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TuftScope

The Interdisciplinary Journal of Health, Ethics, and Policy

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TuftScope

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Cover Image: In this issue, *TuftScope* explores the various issues of healthcare legislation and policy.

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TUFTSCOPE
THE INTERDISCIPLINARY JOURNAL OF HEALTH, ETHICS, AND POLICY

LETTER FROM THE EDITORS

TuftScope: Welcome Back & Special Edition

Dear Reader

As TuftScope comes back to campus this year, we are excited to introduce a special edition on the Patient Protection and Affordable Care Act (ACA), passed by Congress earlier this year. We are thankful to Professor Kevin Irwin and his Spring 2012 Seminar in Health Politics: Promise and Problems in US Health Care Reform for providing the content for this issue. The issue of healthcare is a complex and divisive issue which has become a focus for every branch of government and a key platform in political discourse. As the Presidential Election draws closer, we hope that the variety of perspectives offered in this issue will shed light on the many aspects and consequences of the ACA.

Each of the original articles presented in this issue focuses on different aspects of the impact that the Patient Protection and Affordable Care Act (ACA) will have on America. As described by Rebecca Matyas and Bryn Kass, the ACA, respectively, includes improvements to availability of preventative services like cancer screenings for women, as well as implementation of Hospital Value-Based Purchasing Program (HVBP) to produce a higher quality Medicare system. These examples are just a few of the means by which the ACA will transform the health care system in America.

The effects of the Act will continue to be felt for years to come. Monica Stadecker considers the technological, ethical and social impacts of Electronic Health Records will have on the future of patient-provider relationships. Rebecca Edelberg discusses how the transition to a bundled payment system is both laborious and rife with challenges. It is necessary to understand what changes the ACA will make, when they will occur, and what is to be expected.

As TuftScope enters the 2012-2013 school year, we are excited to continue increasing our presence on campus. We will continue to grow our online presence through the website (http://www.tuftscopejournal.org), our blog (www.tuftscope.blogspot.com) and our Twitter account (http://twitter.com/TuftScope). Within the editorial board, we are sad to say good-bye to our Editor-in-Chief David Gennert as he graduates. We wish him the best of luck. Our Managing Editor, Brian Wolf, will take his place.

The beginning of the school year also means recruitment and bringing in new ideas and perspectives to the journal. Whether you are a freshman or a senior, we always welcome contributions in any size. Submissions for the Fall Edition of TuftScope can be submitted online until October 15. For more information and on how to become involved, email us at TuftScope@gmail.com or attend our staff meetings on Monday nights at 9 PM in Eaton.

We hope you enjoy the issue.

Sincerely,

Eriene-Heidi Sidhom, Brian Wolf & David Gennert

A Workplace in Progress

Wellness Programs Under the Affordable Care Act

Erik Antokal

A wealth of research demonstrates the effectiveness of Workplace Wellness Programs (WWPs) in reducing health care spending, improving employee health and productivity, and making most businesses more financially successful. Under current legislation, a WWP is any employee program that is "reasonably designed to promote health or prevent disease." Despite the benefits and the diversity of acceptable programs, most small firms have not yet been able to implement WWPs. The Patient Protection and Affordability of Care Act (ACA) includes several provisions to encourage WWPs in small firms, and delegated execution of the law's vague framework to the Department of Health and Human Services (HHS). The way in which these aspects are enacted will determine the degree of the WWPs' success. This paper explores how ACA's provisions for small firm WWPs are defined, and proposes strengthening modes of implementation.

Well-framed WWP provisions in ACA include a 3-year program evaluation, increases in allowable employee participation rewards and the allocation of grant funding to initiate WWPs in small businesses. Vague provisions include a technical advising process, workplace assessments prior to implementing a WWP, and the inclusion of existing private consulting firms in program development. Certain modes of implementation would maximize the each component's effectiveness. By defining these provisions via the recommended methodologies, the United States stands to make substantial gains in economic productivity, public health and health care cost containment.

BACKGROUND/CONTEXT:

As 2014 looms, individuals, corporations and government agencies alike are preparing for the implementation of the Patient Protection and Affordability of Care Act (ACA). The diversity and complexity of this implementation are formidable, but each provision must be meticulously enacted in order to achieve the maximum impact in curbing rising health care spending and bolstering the health status of the United States' population. ACA's provisions targeting workplace wellness programs (WWPs) are especially important to this impact on health, because of their capacity to simultaneously reduce health care spending, improve health status, and increase economic productivity. In the ACA, a WWP is defined as any employee program "reasonably designed to promote health or prevent disease," giving the programs a broadness that creates great potential for creative design but also for ineffective implementation.

Perhaps most simply, ACA's focus on increasing small businesses' access to WWPs is appropriate, and may have high marginal returns on investment...

SPECIFIC AIMS

The ACA includes several provisions to encourage WWPs in small firms, but the Department of Health and Human Services (HHS) has not yet defined certain aspects of implementation. The way in which these aspects are practically defined will determine the degree of the WWPs' success. In this paper, I explore how ACA's provisions for WWPs are defined, and critique current plans for policy implementation. Ultimately, I propose measures that would strengthen the well-framed policies and bolster the potential of those that do not yet possess robust implementation frameworks.

RATIONALE

It is important to study and critique ACA's provisions for WWPs for a number of reasons. First, research has shown that WWPs produce net health and economic benefits for employees and employers.[1,2,3,4] Second, the issue is relatively non-polarizing: there is bipartisan political support for increasing wellness in the American workplace, and bipartisan support for small businesses. Third, if the individual mandate is ruled unconstitutional, and rest of the ACA is not dismantled, the provisions for WWPs will become even more important in terms of the ACA's overall impact. Thus, this portion of the law could still be a significant contributor to the goals of the ACA, if the provisions are implemented effectively. Fourth, the relationship between employers and health insurance, and thus, the health of their employees, is likely to continue for the foreseeable future. The ACA is an incremental step in reforming the health systems of the United States, and does nothing to alter the link between employers and health insurance. As long as employee health and health insurance costs are tied to employer economic incentives, firms will continue to seek ways to reduce the costs of poor employee health. Thus, the ACA's WWP provisions warrant study and critique, so as to increase their beneficial impact.

EVIDENCE

WWPs have already demonstrated a capacity for having an impact on employee wellness and the health care system. Annual health care costs attributable to treatment of

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preventable disease amount to between $303 to $493 billion.[1] Programs like WWPs prevent such diseases, thus reducing health care spending. WWPs have been formally promoted by the federal government since the early 1980s; laws have stipulated (and will continue to do so until 2014) that employers may provide employees with a financial reward of up to 20% of the cost of participating in a WWP.[5] These rewards may be disbursed in the form of discounts on participation fees, reduced insurance premiums, reduced cost-sharing, or another health-related financial reward.

These rewards are meant to allow employers to incentivize WWPs, because such programs result in net financial gains for the employers. One study found that for every dollar spent on workplace health promotion, absenteeism costs fall by an average of $2.73. This figure not only included productivity losses due to illness-related employee absence, but also costs due to employee absence not due to an illness. Furthermore, medical costs to the employer fall by an average $3.27 per dollar invested in WWPs.[6] Additional studies found similar results across a wide range of industries and employee health statuses.[2] Another study showed that $1.65 is saved in medical costs alone per $1 spent on wellness programs.[3] Even without considering the benefit to aggregate health care costs and long-term population wellness, the economic benefits of WWPs for employers are clear. The current body of research provides compelling evidence that WWPs are a prudent investment for the vast majority of firms, meriting the encouragement stipulated in the ACA.

Historically, however, larger firms have been more able to reap the benefits of WWPs. A recent study reported that 28% of firms with less than 99 employees had WWPs, while 78% of firms with 100 to 2,499 employees had WWPs.[7] According to another study, only 20% of businesses with less than 100 employees "strongly agreed" that the benefits of WWPs outweighed the costs.[7] Much of the ACA's provisions for encouraging WWPs are focused on closing this disparity in use between small and large firms. With over 30 million Americans employed by firms with less than 99 employees,[8] most of these individuals lack access to a WWP. Thus, a greater number WWPs in small businesses could have a significant impact on the aggregate health of the United States.

ACA'S PROVISIONS FOR WWPS

Under the ACA, small businesses are the primary focus of the legislation regarding WWPs, because of the aforementioned disparity between large and small firms. ACA creates incentives for promoting WWPs in small businesses, which are defined in this section of the law as firms with 100 employees or less each working at least 25 hours per week. Approved WWPs under the ACA are loosely defined; they must simply be "reasonably designed to promote health or prevent disease."[9] Examples include diet and exercise education initiatives, creation of a workplace gym, or hiring a mindfulness instructor to hold classes for employees. The ACA will have a major influence on the long-term shape of these WWPs, and it is thus important to enact its provisions in the most effective manner.

ADEQUATELY-FRAMED PROVISIONS

Perhaps most simply, the ACA's focus on increasing small businesses' access to WWPs is appropriate, and may have high marginal returns on investment, given the current disparities between large and small businesses. Small business employees represent over 30 million people, (10% of the US population),[8] and are underserved in terms of WWPs, suggesting that significant gains can be made in their collective health status and productivity. This, in turn, translates to an increased likelihood of small business successes, and theoretically, to a decrease in aggregate health care costs.

The ACA's mandated 3-year evaluation period will strengthen WWPs' effectiveness. After this initial period, a report is due to HHS detailing the effectiveness that government programs had on promoting WWPs, and what effect WWPs had on promoting health and reducing costs. This provision is effective and necessary for understanding the impact of the ACA on small businesses, their employees, and on the law's impact on health status as a whole. Most importantly, this data will allow HHS to correct flaws and build on the strengths of its programs.

In 2014, the federal government will raise the potential reward of the cost of participation in a WWP from 20% to 30%. Employers may still apply these rewards as reduced premiums, reduced cost-sharing, or other health-related, non-cash financial benefits. Further, if HHS deems appropriate, the reward cap may be increased to 50%, a measure that would allow employers to even further incentivize participation in WWPs.[10] With less disease and better health, employees will be present at work more often, and will be more productive assets to the firm. In cases where the economic benefit of providing a wellness program exceeds 20% of the cost of the intervention, the ACA's reward increases would enable employers to better incentivize participation in cost-saving WWPs. These increased rewards to employees are effective and necessary for making WWPs more available and attractive for small business employees; if this provision is effectively disseminated to small businesses, it may be effective at increasing participation in WWPs.

The ACA also allocates $200 million as grant funding for small businesses to implement new wellness programs.[11] Due to a limited funding pool, the pursuit of these grants will be highly competitive, helping to ensure that new WWPs are high-quality. In 2008, there were 6,054,454 firms with fewer than 99 employees,[12] giving an average of $33.03 in grant funding per firm. This is not to say that each firm will be provided this small amount, but to illustrate the limitations of the allocated grant funding. With such limited funding, the grant application process must be competitive, selective, and ensure accountability from the small business. An expansion of the funding pool would allow for a larger number of small businesses to implement effective wellness programs, and such an increase may come about after the first three years of these programs have been evaluated by the mandated report.

Importantly, it appears that the Small Business Administration (SBA) already presents an effective platform for disseminating the availability of these grants.[13] On their website, the SBA offers a search tool that allows small business owners

to search for available funding for a variety of purposes. Adding options to include WWP grants would be a relatively simple process, and would thus effectively integrate the grants into small business' funding opportunities. Fortunately, the infrastructure and resources for successfully allocating grant funding already exist. However, despite the promise of this grant funding, it must be closely tied to the technical assistance to be offered by HHS. The provision of this advising is vaguely framed, and will be discussed in the following section.

VAGUE PROVISIONS AND STRENGTHENING RECOMMENDATIONS

The practical implementation of provisions for WWPs is largely undefined. Legislators purposefully did this so that HHS could assess the best ways to enact the ACA's components. As current implementation plans currently stand, there are three critical and yet-to-be-defined provisions where implementation specifics will prove to be important. Here, I will suggest practical steps for implementation that may prove beneficial for the effectiveness of WWPs. The principal areas in which I propose strengthening strategies for WWPs include: the technical assistance programs, workplace assessment enactment and the alternative wellness program requirement.

Under the ACA, HHS is obligated to provide "technical assistance and other resources to evaluate" WWPs, which will presumably be given in conjunction with grant funding.[14] The practical nature of this assistance is undefined, but there are several measures that federal and state agencies can adopt in order to maximize its effectiveness. Because of the increasing corporate demand for WWPs, a wellness consulting industry has been consolidated to fill the demand. The technical advising capacity already exists in the private sector, at a level of expertise that HHS would not be likely to match, given only two years to prepare the service. Thus, it seems that WWPs could be better advised were HHS to secure contracts with private consulting firms. Such a public-private partnership between private wellness consulting firms and HHS could, include rate reductions for small businesses, negotiated using the dramatically augmented customer base that the ACA would provide to consulting firms.

Further, such a partnership could consist of government subsidies for small businesses seeking consulting from a "certified" consulting firm, who would agree to certain standards in its programs, which would at least include: a reflection of existing legislation, integration of evidence-based best practices, and a demonstrated ability to design cost-effective WWPs at an affordable rate. This certification process would necessitate a larger bureaucracy, and thus, larger costs. However, the total cost of this bureaucracy would likely be lower than the creation of a countrywide technical advising program for the immense diversity of small businesses in the US. Such a public-private partnership would reduce costs to HHS, bolster private consulting firms, and optimize the WWPs implemented by small businesses. This proposed partnership may take any number of forms, but certainly bears the potential to optimize the consultative function of WWP technical advising.

In order to best ensure the feasibility of proposed WWPs, workplace assessments must be conducted. However, because small businesses are so diverse (in employee demographics, in workplace environments, in capacities to fund WWPs, and a host of other facets), technical advising cannot apply predetermined models for WWPs. Instead, the advising process must include individualized assessments of each case. Further, assessments should be carried out in person, with a high degree of collaboration, so as to effectively discern the challenges and opportunities presented by each case. This lends clout to a public-private consulting partnership, given the difficulty of expanding state and federal advising to businesses all over the country.

Such a measure would address the fact that apparently viable and effective WWP proposals may, in reality, be at risk for failure. For example, a small business may propose a yoga class, but if employees perceive yoga as a waste of time, participation will be low, and the grant funding will not create health or productivity gains. In this situation, the grant funding will have been wasted. Furthermore, as with the technical advising, grant disbursement should be contingent on the completion of a workplace assessment. That way, the proposed wellness program will be molded, if not overhauled, such that it is appropriate, and thus, effective for the target population. Though necessitating greater initial costs, these assessments would reduce overall cost by reducing grant waste. Further, workplace assessments may reveal more attractive and feasible WWPs.

Under the ACA, approved WWPs must include an alternative wellness program that allows employees for whom participation is not feasible to receive the same reward. For example, if an employee is wheelchair-bound, jogging groups cannot be the only wellness program provided. This provision, while necessary to curb discrimination in reward disbursement, is not fully supported by an appropriate framework. The cost of implementing a second program may preclude the implementation of any wellness program, especially for small businesses. Further, without the aforementioned workplace assessments, it will be difficult to determine the physical, contextual or cultural appropriateness of a given WWP. It is thus imperative that the cost of the alternative program is clear during the grant application process, and that technical advising also include these alternative programs. Again, this necessitates a strong attentiveness in advising, grant review and to workplace needs on the part of HHS and any associated agencies.

CONCLUSIONS / RECOMMENDATIONS FOR FUTURE RESEARCH

Clearly, there is still work to be done in shaping the implementation of the ACA's provisions for WWPs. However, further research will augment the effectiveness of that work. Given the diverse array of stakeholders involved with workplace wellness, it is necessary to explore an "Integrator," as proposed by Small Business Majority, a national non-profit focused on elucidating challenges and opportunities for small firms.[15] Such an organization, though potentially adding to the bureaucracy of WWPs, could reduce duplication of work

and facilitate synergies between stakeholders. Furthermore, the proposed model rightly centers around the practical goal of WWPs: choices of individual employees, and seeks to integrate the health care system, businesses, government and non-profits in an effort to encourage individual choices that promote wellness in the workplace. A state-level pilot initiative would be instrumental in developing this "Integrator" and determining its national scalability.

Additionally, more research must be done on current WWPs in small businesses. The current body of research is limited with respect to WWPs' effectiveness, and similarly limited in the documentation of their prevalence in the small business sector.[15] A systematic evaluation of common planning and implementation obstacles would be useful in designing guides for the technical advising process, and for grant selection; by recognizing common pitfalls, the grant committee would be more able to evaluate the quality of the proposal. The Wellness Council of America and the Small Business Wellness Initiative have already made progress in compiling evidence-based tenets of WWPs,[16] and developing efforts to incentivize and reward successful efforts to promote workplace wellness.[17] The expanding efforts, and results produced by these two organizations should be and mirrored in HHS' implementation the ACA's provisions for WWPs.

SUMMARY

The ACA's encouragement of WWPs has the potential for efficacy in preventing disease and reducing economic costs to employers and employees alike. Increasing reward limits, targeting small businesses with support, and mandating evaluations of federal programs all constitute progress toward a healthier, more productive workforce. However, key implementation considerations must be addressed to ensure that the limited funding will be utilized in an efficient and productive manner. HHS must provide high-quality advising, preferably through public-private partnership, to small businesses seeking to implement WWPs; workplace assessments must be executed before WWPs are funded; and these two measures must be closely tied to a competitive grant application process. HHS must also maintain its commitment to implementing the stronger sections of the law as they currently stand. If these goals are met, the United States stands to make substantial gains in economic productivity, public health and health care cost containment through use of WWPs.

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Language and Politics in the Debate Over the Affordable Care Act

Sarah Bleiberg

This paper analyzes the rhetoric in the debate over the Affordable Care Act (ACA) in order to understand the effect of the claims made by either party on the ultimate implementation of this act. In order to accomplish this goal, this paper examines one claim from the Republicans and one claim from the Democrats that has been a central piece of their argument for or against the ACA. The Republicans claim that the ACA is a "government takeover of health care," and the Democrats claim that "prevention saves money." In this analysis, I will examine how the claims were created, how true they are, and whether or not they have been effective in garnering support for the respective sides. In both cases, these claims are based on what will gain either party support without regard for the truth, yet have been very effective in increasing support. The effect of these false claims is to solidify support among their party and increase partisanship, thus reinforcing a debate along party lines as opposed to what is best for the country.

