# Facing the Challenges of Health Care Reform

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January 1, 2014 marked the launch of key provisions of the Patient Protection and Affordable Care Act (ACA). These include Medicaid expansion and the start of health care insurance coverage for individuals enrolled in the new health benefit exchange marketplace. Some elements such as the ban on lifetime spending limits, and prohibition against health plans excluding individuals for pre-existing conditions have already been in place since 2010. The ACA holds the promise of providing health care to millions of Americans. It provides for them what most industrialized first world nations already view as a basic human right. But there have been difficulties from the outset. The roll out of the online health exchange marketplace which began in October of 2013 has faced long wait times and software glitches. It should not be surprising that a program so massive, with as vast a scope as the ACA, should experience some bumps in the road at the start.

## A Dysfunctional System

The current trend in the US health care system is unsustainable. Health care costs in the US over the last 40 years have outpaced gross domestic product growth (Hartman, Smith, Heffler, & Freeland, 2006). Yet despite climbing costs, health care quality is poor (Davis, Schoen, & Stremikis, 2010). Innovations promised by the ACA are essential to cutting the cost curve and improving quality. The continued increase in costs and deficits in quality is in large part due to the current health care delivery system. The current system is a sick care system, focusing on treating people when they are sick. Such a system, by its very nature, leads to increased costs by treating people only after diseases become chronic and exacerbated. One major obstacle to creating a less expensive higher quality system of health care is that our current system of reimbursement is focused on providing care only when people are sick. Most providers in the United States get paid on a fee-for-service system. In other words, they are paid for each service they provide. This creates a perverse incentive for providers to focus on the quantity rather than the quality of care. The dilemma of more versus better care is further exacerbated by the practice of defensive medicine. Providers often order more diagnostic tests to ensure that they are covered in the event of a law suit (Hermer & Brody, 2010). Research has also found that providers are more likely to order expensive new tests if those tests are more available (Fisher, Bynum, & Skinner, 2009). We need to transition to a preventive health care system, one that focuses on maintaining good health and quality of life.

## The Promise of Innovation

Several recent health care innovations are being tested as part of the ACA. The CMS Innovation Center was created as part of the ACA to test and evaluate such potential programs. These programs are designed to control costs and increase health care quality. One of the principal methods for decreasing costs is payment reform. Experiments in payment reform began prior to the official launch of the ACA. The Centers for Medicare and Medicaid Services (CMS) funded pilot accountable care organizations (ACOs) starting in 2012 (Toussaint, Millstein, & Shortell, 2013). ACOs place all of the services that patients need under one umbrella organization. All groups that participate in the care of patients share in costs and savings. Outcomes of the pilot ACOs have been mixed (Toussaint et al., 2013). Another tool is pay-for-performance (P4P) programs. P4P programs pay incentives for evidence of process and outcomes related performance and improvement. Evidence for the effectiveness of P4P as a quality improvement tool is still incomplete (Bardach et al., 2013). Another of the promising quality initiatives currently being tested is the patient-centered medical home (PCMH). The PCMH

focuses on treating the entire person, coordinating care, being culturally sensitive, tracking population health data, is patient-centered, and uses decision support tools to aid clinicians (Crabtree et al., 2006).The success of the PCMH has also been mixed (Schwenk, 2014). And yet another possible way of curbing medical costs is to give providers and patients access to the costs of care up front (Bebinger, 2014). However, accessing such cost data has proven difficult. Due to the way that CMS contracts with institutions to pay medical claims, costs can vary wildly between regions or even between facilities in the same region (Fisher et al., 2009).

**Challenges**
As the ACA gets under way and different models are tested to cut costs and improve care, several challenges will need to be faced. First, in order for the ACA to work there needs to be individuals enrolled who are not sick, who will benefit from the availability of preventive care. These people are often referred to as the young invincibles. They are younger and less likely to have chronic illnesses. As a result, they use fewer health resources and help to fund the care of the older and sicker population. It was feared that it would be difficult to get these individuals to enroll in the ACA despite the fact that they will face fees for not enrolling which increase over time. In fact, recent evidence indicates that at present it may be less costly for these individuals to not purchase health insurance and pay the penalty ("Enrollment in the health insurance marketplace increases by 53 percent in January," 2014).

