

# The Affordable Care Act in Context



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Editor



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# The Affordable Care Act in Context

Eliot Sorel, MD, DLFAPA

## *Introduction*

Health systems across the world remain significantly fragmented affecting access, quality and costs of the care delivered. They also are primarily individually focused, with an emphasis on secondary and tertiary prevention, with insufficient attention to primary prevention and populations' health. Strengthening health systems is a global public health challenge for all countries: low, middle and high income.

The Affordable Care Act (ACA) of the United States was passed by the United States Congress in 2010 and cleared for implementation by the Supreme Court of the United States in June 2012.

The ACA is a complex policy initiative that begins to address the daunting challenges of enhancing access, quality and diminishing costs of the evolving American health system. The Health Group of the Cosmos Club organized *The Future of Affordable Care Act Forum* in October 2012 in collaboration with the Institute of Medicine (IOM) of the U.S. National Academy of Sciences, the Commonwealth Fund of New York, the Satcher Health Leadership Institute of Atlanta and the Brookings Institution.

We are grateful for the superb contributions made to that Forum by Harvey Fineberg, MD, PhD, President of the IOM, Karen Davis, PhD, President of the Commonwealth Fund, David Satcher, MD, PhD, President of the Satcher Health Leadership Institute and Henry J. Aaron of the Brookings Institution. We are pleased to document in this monograph highlights of their presentations.

We hope that this publication, *The Affordable Care Act in Context*, will serve as a stimulus for further discussion and debate on ways to enhance the structures, functions and outcomes and be catalytic to improving access and quality while diminishing costs of the American health system as well as health systems globally.

Eliot Sorel, MD

Washington, DC, October 2013

# The Affordable Care Act in Context

*Comparative effectiveness, health system performance, and the cost of health care.*  
Harvey V. Fineberg, MD, PhD, President, IOM, NAS

Health care in America presents a fundamental paradox. The past 50 years have seen an explosion in biomedical knowledge, dramatic innovation in therapies and surgical procedures, and management of conditions that previously were fatal, with ever more exciting clinical capabilities on the horizon. Yet, American health care is falling short on basic dimensions of quality, outcomes, costs, and equity. Available knowledge is too rarely applied to improve the care experience, and information generated by the care experience is too rarely gathered to improve the knowledge available. The traditional systems for transmitting new knowledge—the ways clinicians are educated, deployed, rewarded, and updated—can no longer keep pace with scientific advances. If unaddressed, the current shortfalls in the performance of the nation's health care system will deepen on both quality and cost dimensions, challenging the well-being of Americans now and potentially far into the future. Health care needs major improvements with respect to its ability to meet patients' specific needs, to offer choice, to adapt, to become more affordable, to improve—in short, to learn. Americans should be served by a health care system that consistently delivers reliable performance and constantly improves, systematically and seamlessly, with each care experience and transition.

In the face of these realities, the Institute of Medicine (IOM) convened the Committee on the Learning Health Care System in America to explore the most fundamental challenges to health care today and to propose actions that can be taken to achieve a health care system characterized by continuous learning and improvement. This report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, explores the imperatives for change, the emerging tools that make transformation possible, the vision for a continuously learning health care system, and the path for achieving this vision. The title of the report underscores that care that is based on the best available evidence, takes appropriate account of individual preferences, and is delivered reliably and efficiently—*best*

*care*—is possible today, and also is generally less expensive than the less effective, less efficient care that is now too commonly provided.

The foundation for a learning health care system is continuous knowledge development, improvement, and application. Although unprecedented levels of information are available, patients and clinicians often lack access to guidance that is relevant, timely, and useful for the circumstances at hand. Overcoming this challenge will require applying computing capabilities and analytic approaches to develop real-time insights from routine patient care, disseminating knowledge using new technological tools, and addressing the regulatory challenges that can inhibit progress.

Engaged patients are central to an effective, efficient, and continuously learning system. Clinicians supply information and advice based on their scientific expertise in treatment and intervention options, along with potential outcomes, while patients, their families, and other caregivers bring personal knowledge on the suitability—or lack thereof—of different treatments for the patient’s circumstances and preferences. Both perspectives are needed to select the right care option for the patient. Communication and collaboration among patients, their families, and care teams are needed to fully address the issues affecting patients.

Health care payment policies strongly influence how care is delivered, whether new scientific insights and knowledge about best care are diffused broadly, and whether improvement initiatives succeed. New models of paying for care and organizing care delivery are emerging to improve quality and value. While evidence is conflicting on which payment models might work best and under what circumstances, it is clear that high-value care requires structuring incentives to reward the best outcomes for patients.

Finally, the culture of health care is central to promoting learning at every level. Creating continuously learning organizations that generate and transfer knowledge from every patient interaction will require systematic problem solving; the application of systems engineering techniques; operational models that encourage and reward sustained quality and improved patient outcomes; transparency on cost and outcomes; and

strong leadership and governance that define, disseminate, and support a vision of continuous improvement.

Achieving the vision of continuously learning health care will depend on broad action by the complex network of individuals and organizations that make up the current health care system. Missed opportunities for better health care have real human and economic impacts. If the care in every state were of the quality delivered by the highest-performing state, an estimated 75,000 fewer deaths would have occurred across the country in 2005. Current waste diverts resources from productive use, resulting in an estimated \$750 billion loss in 2009. It is only through shared commitments, with a supportive policy environment, that the opportunities afforded by science and information technology can be captured to address the health care system's growing challenges and to ensure that the system reaches its full potential. The nation's health and economic futures—best care at lower cost—depend on the ability to steward the evolution of a continuously learning health care system.

# Estimated Sources of Excess Costs in Health Care (2009)

In addition to unsustainable cost growth, there is evidence that a substantial proportion of health care expenditures is wasted, leading to little improvement in health or in the quality of care. Estimates vary on waste and excess health care costs, but they are large. The IOM workshop summary *The Healthcare Imperative: Lowering Costs and Improving Outcomes* contains estimates of excess costs in six domains: unnecessary services, services inefficiently delivered, prices that are too high, excess administrative costs, missed prevention opportunities, and medical fraud (IOM, 2010). These estimates, presented by workshop speakers with respect to their areas of expertise and based on assumptions from limited observations, suggest the substantial contribution of each domain to excessive health care costs (see Table S-1).

## Estimated Sources of Excess Costs in Health Care (2009)

Category	Sources	Estimate of Excess Costs
<b>Unnecessary Services</b>	<ul style="list-style-type: none"> <li>• Overuse—beyond evidence-established levels</li> <li>• Discretionary use beyond benchmarks</li> <li>• Unnecessary choice of higher-cost services</li> </ul>	\$210 billion
<b>Inefficiently Delivered Services</b>	<ul style="list-style-type: none"> <li>• Mistakes—errors, preventable complications</li> <li>• Care fragmentation</li> <li>• Unnecessary use of higher-cost providers</li> <li>• Operational inefficiencies at care delivery sites</li> </ul>	\$130 billion
<b>Excess Administrative Costs</b>	<ul style="list-style-type: none"> <li>• Insurance paperwork costs beyond benchmarks</li> <li>• Insurers' administrative inefficiencies</li> <li>• Inefficiencies due to care documentation requirements</li> </ul>	\$190 billion
<b>Prices That Are Too High</b>	<ul style="list-style-type: none"> <li>• Service prices beyond competitive benchmarks</li> <li>• Product prices beyond competitive benchmarks</li> </ul>	\$105 billion
Missed Prevention Opportunities	<ul style="list-style-type: none"> <li>• Primary prevention</li> <li>• Secondary prevention</li> <li>• Tertiary prevention</li> </ul>	\$55 billion
Fraud	<ul style="list-style-type: none"> <li>• All sources—payers, clinicians, patients</li> </ul>	\$75 billion

SOURCE: Adapted with permission from IOM, 2010.