Since before it was first introduced, the Patient Protection and Affordable Care Act (ACA) has been surrounded by vigorous debate. The nature of this debate has a profound effect on the ultimate implementation of the bill. In order to understand this effect, I will analyze one claim from the Republicans and one claim from the Democrats that has been a central piece of their argument for or against the ACA, the claim that ACA is "a government takeover of health care" and that "prevention saves money" respectively. Both of these claims are broad oversimplifications that were designed to appeal to the public, as opposed to being an explanation of a rational argument. Despite their falsity, both of these claims have resonated with the public. The ultimate impact of these false claims is to strengthen the partisanship of the debate over ACA despite the broad support for many of its provisions.

THE REPUBLICAN CLAIM: "A GOVERNMENT TAKEOVER OF HEALTH CARE"

Anyone who has been following the debate over health care reform will have heard the phrase "a government takeover of health care" coined by Republicans to describe the Affordable Care Act. In fact, Frank Luntz, a well-known Republican strategist created the phrase as a part of his report entitled "The Language of Health Care 2009." Luntz's 28-page document describes the words and phrases Republicans should use when talking about health care. In reference to a government takeover he states, "takeovers are like coups—they both lead to dictators and loss of freedom."[13] Luntz explains that people "are deathly afraid that a government takeover will lower their quality of care – so they are extremely receptive to the anti-Washington approach. It's not an economic issue. It's a bureaucratic issue."[13] Here and with other strategies he proposes in his memo, he suggests language that will resonate with the American people, with no thought to the accuracy of his statements. Luntz states that his report "captures not just what Americans want to see but exactly what they want to hear."[13] The goal of a strategy memo such as this is to teach elected officials how to give people what they want, as opposed to explaining their opposition to reform.

While this claim might appeal to the public, further examination reveals that, in fact, the Affordable Care Act is not "a government takeover of health care." Politifact.com, a Pulitzer Prize winning political fact checking website, rated this claim a "pants on fire myth" in addition to awarding it the 2010 "lie of the year."[2] The inaccuracy of this claim comes from the lack of distinction between health care and health insurance. The phrase "government takeover of health care" invokes the idea of a system similar to those in place in many European countries, such as England in which the government owns the hospitals and doctors are government employees.[2] In fact, the ACA creates a system in which more people will be brought into the insurance market through private insurance. The current system, which Republicans are fighting to protect, includes more government involvement than many people realize. In recent years employers have become less likely to offer private health insurance, causing the government to expand its programs to cover more of the newly uninsured. In 1990, health care spending was split 60-40 between the private and public sectors, compared with 56-44 in 2000. During this time period, government spending on health care rose by 10%.[7] By brining more people into the private insurance market, the ACA is in some ways reducing government influence over health care.

By bringing more people into the private insurance market, ACA is in some ways reducing government influence over health care.

While the ACA does little to give the government more authority over health care, it does allow the government to further regulate the insurance market. The essential aspect of the Affordable Care Act which reforms the market is the creation of health insurance exchanges. These exchanges will provide a venue for the government to influence the insurance market. For example, the ACA includes regulations for the minimum benefits each plan must include in order to be eligible

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for purchase on an exchange.[6] Beyond insurance exchanges, the ACA includes other regulations on insurance companies, including the policy that insurance companies can no longer reject people who have preexisting conditions on that basis alone. While the Affordable Care Act does enact additional regulations on private insurers, the new system it creates still relies primarily on competition in the private market.[2] Thus the issue of how much control government will have over health care under the ACA is complex and broad; short statements are an insufficient explanation.

The key to Republicans' success with marketing of this phrase is that its simplicity allows for easy repetition. PolitiFact attempted to measure the total number of times the phrase was used in 2010 but the magnitude of the task proved too difficult.[2] The phrase appears more than 90 times on John Boehner's website and over 200 times on the website of the Republican National Committee.[2] Furthermore, the media picked up on the usage of the phrase and participated in spreading the Republican message. In 2010, "government takeover" was mentioned 28 times in the Washington Post, 77 times in Politico and 79 times on CNN.

Furthermore, Republicans faced little successful challenge from Democrats, allowing them to get away with their inaccurate message more easily. Howard Dean, former head of the Democratic National Committee explained, "the Democrats are atrocious at messaging… First of all, you don't play defense when you're doing messaging, you play offense. The Republicans have learned this well."[2] When Democrats attempt to refute the Republican claim of a takeover, they get bogged down in the details of the ACA. They do not have a quick and easily deliverable message as the Republicans do. Furthermore, when Republicans present their message they often go unchallenged. For example, John Boehner appeared on Meet the Press on January 31st and used the phrase five times, not once being challenged.[2] When a spokesman for Boehner was asked about the truth of the claim, the response was: "We believe that the job-killing Obama Care law will result in a government takeover of healthcare. That's why we have pledged to repeal it, and replace it with common-sense reforms that actually lower costs."[2]

In general, the sheer repetition of the phrase has proven to be an effective strategy. According to a poll by the Kaiser Family Foundation and Harvard School of Public Health, 54% of respondents felt that the ACA would lead to too much government involvement in the health care system.[18] Additionally, a Bloomberg poll found that 53% of people believed that "the current proposal to overhaul health care amounts to a government takeover."[5] The Republicans' success in taking back the house in the 2010 midterm elections is also a sign of their successful messaging tactics. The ACA passed Congress without a single Republican vote, foreshadowing of the fact that they planned to use it as a significant part of the national Republican campaign strategy in 2010.[1] It is impossible to quantify how much of the Republican victory in the midterm elections is due to their campaigning on health care issues. However, the ACA played a huge role in these elections and it is clear that Republicans' campaign against health care reform played a part in their success.

THE DEMOCRATIC CLAIM: "PREVENTION SAVES MONEY"

A popular campaign platform among politicians on both sides of the aisle has been the idea that preventive care saves money. In the 2008 presidential election, candidates from both parties embraced the importance of prevention. John Edwards stated, "Study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients' health."[4] On the Republican side, Mike Huckabee claimed that prevention "would save countless lives, pain and suffering by the victims of chronic conditions, and billions of dollars."[4] Prevention has always been a popular idea with both sides because the public likes the idea of not getting sick. However, because emphasis on prevention is a central component of the ACA, during the debate over the ACA, "prevention saves money" has become the democratic mantra.

While prevention may save some money in some cases down the line, it is not true that prevention is always a cost-saving measure.

Despite Democrats widespread adoption of this claim, it is not the whole truth. While it is certainly true that preventive care is good medical practice, it does not necessarily save money. The idea is that the cost to prevent disease is lower than the cost to treat disease, especially in the case of chronic diseases, which by nature are very expensive. However, numerous studies demonstrate the fact that prevention usually adds to medical spending.[16] One study used cost-effectiveness analysis to examine the cost and health outcomes of two or more interventions. Of the preventive interventions examined, 80% were more expensive.[16] Preventive care is more expensive because for most diseases you have to provide preventive treatment to many more people than would eventually get the disease. For example, prostate cancer screening is often more expensive due to the number of people that must be screened for one case of cancer to be prevented. Furthermore, prostate cancer is a particularly extreme case because screening uncovers more cases of the disease that would ever need to be treated because some people would die of other causes before experiencing symptoms of cancer.[4]

However, there are some examples of preventive care that do save money. Childhood immunization according to the recommended schedule is one example. For many interventions, if they are targeted at a specific, high-risk population it is possible to increase the cost-effectiveness. One example of this is middle-aged people taking aspirin to prevent heart disease. When targeted at the correct age group this preventive action can save money.[3] Thus, it is clear that whether or not prevention saves money is dependent on a variety of factors. While it may be true that it is possible for prevention to save money, broader claims about prevention are false.

The way in which the Democrats have presented this phrase is intended to lead the public to believe that prevention is the key to cost savings in the Affordable Care Act. In a speech to Congress in September of 2009, President Obama stated, "That makes sense, it saves money, and it saves lives", with reference to cancer screenings.[15] More recently, the President made this claim in reference to the debate over contraception and its regulation under the ACA.[9] In an interview with PBS News Hour in July of 2009, Nancy Pelosi went as far to claim that tax increases may not even be needed because "because the prevention will provide so much saving."[17] Claims of this nature present this idea as if it is the key to health care reform. While prevention may save some money in some cases down the line, it is not true that prevention is always a cost-saving measure.

However, the Democrats have faced significant opposition to this idea in the media and from conservatives. David Brooks, a conservative New York Times columnist publicized the idea that prevention does not save money. Writing about it in his column and appearing on a number of other media outlets, Brooks provided an effective critique of the Democrats' claim. Much of his argument was based on a report by the Congressional Budget Office. In a letter to Representative Nathan Deal, the top Republican on the congressional subcommittee involved in the health care debate, Douglas Elmendorf, CBO director said, "the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall."[9] Thus, the Democrats have faced more significant opposition to their claim than the Republicans to theirs.

Despite the truthfulness of the statement, Democrats' claim about preventive care has resonated with the public. One poll found that 77% of Americans believe that prevention saves money with 56% believing so strongly.[11] Another poll by Trust for America's Health and the Robert Wood Johnson Foundation found that 70% of people think prevention will save money, compared with 24% who believe it will cost money.[14] Additionally, the same poll found that almost 2/3 of Americans rank prevention above 8 on a 0-10 scale with zero meaning not at all an important health care priority and 10 being very important. Prevention was ranked second highest, with the only proposal to rank higher being prohibiting insurance companies from denying coverage based on a pre-existing condition.[14] It seems that a majority of Americans have embraced the idea that prevention saves money.

THE EFFECT ON IMPLEMENTATION

Both the Democrats and the Republicans have effectively created claims that resonate with the public, despite the fact that they're not entirely true. These efforts of both parties to frame the ACA to their advantage has polarized support for the bill along party lines.[8] As a result of this polarized debate, public opinion has changed significantly. Prior to President Obama's inauguration there was widespread support for health care reform with over 6 out of 10 Americans in favor. However, after the fiery political debate that took place during the midterm elections of 2010, public opinion declined significantly to about 45% of Americans in favor.[8] Now public opinion is about evenly split, but very polarized among Democrats and Republicans. However, a majority of Americans continue to be in favor of specific elements of the reform including health insurance exchanges, tax credits for small businesses, and closing the Medicare doughnut hole.[8,10] Thus, the claims that Republicans and Democrats have made have been successful in convincing their party base to support their side, however, regardless of partisanship, a variety of the specific proposals receive widespread support. This contradiction in public opinion demonstrates the effects of the claims that Republicans and Democrats have made.

CONCLUSION

There is a common perception in this country that you cannot trust politicians, and the false nature of these two claims seems to prove that perception to be true. In the case of health care policy, in which the issues and arguments are complex, politicians tend to forego the truth and create easily digestible arguments that the public can understand. However, this distillation of arguments has a significant effect on public opinion. By creating simplified arguments based on what the public wants to hear, each party has secured support from their base, dividing public opinion on the ACA. In reality, the public does not understand the complexity of these claims and when confronted with more specifics, tend to be widely in favor of reform. In this way, the ACA provides a cautionary tale for politicians on how simplicity can be dangerous.

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Does Sunshine Mean Transparency?

Will the Physician Payment Sunshine Act Be Effective

Kaitlyn Bowles

This article critiques the potential effectiveness of implementing the "Sunshine Act" portion of the Affordable Care Act. While the Sunshine Act, which will require drug and medical device manufacturers to publicly report gifts and payments made to physicians and teaching hospitals, may look good on paper, I aim to assess whether or not the Act will actually deter conflicts of interest between the pharmaceutical industry and medical professionals. I examine the rationale behind implementation of the Act by discussing problems in the current system. It is my contention that the recent shift to a more medicalized culture has paved the way for an industry-led consumer society in which Americans take far too much medication, doctors prescribe too many pills and pharmaceutical companies control the development and marketing of drugs. I will explain how this shift has led to physician-industry financial relationships which likely cause conflicts of interest within medicine. Although the goal of the Sunshine Act is to publicize, and consequently decrease, these financial relationships, the Act will likely fail in achieving its goals. I intend to demonstrate that the Act will be costly and difficult to implement. Furthermore, I will illustrate how similar acts have failed in the past, and in some cases, actually served to perpetuate industry-physician financial relationships. In conclusion, it is my contention that this regulation only skims the surface of a much deeper problem entrenched in the medicalization of the American culture.

INTRODUCTION

In a consumer driven society, the market must constantly evolve through the creation of new, innovative products. In the medical field, a significant portion of the market revolves around the pharmaceutical industry, "Pharma". Through ingenious marketing techniques and the creation of new diseases and, industry has played a pivotal role in the medicalization of the American population. To promote, support and disperse their wide array of products, Pharma has enlisted the help of physicians. In the modern medical field, physician-industry financial relationships range from delivery breakfasts to teaching conferences and product spokesperson deals. This relationship, between physicians and industry, serves as a launching point for many critiques that claim that the financial relationships generate conflicts of interest. In an effort to address existing and emerging conflicts of interest, a series of new standards and guidelines have been developed; perhaps the most pertinent being the Physician Payment Sunshine Act.

Under the Patient Protection and Affordable Care Act, the Physician Payment Sunshine Act, Section 6002, requires drug and medical device manufacturers to publicly report gifts and payments made to physicians and teaching hospitals. The Act was signed into law on March 23, 2010, but the first official reports aren't due until March 2013. The law requires manufactures (pharmaceutical companies) to publically report any transfer of value over $10 in value, and any transfer less than $10 provided that the yearly, cumulative transfer to an individual is at least $100.[1] The information must first be submitted to the Centers for Medicare and Medicaid Services (CMS); after review, the CMS will then publically disseminate the information on a website designed specifically for the Sunshine Act. There is no ban or limits on the allocations; however, all transactions must be placed on a website for public viewing. Failure to comply with the reporting requirements will result in a monetary penalty of $1,000-$10,000 for each payment or transfer of value that is not reported (not to exceed $150,000 annually). Additionally, violators will be subjected to a fine of $10,000-$100,000 for knowingly failing to report transactions (not to exceed $1,000,000 annually).[2] All penalties will be posted on the public website. It is expected that such publicity of transfers of value will deter conflicts of interest between the pharmaceutical industry and medical professionals. However, within a $900 billion industry, $1,000 seems trivial. While this legislation looks ideal on paper, skepticism of whether or not it will work effectively in implementation has accrued since the law's enactment in 2010.

This paper will look at the problems within the current system, and analyze how financial transfers of value between industry and medical professionals has resulted in the creation of a more medicalized, industry-led, culture. I will argue that the problems within the system are too deeply embedded in our culture to fix with just the Sunshine Act. While the Sunshine Act aims to deter conflicts of interest due to financial transfers of value between industry and physicians, I will show how implementation of the act will likely be ineffective, economically inefficient, and may in fact propagate these financial relationships.

MEDICALIZATION OF THE AMERICAN CULTURE

By widening the boundaries of human illness, pharmaceutical companies have in effect medicalized many natural processes. In the 1990's, a middle-aged woman who suffered from occasional fatigue and/or anxiety, had a resting blood pressure of 120/80, a fasting blood glucose level of 126 mg/dL, and a bone density T-score of -2.5, would have been considered pretty healthy. Now, not only would she likely be offered medication for adult-onset Attention Deficit Disorder and/or depression, she would also be diagnosed with hypertension, diabetes and osteoporosis.[3] While a few decades ago this woman would be perfectly healthy, she would now be

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considered a patient with many preexisting conditions. This change can in part be attributed to the increased focus on "lifestyle drugs". Although the global market for pharmaceuticals is $900 billion, apart from cancer drugs, few new drugs actually target disease. Instead, the industry has shifted their focus to "lifestyle" or "risk management" drugs. Annually, $60 billion is spent on antidepressants, $34 billion on cholesterol-lowering statins, $24 billion on blood sugar lowering hypoglycemics, and $26 billion on acid reflux dugs.[4] These are "illnesses" that are regularly overdiagnosed and often manageable through healthy lifestyles. However, in our current society, we, as patients, rely on drugs to remedy the day-to-day stresses that we are led to believe delineate serious medical conditions. Arguably, marketing tactics of the pharmaceutical industry have created the patient-base for these drugs. A majority of the $30 million Pharma spends on marketing is allocated directly to physicians. Although the full reports aren't available until 2013, in 2010, the top eight pharmaceutical companies spent over $200 million on speaking fees (to doctors) alone.[5] When billions of dollars are spent to facilitate physician sponsorship and recommendation of drugs, it undoubtedly brings to question the reliability of physician opinion. The Sunshine Act aims to discourage these rampant expenditures that may lead to conflicts of interest in the field of medicine.

RATIONALE BEHIND THE SUNSHINE ACT

The current, pharmaceutical-run, industry makes it nearly impossible for a provider to NOT be affiliated with a drug company. In a survey conducted by the Pew Prescription Project, it was found that 90% of physicians have some sort of financial relationship (accept gifts or payments) with a pharmaceutical company.[4] More specifically, in a survey published in the Archives of Internal Medicine in 2010, 28% of physicians reported that they received some kind of payment from a drug company to serve on a speaker's board, as a consultant, or on an advisory board.[6] Recently, there has been a movement encouraging physicians to be "Pharma-free", but in an already underfunded field, the billions of dollars pharmaceutical companies spend on physicians are hard to entirely avoid. As such, pharmaceutical companies have a certain influence over what doctors do and say to the public.

Nearly 20% of United States government spending goes towards health care. Of that, upwards of 20% are directed related to the cost of drugs.[7] The global market for pharmaceuticals is $900 billion, with the United States being the biggest consumer market in the world. Although the United States consists of less than five percent of the world's population, the U.S. makes up about 50% of the global market in prescription drugs.[8] Clearly, Americans consume pharmaceuticals at a much higher rate, and at a much higher cost, than the rest of the world. From 1990-2005, prescription spending rose 500% in the U.S. (from $40.3 billion to $200.7 billion). Of course, physicians have played a part in this increase in consumption through prescribing more drugs. Although it is not the only reason, an essential contributing factor in the increase of pharmaceutical intake is the fact that in the United States, the pharmaceutical industry spends roughly $30 billion annually on marketing. The majority of these costs are spent on direct marketing to physicians.[9] The Physician Payment Sunshine Act deals specifically with these physician-pharmaceutical company exchanges and how they affect the medical field. Critiques of the current pharmaceutical-lead industry proffer,

"The extent of the pharmaceutical industry's influence over the health system is simply Orwellian. The doctors, the drug reps, the medical education, the ads, the patient groups, the guidelines, the celebrities, the conferences, the public awareness campaigns, the thought-leaders, and even the regulator's advisers – at every level there is money from drug companies lubricating what many believe is an unhealthy flow of influence".[10]

Through convincing marketing schemes, pharmaceutical companies have used the influence of medical professionals, celebrities and academics to "widen the boundaries of human illness."[6] These campaigns have engendered a change in public perceptions about what is healthy. In essence, many believe that public-private, research-pharmaceutical industry relationships have brought about a significant change in the culture of medicine. Accusations of conflicts of interest are based on the most common perpetrator: financial incentives. The transparency provided by the Sunshine Act is designed to discourage these "negative", financial conflicts of interest between medical professionals and the pharmaceutical industry. However, the financial penalties for failing to comply with the new regulations seem far too modest to effectively serve as a deterrent. Furthermore, the penalties are for failing to publicize expenditures; the Act in no way limits the amount of transfers of value pharmaceutical companies are allowed to have. The Sunshine Act was created on the assumption that the stigma associated with financially enticing physicians will serve to deter these relationships; however, as these financial relationships are now deeply embedded in our medical culture, it is unlikely that stigma alone will change the practice.

