Journal of Health Care Law and Policy

Volume 12 | Issue 1 Article 5

# The Ethics of Health Care Reform: Unintended Consequences of Payment Schemes and Regulatory Mandates

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# THE ETHICS OF HEALTH CARE REFORM: UNINTENDED CONSEQUENCES OF PAYMENT SCHEMES AND REGULATORY MANDATES

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In the current era, when physicians in the United States lecture or publish, they are required to make a declaration of whether they might have any significant financial conflict of interest related to the topic presented. This requirement is intended to correct both real and perceived biases that may emerge when physicians have a personal financial stake in the products about which they are speaking or writing.[1] Biased educational sessions and scientific reporting have a negative impact on both the integrity of medicine and the cost of health care.[2] Requiring physicians to offer such a declaration before speaking or writing on the ethics of health care reform seems a bit absurd. However, in the discussion of health care reform, perhaps no one can claim to be without conflict of interest and bias. Every

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1. *See* INT'L COMM. OF MED. J. EDITORS, UNIFORM REQUIREMENTS FOR MANUSCRIPTS SUBMITTED TO BIOMEDICAL JOURNALS: WRITING AND EDITING FOR BIOMEDICAL PUBLICATION 4 (2008), *available at* http://www.icmje.org/urm_full.pdf (arguing that physicians should disclose conflicts of interests when submitting manuscripts for peer review and publication); Roger S. Foster, Jr., *Conflicts of Interest: Recognition, Disclosure, and Management*, 196 J. AM. C. SURGEONS 505, 511 (2003) (arguing that physicians should disclose conflicts of interest at speaking engagements).

2. *See* Kristin Rising et al., *Reporting Bias in Drug Trials Submitted to the Food and Drug Administration: Review of Publication and Presentation*, 5 PLOS MED. 1561, 1562 (2008), *available at* http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050217 (follow "PDF" hyperlink) (stating that reporting bias in publications may lead to unnecessary prescription of more expensive treatment choices); Dennis F. Thompson, *Understanding Financial Conflicts of Interest*, 329 NEW ENG. J. MED. 573, 573–74 (1993) (arguing that the medical profession should regulate conflicts of interest to maintain the integrity of and confidence in professional judgment); *see also* T. Shawn Caudill et al., *Physicians, Pharmaceutical Sales Representatives, and the Cost of Prescribing*, 5 ARCHIVES FAM. MED. 201, 201, 204–05 (1996) (explaining that pharmaceutical companies disseminate information to doctors that leads to the unnecessary prescription of more expensive drugs, increasing the cost of health care); Ashley Wazana, *Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift?*, 283 JAMA 373, 375, 378 (2000) (finding that physicians who interact with pharmaceutical representatives have increased prescribing costs).

citizen is a stakeholder of one sort or another in this debate, and everyone has a financial claim to the outcome. It would be most instructive if politicians, like physicians, were required at the beginning of every discussion of health care reform to declare all of their financial ties to the topic at hand, including a complete listing of every financial contribution from all of the stakeholders. Biased stances of elected officials have an enormous impact on both the integrity of the health care reform debate and the cost of health care,[3] which is likely of much greater magnitude than that of individual physicians.

## I. HEALTH CARE REFORM AND THE SOCIAL COVENANT

In the mid 1990s, I co-taught a course entitled "Patient, Physician and Society" for second year medical students at the Johns Hopkins University School of Medicine.[4] The weekly course included an introductory lecture presenting a current topic. The lectures presented controversial issues that typically had ethical or political implications; e.g., the physician's role in the death penalty, assisted suicide, and health care reform. After the lecture, the students broke out into discussion groups of a dozen students and two faculty facilitators. As a small group discussion facilitator, I was paired with Dr. Barney Berman, who became a staff internist at Johns Hopkins in 1950 and served as a professor at the Johns Hopkins School of Medicine.[5] One day, as the discussion group began, the students started spontaneously discussing the various salaries they expected to earn after completing their training in different medical specialties. Dr. Berman, usually a very engaging and jovial participant in the student discussions, remained silent. It became clear that this discussion was disturbing to him. Finally he spoke, scolding the students:

> Never, in my decades at Hopkins, have I ever heard such a discussion of money. As a medical student it is your duty to apply yourselves to your studies and as a physician to devote yourself to your patients and your practice. If you are diligent in your work, society will reward you amply. You should be interested in medicine, not money. If it is money that interests you, go work on Wall Street.

And with that, he left the room. The classroom was silent. Although I initially participated in the student discussion of specialties and income, all I could say in

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3. *See* James A. Morone, *The Bias of American Politics: Rationing Health Care in a Weak State*, 140 U. PA. L. REV. 1923, 1929–31 (1992) (explaining that organized interests successfully worked to defeat plans for national health insurance); *see generally* Jacob E. Gersen, *Temporary Legislation*, 74 U. CHI. L. REV. 247, 268 (2007) (noting that bias affects elected officials' decision-making).

4. The Johns Hopkins School of Medicine Academic Catalog, *available at* http://www.hopkinsmedicine.org/som/students/academics/catalog (follow "Instruction Leading to the M.D. Degree" hyperlink) (last visited May 11, 2009).

5. Joe Nawrozki, *Dr. Barnett Berman, 81, Internist, Army Veteran*, BALT. SUN, Feb. 9, 2004, at B4.

response to Dr. Berman's reproach was, "Class dismissed." The lesson for the day had been delivered. The generations had clashed. In Dr. Berman's day, the social covenant of medicine was strong.[6] Johns Hopkins Hospital was a temple of medical science and the department chiefs were its high priests. Medicine was a sovereign profession with more moral authority than economic power.[7] Today, however, the opposite seems true. Although medical students may learn about new scientific discoveries and the latest breakthroughs in medicine from the *New England Journal of Medicine*, they cannot understand the vast health care industry they are entering without reading *The Wall Street Journal*.[8] One physician MBA program brochure proclaims, "practicing good medicine also means practicing good business."[9] An academic medical center CEO proclaimed that "Medicine today is nothing more than retailing."[10]

Many medical students are leaving their training with $150,000 or more in educational debts[11] to find that primary care fields and jobs working with underserved populations may not allow them to service their academic debts and live the economic lifestyle they believe they are entitled to enjoy.[12] Medical students consider the number of hours worked per week, including on-call responsibilities, versus the remuneration. They do not trust society to compensate

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6. *See generally* Ira Byock, *Rediscovering Community at the Core of the Human Condition and Social Covenant*, HASTINGS CENTER REP., Mar.–Apr. 2003 Supplement, at S40–S41 (defining a social covenant as a belief that the well-being of others affects one's own well-being); Alvin H. Strelnik, *Increasing Access to Healthcare and Reducing Minority Health Disparities: A Brief History and the Impact of Community Health Centers*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 63, 64–67 (2004) (stating that in the early 1960s the Kennedy administration passed legislation to create community health centers to provide healthcare to those who lacked access).

7. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 4–5, 14–15 (1982) (explaining doctors' social and cultural authority).

8. *See* Kenneth Kressel et al., *Managing Conflict in an Urban Health Care Setting: What Do "Experts" Know?*, 5 J. HEALTH CARE L. & POL'Y 364, 394 (2002) (discussing the challenge of managing health care like a business); *see generally* DEREK BOK, THE TROUBLE WITH GOVERNMENT 313–14 (2001) (noting the level of regulatory complexity that exists in the American health care system).

9. The Johns Hopkins University Carey Business School, MBA Medical Services Management, http://carey.jhu.edu/businessofhealth (follow "MBA Medical Services Management" hyperlink) (last visited May 11, 2009).

10. Interview with Morton Rappoport, Chief Executive Officer, Univ. of Md. Med. Sys., in Balt., Md. (Nov. 1996).

11. William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 475 (2004).

12. *See* Kristine Marietti Byrnes, Note, *Is There a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage*, 25 RUTGERS L.J. 799, 803–05 (1994) (noting that primary care fields and practicing in underserved areas often provide lower compensation); *see also* Am. Med. Sch. Ass'n, Medical Student Debt, http://www.amsa.org/student/studentdebt.cfm (last visited May 11, 2009) (finding that medical school student debt hinders efforts to improve care in underserved areas and prevents students from entering primary care fields).

them "amply" for their efforts.[13] Instead of entering fields that interest them or that they believe to be good for society, many graduates are entering fields that will allow them to service their educational debts and meet the needs of their preferred lifestyles.[14] Some medical specialties are rewarded "amply" while others are not.[15] The students do not want to devalue their years of training and investment in their futures by making the wrong economic choices.[16] In the absence of a strong, healthy social covenant, why should they?

Physicians have become a constantly hurried and harried group of "pieceworkers." Because we are paid per visit or procedure, the only way to maintain income in the face of rising costs is to increase the volume of services provided.[17] Patients have become our means of production. Because each "piece" of work has become devalued, physicians must perform higher volumes to meet their budgets.[18] For example, if a primary care physician does not make twenty-four to thirty billable visits per day, he may not be able to meet his overhead expenses.[19] The non-reimbursed aspects of care, such as case management and communication, fall by the wayside.[20] Some practices charge for after-hours calls when the

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13. *See* Sara Fritz, *As Health Reform Plans Lower Expectations, 5 Graduates Enter a Career That's No Longer a Sure Thing*, L.A. TIMES, May 24, 1993, at A1 (discussing doctors' distrust of the direction of the American health care system in relation to their salaries); *see* Ann Pomeroy, *The Doctor Is* Still *In*, HR MAG., Feb. 2002, at 36, 37–39 (asserting that doctors work long hours and on call while "earnings many [sic] not be much above minimum wage"); *but see* Jonathan Foster, Letter to the Editor, *Young Doctors, Listen to Patients; New Ways to Prosper*, N.Y. TIMES, Oct. 22, 1995, sec. 4, at 12 (opining that economic considerations, not student values, have changed in recent years).

14. *See* Byrnes, *supra* note 12, at 804–05 (explaining that many economic factors, including education related indebtedness, bear on a physician's career choice); Fritz, *supra* note 13, at A1 (stating that while medical students understand the need for more primary care physicians, many still choose to go into the higher paying specialties).

15. *See* Caitlin M. Simpson, *Income Discrepancies Highlight Disparities in Health Care Industry*, ACAD. INTERNAL MED. INSIGHT, 3d. Iss. 2008, at 10, 10–11, *available at* http://www.im.org/Publications/Insight/Archives/Documents/Vol6Issue3/PhysIncome.pdf.

16. *See* Lewis A. Kornhauser & Richard L. Revesz, *Legal Education and Entry into the Legal Profession: The Role of Race, Gender, and Educational Debt*, 70 N.Y.U. L. REV. 829, 956–57 (1995) (explaining that high debt could cause medical students to pick more lucrative specialties); Kristin Madison, *The Residency Match: Competitive Restraints in an Imperfect World*, 42 HOUS. L. REV. 759, 814 (2005) (noting that low compensation could cause a "prospective resident [to choose] the wrong residency program"); Fritz, *supra* note 13, at A1 (discussing the variety of economic factors a medical student must take into consideration when planning a career).

17. *See* Arnold S. Relman, *Reforming the U.S. Health Care System: What the Legal and Medical Professions Need to Know*, 15 HEALTH MATRIX 423, 428, 430 (2005).

18. *See id.* at 428 (explaining that when the government and insurers reduce prices, physicians perform more services to maintain their income); *see also* Cynthia A. Smith, Note, *A Legislative Solution to the Problem of Concierge Care*, 30 SETON HALL LEGIS. J. 145, 147 (2005) (explaining that primary care physicians must take on several thousand patients in order to deal with low reimbursement rates).

19. *E.g.*, Smith, *supra* note 18, at 147.

20. *See* Arlene D. Luu & Brian A. Liang, *Clinical Case Management: A Strategy to Coordinate Detection, Reporting and Prosecution of Elder Abuse*, 15 CORNELL J.L. & PUB. POL'Y 165, 190–91

physician feels that twenty-four hours per day, seven days per week availability is not compensated by the current fee structures[21] or that the free service is abused by the callers.[22] Because medicine has become commodified,[23] there is less emphasis on doctor-patient relationships and more emphasis on the elements within the interaction that serve to justify the reimbursement.[24] Patients have expressed frustration with primary care physicians who seem more interested in the computer in the room than the patient.[25] Both physicians and patients are discontented with the status quo. Both groups blame "the system."[26]

How did we get here? Why is our health care system too expensive, uncoordinated, lacking in preventative care, and inadequate in providing continuity of care and care coordination?[27] Why are those who deliver care, those who receive care, and those who pay for care dissatisfied?[28] Looking back on the history of the

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(2005) (explaining that in the health care system, designated case managers are used to improve health care delivery and that most case managers are nurses or social workers, not physicians); Smith, *supra* note 18, at 145–47 (asserting that patients and physicians believe that managed care organizations have placed time constraints on office visits).

21. *See* Susan Gilbert, *Some Doctors Call Talk Too Cheap*, N.Y. TIMES, Apr. 30, 1997, at C10.

22. *See id.* (asserting that some U.S. physicians charge for after-hour calls and how such calls made some "want to stop practicing"); Paul Clay Sorum & Rajiv Mallik, *Physicians Opinion on Compensation for Telephone Calls*, PEDIATRICS, Apr. 1997 e3, at 1, 4 tbl.4, http://pediatrics.aappublications.org/cgi/reprint/99/4/e3.pdf (discussing doctors' opinions that after-hours calls create feelings of burden, annoyance, and abuse to the point of considering quitting, but that compensation remedies some of these feelings).

23. *See* Dahlia Schwartz, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 632 (1999).

