Hospitals only remain viable if they have patients in beds and procedure rooms. Physicians only remain in business if they are treating and testing patients. Historically, no one has paid to prevent or limit the need for acute medical intervention. Essentially, the less procedures, the less money. The healthier the patient, the less money. Hospitals and physicians are doing exactly what the system incentivizes them to do. Our system so incentivizes hospitals to keep beds filled and procedure rooms full that we have drafted, literally, thousands of pages of regulations and guidance to try to prevent hospitals from paying physicians to refer patients to them.

24. The OECD is an international inter-governmental organization of thirty-four democratic countries. About the Organisation for Economic Co-Operation and Development, OECD, www.oecd.org (follow “About” hyperlink). Its mission is to promote policies that will improve the economic and social well-being of people around the world. Id.


Some other factors also contribute to our high cost structure. Health care delivery is fragmented, with providers not communicating with each other, which results in duplicate tests and inefficient care for patients. Additionally, medical technology has advanced at a rapid pace, allowing for more sophisticated equipment and more nuanced testing. Many of these advances are reimbursed by the payers, resulting in more hospitals making the capital investment to acquire the latest technology, which, in turn, attracts patients and increases procedural volumes. Technological advances allow better care and better outcomes for some individuals. However, medical technology advances also increase community expectations regarding the availability, sophistication, and frequency of testing and treatment. The utilization factor is further exacerbated by liability concerns that make physicians and hospitals practice defensive medicine, and consequently test more people more frequently. One indicator of our utilization: the United States has the highest number of MRI and CT exams per capita of all reporting OECD countries.

In conjunction with the general financial incentive to do more procedures and tests on more people, providers are facing reduced reimbursement as well as higher costs as a result of increased

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31. Id. at 9.


administrative time dedicated to billing, paperwork, and trying to ensure compliance with a myriad of regulations, which in turn lead to higher legal fees to comply with fraud and abuse regulations, billing rules, and appealing insurer denials. Collectively, hospitals and physicians are under enormous pressure to see more patients, to admit more patients, and to perform more procedures, just to maintain their historic levels of income.

It is no wonder that so many hospitals have focused on developing service lines that reimburse neuroscience, oncology, and heart procedures and closed down low-reimbursed services like behavioral health, despite the fact that mental disorders represent one of the five most prevalent chronic health conditions. It is no wonder why physicians are competing with hospitals and opening specialty hospitals and ambulatory surgery centers, as well as integrating ancillary services, like lab and radiology, into their office practice. It allows them to survive.

III. DELIVERY REFORM INITIATIVES

With all the hoopla over the individual mandate, the delivery and payment reform components of the Act have been shunted off to the corner. And yet, these are the building blocks to a sustainable future. Recognizing that primary care is the key to prevention and wellness, the Act includes funding for scholarships for primary care doctors and nurses in underserved areas and increases Medicaid payments to primary care doctors. The Act

34. Regulations have become so onerous that the simple failure to have a signature on a contract between a physician and a hospital, in and of itself, may violate Medicare billing rules and potentially require the pay back of all government reimbursements received from Medicare and Medicaid, resulting from services provided by the hospital by referrals of that physician. See Inspector General: Audits, Legal Actions May Net Up to $3.4 Billion, OFFICE OF INSPECTOR GEN., U.S. DEPT OF HEALTH AND HUMAN SERVS. (June 1, 2011), http://oig.hhs.gov/newsroom/news-releases/2011/sar_release.asp. Currently, there are approximately 18,000 codes used by hospitals and physicians to bill medical services. See Anna Wilde Mathews, Walked Into a Lampost? Hurt While Crocheting? Help is on the Way, WALL ST. J. Sept. 13, 2011, http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html. That number will expand to about 140,000 with the implementation of the new coding system. Id.


36. See Focus on Health Reform (last visited Feb. 29, 2012); Focus on Health Reform: Summary of New Health Reform Law, KAISER FAMILY FOUND., http://www.kff.org/healthreform/upload/8061.pdf (last modified Apr. 15, 2011); U.S. DEP'T OF HEALTH & HUMAN SERVS., Fact Sheet: Creating Jobs and Increasing the Number of
requires some free preventive care, including annual wellness visits for seniors, and it requires that new healthcare plans cover certain preventive services, such as mammograms and colonoscopies, without any deductible or co-pay charges.\footnote{37}

Finally, but perhaps most importantly, the Act establishes a number of pilots and demonstration projects that are designed to incentivize coordinated care across providers for the benefit of the patient, efficiency, prevention, and wellness. Pilot and demonstration projects include payment bundling (paying hospitals a lump sum for all treatments given during an entire episode of care, with hospitals distributing the payment between physicians and other providers); evaluation of community-based prevention and wellness programs for Medicare beneficiaries; development of individualized wellness plans; and paying for quality outcomes.\footnote{38}

