Medical Education and the Future of American Health Care: Policy Recommendations

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Executive Summary

“In just five years, the shortage of doctors in the United States will be almost 63,000, according to a report from the Association of American Medical Colleges Center for Workforce Studies. That number is expected to hit 130,600 by 2025.”

-DOTmed from the AAMC

This policy memo addresses the current and projected shortage of primary care health professionals in light of population dynamics and health care reform. We identified three different scenarios: worst, likely, and best, and made recommendations to encourage the “best” result. Those recommendations include:

1.) Lowering tuition or offering tuition reimbursements for those who enter primary care fields or practice in poor urban and rural communities
2.) The adaptation of electronic medical records and “medical home” style delivery of coordinated care
3.) Adopting a model of primary care in underserved areas that would effectively be a smaller medical home comprised of nurses, nurse practitioners, physicians, and others who manage care on a coordinated basis.
4.) Working with organizations such as the AMA and ANA to work with the Centers for Medicare and Medicaid Services (divisions of the Department of Health and Human Services) to increase health insurance primary care reimbursements and to make clearer, more logical distinctions about the scope of practice of different types of providers.
5.) A competitive grant model for primary care incentives similar to “Race to the Top” in PPACA where, essentially, the federal government could solicit proposals for reforms and projects from states and educational institutions and then evaluate these proposals based on a specific rubric. Even though the government would only be able to fund the top few applications, many states and schools would be committing to changing existing practices and implementing innovative new programming.

With specific, practical, evidence-based policy recommendations the primary care needs of Americans can be adequately met, but it will require a great deal of preemptive effort on behalf of medical educators, policymakers, and health care providers in order to provide quality care and better patient outcomes.

Introduction:

A Future-Oriented Approach to the New American Health Care System

In March 2010, President Barak Obama signed two monumental pieces of legislation into law: the Patient Protection and Affordable Care Act (PPACA) and the Health Care Education and Reconciliation Act of 2010. Together, these two bills promise to cover approximately 94% of the United States population. This would fundamentally change America’s health care system by increasing the access to and quality of care, as well as reducing health care costs to an already severely strained federal budget. As the laws take effect over the next several years, an estimated 32 million people will become newly insured and undoubtedly increase the demand for primary care services. With a large population of newly insured people, the health care system must be prepared to meet a sudden and voracious demand for primary care services beginning in 2014.

One critical piece of primary care delivery is increasing the number of trained health professionals and clinics that could offer the services needed for the newly insured. PPACA has several provisions increasing access to and availability of primary care and primary care providers. In 2010, PPACA initiated the following actions:

- Incentivizing primary care in underserved areas by providing payments to health care providers working in said areas
- Funding the development of community primary health centers that would give more than 20 million people access to care
- Increasing payments to rural health care providers, especially because approximately 68% of rural medical communities are underserved.

In future years, primary care incentives will continue to unfold: in 2013 PPACA mandates that primary care physicians are paid equally whether their patient is on Medicaid or Medicare, so providing care to lower income individuals does not result in a financial loss for the physician. Additionally, PPACA encourages health care providers to “join together” to create “Accountable Care Organizations” to increase the quality of care through a unified

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3 Sara R. Collins and Jennifer L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010* (The Commonwealth Fund, 2010), 12.
4 Indeed, the Congressional Budget Office (CBO) estimates that these bills will save approximately $143 billion between 2010 and 2019 “Congressional Budget Office - Health Care”, n.d., https://www.cbo.gov/publications/collections/health.cfm.
7 “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.” Ibid.
provider organization and also encourages moving away from paper patient records to electronic patient records. These are just a few of many provisions intended to fortify the primary care delivery system in the future. However, even in light of these provisions, the projections for the future of primary care delivery are bleak. With an estimated shortfall of primary care physicians of “about 35,000 to 44,000” by 2025 from the American College of Physicians and 260,000 nurses by 2025 according to the American Association of Colleges of Nursing, incentivizing primary care is critical to the success of the newly reformed system.

