Access to Care:
Beyond an Insurance Card

ALLIANCE FOR HEALTH REFORM

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Policymakers are debating how to cover the more than 46 million uninsured in the U.S. But if tens of millions of Americans gain coverage, does the current health care system have the capacity to meet the new demand?

It is estimated that more than 36 million people already live in physician shortage areas and are currently underserved. Projections indicate a worsening of the shortage even if coverage is not expanded. (See chart, "Projected Physician Demand and Supply, Selected Years.") Other studies show that a decline in access to health care was already evident during 2003–2007. The decline in access was clearly related to physician shortages, including a lack of specialists.

Particularly striking was how long it takes to schedule an appointment in underserved areas. Health insurance issues presented other barriers, including instances where the health plan would not cover particular treatment options, and where the provider would not accept a patient's insurance.

Though committees of jurisdiction in the U.S. House of Representatives and the U.S. Senate are addressing these and other insurance issues in the health reform proposals under consideration, the question remains: Will the shortage of physicians and allied health professionals, especially those in primary care, be exacerbated by health reform, or are there adequate provisions in the proposals to allay the shortage?

The declining interest in primary care as a professional goal contributes to the adult primary care shortage.

U.S. medical students are less interested in such careers now than they were in the late 1990s. Far fewer medical graduates entered residencies in family medicine and internal medicine in 2009 than in 1999.

Among the reasons graduating physicians choose specialties and subspecialties rather than careers in adult primary care are:

1) the large educational debt they accumulate and
2) the relatively low compensation primary care physicians receive, meaning it takes longer to pay back their debt.

The median income of family physicians was a little under $200,000 in 2009 vs. $548,186 for neurosurgeons and $641,728 for spinal orthopedic surgeons. With some regional variation, anesthesiologists, cardiac surgeons and dermatologists all earned in excess of $350,000.

It's not just the money that steers medical graduates into the higher paying specialties. "When we get people in medical school, we often don't mentor them," said Nancy Dickey, president of the Texas A&M Health Science Center and a former president of the American Medical Association. **"We don't tell them that family medicine or general internal medicine is a good place to go."**

In addition to these barriers, rural areas face difficulties recruiting and retaining primary care providers due to professional isolation, limited time off and scarcity of jobs

Fast Facts

- More than 36 million people live in physician shortage areas and are currently medically underserved.
- Far fewer U.S. medical graduates entered residencies in family medicine and internal medicine in 2009 than did in 1999.
- The median income for family physicians in 2009 was $197,655, compared to $548,186 for neurosurgeons and $641,728 for spinal orthopedic surgeons.
- Rural areas face additional difficulties recruiting and retaining primary care providers, such as professional isolation, limited time off and scarcity of jobs for spouses.
- In the early period following health reform in Massachusetts, increased demand for primary care has led to longer waits for appointments.

In August 2009, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a Capitol Hill briefing to examine the premise that universal health insurance coverage alone does not guarantee access to care. Panelists were Susan Dentzer, Health Affairs; Nancy Dickey, Texas A&M Health Science Center; Deborah Devaux, Blue Cross Blue Shield of Massachusetts; and Sharon Long, Urban Institute. This issue brief draws from information presented at that briefing.

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for spouses. Recruiting physicians to practice in a rural area is somewhat easier and retention more likely if the physician grew up in a rural area. However, relatively few students from rural areas pursue medical careers, resulting in an unequal distribution of physicians and other health professionals between urban and rural areas.

Public programs and states implementing health reform provide additional examples of access barriers. **Having a Medicare card, for example, does not guarantee access.** As some people turn 65, they may find that their long-time provider who previously accepted their private insurance does not accept Medicare.

Though most beneficiaries do not encounter this problem, those who do have to seek primary care providers who will accept new Medicare patients. Ten percent of Medicare beneficiaries report seeking a new primary care provider. Of these, about 30 percent report having some difficulty finding a new primary care physician. This compares to 15 percent of beneficiaries seeking a new specialist and 15 percent of this group having difficulty finding one.

