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How Obamacare Will Re-Shape the Practice of Medicine

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Abstract: Critics and supporters alike have framed the Affordable Care Act as an effort primarily aimed at expanding access to healthcare insurance. As the refrain goes, the legislation placed much less emphasis on pursuing ways to make healthcare delivery more affordable. This analysis belies significant measures that the legislation pursues, in the name of cost control, which will fundamentally transform the delivery of medical care. These provisions are based on a primary belief that there is a lot of waste in the delivery of medical care. Moreover, the President and his advisers believed that this waste owes largely to the inefficient and sometimes-inappropriate decisions made by providers. The legislation sets out, through a collection of policy measures, to restructure the organization and delivery of medical care. Among other things, it consolidates providers around hospitals where they will become salaried employees that are easier to regulate and supposedly less likely to overprescribe services. History shows, such measures do not produce the promised savings. Moreover, this re-organization comes at a significant cost, not only in terms of the quality of medical care, but its affordability. Provider productivity will inevitably decline. Continuity of care will suffer. Entrepreneurship in medical practice will be squelched. Obamacare will dramatically change the practice of medicine. This will perhaps be its most enduring legacy, and its most significant human cost.

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How Obamacare Will Re-Shape the Practice of Medicine

Efforts to Transform Outpatient Medicine Will Put the Entire Health Care System at Risk

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The Affordable Care Act (ACA) is a plan at war with itself.

Consider this, for example. The scheme depends on the participation of private insurers to integrate the delivery and financing of medical care. This, in turn, requires them to make costly investments in information tools that can lead to better care coordination.

Yet at the very same time, the ACA puts explicit caps on the operating margins of these companies by regulating their medical loss ratios (the amount of premium money that they can spend on overhead and retain for profits). This sharply limits the capital available to invest in the kinds of care integration tools, like IT systems, that the law aims to encourage.

It also makes it hard for new health plans to launch and make their initial debut in the "exchanges" since overhead costs are typically higher at the outset of a new plan. If the health plans are not able to divert more of their premium revenue to cover their Selling, General and Administrative (S,G&A) costs in the first few years of operation, then many new plans (not backed by legacy insurers) can't get started. This, in turn, will limit the number of plans that are available for purchase on the exchanges.

Or consider another one of the ACA's many internal inconsistencies. The architects of the ACA expressed disdain for what they dubbed "mini medical plans" – slimmed down health insurance that often capped benefits and offered only partial coverage for routine care.

Yet the combination of policies that the ACA adopts to regulate insurance has been so costly that the resulting plans are limiting catastrophic benefits, and offering very narrow provider networks as a way to pay for the mandated benefits and still meet affordability requirements. There are also no caps on co-insurance when patients go outside these slimmed down schemes. Patients with serious conditions could be hit with astronomical bills if they seek specialty care. Plans are meeting the law's costly mandates by offering very slimmed down coverage for serious conditions even while providing first-dollar coverage for more routine care. Some of these plans don't even cover hospital stays or surgery. See Weaver and Matthews (2013). It's precisely these circumstances that President Obama said he had set out to rectify in pursuing major healthcare legislation.

Consider also the way the law tries to curtail underwriting based on risk and accomplish a national community rating for health plans. The ACA largely ends age-based

underwriting. So it depends on young people enrolling in the new health plans. But the combined regulation has made the resulting plans so costly relative to coverage sold in the individual market, that in many cases young consumers will be better off paying the fines (the individual mandate) and buying a plan that doesn't conform to the ACA's dictates. Some health plans are pitching to young consumers non-conforming insurance products that offer basic benefits and catastrophic coverage and take care of paying the penalty for them.

But nowhere is the structure of the ACA more at odds with its own aspirations than when it comes to the organization and delivery of medical care. The ACA aims to fundamentally re-shape the American practice of medicine by turning doctors into salaried employees of large, integrated delivery systems. It seeks to end the traditional model of outpatient medical practice where doctors work in physician-owned, physician-led groups. But the combined effect of these changes will only make medical care more costly and less efficient. Once again, the methods that the ACA adopts will undercut the very purpose of its provisions.