However, as these financial relationships are now deeply embedded in our medical culture, it is unlikely that stigma alone will change the practice.

COSTS ASSOCIATED WITH THE SUNSHINE ACT

There are numerous costs related to implementing the Sunshine Acts. Not only will there be considerable amounts of time and effort spent collecting data and compiling reports to send to the Centers for Medicare and Medicaid Service (CMS), but there will also be an extensive process for registering, submitting and reviewing the data submitted. CMS estimates that approximately 1,150 manufacturers and 420 GPO's will submit reports.[2] Based on estimations extrapolated from reporting in Massachusetts, Minnesota and Vermont (where

Sunshine Acts are already in place), "CMS anticipates that the total estimated burden of the Act for year 1 is 4,619,000 hours, at a cost of $224,360,000. For year 2, and annually thereafter, the total estimated burden is 3,372,000 hours, at a cost of $163,087,390."[2] These numbers do not include any hours that may be spent on training, education, and compliance. At a cost of $224.4 million dollars, the goal is to increase transparency associated with irresponsible pharmaceutical-physician payments. But many critiques of the Act anticipate that the cost will extend past economic expenditures and influence the efficacy of medical teaching, technology and research.

EFFECT ON THE MEDICAL COMMUNITY

All expenditures between industry and physicians have the potential to promote conflicts of interest, but not all do. Not all physicians are paid to simply endorse a particular drug; the Sunshine Act reporting includes transfers of value for both teaching and research. In a country where primary care physicians are already scarce, over-worked and paid very little, physicians cannot be expected to take-on extra teaching engagements voluntarily. However, the stigma associated with having to report payments, even if they are teaching-related, may discourage further involvement on the physician's end. This would be a major disadvantage to the advancement and progress of the medical field.

Along the same lines, pharmaceutical companies fund a majority of drug research. A commonly spewed startling figure is that "more than 50% of the FDA's work checking the safety and effectiveness of drugs was now paid for by the companies whose products were being reviewed."[6] What this statistic fails to elaborate on is the law, the Prescription Drug User Fee Act (PDUFA), that requires industry to pay the FDA to review any new drugs.[11] While initially this payment may seem to entrench conflicts of interest (and it may actually do so), it is also one of the only ways FDA receives funding. If the pharmaceutical companies don't fund medical research, who will? Every five years, congress has the ability to change this law; however, since 1992, they have continued to deny the opportunity take on funding such research themselves, and instead, have passed the legislation as is, preserving industry-public financial ties. Thus, pharmaceutical companies continue to generously fund physicians and research, and physicians must continue to rely on their financial support.

(IN)EFFECTIVENESS OF THE ACT

Although public reporting and publication are the only identified means of obtaining transparency in this field, there are many potential inadequacies of the Sunshine Act. First of all, it has yet to be proven that the Sunshine Act will actually have a positive affect on the pervasiveness of financially motivated conflicts of interest between Pharma and physicians. In fact, a study completed by a Yale research team suggests the Act may actually worsen the problem of bias. The lead researcher explains the issues associated with the Act.[12] First of all, under the false impression that publicizing payments equates accountability, patients may be more likely to unquestionably trust professionals who disclose their payments. Conversely, experts who disclose their payment history are more likely to embellish and exaggerate their advice; after publicizing their financial relationships, many feel as through they are licensed to give more biased advice. Lastly, disclosure may encourage more doctors to enter into such relationships with Pharma. Psychologists refer to this as the "Principle of Social Proof"; in effect, if more people are publically, commonly doing something, others are likely to join in. Thus, this research questions whether the Sunshine Act will even have the intended psychological impact on the medical profession and patients. While the effects of the ACA Sunshine Act cannot yet be analyzed (as the first full report is not due until next year), we can draw on similar, past legislation to predict and assess the possible outcomes.

In 2009, Massachusetts passed a similar law requiring any payments of more than $50, from industry to a health care practitioner, to be reported and the publically published on a state website. While the law was supposed to increase transparency, there was no reporting on the information for over two months after Massachusetts published their data. Furthermore, the state encountered many issues in gathering and reporting the data in a timely, efficient manner. In fact, before the nationwide law was implemented, the state considered repealing the regulations due to its apparent shortcomings.[13] If one state has difficulties organizing and publicizing Sunshine Act-related information, how will the nation fair?

To preempt some of the complications associated with reporting this data, the CMS attempted to "minimize the burden on reporting entities by trying to simplify the reporting requirements as much as possible within the statutory requirements."[2] However, in doing so, it limited the information that companies must provide to the CMS; additionally, it reduced the amount of information the public has the ability to view. For example, it is not required to submit a document explaining the nature of payments, but companies may voluntarily give this information. Alternatively, while the act requires industry to include "physicians' National Provider Identifiers (NPIs) in their annual submissions" to the Department of Health and Human Services, it prohibits the department from disclosing NPIs in public reports.[13] This injunction inhibits interested parties from fully understanding the scope and nature of industry's financial relationships. Not all physician-pharmaceutical relationships are bad, but the exclusion of contextualizing information may serve to propagate the assumption that they are.

LOOKING FORWARD

It will be impossible to accurately discern the full effects of the Physician Payment Sunshine Act until after the first cycle of reporting is due; even then, it may take many additional years to understand the effectiveness of the Act. What we currently know is that as a country, we spend far too much money on health care, as patients we spend an unreasonable money on medications and as an industry, they spend an egregious amount of money on marketing. Public disclosure serves an essential purpose; however, the primary problem is not the secrecy of transfers of value, but rather, the influence the transfers have on physicians. That influence will continue to affect the medical community whether or not payments are

disclosed. For now, the PPSA is a step in the right direction; however, it undoubtedly has room for improvement.

As one drug developer stated, "I don't know any physician that prescribed a particular drug as a result of receiving a pen from a pharmaceutical representative". The point being, that the minimum for reporting of $10 (or less than $10 if cumulatively over $100) is far too low. Without viewers being able to easily differentiate and comprehend the nature of transfers of value, the information will lead to inaccurate assumptions about physicians' acceptance of such financial "gifts." Furthermore, the lack of contextualization could additionally lead to misrepresentation of conflicts of interest. While CMS is attempting to make reporting as simple as possible, more in depth descriptions (available to the public) may help avert these potential problems.

Transparency of industry-physician financial transfers is not going to change the system; however, it is a start. I argue that, while the Sunshine Act will likely not effectively bring about change in our market society, the implementation of the Act is the first step in acknowledging that there is a problem. The problem isn't physicians, nor is it solely the pharmaceutical industry, it is how our market-based medical industry is regulated. There needs to be a paradigm shift in the way we, as Americans, approach medicine. Industry isn't going to stop creating lifestyle drugs if consumers continue to demand medication to cure our daily challenges; physicians aren't going to stop accepting financial "incentives" from industry if their livelihood and research depends on it; and patients aren't going to stop taking excessive lifestyle drugs until their physicians stop prescribing them. Our current system perpetuates overmedication, overdiagnosis and the potential for conflicts of interest in medicine. Information alone will not be successful in fostering behavior change; as such, transparency through the Sunshine Act isn't going to overhaul the way our society works. However, the information gathered via Sunshine Act will bring into question the influence the pharmaceutical industry has on a variety of practices many people currently accept as unavoidable, common practice. While this will not effect change itself, it will hopefully trigger more interest on and support of the issue; public awareness of Pharma's role in society, and the momentum that the "Pharma-free" movement could potentially gain from the Act, are likely to be the Act's most successful feats.

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Clarifying the Commerce Clause

The Constitutionality of the Individual Mandate

Alexis Daniels

The individual mandate – the central provision of the Patient Protection and Affordable Care Act (ACA) that requires U.S. citizens to have health insurance or face a tax penalty – is currently on the chopping block. The debate in the Supreme Court of the United States splits on ideological lines, and centers on the interpretation of the Commerce Clause: is the individual mandate a permissible exercise of Congressional power, or does it overstep an essential boundary? In this paper, I review the recent Supreme Court cases on this subject – including Wickard v. Filburn (1942), U.S. v. Lopez (1995), and Gonzalez v. Raich (2005) – and distill the rules that the Court has set out with respect to the limits of the Commerce power. I then apply those rules to the contemporary debate about the individual mandate, highlighting in particular the unique problem of regulating "non-activity." The Supreme Court oral arguments on March 27, 2012 provide opportunities for conjecture, particularly the opinion of "swing vote," Justice Anthony Kennedy. I argue that despite the major strains of criticism, the individual mandate is a permissible exercise of the Commerce Clause power – and a necessary one, to provide millions of Americans with health insurance coverage.

The individual mandate is a central provision of the Patient Protection and Affordable Care Act (more popularly called "Obamacare"), which was signed into law on March 23, 2010. The individual mandate requires U.S. citizens and legal residents to have qualifying health coverage.[1] Those without coverage will pay a tax penalty, which will be phased in beginning in 2014. Twenty-six states have challenged the law in courts of appeals, claiming that the mandate exceeds Congress' authority; parties against the law petitioned the Supreme Court of the United States to review the decisions of the courts of appeals. The debate centers on the interpretation of the Commerce Clause – an enumerated power in the constitution – stating that Congress has the authority "to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." Obama and his administration justify the legitimacy of the individual mandate under this clause. Now, the debate rests in the hands of the Supreme Court of the United States.

The question of whether the individual mandate is constitutional may determine the success of the Affordable Care Act; some scholars believe that the ACA enterprise cannot survive without the mandate. Therefore, if the mandate does not survive the Supreme Court, the Affordable Care Act may not survive either.

BACKGROUND

Historically, Congress has used the Commerce Clause as a hook for a wide range of legislation. For example, the Endangered Species Act, the Clean Air Act, and the Occupational Safety and Health Act were all founded on the Commerce Clause. Between the New Deal and 1995, the Supreme Court has accepted almost no challenges to such broad legislation on Commerce Clause grounds. However, in 1995, the Court began to set new limits on Congress' Commerce Clause authority. Because the cases on the subject have been few and far between, it is not yet entirely clear what the Supreme Court believes are the limits of the Commerce Clause. It has signaled, however, that legislation with a very attenuated connection to interstate commerce may not be constitutionally permissible. This new line of Commerce Clause authority has led some scholars and lawyers to assert that the Supreme Court may hold the individual mandate provision of the Affordable Care Act unconstitutional on Commerce Clause grounds. With the Supreme Court of the United States oral arguments underway, predictions and evaluations of the court's rulings are now possible.

In this paper I will focus on whether the individual mandate is a permissible exercise of Congress' Commerce Clause authority. Answering this question will require reviewing the recent Supreme Court cases on this subject, distilling the rules that the Court has set out with respect to the limits of the Commerce power, and applying those rules to the contemporary debate about the Affordable Care Act. I will try to demonstrate that despite the debate, the mandate is a permissible exercise of the Commerce Clause power.

REVIEW OF RECENT SUPREME COURT CASES

Wickard v. Filburn (1942)

Wickard v. Filburn was a 1942 United States Supreme Court decision that recognized the power of the federal government to regulate economic activity according to the Commerce Clause.[2] Roscoe Filburn was a farmer growing wheat for his own consumption. At the same time, the U.S. government had implemented limits on wheat production to drive up wheat prices; Filburn was growing more wheat than he was allowed, according to federal guidelines.

The central issues argued were as follows: can Congress regulate the production of wheat intended for personal use and not placed in interstate commerce? Secondly, can Congress regulate trivial local, intrastate activities that have an aggregate effect on interstate commerce via the commerce power? The ruling was unanimously "yes," deriving from the opinion that the power to regulate interstate commerce includes the power to regulate commodity prices and practices affecting them. In essence, the Court found that while wheat consumption on just one farm may be trivial, the aggregate effect of many individual farms is large. The Court explained that, "Wickard thus establishes that Congress can regulate purely intrastate activity that is not itself 'commercial,' in that it is not produced for sale, if it concludes that failure to regulate that class of activity would undercut the regulation of the interstate market in that commodity."[3] The Wickard ruling established grounds for decades more rulings, and marked an era of federalism that has extended as recently as 2005 (see below).

U.S. v. Lopez (1995)

U.S. v. Lopez was the first Supreme Court case since the New Deal to limit Congressional power under the Commerce Clause.[4] The case involved Alfonso Lopez, Jr., a high school student, who carried a concealed revolver into school. He was delivering the unloaded gun to someone else for $40. He admitted possession when confronted by school authorities. He was charged with a violation of the federal Gun-Free School Zones Act of 1990. Lopez argued to dismiss the indictment, saying that it was unconstitutional under the Commerce Clause. To sustain the Act, the government had to

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show that the decision regulated a matter which "substantially affected" interstate commerce. The government argued that possession of a firearm in an education environment would lead to violence, which would affect economic conditions.

The court ruling said that possession of a gun near school is not an economic activity that has a substantial effect on interstate commerce; a law prohibiting guns near schools is a criminal statute that does not relate to commerce or any sort of economic activity. Moreover, they found that these arguments initiated a "slippery slope;" an endless list of activities could be said to have social costs that weakly have a connection to interstate commerce. In the words of Justice Rehnquist,[4] "we [would] have to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States." What would prevent Congress from regulating any activity that had economic implications?

Notably, members of the current Supreme Court held dissenting opinions to *U.S. v Lopez*. Antonin Scalia was in the majority, with dissent from Justice Ruth Bader Ginsburg and Justice Stephen Breyer. In his dissent, Breyer concluded that gun related violence obviously could have an effect on interstate commerce. For him the question was whether the effect could be deemed "substantial." The final decision was a 5-4 split – a divide anticipated for the health care decision, as well. In the case of ACA, the four liberal justices are anticipated to vote for and the four conservative justices against the constitutionality of the mandate, based on previous opinions of Commerce Clause cases; Justice Anthony Kennedy is the expected swing vote. Similar to *U.S. v. Lopez*, the controversy lies in the potential "slippery slope" of Congress regulating certain activity.

Gonzales v. Raich (2005)

The Supreme Court decision *Gonzales v. Raich* addressed the constitutionality of the federal Controlled Substances Act (CSA) as applied to individuals who grow marijuana for personal and medical use under California's Compassionate Use Act (CUA).[5] The ruling stated that Congress may ban the use of marijuana even where states approve its use for medicinal purposes, essentially endorsing Wickard once more.

Justices Antonin Scalia and Anthony Kennedy departed from their previous positions in *Lopez*, to uphold a federal law. Although the marijuana had been grown and consumed in a single state, and never entered interstate commerce, the court held that Congress could regulate a non-economic good – which is intrastate – if it does so as "part of a complete scheme of legislation designed to regulate Interstate Commerce."[5]The court's decision had important implications for the "federalism" debate, and marks a shift in attitude from previous rulings; states' power to set public health policy is greatly affected by this debate, as is evident in the battle for ACA.[6]

WHY THE INDIVIDUAL MANDATE IS PERMISSIBLE

To summarize, the Supreme Court has interpreted the Commerce Clause broadly, saying it allows Congress to limit how much wheat may be grown on a family farm and to punish the cultivation of homegrown marijuana. There are only two contemporary exceptions to that broad interpretation. The court struck down a federal law regulating guns near schools in 1995 (and in 2000 it struck down a federal law allowing suits over violence against women). The court ruled, in both cases, that the activity in question was local and noncommercial – the Commerce Clause did not apply.

While all agree that there must be limits to Congress's power, supporters of the individual mandate argue that regulating non-activity is constitutional, and that Congress can create commerce. Justice Breyer said, "I look back into history and I see it seems pretty clear that if there are substantial effects on interstate commerce, Congress can act."[7] An example, he said, was "the national bank, which was created out of nothing to create other commerce out of nothing." Former Solicitor General Paul Clement, representing the 26 states in the case, said it was one thing to establish a bank and another "to force the citizenry to put all of their money in the bank." The second sort of law, he suggested, was analogous to the individual mandate.

Opponents to the law, including Clement, claim that the mandate steps outside the reach of the clause, primarily positing that the law attempts to define the non-purchase of insurance as "commerce." Is non-activity – this non-purchase – commerce that can be regulated? The schism breaks down on ideological grounds. Like the previous cases, the major concern is that stepping beyond non-action would be regulating mental activity, an over-stepping of federal power. The controversial argument, posited by Justice Scalia in the oral arguments, is that if Congress can create commerce and regulate non-activity, they could mandate us to eat broccoli.[8] Unlike the previous cases, which involve people doing something which was already being regulated (and the question was whether you could regulate them intrastate, doing that thing), this controversy involves regulating – and penalizing – the failure to act. The constitution says nothing about the definition of non-activity, and so the decision boils down to the opinion of Justice Anthony Kennedy, the swing vote.

Commentators have noted that in the oral arguments on March 27, 2012, Justice Kennedy began harshly skeptical. At the end of the debate, however, he sounded sympathetic:

"But I think it is true that, if most questions in life are matters of degree, in the insurance and health care world, both markets – stipulate two markets - the young person who is uninsured is uniquely proximately very close to affecting the rates of insurance and the costs of providing medical care in a way that is not true in other industries. That's my concern in the case."[9]

He acquiesces the essential point of supporters of the individual mandate: healthcare is unique. It is unlike any other good or service, in that everyone in their lifetime will need it, and the timing of need is largely unpredictable. Moreover, it is distinguishable from a mandate to eat broccoli because the public does not bear any burden if individuals choose not to eat broccoli. The Supreme Court must see this scenario as a special time to interpret the Commerce Clause in this way – "inactivity" can be regulated, particularly if the benefits are so clear and the need so great.

MAGNITUDE OF THE RULING

While the mandate perhaps implies limited individual liberties, Congress has the power to enact the measure according to *Wickard v. Filburn*. The only way to make individual mandates consistently out of bounds would be to overturn *Wickard*.[10] Moreover, Solicitor General Verrilli highlighted in his concluding remarks that this is the kind of choice that the Constitution leaves to the democratic process – the health and quality of life of forty million Americans is dependent on this decision.