This project focuses on adaptations and improvements within the medical education system that might help meet major challenges with respect to the shortfall of primary care health professionals. After examining the shortage of primary care providers, this report will define three possible policy responses to the problem: a worst-case scenario, a likely scenario, and a best-case scenario. It will then offer recommendations for progressing from the “likely” outcome to the “best” one. Specific action items for stakeholder organizations and institutions are incorporated into these recommendations, as well as an Appendix for additional information for the inquisitive reader.

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8 Incentives will be enacted in 2012. Ibid.


10 “American Association of Colleges of Nursing | About”, n.d., http://www.aacn.nche.edu/media-relations/nursing-shortage-resources/about. Additionally, see this website for useful information and specific suggestions regarding initiatives taken to address the nursing shortage.
Background:

The Primary Care Shortage in America

Primary care provides patients with basic screenings and treatments, health education, and referrals to specialists in order to address more serious problems. A primary care provider is often and ideally the first contact for new any new health issue, and he or she is generally responsible for providing long-term, comprehensive, patient-focused care. As such, there are a number of trained health professionals — including physicians, nurse practitioners, and physician assistants — who are responsible for some aspect of primary care.

Approximately 32 million individuals are expected to gain health care coverage under PPACA. Of these people, approximately 30 percent are between the ages of 19 and 29, fairly healthy, and very cost-sensitive. Indeed, the PPACA legislation increases access to care particularly in his age group as it allows young adults to remain on their parents’ health insurance until age 26, expands Medicaid eligibility by allowing adults with 133 percent of the federal poverty level to qualify, and penalizes employers that offer no or poor coverage, among other provisions. Because this group is generally young and healthy, we imagine that many of their health care needs (physicals, vaccinations, etc.) would most appropriately addressed by primary care providers.

However, the strain on primary care will be tremendously felt as the “Baby Boomer” generation turned 65 in 2011, increasing the demand for senior health services. With that, PPACA also expands Medicare coverage by offering of preventive services for free and reducing the cost prescription drugs otherwise not covered by the “donut hole” gap in insurance.

Thus, it seems evident that there will be a greatly increased demand for primary care as a result of PPACA. However, there is already a shortage of primary care providers. In fact, even ignoring the sharp increase of newly-insured individuals after PPACA, this shortage is predicted to climb to approximately 40,000 primary care physicians between now and 2025. It will, of course, be even more staggering with more than 30 million new patients. According to the New York Times, “Primary care is expected to be one of the hardest-hit areas. Already stretched thin by the declining number of medical school graduates who choose to pursue family medicine, the American Academy of Family Physicians projects a shortage of 40,000 generalists by 2020, a group that includes family practitioners, general internists, geriatricians and general pediatricians.” Currently, PPACA raises Medicare reimbursement for primary care providers and offers incentives for students to pursue primary care through an increased number of residency slots and lower student loan interest rates. However, those efforts are insufficient to

11 Sara R. Collins and Nicholson, Rite of Passage: Young Adults and the Affordable Care Act of 2010.
12 Ibid., 4
16 Ibid.
17 Ibid.
address the complete problem of not only number of providers but also quality and coordination of care to yield better patient outcomes. The graph below illustrates the anticipated shortages.

Recently, medical students have demonstrated an increasing lack of interest in pursuing careers in primary care. Primary care physicians usually earn less money than their colleagues in more specialized fields of medicine. This means that primary care physicians are often forced to take on more patients (and, thus, work longer hours) in order to repay their student loans. As a result, even as the number of patients seeking primary care is increasing (particularly due to PPACA), the number of physicians seeking jobs in primary care is decreasing. Indeed, according to a recent USA Today article, “The number of U.S. medical school students going into primary care has dropped 51.8% since 1997, according to the American Academy of Family Physicians (AAFP).” The article continues, “The U.S. health care system has about 100,000 family physicians and will need 139,531 in 10 years. The current environment is attracting only half the number needed to meet the demand.” According to the article, “Medical school tuition and expenses generally range from $140,000 to $200,000, according to Merritt Hawkins & Associates, a leader in recruiting and placing physicians. A primary-care doctor usually makes $120,000 to $190,000 a year, compared with $530,000 and higher for those in neurosurgery, according to the Merritt Hawkins salary survey from 2007.”