24. *See id.*; *see also* Andrew M. Knoll, *The Reawakening of Complementary and Alternative Medicine at the Turn of the Twenty-First Century: Filling the Void in Conventional Biomedicine*, 20 J. CONTEMP. HEALTH L. & POL'Y 329, 351–52 (2004) (stating that modern medicine causes doctors to measure productivity in terms of outcomes rather than in terms of patient care).

25. *See* Michael Hochman, *Eyes Shift from Patient to Keyboard*, BOSTON GLOBE, Sept. 10, 2007, at C1.

26. *See* Theodore R. Marmor, *The National Agenda for Health Care Reform: What Does It Mean for Poor Americans?*, 60 BROOK. L. REV. 83, 100 (1994); Smith, *supra* note 18, at 145; *see also* Kenneth R. Cohen et al., Correspondence, *Doctor Discontent*, 340 NEW ENG. J. MED. 649, 649–53 (1999).

27. Dana Derham-Aoyama, *U.S. Health Care Reform: Some Lessons from Japanese Health Care Law and Practice*, 9 TEMP. INT'L & COMP. L.J. 365, 368 (1995) (explaining that United States' medical establishment does not emphasize preventative care); Jennifer Honig & Susan Fendell, *Meeting the Needs of Female Trauma Survivors: The Effectiveness of the Massachusetts Mental Health Managed Care System*, 15 BERKELEY WOMEN'S L.J. 161, 197 (2000) (noting how low reimbursement rates compromise continuity of care); Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 554 (2006) (finding that the system has coordination deficiencies); Alexee Deep Conroy, Note, *Lessons Learned from the "Laboratories of Democracy": A Critique of Federal Medical Liability Reform*, 91 CORNELL L. REV. 1159, 1165 (2006) (stating that the United States spends more per capita on health care than any other nation).

28. *See* Marmor, *supra* note 26, at 100.

U.S. health care system, it becomes clear that past reform efforts led us to where we are today.[29]

## II. REFORM AND UTOPIA

When discussing the ethics of health care reform, it is instructive to return to the basic definition of the word "reform." To "reform" something is to change it into a new and improved condition or to restore it to a former good state.[30] Reform looks to a future ideal or to an idealized past.[31] Reform is therefore utopian in nature. Simplistically, reform means to change from bad to good. Most Americans want a good system of health care. A good system would deliver high-quality medicine and be available to everyone at the lowest reasonable cost.[32] The complexity of the reform debate is in determining the ethical principles that should be dominant in defining the "good."[33] The differing ethical principles, or the dominance of certain principles over others, translate into political stances and the divisions that create the health care reform debate.

A reform movement is often defined by its associated political campaign to revise the laws and regulations that govern collective life.[34] These campaigns often characterize existing institutions, and individuals working within them, as bad.[35] There is often a punitive aspect to reform, intent upon punishing those who have promulgated the real or perceived abuses, wrongs, or errors, or who have profited from the bad situation of the present.[36] This concept is illustrated by the term

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29. *See id.*; David Pratt, *The Past, Present and Future of Health Care Reform: Can It Happen?*, 40 J. MARSHALL L. REV. 767, 769–73 (2007).

30. *See* WEBSTER'S II NEW COLLEGE DICTIONARY 931 (3d ed. 2001) (defining "reform" as "To improve by altering, correcting errors, or removing defects. . . . A change for the better.").

31. *See id.*

32. *See* Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 359–60 (1996) (arguing that in modern health care, policy makers must not only aim to achieve quality medicine but also consider costs); Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J.L. & MED. 37, 37 (1994) (suggesting that the fundamental goals of the health care reform include "universal access to an acceptable quality of health care at an affordable cost").

33. *See* Norman Daniels, *Principles for National Health Care Reform*, HASTINGS CTR. REP., May–June 1994, at 8, 8–9 (explaining how all health care proposals will require trade-offs between principles and values); Malinowski, *supra* note 32, at 334–37, 359–60 (discussing modern medical ethical views in the context of the health care reform debate); Robert M. Veatch, *What Counts as Basic Health Care? Private Values and Public Policy*, HASTINGS CTR. REP., May–June 1994, at 20, 20–21 (arguing that what constitutes good medicine is ultimately a private decision and that the current health care debate is challenging the notion that personal values belong in the private realm).

34. *See, e.g.*, RICHARD HOFSTADTER, THE AGE OF REFORM: FROM BRYAN TO F.D.R. 238–43 (1955) (discussing the Progressive movement and the use of laws and regulations to curb industrialism).

35. *See, e.g., id.* at 241, 247 (explaining that during the Progressive era, the capitalist institutions that held power, such as big businesses and political machines, were criticized).

36. *See, e.g., id.* at 242, 247 (explaining that during the Progressive era, political reformers sought to enact laws and regulations to remedy perceived capitalist abuses and punish bad acts).

"reformatory," where wayward youth are sent not only to change their ways but also to be punished.[37] Health care reformers must be mindful that the vast majority of the current participants in the health care system are good and moral agents, doing the best they can within a bad system.[38] Current efforts at health care reform often punish good people working within a bad system. American physicians and health care workers today often feel victimized by the reform efforts foisted upon them.[39] Their grievances are viewed as "collateral damage" by some health care policymakers and administrators,[40] confirming the existence of the metaphorical battle and conquest in the pursuit of reform. Reform processes have winners and losers, making the process more difficult and contentious.

There is a religious connotation to "reform," as illustrated by the periods of "reformation" within many of the world's religions.[41] Secular reformers may conduct their political campaigns with religious-like zeal in their attempt to create a more ideal society. In 1973, as he was lamenting the difficulty in translating legislative mandates into regulatory processes, Health, Education & Welfare Secretary Joseph Califano[42] used a religious metaphor, commenting that legislators found it "more fun to be Moses and deliver the commandments than to be the rabbis and priests who had to make them work."[43]

The dominant "-ism" of modern secular American life may be "regulatarianism" because society seems to believe that most of its ills can be

37. *See* WEBSTER'S II NEW COLLEGE DICTIONARY, *supra* note 30, at 931 (defining "reformatory" as "[a] penal institution for the discipline, reformation, and training of young offenders"); *cf.* Earl D. Myers, *England's Industrial and Reformatory Schools*, 11 SOC. FORCES 373, 375–76 (1933) (explaining that in the past, children in England were sent to reform schools after committing a crime and that physical punishment was used within these schools).

38. *See* Cohen et al., *supra* note 26, at 650–51 (physicians discussing their frustration with a managed-care system that they perceive as interfering with good-faith desires to provide high-quality patient care); Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, HASTINGS CTR. REP., Mar.–Apr. 1994, at 28, 28 (discussing the ethical dilemmas that health care reform proposals place on physicians).

39. *See* PHYSICIANS' FOUND., THE PHYSICIANS' PERSPECTIVE: MEDICAL PRACTICE IN 2008, at 9 (2008), *available at* http://physiciansfoundations.org/usr_doc/PF_Survey_Report.pdf (explaining how the reform to expand health care access creates an untenable workload on doctors who cannot see the number of patients created by the reform).

