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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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, 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. 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. 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


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


\(^12\) 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

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).


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\textsuperscript{21} or that the free service is abused by the callers.\textsuperscript{22} Because medicine has become commodified,\textsuperscript{23} there is less emphasis on doctor-patient relationships and more emphasis on the elements within the interaction that serve to justify the reimbursement.\textsuperscript{24} Patients have expressed frustration with primary care physicians who seem more interested in the computer in the room than the patient.\textsuperscript{25} Both physicians and patients are discontented with the status quo. Both groups blame "the system."\textsuperscript{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?\textsuperscript{27} Why are those who deliver care, those who receive care, and those who pay for care dissatisfied?\textsuperscript{28} Looking back on the history of the


\textsuperscript{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, \textit{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).


\textsuperscript{26} See Theodore R. Marmor, \textit{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, \textit{Doctor Discontent}, 340 NEW ENG. J. MED. 649, 649–53 (1999).


\textsuperscript{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.  

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. Reform looks to a future ideal or to an idealized past. 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. The complexity of the reform debate is in determining the ethical principles that should be dominant in defining the "good." 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. These campaigns often characterize existing institutions, and individuals working within them, as bad. 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. This concept is illustrated by the term

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).
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.\(^3\) 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.\(^3\) 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.\(^3\) Their grievances are viewed as "collateral damage" by some health care policymakers and administrators,\(^4\) 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.\(^4\) 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\(^4\) 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."\(^4\)

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

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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).


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).


43. Id. at 259.
corrected or reformed through the promulgation of governmental regulations.\textsuperscript{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.\textsuperscript{45} For physicians, professionalism guided actions and formed the governance structures in medicine.\textsuperscript{46} In American health care reform, however, the dominant ethos of professionalism is increasingly yielding to federal regulatarianism.\textsuperscript{47}

When a political reform movement involves the unseating of a ruling class, it may be labeled a revolution.\textsuperscript{48} Physicians who practiced medicine prior to the emergence of the cost control mandates of Medicare in the 1980s\textsuperscript{49} may consider what has happened to the profession over the past twenty to thirty years as a revolution rather than a reformation.\textsuperscript{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, \textit{The Age of Reform}, Professor Richard Hofstadter claimed that reform movements have characterized

\textsuperscript{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).

\textsuperscript{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, \textit{The Politics of Evidence-Based Medicine}, 26 J. Health Pol’y, 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).

\textsuperscript{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).

\textsuperscript{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).

\textsuperscript{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”).


American political life from the late nineteenth century into the mid-twentieth century.\textsuperscript{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.\textsuperscript{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.\textsuperscript{53}

The 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.\textsuperscript{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.\textsuperscript{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).\textsuperscript{56}

\begin{itemize}
  \item \textsuperscript{51} Hofstadter, supra note 34, at 3.
  \item \textsuperscript{52} Id. at 6.
  \item \textsuperscript{53} Id. at 26.
  \item \textsuperscript{54} Id. at 17.
  \item \textsuperscript{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").
\end{itemize}
The SSA was intended to end poverty for elderly Americans.\footnote{Social Security Act § 1; see also Nancy J. Altman, Social Security and the Low-Income Worker, 56 AM. U. L. REV. 1139, 1152 (2007).} 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.\footnote{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).} Although this provision was later stricken,\footnote{Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 1, 2184(a)(4)(A), 95 Stat. 357, 357, 816.} it created the conditions for the emergence of the for-profit nursing home industry in America.\footnote{Bohm, supra note 58, at 329 & n.62.} 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.\footnote{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.sigmundpapers.com/shapers_pdf/shapers_hospital_survey_construction.pdf; V. M. Hoge, The Hospital Survey and Construction Act, 62 PUB. HEALTH REP. 49,49 (1947).} The health care institutions built with Hill-Burton funds were expected, in exchange, to provide uncompensated charity care.\footnote{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.} 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.”\footnote{STARR, supra note 7, at 281-83.} But if 4 percent was too little, few disagree that 16 percent of GDP is too much.\footnote{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).} 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.\footnote{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).} That dominance has been under attack in current reform efforts mandated by the
Supreme Court's decision in *Olmstead*, which directed states to expand community-based options for the care of disabled persons of all ages.

Prior to the passage of the Medicare and Medicaid legislation of 1965, nearly half of chronically ill Americans had no health insurance. These federal programs improved the overall percentage of insured Americans to approximately 85 percent. Although 85 percent looks like a substantial improvement from the 1960s, it is almost universally considered an unacceptably low number in today's world. A major unintended consequence of the Medicaid legislation was that it became a form of universal long-term care insurance for older Americans. 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.

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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).
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.
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).
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. 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. 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.

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. It created a level of medical inflation in the 1970s that was unsustainable, 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). The prospective payment system to hospitals sought the discharge of patients after fewer days of hospital care. The term “quicker and sicker” came to refer to patients discharged from a hospital but still in need of medical and nursing care. 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. The difficulties today in obtaining adequate medical


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).
80. See Karl Pillmer & 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. The reform of medical care in nursing homes is still playing catch-up to the changes Medicare instituted in the 1980s.

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. 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, 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.


prevailing, and reasonable" (CPR) Medicare standards." 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.

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. 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, 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.

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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).


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." 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. 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

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 office 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).

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. Erickson Health developed an electronic health record (E.H.R.) customized to the needs of frail elders. The E.H.R. is integral to promoting quality care, assuring regulatory compliance, accountability, and data reporting. 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.”

The current call for accountability in medicine 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. 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...
diabetic patients have an average Hemoglobin A1C of 8 percent, 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. 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. 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. 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. 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. Small practices will need to find ways to work collectively and


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”).


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”).

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.

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).


108. BOK, supra note 8, at 317.