Obamacare's architects see the traditional model of medical practice as needlessly costly and inefficient. In the view of those who crafted the law, the existing model of outpatient medical practice motivates individual doctors (who are essentially operating their own businesses) to try to maximize their revenue by delivering more medical services against their relatively fixed overhead costs. Moreover, having doctors dispersed in so many small, disparate, and independent practices makes them inefficient and harder to regulate.

So Obamacare sets out to fundamentally refashion the organization and delivery of outpatient medical care and the American practice of medicine. To see how, one must start at the legislation's origins and the initial ambitions expressed by its architects.

The Intellectual Underpinnings of Obamacare

In Washington, every major policy battle has an illustrative anecdote or a defining story that encapsulates its intellectual premise and distills the core purpose into a seductive dictum. For President Barack Obama, his effort to enact major health care legislation was made more vivid by a celebrated cover story, Gawande (2009), written by Harvard surgeon Atul Gawande and published in *The New Yorker*.

The article neatly summarized a simmering refrain inside the Obama team: That doctors -- influenced by financial prerogatives – aren't efficient, and sometimes not effective either. President Obama clung to data that his team helped make fashionable which purportedly revealed wide (and clinically inappropriate) variation in how similar Medicare patients are treated for seemingly comparable medical problems. According to the data, the only distinctive factor that varied between these differently managed patients was where they were treated for their conditions.

Moreover, when this variation in clinical practice was mapped against the costs of that care, there was no correlation between high spending regions and better outcomes. In fact,

some of the highest cost regions reported some of the lowest adjusted outcomes. Meanwhile, some of the lowest spending regions had the best results. This, President Obama said, showed that there was a lot of waste in the existing medical system. By getting better control of that misuse, the money saved could be used instead to expand access to health insurance.

In other words, the President's program could pay for itself, if only we could bring the entire system in line with the most cost-effective regions for care.

Researchers at Dartmouth School of Medicine developed most of the data that underpinned these assumptions. Setting aside methodological problems with their analysis, including those raised by Martin, *et al* (2007), Cooper (2009)[1] and Franzini,*et al* (2010) (and Gawande's interpretation of the Dartmouth results), the observations became a rallying point for Obamacare.

Like efforts to deploy broader use of healthcare IT or more vigorous efforts to stamp out "waste, fraud, and abuse," the political class seized on the Dartmouth Data because it seemed to offer another painless way to cut health care costs. Bringing down health care costs under the prevailing orthodoxy didn't require painful measures like cuts to reimbursement. It just required everyone to practice medicine in the same manner as the most efficient providers.

Obamacare could pay for itself. If only we could change the practice of medicine.

President Obama and his budget director neatly summarized this political philosophy in the run-up to Obamacare's passage. During a town-hall style event that ABC News (2009) hosted at the White House, the President, Obama (2009), memorably said in response to one audience member who was recounting the story of her mom's medical travails: "At least we can let doctors know — and your mom know — that you know what, maybe this isn't going to help. Maybe you're better off, not having the surgery, but, taking the painkiller." At another moment, the President noted: "You come in and you've got a bad sore throat, or your child has a bad sore throat or has repeated sore throats. The doctor may look at the reimbursement system and say to himself, 'You know what? I make a lot more money if I take this kid's tonsils out'."

Setting aside the dim view of doctors and medical practice that these statements make bare, the fact is that they weren't errant comments but the reflection of a political philosophy that traced problems with the cost and quality of health care directly to

[1] Cooper (2009) notes that "the Dartmouth Institute for Health Policy and Clinical Practice, acknowledged in an op-ed outlining "10 steps to better health care" that because "we relied on Medicare data for our selections, it is possible that some of these regions are not so low-cost from the viewpoint of non-Medicare patients." In other words, Dartmouth admitted that Medicare is not a proxy for the whole while also downgrading (to about 16 percent) its forecast of likely savings based on regional reforms."
http://articles.washingtonpost.com/2009-09-11/opinions/36922576_1_medicare-patients-medicare-and-medicaid-medicare-data

providers and what was viewed as self-interested decisions that doctors purportedly made in the exercise of clinical practice.