40. *See* Patric Hooper & Jordan B. Keville, *Collateral Damage in the Government's War on Health Care Fraud: Violations of Providers' Rights*, HEALTH LAW., June 2006, at 28, 29–30 (explaining how health care providers are collateral damage in some politicians' and government agencies' attempts to reform health care expenditures).

41. *See* Mark C. Modak-Truran, *Beyond Theocracy and Secularism (Part I): Toward a New Paradigm for Law and Religion*, 27 MISS. C. L. REV. 159, 169–71, 173 (2008) (discussing the rise of the Protestant Reformation and the ensuing Christian Revolution across Europe).

42. JOSEPH A. CALIFANO, JR., GOVERNING AMERICA: AN INSIDER'S REPORT FROM THE WHITE HOUSE AND THE CABINET, 258–59 (1981).

43. *Id.* at 259.

corrected or reformed through the promulgation of governmental regulations.[44] Regulations are expected to tell us how to do the right thing the right way. In earlier times, it was religious upbringing or educational training that taught people how to do the right thing the right way.[45] For physicians, professionalism guided actions and formed the governance structures in medicine.[46] In American health care reform, however, the dominant ethos of professionalism is increasingly yielding to federal regulatarianism.[47]

When a political reform movement involves the unseating of a ruling class, it may be labeled a revolution.[48] Physicians who practiced medicine prior to the emergence of the cost control mandates of Medicare in the 1980s[49] may consider what has happened to the profession over the past twenty to thirty years as a revolution rather than a reformation.[50] No one believes that the revolution is over.

When discussing the current health care reform debate in America, it is helpful to remember that calls for reform in various aspects of American governmental policies are nothing new. In fact, they are a defining feature of the American experience. In his 1955 award-winning text, *The Age of Reform*, Professor Richard Hofstadter claimed that reform movements have characterized

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44. *See* HOFSTADTER, *supra* note 34, at 233–34, 242 (discussing the modern shift toward reliance on government regulation to cure big business abuses, beginning with the Interstate Commerce Act of 1887 and the Sherman Act of 1890).

45. *See* STARR, *supra* note 7, at 4–6 (discussing the medical profession's claim to authority in the late nineteenth and early twentieth century based on their specialized knowledge of modern medicine); Marc A. Rodwin, *The Politics of Evidence-Based Medicine*, 26 J. HEALTH POL. POL'Y & L. 439, 440–41 (2001) (explaining that until recently physicians based their practice on their "medical training, individual experience, and local custom"); Veatch, *supra* note 33, at 20–21 (commenting how modern health care reform is minimizing doctor's religious views when providing health care services).

46. *See* STARR, *supra* note 7, at 4–5 (discussing the rise of sovereignty and power in the medical profession in the late nineteenth and early twentieth century).

47. *See id.* at 338–78 (suggesting that the political reform and government regulation of medical care and the medical profession in the mid to late 1900s undermined the sovereignty of private physicians).

48. *See* HOFSTADTER, *supra* note 34, at 148–49, 164 (describing the political reform movement in the late 1800s and early 1900s as a "status revolution"); WEBSTER'S II NEW COLLEGE DICTIONARY, *supra* note 30, at 950 (defining revolution as "[a]ctivities directed toward effecting basic changes in the socioeconomic structure, as of a cultural or minority segment of the population").

49. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 102–28, 96 Stat. 324, 331–67 (codified as amended in scattered section of 42 U.S.C.); *see also* Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1166–69 (1986) (discussing the Reagan Administration's structural reforms of government and the health care system in the 1980s).

50. *See* JOSEPH A. CALIFANO JR., AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS? 3 (1986); Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 55, 58–64 (discussing the failures of the health care revolution in the managed care era); Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1105–06 (2003) (discussing the political climate leading to a "quiet revolution" in Medicare during the 1980's).

American political life from the late nineteenth century into the mid-twentieth century.[51] His book focused on "neither the political campaigns, the enactments of legislatures, the decisions of the courts, nor the work of regulatory commissions, but [rather on] the ideas of the participants—their conception of what was wrong, the change they sought, and the techniques they thought desirable."[52]

> A great part of both the strength and the weakness of our national existence lies in the fact that Americans do not abide very quietly the evils of life. We are forever relentlessly pitting ourselves against them, demanding changes, improvements, remedies, but not often with sufficient sense of the limits that the human condition will in the end insistently impose upon us.[53]
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> [T]he evils they [the reformers] are troubled about do exist in some form, usually something can be done about them, and in a great many historical instances, something has been done. It is the merit of our reform tradition . . . that it has taken the initiative in making improvements. It is its limitation that it often wanders over the border between reality and impossibility.[54]

As we consider the ethics of health care reform, Hofstadter's construct is a guidepost when examining ideas of the participants in the debate. What is wrong (access, cost, and quality), what changes are sought, and what techniques are desirable? Whatever the outcome of the debate from a policy perspective, it is likely that there will be unintended consequences, as there have always been.[55]

## III. HEALTH CARE REFORM: FROM THE NEW DEAL TO MEDICARE

The American reform effort of the early twentieth century that helped to create our current health care system was the Social Security Act of 1935 (SSA).[56]

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51. HOFSTADTER, *supra* note 34, at 3.

52. *Id.* at 6.

53. *Id.* at 26.

54. *Id.* at 17.

55. *See* STARR, *supra* note 7, at 405, 408, 416 (noting that the extensive regulations enacted in health care during the 1970's were criticized by the end of the decade as inefficient because the focus shifted from improving quality and access to health care to cost control and also because the reforms had created a vast unintended bureaucracy); Kevin Sack, *Universal Coverage Strains Massachusetts Care*, N.Y. TIMES, Apr. 5, 2008, at A1 (explaining how Massachusetts's universal health care reform unintentionally created a "widening gap between the supply of primary care physician and the demand for their services").

56. Social Security Act, Pub. L. No. 74-271, §§ 1–1105, 49 Stat. 620, 620–48 (1935); Ruth-Arlene W. Howe, *Transracial Adoption (TRA): Old Prejudices and Discrimination Float Under a New Halo*, 6 B.U. PUB. INT. L.J. 409, 447 (1997) (describing the Social Security Act as "the first time that the federal government assumed 'collective responsibility for the inadequacies of a badly functioning economic system'") (quoting Harry L. Lurie, *The Drift to Public Relief, in* PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK 212 (1931)). Lack of health care was a recognized problem at the passing of the Social Security Act of 1935, even though the Social Security Act did not specifically

The SSA was intended to end poverty for elderly Americans.[57] Because the initial provisions of the SSA prohibited payments to those older persons living in government institutions, only by leaving a government institution and moving into a private setting could an elderly person claim Social Security benefits.[58] Although this provision was later stricken,[59] it created the conditions for the emergence of the for-profit nursing home industry in America.[60] The for-profit nursing home industry in turn became the focus of a highly organized reform movement spanning the last thirty years.