**The Common Good**
In the United States, the ideal of rugged individualism has often won out over concern for the social welfare of others. The individual mandate, which forces individuals to purchase health care to make it more affordable for all, has been a major point of contention. In contrast individuals within societies that possess national health care systems, such as Britain and Denmark, view it as their civic duty to support one another. It is curious to note that research has found the quality of life to be higher in these societies compared to the United states ("OECD Better Life Index," 2014). How can we surmount this road block of values and beliefs and move in the direction of the common good?

**Health Education**
Beyond the practical and structural difficulties faced by the implementation of the ACA are difficulties that arise from the expansion of care to a population that in many cases is unfamiliar with how to use health insurance. Just having health insurance does not mean that individuals have health care. Getting people access to health care will require intensive education efforts. It is among the uninsured within the United States that health literacy rates tend to be especially low (Sentell, Zhang, Davis, Baker, & Braun, 2014). We will need to focus time and money on this education effort to ensure that this large newly insured population can use health care appropriately—to bend the cost curve, rather than merely speed up the rate with which costs increase.

Many uninsured individuals have learned to rely on health care obtained through community clinics and emergency departments (EDs). The use of the ED as a source of primary health care results in poor care coordination, duplicated tests, and potentially dangerous combinations of medications. Individuals who are accustomed to a combination of community clinics and the ED for care will require the guidance of health educators. Without it the increase in ranks of the insured could lead to increases in expensive ED utilization. Redirecting this population from the ED will be further challenged by the fact that many of those currently without insurance also have untreated mental health conditions.

**Quality Improvement**
Care coordination is just one factor in good quality health care. Increasing overall health care quality is also a focus of the ACA. In addition to increasing the ranks of the insured it will be important to increase the quality of health care that is available. Efforts to increase the quality of health care in the United States have been a major focus of the US health system for the past two decades. The Institute of Medicine (IOM) published two seminal reports on health care quality at the turn of the century,

"Crossing the Quality Chasm: A New Health System for the 21st Century" (Institute of Medicine, 2001) and "To Err is Human: Building a Safer Health System"(Institute of Medicine, 2000). These timely reports brought the deficit in health care quality within the US to the forefront of the public's consciousness. In the domain of health care quality the Institute for Healthcare Improvement (IHI) has championed the pursuit of the triple aim: to increase population health, improve the patient experience, and decrease costs (Institute for Healthcare Imrpovement, 2014).

Within the ACA several components are designed to address the quality of care. The adoption of Health Information Technology (HIT), most notably Electronic Health Records (EHRs) holds the promise of improving care coordination, making health care more efficient and evidence based, and simplifying record keeping and billing. The promise of EHRs has yet to be realized. The adoption of EHRs has faced many obstacles, including difficulties in vendor selection, and vendor quality. There are still many problems to be solved for EHRs to show positive impacts on health care quality. For EHRs to be able to improve quality and care coordination it will be necessary that EHRs at different levels of care (primary care physicians, hospitals, clinics, specialisst, EDs) can talk to each other. This is the holy grail of interoperability. These steps in the evolution of EHRs are outlined in the Health Information Technology for Economic and Clinical Health (HITECH) Act. This act was enacted as part of the American Reinvestment and Recovery Act of 2009 (ARRA). It supports a move towards the meaningful use of EHRs. In addition to the dream of EHRs replacing paper charts, the meaningful use of EHRs includes giving patients access to their own medical data. This access will empower patients to take control of their own medical care.

## Conclusion

There are many factors that will affect the success of the ACA and health care reform. Implementing such sweeping and ground-breaking change in a country as large as the United States is an immensely complicated task. The difficulties that have arisen to date should not be unexpected. For example, within California, the health exchange website Covered California experienced software glitches that recently caused it to be shut down for several days. But there are also things to celebrate such as the fact that a large percentage (28%) of the Covered California enrolled population are young invincibles (U.S. Department of Health & Human Services, 2014). Health reform is steering a very big and fast moving ship. It has been said many times but is worth repeating – that health care reform is a marathon, and not a sprint.

## Disclaimer

The opinions expressed in this editorial are completely my own and do not in any way reflect the opinions of my current employer, L.A. Care Heath Plan.

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