EDITORIAL

The Affordable Care Act: Unprecedented Opportunities for Family Physicians and Public Health

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The Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010 and held constitutional by the US Supreme Court in June 2012. It survived intact the November 2012 election. The blurry federal legislative provisions come into sharp focus as state executive branches implement them.

After spending one-half of my life practicing and teaching family medicine, I spent a year in Washington, DC, as a Robert Wood Johnson health policy fellow working for US Senator Jeff Bingaman (D-NM, retired 2013), researching and drafting health workforce provisions that ended up in ACA Title V.[1,2] After that legislative branch immersion, Governor Susana Martinez (R-NM) appointed me director of the New Mexico Office of Health Care Reform in 2011. I mediated between disappointed single-payer advocates at one end of the spectrum who believe the law did not go far enough and those fearful of the "Obamacare government takeover of health care." Through this firsthand state executive branch experience, I gained perspective of the scale and urgency of ACA coverage provisions and the crucial importance of family physician and public health engagement in ACA implementation.

The timeline for the ACA implementation is ambitious—expanding Medicaid and standing health insurance marketplaces are slated for pre-enrollment in October 2013 and full operations are to begin January 2014. The Congressional Budget Office estimates Medicaid expansion will cover 13 million uninsured Americans with incomes of less than 133% of the federal poverty level (FPL; equal to $15,282 for an individual in 2013) and another 24 million through the new federal and/or state health insurance marketplaces for 133% up to 400% of the FPL ($45,960 for an individual).[3]

During the next decade, there will be a net increase of 25 million insured, and a residual 31 million uninsured, individuals.[3] States with health workforce shortages must innovate to meet the pent up demand of this newly insured population, especially in rural areas.

Family physicians can assure a clear vision of high-quality, accessible care. There are 3 ACA coverage implementation challenges that desperately need family physician and public health advocacy.

EXPAND ACCESS TO COMMUNITY-BASED PRIMARY CARE

As pointed out by Chang and Davis[4] and Devoe[5] in this issue of the *Annals*, being uninsured is deleterious to health. Furthermore, insurance without access to primary care is a looming problem as 25 million uninsured gain coverage. Because the training pipeline is long, new delivery models emphasizing integrated, community-based care must be quickly developed and deployed to meet demand and fulfill the ACA promise of access to high-quality, affordable care.

Yet, most of the $13.3 billion in federal Medicare and Medicaid funding supports urban, tertiary care physician training.[6] Nonelderly Medicaid enrollment will increase by one-third through ACA expansion. New models of interprofessional, community-based health professions education could be funded by Medicaid expansion and the exchanges in the new ACA teaching health centers (community-based, ambulatory, primary care service learning models) by creating an all-payer health professions education funding mecha-

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nism similar to direct and indirect graduate medical education for physician residency training. The 5-year ACA funding for teaching health centers needs permanent reauthorization and expanded funding to include physician and nursing primary care training in community-based ambulatory settings.

ASSURE THAT UNINSURED INDIVIDUALS ELIGIBLE FOR COVERAGE ARE ENROLLED, EMPHASIZING RURAL AND MEDICALLY UNDERSERVED AREAS AND POPULATIONS

Covering the uninsured improves health outcomes and narrows health disparities.[4,5] Yet disturbing racial and ethnic differences in coverage and outcomes persist. Uninsured rates for blacks, Hispanic/Latinos, and American Indians are 2 to 3 times higher than for non-Hispanic whites.[7,8] Decisions are being made that determine whether every American can enjoy the privileges of a healthy citizenship. Special efforts and accountability are needed to help the eligible uninsured population enroll for coverage in rural areas and for minority populations.

