Impact of the Affordable Care Act on Physicians and Their Practices

"The future ain't what it used to be."

– Yogi Berra, Baseball Hall of Fame player, coach, manager and often quoted philosopher

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The Recent Healthcare Landscape

The United States has seen an unsustainable growth in healthcare costs. From 1998 to 2011, we have seen total healthcare spending grow from 1.2 trillion dollars to 2.9 trillion dollars. Over that same period, total annual family health insurance premiums grew at 8.4 percent annually; Medicare expenditures per enrollee increased by 6.8 percent annually; and healthcare spending grew at a rate of two to three times the growth of the gross domestic product (GDP).

Compared to other industrialized nations, the United States spends almost double on healthcare, yet our life expectancy averages two to three years less, and the amount spent on people over age sixty is approximately eight times that which is spent in similar nations. In 1970, Medicare costs were 3.5 percent of the Federal budget; by 2020, it is projected to be 17.4 percent.

Healthcare has been facing the "perfect storm." Rising costs and declining revenues; shifting demographics (i.e., the aging population); an increasing demand for quality and cost performance; and limited access to capital and payment reform are all contributing to the problem. Medicaid is virtually bankrupt and Medicare's trust fund is projected to be bankrupt by 2024. For employers, their benefit costs have threatened their viability and consumers lack affordability in the individual market.

Patients, employers, providers, and payors are each utilizing strategies to deal with the crisis. Examples include: high deductible plans; increased utilization of emergency departments; self-insured employer plans; a massive shifting of costs to patients; reduced reimbursement to providers; added penalties for non-value-added work (i.e., "never events" and 30-day readmissions); formation of clinically integrated networks; and partnerships between payors and purchasers to transform care.

The current system hasn't been working and there has been the need for significant change. **The Patient Protection and Affordable Care Act (ACA)** was signed into law in March 2010 and has since been upheld by the U.S. Supreme Court. The key elements of the ACA are to decrease costs, increase access to care, and improve quality. These goals are similar to the "*Triple Aim*," promoted by the Center for Medicare and Medicaid Services (CMS): improve the health of entire populations, reduce the cost of care, and improve the experience of care. For health systems, a "*two curve*" strategy is being developed, moving from a "heads in beds" mentality to an "integrated care continuum." Both physicians and health systems will move from *clinical production* to *clinical performance* and *fees for activities* will become *fees for results*. Healthcare is moving from *transactional care* to *outcomes-based care*. *Payer risk* is becoming *provider risk*.

So, How Will the ACA Affect You?

First, there will be more patients with coverage and thus more patients requiring care. The ACA provides for more (and new) covered services for patients with 63 preventive services now covered without patient co-pays; lifetime limits have disappeared. Patients with pre-existing conditions can no longer be discriminated against. Expansion of Medicaid to 138 percent of the poverty level and federal and state-run health exchanges have recently been instituted. There is much pressure to keep premiums down to increase coverage for low-income patients. Some physicians are refusing to join exchange networks; therefore, be aware of "all-products" clauses in commercial contracts now and in the future. Health plans will need to provide reasonable rates to retain physicians, especially those in primary care.

Patients previously without coverage will need resources and education to use the new system. Many younger patients will also

join the exchanges. To meet the needs of the increasing number of patients, practices may want (or need) to expand hours and possibly hire new providers. As there may be higher "out of pocket" payments and higher deductibles, many physicians are responding by collecting these charges prior to providing care and offering budget plans or accepting credit card payments in offices. Perhaps the greatest impact will be on specialists with expensive services. As existing commercial "customers" move into exchanges creating lost revenue, there will be more uninsured patients moving into the exchanges as well, creating new revenues.

The ACA increases demand (and prestige) for primary care. There will be higher reimbursements from Medicare and Medicaid, for practices designated as patient-centered medical homes (PCMH), and for preventive services. Some payers are now paying for phone "visits" and subsequently reducing costs. More students seem to be going into primary care since the ACA was enacted; however, rising costs of medical education and debt at graduation are still deterrents to entering the field of primary care.