Some primary care physicians and specialists choose not to be Medicare providers because the program's reimbursement rate is well below their customary rate. Medicare fees average 81 percent of private payers' fees, a percentage that varies widely from place to place. In addition, physician practice costs have risen steadily over the past decade, while Medicare reimbursement rates to physicians are virtually unchanged. **The Medicare Sustainable Growth Rate formula (SGR) could force repeated and sizeable cuts in Medicare payment to physicians in the future, putting access at even greater risk.** (For more information on SGR, see the testimony offered at a Sept. 11, 2008, hearing on *Reforming Medicare's Physician Payment System* by the House Ways and Means Committee's Sub-committee on Health (http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=645&comm=1).

Provider payment rates tend to create barriers for Medicaid beneficiaries as well. Medicaid reimbursement rates are set by states and vary widely. Overall, Medicaid fees are 72 percent of Medicare fees—66 percent for primary care services. Medicaid beneficiaries in many states have long found a limited supply of physicians willing to accept that form of payment, severely limiting their choice of providers.

Many physicians claim that Medicaid reimbursement schedules do not cover their costs. Some states have raised, or are looking to raise, reimbursement rates to improve this situation. Massachusetts, for example, has raised its Medicaid payment rates for doctors and hospitals to help address the capacity issue.

Research shows that ethnic and cultural diversity among providers is important to improving access to health care, particularly in disadvantaged communities. Health professionals from racial and ethnic minority groups are more likely to practice in primary care settings that serve their corresponding minority groups, and tend to practice in underserved areas more frequently than their non-minority colleagues. Support for training programs that promote diversity in the health care workforce can improve access in these areas.

Some analysts call for a three-pronged approach to remedy the primary care dilemma: revitalizing the training pipeline, reforming provider payments and reorganizing health care delivery.

Revitalizing the pipeline

Relief from medical education debt could provide an incentive for newly trained physicians to join the primary care workforce. The American Recovery and Reinvestment Act of 2009 (ARRA)

Projected Physician Demand and Supply, Selected Years

Source: AAMC (2008). "The Complexities of Physician Supply and Demand: Projections Through 2025." November (https://services.aamc.org/publications)

provided such relief through expanded funding for the National Health Service Corps. It is too early to measure the effect of this effort.

The House health reform bill (H.R. 3962)* would build on ARRA and expand support for primary care through the National Health Service Corps, bringing scholarships and loan repayment funding levels to $300 million annually. The House bill also contains measures to prepare the workforce to adapt to changes in health care delivery; and recognizes the need for diversity in the health care workforce. The bill also supports expanded nursing education, and the training of advance practice nurses who will deliver care in shortage areas.

The bill approved by the Senate Committee on Health Education Labor and Pensions (HELP) addresses workforce issues in two major provisions. One would establish a National Health Care Workforce Commission to make recommendations and disseminate information on workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention practices. The other provision would enhance graduate medical education (GME) to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatrics, geriatrics and primary care.

This part of the bill authorizes $125 million in grants to develop and operate training programs and academic units in primary care, including financial assistance of trainees and faculty, and faculty development in primary care and physician assistant programs. It gives priority to programs that educate students in team-based approaches to care, including the patient-centered medical home. Provisions to support an increase in funding for GME with a preference for primary care also appear in the Senate Finance Committee bill.

* The provisions in various health reform proposals cited as of this writing are likely to receive extensive debate in Congress and may be revised throughout the legislative process.

Reforming provider payments

More health care professionals might enter primary care if they were paid more or differently. This could mean paying physicians more for primary care services such as chronic care management that don't necessarily require visits to the doctor's office. It could also mean paying for allied health care professionals, such as nurse practitioners and physician assistants, to provide some of the services previously delivered by physicians.

Paying differently might mean bundling payments for physician and hospital care, and paying for episodes of care rather than fee for service for individual visits or procedures. Many questions arise when considering payment reform. They include: Where will the money come from? Will specialists have to sacrifice some of their incomes for the system to be able to distribute more to primary care physicians? In bundled payments, who gets the payment? How will episodes of care be defined? Will there be monetary rewards for higher quality outcomes?

Reorganizing health care delivery

The private sector has fostered a number of innovative integrated delivery system models that have been able to cut costs, improve quality and offer patients a "medical home." Examples include the Mayo Clinic, Intermountain Healthcare and the Geisinger Health System. Though hard to duplicate widely because of their unique organizational histories, these models have been getting a fair bit of attention.