Peter Orszag, the President's Director of the Office of Management and Budget (OMB) summed up the policy view more directly, observing that: "wasteful spending — perhaps $700 billion a year — does nothing to improve patient health but subjects you and me to tests and procedures that aren't necessary and are potentially harmful." Later, Orszag put that estimate even higher, writing on the White House blog "we spend more than $800 billion a year on health care that does not make us healthier." See The White House Blog (2009).

For the President and his budget director, the waste wasn't driven simply by demand for medical care, but also the supply of these services. That was the unmistakable conclusion of Gawande's treatise (2009). If you installed a sophisticated robot to do surgery, you would get more robotic surgeries, even some that were unnecessary. If a community had more cardiologists, then its residents received more cardiology tests and procedures relative to matched patients in other regions. This observation was proof of that classical economics concept known as Say's Law.[2] In a distilled form, it held that supply could create its own demand.

But there was a problem. Even if you accepted the Dartmouth data (and Gawande's construal of it) that there was wide variation in how similar medical problems were approached–that this variation was a measure of inefficiency, waste, and the misplaced financial incentives of our fee-for-service payment system that paid doctors better when they performed more tests and procedures–even if you accepted all of these theories as fact, one problem remained. How would you get American doctors to play off the same songbook?

Transferring Risk To Providers

The Affordable Care Act tried to offer a solution. By changing the organization and financing of medical care, you can also change its delivery. The ACA promises a fundamental restructuring of the practice of medicine, by changing who bears the risk for clinical outcomes and the cost of health care. The law shifts medical risk away from insurers (and patients) and onto providers. This is a shift that's being encouraged by health insurance companies, who seem eager to leave their traditional underwriting businesses and become service providers to those entities who will be bearing the risk in the future–providers, large employers who continue to self-insure, and then, increasingly, the government.

By transferring the financial risk to providers, the ACA seeks to make medical care more efficient. By putting all providers on the same economic footing, the belief is that these measures will reduce the variation and waste observed by the Dartmouth researchers.

[2] Baumol, William, (1999). "Retrospectives: Says Law". *The Journal of Economic Perspectives* (1), pp. 195-204

The ACA moves the risk onto providers principally by turning to various forms of capitation. To enable providers to bear the costs and burdens of taking on the risk for patient care, the ACA pursues numerous financial inducements and penalties to drive doctors to consolidate into large, integrated delivery systems, typically with a hospital at the hub. It's believed that only by consolidating doctors into large, integrated medical systems can providers have the scale to take on the financial risk for the provision of medical care.

This premise isn't entirely novel. Private managed care companies adopted the same economic prescriptions in the 1990s, mostly with failed results.

The venture capital firm Welsh Carson was among the first to back the development of new kinds of for-profit health maintenance organizations seeking to reduce health care costs by transferring risk to providers through capitation. The idea was to give consumers a narrow choice of doctors, which in turn would give providers more leverage to control utilization. One of the first of these new kinds of HMOs was the firm U.S. Healthcare.

Alongside these HMOs, venture firms like Welsh Carson started to capitalize the formation of physician practice management companies (PPMs) such as Phycor and MedPartners. The idea was that these PPMs would consolidate providers into large, integrated networks, mostly by purchasing medical practices and then turning the doctors into salaried employees of these companies. This, it was argued, would make it easier to install professional management over these medical groups. It would also give the HMOs the ability to form networks more easily by contracting with PPMs that already maintained the infrastructure necessary to manage the financial risk that was being transferred to the providers.

These concepts failed. The first issue was the medical care itself. Capitation, patients argued, created a pernicious conflict by giving providers a financial incentive to withhold certain care since doctors were on the hook for its costs. The proliferation of HMOs eventually led to the introduction of the "Patients' Bill of Rights" in Congress, which sought to constrain some of the ability of these organizations to transfer the financial risk to providers. [3]

The PPMs failed as well. Most of these firms paid large upfront sums to purchase medical practices. But these companies were unable to introduce the promised efficiencies that would help them recoup these costs. Similarly, hospitals that had purchased doctor practices (to consolidate them into more integrated health systems) also fared badly. A few hospital-based systems (including the Geisinger Clinic and Intermountain Health) were forged during this era and went on to prosper. Ironically, these few survivors have become a template for today's wave of legislative reforms, even though they are the outliers. Most of these "Physician Service Organizations" couldn't

[3] Senate Bill S.1052, also called the "McCain-Edwards-Kennedy Patients' Bill of Rights."

manage the financial risks of capitation and failed. Like the PPMs, they unwound many of the medical practices that they had acquired.

