Lesser Politicized Cost-Controlling Measures of the Affordable Care Act

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Since its inception in 2009, the Affordable Care Act (ACA) has been highly politicized. Because of the negativity surrounding the passage of the bill, most of the more promising cost-controlling measures have not been fully discussed or appreciated. Many researchers agree that our current health care delivery model is inefficient and costly. “The United States spends more than any other country in the world on health care, yet we rank 37th in overall quality” (Paradis et al., 2009, p. 282). This nation is poised to embark on the biggest change in the way we not only deliver care but also how providers are reimbursed. As we move our health care delivery model away from paying for quantity of procedures, tests and pills and toward a model that pays for performance and patient outcomes, the cost curve should bend. The following literature review will delve into some of the lesser-politicized, cost controlling measures incorporated in the Affordable Care Act.

Health Care Exchanges are one of the central provisions of the Affordable Care Act. In his article, “Benefits and Challenges of Health Insurance Exchanges,” Kingsdale (2012) states that exchanges will help control the cost curve on medical expenses by increasing access to affordable coverage and preventative care (p. 96). Individuals will be able to use the exchange databases to compare coverage and costs between insurance plans. Americans' satisfaction will increase because they will have more control over their health, as they will be making more of their own decisions based on competition and transparency (p. 98). Small businesses will also benefit from the exchanges. If health care costs can be better contained, employers will be better poised to compete globally (Sperling, 2012, p. 17). Kingsdale (2012) does have concerns as to how much money will be saved by reducing emergency room visits, as he feels that some patients will continue to go where care is convenient for them. Access to primary medical

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doctors will still be a challenge (p. 97). The impetus will now be focused on the patient's choice of plans and the ability of the insurance companies to offer a product that meets their needs, is affordable, and has other benefits like excellent customer service, efficiency, and programs that offer a return on their investment (Sperling, 2012, p. 20). Another approach to healthcare cost savings is to bundle payment for services. According to DeJong (2010), bundling of acute and post-acute care "offers enormous opportunities to enhance patient care while reducing costs" (p. 658). One of the extra benefits of bundling is that it has the potential to allow the providers more autonomy and innovative creativity to find best practices and increase organizational efficiency (p. 660). Accountable Care Organizations can include providers across multiple disciplines (Boyce, n.d., p. 978). Hospitals, Physicians, Nurse Practitioners, Dieticians, Pharmacists, Physical Therapists, and Respiratory Therapists are just some of the disciplines that may be included. According to Boyce, the Congressional Budget Office (CBO) projects that Medicare could save $18.6 billion by 2019 (p. 974). The biggest concern seems to surround the fear that Primary Care Physicians may take a cut in reimbursement levels (p. 975).

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The Affordable Care Act also created pilot programs for Medical Homes. Currently, there are several different organizations experimenting with the structure and services provided by a medical home model. Health insurance plan administrators, employers, and providers are searching for the best way to improve organization efficiency, increase access, decrease costs, and coordinate patient care across disciplines. During 2009 and 2010, Qliance decreased their hospital days by 45% and their emergency room visits by 65% (Wood, 2012, p. 21). Primary Care Physicians increased access by extending office hours to seven days a week and smaller panels for each team. With smaller panels, patients tend to learn more about their chronic conditions and medications, prevention and treatment of their symptoms, and control of their

disease process through proper nutrition, moderate exercise, and decreasing their risk factors. Cost savings are predicted to decrease health care costs by 5.6%, which equals a cost savings of $67 billion annually (p. 23).

By far, the biggest change brought about by the ACA will be changing the way providers and corporations are reimbursed for health care delivery. Reimbursement levels will now be structured to pay for patient outcomes and best practices; this is referred to as paying for performance. According to a study by the Healthcare Financial Management Association (2011), "readmissions drive up healthcare costs by as much as $4.5 billion to $11 billion. Starting in October of 2012, hospitals with high readmission rates for certain patient diseases and conditions will face reductions in Medicare payment" (p. 1). Medicare will also have the discretion to deny payment for preventable harm caused by hospitals like infections or falls. Certain reportable performance measures will also be published publicly so that consumers can compare the care received at all hospitals (p. 1). This model will require increased collaboration of care—one that focuses on close patient contact to avoid noncompliance and lack of understanding with the patient's plan of care (p. 4).

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The new mandate in the law brings the debate on medical loss ratios to the forefront. Medical loss ratios are defined as the amount of premiums that are devoted to clinical services and quality improvement (Demers, 2011, p. 8). One of the bigger targets of the ACA is to decrease wasteful spending. According to Demers (2011), these costs are "defined as costs that can be avoided without impacting the quality of care; some estimate that it accounts for more than half of healthcare's annual $2.2 trillion annual price tag" (p. 8). Most of this unnecessary spending is entrenched in the practice of defensive medicine, patient noncompliance, misuse of the emergency room, and readmission of patients. Demers believes these four issues account for

$349 billion alone (p. 8). Basically, the ACA requires that insurance plans spend at least 80–85% of the premiums received on quality care and treatment of patients. If they do not, they must refund the difference to those patients. The concept is that providers will now be required to spend their premium money on a "more coordinated and proactive care management" approach to patient treatment while also decreasing duplication of tests and unnecessary services (p. 8).

Along with wasteful spending comes fraud, abuse, and unnecessary services in the system. According to Pickett (2012), billions of dollars could be saved annually if less unnecessary tests, procedures and pills were prescribed (p. 1). Fighting fraud and abuse has been a focus of the White House administration this term. The Department of Health and Human Services (2012) has created a team of experts and a new software program that concentrates on monitoring payments for suspicious activity and illegal billing practices (p. 1).
So far, the team has discovered $1.5 billion in fraud for illegal billing practices (p. 2).

Many Americans wonder how all of this will be tied together and implemented. Electronic medical records (EMR) appear to be the answer to implementing most all of these measures successfully. Dell Services (2010) states that, if all providers and hospitals implement the use of an EMR, it will save the "healthcare sector about $80 billion" ("Benefits: Economic," p. 2).

It will become increasingly important for health care providers to have a more positive voice in the improvements that will become instrumental as more of the ACA is rolled out. Our focus will need to implement best practices and improve patient outcomes. At the same time, it will be a benefit that we are able to control the cost curve on health care expenses.

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