Specifically, the Centers for Medicare and Medicaid Services (CMS) could work with state chapters of the American Academy of Family Physicians and other advocacy groups to improve the uptake rate with outreach to those uninsured persons who are eligible for the Medicaid expansion or qualified health plans offered on the state or federally facilitated marketplaces. Family physicians provide almost two-thirds of the National Health Service Corps physicians serving rural counties[9] where there are higher percentages of uninsured persons. CMS could help the rural and urban inner-city uninsured population thought direct navigator grants to family physician practices in these areas to decrease the uninsured population and reduce health disparities.

As DeVoe notes in this issue, "ensuring that all patients have the best and most continuous coverage available to them under existing and newly expanded programs may be as (or more) important than ensuring that all patients have optimal blood pressure control, diabetes control, or timely cancer screenings."[5]

FUND PREVENTION, PUBLIC HEALTH, AND PRIMARY CARE

As federal and state budgets are cut, prevention, public health, and primary care are often the first to go. Budgets that propose Medicare vouchers forcing seniors to buy their own coverage and Medicaid block grants shifting fiscal risk from the federal government to states with fragile budgets are thinly veiled efforts to cut entitlement programs. That's not repealing and replacing so-called Obamacare,[10] that's undermining the Social Security Act, an approach resoundingly rejected by voters, especially those aged 65 and older.

Such entitlement cuts are Trojan horse taxes, shifting costs to critical access hospitals and safety-net providers and to the uninsured, who have few resources to pay for care. Arizona provides a case in point. When budget deficits forced the state to freeze Medicaid enrollment for childless adults making less than 100% FPL, more than 150,000 of Arizona's population lost coverage, and uncompensated care costs for hospitals skyrocketed by more than 80% in just 6 months.[11]

Arizona's Governor Brewer pushed through the legislature the restoration of Medicaid coverage to 100% FPL (as resoundingly supported by more than 60% of voters on 2 occasions in the last 10 years) and the expansion of coverage to 133% FPL, as allowed in the ACA. It takes courage for a Republican governor to do that and to be explicit about levying a provider (hospital) assessment to finance the state's share of restoring Medicaid. It's far simpler for legislators to cut coverage, shifting state costs to physicians and hospitals caring for a burgeoning uninsured population. As Chang and Davis observe in this issue, those newly covered by Medicaid expansion may be healthier than current enrollees, underscoring the importance of active outreach to improve enrollment, and thereby address the modifiable risk factors associated with chronic disease and better control health system cost growth.[4,5]

In May of 2012, minorities comprised a majority of US births (50.4%).[12] The changing demographics of the nation's voting population forces politicians to combine conscientious policy making with pragmatic politics or lose office.

Lost in the cacophony of ACA partisan rhetoric is that the costs of caring for the uninsured already accrue to our health system. That's why we pay more than twice what any other country pays per capita for health care, yet many of our population outcomes are worse. Covering the uninsured improves health outcomes and eliminates the regressive taxes of uninsured cost shifting.

Family physicians, whatever their party affiliation, can help policy makers understand how ACA implementation will play out in communities.

The ACA covers one-half of the nation's uninsured. I'm for that! I'll lean whichever way gets us through the door. We could try what my dad did in our house with 7 children and only 5 rooms. He removed all of the doors.

For 49 million uninsured individuals, the door is cracked open. Family physicians can help patients through. No half measures, no closed doors.

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EDITORIAL

The Affordable Care Act: Objectives and Likely Results in an Imperfect World

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The Patient Protection and Affordable Care Act (ACA) has 3 main objectives: (1) to reform the private insurance market—especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level, and (3) to change the way that medical decisions are made. All 3 objectives rely primarily on private choices rather than government regulation and are rooted in expectations of rational decision making shaped by incentives but unfettered by other constraints. The implicit assumption is that individuals and groups will act within these reforms to produce a valued good (access to medical care) at an appropriate price (what it would cost an efficient provider) financed by fair risk sharing (spreading the cost of necessary services across a large pool). The result will be affordable care.

Although the ACA may go far toward this goal, the assumptions of efficient and fair mechanisms of

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