## Better Care at Lower Costs

### Categories of the Committee's Recommendations

#### Foundational Elements

**Recommendation 1: *The digital infrastructure.*** Improve the capacity to capture clinical, care delivery process, and financial data for better care, system improvement, and the generation of new knowledge.

**Recommendation 2: *The data utility.*** Streamline and revise research regulations to improve care, promote the capture of clinical data, and generate knowledge.

#### Care Improvement Targets

**Recommendation 3: *Clinical decision support.*** Accelerate integration of the best clinical knowledge into care decisions.

**Recommendation 4: *Patient-centered care.*** Involve patients and families in decisions regarding health and health care, tailored to fit their preferences.

**Recommendation 5: *Community links.*** Promote community-clinical partnerships and services aimed at managing and improving health at the community level.

**Recommendation 6: *Care continuity.*** Improve coordination and communication within and across organizations.

**Recommendation 7: *Optimized operations.*** Continuously improve health care operations to reduce waste, streamline care delivery, and focus on activities that improve patient health.

### Supportive Policy Environment

**Recommendation 8: *Financial incentives.*** Structure payment to reward continuous learning and improvement in the provision of best care at lower cost.

**Recommendation 9: *Performance transparency.*** Increase transparency on health care system performance.

**Recommendation 10: *Broad leadership.*** Expand commitment to the goals of a continuously learning health care system.

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# Characteristics of a Continuously Learning Health Care System

## Science and Informatics

*Real-time access to knowledge*—A learning health care system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality.

*Digital capture of the care experience*—A learning health care system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.

## Patient-Clinician Partnerships

*Engaged, empowered patients*—A learning health care system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.

## Incentives

*Incentives aligned for value*—In a learning health care system, incentives are actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.

*Full transparency*—A learning health care system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients and their families.

## Culture

*Leadership-instilled culture of learning*—A learning health care system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.

**Supportive system competencies**—In a learning health care system, complex care operations and processes are constantly refined through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.

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# **Lessons from International Health System Performance: Affordable Care Act Payment and Delivery System Innovations**

Karen Davis, PhD and Kristof Stremikis

The United States health system is the most expensive in the world, but comparative analyses consistently show the U.S. falls short of other countries on most dimensions of performance.<sup>1</sup> Many of these shortcomings can be traced to health financing policies that foster fragmentation, encourage greater use of specialized care, and contribute to higher costs.<sup>2</sup> Current fee-for-service methods of physician reimbursement are particularly problematic and reward providers for the volume of services and procedures they provide rather than the value they deliver, leading to potentially wasteful, unsafe, and expensive encounters for patients and their families, and introducing a bias that favors specialty care over primary care.<sup>3</sup> Not surprisingly, this has contributed to an imbalance in care provision, and weakened the primary care foundation of the U.S. health system.

The U.S. can improve the performance of its health system by examining international innovations, and testing adaptations for the U.S. context. There are three key policy issues that hold particular potential for improving U.S. health system performance: 1) organization of primary care; 2) payment reform; and 3) information technology. In each of these areas, international innovations adopted over the last decade provide lessons on how to achieve gains in access to care, patient experience, and outcomes of care, as well as lowering cost. Along with provisions of the Affordable Care Act that expand health insurance coverage and enhance the affordability of coverage and care, the Affordable Care Act has provisions which permit testing and implementing successful payment and delivery system innovations.

## Primary Care

Our fragmented health financing policies are having measurable impacts in many areas of physician practice. A recent Commonwealth Fund survey found more than half of American adults have experienced duplicative and disorganized care in the health system within the past two years.<sup>4</sup> In addition, Commonwealth Fund surveys indicate that patient-physician relationships are less stable in the United States relative to other industrialized countries, with less than half of chronically ill Americans report receiving care from the same doctor or place for at least five years, compared to nearly 80 percent of those in Germany and the Netherlands.<sup>5</sup> In 2009, just 26 percent of U.S. primary care physicians had advanced health information technology systems in their practice—a stark contrast to New Zealand, Australia, and the United Kingdom, where upwards of 90 percent reported high functionality.<sup>6</sup> And, only 36 percent of American primary care physicians report being able to receive any financial incentive to quality, compared to 50-89 percent in most other countries.<sup>7</sup>

Countries such as Denmark, the Netherlands, and the U.K. require patients to enroll in a primary care practice of their choice. France strongly encourages enrollment through financial incentives for patients, including reduced cost-sharing for services received on referral from a primary care physician.<sup>8</sup> Enrollment of a patient panel facilitates long-term physician-patient relationships, as well as a more pro-active style of primary care that monitors control of patients' chronic conditions.

Several countries, including the Netherlands, Denmark, and Germany, have sought to expand access to after-hours care—often by transitioning from the traditional approach, in which practices designate someone to be “on-call,” to group-based or regional approaches.<sup>9</sup> As the U.S. seeks to strengthen primary care, particularly through the development of patient-centered medical homes, it has a great deal to learn from these international models. In the Netherlands, cooperatives include 40 to 250 GPs and cover between 100,000 and 500,000 patients, all living within roughly 20 miles of the cooperative. When patients call the cooperatives, they are triaged by nurses who can choose to provide

self-care advice over the phone, advise the patient to visit their GP the next day, invite the patient to visit a GP at the cooperative, order a GP house call, or refer the patient to an emergency department or ambulance service. For house calls, cooperatives have chauffeured vehicles outfitted with communication equipment, oxygen, infusion drips, and automatic defibrillators.

## **Payment Reform**

Changing how the U.S. organizes and pays for health care is critical to achieving the triple aim of improved population health, enhanced patient experience, and reduced healthcare costs.<sup>10</sup> A review of several initiatives among our international peers shows that moving away from fee-for-service reimbursement to primary care medical home payment, bundled payment, and salaried practice within integrated delivery systems are important strategies that can encourage providers to assume more responsibility for quality and prudent use of resources. Fortunately, innovative models like these that encourage greater accountability are used and given high priority under the Patient Protection and Affordable Care Act.<sup>11</sup>

High-quality care for patients with chronic and complex conditions often involves coordinating between multiple providers and sources of care. Bundled payments—also known as episode-based payment or case rates—have been proposed as a way to encourage coordination across providers and to promote more efficient care. The Netherlands is an innovator and early leader in bundled payment methods, instituting a system for diabetes care in 2007.<sup>12</sup> This scheme created a new health care entity—“care groups”—to which insurers pay a single bundled fee to assume responsibility for a patient’s diabetes care for a defined time period. Care groups are made up of health care providers, often only general practitioners. The services covered under the bundled payment are nationally defined and agreed on by all providers and patient associations, and must be offered free of charge to patients.

