

Health Care Reform: A Perspective From Primary Care

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Although the Affordable Care Act (ACA) is not perfect, it takes significant steps forward on many of the key tenets of health promotion, prevention, and primary care. This commentary discusses a few aspects of the legislation that the North Carolina Pediatric Society and the North Carolina Academy of Family Physicians believe will help improve the health of North Carolina's citizens by increasing the access to and the quality of health care delivered in the state.

First, take a look at where the US health care system stood before reform. A total of 17.2% of the gross domestic product is related to health care expenditures. This equates to \$8,160 spent on health care for every man, woman, and child in the United States. From 1999 through 2008, health care costs grew by 119%, compared with an average annual increase of 29% in inflation, and employers continued to face double-digit increases in premiums, forcing them to pass more of the cost to the employee or to eliminate benefits altogether [1].

Without a doubt, the direction of care and associated increased costs could not be sustained long-term. According to the Dartmouth Atlas, almost 1 in 3 health care dollars are used for unnecessary tests, unproven or ineffective treatments, unwanted procedures, or overpriced, cutting-edge drugs and devices that are not significantly better than the less expensive treatments they are replacing [2].

A call for changes to the US health care system is not a new proposition. In a widely cited example, the editors of *Fortune* published a critique of the system in 1970, asserting that "[t]he time has come for radical change" because "most Americans are badly served by the obsolete, overstrained medical system that has grown up around them helter-skelter" [3p79]. Regardless of one's views about the provisions of the ACA, one thing that was certain 40 years ago and remains so today is that changes were necessary for a system much in need of repair.

Consider what the ACA will do. First and foremost, the act moves toward a concept that has long been promoted by the North Carolina Pediatric Society and the North

Carolina Academy of Physicians—health care coverage for all. For more than 20 years, the American Academy of Family Physicians has advocated for health care coverage for all. The American Academy of Pediatrics has promoted the same idea, with a focus on children and adolescents. Primary care physicians understand—and see in their practices—that people without insurance delay or avoid receiving necessary preventive care, develop preventable illnesses, get medical attention at a later stage of serious illness, and, as a result of these factors, tend to have higher overall medical expenses.

Before passage of the ACA, researchers estimated that without health care reform, the number of uninsured Americans would rise to 52 million [4], and analysts estimate that in 2007, 75 million Americans were uninsured or underinsured [5]. Even those who have health insurance struggle with high copayments, deductibles, and other costs. In 2007, medical costs were an underlying cause of more than 62% of personal bankruptcies [6]. Although the ACA does not ensure coverage for all, it does take significant steps in that direction.

While we agree that individuals should acquire health insurance before they become sick, the penalties for not acquiring coverage may not be significant enough to motivate everyone to obtain insurance. For example, nationally, the average annual premium for family coverage is \$13,375 [1], yet the penalty imposed by the ACA for not purchasing insurance is less than 16% of this average premium, with a maximum penalty of \$2,085 per family.

The act strongly encourages preventive care, which helps to control costs by moving patients into medical homes. For example, health insurance plans will be required to provide first-dollar coverage (ie, coverage that does not require payment of a deductible or a copayment) for all preventive services given an A or B rating by the US Preventive Services Task Force, including immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The ACA also heavily invests in prevention, with \$500 million authorized this fiscal year for the

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Prevention and Public Health Fund and up to \$2 billion authorized by 2015. The effort includes support for the new National Prevention, Health Promotion, and Public Health Council and funding for a national outreach and education campaign to promote health improvement. The ACA also helps educate consumers about the nutritional content of food by requiring chain restaurants and vending-machine operators to clearly post the nutritional information of their products.

Other key prevention efforts in the ACA include a childhood obesity demonstration project and competitive grants to states and communities to promote health by reducing the incidence and prevalence of chronic disease and addressing health disparities. In addition, the ACA requires that there be parity between mental health and substance abuse services and other more traditional benefits that are included in the essential benefits packages developed by the US Department of Health and Human Services.

Another key focus area is the health care workforce, particularly in the most underserved areas and for underserved populations. For example, the ACA mandates that in 2013 and 2014 and, possibly, beyond, Medicaid pay primary care physicians at 100% of the Medicare fee schedule. In addition, Medicare will offer a 10% bonus for primary care physicians in underserved areas, which encompasses a sizable portion of North Carolina, and it provides significant increases in authorizations to the National Health Service Corps for loan repayment, which is a key component of physician recruitment for rural and underserved communities in North Carolina. The ACA also authorizes the development of teaching health centers under Title VII to provide training in primary care to medical and dental residents at federally qualified community health centers. Whereas graduate medical education funding has traditionally flowed through hospitals, the creation of teaching centers recognizes the realities of ambulatory care by providing more exposure to outpatient settings that are essential to the medical home concept, so effectively used by Community Care of North Carolina (CCNC).

The provisions of the ACA move health care toward a more balanced focus on prevention, continuity of care, and chronic disease management, but they do not go far enough to bend the cost curve by improving the emphasis on primary care. Although health care costs in the United States have continued to increase dramatically, many other developed countries have produced better health outcomes at much lower costs. A key part of their systems is an equal ratio of primary care to specialist physicians. In the United States, close to 70% of physicians are specialists, with an even higher percentage of recent medical student graduates choosing careers in subspecialties. As North Carolina's public medical schools work to expand class sizes, the state must ensure that tax dollars are producing the right kind of physicians to care for the people of North Carolina well into the future.