In an attempt to expand hospital and nursing home capacity after World War II, Congress passed the Hill-Burton Act of 1946.[61] The health care institutions built with Hill-Burton funds were expected, in exchange, to provide uncompensated charity care.[62] President Harry Truman, noting that the federal government was spending only about 4 percent of the gross domestic product (GDP) on medical services, remarked, "We can afford to spend more for health."[63] But if 4 percent was too little, few disagree that 16 percent of GDP is too much.[64] One unintended consequence of the Hill-Burton Act and its amendments has been the dominance of institutional care for frail seniors and disabled persons of all ages.[65] That dominance has been under attack in current reform efforts mandated by the

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address health care at that time. *See* Presidential Franklin D. Roosevelt, Message to Congress on the National Health Program (Jan. 23, 1939), *available at* http://www.ssa.gov/history/fdrstmts.html#12.

57. Social Security Act § 1; *see also* Nancy J. Altman, *Social Security and the Low-Income Worker*, 56 AM. U. L. REV. 1139, 1152 (2007).

58. *See* Social Security Act § 3(a); *see also* David A. Bohm, *Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317, 329 & n.62 (2001).

59. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 1, 2184(a)(4)(A), 95 Stat. 357, 357, 816.

60. Bohm, *supra* note 58, at 329 & n.62.

61. *See* Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946). The Hospital Survey and Construction Act is popularly known as the Hill-Burton Act after the two senators who introduced the bill; Senators Lister Hill of Alabama and Harold Burton of Ohio. *See* LEWIS E. WEEKS & HOWARD J. BERMAN, SHAPERS OF AMERICAN HEALTH CARE POLICY 27, 36–39 (1985), *available at* http://www.sigmondpapers.com/shapers_pdf/shapers_hospital_survey_construction.pdf; V. M. Hoge, *The Hospital Survey and Construction Act*, 62 PUB. HEALTH REP. 49, 49 (1947).

62. *See* Hospital Survey and Construction Act § 601 ("The purpose of this title is to assist the several States . . . for furnishing adequate hospital, clinic, and similar services to *all* their people; and to construct public and other nonprofit hospitals . . . .") (emphasis added); STARR, *supra* note 7, at 389.

63. STARR, *supra* note 7, at 281–83.

64. *See* Ctrs. for Medicare & Medicaid Servs., National Health Expenditure Data, tbl.1, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf (showing total national health expenditures of approximately $2.1 trillion against a gross domestic product of $13 trillion in 2006 with similar spending in 2007).

65. *See* Bohm, *supra* note 58, at 329–30, 330 n.67 (explaining that the Hill Burton Act and its subsequent amendments made nursing home care more profitable for providers).

Supreme Court's decision in *Olmstead*,[66] which directed states to expand community-based options for the care of disabled persons of all ages.[67]

Prior to the passage of the Medicare and Medicaid legislation of 1965,[68] nearly half of chronically ill Americans had no health insurance.[69] These federal programs improved the overall percentage of insured Americans to approximately 85 percent.[70] Although 85 percent looks like a substantial improvement from the 1960s, it is almost universally considered an unacceptably low number in today's world.[71] A major unintended consequence of the Medicaid legislation was that it became a form of universal long-term care insurance for older Americans.[72] If an impaired older person met the medical and functional criteria for nursing home admission, she could spend down her assets on the monthly nursing home fees until they were depleted and know that Medicaid would allow her to stay there until death.[73] An unintended consequence of Medicaid as a form of long-term care

66. Olmstead v. L.C., 527 U.S. 581 (1999).

67. *Id.* at 607; *see also* Stefan Staicovici, *Respite Care for All Family Caregivers: The Lifespan Respite Care Act*, 20 J. CONTEMP. HEALTH L. & POL'Y 243, 265–66 (2003).

68. Health Insurance for the Aged Act, Pub. L No. 89-97, §§ 100–22, 79 Stat. 286, 291–353 (1965) (codified as amended in scattered sections of 26, 42 & 45 U.S.C.).

69. NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH INSURANCE COVERAGE: UNITED STATES, JULY 1962–JUNE 1963, at 1–2, 18 tbl.7 (1964), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_011acc.pdf (estimating that 44.3 percent of persons with "chronic conditions that limited their ability to work, keep house, or go to school" did not have hospital insurance, the "most basic form of coverage" at the time). The report estimates that 29.2 percent of all Americans did not have basic hospital insurance and 33.2 percent did not have surgical insurance. *Id.* at 18 tbl.7.

70. ARLOC SHERMAN ET AL., CTR. ON BUDGET & POLICY PRIORITIES, POVERTY AND SHARE OF AMERICANS WITHOUT HEALTH INSURANCE WERE HIGHER IN 2007 AND MEDIAN INCOME FOR WORKING-AGE HOUSEHOLDS WAS LOWER THAN AT BOTTOM OF LAST RECESSION 2 (2008), *available at* http://www.cbpp.org/8-26-08pov.pdf.

71. *See* KAREN DAVIS ET AL., COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: AN INTERNATIONAL UPDATE ON COMPARATIVE PERFORMANCE OF AMERICAN HEALTH CARE 20 (2007), *available at* http://www.commonwealthfund.org/Publications.aspx (follow "International Health Policy" hyperlink; then follow "MIRROR, MIRROR ON THE WALL" hyperlink) (finding that the United States was the only country without a type of universal health care, covering 100% of the population, amongst Australia, Canada, Germany, New Zealand, the United Kingdom and the United States); William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 157 (2006) (characterizing the United States as "one of the only industrialized nations, and the sole remaining Western democracy" without a form of universal health care).

72. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, LONG-TERM INSURANCE CARE: PARTNERSHIP PROGRAMS INCLUDE BENEFITS THAT PROTECT POLICYHOLDERS AND ARE UNLIKELY TO RESULT IN MEDICAID SAVINGS 16 (2007), *available at* http://www.gao.gov/new.items/d07231.pdf (naming Medicaid as "the primary source of financing long-term care services in the United States"); Stephen A. Moses, Address, *The Brave New World of Long-Term Care*, 21 NOTRE DAME J.L. ETHICS & PUB. POL'Y 561, 564 (2007) (explaining how Medicaid has "crowded out" private payors of long-term care).

73. MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS IN A NUTSHELL 8 (2d ed. 1999); Charlene Harrington, *The Politics of Long-Term Care*, *in* POLICY & POLITICS IN NURSING AND HEALTH CARE 295, 301 (Diana J. Mason et al. eds., 5th ed. 2007).

insurance was promotion of institutional options over community-based forms of care.[74] Medicaid legislation also gave birth to estate planning services intended to transfer assets to other family members through trusts or other mechanisms, with the goal of maintaining inheritances rather than spending the assets on the cost of long-term care.[75] Families were no longer expected or required to take care of their elderly family members themselves, and they could avoid paying others to do so because Medicaid would pick up the bill.[76]

The current status of medicine in America is a direct outcome of the Medicare legislation of 1965. Medicare resulted in a substantial infusion of capital into the health care sector.[77] It created a level of medical inflation in the 1970s that was unsustainable,[78] leading to the cost control efforts of the early 1980s, such as the prospective payment system for hospital reimbursement through the diagnostic related groups (PPS/DRGs).[79] The prospective payment system to hospitals sought the discharge of patients after fewer days of hospital care.[80] The term "quicker and sicker" came to refer to patients discharged from a hospital but still in need of medical and nursing care.[81] The nursing home industry stepped up to the plate, accepting these patients under Medicare's skilled nursing facility benefit after a three-night hospital stay.[82] The difficulties today in obtaining adequate medical

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74. *See* ELLEN O'BRIEN & RISA ELIAS, KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM CARE 15 (2004), *available at* http://www.kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-2.pdf (explaining that Medicaid limits access to community based long-term care); STARR, *supra* note 7, at 445 (stating that Medicare and Medicaid stimulated the growth in proprietary nursing homes, an institutional form of long-term care).

75. *See* HALL ET AL., *supra* note 73, at 8.

76. *See* O'BRIEN & ELIAS, *supra* note 74, at 20–21 (explaining that Medicaid helps to fill the gaps in existing insurance arrangements which place large financial burdens on individuals and their caregivers).

77. *See* Health Insurance for the Aged Act, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343–44 (1965); Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 84 (1993) (noting that "[h]ealth care institutions receive large sums of federal money for treating Medicare and Medicaid patients").

78. *See* M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1049 (1992) ("Medicare's vague payment standard—reimbursement for 'customary' and 'prevailing' or 'reasonable' fees—invited physicians to push fees upward to new 'customary' levels."); Michael E. Nitardy, Note, Moran, Kentucky Ass'n of Health Plans, *and* Davila*: The (R)evolution of ERISA Preemption*, 18 ST. THOMAS L. REV. 139, 153 (2005) (noting that, because Medicare and Medicaid are the largest payors, other managed care services tie their reimbursement rates to the Medicare rates).

79. Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 100, 601, 97 Stat. 65, 65, 149–63; Andrew I. Batavia, *Preferred Provider Organizations: Antitrust Aspects and Implications for the Hospital Industry*, 10 AM. J.L. & MED. 169, 171 (1984).

80. *See* Karl Pillemer & Marc S. Lachs, *The Crisis in the Long-Term Care Workforce*, 4 J. HEALTH CARE L. & POL'Y 294, 304 (2002).

81. *Id.*

82. *See* 42 C.F.R. § 409.30(a)(1) (2007); GEN. ACCOUNTING OFFICE, SKILLED NURSING FACILITIES; MEDICARE PAYMENTS EXCEED COSTS FOR MOST BUT NOT ALL FACILITIES 8 (2002),

supervision for high acuity sub-acute patients in nursing facilities traces back to the PPS transitions of the early 1980s. Although the nursing homes made provisions to accept the discharged patients who were still in need of medical care, the model of community physicians coming into the nursing facilities in their spare time did not change in many facilities.[83] The reform of medical care in nursing homes is still playing catch-up to the changes Medicare instituted in the 1980s.[84]

## IV. GROWING UP WITH MEDICARE

I was eleven years old when the Medicare legislation was passed into law, and having entered medical school in 1977, I feel that Medicare and I have grown up together. Both of my grandfathers died before the introduction of the Medicare benefit. Both of my grandmothers died with Medicare paying their health care bills, as did my father. My mother received outstanding health care paid for by Medicare, including an early diagnosis and cure from breast cancer at the age of seventy-five and two brand new knees in her eighties. She recently celebrated her eighty-fourth birthday in robust health.

As I finished my fellowship training in geriatric medicine in 1985 and joined the academic internal medicine practice where I had trained, Medicare had just entered the realm of fee-setting for physicians.[85] I decided to become a Medicare-participating physician in 1985, the only participant in the sixty-member internal medicine group. I thought it was the right thing to do for my patients. As a new Medicare-participating physician, however, I was constrained by the "customary,

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*available at* http://www.gao.gov/new.items/d03183.pdf. The General Accounting Office was redesignated as the Governmental Accountability Office under the GAO Human Capital Reform Act of 2004, Pub. L. No. 108-271, §§ 1(a), 8(a), 118 Stat. 811, 811, 814.

83. *See* CARI LEVY ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., PHYSICIAN PRACTICES IN NURSING HOMES 11, 18 tbl.3 (2006), *available at* http://aspe.hhs.gov/daltcp/reports/2006/phypracfr.pdf (reflecting amount of time physicians spent caring for nursing home patients as a percentage of practice); Lawrence A. Frolik & Stephanie R. Gallo, *Assuring Safety in Long Term Care, in* 9 ETHICS, LAW, AND AGING REVIEW 43, 44–45 (Marshall B. Kapp ed. 2003) (arguing that the substandard quality of care in nursing homes stems from a lack of qualified medical care professionals).

84. *See* David G. Stevenson, *Planning for the Future—Long-Term Care and the 2008 Election*, 358 NEW ENG. J. MED. 1985, 1987 (2008) (stating that the current problems with "U.S. nursing home policy" were present in 1980); Dennis G. Smith, *State Health Reform: How States Can Control Costs and Expand Coverage*, BACKGROUNDER, NO. 2183, Sept. 22, 2008, at 1, 9, *available at* http://www.Heritage.org/research/healthcare/upload/bg_2183.pdf (arguing that the high costs of one state's health care market are "due to lack of competition dating back to rating setting actions in the 1980s").

85. *See* Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, §§ 2300, 2306(a), 98 Stat. 1061 1061, 1070 (codified at 42 U.S.C. § 1395u) (freezing physician fee charges for fifteen months starting from July 1, 1984); *see also* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society?(A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 41–43 (1986) (explaining how rising medical costs led to federal regulation of physician fee schedules in 1984).

prevailing, and reasonable" (CPR) Medicare standards."[86] My academic group, it turned out, was at the top of the fee schedule in the region. Therefore, by deciding to participate in Medicare right out of training, I limited my own earning potential relative to my colleagues. Several of the older physicians were very upset with me for this decision. They warned me that this was the beginning of the end. In a sense, they were correct. Medicare ushered in the period of industrialization and federal regulation of health care in America.[87]

As I have grown to a more senior rank within my profession, I have personally experienced an unintended consequence of Medicare reimbursement policy. Medicare pays a rate for each service that gives no weight to whether it is provided by someone right out of training or by a physician who has twenty or thirty years of experience.[88] Generally, doctors with decades of experience expect to earn more than someone right out of training. Because Medicare prohibits physicians from balance billing, i.e., charging patients for the difference between the physician's fee and the Medicare reimbursement for service,[89] an older and more experienced physician must either see a proportionally larger number of patients each day, or find alternative means of support, other than direct patient care, in order to earn more money over time. Therefore, the Medicare system unintentionally encourages experienced physicians to leave direct patient care and enter administrative positions or other arenas offering higher reimbursement.[90]

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86. *See* Medicare and Medicaid Budget Reconciliation Amendments of 1984 § 2309(b) (establishing a "centralized . . . charge data base" and using as one of the parameters the "customary and prevailing" rates of physician billing); RICK MAYES & ROBERT A. BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE 81–83 (2006) (explaining how physician billing parameters started out conforming to insurance companies' label of "usual, customary, and reasonable," which Medicare adopted using the terminology "customary, prevailing, and reasonable"); *see also* Ira Burney et al., *Medicare Physician Payment, Participation, and Reform*, HEALTH AFF., Winter 1984, at 9, 24 n.7 (explaining why Congress adopted the "customary, prevailing, and reasonable charges" for physician fee schedules).