Another alternative to fee-for-service payments is pay-for-performance reimbursement, which rewards providers for meeting

designated targets. Rather than replacing traditional payment methods, pay-for-performance approaches can be combined with them to provide incentives to improve. England's Quality and Outcomes Framework (QOF) remains the largest-scale achievement in pay-for-performance, as a nationwide program spanning a wide array of performance targets.<sup>13</sup> In its current iteration, the QOF offers GPs additional payments for meeting up to 134 target indicators. Performance areas included in the QOF relate to clinical indicators (including for managing chronic conditions such as asthma or diabetes), organizational indicators, patients' care experiences, and providing "extra" services such as child health and antenatal services. Participation in the QOF is voluntary but nearly all GP practices in the country participate.

## **Information Technology**

The organization of provider payment to improve accountability for a defined panel of patients and ensure accessibility to appropriate care 24/7 is further strengthened with the use of modern information technology. Over 90 percent of primary care physicians in countries such as the Netherlands, New Zealand, Norway, and the U.K. have electronic patient medical records.

Denmark has led the way over the last decade in developing an information system that puts patient information quickly in the hands of physicians and nurses caring for a patient.<sup>14</sup> Use of electronic health information systems by primary care physicians is required (with the minor exception of general practice physicians nearing retirement). The Danish government funds an information portal where all patient information is stored under the patient's ID number. Specialists are not paid for consultations until their reports have been filed in the system. Medications are prescribed electronically, and a reference pricing system which pays the price of the lowest cost drug for treating a given condition is updated automatically every two weeks – so that physicians, pharmacists, and patients always know the price of the lowest cost drug and can avoid paying extra for a more costly but no more effective alternative medication. Hospital discharge letters are filed in the system within 48 hours of discharge. All lab and imaging reports are included in the system. Patients can access their own medical records, and can

check who has accessed their records. Physicians and other health personnel accessing the record note that they have received the patient's permission, or indicate the reason why permission was not obtained in advance. Physicians providing off-hours care, including telephone consultations, have access to the medical record, and e-mail the patient's responsible primary care physician about care rendered during off-hours.

## **Key Payment Reform Provisions of the Affordable Care Act**

Payment reform provisions of the Affordable Care Act (ACA) should help accelerate movement toward a high performance health system.<sup>15</sup> The most important of these include:

*Incentivizing Primary Care and Prevention.* The ACA includes provisions to increase primary care payment rates in Medicare and Medicaid, cover effective preventive services without patient cost-sharing, and support community- and employer-based prevention and wellness programs. The ACA establishes the Prevention and Public Health Trust Fund and increases funding for federally qualified community health centers and the National Health Service Corps, expanding access to basic health care services for some of the nation's most vulnerable and underserved communities. These provisions could begin to reorient our health system toward prevention and primary care and away from specialty care, counter the impending shortage of primary care providers, and lay the groundwork for more fundamental payment reforms.

*Stimulating Innovative Provider Payment Reform.* The new health reform law establishes the Center for Medicare and Medicaid Innovation, which has broad authority to test innovative payment methods. At least 17 innovative pilot programs are specified, with the most important ones launched to date including:

- The Comprehensive Primary Care Initiative
- Hospital and Post-Hospital Acute Care Bundled Payment
- Pioneer Accountable Care Organizations

The ACA also allows states to test and evaluate the complete integration of Medicare- and Medicaid-covered health services provided to “dual eligibles”—the low-income elderly and disabled persons covered by both programs—thereby permitting greater coordination of acute and long-term care services. It also permits states to test and evaluate systems of all-payer payment reform that encompass private insurers and Medicaid.

*Utilizing Value-Based Purchasing.* Beginning in October 2012, hospitals meeting certain performance standards will become eligible for value-based incentive payments. Medicare payments to hospitals are reduced to account for preventable hospital readmissions. And beginning in January 2015, the Centers for Medicare and Medicaid Services (CMS) will begin using the Medicare fee schedule to give larger payments to physicians who provide high-quality care relative to cost. Further, the ACA includes provisions that reduce payment for hospital-acquired conditions, and the new Partnership for Patients initiative is engaging hospitals and other organizations in a national campaign to improve the safety and coordination of care.

*Creating Accountable Care Organizations.* The ACA creates a national, voluntary shared savings Medicare program for accountable care organizations (ACOs). ACOs are a collection of health care providers that formally assume responsibility for the total cost and quality of health care given to a defined group of patients. They can share in savings if outlays for their patients are less than projected targets, contingent upon meeting a broad array of quality standards.

*Controlling Spending Growth: Independent Payment Advisory Board.* The Independent Payment Advisory Board (IPAB), which the ACA creates within the executive branch, has significant authority to identify areas of waste and opportunities for improving quality of care for Medicare beneficiaries. The IPAB payment recommendations will take effect in years when Medicare spending is projected to exceed predetermined targets (currently set at gross domestic product per capita plus 1%) unless Congress passes legislation to override those recommendations—

in which case Congress would be responsible for achieving the same level of savings. The IPAB will also make recommendations for improving quality of care and slowing excess cost growth in the private sector. Controversy over this provision, and the requirement that members be confirmed by a politically divided Senate, have slowed implementation.

*Promoting Quality Improvement and Public Reporting.* Under the ACA, the HHS secretary is tasked with developing a national strategy to improve health care quality and establishing an interagency working group to coordinate and streamline federal quality activities. The law requires public reporting of physician quality and patient experience measures through the “Physician Compare” Web site for Medicare beneficiaries. It also provides for making Medicare data, with privacy protection for beneficiaries, available for pooling with other payer data on provider performance, an important step toward creation of an all-payer database for profiling provider performance. The law also includes a set of quality improvement reporting requirements for health insurance plans offered inside and outside the exchanges. Activities to be reported include: improving health outcomes through care coordination and medical home models; preventing hospital readmissions through a comprehensive program for hospital discharge; and implementing activities to improve patient safety, reduce medical errors, and promote health and wellness. The U.S. Secretary of Health and Human Services (HHS) will make reports by health plans available to the public.

*Patient-Centered Outcomes Research Institute.* Funding for establishment of the Patient-Centered Outcomes Research Institute was included in the ACA, with a mandate to fund and disseminate results of comparative effectiveness research.

*Health Information Technology.* The American Recovery and Reinvestment Act (ARRA), signed into law by President Obama in February 2009, provides significant financial incentives for hospitals and physicians to adopt and demonstrate “meaningful use” of health information technology. These investments facilitate the quality improvement and public reporting activities included in the ACA. Seventeen billion dollars have been allocated toward incentive payments

to physicians and hospitals paid through CMS and individual state Medicaid programs. To qualify for these incentive payments, physicians must attest to meeting a series of criteria. As of May 2012, more than 227,000 physicians had registered for the meaningful-use program and approximately 82,000 had received slightly more than \$1.5 billion in incentive payments.