The demand for advanced practice providers – physician assistants and nurse practitioners – will grow to accommodate expanded access and cost pressures for this lower cost delivery system. "Care managers" in practices and the use of more community-based services for care delivery have become necessary. Coordination of care across an integrated continuum has become the new operating model. Ambulatory services will continue to grow as care migrates to less expensive settings. Group employment of physicians will steadily increase due to the rising demands of market forces and regulations on individual practitioners.

New payment systems are now rewarding high-quality, low-cost care. Fee for service is broken and will be phased out over time. Physicians will be living in two "worlds" for the next five years - fee for service and new payment systems for providing quality outcomes and lower cost. These changes require good information systems and significant data sharing. Providers are learning how to work in teams and need to learn how to better engage patients in their own care. In many areas, payments reward physicians for non-face-to-face visits and this will certainly increase. Over the next few years, one will see "risk" shifting from the employer and payer to the provider and patient.

Currently, the public is demanding greater "transparency" among physicians and health systems. This will create a more rational economic market with decision-making driven by quality, patient safety, patient experience, and cost. Patients have been rating their providers over the past few years through internet sites and these ratings will increasingly become more publicly reported. CMS penalties will reduce payments if not using E-prescribing, reporting on PQRS metrics, or meeting meaningful use criteria. CMS' recent Physician Compare website now includes PQRS data for large groups in ACO's; later it will do so for individual providers.

America's healthcare system has been broken and is now in a radical state of flux. All of us, from patient to employer to payer to provider, have a stake in improving this system. All want to achieve the "triple aim," to have a high-quality, low-cost system that provides us with a great patient experience. We are all part of the solution. As Charles Darwin stated, "It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."

References

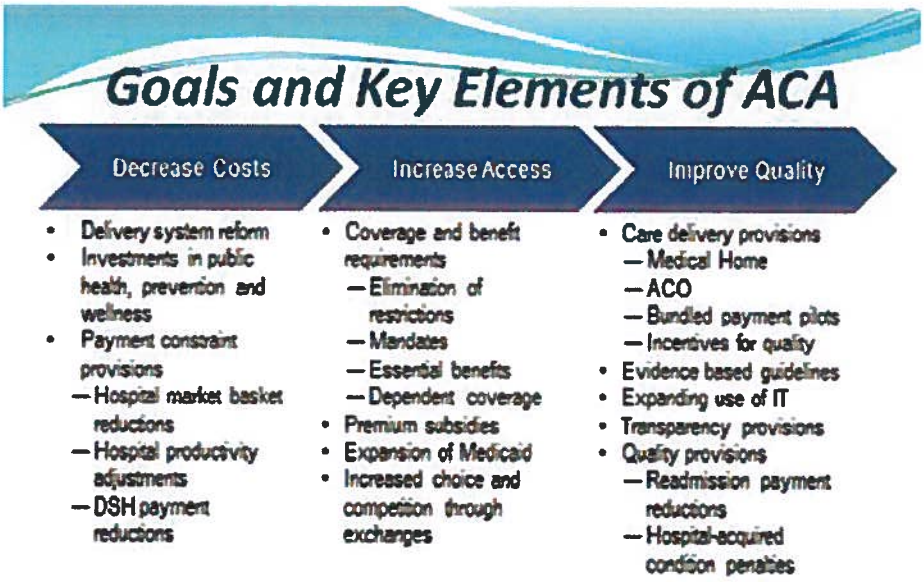
Robert Wood Johnson Foundation, Quality Field Notes: Performance Measurement and Quality Improvement Issue Brief No. 2. Princeton, NJ: December 2013.

McGlynn EA, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States. NEJM, 348(19): 2635–2645, 2003.

American Hospital Association, The Work Ahead: Activities and Costs to Develop an Accountable Care Organization. Washington, D.C.: AMA, April 2011.

Forster AJ, Childs BG, Damore JE, DeVore SD, Kroch EA, and Lloyd DA, for the Premier Research Institute. Accountable Care Strategies: Lessons From the Premier Health Care Alliance's Accountable Care Collaborative. August 2012.

Page L. 8 Ways That the ACA Is Affecting Doctors' Incomes. Medscape. Aug 15, 2013, http://www.medscape.com/viewarticle/809357.



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