The One-Size-Fits-All Approach of the Affordable Care Act

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My remarks today will address three aspects of health care reform. First, I will address some concerns I have about the Medicare Shared Savings Program in the Affordable Care Act.

promotes the formation and operation of Accountable Care Organizations (‘‘ACOs’’) to serve Medicare fee-for-service beneficiaries. ACOs may be formed from a variety of entities, including networks of individual practices, partnerships, hospitals, and other health care professionals. Some ACOs are expected to be newly-formed joint ventures among previously independent, competing entities. It is expected that most health care providers that form ACOs for Medicare beneficiaries will also seek to use the ACO structure for their commercially-insured patients.

Under the Act, ‘‘groups of providers . . . meeting the criteria specified by the [Department of Health and Human Services] may work together to manage and coordinate care for Medicare . . . beneficiaries through an [ACO].’’[2] An ACO can share in a portion of any savings it creates if it meets certain quality performance standards published by the Centers for Medicare and Medicaid Services (‘‘CMS’’). The Medicare Shared Savings Program in the Affordable Care Act is a topic on which the FTC spent considerable time over the last year. I have previously expressed my personal doubts about whether ACOs will achieve any savings,[3] much less the substantial savings that was forecasted when the legislation was enacted.[4]

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[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). This Act was amended a few days later by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2] Affordable Care Act § 3022 (codified as 42 U.S.C. § 1395jjj).

[3] J. Thomas Rosch, Accountable Care Organizations: What Exactly Are We Getting?, Remarks before the ABA Section of Antitrust Law Fall Forum (Nov. 17, 2011), *available at* http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf.

[4] Congressional Budget Office, Budget Options Volume I: Health Care at 72-74 (Dec. 2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf (estimating $5.3 billion in savings over ten years). In a more recent analysis, CMS estimated $470 million in Medicare savings in the first four years of the program. *See* Final CMS Regulations, *supra* note 3, at Table 8.

II.

A basic problem with the Shared Savings Program is the way in which the quality of care of participating ACOs is measured. CMS's regulations link the amount of shared savings an ACO can receive (and in certain instances shared losses it may be accountable for) to its performance on 33 quality measures.

communication skills, the patient's rating of the doctor, access to specialists, health promotion and education, and shared decision making.

The second domain consists of six measurements intended to assess the degree of coordination of care and patient safety. Examples include hospital readmission rates, frequency of medication reconciliation after discharge from an inpatient facility, admission rates for certain sensitive conditions, and screen rate for risk of falls. Some of this information will come from claims data; some from the ACOs.

The third domain, which falls within the "Better Health for Populations" goal, assesses whether eight specific health screenings or immunizations were provided. The final domain tracks ACOs' efforts to treat and the results of treatment for patients with certain conditions, namely diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease. ACOs are responsible for providing data related to the third and fourth domains to CMS.

As required by the Act, an ACO must demonstrate that it met the quality performance standards in order to share in any savings for that year. For the first performance year, ACOs need only provide complete and accurate reporting for all quality measures in order to qualify for shared savings; that is, ACOs do not have to meet any performance target in their first year. During the second and third performance years, quality performance standards will be phased in such that ACOs will gradually be assessed on performance, as well as accurate reporting.

CMS intends to establish national benchmarks for ACO quality measures and will release benchmark data at the start of the second performance year when the pay-for-performance phase-

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selecting and paying for a CMS-certified vendor to administer the patient survey beginning in 2014.

in begins.[7] For most of the measures, performance at or above the 90th percentile of the performance benchmark will earn the maximum points available. ACOs will need to achieve minimum standards on at least 70 percent of the measures in each domain to avoid being placed on a corrective action plan. CMS claims that it will also use certain measures to help identify ACOs that are avoiding at-risk patients or enga

quality measures but generally only with respect to age and gender. CMS also determined not to include any risk adjustment to account for the many other differences among ACO populations or the personal preferences of beneficiaries. Thus, ACOs that serve healthy or compliant populations – particularly those in more affluent, more educated areas – are likely to achieve higher quality scores.[10]

This problem is compounded by the incentive of ACOs to enroll healthy patients and avoid at risk populations, who are less likely to be healthy and compliant. CMS itself has acknowledged this concern and asserted that it "intend[s] to monitor the quality of care furnished by ACOs in an effort to identify patterns of avoiding at-risk beneficiaries."[11] To what extent CMS will be able to do this is unclear, given the myriad ways ACOs could attempt to jettison at risk patients and enroll healthy ones. For example, ACOs could attract more desirable patients through targeted marketing campaigns or through recruiting physicians that have healthy or compliant patients.