*Independent Payment Advisory Board.* Authorization for an Independent Payment Advisory Board (IPAB) within the executive branch with significant authority to make recommendations on payment for services to ensure spending does not exceed a target rate of increase. This 15-person panel of experts would be charged with identifying areas of overpayment and ineffective care. Recommendations would become law, unless alternative measures achieving comparable savings were enacted into law.

## **Conclusion**

Policymakers need to continue to implement and build on the Affordable Care Act by incorporating lessons from abroad as well as the evidence generated from the significant testing underway at CMMI. Continuing to support the adoption of health information technology and the creation of health information exchanges are also important priorities—well-functioning and widespread health information technology in the United States will ensure physicians have access to important patient information as well as clinical decision support tools that promote the delivery of evidence-based medicine. Aligning physician interests with those of hospitals, negotiating prices for drugs, devices, and physician-hospital services, and employing multi-payer payment models that magnify the effects of policies across different payers are all additional steps that leaders can take to create the incentives and capacity for all health care providers to achieve the triple aim, match the gains in health achieved by our international peers, and usher in a new era in American health care.

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# The Role of Primary Care in the Affordable Care Act's Implementation: Expanding Access, Quality, and Affordability

David Satcher, MD, PhD  
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For the Satcher Health Leadership Institute, the future of the Affordable Care Act is a major concern. Our mission is to develop a diverse group of exceptional health leaders, advance and support comprehensive health system strategies, and actively promote policies and practices that will reduce and ultimately eliminate disparities in health. We see the Affordable Care Act as the most significant development since the setting of the goal of eliminating disparities in health in January 2000. It has the potential to positively impact access to care, quality of care, and especially prevention and preventive services.

The first official report on primary care or the primary provider was issued in 1966 by the Millis Committee and it was entitled, The Millis Report. In that report, the primary provider was defined as “one who provided first contact care for the undifferentiated patient, comprehensive care responding to most of the health care needs of patients, continuity of relationships between providers and patients over the years, and coordinated care- especially for chronic diseases needing care within the various levels of specialty”. This definition of primary provider would set the stage for the development of primary care training programs; including family practice, general internal medicine, and general pediatrics. For many years, medical students pursued careers in these primary care areas.

However, in recent years, primary care in the United States has declined significantly, especially when compared to the picture in other developed countries- primarily because of declining incentives. Because

our system of care has rewarded procedures and volume of care as oppose to value in care and the cognitive aspects of care, the number of medical students pursuing careers in primary care has dramatically declined. Medical students in most medical schools have been exposed to faculty role models who were overwhelmingly specialists. When they were exposed to primary care providers, they saw and heard of their struggles. That decline has dropped below 1,000 students a year in 2008 and is showing some tendency for increase in 2012. There are major concerns that as we face the future of the Affordable Care Act, we also face a major shortage of primary care physicians. It is projected that by 2015 that shortage could be as high as 30,000. Thus, there is major concern about the future of primary care and its impact on the Affordable Care Act.

But the Affordable Care Act attempts to promote primary care by changing incentives in the health systems, from one based on procedure or volume to one based on the value and outcome of care. The Affordable Care Act also provides incentives for preventive services and incentivizes an increase in the number of primary care providers by rewarding residency programs that contribute to this goal. This commitment on the part of the Affordable Care Act is in part in recognition of the fact that countries that have a higher percentage of primary care providers tend to have better patient outcomes. While less than 1/3 of providers in this country are primary care providers, in most developed countries over 2/3's of the providers are primary care providers and those countries have better health outcomes. Even in this country the Institute for Health Improvement (IHI) has demonstrated that in communities with a higher concentration of primary care providers as opposed to more specialty services, there are better health outcomes. So it is understandable that the Affordable Care Act would choose to incentivize primary care as we seek to improve the quality of outcome at lower cost.

The Affordable Care Act attempts to incentivize primary care in several ways. First, it increases Medicaid payments in fee for service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) to 100% of the Medicare payment rates for 2013-2014. States will receive

100% Federal financing for the increased payment rates. This is effective January 1, 2013. It will also provide a 10% bonus payment to primary care physicians in Medicare from 2011-2015. This is effective for 5 years, beginning January 1, 2011. So, in many ways the Affordable Care Act attempts to provide incentives and support for those involved in primary care practice.

The Affordable Care Act also seeks to establish a national preventive program entitled, The National Prevention Agenda. The National Prevention Agenda, which was developed by the Surgeon General in conjunction with a council representing all of the agencies of the Federal government, not just the Department of Health and Human Services. These agencies, including Education, Commerce, Justice, and others, met and agreed on strategies for incorporating the social determinants of health in our plans for improving the health of the American people. In short, in many of these areas an assessment was made of the potential health impact of policies & policy changes and based on that the proposal was put forward. The Prevention Agenda funds communities to establish prevention programs and it sets aside funds for research in the area of enhancing prevention and preventive services. Separate from the Prevention Agenda, primary care providers are incentivized to provide preventive services, such as hypertension and breast cancer screening with no cost sharing, with the understanding that this would be funded by Federal funds.

The Affordable Care Act strongly supports the development of wellness programs based on the models of success that have been established in industry. Thus, the Affordable Care Act supports the development of wellness programs in industry and in other settings with the understanding of the potential for this to improve health and health outcomes. This also includes some support for community transformation, removing barriers to healthy behavior- such as the absence of sidewalks or parks and grocery stores, along with fresh fruits and vegetables.

The recent Supreme Court's decision, while upholding the key components of the Affordable Care Act, also placed in some jeopardy the future of that component of the Affordable Care Act dealing with the expansion of Medicaid. This expansion of Medicaid is really critical to the goal of eliminating disparities in health. Disparities in access to health care based on disparities in insurance coverage, has long been a major component of the problem of disparities in health outcomes. So, if states elect not to expand their Medicaid program, it means that many people will be left out. For example, in Georgia over 600,000 people would gain access to coverage or care through the Affordable Care Act if Medicaid is expanded as proposed in that Act. But the governor of Georgia has threatened the expansion of Medicaid, as have other state leaders. Such behavior could exacerbate disparities in health.

Therefore, while the Affordable Care Act significantly incentivizes the expansion and enhancements of primary care as well as prevention services and the Prevention Agenda, recent changes brought on by the Supreme Court's decision could place in jeopardy some of the most important aspects of the Affordable Care Act relative to the goal of eliminating disparities in health.

But it is clear that the ACA seeks to advance our health system by changing incentives to achieve desired outcome. There are major incentives for states to expand their Medicaid program. 100% of that expansion will be funded by the federal government over the next two years, and after that 90%. So, seemingly the rewards for expanding Medicaid should outweigh other concerns that some states have expressed. This is one of the critical issues related to our moving forward.

So, while the future of The Affordable Care Act is not assured, it represents the most significant policy change in health and healthcare in this country since the enactment of Medicaid and Medicare almost half a century ago. It has already created momentum toward health and healthcare behavior change that will be difficult to turn back. So, we are optimistic.