In many respects, the change now underway in healthcare—hastened, if not originated by the Affordable Care Act—is a throwback to this earlier period of consolidation. The President's healthcare team recognizes these similarities but argues that their regulatory provisions, as well as changes in the market itself, will finally make these concepts feasible.

Regulation, they argue, will blunt the more insidious aspects of capitated financial arrangements while making sure providers don't skimp on care. Meanwhile, better systems for sharing information mean that integrated arrangements that failed in the 1990s are today better positioned to manage the financial risk. The healthcare system itself has also changed. It is far less fragmented than it was in the 1990s. Many integrated delivery systems already exist. In short, the market wasn't ready for these concepts in the 1990s. However, the Obama Administration is betting that the system is now able to accommodate these concepts.

So the Affordable Care Act sets out to change the organization of medical practice to fully transform its delivery under these new financial and business arrangements. To accomplish these goals, the legislation turns to three primary constructs.

First Step: Change The Structure and Delivery Of Medicine

The first of these is the creation of "accountable care organizations" (ACO) —a throwback to the PSO delivery systems made fashionable in the 1990s. Typically in these arrangements, hospitals purchase local medical practices, joining them into large outpatient networks that they operate. The idea is to turn doctors into salaried employees of the resulting systems, making it easier to manage what services the doctors perform (and what they are paid).

Under the concept, the ACO takes overall responsibility for the care of each patient and the associated costs. In the President's construct, patients are assigned to an ACO based on which doctors they currently frequent. An ACO can be a large multispecialty group of doctors. But more likely, it will be a hospital that owns local doctor practices in its geographic region.

Under Obamacare, an ACO will take financial "accountability" for a local population of Medicare patients. Patients, in turn, get most of their care from providers working inside the ACO's network. To encourage efficiency and cost cutting, the doctors practicing inside an ACO can share in some of the cost savings that they achieve. The idea is to give doctors a financial incentive to reduce utilization of expensive services and work more closely as part of coordinated teams that can, in turn, make care more efficient.

The ACO concept is attributed to Elliot Fisher, the chief architect of the Dartmouth Atlas Project, the same program that documented the seeming variation in the cost of medical

care and outcomes across the U.S. The concept had its origins in the work of the Dartmouth Atlas and its conclusion that Medicare spending can be reduced while also improving clinical outcomes. The term ACO itself is said to have grown out of an exchange Fisher had with Glenn Hackbarth at a November 2006 meeting of the Medicare Payment Advisory Committee. According to Bach (2010), Fisher's findings on variation in medical outcomes and their inverse correlation to health spending became the intellectual foundation for ACOs and Obamacare.

The second tools that the ACA uses to try and change the structure and delivery of medical care are various forms of capitated payment arrangements themselves. These are being implemented as part of Medicare and Medicaid. The most prominent are "bundled" payments that give providers lump sums of money to take charge of certain common medical problems or episodes of illness (like the length of a hospital admission for heart failure or pneumonia). Many of these bundled payments aim to pay providers a pre-specified amount of money for the acute and post-acute portion of these medical conditions.

The belief is that these lump-sum payment schemes will put the financial responsibility for medical care onto doctors, who are (it is argued) best equipped to manage costs. By linking the inpatient and outpatient portion of care under a single payment rate, the scheme will also give providers an additional impetus to consolidate their medical practices around hospitals.