87. Ani B. Satz, *The Limits of Health Care Reform*, 59 ALA. L. REV. 1451, 1461 (2008) (describing the extent of federal regulation of health care).

88. Richard Dolinar & S. Luke Leininger, *Pay for Performance or Compliance? A Second Opinion on Medicare Reimbursement*, 3 IND. HEALTH L. REV. 397, 397 (2006).

89. *See* David C. Colby et al., *Balance Billing Under Medicare: Protecting Beneficiaries and Preserving Physician Participation*, 20 J. HEALTH POL. POL'Y & L. 49, 51–52 (1995) (describing to what degree federal laws prohibit balance billing and state legislation barring balance billing allowed by federal law). In contrast to existing law, in 2007, a federal bill was introduced to "repeal limiting charges [such as balance billing] under the Medicare program for non-participating physicians and to preempt State laws that prohibit balance billing. H.R. 4736, 110th Cong. (1st Sess. 2007).

90. *See generally* Lisa Belkin, *Sensing a Loss of Control, More Doctors Call It Quits*, N.Y. TIMES, Mar. 9, 1993, at A1 (explaining how experienced doctors are retiring or obtaining positions without patient interaction, such as teaching positions, to avoid overly burdensome administration and "constantly justifying . . . decisions to . . . Federal Medicare clerks"); Vicki Kemper, *The Nation; Seniors See a Doctor Shortage; Lower Medicare Reimbursements Are Causing a Worsening Problem for the Elderly, as They Scramble to Find Physicians*, L.A. TIMES, Nov. 4, 2002, at 14 (reporting that the combination of escalating health-care costs, cuts in Medicare reimbursements, problems, with Medicare

Over the years I have developed a profoundly ambivalent, love-hate relationship with Medicare. Several years ago I received a notice that I had tripped the "99214 wire."[91] The warning letter claimed that I was an outlier relative to my peers, billing too high a percentage of my outpatient visits at the higher-level code. The letter warned that I should be absolutely sure that my documentation justified such billing because "tripping the wire" placed me at risk of audit. Of course, I was an outlier relative to my internal medicine peers. I am a geriatrician. I cared for more people over the age of ninety than below the age of sixty. We scheduled thirty-minute follow-up visits for this population. Although I felt we were in compliance with our billing practices, this letter caused significant anxiety every time I sat down to write a chart note. We were still using nineteenth century paper charts. I wanted to document more than usual, which took me more time. Still, I could not be sure that I had documented all the requirements each time to bill at the appropriate level for the time involved. I felt compelled to down code the visit to bring myself into alignment with my internal medicine peer group, for fear of having an audit conducted on my work.[92] I knew providers who had undergone audits. They expressed that it was an absolutely awful process, even if in the end they were vindicated. My down coding resulted in increasing financial pressure on me from the hospital that owned our practice. The budget became an unsolvable problem in a fee-for-service Medicare environment. I could not provide high-quality care and meet budget requirements. I quit the practice at the age of fifty-three, hoping to find a different way of providing quality care for frail elders in community settings. I convened a symposium for all the hospital-sponsored

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HMOs, and political gridlock in Washington is causing a severe physician shortage); Jenny Maher, *Delaware, Nation Need More Family Doctors, Report Says*, DEL. ST. NEWS, Sep. 27, 2006 (reporting that family physicians are retiring early partly due to Medicare reimbursement issues).

91. The number 99214 is the Current Procedural Terminology (CPT) code for an

> [o]ffice or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

AM. MED. ASS'N, CURRENT PROCEDURAL TERMINOLOGY: CPT 2009 PROFESSIONAL EDITION 10 (2008). Medicare's coding system is called the Healthcare Common Procedure Coding System, Levels I and II; Level I is compromised of the CPT code, while Level II covers care not addressed by the CPT code. Ctrs. for Medicare & Medicaid Servs., HCPCS Coding Questions, http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp (last visited Apr. 2, 2009). Medicare physician reimbursement uses a "relative value unit" which is "a relative value scale in which the value of physicians' work for a particular service is rated relative to the value of work for other physician services." 42 C.F.R. § 414.22 (2007).

92. *See* Joyce Frieden, *"Downcoding" for Medicare Visits May Be a Trend for Greater Number of Doctors*, FAM. PRAC. NEWS, June 15, 2000, *available at* http://findarticles.com/p/articles/mi_m0BJI/is_12_30/ai_63922899.

geriatric medicine programs in the Baltimore-Washington area about how to drop out of Medicare as I planned to do so myself. Medicare, in my opinion, had become one of the biggest obstacles for providing quality care to frail seniors.

## V. MODELS FOR PRIMARY CARE QUALITY MONITORING AND REPORTING

I feel enormously fortunate that, instead of dropping out of Medicare, I was given the opportunity to participate in a new financial model for providing care to frail elders living in a community setting through Erickson Health Medical Group. This project brings high-quality medical care to the Medicare population through a mix of fee-for-service and managed care enrollees, in collaboration with nursing homes and assisted-living facilities whose residents benefit from the model.[93] Erickson Health developed an electronic health record (E.H.R.) customized to the needs of frail elders.[94] The E.H.R. is integral to promoting quality care, assuring regulatory compliance, accountability, and data reporting.[95] I am once again hopeful that this model will enable high-quality geriatric medical care in a community setting in a manner that is sustainable, accountable, and replicable. "Hope, till hope creates from its own wreck, the thing it contemplates."[96]

The current call for accountability in medicine[97] cannot be met by payment schemes such as pay-for-performance. Pay-for-performance schemes are reductionist and do not capture overall quality of care.[98] For example, if an insurance company plans to pay more to a physician whose diabetic patients have Hemoglobin A1C measurements below 7 percent than to the physician whose

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93. *See* Lorraine Mirabella, *Erickson to Open Off-Site Practice for Seniors*, BALT. SUN, July 8, 2008, at 1D; *see also* Erickson, *About Us*, http://www.erickson.com/aboutUs/ (last visited Apr. 2, 2009).