In the greater picture of health insurance reform, the question of whether the individual mandate is constitutional may determine the success of the Affordable Care Act. The individual mandate is a central provision of the law; it not only increases the insurance rate, providing coverage to an estimated 40 million people currently under- or uninsured, but it also keeps premium costs lower, by preventing adverse selection, and calls for shared responsibility in financing coverage. The mandate must pass the Supreme Court for the ACA to survive. While guesses and commentaries abound, they remain just that – guesses. Conversations behind closed doors will determine the ultimate outcome. The country awaits the high profile ruling at the end of June.

Bundled Payments

Moving from Theory to Practice

Rebecca Edelberg

It is widely recognized that our current patterns of health care consumption and spending here in the U.S. are unsustainable. Researchers and policy-makers have proposed various measures aimed to control health care spending, but one concept that has gained traction is that of replacing fee-for service payment schemes with a bundled payment scheme. Support for bundled payment is strong among some stakeholders because it is viewed as an innovative way to control costs while increasing coordination among multiple providers attending to a patient. Although past experiments with bundled payment have demonstrated the potential for long-term improvements in quality of care and reductions in cost, they have also revealed that transitioning to a bundled payment system is both time-consuming and rife with administrative challenges. The Patient Protection and Affordable Care Act (ACA) is currently piloting several different models of bundled payment through the Centers for Medicare and Medicaid Services. The results of the ACA pilot will likely be illuminating in terms of the feasibility of implementing a large-scale bundled payment scheme.

INTRODUCTION

The United States spends an enormous amount of money on health care. Not only do we spend a larger percentage of our GDP on health care than do similarly developed countries (Current estimates indicate that health care spending accounts for between 17.2%-17.9% of our GDP), but our annual increase in national health expenditures continues to outpace inflation each year. There is widespread agreement that our current patterns of health care consumption and spending are unsustainable.

Researchers and policy-makers have proposed various measures aimed to control health care spending, but one concept that has gained traction in the two years since the Affordable Care Act (ACA) was passed in 2010 is that of integrating a bundled payment reimbursement system in several areas of our national health care system. In this paper, I will analyze the strengths and weaknesses of bundled payment, which is currently being piloted though the Centers for Medicare and Medicaid Services under the auspices of the ACA.

BACKGROUND

Bundled payment is a form of episode-based payment, in which all medical services associated with a particular diagnoses are considered to be part of a single "episode" of care, and are billed together. Different forms of episode-based payment define episodes of care differently. Under some forms of episode-based payment a single episode might include treatment administered for a particular diagnosis over a period of several days; in others, it might include treatment administered over a period of several months. Episode-based payment systems may also differ as to whether services administered in different care settings may be part of the same episode. The ACA's bundled payment system defines an episode far more inclusively than its predecessors. While previous Medicare experiments with episode-based payment have only incorporated hospital care, the ACA's bundled payment system includes hospital, physician, post-acute, and home care into a single episode.

In all forms of episode-based payment, the amount to be paid is negotiated between the provider and third party payer based on the available historical data on what it should cost, theoretically, to treat a patient with a given diagnosis. If providers are able to treat a patient without exceeding the agreed-upon amount, then they can divvy up the savings between them; however, if providers exceed the agreed-upon amount, then the loss is their own. In this way, episode-based payment incentivizes coordination of care among providers, since they must work together to achieve the best possible financial outcome. Epsiode-based payments diverge sharply from the traditional fee-for-service model, under which each medical service rendered or procedure performed by a provider is billed separately and retroactively. Critics of fee-for-service say that it incentivizes more (not necessarily better) care, and that it also leads to fragmented care, since each of the providers working with a given patient essentially operates independently of one another.

The ACA set up a national pilot program to assess the efficacy of episode–based payment in practice. The Bundled Payment for Care Improvement Initiative began in August 2011, when providers were asked to submit applications to pilot one of four different models of care. Although each of these models incorporates payment bundling, they differ in terms of how an episode of care is defined. Note that both Models 1 and 4 define an episode of care as "Acute Hospital Stay Only," but Model 1 pays providers retrospectively, while Model 4 pays providers prospectively:

- Model 1- Retrospective Acute Care Hospital Stay Only
- Model 2- Retrospective Acute Care Hospital Stay and Post-Acute Care
- Model 3- Retrospective Post- Acute Care Only
- Model 4- Acute Care Hospital Stay Only

REVIEW OF PREVIOUS ATTEMPTS TO BUNDLE PAYMENT

It is still too early in the ACA pilot to speculate about

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whether bundled payments scheme will live up to its potential, but there are several studies currently available from which to draw conclusions about the demonstrated effectiveness of bundled payments on quality improvement and cost of care. These studies suggest that bundled payments have the potential to improve care and reduce cost in the long run, but present a series of implementation-related challenges in the short run.

The ACA pilot does not mark the first time Medicare has experimented with payment bundling. In the early 1990s, rapidly growing costs for post-acute care as well as high rates of readmission to hospitals for acute care prompted Medicare to act.[1] In 1991, the "Medicare Participating Heart Bypass Center Demonstration" was introduced, which piloted bundling payments for coronary artery bypass graft surgery at four different hospital sites. According to a 1993 evaluation of the program, the total savings accrued as a result of the program was $17 million dollars over the course of 2.25 years, averaging $4,700 per case. Some of the practices adopted by providers in order to save were the substitution of generic drugs for brand name ones, and consolidation of equipment and supply purchases in order to negotiate greater bulk discounts.[1,2]

More recently, in 2007, bundled payment was introduced in the Netherlands to manage chronic conditions such as diabetes, chronic obstructive pulmonary disease (COPD), and vascular disease. Among the benefits of the program, providers noted that coordination among care providers, protocol adherence, and transparence of care all improved. It is still too early to draw conclusions about the effect of the program on the overall quality of care or cost of care. One reason why it is challenging to determine overall impact on quality of care is that payments varied widely among providers, due to free negotiations between provider groups and third-party payers.[3] This variation in payment amounts will something to take into consideration when it comes time to evaluate the ACA's Bundled Payment Initiative, seeing as how providers and payers will also be neogitating freely.

Another international example of success with bundled payments has been Japan's treatment of end stage renal disease (ESRD). As is typical here in the U.S., Japan used to rely predominantly on costly ESA therapy to treat patients with ESRD. With the introduction of bundled payments, Japanese providers began to rely less on ESA therapy, compensating by making small increases in patients' dose of IV iron.[4] In this way, Japanese providers managed to keep their patients' hemoglobin levels stable through far less extensive means. This example is particularly relevant to the U.S. because Medicare has covered ESRD care since 1972 at an average annual cost ranging from $26,668 for transplant recipients to $77,506 for patients receiving dialysis, and 10% of all Medicare spending on ESRD goes toward ESA therapy.[5]

DISCUSSION

Despite all of these promising case studies from abroad, there is reason to approach the idea of bundled payment cautiously. In 2007, The PROMETHEOUS project, funded through grants from the Robert Wood Johnson Foundation, set out "to determine whether [bundled payment] could be implemented under real-world conditions".[6] Despite its ambitious beginnings, all of the participating health centers quickly fell behind in the their implementation schedules. They reported that switching from fee-for-service to bundled payment claims processing was far more complicated than they had anticipated from an administrative perspective. Specifically, challenges included defining bundles; defining the payment method; implementing quality measurement; determining accountability within provider group; and engaging providers. One thing that might cut back on the administrative hassle of implementing a bundled-payment system is the introduction of appropriate software. Several software firms are currently in the process of developing "engines" to automatically convert fee-for-service claims into episode-based payments, but it is an extremely complex endeavor.[7]

Other concerns associated with bundled payment are that the financial incentives will encourage providers to stint on effective care or avoid sicker patients, and that independent providers might not be willing to collaborate and share payment. With respect to the financial incentives piece, a bundled payment system would not be any more manipulative of providers than the current fee-for-service system is. It would certainly incentivize going in the other direction (under-treating patients versus over-treating them) but given that any payment system will inevitably incentivize and disincentivize certain practices, this is not reason enough to turn away from bundled payment. In terms of provider buy-in, providers might be more willing to participate if and when there are established protocols in place.

CONCLUSION

Health care providers and organizations should keep a few things in mind when it comes to operationalzing a bundled payment system. First, bundled payment is not a silver bullet. Shifting to a bundled payment system is a long-term investment, and it may not be realistic to expect to see improvements immediately. In the interim, sites that choose to adopt a bundled payment system should focus on: 1) defining clearly what an episode of care means, and what is included in each bundle, and 2) creating a system to determine how responsibility and/or payment will be allocated among providers.

Once data becomes available from the ACA pilot, it may be that some of the lingering doubts questions associated with implementation of bundled payment are resolved. In the meantime, even taking into account its limitations, bundled payment appears to be a viable option when it comes to thinking of alternatives to fee-for-service reimbursement.

References for this article can be found at

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Paying for Performance

An Analysis of the Medicare Hospital Value-Based Purchasing Program

Bryn Kass

The Hospital Value-Based Purchasing Program (HVBP) was crafted within the ACA to curb Medicare spending without compromising quality of care in Medicare. In 2010, there were 40.3 million Americans 65 and older, and that number is projected to more than double by 2050. The federally sponsored Medicare Program provides health care to each and every citizen over 65. Total Medicare spending is projected to increase to $932 billion by 2020 if spending continues at its present rate; it was $523 billion in 2010. HVBP will create a system in which hospitals are rewarded for quality, efficiency, and a positive experience for their patients. It will give hospitals payment-based incentives to improve quality of acute care and transparency of that quality, allowing Medicare consumers to make knowledge-based decisions about their care.

The program will be based on relative ratings and improvement, giving every hospital motivation to improve their cost efficiency and quality of care. The allocated money, about $850 million, will come from a funding pool of costs that were previously used for inefficient, costly inpatient treatment, which will be substituted with better, less expensive, care. Furthermore, HVBP was designed for future alterations based on statistical feedback, which will allow the program to adapt to the future changes in health care. If HBVP is passed, it will be the first step to a more affordable, more efficient, and higher quality Medicare system.

THE BACKGROUND OF A VALUE-BASED SYSTEM

The Birth and Growth of Medicare.

In 1965, the federally sponsored Medicare Program became law under President Linden B. Johnson, guaranteeing access to health insurance for Americans ages 65 and older. At the time, many of the then 18 million Americans over the age of 65 had low incomes, were threatened by illness, and could not afford medical expenses.[1] The President publically introduced the idea that the small individual contributions from the people of America could provide the funds to pay for such cases. Medicare was designed to cover hospital care under Part A and outpatient medical services under Part B, alleviating Medicare consumers of many but not all of their health care costs. According to Johnson in 1965, the new program had "few defects."

However, the accelerating cost of medical services coupled with a rapidly growing elderly population has revealed inefficiencies in the program's woodwork. On April 1, 2010, the United States Census counted 40.3 million American citizens 65 and older; it projects that that population will more than double that by 2050.[2] Medicare spending, now one of the most significant additions to the federal debt, is anticipated to reach *$932 billion* in *2020, almost double what it was in 2010.*[17]

Considering these statistics, it has become increasingly necessary to provide efficient and cost-effective care through the Medicare system. This could be accomplished by simply cutting out expensive medical practices, but, doing so would likely contradict the reason for Medicare's existence in the first place: to provide an often-threatened population *complete* access to *effective* health care. Furthermore, compromising the integrity and completeness of medical care in order to meet short-term financial goals will only lead to future medical problems, medical care, and medical expenses down the road. The challenge, since the birth of Medicare in 1965 and still today is how best to ensure that the 65 and older population is receiving quality care as they have been promised at the minimal expense to the federal government and, consequently, to all taxpaying Americans.

The Beginning of Value-Based Care.

In 2004, the Hospital Inpatient Quality Reporting Program (IQR) was established. IQR commissioned the then-39-years-young Center for Medicare and Medicaid Services (CMS) to reward hospitals that adequately reported the program's stipulated quality measures with a higher annual update to their payment rate.[3] The potential success of IQR lay in the hope that financial incentives would inspire hospitals to provide a higher quality of service at an efficient cost and that the self-reported hospital data would allow healthcare consumers to make evidence-based decisions about their own care.

Although beneficial and applicable in theory, IQR was plagued with several systematic loopholes. First, the financial incentives created by the program were simply a means of *avoiding* pay cuts;[3] once a hospital reached its top payment rate, it had no incentive to perform better or be more efficient. Second, the incentives were granted (or not) to hospitals solely based on self-reported data, which all too often represent only a small piece of complex puzzle that is health care practice.[4;5] Third, the lack of reliable reported data compromised the intended public transparency of the program's results and its ability to act as a means for informed decision-making on the part of the consumers. However as incomplete and easily undermined IQR was, it was a significant starting block for reporting-based payment methods. With the hopeful implementation of new healthcare legislation under the Affordable Care Act (ACA), the government created a more thorough reporting program to fill in the gaps of its predecessor.

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The System, Improved

The Hospital Value-Based Purchasing Program (HVBP) will add thirteen new measures to the existing reporting standards of acute care from IQR, including measures for the ten most common diagnoses for Medicare inpatient care.[6] For several of these measures, HVBP will be not on self-reported claims but rather on objective Medicare claims data, which, up until this point, has remained relatively hidden and unused. These reports will be accessible to consumers, insurers, and employers to increase overall system transparency, promote heightened competition among providers, and enable consumers to make knowledge-based decisions about their healthcare.[7] HVBP will not replace the old IQR program with an entirely new version but rather will "transform the program from pay-for-reporting to actual pay-for-performance."[8] The loopholes that presented obstacles in the incomplete IQR program will be filled and built upon in the new HVBP program.

A VALUE-BASED SYSTEM UNDER THE ACA

Applicable Intentions of the ACA

The intentions of the Obama Administration's Affordable Care Act include but are not limited to: (1) greater access to healthcare for all Americans; (2) better coordination and quality in clinical practice; (3) increased access to information to allow consumers to be value-conscious; (4) the creation of a payment system that rewards value. Considering the Medicare system in particular, the government is taking action to prevent and lessen payment fraud, inefficiency, extortion, and exploitation.[9]

HVBP will enable hospitals to receive more than they otherwise would, all things being equal, if their results prove relatively deserving enough.

Under HVBP physicians and hospital staff that successfully collude and cooperate with other providers to boost patient results and experiences will advance and be the forerunners of the new healthcare system.[10] According to CMS, "Value-Based Purchasing will transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive.[3] The program will give hospitals significant financial payment-based incentives to improve the quality of acute care by financially rewarding them for the quality of such care, not simply the multitude of services provided.[9]

The United Kingdom's National Health Service sponsored a three-year pay-for-performance trial period with which to measure the program style's effectiveness. English practitioners working within the statutes of the trial program received an average of 97% of the available points for clinical measures. Furthermore, about 90% of diabetic patients had their hemoglobin levels measured under the UK pay-for-performance program in 2004. In the same year, in comparison, only 83% of Medicare patients with diabetes received the same thoroughness of care from US practitioners working within the Prospective Payment System (PPS). Under Medicare's PPS, a pre-determined amount of money is allocated for each circumstance for inpatient care, no matter the amount of price of care used in reality.[12] The trial suggests that pay-for-performance programs can bring about significant positive changes in professional practice.[17]

How HVBP Will Work

Beginning in October 2012, Medicare will incentivize high quality acute care for their patients through HVBP.[11] Unlike the incentives under IQR, HVBP will enable hospitals to receive *more* than they otherwise would, all things being equal, if their results prove relatively deserving enough. The money for these financial incentives will be taken from funding for PPS.[12] According to American Academy of Actuaries senior health fellow, Commissioner Cori Uccello, when considering the use of PPS in skilled nursing facilities, "The levels of [PPS] payments are too high, they're distributed poorly, and there's not enough that's targeting quality."[18] The government will reduce PPS payments by one percent starting in 2013 to create the endowment for the new system. The money will, in theory, be taken from what the government would have allocated to unnecessary hospital stays and inefficient clinical practices. This fund is expected to make available $850 million in 2013 to distribute to deserving hospitals participating in HVBP.

Each hospital providing acute care will be scored depending on its performance on twelve Clinical Process of Care Measures and eight Patient Experience of Care Measures, compared to other hospitals or compared to its previously lower score.[11] Hospitals that receive relatively high scores and/or improved score swill be granted monetary rewards that will, in total, reach a sum of exactly that amount which is taken from PPS funds, no more, no less.

Clinical Process of Care Measure scores will include standards of time to receive therapy, discharge instructions, and promptness of discontinuing antibiotics after surgery, while Patient Experience of Care Measures scores will include communication and pain management. These are the only two domains of performance scoring.[11] Every participating hospital will recieve an improvement score and an achievement score, relative to other participating hospitals, for each measure during a given performance period, which lasts about nine months.[12]

Improvement scores will be based on relative change from the previous performance period; in the case of the first period, the base period from July 1, 2009 - March 31, 2010 will act as the relative standard. A given hospital will be granted the higher of the two scores, whether that be its achievement score or its improvement score. CMS plans to include additional outcomes measures as the program progresses to ensure a maintained focus on positive patient outcomes and the avoidance of illnesses acquired in the hospitals

themselves. Using a set mathematical formula, scores will be converted into monetary compensation depending on the amount of available funding.[11]

BALANCING THE GOOD AND THE BAD IN HVBP

Potential Benefits of HVBP

The goals for HVBP, according to CMS, include "improving clinical quality, encouraging more patient-centered care, encouraging hospitals and clinicians to work together and improve quality of care, and empowering consumers to make value-based decisions about their healthcare."[8] Each of these goals individually applies to and aligns with at least one of the overarching goals of the ACA at large, some of which were previously mentioned. In the words of Dr. Don Berwick, CMS Administrator, "Instead of payment that asks, 'How much did you do?' the Affordable Care Act clearly moves us toward payment that asks, 'How well did you do?' and more importantly, 'How well did the patient do?'" Value-based purchasing marks a noteworthy step in the direction towards quality care and medical efficiency.

If HVBP proves successful, it will set an influential precedent for all other types of care. Furthermore, it will realign financial incentives and priorities on the part of physicians and hospital staff with a new focus in a positive patient experience, and healthcare consumers will have the power to be their own agents when it comes to making informed decisions. CMS estimates that about half of all hospitals involved in the program will receive an overall growth in compensation as a result of this system. Ultimately, if physicians and hospitals increase efficiency and quality in their medical practices, extraneous expenses of medical care will be avoided, and the heavy financial burden of the Medicare program on the Federal Bank and the American public will be significantly reduced.

