Health care coverage in the United States — What's an ACO?

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Write The Author

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This article is the fourth in a series on health care reform. Our new health care law, aka ObamaCare, has a myriad of features. It is extremely difficult to anticipate what their effects will be in the short run, let alone in years to come.

As with most complex systems, the "devil is in the details." This law has so many details there may be a lot of devils. Let us hope there are a few "angels" hiding in there as well. But before I try to wade through the new law, let's look back to see how we got to where this law became necessary.

I don't like the term ObamaCare. I think it is used to demean the legislation. Unfortunately, its proper name is the Patient Protection and Affordable Care Act of 2009. This doesn't lend itself to a comfortable acronym. Some are calling it the ACA, but that is confusing since it sounds too much like one of its central features, the ACO, or Accountable Care Organization. For now let's just call it the "new law."

If the new law is to do its job it must accomplish three things: 1) expand healthcare coverage to reach at least 95 percent of the population; 2) reduce, or at least slow, the rise in costs and 3) improve the quality of care provided. All three are required for success. Most people know how the first is supposed to happen. Everyone is required to buy health insurance or be penalized through the tax system. Those who truly can't afford the insurance will be subsidized by the government. Other bells and whistles are included like insurance cooperatives to help small businesses purchase insurance at similar rates to huge corporations.

The other two parts are trickier and certainly haven't been explained well. I'll try to relate the little I have learned. The main engine for controlling costs and improving quality is supposed to be the Accountable Care

Organization. This is a proposed partnership between doctors and hospitals. The ACO will get paid by Medicare or an insurance company (initially, just Medicare). The payer will pay fee for service. The new law sets guidelines to define quality care. The ACO will attempt to keep its cost below what would be expected for similar Medicare patients. If it is successful, and it has met the quality guidelines, it will receive a bonus equal to a percentage of the savings. The ACO must have at least 5,000 patients to qualify.

This may sound a bit like our old friend the HMO, but there are some very important differences. The ACO is supposed to be transparent to the patient. The patient doesn't sign up for it. The patient doesn't even have to know that he/she is in it. The only thing the patient should notice is that their care is improving. How the ACO is supposed to take responsibility for patients when the patient can come and go as he/she pleases is one of the many unknowns.

A second difference is the ACO attempts to get savings by improving the care. The idea is that the best way to decrease cost is to give good care. The patient won't have to be re-hospitalized. The inpatient care won't be extended by post-surgical infections. Treatment won't be necessary for medication mistakes. The HMOs got savings by giving less care. The ACO will get savings by giving better care.

Remember, I said the ACO gets paid fee for service. But, nobody knows how the ACO will divide up the income between the hospital, the specialists and the primary care doctors. There is a lot of anxiety over this. Everybody seems to think we need to pay the primary care people more. (No argument from me on that!) But all of us old primary care givers have been hearing that for decades. You don't have to do calculus to figure that if the total bill is going to be reduced, somebody is going to get less. All parties concerned are sure to fight like mad to make sure it's not going to be them.

At the moment, I understand there is a major movement afoot by hospitals to buy up doctors' practices. The hospitals feel they must do this in order to be an efficient and effective ACO. The doctors are trying to make deals to insure they continue to make at least as much as they are now. We'll see what happens.

An important feature of the ACOs is transparency. Doctors and hospitals will make public their ACO affiliation. They will also make public the policies of the particular ACO, explaining how they expect to control cost and improve care. It is also intended that the "scorecard" on meeting guidelines and controlling costs will be public information as well. The light of day should make a big difference compared to what is going on now.

Comparing an HMO to an ACO:

• Who owns it?

HMO: Generally owned by private, for-profit insurance companies.

ACO: Intended to be a partnership between doctors and hospitals.

• Who joins?

HMO: Providers and patients both have to sign up.

ACO: Providers only — patients can go to whichever they please without restrictions.

• How are the providers paid?

HMO: Generally by capitation: provider gets paid a small amount each month regardless of how much service is provided.

ACO: Intent is for payment to the ACO to be fee-for-service. Each ACO will make its own arrangements for payments with its providers.

• What are the incentives?

HMO: Strong incentive to "cherry pick" healthy patients so the provider can write large capitation checks without having to provide a lot of service.

ACO: The providers are required to give service, and only then share in the savings created by having healthier patients.

• Transparency:

HMO: All guidelines and payment policies are closely held secrets.

ACO: Guidelines, payment policies and patient care results will all be made public.

Just my opinion, but, if you believe all this will work as designed, you probably also believe in the tooth fairy.

Dr. Alan Cooper, retired, maintained a family practice of medicine for many years in the Three Village area. Consult your physician for personal medical decisions and care.