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The Patient Protection and Affordable Care Act, March 23, 2010

The National Residency Matching Program

# The 2012 Presidential Election & The Affordable Care Act

Henry J. Aaron, PhD, The Brookings Institution

I. The first presidential debate is over—it made clear that this is going to be a very close election and the outcome is uncertain.

A. But when I say uncertain, I don't mean that we don't know which of two possible candidates will win

B. I mean that there are multiple possible outcomes which are interrelated but distinct

1. First and most obviously, Governor Romney or President Obama may win the White House—two possibilities

2. Second, the Democrats may retain or Republicans may win control of the Senate—two more possibilities—2 times 2 is 4

3. Next, Republicans may maintain their majority in the House, see it erode, or, conceivably if improbably, the House could go Democratic

4. Finally, what for short I will call the Tea Party faction of the Republican party could maintain or even enhance its strength or see its numbers and clout seriously eroded

C. All four of those dimensions, each with at least two broad possible outcomes, is relevant to the environment within which health policy will be made

—2 times 2 times 3 times 2 is 24—twenty-four possible electoral outcomes that are relevant to what form health

policy will take in the next two or four years;  
—while some combinations are close to unthinkable—a Romney presidency with a Democratic House, for example—  
but there are a lot more than two possible outcomes to think about

II. So, what I want to do is take a couple of those possible outcomes and speculate on what form health policy might take in each of them

If you are interested in doing so, during question period, we can go into other combinations than those I am going to mention

III. Let's start with full-blown Republican control—the White House and both houses of Congress

1. Governor Romney has promised in no uncertain terms to seek repeal of the whole Affordable Care Act; Vice-presidential candidate Ryan and most of House Republicans are there to make sure he sticks to his word.

2. All of them have pledged to seek to convert Medicaid into a block grant to the states and to convert Medicare into a voucher that the elderly and disabled could use to buy insurance

3. Even with a Republican sweep, there is little chance of getting sixty votes in for any of these actions in the Senate

4. In that event, there is one key word—RECONCILIATION, the procedure under which the Senate can by a simple majority vote—no filibusters allowed—make any changes necessary to bring Senate action in line with instructions to committees contained in a budget resolution

—the first step is a budget resolution instructing the various committees to report back legislation with certain broad characteristics; if they do, and they are passed by both houses, that is the end of the story.

But that takes 60 votes in the Senate. If they don't pass, a single bill can accomplish what the budget resolution set out to do.

5. Through reconciliation it is possible to repeal everything in The Affordable Care Act that affects the budget by spending money or collecting taxes; one can convert Medicaid into a block grant, and once convert Medicare into a voucher program

6. If there is a Republican sweep, I would fully expect that a president Romney, Speaker Boehner and Majority Leader McConnell to interpret the election as a mandate and try very hard to do all three of these things.

7. There is no guarantee they would succeed; there are all sorts of obstacles,

—one of them is that president Romney, or enough members of Congress, might not want only to appear to make those changes

—after all, the problems of declining insurance coverage and rising health costs are not going away by themselves

—on the 'if you break it, you own it' principle, if a president Romney wins repeal of the Affordable Care Act, the number of uninsured continues to grow and health costs continue to gobble up more and more of the federal budget and national income, he will be held responsible

— but the stage would be set for a fundamental shift in governing philosophy, rolling back or changing in fundamental ways all of the major federal legislation affecting health care

IV. Next, let's assume that President Obama wins reelection, the Senate stays Democratic, and the Republicans retain control of the House with a reduced majority, but Tea Party influence increases because moderate Republicans in swing states

A. Implementation of the Affordable Care Act will proceed. But the roll-out of the program will be messy, fraught with screw-ups, and a backlash is quite possible.

B. States will gradually and in some cases grudgingly fall into line, especially on the Medicaid extension, as refusing that extension is simply an unsustainable position—we'll pay taxes to cover Medicaid extensions in other states, but we won't take 90 to 100 cents on the dollar

C. Voucherizing Medicare and block-granting Medicaid will go nowhere, although there will be spending cuts in both programs

D. Then we come to the messy cases

—a Romney presidency with a Democratic Senate; would the Romney who governed Massachusetts, rather than the Romney that won the Republican nomination reemerge? Would Congressional Republicans allow it?

—an Obama presidency with a Republican Senate and a House as conservative and as Tea Party dominated as the current one

V. Shadowing the debate on these substantive legislative issues will be the confluence of the multiple fiscal events that have come to be called the fiscal cliff, all taking place on or just after New Years Day, 2013

—including expiration of the Bush tax cuts, expiration of the Obama payroll tax cuts, the decrease in physicians salaries under

Medicare of approximately 30 percent, two sets of spending cuts enacted in 2011, and the need once again to boost the debt ceiling

—the consequences of failure to delay the expiration of at least some of the tax cuts and the implementation of at least some of the spending cuts and an increase in the debt ceiling and suspension of the cuts in physician fees under Medicare would be recession, a possible financial panic, and a lot of very angry Medicare beneficiaries

—who is president and who is in control of Congress will profoundly shape how these multiple legislative challenges are met.

VI. So I want to leave you with the following thought: this election is about whether to sustain or to roll back key elements of the social insurance legislation enacted during the middle third of the 20<sup>th</sup> century as well as the recently enacted health reform legislation

—that includes Medicare and Medicaid; it might even include Social Security; it includes tax policy; in fact, it includes everything that the government does

—that is why I believe that those who have described this election as the most important in living memory are speaking the simple truth.

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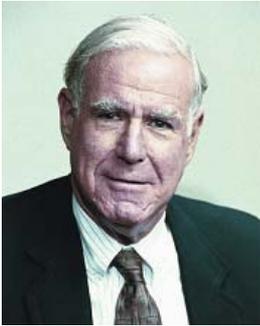
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# The Affordable Care Act in Context

## *Brief Bios*

HENRY J. AARON, Ph.D.

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**Henry J. Aaron, Ph.D.**, is currently the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies program at the Brookings Institution. From 1990 through 1996 he was the director of the Economic Studies program.

He initially joined the Brookings staff in 1968. From 1967 until 1989 he also taught at the University of Maryland. In 1977 and 1978 he served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. He chaired the 1979 Advisory Council on Social Security. During the academic year 1996-97, he was a Guggenheim Fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford University.

He is a graduate of U.C.L.A and holds a Ph.D. in economics from Harvard University.

He is a member of the Institute of Medicine, the American Academy of Arts and Sciences, the advisory committee of the Stanford Institute for Economic Policy Research, and the visiting committee of the Harvard Medical School. He is a member of the board of directors of Abt Associates and the Center on Budget and Policy Priorities. He was a founding member, vice president, and chair of the board of the National Academy of Social Insurance. He has been vice president and member of the executive committee of the American Economic Association and was president of the Association of Public Policy and Management. He

has been a member of the boards of directors of the College Retirement Equity Fund and Georgetown University.