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18 Ibid.
19 “Doctor shortage looms as primary care loses its pull - USATODAY.com.”
20 Ibid.
21 Ibid.
22 Ibid.
physicians ultimately leads to an increased number of patients using the emergency room as their clinic, thereby inefficiently using hospital resources and possibly worsening their health outcomes as they wait to be treated until their health is in a state of emergency.

The federal government is not blind to this problem. President Obama’s 2009 economic stimulus package included $500 million for health profession training programs. Of that, 60 percent of that sum was used to expand the National Health Service Corps (NHSC), which helps health care professionals to repay their student loans in exchange for working in primary care in Health Professional Shortage Areas (HPSAs). The NHSC also offers scholarships for individuals who commit to working in HPSAs. The funding it provides is substantial, usually totaling in the tens or hundreds of thousands of dollars for each aspiring medical practitioner who receives it. More importantly, it boasts remarkable results. There are currently 4,808 NHSC medical professionals working in underserved communities. Of these, 80 percent stay in HPSAs for longer than their initial commitment to the Corps. Indeed, 70 percent remain there for at least 5 years, and 50 percent stay for their entire careers. It has also been noted among scholars and professionals who are examining this issue that recruiting future doctors early in their educational careers from underserved areas also increases the likelihood that they will return to where they are from to practice medicine.

An additional way to increase the number of primary care providers is to enhance the availability and affordability of “ladder” programs for nurses. These programs would allow nurses without advanced degrees to partake in accelerated programs to attain a master’s or PhD level degree in nursing (the latter allows them to train new BSNs). Along with these programs, increasing the scope of practice for nurses will be critical in addressing the primary care needs of this newly insured population. Additionally, the USA Today article notes that the future of effective American health care delivery may be in the patient-centered medical home: “The medical home approach surfaced in the ’90s and delivers service that is supposed to be better-coordinated, family-centered and more accessible with expanded hours. Nurse practitioners and physicians assistants play bigger roles in office visits and relieve physicians of other time-consuming tasks so they can focus on the continuity of quality care. ‘Home’ implies continuous, preventive care rather than seeing the doctor only for acute problems.” Though Harvard University Health Services (HUHS) does not explicitly identify as a medical home model, but rather as a “multi-specialty medical practice in four convenient locations across the Harvard University campuses, with 24-hour urgent care provided 365 days of the year,” the framework for care looks much like a medical home model. At HUHS, the patient selects his or her primary care physician in the

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23 Such health care professionals include physicians (both M.D. and D.O.), dentists (general and pediatric), nurse practitioners, nurse-midwives, physician assistants, dental hygienists, psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, and professional counselors.


27 “Doctor shortage looms as primary care loses its pull - USATODAY.com.”

building, but also can see “in house” specialists for the same cost. The patient’s records are all kept electronically and nurse practitioners play a tremendous role in delivery of care.
Future Scenarios

WORST-CASE:

The worst-case scenario features a health care system that is unable to meet the primary care needs of the substantial population of newly-insured Americans. This poses a situation where patients use the emergency room as their place of care, or wait a long time to see a primary care physician. Both of these outcomes are not ideal for providing quality of care, as early treatment and prevention are key aspects to better health outcomes.

An example of what the situation might look like was reported in October, 2010 in the Boston Globe, which stated: “When primary care patients do secure an appointment for a non-urgent matter, they have to wait to get in the door, the survey found. The average delay is 29 days to see a family medicine doctor.”29 The delays in primary care are problematic because they deter early detection of diseases that could later become much more serious if left untreated. Those who do not receive adequate primary care (and, thus, lack a point of initial contact with the medical system) will wait to come to an emergency room or other medical facility until they are too sick to ignore their problems.

As a result, they will be far more likely to require complex and/or emergency treatments, both of which significantly increase the cost of health care. Additionally, a health situation like this does not offer any sort of continuous, coordinated care that would be ideal to maximize health outcomes. Furthermore, a drastic increase in the number of extremely sick patients will impose new strains upon medical professionals. Assuming that compensation does not increase in proportion to these additional strains, entering medical professions will become much less attractive option, compounding the shortage problem.

