The Affordable Care Act: Part V of V

By Tom Szostak

This is the fifth article in a five part series on the changes due to healthcare reform and their impact on imaging. Part V addresses the future of the healthcare market.

The Affordable Care Act (ACA) has served as a catalyst for placing the US healthcare system into overdrive. Despite the fact that Congress has voted to repeal the ACA 56 times, turning back the dial on healthcare is no longer an option.

In the first part of March 2015, the Supreme Court heard arguments regarding use of federal funds to assist those who would qualify for subsidies to purchase health insurance in states that defaulted to the federal government as the operator of their state-based marketplace. A decision will be made by the end of June 2015. The court's decision could affect up to 7 million people who purchased health insurance within these 37 states.

Again, regardless of what the result is from the Supreme Court, changes within the healthcare sector will continue. Health reform continues to gain momentum as the public and private sectors announce changes on a daily basis. New relationships are formed between physicians, hospitals, insurance payers, retail clinics, sub-acute care providers, imaging centers, pharmaceutical companies, and medical device manufacturers. Relationships that were once viewed as adversarial are now embraced as stakeholders in healthcare work to maintain or increase their footing within the market.

As noted in Part II of this series, the ACA is best simplified as two types of reforms: insurance reform and delivery reform. Single-handedly, insurance reform has had the greatest impact on the healthcare sector to date. One of the key intents of insurance reform was to eliminate all barriers for citizens and residents to have access to purchasing health plans. Health plans were mandated to operate within strict guidelines regarding policy requirements and premium spending percentages on healthcare services. Insurance carriers were challenged with meeting policy requirements while attempting to maintain plan profitability. Risk corridors were included within the law to ensure that health plans actively participated in the state-based health insurance marketplace and mitigated risk from absorbing higher-acuity populations.

Health plans and employers redesigned their offerings to consumers and employees. Insurers sought to make plans affordable in the marketplace as employers sought to reduce the cost of their health benefit expenses through the use of high-deductible health plans (HDHPs). These HDHPs shifted the cost burden to consumers and employees as insurers worked to maintain profitability and employers looked to improve operating margins. These transformational shifts within the insurance sector gave rise to the emergence of the healthcare consumer.

As the health insurance marketplace and employer-based insurance design transform, they facilitate greater engagement between patient, provider, and carrier. Providers become tasked with remaining in networks while having to determine whether they want to accept lower payments from carriers. Patients determine the level of risk they're willing to take by determining what type of health plan they should purchase, with varying levels of premiums, deductibles, and co-pays. And employers determine whether they want to elect to stay in the business of providing health benefits to their employee base. Alternatively, employers can decide to transition to a defined contribution plan and provide employees with access to a private health insurance marketplace exchange.

Effective January 1, 2018, under the ACA, lucrative health benefits packages provided by employers that exceed annual dollar limits of $10,200 for individuals and $27,500 for family/other will be subject to a 40% excise tax for the excess benefit dollars. This "Cadillac" tax applies to both fully insured and self-insured employer-based coverage. This tax will also apply to state and federal group health plans.

The potential cost implications to employers within the private sector has served as a catalyst for change in terms of how health plans/benefits will be offered to employees in the future. It is anticipated that the private health insurance marketplace will grow from today's 4 million users to over 45 million by 2018. As the employer-based health insurance market evolves, beneficiary

behaviors will change as employees determine the level of risk they are willing to take based on an array of health plans they can choose from in the marketplace. Additionally, health plan beneficiaries will become more sensitive to the cost of healthcare services and the impact on "real" income.

As the level of risk increases for the new healthcare consumer, the demand for pricing transparency increases, as beneficiaries will want to make informed decisions on care and cost. This consumer demand within the market requires providers to formulate pricing strategies that are better aligned with other sectors of the economy. Providers that begin to post prices will more than likely begin to receive more patients. This consumer demand for pricing transparency introduces a retail aspect to healthcare that was virtually nonexistent in a market dominated by wholesale pricing.

Diagnostics and low-level acuity services are the entry point for the healthcare market's transition from wholesale to retail. For the first time in the history of healthcare in the United States, "price" versus "charge" begins to emerge as the new normal. The rapid rise of low-acuity clinics within retail pharmacies and urgent care centers within retail stores has given way to this market transformation. Hospitals, health systems, and primary care clinics begin to evaluate this emerging market segment and determine how best to partner or compete.

Purchasers of healthcare services are demanding to know what the price of the service will be prior to scheduling appointments for diagnostic tests or low-level, acuity services. With real income at stake from the cost exposure created by HDHPs, healthcare consumers will force the provider market to display transparent prices through price boards, menus, websites, or smartphone apps. Consumers will require that a reluctant and somewhat resistant sector to transform and meet economic demands that will initiate price elasticity within an industry sector that has been neither transparent nor elastic.

Alternative payment models (APMs) evolve to support this market transformation that is driven through the reformation of the health insurance sector. These APMs, which are better known as accountable care organizations (ACOs), payment bundling for clinically defined episodes, patient-centered medical homes (PCMHs) for the chronically ill, and payment models for specialty care are all grounded in improving health, reducing costs, and elevating patient care. Providers share risk with healthcare stakeholders to find a way to dissolve the costly, fragmented, and fractured healthcare maze that we have developed into one that is connected, integrated, and fluid. In some cases, advanced or further evolved providers elect to take on full risk of a patient cohort or local community. These healthcare providers might be integrated health systems, clinically integrated networks, or an alliance/consortium of hospitals that are optimizing their clinical strengths to meet population needs.

The demand for seamless care requires that these providers do more than think on a transactional basis. As risk is shared or fully assumed by providers, the mindset of the healthcare provider transforms into that of a health plan. No longer is the focus on filling beds in a hospital; the focus is directed at keeping the patient population healthy and maintaining them within the ambulatory setting, if possible.

Clinics and ambulatory surgical centers are aligned with hospitals within the network and work in concert to ensure that transitions of care are optimized and patients maintain wellness upon discharge. The health system examines their resources and optimizes performance by place of service to ensure that they maintain a healthy profit margin. Revenue centers transition to cost centers, and greater weight is placed on appropriate utilization of services and resources that have a direct impact on patient outcomes, quality, and costs.

It sounds simple and reasonable, but remember that healthcare is the last sector of the US economy to migrate from a wholesale product to a retail product. Healthcare represents one-sixth of the US economy. Change within this sector will happen, but it will occur over the course of several generations, as the philosophical and cultural approach to delivering and consuming care transforms.

There will be great disruption in healthcare over the course of the next decade as healthcare consumers become better educated on and more engaged with the delivery of care and their preferences for how that care is delivered. Providers will become better engaged with the healthcare consumer, as their demands will determine how these providers redefine themselves under the guise of health reform. Innovators will seize on the opportunities defined by the needs of the new healthcare consumers, who are seeking value in the purchased service.

Who knows? Maybe health reform is a part of a master plan to help the federal government exit from the healthcare business. Is it possible for future generations to be conditioned to manage their own care and determine the level of risk they are willing to take? One can only imagine the favorable impact that this would have on the federal deficit if Medicare beneficiaries transformed into Medicare healthcare consumers.

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