The second problem with CMS's 33 quality metrics is that they suffer from a number of inherent limitations. As I previously mentioned, seven of the quality metrics are based on patient surveys. It's no secret that designing an accurate survey is not easy, and CMS has acknowledged that "survey mode and methodology can affect results."[12] For example, patients with limited English skills are unlikely to complete written surveys. Furthermore, survey results are influenced by a variety of subjective factors, including patients' attitudes toward their own health. Imagine a physician that repeatedly urges a patient to get stop smoking, but the patient

[10] The same is true for individual physicians or physician groups within an ACO. Those that

refuses. Despite following recommended guidelines, the doctor may receive low survey scores because of the patient's displeasure with the doctor's repeated counseling. In addition, studies have shown that socioeconomic status is correlated with an individual's views about his health.[13] Thus, we can expect more favorable survey results from ACOs serving more educated, affluent areas.

Another inherent limitation with some of the quality metrics is that they measure processes or outcomes that are beyond the ACO's control. A patient may refuse to have a colonoscopy, for example, despite the best efforts of his physician. In this case, the physician would be penalized on one of the process metrics. Likewise, outcome metrics do not account for patient-specific health issues, individual patient compliance, or care provided by providers outside the ACO. As a result, the quality metrics may overstate – or understate – the true quality of care provided by an ACO.

A third problem with the CMS quality metrics is that they are not universally accepted. Physicians participating in ACOs that follow different, but equally valid, clinical practice guidelines will either be penalized or have to abandon their preferred guidelines.

The final problem with CMS's quality metrics is that ACOs may be able to develop strategies to perform well on the quality metrics but provide sub-standard care in other respects. In other words, there is a risk of "teaching to the test."[14] For example, ACOs will be rated on their screening for weight, tobacco use, depression, colorectal cancer, breast cancer, and blood

[13] *See, e.g.*, Jane Wardle & A. Steptoe, *Socioeconomic Differences in Attitudes and Beliefs About Healthy Lifestyles*, 57 J. Epidemiol Community Health 440 (2003) ("Socioeconomic differences in healthy lifestyles are associated with differences in attitudes to health . . . ."); Paula M. Lantz, et al., *Socioeconomic Factors, Health Behaviors, and M lh 0 c87.0 TD- ACO.*

pressure, but are not rated on

each state to identify the specific benefits within the ten categories based on existing insurance plans.[17]

As Robert Samuelson, a columnist for the Washington Post, observed, this move was designed to make it appear that "Washington isn't dictating how medicine should be practiced" and that the Administration has "left crucial decisions to the States."[18] To be sure, the surprise announcement may provide for some flexibility where before there was none. But what has not changed is that insurance in the individual and small-group markets will still need to provide the ten categories of essential health benefits mandated by the Affordable Care Act. In other words, the federal government is still calling the shots. For example, the Act "mandates that some benefits not routinely included in most plans—eye care and dentistry for children, and mental health and substance abuse—be covered."[19] Furthermore, it remains to be seen how much

[17] States will select a benchmark plan that reflects the scope of services offered by a "typical employer plan." States will choose one of the following health insurance plans as a benchmark:

> One of the three largest small group plans in the state by enrollment;
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> One of the three largest state employee health plans by enrollment;
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> One of the three largest federal employee health plan options by enrollment;
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> The largest HMO plan offered in the state's commercial market by enrollment.

If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state. The benefits and services included in the benchmark health insurance plan selected by the state would be the essential health benefits package.

Health plans would have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all ten categories and the coverage has the same value.

[18] Robert J. Samuelson, *Punting on Health Care*, Washington Post, Dec. 23, 2011, at A21.

[19] *Id.*

discretion HHS will have to revise the benefit benchmarks in the future or to otherwise limit the discretion of the states in determining benefits.[20]

With its announcement, HHS also avoided making some difficult decisions about controlling health care costs. HHS declined to set a limit on the cost of the minimum essential package, as recommended by its own group of experts from the nonpartisan Institute of Medicine.[21] Instead, states will be free to require greater levels of coverage—as all of them now do—thereby driving up costs. And because the federal government partly subsidizes this coverage, states will have a stronger incentive than they do in the current commercial market to add these mandates. As a result, some healthy individuals may decide to pay a penalty instead of buying expensive insurance, skewing the risk pool toward the sick and causing premiums to spiral even higher. The net result may well be higher costs to individuals, employers, and the federal government.

HHS' announcement would have been far better if, in addition to allowing states true flexibility to make coverage decisions, it had also allowed individuals and small businesses to purchase insurance across state lines, including from Exchanges operated by other states.[22] That

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[20] HHS's announcement was not in the form of a final rule change, but rather a "bulletin" outlining a proposed new policy. Comments on the bulletin are due January 31, 2012.