94. Gary H. Brandeis, *Electronic Health Record Implementation in Community Nursing Homes*, 8 J. AM. MED. DIRECTORS ASS'N 31 (2007); *All Seniors Should Have Electronic Medical Records, Says Erickson Health System Official*, MED. NEWS TODAY, Mar. 18, 2008, http://www.medicalnewstoday.com/articles/100861.php (last visited Apr. 2, 2009).

95. *See* Catherine M. DesRoches et al., *Electronic Health Records in Ambulatory Care—A National Survey of Physicians*, 359 NEW ENG. J. MED. 50, 54, 57 fig.1 (2008); Richard Hillestad et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, 24 HEALTH AFF. 1103, 1108–10 (2005); Brent C. James, Editorial, *Making It Easy to Do Right*, 345 NEW ENG. J. MED. 991, 992 (2001).

96. PERCY BYSSHE SHELLEY, PROMETHEUS UNBOUND 120 (Vida D. Scudder ed., D.C. Heath & Co. 1892) (1820).

97. *See* L. Gregory Pawlson & Margaret E. O'Kane, *Professionalism, Regulation, and the Market: Impact on Accountability for Quality of Care*, 21 HEALTH AFF. 200, 200–01 (2002) (discussing recent views on the need to increase physician accountability); John W. Rowe, *Pay-for-Performance and Accountability: Related Themes in Improving Health Care*, 145 ANNALS INTERNAL MED. 695 *passim* (2006) (explaining that although pay-for-performance schemes improved over the past five years, further development can increase quality of care).

98. *See* Rowe, *supra* note 97, at 696–97 (explaining that physicians desire higher pay for better quality care as opposed to the flat reimbursements common to pay for performance schemes); Bill Steiger, *Poll Finds Physicians Very Wary of Pay-for-Performance Programs*, PHYSICIAN EXEC., Nov.–Dec. 2005, at 6, 6–7.

diabetic patients have an average Hemoglobin A1C of 8 percent,[99] the insurance company may be inadvertently rewarding a physician whose patients are less challenging and more compliant with their medical plans of care. Pay-for-performance may unintentionally encourage physicians to "cherry pick" patients and turn away the more challenging patients who would threaten the ability to meet the benchmark.[100] Physicians with the worst performance measures may have worked skillfully and much harder with more difficult patients to achieve the poorer number. For example, the 8 percent may reflect an improvement for the difficult patients from 9 percent or 10 percent and actually represent a remarkable achievement. However, if the benchmark is 7 percent, the physician will not be rewarded for his diligence and good work.

Med Chi, the Maryland Medical Society, held a series of symposia in 2006 to teach primary care physicians what is expected for pay-for-performance criteria from various insurers and national organizations measuring quality of care.[101] The presentations overwhelmed the attendees (myself included). Most small practices cannot invest the time required to learn all of the differing requirements and do not have the infrastructure to collect and report the information requested.[102] Medicare was surprised that, in its first year, only 16 percent of physicians participated in the voluntary Physician Quality Reporting Initiative (PQRI) measures, despite the fact that participation could result in up to a 1.5 percent increase in payment.[103] Most small practices do not have the capacity to capture and report the requested information.

The momentum in medicine is toward increasing industrialization and consolidation.[104] Small practices will need to find ways to work collectively and

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99. *See generally* Todd S. Harwell et al., *Do Persons with Diabetes Know Their (A1C) Number?*, 28 DIABETES EDUCATOR 99 (2002) (describing A1C testing as an important part of delivering quality care to diabetes patients).

100. Rowe, *supra* note 9797, at 698 (describing how physicians "gamed" a United Kingdom pay-for-performance system by "exclud[ing] certain patients"); Steiger, *supra* note 98, at 8 (citing concerns that pay-for-performance will cause "dumping of non-compliant or difficult patients in order to have physicians' performances appear good").

101. *Ethics Forum on Pay for Performance*, MEDCHI NEWS, Sept. 25, 2006, http://www.medchi.org/sites/default/files/pdfs/060925news.pdf.

102. *See* Robert Cunningham, *Professionalism Reconsidered: Physician Payment in a Small-Practice Environment*, 23 HEALTH AFF. 36, 39–41 (2004); Eric Holmboe et al., *Primary Care Physicians, Office-Based Practice, and the Meaning of Quality Improvement*, 118 AM. J. MED. 917, 919 (2005).

103. *See* Jennifer Lubell, *Push for More PQRI Responses*, MOD. HEALTHCARE, Mar. 3, 2008, at 10 (reporting that the Centers for Medicare and Medicaid Services will "move quickly to encourage broader participation by physicians and other eligible professionals").

104. *See* Darren Bush, *Antitrust and Health Care*, 7 HOUS. J. HEALTH L. & POL'Y 183, 183–85 (2007) (commenting on the "continuing trend" of the health care industry's consolidation); Thomas R. Oliver, *Policy Entrepreneurship in the Social Transformation of American Medicine: The Rise of Managed Care and Managed Competition*, 29 J. HEALTH POL. POL'Y & L. 701, 702–03, 724 (2004) (discussing the vertical integration of the health care industry and the growth and spread of HMOs).

collaboratively in the data collection functions. Whether the concept of "accountable care systems" will be able to connect small practices and provide the needed infrastructure is uncertain.[105] Small practices may be destroyed over time and be replaced by larger corporate-owned practices that have the infrastructure to do the reporting that is currently requested on a voluntary basis,[106] but may well be mandatory in the near future.[107]

## CONCLUSION

As Derek Bok said, "Even the most artfully crafted compensation scheme cannot ensure a perfect balance between cost and quality of care. . . . Medical care requires innumerable judgments for which there is no one obvious answer."[108] Similarly, health care reform requires innumerable judgments for which there is no one obvious answer. As current discussants describe the American health care system as "a mess,"[109] it is useful to remember how we arrived at the current messy situation. The answer lies in the efforts of reform movements of the past, with all of their intended and unintended consequences. Our current system of health care in America can perhaps be defined as the sum of the intended and unintended consequences of market forces combined with past legislative, judicial, and regulatory efforts aimed at achieving an ideal, but typically falling short. We may never successfully land on the rocky coast of utopia, but that does not mean we should not try.

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105. *See* Stephen M. Shortell & Lawrence P. Casalino, *Health Care Reform Requires Accountable Care Systems*, 300 JAMA 95 *passim* (2008). An accountable care system is "an entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for the results." *Id.* at 95.

106. *See* Lubell, *supra* note 103, at 10 (explaining that Medicare's PQRI is currently a voluntary program).

107. *See* Paul D. Freeman, *PQRI–deux*, 79 OPTOMETRY 115, 115 (2008); James Markland, *Growth Pangs for PQRI*, IMAGING ECON., Nov. 2008, *available at* http://www.imagingeconomics.com/issues/articles/2008-11_02.asp.

108. BOK, *supra* note 8, at 317.

109. *See, e.g.*, JULIUS B. RICHMOND & RASHI FEIN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT 1–3 (2005).