To manage these episodes of illness across the acute and post-acute portion of care, hospitals will not only need to control local providers but also must develop tighter alignment with post-acute facilities (skilled nurse facilities, rehabilitation centers, long-term care facilities) that take care of patients once they leave the hospital. It's unlikely that hospitals will try to buy these post-acute facilities (as they did in the 1990s, with often disastrous results). More likely, hospitals will try to develop close collaboration through contracting with post-acute networks that themselves have consolidated different options in order to offer hospitals a suite of services. But the hospitals will want to own the doctors. This is another way that the ACA is driving the consolidation of providers around the hospital as an organizing hub for the delivery of medical care.

A final way that the ACA sets in motion profound changes in the organization of medical practice is with new payment authorities that it confers on the Centers for Medicare and Medicaid Services (CMS). The new law gives CMS sweeping authority to unilaterally change what it pays to providers in order to cut "mispriced" outpatient payment codes while maintaining an arbitrage between the higher prices it pays for services delivered in hospitals relative to the same tests and procedures delivered in the outpatient setting. So far, CMS has used these authorities to further expand the gap between the higher prices paid in hospitals relative to the reimbursement rates for the same services delivered in outpatient medical offices.

These payment schemes give doctors another powerful financial incentive to sell their medical practices to hospital-owned arrangements and come under the hospital billing

scheme. CMS has used this authority to lower reimbursement rates for procedures done outside the hospital. Doctors are seeing their earnings decline under these new schemes, while overhead costs continue to rise. This has made it more profitable to deliver many services and procedures inside a hospital-owned outpatient clinic rather than in a physician-owned office.

CMS says it wants to make payment rates "site neutral." But the effect has been to tilt the playing field in favor of hospitals. This is prompting procedure-based specialties like cardiology to sell medical practices to hospitals so that they can bill for procedures under the hospital's more generous (Part A) payment rates, according to Jackson HealthCare.com (n.d.(a)). The same study reports that, in 2012, 18 percent of all medical practice acquisitions were of cardiology practices, the fourth-highest of any specialty behind family practice, internal medicine, and obstetrics/gynecology. It's likely that in the future, once this consolidation has run its course, the government will start sanding down the hospital billing rates, making many of these new arrangements unprofitable.

In addition to these payment changes, embedded in the new legislation is another obscure provision that gives CMS the legal authority to adjust what physicians are paid based on how "productive" doctors are in their individual medical practices. If that sounds like a fuzzy standard, it is intentional. When an earlier version of the same section of the legislation had a lot more specificity, it generated hackles from the doctor community. So exactly what "productivity" means is left to be decided later. But it is clear from the legislation (and subsequent regulations and guidance) that the term "productivity" is intended to capture how cost-efficient doctors are, and how much money they spend treating patients.

When the Senate Finance Committee debated the original version of health reform law, this particular passage contained specific references to what legislators had in mind. It called on CMS to penalize any physician whose "resource use" is considered too high.

Beginning in 2015, Medicare would have been required to rank doctors against their peers based on how much they cost the program—and then automatically cut all payments by five percent to anyone who falls into the 90th percentile or above. Any physician who ordered too many tests or referred patients for too many expensive consults or services could be ensnared, regardless of whether or not the medical treatments result in better patient outcomes.

Effects are seen in Current Industry Trends

The end result is that today, about two-thirds of American physicians are working as salaried employees of large groups and hospitals. Over the last decade, the number of independent physicians was falling by about two percent a year. But since 2012, the number of independent physicians has been declining by five percent a year, according to Accenture Health (2011). Mutti and Stensland (2012) show that the largest proportion of these newly salaried physicians is being directly employed by hospitals or hospital-owned medical practices. Hospital physician employment rose 32 percent from 2000 to

roughly 212,000 physicians in 2010. That means that hospitals directly employ about a quarter of all U.S. physicians. See Gottlieb (2012).

Cheung (2011) finds that 70 percent of U.S. hospitals and hospital-owned health systems planned to hire more physicians in the following three years. Meanwhile, two-thirds of hospitals reported that they were seeing more requests from independent physician groups seeking direct employment or collaboration with hospitals.

These developments are further supported by a review of the open job searches done by one of the country's largest physician recruiting firms; see Medical Group Management Association (2010). It showed that after Obamacare's passage, nearly 50 percent of the open searches are for jobs in hospitals, up from 25 percent before its passage.