His publications include: *Reforming Medicare: Options, Tradeoffs, and Opportunities* (co-authored with Jeanne M. Lambrew); *Taxing Capital Income: Do We? Should We? Can We?* (coedited with Leonard Burman and Eugene Steuerle); *Can We Say No: The Challenge of Health Care Rationing* (with Melissa Cox); *Coping With Metbuselah: The Impact of Molecular Biology on Medicine and Society*, (co-edited with William Schwartz); *Agenda for the Nation* (coedited with James Lindsay and Pietro Nivola); *Crisis in Tax Administration* (co-edited with Joel Slemrod); *The Plight of Academic Medical Centers*; *Countdown to Reform: The Great Social Security Debate* (with Robert Reischauer); and *Setting National Priorities: The Year 2000 and Beyond*, which he co-edited. Other books include *The Painful Prescription: Rationing Hospital Care* (co-authored with William Schwartz); *Can America Afford to Grow Old?*, (co-authored with Barry Bosworth); *Serious and Unstable Condition: Financing America's Health Care*; *Economic Effects of Fundamental Tax Reform* (co-edited, with William Gale); and *Behavioral Aspects of Retirement Economics* (editor).

## KAREN DAVIS, Ph.D.

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**Karen Davis, Ph.D.**, is president of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues. Dr. Davis has had a distinguished career in public policy and research. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins School of Public Health, where she was also a professor of economics.

The first woman to head a US Public Health Service agency, she served as deputy assistant secretary for health policy in the US Department of Health and Human Services from 1977-1980. Prior to that, she was a senior fellow at the Brookings Institution, a visiting scholar at Harvard University, and an assistant professor of economics at Rice University.

She has written extensively on health and social policy issues, including the books Health and the War on Poverty: A Ten Year Appraisal, and National Health Insurance: Benefits, Costs, and Consequences. Dr. Davis received the Baxter Health Services Research Award in 2000, the Academy Health Distinguished Investigator Award and the Picker Award for Excellence in the Advancement of Patient Centered Care in 2006. She has been awarded honorary doctorates from Johns Hopkins University, the University of Maryland Baltimore and Newcastle University in the United Kingdom.

She is on the Board of Directors of the Geisinger Health System and Health Plan, an Academy Health distinguished fellow, and a member of the Kaiser Commission on Medicaid and the Uninsured. She was elected a fellow of the American Academy of Arts and Sciences in 2009 and an honorary fellow of the Royal College of Physicians in 2011.

## HARVEY V. FINEBERG, M.D., Ph.D.

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**Harvey V. Fineberg, M.D., Ph.D.**, is President of the Institute of Medicine. He served as Provost of Harvard University from 1997 to 2001, following thirteen years as Dean of the Harvard School of Public Health. He has devoted most of his academic career to the fields of health policy and medical decision making. His past research has focused on the process of policy development and implementation, assessment of medical technology, evaluation and use of vaccines, and dissemination of medical innovations.

Dr. Fineberg helped found and served as president of the Society for Medical Decision Making and has been a consultant to the World Health Organization. At the Institute of Medicine, he has chaired and served on a number of panels dealing with health policy issues, ranging from AIDS to new medical technology. He also served as a member of the Public Health Council of Massachusetts (1976-1979), as chairman of the Health Care Technology Study Section of the National Center for Health Services Research (1982-1985), and as president of the Association of Schools of Public Health (1995-1996).

Dr. Fineberg is co-author of the books *Clinical Decision Analysis*, *Innovators in Physician Education*, and *The Epidemic that Never Was*, an analysis of the controversial federal immunization program against swine flu in 1976. He has co-edited several books on such diverse topics as AIDS prevention, vaccine safety, and understanding risk in society. He has also authored numerous articles published in professional journals. Dr. Fineberg is the recipient of several honorary degrees and the Stephen Smith Medal for Distinguished Contributions in Public Health from the New York Academy of Medicine. He earned his bachelor's and doctoral degrees from Harvard University.

## DAVID SATCHER, M.D., Ph.D.

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**David Satcher, MD, Ph.D.**, is Director of The Satcher Health Leadership Institute which was established in 2006 at the Morehouse School of Medicine in Atlanta, Georgia. The mission of the Institute is to develop a diverse group of public health leaders, foster and support leadership strategies, and influence policies toward the reduction and ultimate elimination of disparities in health. The Institute's programs reflect Dr. Satcher's experience in improving public health policy and his commitment to eliminating health disparities for underserved groups, such as minorities and the poor and shedding light on neglected issues, such as mental and sexual health.

Dr. Satcher was sworn in as the 16<sup>th</sup> Surgeon General of the United States in 1998-2002. He also served as Assistant Secretary for Health in the Department of Health and Human Services making him only the second person in history to have held both positions simultaneously. His tenure of public service also includes serving as Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Toxic Substances and Disease Registry from 1993 to 1998. He was the first person to have served as Director of the CDC and Surgeon General of the United States.

Dr. Satcher has held top leadership positions at the Charles R. Drew University for Medicine and Science, Meharry Medical College, and the Morehouse School of Medicine. He has been a Macy Foundation Fellow, Robert Wood Johnson Foundation Clinical Scholar, and a Senior Visiting Fellow of the Kaiser Family Foundation.

Dr. Satcher held the position of Director of the new National Center for Primary Care (NCPC) at the Morehouse School of Medicine from 2002 to 2004. He presently occupies the Poussaint-Satcher-Cosby

Chair in Mental Health at the Morehouse School of Medicine. This recognizes his long commitment to removing the stigma attached to mental illness, as evidenced by *Mental Health: A Report of the Surgeon General*, the first surgeon general's report on mental health released during his tenure as surgeon general. As Surgeon General and Assistant Secretary for Health, Dr. Satcher led the department's effort to eliminate racial and ethnic disparities in health, an initiative that was incorporated as one of the two major goals of *Healthy People 2010*.

Dr. Satcher has received over 40 honorary degrees and numerous distinguished honors including top awards from the National Medical Association, the American Medical Association, the American Academy of Family Physicians, the Ronald Davis Special Recognition Award from the American College of Preventive Medicine and the Symbol of H.O.P.E. Award for health promotion and disease prevention. In 2005, he was appointed to serve on the World Health Organization Commission on Social Determinants of Health.

Presently, Dr. Satcher serves on the Board of Directors of Johnson and Johnson, MetLife, and the CDC Foundation. He also serves locally on the board of United Way of Greater Atlanta and The Community Foundation for Greater Atlanta.

Dr. Satcher graduated from Morehouse College in Atlanta, Georgia in 1963 and is a member of Phi Beta Kappa. He holds MD and PhD degrees from Case Western Reserve University in Cleveland, Ohio. He is a member of Alpha Omega Alpha Honor Society and a Fellow of the American Academy of Family Physicians, the American College of Preventive Medicine and the American College of Physicians. He is a member of the Institute of Medicine, National Academy of Sciences, the 100 Black Men of Atlanta and the American Academy of Arts and Sciences.

A proponent of healthy lifestyles through physical activity and good nutrition, Dr. Satcher is an avid runner, rower, and gardener.