Additionally, since the money shared will be exactly equitable to the money available to distribute as rewards, the government should see no financial burden in the implementation of this program, a common deal breaker in other pieces of the ACA. The way in which the standing budget will be shared is completely determined by the standard that hospitals are able to demonstrate.[14] As stated previously, hospitals are able to not only perform relatively well but also to improve upon their existing scores; there is never a lack of incentive. The achievement curve will inspire hospitals doing really "well" to do even better by gaining compensation through scoring higher than previous years.

Perhaps one of HVBP's greatest strengths is its future flexibility. Unlike many programs that become outdated and inapplicable over time, HVBP has been drafted to change and to be altered as necessary. The secretary will be required to create and organize plans to put into action similar programs specific to Medicare providers that cannot or do not follow the same standards of acute care. These providers will include skilled nursing facilities, home health agencies, and ambulatory surgical centers so all factors of changing dynamics will be taken into account when standards are tested and rewarded.[15] Expecting the program to evolve with time and planning for such a course of action as the government has will increase its sustainability and overall chances for success.

Potential Pitfalls of HVBP

Some worry that hospitals providing high quality acute care will unfairly lose financial compensation either because they are unable to achieve high enough scores relative to other, bigger hospitals or because they are unable to improve their score beyond what it is. Because of the relative nature of the scoring system, all rewards are based on the performance of all other hospitals; technically, even if all hospitals excel, only the highest scoring will receive deserved compensation. On the other hand, hospitals scoring in the 99th percentile with hardly any room for improvement could very well receive less payment than a hospital in the 90th percentile that improves three percent.[16] Similarly, some hospitals will inherently receive lower scores due to lack of resources and disadvantaged health statuses of their patients. It will be exceedingly difficult to create a separate, personalized scoring rubric for every hospital in a unique circumstance inherently placing it outside of the realm of normal scoring. Hospitals specializing in end-of-life care, for instance, will most definitely have higher mortality rates than other acute care centers; surely they will need their own scoring performance standards since it would be unfair to rate them against counterparts specializing in healthcare with more promising patient outcomes.

Additionally, there is a risk that hospital physicians and staff will become so focused on patient satisfaction that they ignore the necessary and often displeasing responsibilities of in-patient care. Hospitals may begin to refer patients elsewhere in hopes of avoiding "low-scoring cases." As Dr. Haywood, the former deputy chief medical officer at CMS says, "This type of value-based purchasing is not a collaboration but a competition in which every hospital is pitted against the entire market."[8] Under a payment system such as HVBP, there will winners and there will be losers, and only the winners will be rewarded. This is a system that can lead to a vicious cycle of gaining resources and scoring well, while those hospitals without continue to lose out.

THE EVIDENCE IS IN: ENDORSE HVBP

The promise of HVBP lies in its structural strengths. The program will be based on incentives, not disincentives. Thus, even if a provider does not score well enough to receive a great deal of financial compensation it will not lose monetarily. The money will come from a funding pool of seemingly extraneous inpatient costs; it will act as a reward, not a potential penalty. Because scores are, in a large part, dependent on the good will of the patient, hospitals will have incentive to provide complete and effective care. Considering the nature of unique hospitals in disadvantaged positions or with different standards, CMS has already promised that the Secretary will create a specialized scoring system, and the system as a whole is expected to change as seen fit. Thus unfair advantages will be accounted for, if not now, surely once results are first obtained and analyzed.

HVBP *does* instigate competition, a healthy competition that many parts of the ACA, particularly the Exchanges, will

create and enthusiastically endorse. Competition in this case, will create efficiency and a greater focus on consumer satisfaction as well as an assurance that hospitals will have to respond to the needs of informed consumers and not the other way around. HVBP will revolutionize payment methods in not only Medicare's acute care but in Medicare as a whole and, beyond that, in all types of healthcare. This legislation is a stepping-stone to creating more affordable, more efficient, and better quality care, and it will rightfully reward hospitals in the process. Considering the ever-increasing elderly population and cost of healthcare in America, the time to act is now, in the innovative and metamorphic context of Obama's ACA.

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In Defense of Community Health Centers

Reducing Racial and Ethnic Disparities in Health Care Access and the Affordable Care Act

Laura Kroart

Community Health Centers play a critical role in the reduction of racial and ethnic disparities in health care access, as they use community-based care to serve a disproportionately poor and uninsured population of patients.[1] The Patient Protection and Affordable Care Act appropriates $11 billion to the operation and expansion of Community Health Centers.[2] However, in March 2011, $600 million of these appropriated funds were revoked in the federal budget compromise to avoid government shutdown, consequently inhibiting expansion initiatives of Community Health Centers across the country.[2] Furthermore, despite their necessary role in reducing racial and ethnic disparities in health care access, Community Health Centers continue to be a vulnerable aspect of the Affordable Care Act, as plans to reinstate this funding is lacking from the proposed budget for fiscal year 2013.[2] In this essay, I argue that we should turn a critical eye to cuts that negatively affect Community Health Centers, as inhibiting their expansion risks exacerbating these disparities in health care access that the United States claims to be committed to addressing in the goals set forth by Healthy People 2020. In order to address these disparities, the critical role that Community Health Centers assume must be recognized and funding for the expansion of Community Health Centers reinstated for fiscal year 2013.

INTRODUCTION

The first Community Health Centers (CHCs) in the United States were established in 1965 under President Lyndon B. Johnson as a means of developing health resources to serve uninsured and marginalized populations.[3] Following their original mission, Community Health Centers today serve a disproportionately poor, uninsured, and/or publicly insured group of patients, and play a critical role in reducing racial and ethnic disparities in health.[1]

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law, and in so doing appropriated $11 billion over the period of 2010 to 2015 to the operation and expansion of Community Health Centers across America. However, budget cuts to federal funding have negatively impacted expansion plans of these centers that provide the backbone for serving patients with the least access to primary care. Furthermore, even though the number of patients that Community Health Centers serve has more than doubled from 10 million people in 2000 to 20.8 million in 2010, funding for CHCs remains vulnerable, as bipartisan efforts to reduce national spending have resulted in large budget cuts for many programs including some of those included within the ACA.[4]

In order to commit to reducing racial and ethnic disparities in health as laid out in the goals of Healthy People 2020, we must question why funding for the expansion of Community Health Centers is at stake, and consider the risks of inhibiting their role in producing this outcome. If we are truly committed to addressing racial and ethnic disparities in health care access in the United States, federal funding for the expansion of Community Health Centers must be reinstated for fiscal year 2013.

UNINSURED IN AMERICA

Following the recession period of December 2007 to June 2009, the United States has seen a significant increase in the number of uninsured Americans and a significant drop in the number of Americans covered by employer-based insurance. It is estimated that as of 2011, 50.7 million Americans, or 17.1%, are without health insurance. This is up from 16.8% in 2010.[5] The number of families in poverty increased from 8.8 million, or 11.1%, in 2009 to 9.2 million, or 11.7%, in 2010.[5] With the unemployment rate on the rise, the percentage of Americans covered by employer-based coverage dropped from 56.1% to 55.3%.[5] In addition, between 2009 and 2010, the percentage of Americans covered by private insurance has decreased from 64.5% to 64%, while the percentage covered by government health insurance has increased from 30.6% to 31%.[5] With no established source of primary care or health insurance coverage, an increasing number of Americans must rely on resources such as Community Health Centers to seek affordable, accessible, and quality primary care. These Community Health Centers must be prepared to expand and account for the growing need in America; a trend with no foreseeable conclusion without provisions to expand coverage and other forms of prevention.

Data show the number of under and uninsured Americans has reached a 45 year high at over 50 million persons as of 2011, and has been shown to have a disproportionate affect upon vulnerable populations.[5] For example, racial and ethnic minorities in the United States experience disparities in health care access relative to their white counterparts. It is estimated that about 30% of Latinos and 20% of African Americans lack consistent primary care access, compared with less than 16% of whites.[6] In addition, African Americans and Latinos are more likely to rely on hospitals or emergency care clinics for their usual source of care, 16% and 13% respectively, than white Americans, who comprise only 8% of those who use these services as their primary source of care.[6] Disparities in health care access in America are also seen among those with less than a high school education or below the poverty line. However, these distinctions are confounded by the fact that people of color are more likely to have a lower level of education or to be below the poverty line than their white counterparts.[6]

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SETTING GOALS TO ADDRESS DISPARITIES: HEALTHY PEOPLE 2020

Addressing these disparities in health care access is a goal that the Department of Health and Human Services has outlined as a goal for the decade approaching year 2020. Healthy People, set forth by the Department of Health and Human Services in ten-year increments, outlines the goals and guidelines in health hoped to become reality in the United States. Healthy People 2000 set the overarching goal of reducing disparities in health in the United States, and Healthy People 2010 expanded this goal to eliminating health disparities entirely. Healthy People 2020 takes this goal a step further by outlining goals for both eliminating disparities and "achieving health equity."[5] The United States is therefore given the task of responding to these goals by developing resources to address these disparities as we approach year 2020. Community Health Centers are critical in taking on this task and accounting for the goals set forth by Healthy People 2020, as they not only address disparities in health care access, but also function to improve overall health for all groups.

THE RESPONSE: COMMUNITY HEALTH CENTERS

Community Health Centers are critical to reducing disparities in health in America, as they are currently serving over 20 million people in all fifty states who are disproportionately poor, uninsured, and/or publicly insured.[8] 71.8% of patients served by Community Health Centers in 2010 were living at or below federal poverty guidelines.[9] Research demonstrates that these centers are successful in reducing and eliminating health care access disparities by establishing themselves as their patients' regular source of care.[10] With community-based access to care that accounts for the needs of their population, health status disparities are better managed.[10] For example, Community Health Centers have structures in place to provide culturally competent care, such as the provision of local community leadership on the boards of Federally Qualified Health Centers.[9] By emphasizing coordinated primary care and preventative services that maintain a focus on the specific communities they serve, Community Health Centers provide a "medical home" that "promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations."[10] Therefore, CHCs are an effective and necessary tool for reducing disparities in both health care access and outcomes.

The expansion of Community Health Centers is an investment in not only the health of racial and ethnic minorities, but also in the local economies of CHCs and in the health care system. It is estimated that the primary and preventative care that Community Health Centers provide saves the health care system $24 billion annually. This is approximately an 8:1 return on investment in terms of the employment opportunities they create and the economic activity they generate.[2] They provide this investment by keeping patients out of the waiting rooms of emergency facilities, instead providing them with community-based, quality health care at a low cost.[8] By expanding the capacity for Community Health Centers to provide primary care and prevention programs for more people, we not only have the capacity to reduce racial and ethnic disparities in health, but also to save money that could be appropriated to fund other avenues of the Affordable Care Act. By inhibiting expansion, we not only risk the loss of this investment that is so critical at a time when we are attempting to reduce government spending, but we also risk exacerbating the racial and ethnic disparities already observed, thereby increasing spending in the future. By accounting for this need for community based health care, we are making an investment in the health care system as a whole. In addition, expansion of Community Health Centers also plays a significant economic role on a local level, as CHCs provide job creation for many communities they serve.[9]

They provide this investment by keeping patients out of the waiting rooms of emergency facilities, instead providing them with community-based, quality health care at a low cost.

EXPANSION BROUGHT TO A HALT

Community Health Centers are funded through several different revenue streams, with Medicaid constituting 38% of financing and federal grants another 23%.[2] The Affordable Care Act appropriated $11 billion over a five-year period to the maintenance and expansion of Community Health Centers and their programs. Under the provisions of the Affordable Care Act, $9.5 billion was appropriated to expanding services and creating brand new sites in medically underserved areas. Another $1.5 billion was allocated to renovating existing sites and supporting major construction to improve and support Community Health Centers in need.[11] As Medicaid has become a main source of revenue for CHCs, this federal grant money that would have otherwise been allocated to Medicaid recipients enables centers to expand and cover a larger portion of completely uninsured patients.[2]

In April 2011, the United States Congress passed $38 billion in budget cuts in order to prevent a possible impending government shutdown. The bipartisan effort resulted in $600 million for fiscal year 2011 that had been allocated for the expansion and renovation of Community Health Centers across the country, cut from the $11 billion that had originally been provided.[12] These budget cuts marked the first-ever cut to the federal government's direct investment in primary health care capacity since 1982.[2] In order to preserve existing services and prevent cutback from already operating health centers, expansion of new Community Health Centers was drastically cut back, and for some communities, eliminated completely. These budget cuts halted the expansion of

programs that would accommodate more patients, and significantly cut back expansion plans in the 2011 fiscal year.[8] As of April 2012, plans for fiscal year 2013 include the similar reduction in appropriations for expansion of Community Health Centers, instead focusing on the continued operation of existing centers through the use of the Health Center Trust Fund to offset the retrenchment of funding.[2]

In addition to the cutbacks to expansion, the United States health care system is already bracing itself for the expected rising demand for health care services following the expansion of coverage that the ACA provides. Under the Affordable Care Act, the expansion of Medicaid means that there will be a larger number of people covered by publicly-funded insurance who will need a reliable, accessible, and quality source of care. The expansion of Medicaid as made possible by Affordable Care Act provisions will extend coverage to 15 million low-wage workers who would otherwise go without health insurance.[13] With this influx of new patients, Community Health Centers need to have the infrastructure provided through additional funding to support the provision of their care. Therefore, in the wake of budget cuts to expansion, Community Health Centers are faced with providing for more patients with fewer resources. Reducing funding for their expansion when there will soon be an even higher demand for their services is therefore counter-intuitive. While we make strides in providing access to care through insurance, without a medical home to use these benefits, we inhibit this opportunity to address disparities in health access through Community Health Centers.

SUPPORTING EXPANSION

Faced with the goals set forth by Healthy People 2020 to "achieve health equity" in the next decade, the Affordable Care Act bolsters the expansion of Community Health Centers as it is a proven method for reducing racial and ethnic disparities in health. However, the retrenchment of the federal funding for Community Health Centers puts this goal at risk. Halting expansion of Community Health Centers not only risks exacerbating racial and ethnic disparities in health by failing to address this growing population of uninsured Americans of color, but also risks losing the economic savings that Community Health Centers provide. The role that these community-based health resources play in not only providing care for vulnerable populations such as racial and ethnic minorities but also in reducing overall health care spending must be emphasized. If we are truly concerned with reducing health disparities in America as set forth by Healthy People 2020, we must consider the implications of cuts to programs such as CHCs that have been proven to be imperative to completing this goal, and advocate for the reinstatement of this federal funding for fiscal year 2013. The continued existence and expansion of Community Health Centers depends on advocacy and research done on their behalf. We must search for alternative sources of budget cuts that do not impair the expansion, progress, or maintenance of Community Health Centers, which should not be seen as a bargaining chip in partisan negotiations, but instead as a foundation for the continued efforts to reduce overall health care spending and achieve heath equity in America.

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Women's Preventative Health and the Abortion Issue

Prioritizing the Health of Women Above Politics

Rebecca Matyas

The Patient Protection and Affordable Care Act (ACA) includes provisions to improve accessibility of preventative services like cancer screenings for women. Some of the most important sources of care are women's health clinics. Clinics serve a disproportionate fraction of traditionally underserved populations such as minorities, youth, or groups with low socioeconomic status. However, political controversy over the legality of abortion prevents the utilization of these services when political views on abortion lead to loss of funding and to closing of the women's health clinics. This is because many pro-life advocates, who understandably do not want to fund abortion, work to remove funding for clinics in any way connected with providing abortion, regardless of the clinics' other functions such as mammograms, pap smears, or other preventative services. For many women, there are no other options for getting these services besides clinics. This paper focuses on explaining the importance of women's health clinics and showing the effect of abortion politics on the ability of clinics to provide other important services. It then calls for bipartisan support of women's health clinics. In order to fully take advantage of the women's preventative health benefits provided by the ACA, citizens and politicians on both sides of the abortion issue must work together to support clinics that offer preventative services to ensure access and protection for women together to put aside political issues and prioritize women and their health to support the ways that they can get care.

INTRODUCTION

Women's preventative health is under attack by the political forces of the abortion issue. Abortion is a divisive issue for many Americans. This contention also affects other services offered in women's health clinics. One of these services, preventative healthcare, particularly non-reproductive services like cancer screenings, is an investment most citizens can support or compromise on despite disagreement on the abortion issue, because these services benefit all women. The Patient Protection and Affordable Care Act (ACA) mandates that many preventative services for women be covered without cost sharing for all patients who have insurance. The new regulations provide a valuable advance in access to these services for women for whom money was a barrier. According to a Guttmacher Institute report in 2000, a sixth of American women, 7.4 million women, go to women's health clinics for those services.[1] These clinics serve a disproportionately high fraction of traditionally underserved groups like minorities, youth, and women of low socioeconomic status. However, because of the real or imagined association with abortion services, many clinics are under political and financial attack. This paper will describe the role of abortion relative to the utilization of newly provided women's preventative services through the ACA. The paper will address the importance of clinics to provide preventative services and the way that abortion politics is negatively affecting those clinics. From there, it will emphasize the importance of bipartisan support of clinics that provide preventative services for women, without having to take sides on the abortion issue. In order to take full advantage of the women's preventative health benefits provided through the ACA, citizens and lawmakers on all sides of the abortion issue must work together to support clinics that offer preventative services in order to ensure access and protection for women.

THE ABORTION ISSUE

To understand the effect of the abortion debate on clinic access to preventative health services, one must understand the basic history of the pro-life and pro-choice conflict in the United States. Essentially, there are two main positions in the debate of whether abortion is morally permissible as well as if it should be legal in the United States. The pro-life side of the dispute argues that abortion is wrong and should not legally be an option. This is influenced by reasoning that a fetus is a person from the time of conception for reasons such as DNA composition or developmental factors like a heartbeat. This means that to terminate a pregnancy is murder. Other pro-life arguments cite the potentially devastating emotional effect on those involved in an abortion, particularly the mother. Some individuals share the pro-life stance for religious reasons, but there are also many secular pro-life advocates.

The pro-choice side argues that abortion is not always wrong and a woman should legally be allowed to choose for herself whether or not to terminate a pregnancy. The reasons for this opinion stem from a range of perspectives including a value on autonomy; a social and financial societal benefit by not bringing unwanted children into the world; or specific situations, such as rape or danger to the mother's life, that would merit abortion.

The abortion argument is not black and white. Many believe that abortion is wrong in some circumstances and not others. However, the pro-life and pro-choice sides to the argument are the most common distinction. There is no way to prove that one stance is right or wrong.