In addition to identified pilot and demonstration projects, the Act establishes an innovation center within the Centers for Medicare and Medicaid Services that will serve as a clearinghouse and funding vehicle for new health care delivery and payment system models.\footnote{39}

One of the primary vehicles promoted by the government in the Act to facilitate healthcare delivery reform is the concept of accountable care organizations ("ACOs").\footnote{40} ACOs are a bit of an amorphous creature and somewhat similar to the health maintenance organization model ("HMO"). Depicted initially in just seven pages of the 906 page Act, ACOs are intended to create incentives for health care providers to work together to treat an individual patient across care settings, including doctors' offices and hospitals, with the desired consequence, in theory at least, of coor-

\begin{enumerate}
\item \footnote{40} See Patient Protection and Affordable Care Act § 3022. See also 76 Fed. Reg. 67,802 (Nov. 2, 2011) for final ACO regulations and commentary.
\end{enumerate}
ordinated, more efficient, less expensive care, resulting in better health and quality of life for the patient.\textsuperscript{41}

The incentive for hospitals and physicians to align in order to participate in an ACO is that the government will share a portion of the overall savings with the ACO providers.\textsuperscript{42} The downside is the high anticipated cost of providers/insurers creating the necessary infrastructure to become an ACO and, at least in some models, the fact that the ACO shares that risk that there may not be savings, but rather excess costs.\textsuperscript{43}

While nearly everyone applauds the concept behind ACOs, it is hard to get a concrete handle on what one looks like and how it operates. Interest has been keen, but the draft regulations issued in March 2011, a year following the passage of the Act, have generated less than an enthusiastic response, with providers and insurers roundly criticizing the ACO model as too expensive and the risks too high.\textsuperscript{44}

There are other issues that make the viability of ACOs vulnerable. For now, at least, participation is purely voluntary and the number of volunteers seems to be slim.\textsuperscript{45} So slim, in fact, that the government issued a modified "Pioneer ACO" model that minimiz-

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es the ACO’s risk, but continues to reward improvement, in an effort to jumpstart interest.\textsuperscript{46} Furthermore, and maybe more significant, hospitals and physicians participating in an ACO will still be paid on a fee-for-service basis for procedures,\textsuperscript{47} so the promise of sharing in future potential savings will be competing with the very real, immediate loss of fee-for-service reimbursement, if less tests and procedures are performed.

Sometimes big changes are hard. Nonetheless, paying for coordinated care, rather than fragmented care, and paying for wellness and maintenance care, rather than episodic care in response to acute events, make sense. The federal government, the ACO regulations, and the individual mandate lawsuits should not bury a good idea.

IV. HOME GROWN REFORM IN WESTERN PENNSYLVANIA

So let us focus on our hometown. While the federal government battles through its legal challenges and while others page through the federal ACO regulations and try to determine whether the proposal is workable, let us change our corner of the world. Western Pennsylvania offers a nearly perfect scenario to develop innovative health care payment and delivery models that enhance quality of life and reduce costs. We have two local, community-based, well-funded systems to develop and test integrated health care delivery and payment innovations: University of Pittsburgh Medical Center (“UPMC”) and Highmark.

Nationwide, hospitals and insurers, recognizing that some form of payment reform is around the corner, are scrambling to acquire physicians and trying to figure out how to work together.\textsuperscript{48} Pitts-
burgh is already there. UPMC is a fully integrated system. It has
a network in western Pennsylvania of tertiary and community
hospitals.\textsuperscript{49} It has 400 physician offices and over 3,000 employed
physicians.\textsuperscript{50} It has 17 retirement and long-term care facilities.\textsuperscript{51}
It operates an insurance company.\textsuperscript{52}

Highmark has the dominant insurance network, with a market
share of over 65%, and is intending to enter the provider market
with the second largest health system in Pittsburgh, which comes
with its own integrated network of employed specialists and pri-
mary care doctors.\textsuperscript{53} Our community also benefits from the re-
sources, expertise, and passion of the Pittsburgh Regional
Healthcare Initiative ("PRHI").\textsuperscript{54} PRHI is dedicated to perfecting
patient care and has been on the forefront of patient care-focused
initiatives.\textsuperscript{55}