**Eliot Sorel, M.D., D.L.F.A.P.A.**, is an internationally recognized global health leader, educator, health systems policy expert and practicing physician. Dr. Sorel is a member of the Oversight Committee on US Health Disparities of the Trans-disciplinary Collaborative Center at the Satcher Health Leadership Institute and co-chairs the World Psychiatric Association's

*Task Force on non-communicable diseases and integrated care*. He is a member of the Board of Trustees Work Group on American Health Reform and of the Council on Healthcare Systems and Financing, both of the American Psychiatric Association. He has *professorial appointments in Global Health, Health Services Management and Leadership in the School of Public Health* as well as in *Psychiatry and Behavioral Sciences in the School of Medicine at George Washington University*. Dr. Sorel is the Founder of the Conflict Management & Conflict Resolution Section of the World Psychiatric Association, the World Youth Democracy Forum at the Elliott School of International Affairs of the George Washington University, the Cosmos Club Health Group and the Career, Leadership and Mentorship program of the Washington Psychiatric Society.

Dr. Sorel is a former President of the Medical Society of the District of Columbia, the World Association for Social Psychiatry, the Washington Psychiatric Society and has served as a United States National Institutes of Health/Fogarty International Center grants reviewer. He is a Life Member of the American Medical Association, a Fellow of the American College of Psychiatrists, and a Distinguished Life Fellow of the American Psychiatric Association. He did his psychiatric training at Yale University, obtained his B.A. from New York University, and M.D. from the State University of New York. He has developed and led health systems in North America and the Caribbean, has consulted and taught in more than twenty countries in Africa, Asia, Europe and the Americas. Dr. Sorel is the author of more than sixty scientific papers and book chapters and

the editor of seven books. His most recent books are, *The Marshall Plan: Lessons Learned for the 21st Century*, accessible at [www.oecd.org](http://www.oecd.org) and *21st Century Global Mental Health* accessible at [www.jblearning.com](http://www.jblearning.com).

In August 2013, Dr. Sorel presented the UNESCO Summer Academy lecture on 21st Century Trans-disciplinary Challenges & Opportunities, delivered virtually from the GWU campus in Washington to the Atlantykrón program on the Danube in Romania. In April 2013, he cochaired the Scientific Committee of the WPA 2013 Bucharest Congress on *strengthening health systems for southeast Europe and Eurasia via the integration of primary care, mental health and public health*, accessible at [www.wpa2013bucharest.org](http://www.wpa2013bucharest.org). In July 2010, Dr. Sorel convened the *Black Sea & Caspian Sea Area Studies Network*, a Euro Atlantic, universities partnership that developed the *Bucharest Consensus on Higher Education, Innovation & Development*. In June 2008, he participated as PAHO/WHO advisor, in the *WHO Europe Health & Finance Ministers' meeting on Health Systems, Health & Wealth* in Tallinn, Estonia, that ratified the *Tallinn Charter*. In 2007 Dr. Sorel was a PAHO/WHO advisor to *Renewing Primary Care and Health Systems in the Americas* conference in Buenos Aires, Argentina.

In October 2009, Dr. Sorel was awarded the *Doctor Honoris Causa* by *Carol Davila* Medical University in Bucharest, Romania. The President of Romania awarded Dr. Sorel the *Star of Romania Order of Commander* in 2004.

## APPENDIX I\*

### Key Features of the Affordable Care Act By Year

On March 23, 2010, President Obama signed the Affordable Care Act. The law puts in place comprehensive health insurance reforms that will roll out over four years and beyond. Use the links below to learn about what's changing and when:

#### OVERVIEW OF THE HEALTH CARE LAW

**2010:** A new [Patient's Bill of Rights](#) goes into effect, protecting consumers from the worst abuses of the insurance industry. Cost-free [preventive services](#) begin for many Americans.

[See More 2010 Changes.](#)

**2011:** People with Medicare can get [key preventive services for free](#), and also receive a [50% discount on brand-name drugs](#) in the Medicare "donut hole."

[See More 2011 Changes.](#)

**2012:** Accountable Care Organizations and other programs help doctors and health care providers work together to deliver better care.

[See More 2012 Changes.](#)

**2013:** Open enrollment in the Health Insurance Marketplace begins on October 1st.

[See More 2013 Changes.](#)

**2014:** All Americans will have access to affordable health insurance options. The Marketplace will allow individuals and small businesses to compare health plans on a level playing field. Middle and low-income families will get tax credits that cover a significant portion of the cost of coverage. And the Medicaid program will be expanded to cover more low-income Americans. All together, these reforms mean that millions of people who were previously uninsured will gain coverage, thanks to the Affordable Care Act.

[See More 2014 Changes.](#)

\*Source, [www.hhs.gov](http://www.hhs.gov)

## 2010

### NEW CONSUMER PROTECTIONS

- **Putting Information for Consumers Online.** The law provides for where consumers can compare health insurance coverage options and pick the coverage that works for them. *Effective July 1, 2010.*
- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.** The health care law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition. *Effective for health plan years beginning on or after September 23, 2010 for new plans and existing group plans.*
- **Prohibiting Insurance Companies from Rescinding Coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when he or she got sick. The health care law makes this illegal. After media reports cited incidents of breast cancer patients losing coverage, insurance companies agreed to end this practice immediately. *Effective for health plan years beginning on or after September 23, 2010.*
- **Eliminating Lifetime Limits on Insurance Coverage.** Under the law, insurance companies will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays. *Effective for health plan years beginning on or after September 23, 2010.*

**Regulating Annual Limits on Insurance Coverage.** Under the law, insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans. *Effective for health plan years beginning on or after September 23, 2010.*
- **Appealing Insurance Company Decisions.** The law provides consumers with a way to appeal coverage determinations or claims to their insurance company, and establishes an external review process. *Effective for new plans beginning on or after September 23, 2010.*
- **Establishing Consumer Assistance Programs in the States.** Under the law, states that apply receive federal grants to help set up or expand

independent offices to help consumers navigate the private health insurance system. These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies. The programs will also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight. *Grants Awarded October 2010.*

## IMPROVING QUALITY AND LOWERING COSTS

- **Providing Small Business Health Insurance Tax Credits.** Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit. *Effective now.* Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole." An estimated four million seniors will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. Each eligible senior will receive a one-time, tax free \$250 rebate check. *First checks mailed in June, 2010, and will continue monthly throughout 2010 as seniors hit the coverage gap. Learn more about the "donut hole" and Medicare.*
- **Providing Free Preventive Care.** All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. *Effective for health plan years beginning on or after September 23, 2010. Learn more about preventive care benefits. See the full list of covered preventive services.*
- **Preventing Disease and Illness.** A new \$15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity. *Funding begins in 2010. See prevention funding and grants in your state.*
- **Cracking Down on Health Care Fraud.** Current efforts to fight fraud have returned more than \$2.5 billion to the Medicare Trust

Fund in fiscal year 2009 alone. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and CHIP *Many provisions effective now.*