Two other areas of emphasis in the ACA are health information technology and new models of care. North Carolina has a head start on both thanks to leadership from the statewide Area Health Education Center (AHEC) system and to cooperation between private and public medical organizations. These partnerships are a well-known hallmark of North Carolina's efforts to pilot special projects and demonstrate health care innovation. Unfortunately, the ACA does not go far enough on tort reform, but it does allow for some state demonstration projects.

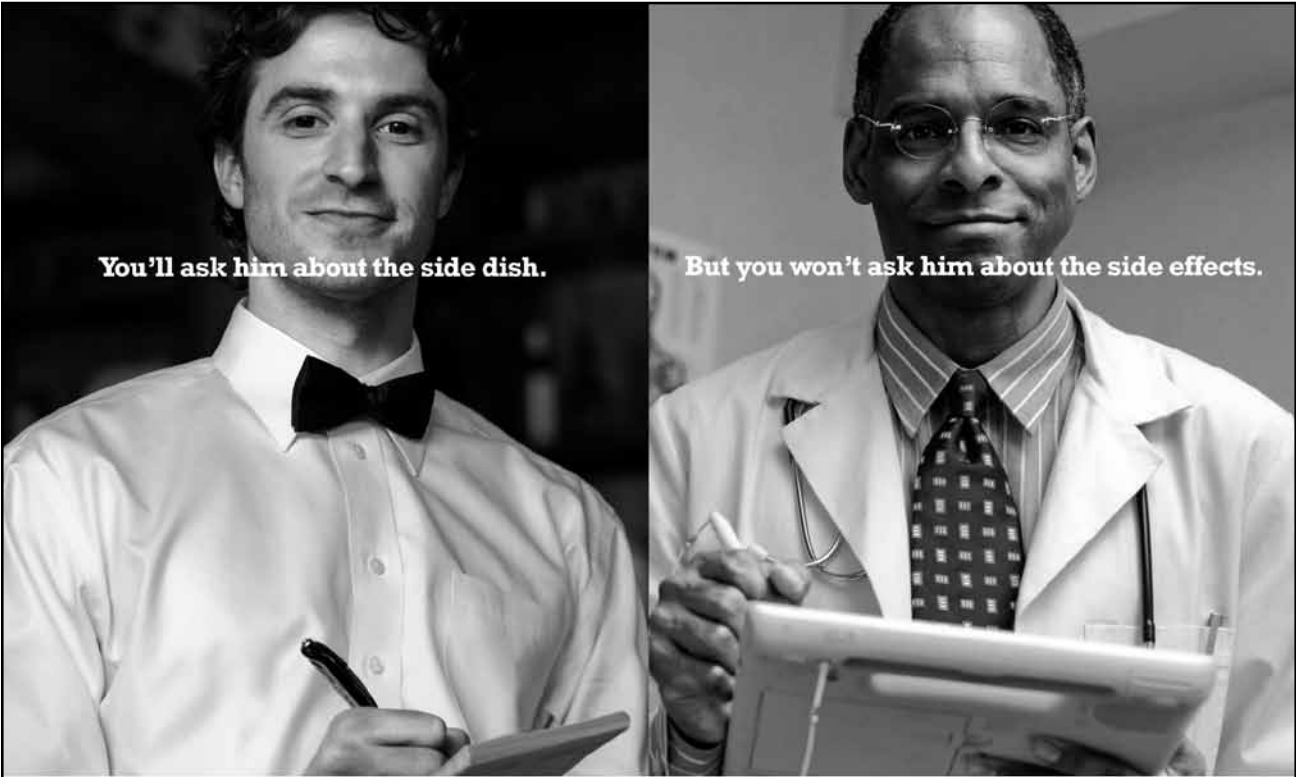
Much has already been done to encourage implementation of electronic health recordkeeping technology in North Carolina, and a number of groundbreaking efforts are currently underway. Steve Cline, former deputy state health director, has recently been appointed as the state's health information technology coordinator and is leading the effort to implement technology in health care settings throughout North Carolina. Fortunately, the state has already received federal funding through the American Recovery and Reinvestment Act to jumpstart the effort. This includes \$12.6 million for building health information exchange capacity and \$13.6 million to the AHEC system for developing regional extension centers to help primary care physicians implement electronic health recordkeeping technology and to use these records effectively. Both Medicaid and Medicare are now offering significant financial incentives to practices that are using electronic records in a meaningful manner, particularly for population management and quality improvement. Collectively, these efforts reflect an appreciation of the importance of the medical home concept and quality improvement to the health care system.

The ACA also authorizes demonstration projects to test new payment models for health care, including accountable-care organizations and the patient-centered medical home. North Carolina has already achieved national attention for multiple CCNC projects, including the program's focus on care coordination in the medical home, and there are already several new ideas in the works. Changes to payment and care models are clearly possible in North Carolina, as demonstrated by the efforts of CCNC, and will be complemented by health care reform, thanks to the strong partnership between state government, public health agencies, health insurers, and the private medical community.

Although everyone will likely find at least one item they dislike in this extensive piece of legislation, the old health care system needed to be changed. Now, North Carolina must continue to do what it does best—demonstrate, innovate, and lead—as the provisions of the ACA are implemented. If North Carolina is really serious about improving the access to and quality of health care, now is the time to start building a new health care system for the state. NCMJ

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