History has shown that these two most extreme positions are fundamentally incompatible from a legal and legislative perspective. There have been various high profile court cases including several landmark Supreme Court cases that have shown the various sides to the argument and set precedents for United States policy. The most famous case is *Roe v. Wade*, which defined and protected the right of a woman

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to terminate a pregnancy. The court made this ruling as a defense of the woman's privacy. More specifically this has included, first:

"'A recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State'; second, 'a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman's life or health'; third, 'the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.'"[2]

Since the *Roe v. Wade* decision in 1973, court cases have challenged this right and at times weakened the stance taken by the Supreme Court. Overall, there has not been a clear consensus about the issue of the legality of abortion.

WHERE ABORTION AND PREVENTATIVE HEALTH SERVICES MEET

Initially it might seem as though abortion and uncontroversial preventative services like cancer screenings are unrelated. The conflict arises in the fact that abortions and preventative services are often provided to women in the same clinics or by the same organizations. Therefore, many pro-life activists oppose these organizations and clinics that offer both abortions and preventative services in order to uphold political and moral ideals. Clinics that do not provide abortions but have affiliations with larger organizations that offer abortions also become political and financial targets. For example, of the 69 Planned Parenthood clinics in Texas, only thirteen provide abortion services, yet pro-life advocates like Governor Perry target both clinics that provide abortions and those that do not provide abortions but have affiliation with organizations that do.[3]

Abortion is such a controversial and political issue that the repercussions of decisions made based on abortion politics affect other aspects of health, particularly preventative services. For example, it is understandable that pro-life advocates do not, at the very least, want to privately fund abortion. It also stands to reason that pro-life individuals do not want abortion funded with their money through taxes or with other federal funding. Because abortion is such an emotionally and ethically charged concern, pro-life advocates work very hard to ensure that the government does not use any public funding for abortion services. In the ACA, this political concern is easily visible in the five separate provisions in the ACA that prohibit "affordability credits under the ACA from being used for abortion coverage, subject to the Hyde amendment" and establish "new segregation rules to ensure that federal funds are not used to pay for abortion beyond those exemptions permitted by the Hyde amendment."[4] This means not only does the ACA uphold existing limitations, it further ensures the prevention of the use federal funds for abortion.

On the other hand, most people can agree on the importance of women's preventative services. This includes cancer screenings like mammograms to identify breast cancers early or pap smears to identify human papilloma virus that can cause cervical cancer. Of course, there are some more controversial grey areas, such as contraception as a part of preventative services, but the majority of services, the most basic example being cancer screenings, have very little controversy. People on both sides of the abortion debate have mothers, sisters, spouses, and friends who are women and whom they would want to protect from cancer and other preventable or treatable conditions. In this respect, women's health, regardless of politics in the United States, is nearly a universal concern.

THE ACA AND WOMEN'S PREVENTATIVE SERVICES

The ACA offers great opportunity to improve women's access to preventative services. To promote wellness care, ACA policymakers eliminate cost sharing for the following women's preventative health services in all new insurance plans:

- Well-woman visits;
- Screening for gestational diabetes;
- Human papilloma virus DNA testing for women 30 years and older;
- Sexually Transmitted Infection counseling;
- HIV screening and counseling;
- FDA-approved contraception methods and contraceptive counseling;
- Breastfeeding support, supplies, and counseling; and
- Domestic violence screening and counseling.[5]

Insurance plans must offer these services without co-pay, coinsurance, or payment towards a deductible. This part of the law expands access to insured women for whom cost was previously a deterrent to getting preventative care. Eighty-six million Americans have already used the preventative services without cost sharing since 2011, when the ACA became law.[6] Additionally, the ACA is projected to insure 32 million previously uninsured people. Women in that group will also be able to access wellness-focused preventative services. The ACA provides a valuable opportunity to decrease gaps in use of women's preventative services due to cost. However, the changes made in the policy are only useful if women have access to facilities that offer these services.

While the ACA makes these advances with preventative services, some prominent pro-life activists attack the funding of clinics that offer these services. This has occurred in many situations across the country. For example, in Texas, more than twele clinics in the state have closed after the Republican-controlled Legislature cut financing for women's health by two-thirds, which "grew out of the effort to eliminate state support for Planned Parenthood."[7] The abortion issue is important enough that these individuals have prioritized eliminating abortion over protecting the other services offered by the clinics. This paper proposes, not a change of pro-life views, but an alteration of these priorities. Pro-life groups or individuals should not feel they must fund or support abortion, and it is already impermissible to use public or federal funds for abortion. One limitation is that it might be difficult to know for what clinics use the funds, but this could be monitored and regulated. Even if one chooses to stipulate that clinics are not permitted to use pro-life funds for

abortions, clinics that provide women's preventative services and may in some way be associated with abortion services are worthy of support. These clinics are extremely important to women's health access and utilization and, for many, there is no viable alternative if the clinics are not available.

THE IMPORTANCE OF CLINICS

Government funding in Title X funded 4,389 service sites in the family planning network of clinics in 2010.[8] These are not the only existing clinics, but shows the magnitude of the women's clinic network. The clinics are also far reaching: "In approximately 75% of U.S. counties, there is at least one clinic that receives Title X funds."[9] To show how valuable clinics are in providing preventative services, Guttmacher Institute reports give the following facts about the role of clinics:

- Clinics serve one in seven women of reproductive age who receive Pap smears, pelvic examinations and testing or treatment for gynecologic infections.
- One in four women of reproductive age seeking HIV tests each year, and one in three obtaining other STD services, get these services at a clinic.[10]
- In 2002, over one in four (28%) black women who received any reproductive health service did so from a family planning clinic; cervical cancer incidence among black women is nearly 1.5 times that among white women, and mortality is more than twice as high.
- Four in ten Hispanic women who received any reproductive health service did so from a family planning clinic; Hispanic women have the highest levels of cervical cancer in the United States.
- One-third of all women aged 15–24 who received any reproductive health service at all did so at a family planning clinic.
- Among women with incomes below 250% of the federal poverty level, nearly four in ten who received any reproductive health service did so at a family planning clinic.[11]

As one can see from these statistics, a substantial fraction of women receive preventative care seek that care at a clinic. Not only do clinics cover a large group of women, the clinics specifically work with traditionally underserved racial and socioeconomic minorities. Also youth ages 15 to 24, a commonly neglected group in preventative healthcare, also frequent clinics.

Some clinics provide abortion and some do not. Planned Parenthood runs some of the most well known family planning clinics. These, clinics, although famous abortion providers, show in a breakdown of Patient Care Provided by Planned Parenthood Affiliate Health Centers that only 3% of their services are providing abortion. 38% goes to STI treatment and screening, 14.5% goes to cancer screening and prevention, and 10.4% goes to other women's health services.[12] Abortion is a small but still important and relevant factor, yet other women's health services are a far greater portion of the clinic's services.

There are various reasons that one might choose a clinic, including privacy or cost. Most importantly, however, for many women, the clinic is their only choice for accessing these services, particularly if other medical centers are far away or over capacity. To underfund or do away with these clinics would be a serious blow to the ability of women to access the preventative services that the ACA attempts to make more accessible.

THE BATTLE OVER FUNDING CLINICS

As explained earlier, the abortion debate creates some serious tensions in the funding of clinics because some of the same clinics that offer preventative services either provide or have affiliations with organizations that provide abortions, like Planned Parenthood. This includes taxpayer dollars. The conflicts over public funds for these clinics, some of which may be affiliated with an organization that provides abortions, are contentious and lead to accusations by both pro-life and pro-choice affiliates, as each tries to justify decisions made, based on abortion doctrine. For example, in a press release, Texas Governor Rick Perry accuses the Obama administration of placing pro-abortion policies over women's health. This was in response to the federal government's threat to cancel the women's health program in Texas if Texas refuses to fund clinics that offer abortions. He sees the problem as a state's rights issue and the government manipulation as unconstitutional.[13] In contrast, a New York Times editorial, "Women in Texas Losing Options for Healthcare in Abortion Fight," frames the same issue in a different way. The article accuses the Texas government of cutting off funding to clinics under the pretense that the money went to abortions, even though those clinics did not offer abortions. The article does explain that some of the clinics received funding from organizations that in other locations do abortions like Parenthood.[7] Both pro-life and pro-choice affiliates feel that their groups are in the right with funding and the abortion issue, but overall there are many accusations and little progress.

Some of the disagreement regarding public funding of abortion can be settled by the legislation. The Hyde Amendment, passed in Congress in 1976, bans federal funding of abortion in all but the most extreme circumstances.[14] Therefore, some of the concerns about federal or public money going to fund abortions at these clinics are unfounded because to use the funds in that way would already be illegal. One of the main ways that federal money funds clinics is through Title X.[10] The policy echoes the Hyde Amendment in the prevention of using this federal money for abortion services. Finally, in the ACA, the law clearly states multiple times that none of the money appropriated by the law would fund abortions.

This leaves us with the main issue of whether it is worthwhile for pro-life groups and individuals to support, or at least not attack, a clinic or program in another way even though they disagree on the abortion issue. This paper argues that the ability to support these clinics in spite of these very important and controversial disagreements is extremely important. For many women, these clinics are their only accessible source of preventative healthcare.[7] For others, they would go to a clinic but not a hospital for reasons of finances or privacy. In the end, if the clinics are underfunded or closed, these women

will not receive preventative healthcare. This will be detrimental to the health of these women, expensive when they need acute care after not catching problems early, and problematic, affecting people on both sides of the abortion debate. At this time, there is no one offering a pro-life alternative to these women's health clinics that would be able to support all who are left without care because of clinic closings. Therefore, it would be valuable for those on both sides of the abortion issue to rally around supporting at least the preventative programs in women's health clinics, regardless of the clinics' standing on abortion.

It is important to remember that practically all Americans spend money on taxes, which overall benefits the contributing citizen. Nonetheless, an individual may not agree with all things that the tax money sponsors. For example, an individual might believe in military for self-defense but not for any aggressive warfare. Yet, his American citizenship and the other government expenditures that taxes support are more important than his protest of particular military activities. Because so many good things come out of taxes, it is not worth "throwing the baby out with the bathwater." Everyone has unique values, and this compromise is part of being a citizen and taxpayer. The same goes for healthcare in this situation; even if one opposes abortion, it is worth supporting clinics even though one does not agree with every part of their practice, only the majority. The overall public health good is worth the compromise.

CONCLUSION

In conclusion, to fully take advantage of the women's preventative health benefits provided by the ACA, citizens and politicians on both sides of the abortion issue must work together to support clinics that offer preventative services to ensure access and protection for women. We must prioritize women and their health over political issues and support the ways that they can get care. An article from the journal, *Feminist Teacher*, argues for putting aside the polarizing pro-life/pro-choice rhetoric and language, in order to be able to "reframe the discussion of abortion to *center on women*."[15] In this way we can work together to find solutions that will improve the lives of women, no matter one's political inclination. The importance of this model continues into modern politics. Recently, the Susan G. Koman foundation decided to cut funding to Planned Parenthood breast cancer screenings because of Planned Parenthood's abortion services. In response, Leahy and 25 other US senators challenged Koman's decision saying, "It would be tragic if any woman - let alone thousands of women - lost access to these potentially life-saving screenings because of a politically motivated attack."[16] Similarly, this paper calls for bipartisan support of clinics that provide preventative services for women, without proposing that pro-life groups change their views on abortion. In spite of politics, the health of American women should remain the priority.

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Anthropology and the ACA

A Context Dependent Model of Quality Care

Marianna Papageorge

Anthropology, as a discipline and methodology, can be used in the current evaluation of quality care under the Affordable Care Act. It is shown, with the foundation of economics and policies such as Electronic Health Records, Affordable Care Organizations and Comparative Effectives, that anthropology is disregarded by the aspects of the ACA related to the assessment of quality. This is problematic, as the prevailing definition of quality does not allow for a holistic approach. The current system is limited, as it does not involve such crucial aspects as patient participation, concern with satisfaction or the social acceptability of health services. Therefore, it is concluded that quality needs to be viewed in an interdisciplinary light, beyond economics and the current policies in motion. Groundwork is laid for an evidence–based method that allows for a more contextual definition of quality. The organization and analysis of feedback from patients and community members is recommended in order to improve services provided. This review of satisfaction and patient opinion will allow policies under the ACA to respond to the environment in which they have been implemented. This outlook is critical in the evaluation of quality as it incorporates various perspectives, which are currently ignored in this diverse field of health care reform.

INTRODUCTION

The Institute of Medicine defines "quality care" as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] In the United States, quality care is assessed in a variety of ways, prioritizing the biomedical model and focused on issues such as medical errors, epidemiological markers, education and technology. Despite a focus on more biomedical forms of evaluation, there exist alternative parameters in the assessment of quality care. The question then arises, how do we measure quality for factors such as prevention, wellness and patient perspective?

With the passing of the Patient Protection and Affordable Care Act in 2010, quality reform became a central component of health care. This need for quality care is also competing with economic priorities as it becomes increasingly attached to cost (and measures to reduce cost are likewise tied to quality). Therefore, how does this connection impact the conception of quality care? What needs to be done to improve the current system?

In this paper I will demonstrate how anthropology is neglected in the current assessment of quality care in the ACA, as seen in terms of economic needs and the policies of Electronic Health Records, Affordable Care Organizations and Comparative Effectiveness. This is problematic as the prevailing definition does not allow for a complete and holistic approach to quality in health care. I work to demonstrate that quality evaluation of health care services requires the integration of anthropological research methods in order to fix this problem. Therefore, I lay the groundwork for an *evidence-based method* that allows for a more contextual definition of quality care involving patient participation.

THE DISREGARD OF ANTHROPOLOGY

Under the ACA, anthropology is currently disregarded in the evaluation of quality care, despite its value as an alternate and useful method. In the traditional sense, anthropology is the study of human kind, involving such concepts as culture, societal organization and collective experience. Most anthropologists would define culture as a shared set of implicit and explicit values, ideas, concepts and rules of behavior that allow a social group to function and continue. Culture is understood as a dynamic and evolving socially constructed reality. In order to study cultural forms, anthropologists employ a qualitative research approach, which seeks to understand events, actions, norms and values from the perspective of the people who are being studied. Anthropology emphasizes context and this can be applied to the understanding of quality and quality care.[2]

Despite the potential of anthropology to holistically evaluate and improve health care quality, the ACA is overwhelmed by economic discourse and policies that exclude this prospect. Health care spending in the United States reached $2.6 trillion in 2010, accounting for 17.9% of the Gross Domestic Product.[3] As a result of this increasing trend, major parts of the ACA represent an attempt at cutting costs, and as such, economists played a pivotal role in the drafting of the ACA and consequently, the definition of quality care within the bill. In fact, one of the main arguments regarding the ACA and the individual mandate involves lower costs. By requiring all citizens to purchase health insurance, more consumers will be in the system, thus lowering costs, such as premiums, for those involved.[4] Additionally, many of the individual components of the ACA that are meant to improve quality are actually tied into economics. This includes measures such as Accountable Care Organizations, Electronic Health Records and Comparative Effectiveness. It is important to ask if these programs really improve quality or if they were just created to cut costs. Therefore, the ACA, and its focus on quality, is in many ways driven by economics and this can be seen in its policies.[5]

Accountable Care Organizations are composed of health providers responsible for the overall quality, coordination and cost of care and services delivered to a population. Accountability rests with providers rather than insurers, as they are

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responsible for clinical outcomes as outlined by third party (i.e. Medicare) performance standards measuring quality thresholds and care furnished. These standards are yet to be formulated, although in 2010, it was decided that the guiding principle of an ACO is to increase access, improve quality and ensure the efficient delivery to and of care. It is also recommended that in the interim of the creation of these quality standards, providers take the lead in developing their own quality performance standards.[6]

Another similar measure in the search for quality care is the "meaningful use" of Electronic Health Records (EHR). Ideally, this data infrastructure will provide financial incentives, reduce error, increase the availability of records and data, use reminders and alerts, provide clinical decision support, and make use of e-prescribing/refill automation. The use of EHR must be done in a) a meaningful manner, b) for the electronic exchange of health information to improve quality of health care and c) to submit clinical quality and other measures. Although "meaningful manner" is not completely defined, health providers are expected to report on 12 to 15 "clinical quality measures", which include data measurements and definitions.[7]

Lastly, a third important component in the movement towards quality improvement under the ACA is Comparative Effectiveness Research (CER). This method is designed to inform health care decisions by providing evidence on the effectiveness, benefits and harms of different treatments. This is done by looking at evidence from existing trials and by conducting new experiments that generate original, ideally objective evidence. This is done to determine the best treatment option for patients.[8]

These three measures, although beneficial in their attempts to improve quality, neglect anthropology in their fundamental outline. All three policies ignore patient views and context specific factors that influence quality care. Alternative perspectives are not taken into account, rather, conventional outlooks such as health care professionals and government groups decide what is important and necessary for the quality of care in these programs. In fact, ACOs go so far as to allow health care providers to develop their own quality standards, completely ignoring all other factors. By not involving patients or understanding the context in which the policy is implemented, these national models miss meaningful sources of evaluation. The introduction of anthropology would help create a more complete understanding of health care quality that would allow these programs to run more effectively in the diverse communities and populations of the United States.

PROBLEMS IN THE SYSTEM

The inattention to anthropology in the evaluation of quality care presents serious limitations. At this point, economic forces in health care are so influential that they tend to leave behind quality in order to serve their own purposes. This can be seen in various cost and benefit analyses of health related services, which focus solely on quantitative factors.[9] There are serious limitations to this methodology on technical, ethical and appropriateness grounds.[10] The policies implemented, and discussed earlier, are not specific or comprehensive enough in their understanding. These programs do not take individual preference or contextual factors, such as socioeconomics, into account. These variables can have serious effects on quality care, how it is delivered and how it is viewed. For example, a community with a higher proportion of individuals living in poverty will have poorer health outcomes as compared to a wealthier community. Hence, quality will have different meanings in both settings, as quality care might require more resources in the community living in poverty.[11] Quality is different for everyone and the current system does not provide enough flexibility to account for different perceptions of this idea. Various critiques call for further research and the development of individual prototypes.[12] Therefore, due to severe limitations in the current system, something must be done to ensure that economic considerations do not completely dominate the meaning and experience of quality. Quality needs to be viewed in an interdisciplinary light beyond economics and the current policies.

Quality needs to be viewed in an interdisciplinary light beyond economics and the current policies.