LIKELY:

A more likely scenario is that small, federally-funded incentive programs (such as the NHSC) will help to make primary care a marginally more attractive option for medical professionals. Currently, the health care system is on a course to learn lessons about primary care “the hard way”; that is, to discover the ramifications of the primary care shortage problem once they have become dramatically worse and are, thus, much more complicated to fix. Improving the medical education system to produce more health care professionals will take a great deal of time and effort, and waiting several years to observe worsening primary care will only make the process more difficult. Fortunately, it is plausible that some states will recognize the problems more quickly and begin to develop innovative solutions to them. For instance, states in which organizations that seek to defend the interests of physicians have less power may begin to abolish laws that restrict nurses’ “scope of practice” (that is, the tasks that nurses are legally allowed to perform) and increase primary care providers in that way.

BEST:

The best-case scenario involves an outcropping of medical education programs designed to encourage students to enter primary care professions in underserved areas (i.e., poor urban and rural communities). The creation of such programs on a larger scale is likely to depend on funding to support them (at both the state and federal levels). This is extremely important, as a doctor said to a member of our group: “People are more than willing to take a lower salary for family medicine, but they are simply not able to do so with the amount of crushing debt they have.” In terms of economics, if more primary care physicians are needed, there has to be some debt flexibility in the form of forgiveness, lower interest rates, or longer time periods to pay back student loans.

Moreover, a best-case outcome must include a better division of labor: nurses, nurse practitioners, physician assistants, and other providers of primary care services. This change would make a great deal of sense, given that such health care providers are generally able to perform many aspects of routine primary care. Furthermore, it would help to foster the development a broader-scope of training programs to allow them to do so.

Health care must also become more efficient in its use of human capital, a goal that is coterminous with advances in technology. The best-case scenario also includes a dramatic system-wide shift in the way medical care is provided in order to focus on continuous and well-coordinated care along with electronic records in a medical home model. This would allow the physician to better manage chronic conditions, perform screenings in a timely fashion, and so on, in order to provide the best care possible.
Recommendations

In order to progress from the “likely” scenario to the “best-case” scenario, the medical education system must find ways to make working in primary care and working in underserved areas more appealing to students. Lowering tuition or offering tuition reimbursements for those who enter primary care fields or practice in poor urban and rural communities would be an excellent start towards this goal for educational institutions. Similarly, schools, the government, and private funding entities could offer loan forgiveness programs to make such choices more attractive.

Schools can also create targeted programs that seek to provide medical students (i.e., those who have already expressed an interest in being physicians) with training that is specific to primary care or to working with disadvantaged communities. Already, schools like the University of Minnesota, the University of Washington, and Harvard University have implemented such programs. Furthermore, schools may be able to recruit nurse practitioners from the pool of students who have already expressed an interest in being nurses. In many cases, nurse practitioners are able to address fully the primary care needs of patients, and becoming a nurse practitioner takes less time and money than does becoming a physician. Indeed, nursing schools may even consider expanding the range of degree programs that they offer. For example, in addition to nurses and nurse practitioners, some schools offer an advanced degree called “Doctor of Nursing Practice.” The preparation for this degree is more extensive than that of a nurse practitioner but less extensive than that of a physician. As a result, although doctors of nursing practices are not qualified to handle all clinical situations, they are almost as prepared for most primary care procedures as any physician.

This suggests that one model for providing primary care in underserved areas would be to recruit a group of nurse practitioners working with a much smaller number of physicians and/or doctors of nursing practice. This sort of model could be implemented at a hospital or regional level (or both), and especially in the well-coordinated medical home setting. The physicians would be able to handle unusual cases, while the nurse practitioners would be able to ensure that everyone within a community got the primary care that they needed. Of course, this model would require substantial reforms to scope of practice policies, depending on the state. However, it might prove far more successful, particularly in rural areas with low population densities, than a model in which the medical education system must produce tens of thousands more physicians than it will at current rates in order to ensure that everyone has access to a primary care provider.