All of these Pittsburgh-based community organizations are al-
ready thinking and acting innovatively. As UPMC Health Plan's
President and CEO recognizes, "[a]t UPMC, we actually have the
ability to be a laboratory for change, to measure what's an effec-
tive treatment, what's an effective impact with benefit design,
what is the right way to improve access, and what is the right way
to enhance coordination of care."\textsuperscript{56}

Highmark and UPMC provide benefits such as wellness pro-
grams, offer telephone and on-line tools, and invest in electronic
medical records, which are a fundamental building block of coor-

\begin{itemize}
\item \textsuperscript{49} UPMC Provider Services Division Fast Facts, UPMC (2012),
\item \textsuperscript{50} Id.
\item \textsuperscript{51} Id.
\item \textsuperscript{52} UPMC Insurance Services Division Fast Facts, UPMC (2011)
\item \textsuperscript{53} UPMC-Highmark Dispute: Hearing Before the Pa. State S. Comm. on Banking and
Ins. (testimony of David Balto, Senior Fellow, Center for American Progress) (2011), avail-
able at http://www.acms.org/2011Testimony/%5BUPMC%20Highmark%5D%20Senate%20Banking
%2009132011.pdf; Steve Tweedt, Highmark, WPAHS Announce Agreement; ER to Reopen,
100.stm. See also WEST PENN ALLEGHENY HEALTH SYS., www.wpahs.org (last visited Mar.
13, 2012).
\item \textsuperscript{54} PRHI is a supporting organization of the Jewish Healthcare Foundation and is
dedicated to perfecting patient care. About Pittsburgh Regional Health Initiative, PHRI,
\end{itemize}
ordinated care.57 One of the most promising pilots that both UPMC and Highmark are involved in, and which PRHI has history in, is something called a “medical home” model.58

Somewhat akin to the elusive ACO, but in reality more similar to HMOs, in a medical home model, the focus is on keeping individuals with chronic conditions healthy through the provision of coordinated care across the spectrum of providers.59 Where an

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While considered an “innovation,” the concept of a medical home was introduced several years ago by the American Academy of Pediatrics (“AAP”). Am. Acad. of Family Physicians, et al., Joint Principles of the Patient-Centered Medical Home, AM. ACAD. PEDIATRICS (2010), http://practice.aap.org/content.aspx?id=2063. In 2007, the AAP, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, issued guiding principles for medical homes. Id.

ACO is most often envisioned as an alignment of hospitals and physicians, a medical home model is centered on the primary care physician. It is the patient’s primary care physician who serves as the patient’s ‘medical home,’ overseeing both the delivery of acute healthcare services to patients and managing patients’ overall health. The primary care group helps to coordinate lab tests and specialist visits, but also makes sure patients are doing things like taking their medications. They monitor a patient’s health status on a routine basis. By providing continual oversight, changes in a patient’s condition are identified and managed quickly, before requiring critical intervention with attendant medical costs.

The costs of implementing a medical home model generally include investment in information technology to manage and track patient care. Additional payments to the primary care physician group are also likely to be necessary in order to compensate the group for the increased personnel and time commitments required in order to focus on patients’ health on a routine, consistent, and frequent basis. The costs are not extraordinary.

The benefits, however, can be extraordinary. In a study performed by Seattle’s Group Health Cooperative, patients participating in a medical home program required 29% fewer emergency room visits and 6% fewer hospital admissions than those in conventional programs. Patients in medical homes reported higher satisfaction. Quality scores were also higher. While primary and specialist physician costs were higher in the medical home model, these increased expenses were more than offset by savings achieved through lower emergency room and urgent care visits.

60. Anderson, supra note 59; Meyer, supra note 59.
63. Anderson, supra note 59; Meyer, supra note 59.
64. Anderson, supra note 59; Meyer, supra note 59.
68. Id.
69. Id.
and fewer hospital admissions. Overall savings were $10.30 per member per month. CareFirst BlueCross BlueShield in Maryland/Washington D.C. has also implemented a medical home program, paying the physicians who voluntarily enroll a 12% increase in their insurance payments, as well as extra payments for developing and implementing patient treatment plans. CareFirst sets a global budget for each patient based on the typical cost of care for patients with similar conditions. Costs for services and specialists are paid out of the budget, and if there is an amount remaining at the end of the year, the doctor can share in the savings if quality and other metrics are satisfied. If the doctor goes over the budget, there is no penalty. The ‘no penalty’ rule seems to be designed to offset fears that doctors will not order necessary tests or send patients to specialists, which was a core criticism of the HMO model.