## INCREASING ACCESS TO AFFORDABLE CARE

- **Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions.** The Pre-Existing Condition Insurance Plan provides new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of running this program in their state. If a state chooses not to do so, a plan will be established by the Department of Health and Human Services in that state. *National program effective July 1, 2010.*
- **Extending Coverage for Young Adults.** Under the law, young adults will be allowed to stay on their parents' plan until they turn 26 years old (in the case of existing group health plans, this right does not apply if the young adult is offered insurance at work). Check with your insurance company or employer to see if you qualify. *Effective for health plan years beginning on or after September 23.*
- **Expanding Coverage for Early Retirees.** Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of high rates in the individual market. To preserve employer coverage for early retirees until more affordable coverage is available through the new Exchanges by 2014, the new law creates a \$5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. *Applications for employers to participate in the program available June 1, 2010.* **For more information on the Early Retiree Reinsurance Program, visit [www.ERRPgov](http://www.ERRPgov).**
- **Rebuilding the Primary Care Workforce.** To strengthen the availability of primary care, there are new incentives in the law to expand the number of primary care doctors, nurses and physician assistants. These include funding for scholarships and loan

repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses receiving payments made under any state loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments. *Effective 2010.*

- **Holding Insurance Companies Accountable for Unreasonable Rate Hikes.** The law allows states that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for \$250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014. *Grants awarded beginning in 2010.*
- **Allowing States to Cover More People on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents. *Effective April 1, 2010.*
- **Increasing Payments for Rural Health Care Providers.** Today, 68% of medically underserved communities across the nation are in rural areas. These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities. *Effective 2010.*
- **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country. *Effective 2010.*

## 2011

### IMPROVING QUALITY AND LOWERING COSTS

- **Offering Prescription Drug Discounts.** Seniors who reach the coverage gap will receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years,

seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020. *Effective January 1, 2011.* [Download a brochure to learn more \(PDF - 1 MB\)](#)

- **Providing Free Preventive Care for Seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. *Effective January 1, 2011.* [Learn more about preventive services under Medicare.](#)
- **Improving Health Care Quality and Efficiency.** The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. These methods are expected to improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Additionally, by January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including by these programs. *Effective no later than January 1, 2011.* [Learn more about the Center for Medicare & Medicaid Innovation.](#)
- **Improving Care for Seniors After They Leave the Hospital.** The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities. *Effective January 1, 2011.*

**Introducing New Innovations to Bring Down Costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care. *Administrative funding becomes available October 1, 2011.* [Learn more about strengthening Medicare.](#)

## INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Services at Home and in the Community.** The Community First Choice Option allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes. *Effective beginning October 1, 2011.*

## HOLDING INSURANCE COMPANIES ACCOUNTABLE

- **Bringing Down Health Care Premiums.** To ensure premium dollars are spent primarily on health care, the law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers. *Effective January 1, 2011.*
- **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over \$1,000 more per person on average than is spent per person in Traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care. *Effective January 1, 2011.*  
[Learn more about Medicare and the Affordable Care Act.](#)

## 2012

### IMPROVING QUALITY AND LOWERING COSTS

- **Linking Payment to Quality Outcomes.** The law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. *Effective for payments for discharges occurring on or after October 1, 2012.*
- **Encouraging Integrated Health Systems.** The new law provides incentives for physicians to join together to form "Accountable Care

Organizations.” These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. *Effective January 1, 2012.*

- **Reducing Paperwork and Administrative Costs.** Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care. *First regulation effective October 1, 2012.*
- **Understanding and Fighting Health Disparities.** To help understand and reduce persistent health disparities, the law requires any ongoing or new federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities. *Effective March 2012.*

## INCREASING ACCESS TO AFFORDABLE CARE

- **Providing New, Voluntary Options for Long-Term Care Insurance.** The law creates a voluntary long-term care insurance program – called CLASS -- to provide cash benefits to adults who become disabled. Note: On October 14, 2011, Secretary Sebelius transmitted a report and letter to Congress stating that the Department does not see a viable path forward for CLASS implementation at this time. View a [copy of the CLASS report](#).

## 2013

### IMPROVING QUALITY AND LOWERING COSTS

- **Improving Preventive Health Coverage.** To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or

no cost. *Effective January 1, 2013.* [Learn more about the law and preventive care.](#)

- **Expanding Authority to Bundle Payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program. *Effective no later than January 1, 2013.*

## INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Medicaid Payments for Primary Care Doctors.** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. *Effective January 1, 2013.* [Learn how the law supports and strengthens primary care providers.](#)
- **Open Enrollment in the Health Insurance Marketplace Begins.** Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and [competitive insurance marketplace](#). *Effective October 1, 2013.*

## 2014

### NEW CONSUMER PROTECTIONS

- **Prohibiting Discrimination Due to Pre-Existing Conditions or Gender.** The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because

of an individual's pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status. *Effective January 1, 2014.* [Learn more about protecting Americans with pre-existing conditions.](#)

- **Eliminating Annual Limits on Insurance Coverage.** The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive. *Effective January 1, 2014.* [Learn how the law will phase out annual limits by 2014.](#)
- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases. *Effective January 1, 2014.*

## IMPROVING QUALITY AND LOWERING COSTS

- **Making Care More Affordable.** Tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. (In 2010, 400% of the poverty line comes out to about \$43,000 for an individual or \$88,000 for a family of four.) The tax credit is advanceable, so it can lower your premium payments each month, rather than making you wait for tax time. It's also refundable, so even moderate-income families can receive the full benefit of the credit. These individuals may also qualify for reduced cost-sharing (copayments, co-insurance, and deductibles). *Effective January 1, 2014.*
- **Establishing the Health Insurance Marketplace.** Starting in 2014 if your employer doesn't offer insurance, you will be able to buy it directly in the Health Insurance Marketplace. Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and competitive insurance marketplace. The Marketplace will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through the Marketplace, and you will be

able buy your insurance through Marketplace too. [Learn more about the Health Insurance Marketplace.](#) Increasing the Small Business Tax Credit. The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50% of the employer's contribution to provide health insurance for employees. There is also up to a 35% credit for small non-profit organizations. *Effective January 1, 2014.* [Learn more about the small business tax credit.](#)

## INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Medicaid.** Americans who earn less than 133% of the poverty level (approximately \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in subsequent years. *Effective January 1, 2014.*
- **Promoting Individual Responsibility.** Under the law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. *Effective January 1, 2014.*

## 2015

## IMPROVING QUALITY AND LOWERING COSTS

- **Paying Physicians Based on Value Not Volume.** A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care. *Effective January 1, 2015.*

*HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.*

## APPENDIX II

### *UN Resolution: Universal Healthcare December 2012*

US has backed a UN resolution on universal healthcare coverage  
(*nonbinding*).

The United Nations General Assembly in its December 2012 meeting adopted a Universal Healthcare Resolution encouraging member states to develop and implement universal healthcare access to all their citizens. It did so by emphasizing the following principles:

- health is necessary for international development,
- social protection supports sustainable, inclusive and equitable economies,
- universal health coverage is linked to foreign policy issues
- health is a fundamental right (WHO 1948, Universal Declaration of Human Rights).

For more details, please check the links below.

<http://www.un.org/News/Press/docs//2012/ga11326.doc.htm>

<http://thehill.com/blogs/healthwatch/public-global-health/272625-us-backs-un-measure-on-universal-health-coverage>







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