THE POTENTIAL OF ANTHROPOLOGY

Anthropology has the ability to provide this interdisciplinary lens, allowing for a more comprehensive definition of quality care. Anthropology has become a major component of the health care field and its research by exploring reasons for use or non-use of services and the user or lay evaluation of services provided. This has proven very useful for a variety of reasons. First, patient satisfaction mediates the outcome of care through use of services and compliance with treatment, as dissatisfaction is usually expressed through rejection of treatment rather than vocalization. Additionally, health professionals are concerned with the viewpoints and opinions of the individuals they are treating. Secondly, the emphasis on effectiveness and efficiency also involves the social acceptability of health services. Thirdly, there is an emphasis on consumer sovereignty and the demand for health services to respond to this need.[13] Anthropology can be used to mediate between the professional and the lay perspective, allowing for greater understanding and better health care.

The success of anthropology in health care can be seen in the example of "medicalization". Medicalization was first introduced as a concept in the 1980's by medical anthropologists and sociologists. Referring to the process in which human conditions come to be defined as medical problems, medicalization is now a common term in our medical discourse.[14] With the help of anthropologists, many studies have found that increased medicalization in our culture has led to increased health care costs and the development of programs

in order to curtail this growth.[15] This is just one example of the ways in which anthropologists can aid in the health care reform. Therefore, anthropological methodology should be applied to the current health system, reform and argument over quality care.

A PROPOSED SOLUTION

By examining current models of quality care, it can be seen that in order to more completely define and evaluate quality, anthropological methodology must be introduced. At this point in time, it would be impossible to completely rid the health care system of its current policies and market forces, and thus improvements must be internal. A key improvement would be the addition of the anthropological framework of context through patient participation.

Through the use of anthropological methods, it can be seen how important context and subject voice is to understanding a situation. Therefore, in the evaluation and construction of quality care, these cannot be absent. In order to effectively do this within the current system, I recommend that each component of the ACA, that directly involves patients and works on quality improvement, be required to request feedback from the population it is serving. Therefore, a team within each health care field or policy associated with the ACA must be organized to deal with this issue of patient satisfaction in order to successfully incorporate patients' ideas. This research team should include anthropologists and health care providers. Patients should be questioned in survey and interview form in regards to the treatment they are receiving and the context in which they receive this treatment. These answers should be compiled and analyzed in order to decide what changes need to be made to the system in order to improve quality. This basic methodology can be replicated throughout the nation.

For example, this could be applied to Comparative Effectiveness. Patients who are receiving various treatments in a medical setting can be asked what they like or dislike about their treatment, how it is affecting them and how it relates to past treatments. These are just a few examples of questions to garner how patients are being affected. The answers would then be compiled and summarized and to determine if the Comparative Effectiveness model and its treatments are successful. This methodology would take both patient opinion and context into consideration.

Additionally, the inclusion of patient opinion will improve patient satisfaction and help tailor care to individual needs. This will result in higher quality services provided for the same cost. Through this, anthropology and economics can truly combine under the ACA.

Many studies have noted the success of anthropologists in hospital and health care settings as they provide a unique perspective for evaluation, collaboration and quality care.[16] Additionally, anthropology has already been implemented in hospital procedures throughout the United States via the principles of "Total Quality Management". This performance improvement measure stresses the systematic nature of hospital organization along with the impact of organizational culture on the effectiveness of policies and processes. In these cases, many quality issues are deferred to anthropological expertise. Although these policies do not yet include patient participation, they are at the forefront of an introduction of anthropological methods to quality care.[17]

Overall, it can be seen that by simply introducing anthropological methodology into the economically based system already established, a more holistic and context specific form of quality care will emerge.

LIMITATIONS

Despite the potential of anthropology in the health care world, its use also poses serious limitations to the understanding of quality care. The American Anthropological Association recently removed the word "science" from its definition and mission, rendering the discipline vulnerable to critique and potentially undermining its goals.[18] This action demonstrates and responds to criticisms of anthropology, which believe it is naturally biased and unable to quantify data. Due to this inability, the discipline cannot replicate situations and work, and thus cannot perform experiments in the traditional sense of the word. Since replicable, quantifiable material is valued in the science and health care field, this poses a limitation to anthropology's place. Nonetheless and despite these denunciations, the context specific aspects of anthropology can still be applied in a meaningful way to the understanding and model of quality care as seen in the examples discussed and the proposed solution.

The solution put forth in this paper has its limitations, as with all groups and research, it takes time, manpower and money. With that said, resources will need to be allocated to each program within the ACA and each research team assembled within it. Additionally, the focus on patients, rather than medical professionals or cost cutting, might be a cultural change for some areas and the ACA programs. These changes will take time and effort, but are very possible if prioritized. Despite these limitations, this solution has high potential for quality care in the future of health care and the reform.

CONCLUSION

A more complete definition of quality care is crucial under the ACA and current health care system. This can be achieved through an anthropological evidence-based model that allows for an understanding of context. By using this tool, quality care can be delivered more efficiently and effectively to each population in which an ACA policy is implemented. This will allow for the ACA to better achieve its many goals. Therefore, the introduction of anthropological methodology into the economically focused policies of the ACA will allow for a holistic picture of quality care that will improve health care services in the United States.

References for this article can be found at

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The Impact of Electronic Health Records on the Patient-Provider Relationship

The Complexity in Evaluating a Personal Interaction

Monica Stadecker

The introduction of Electronic Health Records (EHRs) into the healthcare system brings great potential for positive change. Less certain is the impact of EHRs on the patient-provider relationship, the interface between the healthcare system and the population it seeks to serve. Despite provisions within the Patient Protection and Affordable Care Act that encourage EHR adoption, preliminary research cannot substantiate either an entirely positive or entirely negative effect on the patient-provider relationship. Therefore, efforts should not focus on drawing broad conclusions from EHR research, but rather on creating a guideline for evaluation, taking into account the many diverse factors that play into it. This paper aims to provide such a guideline by identifying the relevant domains in which to conduct research, – the technological, the social, and the ethical – presenting current knowledge within these domains, and suggesting directions for future research. Because the impact of EHRs represents the crossroads of many professional fields and stakeholders, the guideline must work to exclude the bias introduced by conflicting interests and motivations. Thorough evaluation must therefore consider the intricacies of the personal relationship, as well as the external influences on the assessment. Within this framework of understanding, researchers can extract meaningful data and gain a deeper understanding of EHR impact to help ensure that the personal component of the patient-provider relationship is maintained and conceivably enhanced.

INTRODUCTION

With the introduction of Electronic Health Records (EHRs) into the healthcare system, come numerous foreseeable changes. EHRs hold the potential to impart significant positive change to healthcare, but their inevitable role in altering a wide range of healthcare fields must also be acknowledged. The patient-provider relationship is one such area of crucial concern. Increasing EHR adoption makes understanding the extent of this effect imperative. Whether during the face-to-face visit or through other forms of communication, the patient-provider relationship represents the interface between the entire healthcare field and the population it serves. It also plays an integral part in shaping a patient's experience of the healthcare system. Understanding the impact, therefore, provides the opportunity to improve the patient-provider relationship by enhancing communication, maximizing trust and promoting case management. Furthermore, such improvement implies better quality of experience for both the patient and provider and the promise of superior health outcomes through enhanced communication and increased access to health resources.[1]

The Patient Protection and Affordable Care Act (ACA) includes provisions for encouraging adoption of EHRs in recognition of these potential benefits. It cites both small and large-scale roles that EHR may play in bringing advances to healthcare: promoting efficiency and access for the individual and consolidating data for use in comparative effectiveness research, which tracks population trends and streamlines successful treatment protocols on a national level. This potential would advance the overall goals of ACA to improve quality, decrease cost and increase access. ACA also notes, however, that EHRs could evoke issues of high cost of implementation, lack of standardization across EHR operating systems and possible privacy breaches. These dichotomous features of EHRs influence on the healthcare system highlight the uncertainty of its more specific impact on the patient-provider relationship.

Accordingly, evaluation of the net impact proves difficult, since preliminary research demonstrates both benefits and detriments to the relationship as a result of EHR use. An argument for an entirely positive or entirely negative impact would therefore misrepresent the true influence of EHRs. Critical to the analysis is not the ability to make a single broad assessment of the impact, but rather to formulate a guideline for evaluation: identifying the relevant domains in which to conduct research, – the technological, the social, and the ethical – understanding current knowledge within those domains, and suggesting directions for future research. Furthermore, guidelines must take into account the external factors at play. Several distinct professional disciplines have a stake in EHR research outcomes. Consequently, conflicting motivations may contribute to researcher bias and complicate analysis. This issue demands consideration in gaining a thorough understanding of EHR influence. Therefore, a comprehensive and interdisciplinary study to evaluate the impact of EHRs on the patient-provider relationship proves necessary to achieve the objective of an improved healthcare system.

TECHNOLOGICAL IMPACT

Several factors characterize the technological impact of EHRs on the patient-provider relationship relating to communication, access, efficiency and implementation. EHRs provide new methods of correspondence through e-mail, web-based patient portals, chat rooms and online consultation services. These novel technologies represent an asynchronous mode of communication, offering a sense of continuous access to the healthcare system.[6,7] Researchers at the Oklahoma Physicians and Resource/Research Network conducted a survey of an Internet-based patient portal system. They found that of the thirty patient participants, 60.0% "regarded [it] as…improving patient-provider interactions."[8]

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It allows physicians to reach out to patients outside the exam room, suggesting a role in improving adherence to treatment plans through increased follow up, and in patient education, by alleviating confusion with timely responses to questions.[7] Patients express satisfaction with these new communication forums: they do not have to wait on the phone, their original message is not lost in translation and they feel a greater sense of control.[3]

Another technological aspect of EHR use is the facilitation of patient access to health records. This access directly impacts personal involvement in a patient's own healthcare. Increased access contributes to a sense of illness ownership, the active involvement of patients in their own health management.[5] The same study of 30 patients using the web-based portal found that 80% considered it a useful tool in promoting involvement in one's own healthcare.[8] Patients pay more attention and feel more engaged when given easy access to their personal health record.[9] Therefore, providers must emphasize the availability of EHRs and their use as a tool for all involved in a patient's well being.

Increased access, however, does not have an entirely positive impact. EHRs add complexity to the delivery of test results, which may contain sensitive information and have a negative emotional impact on the patient. Providers must demonstrate common sense discretion when considering the most appropriate form of information delivery, online or in person. Patients also expressed general concern that such online communication would actually hinder their correspondence with healthcare professionals, highlighting the strain placed on the traditional patient-provider relationship and associated communication methods.[9]

EHRs also influence the efficiency and flow of the visit, a third characteristic of the technological impact. Often the provider must divide his or her attention between the patient and the computer, attempting to hear what a patient says and simultaneously record the information. Diminished focus on the patient has a negative impact, especially when cues from the computer screen displace patient concerns in the agenda of the visit.[1] Dr. Deborah Spitz corroborates this sentiment. A dermatologist in a private practice with experience in transitioning paper charts to EHRs, she explains that EHR systems display separate data entry boxes for past medical history, present illness, medications, etc. Switching between these boxes throughout the visit causes her to multitask, which poses a challenge in listening to the patient. Disorganized patient narrative with no logical progression, further complicates the task: "It is hard to draw conclusions about differential diagnosis and treatment from disjointed histories, but the issue is now magnified by the distraction of physically jumping from box to box on the computer screen."[3] Consequently, such technological obstacles may sidetrack the provider's thought process and holds negative implications for developing treatment plans and consequently, health outcomes.

In other ways, however, EHRs may increase efficiency and facilitate the smooth flow of a visit. One palpable positive change is the shear volume of information recorded. Since most providers can type or dictate faster than they can hand write legibly, more of the patient narrative is preserved. Access to an entire health record in one electronic device can also serve to increase flow of the visit. The provider can share test results and images with the patient all on the computer, thereby seamlessly integrating disparate sources of information. A study of EHR implementation took place over 22 months at the Family Care Center at Memorial Hospital of Rhode Island. Through observation and interviews, Shield et al. found that "patients generally acknowledged exigencies of the physician's job and expressed appreciation of less wasted time and fewer physician exits,"[4] pointing to a positive response to EHR introduction in terms of efficiency.

The computer serves as a source of knowledge as well as a receptacle for information, but increasingly, it represents a third party in the exam room, complicating the interaction between the patient and provider.

Lastly, the process of implementing EHRs in a medical office – often an arduous task – also factors into the technological impact. Redundancies in data input, computer freezes, delays or other technological glitches, and lack of expertise with the new systems as the transition occurs contribute to the workload on the provider.[4] The additional time spent on administrative tasks means less time devoted to direct healthcare. This decreased time commitment may cause patients to feel neglected, both during and following the visit. Therefore, EHRs have demonstrated both positive and negative influences in the technological realm.

SOCIAL IMPACT

The social impact of EHRs on the patient-provider relationship manifests itself in many ways. They can be separated into two categories: the interaction that occurs in the exam room between the two individuals and the social dynamic that exists between the two as entities. Unlike the traditional patient visit, when EHRs are utilized, the interaction between three components – the patient, the provider and the computer – defines the social experience. The computer serves as a source of knowledge as well as a receptacle for information, but increasingly, it represents a third party in the exam room, complicating the interaction between the patient and provider.

A key aspect of the face-to-face interaction is patient centeredness, the attention and time dedicated to the patient during the visit. It involves social cues such as posture, eye contact and gestures. Perhaps the most conspicuous problem

introduced by exam room computing is the potential loss of eye contact. The spatial orientation of the patient, provider and computer must facilitate focused attention on the patient, rather than diminishing communication as it would if, for example, the placement of the computer forced the provider to sit with his or her back to the patient. This can be mitigated by the use of laptops or iPads when available to the provider. A survey of 150 patients and 23 physicians at the VA New York Harbor Healthcare System Primary Care Clinic studied the effect of the exam room computer on the patient-provider interaction. Rouf et al. revealed adverse effects such as less time spent looking at and examining the patient, less talking and less focus on the patient's chief concern. However, the survey showed positive influence of EHRs through encouragement of questions and clarifying of information.[2] Spitz highlights the importance of striking a proper balance between recording accurate information and the exchange of social cues. She also notes that many of her patients, especially younger ones, appreciate the role of EHR technology in consolidating and organizing information, since they too use new technology such as smart phones for similar purposes. They can therefore recognize the value of keeping an online record, despite the possible detriment to patient-centeredness.[3]

Mutual comprehension throughout the visit is another social factor susceptible to interference. For example, interpretation of patient statements may be altered since some EHRs may not support a structure that accurately records the key points of patient narrative. For example, the system may not include a data entry box appropriate for the type of information provided. The record, therefore, may not accurately reflect patients' values and priorities, causing them to feel ignored: "From the perspectives of patients…their reality is not captured in the medical record…The record becomes less meaningful to the patients as a reflection of their lives and, as a result, less useful," asserts Shield in her study at the Family Care Center at Memorial Hospital.[4] Other EHR systems, however, support free typing in which the provider can record patient information without a rigid structure. Nevertheless, maintaining communication requires a deliberate effort on the part of the provider, whether verbally, visually, or posturally.[1] The visit should not be simply an exchange of information, but also an interpersonal experience wherein both the patient and provider feel understood. A positive rapport requires sensitivity on both sides not only to the need for accurate and organized health information, but also to the psychosocial expectations common to all personal interactions.

In addition to evidence of the social impact of EHRs on the patient and provider as individuals, EHRs redefine the traditional roles of both as entities. Mutual acknowledgement and shared problem solving characterize this marked shift from one-way dependence to interdependency. Given background knowledge of the condition, patients are more likely to experience illness ownership and take initiative in self-care. They are now afforded the legitimacy and the empowerment to act on their own behalf, which places more responsibility on the patient, takes some burden off of the provider and leads to a more equal relationship.[4,5]

ETHICAL IMPACT

The last domain in which to evaluate the changes in the patient-provider relationship is the ethical. Issues of privacy and confidentiality are central to the discussion of ethics, since EHRs facilitate and, in fact, encourage ease of access to records and information sharing between and among patients and providers. Given the fact that most privacy breaches occur among health professionals, whether intentional or not, the unauthorized sharing of patient information is a legitimate concern.[2] Patients must now invest a deeper level of trust in their physicians to use their authority appropriately and with the sole intention of bettering patients' health.

Issues of privacy and confidentiality are central to the discussion of ethics, since EHRs facilitate and, in fact, encourage ease of access to records and information sharing between and among patients and providers.

Moreover, while emphasizing increased access as a key positive feature, EHRs permit the subtle regulation of online communication between the patient and the provider. Providers may receive lengthy and seemingly irrelevant e-mail messages from patients, since online systems remove the receptionist or nurse as a filter. The time providers spend sifting through superfluous information subtracts from the time devoted to direct health management. Some EHR systems try to compensate for this issue by offering patients the choice to receive automatic responses to routine inquiries. These systems support an institutionalized loss of interpersonal connection by bypassing physician involvement. Another example of restricted communication is encouraging brevity by physically reducing the size of the window into which the patient types a message. Though this type of regulation may avoid nonessential information, it could also cause the patient to feel cut off and hinder recognition of their priorities. Rouf explains that "There is a fine line between filtering out inappropriate communication and creating a barrier to access," and EHRs play a significant role in negotiating that line.[2]

Finally, the "digital divide" is an important ethical consideration of EHRs and the patient-provider relationship. This divide describes differential access to new forms of technology between different sectors of the population. These sectors vary in ability to purchase a computer, technological capability to use the device and access to an Internet network. EHRs introduce the possibility of widening social disparities through

a lack of access to technology, which may decrease patient follow up and health education. Due to diminished patient-provider communication and less access to both health information and healthcare itself, the digital divide can result in poorer health outcomes for the disadvantaged compared to their wealthier or more technologically informed counterparts. Finally, worse health status may imply decreased ability to gain access to technology, completing the self-promoting cycle. Therefore, although perhaps less tangible than other effects, the ethics deserve consideration in a thorough analysis of EHR's impact on the patient-provider relationship.

DIRECTIONS FOR FUTURE RESEARCH

While broad domains in which to conduct research have been established, gaps in current knowledge suggest specific directions for future research. One research focus falls under the design and implementation steps. Patient participation will be crucial in this research. Often overlooked in system development, patients can serve as a valuable source of feedback in understanding the psychosocial experience and the practicality of new technology. If the patient's voice is incorporated, satisfaction and perception of EHR usefulness will both benefit, emphasizing the need for a collaborative effort in designing EHRs involving all who participate in its use.[5]

After optimizing design and implementation, a valid next research step would be the development of evidence-based methods for observing and assessing exam room behaviors once these designs are applied. Research may focus on optimizing integration of the computer into the examination and on computer use training. With patient consent, the use of videotapes in the exam room is one technique to accomplish optimization.[1]

When an understanding of these exam room behaviors has been established, research may shift to effects outside the exam room, health outcomes in particular. Discovering how the impact of EHRs on the patient-provider relationship translates into actual health outcomes is a complex but critical next step. EHRs afford systematic organization of patient data, as well as ease of access to medical history for the provider. For patients, EHRs provide new modes of communication and opportunities for increased access to their own data, education and resources to more effectively participate in their care. In combination, these EHR capabilities should lead to better case management and streamlining of care, resulting in better outcomes. Research within this pathway can help to optimize the contribution of EHRs to improved health via changes in the patient-provider relationship.