Three additional pieces of information help to put into perspective the scope of the potential benefit of medical homes for patients with chronic diseases, beyond an individual’s health. Some of the most expensive individuals to treat are those with chronic conditions. Twenty-five percent of the population has one or more of the following chronic conditions: asthma, diabetes, heart disease, hypertension, or a mental disorder. While the cost of treating these conditions is expensive, people with chronic conditions tend to suffer from other ailments as well. Expenses for people with one chronic condition were twice as great as for those without any chronic conditions. Spending for those with five or more chronic conditions was about fourteen times greater than spending for people without any chronic conditions. According to 1996 data, the costs of treating individuals with these five chronic con-

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70. Id.
71. Id.
73. Id.
74. Id.
75. Id.
76. Robert Kane et al., Ch. 2: The Basics of managed Care: Promises and Pitfalls of Managed Care, in MANAGED CARE: HANDBOOK FOR THE AGING NETWORK (Louise Starr et al. eds. 1996), available at www.aspe.hhs.gov/Progsys/Forum/basics.htm.
77. Stanton, supra note 35, at 7.
78. Id.
79. Id.
80. Id.
ditions totaled 49% of total health care costs. Exacerbating the problem is the fact that the prevalence of chronic diseases is on the rise.

Secondly, high hospitalization rates and aggressive medical interventions have generally been found not to result in better quality of life or longer length of life for individuals with chronic conditions. In fact, the reverse appears to be true. Rather, coordinated, routine preventive and maintenance care tends to produce the best quality outcomes, meaning that the medical home model offers a better care model in terms of quality of life and longevity, and is less expensive than the current model of treating acute medical issues arising from a chronic condition.

Third, hospitalization rates in the United States for persons with asthma and for individuals with acute complications from diabetes are among the highest of all of the OECD countries, reflecting a need to improve primary care for these individuals throughout the United States. Equally concerning, based upon 2007 data, Medicare beneficiaries in the Pittsburgh region who suffered from chronic conditions were hospitalized at the highest rate among the forty major regions in the United States. When risk, gender, race, and age were adjusted, data showed that Pitts-

81. Id.
84. Id.
85. One issue not addressed in this essay is the role of personal responsibility in healthcare from a prevention and maintenance perspective, as well as from a cost perspective (e.g. should individuals who smoke or do not exercise pay more for healthcare?). The Robert Wood Johnson Foundation is sponsoring a campaign, “Care about your Care,” designed to encourage people to take an active role in their healthcare. See Laura Landro, Informed Patient: Getting Patients to Care About Their Care, WALL ST. J. HEALTH BLOG (Sept. 12, 2011, 9:27 AM), http://blogs.wsj.com/health/2011/09/12/getting-patients-to-care-about-their-care/.
86. Pearson, supra note 25, at 5. See also ORG. FOR ECON. CO-OPERATION AND DEV., supra note 26, at 104-07 (noting that uncontrolled diabetes hospital admissions rates appear to have improved for the United States, as compared with the OECD 2009 data reflected in Pearson’s presentation relating to diabetes acute complications admission rates).
Healthcare Reform

Pittsburgh ranked highest in the country for Medicare spending for hospitals and skilled nursing facilities.88

The pilot programs demonstrate that medical homes have the ability to impact the quality and cost of care for individuals with chronic conditions in a significant manner. For patients, this means better quality of life. For the economy and employers, it means more productive workers and lower healthcare costs.

The medical home model is just one of many ideas being piloted. The American Recovery and Investment Act of 2009 earmarked nearly $400 million for grants to communities to develop programs to prevent chronic disease and promote wellness.89 For example, Nashville was awarded $7.5 million in federal grants to implement healthier lifestyles to combat obesity.90 With the United States leading the world in obesity and obesity contributing to a variety of health concerns, including type 2 diabetes and heart disease, slowing or halting the increase in obesity seems like a worthwhile endeavor.91 To the extent Pittsburgh can lead the nation in innovative health care delivery and payment reform, we should be doing so. Further, as Nashville and the rest of the country learns what works, we should benefit by implementing the most successful experiments.

V. CONCLUSION

While UPMC and Highmark are piloting new programs and funding research into integrated medicine, there is room for improvement and reason to want that improvement to come at a faster pace. We have come to expect sophisticated, “best in class” healthcare in western Pennsylvania. We should also expect our

88. Miller, supra note 87.
healthcare institutions to be not just thought leaders, but action leaders in healthcare reform. Given the level of provider/insurer integration, Pittsburgh is perhaps better positioned than any other region in the country to be on the cutting edge of healthcare reform. UPMC and Highmark are both financially strong institutions with deep Pittsburgh roots. They are both nonprofit community organizations whose missions—their very purpose for existing—are to make this region healthier. We are looking forward to a new chapter in Pittsburgh's history, as it leads the nation in healthcare reform.