All of these trends have continued. More physicians were employed by hospitals in 2013 than in 2012 according to a survey conducted by Jackson Healthcare (nd(b)), a healthcare staffing company. The survey of 3,456 physicians (polled between March 7 and April 1, 2013) found that 26 percent of doctors were employed by a hospital in 2013, up by six percent from 2012 while 14 percent reported that they were employed by a practice that is owned by a hospital or health system. A separate 2012 survey of physicians by the American Medical Association, Kane and Emmons (2013), showed that only 60 percent of physicians worked in practices that were wholly owned by physicians.

These trends can be seen across all medical specialties, but for a variety of reasons, they can be seen most prominently in oncology. About 400 oncology practices have been acquired since passage of the Affordable Care Act. Between 2005 and 2011, the amount of chemotherapy infused in doctor offices fell from 87 percent to 67 percent according to a new analysis of Medicare billing data done on behalf of community oncology groups. Relative to the physician office, the share of chemotherapy administered in the hospital outpatient department increased considerably over time, from 13.5 percent in 2005 to 33 percent in 2011. Payments made for chemotherapy administration to hospital outpatient departments grew even more, reflecting the higher cost of infusing chemotherapy in the hospital-based setting. The share of payments to hospitals increased from 16.2 percent in 2005 to 41 percent in 2011, according to the Moran Study of Site of Service Shift (n.d.).

Taken together, these developments spell the inevitable demise of outpatient, office-based medicine delivered by independent practitioners. It's not dramatic to say that the ACA seeks to end the existing model for outpatient medicine—and will largely accomplish this goal for all but small pockets of the medical marketplace. These designs were foreshadowed many times by the Obama Administration, which made no secret of its political philosophy.

If the aim were merely to align financial incentives with improved clinical decision making and patient outcomes, there were many payment reforms that could have aligned reimbursement with clinical measures of benefit. CMS has been working on pay-for-performance schemes for a decade. But the designs of the ACA go beyond financial

incentives in clinical practice. The goal is to remove many of the market-based financial constructs from medical care, to take the profit incentive out of medical practice.

These ideas were most directly addressed in a little noticed medical journal article published in 2010, Kocher *et al* (2010). President Obama's former health care czar Nancy-Ann DeParle joined two of her White House colleagues in arguing that "the economic forces put in motion by [the Obama health care plan] are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups."

How Obamacare's Consolidation will Harm Medicine

Proponents of Obamacare say it is about time that we abandon the existing model of outpatient medicine, where doctors often practice independently in small groups. They point to inefficiencies inherent in such a system, such as limitations on the ability of small, independent medical practices to make capital investments in tools like electronic health records. But the new structures that the ACA is erecting to replace the existing outpatient model of healthcare delivery come with some of their own significant flaws. Many of these defects work against the very goals that Obamacare purportedly aims to pursue.

For one thing, it is well documented that clinical productivity declines once doctors become salaried employees of hospitals or other large organizations. Estimates by hospitals that acquire medical practices and by institutions that track these trends, such as the Medical Group Management Association, show that physician productivity falls under these arrangements, sometimes by more than 25 percent. The lost productivity isn't just a measure of the fewer back surgeries or cardiac catheterizations performed once physicians are no longer paid per procedure, as ObamaCare envisions. Rather, the lost productivity is a consequence of the more fragmented, less accountable care that results from these schemes. Estimates from Advisory Board Company show that when hospitals last went on a physician-acquisition binge in the late 1990s, productivity fell by as much as 35 percent. Moreover, there's evidence that these arrangements raise costs more directly, by giving hospitals increased local control over providers that in turn allows hospitals to push up prices on insurers. The Federal Trade Commission has recently expressed concern as well about these arrangements, and the potential for higher costs as a result of the consolidation.

If you believe that the only way to solve our long-term fiscal challenges when it comes to programs like Medicare and Medicaid is to get more health care for each dollar of GDP that we spend on it, then the last thing we should do is adopt policies that lower productivity.

