agree to accept discounted FFS payments in exchange for participating in the network.[33] POS programs generally require consumers to select a primary care gatekeeper, yet allow them to use out-of-plan providers for services in exchange for a higher co-payment. Some physicians who seek to avoid managed care entirely have begun concierge practices, where they provide personalized care, including house calls to patients willing and able to pay out of pocket for health care costs.[34] The price of these options vary, with consumers facing greater out-of-pocket costs if they select less restrictive options.

Health care financing has also moved toward a tiered system of payment. As the prior paragraph states, and Chapter 5 outlines in greater detail, consumers pay less if they select a restricted managed care plan, or use an in-network provider than if they opt for a less restrictive plan or use an out-of-network provider. As Chapters 3 and 6 explain, tiering is also being used for hospitals and pharmaceuticals. Such strategies expose consumers to an increased share of the economic costs of their decisions.[35]

2. Payment for Performance

In health care, payment has generally not been directly tied to the quality of the services that are provided. Numerous commentators have argued that payment for performance (P4P) should be more widely used. The Institute of Medicine (IOM) recently recommended that financing and delivery systems should "[a]lign financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes.[36] A prominent trade association of health plans similarly advocates using "payment incentives that reward quality care."[37] An open letter in a prominent health policy journal similarly argued that strong financial incentives were necessary to motivate providers to improve quality.[38] Other commentators suggest that "quality-

[33] *See* Hurley et al., *supra* note 32, at 56-58.

[34] Carl F. Ameringer, *Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority*, 5 DEPAUL J. HEALTH CARE L. 187, 203 (2002). Some concierge practices charge consumers on a FFS basis for the services they provide, while others impose a flat fee on top of their FFS charges.

[35] *See* Brewbaker 9/9/02 at 22-26.

[36] INSTITUTE OF MEDICINE (IOM), CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 184 (2001) (recommending that financing and delivery systems "[a]lign financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes. Substantial improvements in quality are most likely to be obtained when providers are highly motivated and rewarded for carefully designing and fine-tuning care processes to achieve increasingly higher levels of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.").

[37] AMERICA'S HEALTH INSURANCE PLAN, BOARD OF DIRECTORS STATEMENT: A COMMITMENT TO IMPROVE HEALTH CARE QUALITY, ACCESS, AND AFFORDABILITY (Mar. 2004), *at* http://www.ahip.org/content/default.aspx?docid=428. *See also* Ignagni 5/27 at 59 ("We need to pay for quality and effectiveness, not for overuse, misuse, and underuse.").

[38] Donald M. Berwick et al., *Pay for Performance: Medicare Should Lead*, 22 HEALTH AFFAIRS 8 (Nov./Dec. 2003). *See also* Casalino 5/28 at 134 ("[P]hysicians for the most part don't have an incentive to improve quality . . . .").

incentive programs should be viewed as part of a broader strategy of promoting health care quality through measuring and reporting performance, providing technical assistance and evidence-based guidelines, and, increasingly, giving consumers incentives to select higher-quality providers and manage their own health."[39] Public and private payors are experimenting with P4P.[40]

Panelists noted that some providers have resisted P4P and tiering programs, and refused to provide information regarding the quality of care they provide.[41] Other panelists noted that providers are concerned about the reliability and validity of P4P measures, and the fact that payors are requiring them to invest in expensive equipment without providing additional funds or evidence that such investments are cost-justified.[42]

3. The Road Forward

As Chapters 2, 3, and 5 reflect, there has been considerable ferment in the health care financing and delivery markets in the last three decades. Such "creative destruction" is one of the benefits of a competitive market.[43] Because no single arrangement is likely to satisfy everyone, diversity of financing and delivery options helps ensure that consumer welfare is maximized. Finally, competition is a process; as one commentator noted, "the superiority of open markets ... lies in the fact

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[39] Meredith B. Rosenthal et al., *Paying for Quality: Providers' Incentives for Quality Improvement*, 23 HEALTH AFFAIRS 127 (Mar./Apr. 2004).

[40] *See* David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001); Arnold M. Epstein et al., *Paying Physicians For High Quality Care*, 350 NEW ENG. J. MED. 406 (2004); NAT'L HEALTH CARE PURCHASING INSTITUTE, ENSURING QUALITY PROVIDERS: A PURCHASER'S TOOLKIT FOR USING INCENTIVES (The Robert Wood Johnson Foundation) (May 2002); NAT'L COMMITTEE FOR QUALITY ASSURANCE, INTEGRATED HEALTHCARE ASS'N PAY FOR PERFORMANCE PROGRAM: 2004 CLINICAL MEASURE SPECIFICATIONS AND AUDIT REVIEW GUIDELINES (Dec. 2003); The Leapfrog Group, *Leapfrog Compendium*, http://www.leapfroggroup.org/ir compendium.htm (last visited July 13, 2004).

In Britain, the National Health Service is experimenting with a similar P4P strategy. Peter C. Smith & Nick York, *Quality Incentives: The Case of U.K. General Practitioners*, 23 HEALTH AFFAIRS 112 (Mar./Apr. 2004).

[41] Milstein 5/30 at 32; Milstein 5/28 at 179; Tuckson 5/30 at 113 ("There is no question that we have experienced dominant players in the marketplace who basically can say to us, and who say to employers as well on whose behalf we operate, 'we don't have to play this quality game because (A) we have got the market; or (B) we are the only game in town. And either way we can thumb our nose at this thing and we will continue to do what we are doing and provide lip service to the people who come here saying we are going to give you some information about quality.'"); Probst 5/29 at 90; Romano 5/28 at 95.

[42] Kumpuris 5/30 at 47; KELLY J. DEVERS & GIGI Y. LIU, LEAPFROG PATIENT-SAFETY STANDARDS ARE A STRETCH FOR MOST HOSPITALS 5 (Ctr. for Studying Health Sys. Change, Issue Brief No. 77, 2004), *available at* http://www.hschange.org/ CONTENT/647/647.pdf; The Leapfrog Group, *Leapfrog's Regional Roll-Outs Fact Sheet* (June 2004), *at* http://www.leapfroggroup.org/FactSheets/ RRO_FactSheet.pdf; Hyman & Silver, *supra* note 40, at 1462-1471.

[43] *See* JOSEPH SCHUMPETER, CAPITALISM, SOCIALISM AND DEMOCRACY 83 (1945) ("This process of Creative Destruction is the essential fact about capitalism. It is what capitalism consists in and what every capitalist concern has got to live in.").