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"Changes (Part 2: Providers)"

The Affordable Care Act (ACA) is changing the landscape of healthcare in many expected and unexpected ways. All sectors of healthcare; insurance companies, providers and consumers will be impacted by this sweeping law. Many of the impacts are just beginning to be felt while others will take years to be realized. This article marks the second in a three-part series that will examine some of the changes occurring.

The provider community largely consists of doctors, hospitals, pharmaceutical companies, medical device companies and assorted others. The first three represent the largest components of overall healthcare purchased by Americans totaling nearly 80% of total expenditures. It is also the group that is just beginning to have the bright light of "efficiency and cost justification" directed their way.

The Affordable Care Act is spurring this directly by cost control measures implemented in the Medicare program and indirectly through increased premium/price pressures from insurance companies. Needless to say, it is being met with resistance by all of these provider entities.

Over the years, providers have been somewhat immune to being concerned about the cost of things- somebody else was paying for it. Many of you have shared with me stories about your providers saying, "Don't worry about the cost, your insurance will pay for it." In a recent article in Forbes, Peter Bach, the Director of Memorial Sloan Kettering's Center for Health Policy and Outcomes argued that rather than being the result of the high cost of developing medications, prices are generally a function of the market's "tolerance for high drug prices". I believe this statement would likely hold true across the entire health care provider spectrum.

Things will be changing, but change will come slowly to these powerful groups.

Medicare is sponsoring many trial programs to assist in determining how to lower and/or control costs without negatively impacting the quality of outcomes. The largest of these initiatives revolves around the creation of an Accountable Care Organization (ACO). An ACO is meant to coordinate care from the start to finish of a health care episode. Medicare would pay the ACO a lump-sum for the totality of care and leave it up to the ACO to provide all the care.

Further, Medicare is requiring providers to implement new Electronic Health Record requirements to better coordinate care between settings. This has required a large investment by providers, but ultimately should provide better care. Medicare is also tracking hospital readmission rates and lowering payments to hospitals that don't meet guidelines. This has led to better discharge instructions and follow-up when a patient is released.

Another area that Medicare is exploring relates to "Site Neutral" payment schemes. Under this proposal, Medicare would reimburse based upon treatment code- not the location of the treatment. This possible initiative brings to light the issue that the cost for the same exact service can vary dramatically, sometimes more than 1000%, just based upon where the service is provided. While this would equalize Medicare payments across different types of facilities and likely be good for insurers and consumers, the American Hospital Association is expected to fight it vigorously as hospitals usually are paid much more than any other facility.

Site Neutral payment schemes point to probably the largest issue with the providers of health care- price transparency. There is very little price transparency in health care. It is the only thing in America that I know that costs thousands, if not hundreds of thousands, of dollars that we don't know the price before purchase. Would you buy a new car without knowing the cost first? No. We do this every day for things that can cost as much, if not more, than a new car when it comes to health care.

Many initiatives are in the works to shed light on the cost of care. Medicare has begun to release provider payment information on an annual basis. Medicare's information shows billing amounts for procedures, amount paid to providers and other helpful information. Colorado has been collecting provider payment information under its All Payer Claims Database (APCD) and is making this information available to the public. Most insurance carriers also offer their enrollees detailed price and quality shopping tools utilizing just their own internal data.

Insurance companies also unveiled a new tactic to keep a lid on prices with the widespread introduction of "narrow network" plans. Insurers include only those providers that have scored the best on overall cost and quality measures in these networks. Consumers have reacted very favorably to the lower cost associated with these plans, but some lawmakers have reacted negatively to this reduction in choice of providers.

There are many more initiatives under way by both government programs and private insurers to try to limit the exploding cost of healthcare. Some will be successful and others certainly won't. The key is likely in giving the great American consumer many more useful tools to assist in keeping costs and quality in check. Of course, all of this is made more difficult because who wants to comparison shop when you've just received a cancer diagnosis or had a heart attack. Systems will need to be developed to automatically contain the costs billed and treatments performed by the providers.

Providers will not sit idly by as their revenues begin to be more tightly scrutinized. There is already a wave of consolidation occurring amongst hospitals across the country. Hospitals are also busy purchasing physician practices to provide further insulation from pricing pressures. 2012 marked the first time that more physicians in Colorado were affiliated with hospitals than in a true private practice setting- they may still be in the same office, but are now billing through a new entity. These moves are all being done to afford providers more leverage in the coming debates over cost.

Providers will certainly face increasing pressure to do more to control costs in the coming years. We are just at the beginning stages of this paradigm shift in cost control and quality measures for care delivery.

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