In addition to research within these established domains, a comprehensive evaluation of EHR impact on the patient-provider relationship also requires acknowledgement and understanding of external factors. Inherent in any large-scale analysis is researcher bias; the way in which questions are posed or observations are made directly influences the outcome of the study. Numerous fields have a stake in this particular relationship, whether through financial motivation or professional interest. This analysis brings together the areas of information technology, communications, and cognitive and psychosocial studies, each wanting to generate conclusions relevant to their field and supportive of their own needs for recognition or, in some cases, monetary gain. For example, EHR system firms would want to report an overall positive impact on the relationship and exclude negative findings. There may also exist a dichotomy between the old and the young in studying the relationship. Younger generations, increasingly exposed and receptive to new technology, may adapt more readily to EHRs and promote their positive role in the patient-provider relationship. Older researchers, wanting to preserve the traditional concept of the relationship and established forms of interaction, may highlight the negative effects.[3] Therefore, the conclusions of a given study depend greatly on who conducts the research.

The goal of current research must be to identify with transparency both the positive and negative impacts of EHRs. These contributions to the ongoing comprehensive evaluation will help to create a true picture of how EHRs will modify the healthcare system.

CONCLUSION

The delivery of healthcare, at its most elemental level, is based on the interaction between the patient and the provider, the bridge between the healthcare field and the population it serves. As research and experience have made apparent, the introduction of EHRs is fundamentally changing this personal connection, in both beneficial and detrimental ways. Given these inevitable changes, the purpose of guidelines for EHR evaluation is to examine them critically and be able to improve the quality of experience in the most effective manner. EHR implementation, however, is an ever-evolving process, wherein both patients and providers will become increasingly adapted to its use and more easily incorporate it into their interaction.[3] The observations and conclusions from current studies may not accurately represent the state of the EHR influence once they are published. As such, keeping up to date with this crucial influence is imperative in understanding the development of healthcare delivery.

Throughout EHR implementation, healthcare professionals and patients must work to ensure that new technology does not replace the critical personal experience, but rather, serves to enhance it. Creating guidelines for the evaluation of the impact proves essential in order to ensure optimal healthcare delivery and quality. By acknowledging the technological, social and ethical domains for evaluation as well as the external factors at play, this systematic evaluation will maintain the integrity of the patient-provider relationship throughout EHR implementation.

References for this article can be found at

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Independent Payment Advisory Board

Sifting Through Propagandas-Finding Real Implications

Marian Younge

The cost of Medicare has systematically increased since its implementation in 1965. Currently, Medicare consumes approximately 3.6 percent of GDP.[1] By 2035, this number is projected to increase to 7 percent of GDP if no changes are made to the system.[1] Due to the recent economic crisis and the dire state of finances across the globe, the need to reduce cost in this sector of government spending is a must. Previous legislation has attempted to ameliorate the increasing cost of Medicare. For example, the Sustainable Growth Rate formula sought to decrease physician reimbursement by a rate analogous to gross domestic product. Furthermore, the Medicare Payment Advisory Commission (MedPAC) was established to make recommendations to Congress on issues affecting the Medicare program.[9] However, none of these measures have consistently sustained Medicare cost growth. A more recently proposed initiative to tackle the issue is the Independent Payment Advisory Board (IPAB), a panel of health experts, set within the ACA, who will be granted executive power to rein in Medicare costs. Although the board has not yet been created, it has been under scrutiny in the media and has received bipartisan backlash. [The House repealed the Bill and Congress is set to make a decision in the near future.] The potential threats or benefits of this piece of the ACA have been clouded by misinformation and false propaganda labeling it a death panel and a rationing board. In order to assess the real implications of IPAB and to make concrete adjustments to Medicare, it is necessary to sift through the polarized views of opponents and supporters, especially as the elderly population and the cost of care are predicted to grow in the near future.

INTRODUCTION

The Patient Protection and Affordable Care Act contains within it several measures to defray the drastically increasing health care costs of the nation. Among these measures is the Independent Payment Advisory Board (IPAB), a fifteen member panel of unelected officials who will make recommendations to Medicare that would automatically become law. Supporters of the board say that it would provide a real cost-savings approach to rein in the increasingly growing cost of Medicare. Opponents of IPAB claim that it is unconstitutional and undemocratic because it gives a board of unelected officials unprecedented power to make decisions that will ultimately affect all U.S. citizens. Furthermore, despite explicit language in the legislature stating that the board is barred from making decisions that ration care, increase premiums, and change or restrict benefits, critics claim that IPAB will have detrimental effects on all stakeholders in Medicare, including patients, physicians and hospitals. This paper will investigate the various implications of IPAB and attempt to give an overview of the proposed positive and negative parts of this legislation.

IPAB: STRUCTURE AND OVERVIEW

The Independent Payment Advisory Board was designed on the principle of reducing Medicare spending by isolating health care payment decisions from polarized views or special interest groups.[2] Under the current health law, the board will be activated in 2013 if the CMS Actuary determines that Medicare spending growth per capita exceeds inflation benchmarks set for 2015-2019.[3] Following its activation, the first round of recommendations is to be submitted to the President and Congress in the subsequent proposal year, 2015. Continuing in 2020, the benchmark growth rate will be based on one additional percentage growth of gross domestic product (GDP +1%).[3]

Constituents of IPAB will be appointed by the President and confirmed by the Senate. The board is to be composed of experts such as physicians and health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, and individuals skilled in the conduct and interpretation of biomedical health services, health economics research and in outcomes and effectiveness research.[2] IPAB will also be advised by a Consumer Advisory Council, a group of ten consumer representatives who will serve as a more transparent link between members of the board and U.S. citizens. Terms of appointment are for six years and on a staggered basis, with members appointed on an annual, triennial and sexennial basis.[1]

The board is tasked with making recommendations that improves the health care delivery system, protects and improves Medicare beneficiaries' access to evidence-based services, and considers the effects on Medicare beneficiaries of changes in payments to providers of services and supplies.[2] IPAB is explicitly prohibited from making recommendations that would ration health care, increase Medicare beneficiaries cost-sharing, restrict benefits and limit eligibility.[1] Each recommendation made by IPAB will be implemented automatically unless Congress secures a two-thirds majority vote to override it and proposes its own strategy to achieve equal cost-savings.

IPAB: FUTURE PROJECTIONS

According to the Congressional Budget Office (CBO), if the Patient Protection and Affordability Act remains intact, Medicare cost will be maintained and the IPAB would not be needed until at least the year 2022.[4] However, as current cost trends continue, and as the entire health reform bill is under

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scrutiny and subject to modifications, it is possible that IPAB could be activated sooner than originally anticipated.

The Congressional Budget Office estimates that IPAB will generate $16 billion in savings over the years 2010-2019 if the board is activated in 2013.[5] Furthermore, the Chief Actuary estimates IPAB has the potential to achieve an overall savings of $24 billion.[2] Since total Medicare spending for 2015-2019 is projected at $3.9 trillion, $24 billion in accumulated savings will only account for 0.6% of total program expenditures or $89 per person.[2] As these figures show, the future state of Medicare is dire and all cost-controlling measures; even those with nominal effects are required to improve the financial status of the program.

THE CURRENT STATE OF MEDICARE

Medicare costs are projected to increase from 3.6 percent of GDP in 2010 to 5.5 percent of GDP by 2035 and 6.2 percent of GDP by 2085.[6] Furthermore, the Medicare Health Insurance Trust Fund faces a drastic funding shortfall and is projected to pay more in hospital benefits and other expenses than it receives in income for all future years.[6] According to the Medicare Board of Trustees, the long-term programming costs of Medicare are unsustainable and will require immediate legislative action if this service is to be continued for years to come.[6]

Medicare payments to physicians will be reduced thirty percent by the end of the year 2012 when the doc-fix is no longer applicable. This cost-controlling measure was established in 1997, when Congress enacted the sustainable growth rate formula to set annual limits on the total aggregate payments of Medicare to physicians.[7] Following the formula, payments made to physicians for medical procedures are reduced when these limits are violated. Over the years, Medicare spending has consistently exceeded the limits set and subsequently, physician payments have been steadily decreasing. Even if the doc-fix is sustained, Medicare spending will increase from 3.6 percent of GDP to 5.9 percent in 2035.[1] Without the doc-fix, Medicare spending will account for 7 percent of GDP by the year 2035.[1]

With such bleak projections, there is uniform consensus that changes need to be made to the way Medicare spending is allocated. However, neither Democratic nor Republican parties can agree on the mechanism through which these changes should occur.

PREMIUM SUPPORT-ANOTHER PROPOSED MEASURE TO FUND MEDICARE

The Premium Support System, a method of funding Medicare proposed by Republicans, would force Medicare to become an entirely privately-run entity with government support only through fixed premiums for each individual. According Van de Water (2011), this would create a two-tier system in which the more affluent Medicare beneficiaries would be able to access the most up-to-date care by using their own funds to supplement costs not covered by Medicare while the least affluent and poor would be unable to do this.[8] Furthermore, shifting Medicare entirely into the private sector would reduce the program's large bargaining power, which has enabled it to consistently rein in costs lower than the private sector. For example, Medicare spending per enrollee grew by an average of 1% less than that for private insurance each year from 1970-2009.[8] Following this proposed plan, the cost to the average beneficiary would increase by almost 40% and average out-of-pocket cost would increase by over $6,000 by 2022.[8] It is clear that premium support plans proposed by Republicans will have no cost savings, increase cost and result in discrepancies in care by introducing a third-party beneficiary into the Medicare system.

WHY IS IPAB SO CONTROVERSIAL?

Hospitals, doctors, drug companies and certain patient groups worry that IPAB will achieve its cost-savings goal primarily through reductions in Medicare payments.[3] These groups are concerned that cuts will be made so low that they will be unable to sustain the costs of Medicare patients. Doctors and drug companies are especially concerned because hospitals and nursing homes are not susceptible to the board's cost-cutting recommendations until the year 2020.[3] Other "critics" claim that IPAB will have too much power and will merely ration care rather than promote sustainable effective change.[3]

Dissension on the topic has been evident through not only media and "special-support groups" like the AMA but also by government officials. For example, although the ACA was established with majority Democratic support, the Independent Payment Advisory Board received bipartisan backlash and was repealed by representatives of both parties in the House of Representatives earlier this year. Because of such large-scale opposition, one must wonder whether or not IPAB would shave such detrimental effects for the future.

IPAB UNPRECEDENTED

One claim against IPAB is that it is not constitutional to give a group of unelected officials unprecedented power to make decisions of such magnitude that employs a large amount of taxpayer dollars. However, this is not the first time in American history that a board of unelected officials has been given power to make critical decisions for the general American public. For example, members of the U.S. Cabinet are unelected officials appointed by the president and confirmed by the Senate who have tremendous power over several departments of the U.S. economy.

In addition, other non-elected advisory boards already exist. In 1997, Congress established the Medicare Payment Advisory Commission, an independent agency composed of seventeen unelected members whose primary objective is to analyze access to and quality of care and advise Congress on payments to health plans participating in Medicare.[9] Similar to IPAB, the board is composed of experts from various fields with expertise in the delivery and financing of health services. However, unlike IPAB, MedPAC has no executive clout to make its recommendations law. In other words, MedPAC serves only as an advisory, whereas the IPAB will have the tools necessary to ensure that its recommendations make its way past the walls of Congress and become implemented into the structure of the American health care system. For years

recommendations made by MedPAC to change Medicare reimbursements to physicians from a fee-for-service system have been ignored. Perhaps, IPAB represents the first step to integrating some of these measures that have been proposed for years. The current legislation encourages collaboration of IPAB and MedPAC by requiring the board to submit all its recommendations to MedPAC to make additional recommendations before it finally becomes initiated.[1]

The power of IPAB to make recommendations that automatically become law is a key part of what makes it a powerful force to be reckoned with. For many people, this may be alarming, especially when the means through which the board hopes to execute its goals are unclear and restraints on its power has not been fully explained. In most countries with universal health care or a single-payer system, there exists an advisory board that gives recommendations regarding the way health care costs are allocated. For these countries, IPAB-like boards play a crucial role in the way health care delivery and funds are allocated. However, investigating the effects of this crucial stakeholder to Medicare delivery in the United States is needed to sift through the legitimate pros and cons of IPAB.

IPAB: EFFECT ON PHYSICIAN REIMBURSEMENT

Another claim made by opponents of IPAB is that the board will achieve its cost-saving measures only by slashing reimbursements to physicians to a level so low that they would be forced to discontinue seeing Medicare patients. These concerns are legitimate especially during a time when the future of Medicare reimbursement looms and the doc-fix is set to expire. However, there is currently insufficient evidence to hint that this is the approach that IPAB would use to achieve its goal. Moreover, in lieu of the fact that IPAB is prohibited from implementing recommendations that limit beneficiaries' access to care, one could argue that this type of approach is not even plausible.

Although physician reimbursement could be a large source of cost-savings, it is not the only mechanism through which cost-savings can be achieved (in Medicare). According to a report by the Center on Budget and Policy Priorities, the factors that contribute the most to health care are the introduction of new technologies without comparative information on clinical outcomes or cost-effectiveness, the lack of consumer information, incentives or choice, and the growing market power and consolidation of insurers, providers, and the health industry.[2] As this report demonstrates, physician reimbursement is not the major factor in the increasing cost of care and will most likely not be the sole objective of the IPAB.

CONCLUSION

The Independent Payment Advisory Board is one of the measures within the Affordable Care Act that addresses the cost-issue of Medicare. Despite some adverse projections proposed by critics, the board has immense potential to be a driving force of reducing Medicare spending. The Congressional Budget Office predicted that repealing IPAB would increase the nations' deficit by $3.1 billion over the span of ten years.[10] The unique power of IPAB will not only promote cost-savings in health care but will also keep Congress abreast and accountable to recommendations on Medicare.

As with all other branches of authority within the government system, the board must be adequately monitored in order to minimize abuse of power. The proposals established by IPAB should be both short term and long term in nature in order to achieve maximum cost savings. In addition, in an effort to thwart costs, quality of health care must not be neglected. To attain a high quality, sustainable health care system, health reform must move beyond addressing health care costs, to ensuring coverage, efficiency and quality of care.

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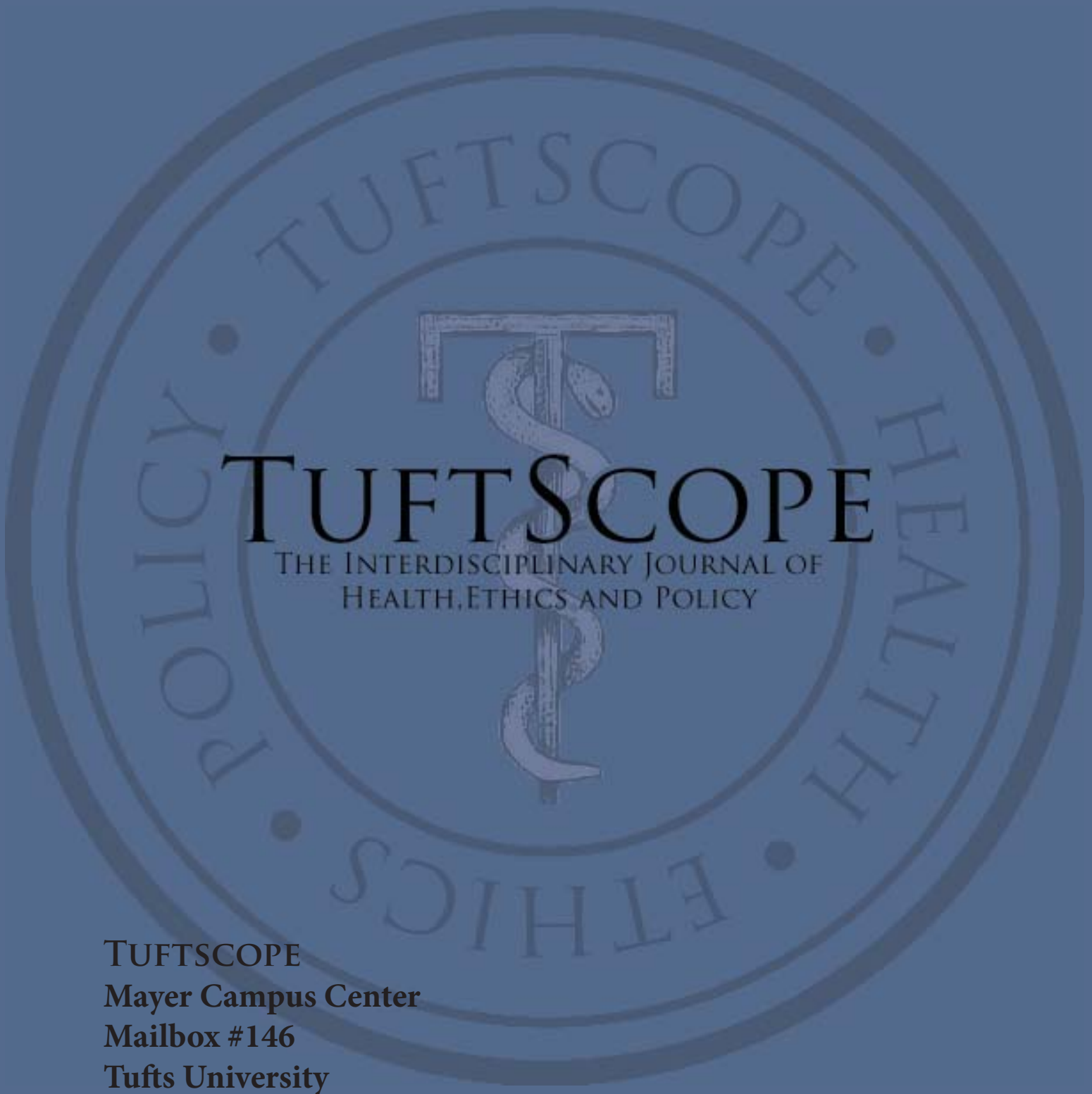

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