In a best-case scenario, professional organizations must adopt a more collaborative attitude with respect to one another. Currently, groups like the American Medical Association (AMA) and the American Nurses Association (ANA) tend to work against each other more often than not. Indeed, on no issue is this opposition more clear than with respect to nursing scope of practice laws. The AMA, worried that physicians will be replaced by nurses, seeks to defeat them, whereas the ANA, interested in creating more nursing jobs, promotes them. However, it

would be far more productive for the AMA and ANA to work with organizations such as the Centers for Medicare and Medicaid Services (divisions of the Department of Health and Human Services) to increase health insurance primary care reimbursements and to make clearer, more logical distinctions about the scope of practice of different types of providers. (Notably, the former issue about reimbursements might also require the input of health care providers like HMOs.) This sort of collective effort would help to facilitate a more efficient allocation of human capital across the entire health care system, which would likely remove some strain from overworked medical professionals and provide better care to those who need it. Professional organizations could also work together to promote the value of working in primary care and underserved areas of the country, as these goals apply similarly to physicians, nurses, and virtually all other medical professionals.

Of course, policymakers also have a substantial role to play in reforming the primary care and medical education systems. For instance, the Department of Health and Human Services (DHS) would need to be closely involved with any changes made to the primary care reimbursement system, and its input about scope of practice and division of labor would be invaluable. At the very least, policymakers must provide funding for medical professionals (to create incentives to work in primary care and underserved areas) and for innovation.

Indeed, another way in which the “likely” outcome might be improved would be a competitive grant program that encourages state- and institutional-level innovations that might help to address the primary care problem. Essentially, the federal government could solicit proposals for reforms and projects from states and educational institutions and then evaluate these proposals based on a specific rubric. For instance, a state might receive points for an initiative to recruit more physicians to work in rural areas and/or for legislative changes that expand nurses’ scope of practice. Even though the government would only be able to fund the top few applications, many states and schools would be committing to changing existing practices and implementing innovative new programming. The Obama Administration has already had a great deal of success with this sort of competitive grant model in “Race to the Top”, and it seems worth attempting to apply to PPACA reforms, as well.

Of course, changes to medical education system will have little impact on the primary care that patients receive in the short term. Even if the medical education system were to improve dramatically and immediately, then, it is unlikely that primary care itself will improve until at least 5 (and probably closer to 10) years later. However, the lack of short-term results is not a reason to ignore the problem. Politically, it may not be popular to invest a great deal of money in medical education with no immediate outcome in sight, but it is the responsible decision to make from a policy standpoint. It is in the interest of both Democrats and Republicans to make health care more available, accessible and affordable. Of course, the existing health care system is highly entrenched, so changing the status quo will require the support of a number of stakeholder groups (discussed above). Ultimately, progressing from “likely” to “best” is critical because the overarching goal is to enhance patient outcomes so Americans can live longer and healthier lives.
Appendix I:

The Patient Protection and Affordable Care Act


“Provisions of the Affordable Care Act, By Year

2010  2011  2012  2013  2014  2015

2010

NEW CONSUMER PROTECTIONS

• Putting Information for Consumers Online. The law provides for an easy-to-use website 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. Learn more about Consumer Assistance Programs.

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.

• **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. Fact Sheet: New Tools to Fight Fraud

### 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.ERRP.gov](http://www.ERRP.gov).

• **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 increases 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. Learn more about Medicaid.

• **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. Learn more about Rural Americans and the Affordable Care Act.

- **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. Fact Sheet: Getting Your Money's Worth on Health Insurance.

- **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. Download a brochure to learn more (PDF - 316 KB)

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. Fact Sheet: Improving Care Coordination for People with Medicare. Watch a video to learn more about Accountable Care Organizations.

- **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. Learn how the law improves the health care system for providers, professionals, and patients.

- **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. Read about the original CLASS proposal.

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.]

• **Providing Additional Funding for the Children’s Health Insurance Program.** Under the law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. Effective October 1, 2013. [Learn more about CHIP.]

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. [Learn how the law will make care more affordable in 2014.]

• **Establishing Affordable Insurance Exchanges.** Starting in 2014 if your employer doesn’t offer insurance, you will be able to buy it directly in an Affordable Insurance Exchange. An Exchange is a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges 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 Exchanges, and you will be able buy your insurance through Exchanges too. Effective January 1, 2014. [Learn more about Exchanges.]

• **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.* Learn more about Medicaid.

• **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.* Learn more about individual responsibility and the law.

• **Ensuring Free Choice.** Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges. *Effective January 1, 2014.* Learn more about coming improvements for small businesses.