These arrangements also have the effect of turning medical practice into shift work. There is less continuity of care and fewer opportunities for patients to develop consistent relationships with the same provider. When a patient shows up in the emergency room on a night or weekend, it will be less likely that their doctor is reachable and more probable

that there is a covering doctor who doesn't know the patient. Access to the electronic health record is no substitute for access to a provider who already knows a patient's history and condition. Some integrated delivery systems have developed good approaches for dealing with issues of care continuity. But these entities represent the exception. Far from reducing unnecessary admissions, most of these arrangements will promote them.

Also gone will be the entrepreneurship that once characterized medical practice in this nation. Critics will argue that this entrepreneurship drove up medical spending by giving individual practitioners a financial motivation to perform unnecessary tests and procedures in order to grow their revenue. Under the integrated systems, with doctors now in salaried roles, there is no longer such a motivation. But the entrepreneurial spirit that characterized local community medical practice also drove service improvements and created incentives to develop and adopt new technology to accommodate patient expectations.

Finally, it's also doubtful that the majority of these integrated delivery systems will be any better at managing the financial risk of capitated arrangements than they were in the 1990s, when the majority of these arrangements spilled red ink and had to be unwound. According to Davidson and Hansen (2013), there are already signs that the hospital sector is under increasing financial strain.

Conclusion: The Costs to Patients

Obamacare seems to be premised on an almost magical belief that merely by consolidating providers into large, integrated delivery systems, these bulky entities will make providers agnostic to the financial underpinnings of their work. They won't. They will merely move these considerations out of the doctor-patient encounter and into the hands of managers that hold sway over those clinicians. The financial prerogatives won't be removed from the clinical encounter. They will just be partially obscured to the doctor and the patient.

The ACA's nod toward capitated arrangements is the triumph of a philosophical tension between conservative and liberal approaches to healthcare reform. For a decade, conservatives pursued reforms aimed at making healthcare more "consumer directed" by exposing patients to some of the cost of the incremental choices they made when it came to their healthcare. But liberals always saw the need for consumers to contemplate cost as a component of their treatment decisions as an affront to egalitarianism.

Yet someone has to consider cost, quality, and value when it comes to competing healthcare choices. Ideally, many liberals would prefer to see these considerations made by expert panels and government agencies like the ACA's Independent Payment Advisory Committee. But these constructs are politically unpopular. So liberals have pursued instead a policy of shifting these financial considerations onto providers. The ACA's various efforts to move providers into capitated payment arrangements are a reflection of this dogma.

Why it's viewed as preferable that doctors be forced to take on these considerations instead of patients is ripe for debate. At the very least, when patients are forced to contemplate cost, they are made aware of the full spectrum of their options. When doctors are put in the same position, there's far less transparency. The patient may never know the option they weren't offered because a capitated provider judged it to be too costly. We are replacing our flawed fee-for-service payment model with a system that could be far worse.

There is another fundamental flaw in how the ACA aims to restructure outpatient medicine. Under the new constructs, providers will be accountable for the short and near-term costs of the care they deliver. But most of the benefits of that spending accrue to patients in the form of reduced morbidity or very long-term benefits that the financial arrangements don't capture. Thus, the benefits will always be undercounted and the costs accentuated.

The ACA is mostly about expanding coverage, but its provisions aimed at cost control should not be discounted. These legislative elements have one unifying aspiration—the transformation of the practice of medicine to make the provision of care more concentrated around hospital-owned health systems and more subject to regulatory control. It is a shortsighted vision that pits Obamacare against its own aspirations by changing the medical delivery system in ways that are ultimately self-defeating.

The hospital-led consolidation of providers will not make healthcare more efficient, just costlier. There's ample evidence that these arrangements lower overall productivity. They'll fall short of producing the hoped for efficiencies and integration — working at odds with the very purpose for their pursuit in the first place. The only benefit of the ensuing hook-ups is to make the resulting system more concentrated and easier to regulate from Washington. Regulation will be what Obamacare will inevitably have to fall back on. Providers will become more closely aligned with government agencies and their budget prerogatives. But in so doing, it moves medical practice further away from the influence of patients.

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