Estimate of the Situation

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The Affordable Care Act: Real World Impacts and Options, Part III

"The future depends on what you do today." — Mahatma Gandhi

Plan B: An Alternative Vision

Despite the best efforts of ACA proponents to maintain and advance centralized control, a competing version of the future of American health care is inventing itself.

There is accelerated movement of traditional diagnostic and treatment services out of the acute care hospital into less costly settings. Increasing numbers of physicians are ending their participation in the Medicare and Medicaid programs. Moreover, *The Accountable Care Act 's* implementation is resulting in (1) a reduction in the number of participating insurance companies and (2) a narrowing of network choices available to insured people with many physicians and even major hospitals finding themselves excluded.

Specialized out-of-hospital patient care providers, unencumbered by the hospital cost structure, regulatory requirements, and organizational complexity, are emerging to compete with acute care hospitals across the entire spectrum of health care services. Shorter feedback loops and service line autonomy provide them with a competitive advantage. They are positioned to provide quality services at a significantly lower cost to patients and respond much more quickly to changing local conditions.

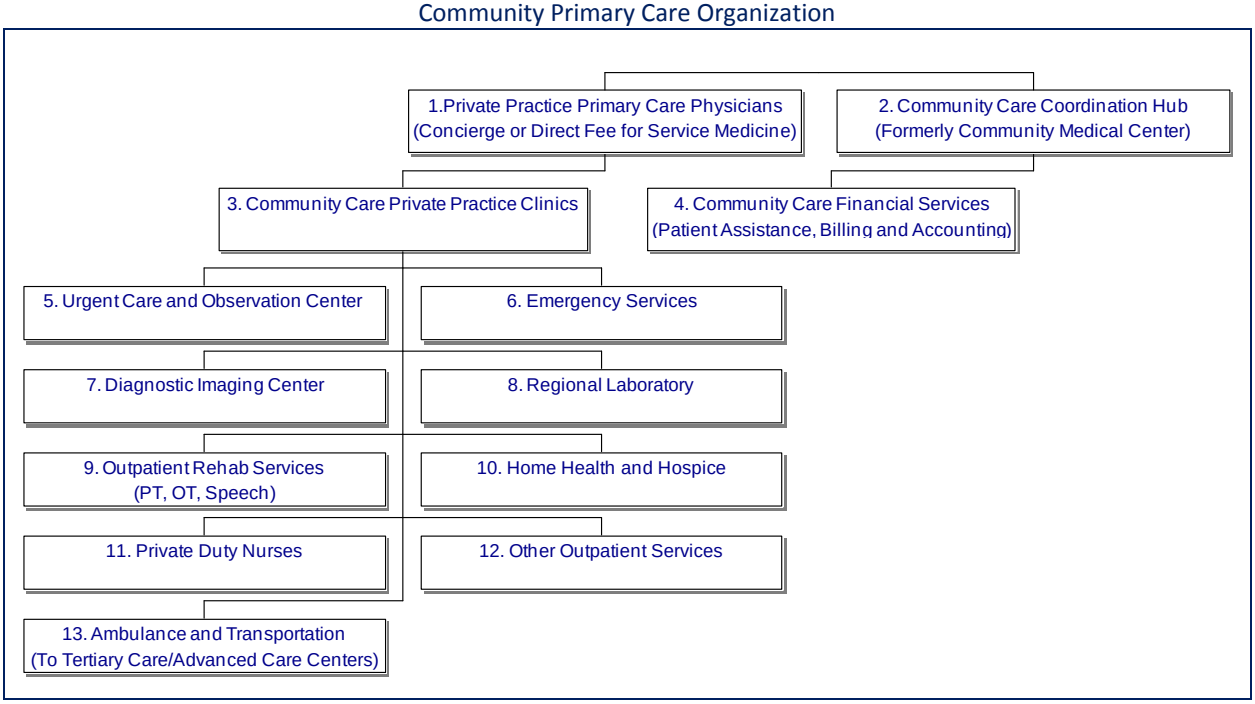
Examples include:

- Diagnostic imaging centers.
- Telemedicine, including teleradiology.
- Regional laboratories.
- Surgery centers.
- Office and clinic-base rehabilitation services (physical therapy, occupational therapy, and speech therapy).
- Home Health and home maker services.
- Assisted living facilities.
- Private duty nursing providers.
- Cancer treatment centers.
- Store front urgent care centers in retail outlets such as CVS Pharmacy, Walgreens, etc., staffed by nurse practitioners or physician assistants.

Where might this lead? Although the shape of the future cannot be predicted with certainty, emerging systems will likely consist of flatter, distributed, decentralized, entrepreneurially-managed components that will be linked in ways ranging from partnerships to purchased services. Driven by market forces, components will offer complete price transparency.

Below is a hypothetical example of an alternative health care organization designed to serve a community that finds itself excluded from the insurance market as a result of *The Affordable Care Act*.

Community Primary Care Organization



The Community Care Organization provides complete price transparency and operates on a cash basis. It does not participate in the Medicare or Medicaid programs. It does not accept insurance although it will help insured patients file claims to cover their deductibles. Because it avoids the structural costs associated with Medicare participation and other hospital regulatory and billing requirements, the Community Primary Care Organization is able to provide appropriate diagnostic and treatment services at a fraction of a hospital's costs through completely transparent negotiated rates.

The Community Care Organization provides basic diagnostic, treatment, and stabilization services only. It can furnish transportation to specialized urban medical centers for advanced care when required. Elements of the Community Care Organization might be owned by the Coordination Hub entity (formerly a hospital in this example), participating physicians, or they might be independently owned and operated through a number of collaborative or cooperative arrangements.

The Care Coordinating Hub functions in lieu of a hospital to provide billing, contracting and other administrative and coordinating services. Community Care Financial Services is a community-owned, for-profit corporate entity that provides short-term, low interest loans to patients who need financial help in paying for their care. Loans come from a pool of funds established by organization components. In this model, the primary role of insurance is catastrophic coverage. Most patients will rely on a combination of self insurance and low-interest financing provided by Community Care Financial Services when needed in lieu of traditional insurance coverage.

This model, which has many potential variants, leaves obvious questions unanswered, one of which is a very valid concern for care to the poor. Although adoption of the Community Care Organization model will result in a dramatic reduction in health care delivery costs for everyone, that alone may not be sufficient. Making essential services available through collaborative arrangements with religious and other community organizations may resolve this concern, depending upon local conditions.

Hospital-based decision makers are apt to reflexively recoil at the thought of walking away from Medicare, Medicaid, and insurance reimbursement. However, the traditional equation has completely changed due to limited participation by insurance companies in the *Affordable Care Act's* Exchanges, the narrowing of provider networks, preferential treatment given to subsidized Accountable Care Organizations, and resulting declines in hospital utilization by insured patients, especially when the costs of continued participation are taken into account. It is worth noting that this model (or variations of it) will most likely to be implemented in rural communities for which the alternative might be no health care service availability at all.

Although a Community Primary Care Organization's labor force will not have the same impact on the local economy that a hospital's payroll provides due to its reduced size, local availability of health care remains essential to any community's growth and stability. The information technology that allows *The Affordable Care Act's* central planners to dream of total control makes that control and the bureaucratic costs associated with it unnecessary, irrelevant, and counterproductive.

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