[21] Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Oct. 2011), *available at* www.iom.edu/EHB ("If the benefits are not affordable, fewer individuals will buy insurance."). The IOM committee suggested that HHS require the benefits to be equivalent to a typical small-employer plan.

[22] This approach could still impose certain requirements, such as solvency standards and appeal rights. Under section 1333 of the Act, the Secretary of HHS is required to issue regulations for the creation of health care choice compacts. Under these compacts, two or more States may agree to allow qualified health plans to cross-sell insurance in their States. *See* Statement of Steven B. Larsen, Dep. Administrator and Director, Center for Consumer Information & Insurance Oversight, CMS on Expanding Health Care Options: Allowing Americans to Purchase Affordable Coverage Across State Lines Before the U.S. House Committee on Energy and Commerce Subcommittee on Health (May 25, 2011), *available at* http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/052511/Larsen.pdf.

would have introduced a measure of competition into a system often characterized by expensive state-imposed mandates and few competitive options for consumers. According to one group, state mandates can raise the cost of a policy by up to 50%.[23] For example, a family policy in New York costs on average over $13,000, while a similar plan in neighboring Pennsylvania costs $6,400.[24] New York, it should be noted, has imposed guaranteed issue and community rating requirements, while Pennsylvania has not.

insured individuals.[27] In addition, allowing cross-state purchases of insurance would allow individuals to keep their health plan when they move from state to state.

The usual argument against this approach is a so-called race-to-the-bottom. In other words, individuals will purchase across state lines to purchase basic coverage with few consumer protections rather than more comprehensive, in-state coverage. But this criticism assumes that Cadillac plans are what consumers necessarily want. It also disregards that coverage has to be balanced against cost. And it reflects a paternalistic view that individuals are unable to determine which health plan will best suit their needs.

It is an adage of basic economics that firms face a downward sloping demand curve. As the price of a product or service drops the quantity demanded increases. Applied here, what that means is that permitting purchases of health care insurance across state lines will not only benefit existing insureds by lowering their costs, but will permit more small businesses and consumers to afford coverage. To the extent that consumers purchase more basic, affordable plans from other states, this should be viewed as a positive, not a negative, because it demonstrates that the in-state mandates were not desired by consumers. To the extent that these mandates actually are valued by consumers, we are likely to see a race to the *top*, not a race to the bottom. That is, we should expect to see individuals from low-mandate states purchasing insurance in high-mandate states.

IV.

I sometimes hear that the competition simply doesn't work in the health care sector and that government intervention, with legislation such as the Affordable Care Act, is needed to

[27] Stephen L. Parente et al., *Consumer Response to a National Marketplace for Individual Health Insurance*, 78 J. Risk & Insurance 389 (2011) (Abstract: "We find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of health insurance across state lines.").

correct widespread and intractable market failures. The argument is that consumers are oblivious to the true price of a health care product or service and, as a result, do not have the usual incentive to reward low cost, high quality providers.

> A proposal by the North Carolina Board of Opticians to restrict the sale of contact lenses, eyeglasses, and other optical goods because the proposal would raise costs to consumers; and
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> A proposal by the Georgia Board of Dentistry to restrict the ability of dental hygienists to provide basic preventive dental services in approved public health settings because it would raise the cost of dental services and reduce the number of consumers receiving dental care, particularly indigent children.

We have also found that some state medical licensing boards have acted to benefit their licensees, rather than to protect the public health. Just last month, the Commission issued an opinion finding that the North Carolina Dental Board violated Section 1 of the Sherman Act by attempting to restrict the practice of teeth whitening to dentists.[30] The results of the Board's actions were increased prices and reduced consumer choice. The Commission issued a final order requiring the Dental Board to stop its restrictive practices.

While the Commission can take action against some anticompetitive restrictions by state boards, we are arguably powerless to prevent the enactment or enforcement of most anticompetitive state legislation due to the state action doctrine. Instead, it is arguable that we are limited to advising state legi

That brings me back to my fundamental objection to the Affordable Care Act, namely that it imposes more government regulation and control over a marketplace that is functioning poorly in large part due to existing over-regulation. The net result of the Act may be greater coverage but with the tradeoff of higher costs to consumers, higher costs to the government, and forcing some consumers to purchase a product they don't want. The better approach, in my view, would have been to eliminate, to the extent possible under our federalist system, the barriers at the state and federal level to a truly competitive health care marketplace. This would have lowered costs to consumers, improved health care quality, increased innovation, and increased coverage—all at little to no cost to the federal government.