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.*

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Appendix II:  
Accelerated Medical Education Programs

At a time when most academics and policy-makers are predicting a coming shortage of primary care physicians (PCPs) in the United States, the rising costs associated with pursuing a career in medicine are worrisome. Future generalist physicians seem to be especially vulnerable to rising costs, as PCPs can expect to have lower earnings than their specialist counterparts, evidenced by the decreasing percentage of medical students who choose to go into primary care.

As a solution to this problem, some schools are offering accelerated paths to become a physician, which can take the form of either combined BS/MD degrees or truncated medical and residency programs. The first option, in which students earn both their bachelors and medical degrees in either six or seven years, is currently offered by approximately 20 higher education institutes.34 The second kind of accelerated program is much more controversial, as instead of combining undergraduate and medical studies to save time, this program actually shortens medical education by a year. Three-year medical school programs are currently being offered in Canada, by DeGroote and the University of Calgary; at DeGroote, learning takes place 11 months out of the year, resulting in a very intense and concentrated experience.35 Similar programs are beginning to be piloted in the United States, mainly as an effort to incentivize careers in generalist medicine. For example, the Lake Erie College of Osteopathic Medicine in Pennsylvania was accredited in 2006 to train PCPs with only three years of coursework. This reduction is made possible by focusing only on the clinical rotations essential to primary care and eliminating electives.36 Reducing the time and financial burden of medical education through such programs may make primary care a more attractive option. Likewise, one study tracked 142 graduates of 12 accelerated family medicine training programs, which consisted of three years each of medical school and residency. At the end of training, in addition to beginning careers in primary care, graduates of these programs chose to work in rural and underserved areas at rates much higher than other graduates.37 Such results indicate that tailoring the medical education experience may be an effective means of recruiting more physicians to where they are needed. Moreover, studies have shown that reducing the length of medical education is the most effective way to ameliorate the costs of becoming physicians. One analysis which compared four different strategies to reduce the financial burden (shortening medical school duration, reducing tuition, increasing residency pay, and shortening residency duration) found reducing the duration of medical school to have the greatest impact.38 These results indicate that accelerated medical training programs may be the most effective strategy to circumvent the looming primary care shortage by reducing the financial burden of medical education and incentivizing careers in generalist medicine.

35 Ibid.
Appendix III:  
Regional Disparities in Medical Education and Health Care

It is clear that there are large disparities between the supply of urban and rural physicians, which seems to be largely a result of underrepresentation of medical school graduates from rural areas. Only twelve point six percent of practicing medical school graduates are located in rural areas and women, in particular, are much less likely than men to practice in rural areas. Indeed, “Four variables were strongly associated with a tendency to produce rural graduates: location in a rural state, public ownership, production of family physicians, and smaller amounts of funding from the National Institutes of Health.”

Rural residency trainees are over three times more likely to practice in rural areas. This fact alone should indicate the importance of medical school programs, which promote and emphasize rural care. Only twelve medical schools accounted for over one quarter of the physicians entering rural practice in the time period in which the Rosenblatt et al study was conducted. Since then, there have been a number of programs put forth in attempt to remedy the low supply of physicians in rural areas. One of these programs is the Physician Shortage Area Program, (PSAP), which “preferentially admits medical school applicants from rural backgrounds who intend to practice family medicine in rural and underserved areas.” This study effectively showed that medical school admissions process can and does have a large and beneficial effect for increasing the supply of physicians who practice in rural areas. Another program, entitled the Rural Physician Associate Program, is also aimed at increasing the number of physicians who practice in rural areas. This is a nine-month, community based program for the University of Minnesota.

Rurality of the state in which the medical school is located in possibly the most important in determining the successful rural graduation rate. This is often due to the political pressures exerted upon the medical schools to meet the rural needs of the state. It is also shown that commitment to the Family Medicine specialty is important, as is the efforts of rural-physician leadership within the school to graduate more rural physicians.

It is therefore our recommendation that we continue to institute rural residency training programs, such as the PSAP and the RPAP. It is crucial to focus on recruiting medical students from rural areas and exposing all medical students to rotation in rural areas. Promoting the

40 Ibid.
42 Ibid.
specialization of Family Medicine is also an extremely beneficial path as is increasing the amount of funding in the forms of loans to those students who take that path

**Works Cited**


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