ACA repeal is about one thing – money

A friend - befuddled by multiple media articles and news segments about repealing and replacing the ACA - asked me what it was all about. I answered, it is simple, money. The solution – how to save and redirect it – is very complex. Rather than balanced analyses, most media accounts have involved hyped distortions and exaggerations focusing on one of many interdependent issues at play.

A few weeks ago, Medscape, a health professional news service, featured an article on the "impact" of the ACA that resulted in many very negative comments - suggesting Medscape stick to medicine. They described the impact of each ACA issue in a vacuum. As I told my friend, it was as if a popular restaurant was to close in a community and the author averred this meant hundreds of its patron would starve.

Local health professionals know that they will find a way to care for patients despite the insurance arrangements or government controls. They always have. The issue is that it would be a lot easier if the huge and increasing amount of health resources consumed by bureaucrats, intermediaries, consultants, stockholders and administrators were redirected to those actually providing care.

A few citizens are interested in repeal for ideological or political reasons such a "keep your doctor" or "no federal mandates", but for most it's the promised, but unrealized, "affordability". How can we get the money and services we need by controlling costs? Let's look at the ways.

***Insurance and payment changes*:** The poor, disabled and old – especially with preexisting conditions – will require care largely government subsidized. Can we find incentives for communities to provide it in the most effective and efficient ways and reduce the hassle and cost of insurance intermediaries? For those better off, can we cut out the massive insurance costs of processing most low cost claims by converting to catastrophic coverage? Through medical savings accounts, can we decrease costs through consumer smart purchasing and also incentivizing folks to use preventive measures to stay healthy? Interstate competition might shave a few pennies more off insurance products.

***Administration and quality oversight*:** Whoever purchases a health service is entitled to check its quality, appropriateness, effectiveness, efficiency and value. Given the nature of health care, many consumers will need help. However, oversight, regulation and review of medical practices (about 25% of a physician's time) has skyrocketed even for many low cost, routine services. Meanwhile a huge number of non-valued added administrators, reviewers, auditors and consultants have been added at every level demanding and providing paper. The challenge is how to promote quality and value by honing and streamlining QI activities to save money. Those activities that mainly employ costly "gaming" consultants to please Washington, not actually improve care quality and efficiency, need to go. Worse are the Ponzi plan operators who play the increasingly complex "coding" game to divert resources to intermediaries and stockholders.

***Investment in community public health*:** Reduce, just a smidgen, addiction, mental health conditions, falls, violence, smoking, STDs, vaccine preventable disease, medication non-adherence, obesity and diabetes, and we will have all the money we need. These are largely cultural, educational, behavioral and social population issues that have to be solved by communities. We are just beginning to capture local population data and few communities have the mechanisms and incentives to collect, analyze and act upon such data, set priorities and share resources to optimally address these issues. A small investment could save millions. Is it cost-effective for Medicare to cover wellness exams every year for the elderly but not for those in their forties who can profit much more from early preventive interventions?

***Local community health reform*:** Any health professional who tells me that his or her community is at optimum efficiency and effectiveness - without any practitioner or institutional waste, duplication, less than maximal productivity, continuity lapses, missed integration opportunities, and so forth - I respond, never practiced in a community. Just integrating federal funding to promote sharing, prudent purchasing, QI and optimal targeting of priorities would save millions. As noted above, there are few mechanisms and incentives to encourage this.

***Drug pricing*:** Finding the balance between leading the world in drug and device research and limiting obscene pricing and profits is necessary.

The federal and many state governments are broke and many Americans cannot afford traditional health insurance premiums even with decreased coverage and increased cost sharing. The patient care sector will still care for all but it would help with some more “money” to be able to give all patients the access and quality they deserve. Fragmentation, political advocacy by each fragment, tradeoffs and the interdependency of the components make reform difficult and complex but it’s necessary.

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