The patient-centered medical home (PCMH) is believed by some to be an important practice-reform model. A PCMH offers coordinated care in treating the complex needs of chronic care patients. It provides a health care setting where patients have an ongoing relationship with a primary care provider, and have access to nonemergent primary, secondary and tertiary care that is linguistically and culturally appropriate.

Though private-sector models have been on-going for several years, the Medicare Medical Home demonstration project authorized in the Tax Relief and Health Care Act of 2006 granted its first awards in January 2009. A provision in the House bill would establish a Medicaid Medical Home pilot program as well.

Both the Senate HELP Committee and Finance Committee bills, and the House bill call for Medicaid expansion to include adults who aren't otherwise eligible. However, unless the Medicaid reimbursement rate is increased in most states, beneficiaries may find themselves without a "medical home."

The HELP bill would also increase the number of community health centers and school-based health centers, steps that may help to alleviate a barrier to access for some populations.

Massachusetts offers both cautions and encouragement to supporters of national health reform.

That state's far-reaching health reforms went into effect in the fall of 2006, ushering in an era of near-universal health coverage. Between fall 2007 and fall 2008, working age adults (age 18 to 64) were more likely than before to report that:

- they had a usual place to go when sick
- they had one or more doctor visits in the past 12 months,
- they had seen a specialist in the past 12 months,
- they had a preventive care visit or a dental care visit, and
- they had taken any prescription drug.

"Gains in insurance coverage have translated into gains in access and use in the state," said Sharon Long of the Urban Institute, who has extensively studied the reform effort there.

But the increased number of insured in Massachusetts created some bottlenecks. Between fall 2007 and fall

2008, the share of adults reporting that they did not get care they thought they needed in the past 12 months increased slightly for:

- doctor care
- specialist care
- medical tests, treatment or follow-up care,
- prescription drugs, and
- dental care.

This demand is expected to stablize over time as people have coverage for a full year and longer, according to Ms. Long.

The increased demand, moreover, created an environment ripe for innovative solutions to take hold. Retail clinics came in to help fill the access gap and within a few months, more than ten thousand patients were treated for acute problems on a walk-in basis.

However, retail clinics are not seen universally as a solution to filling primary care shortages, and the rate of expansion of retail clinics in Massachusetts has not been mirrored nationwide. In fact, most large clinic chains have not met growth expectations; there were more clinic closings than openings in spring 2009. A change of strategy may be on the horizon, with analysts foreseeing more retail clinic partnerships with hospitals to help clinics weather initial losses in tough economic times.

Other innovations in Massachusetts include supporting access through alternative payment methods on the part of the insurer. Blue Cross Blue Shield of Massachusetts is experimenting with an Alternative Quality Contract—a five-year, global payment contract in which the physicians and hospital are paid as a single system accountable for meeting quality and cost standards. Primary care payments are to be significantly increased.

No matter the approach to expanding coverage, policy options to improve access will need to be considered as well. Among these, workforce issues merit major consideration. Proposals to establish a national planning commission to address workforce policy appear in the House bill and the Senate Finance Committee bills.

Such a commission might consider workforce policy issues like training and education, recruitment and retention, payment reform, and the use of an expanded workforce—including physicians, nurse practitioners, physician assistants and other clinicians and allied health professionals—to meet current and future health care needs.

As evidenced in Massachusetts, health reform is a dynamic process. Coverage expansion is not an end, but a beginning. The reform process will have to continue to address other aspects of access to care, including expanding the workforce and serving the underserved while changing payment incentives, maximizing efficiency, and improving quality.

For the sources used in writing this issue brief, email info@allhealth.org or call 202/789-2300.

Expert sources

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Websites

- **Alliance for Health Reform** www.allhealth.org
- **Association of American Medical Colleges** http://www.aamc.org/
- **US Government Accountability Office** http://www.gao.gov/
- **Health Resources and Services Administration** http://www.hrsa.gov/
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- **Office of Rural Health Policy** http://www.ruralhealth.hrsa.gov/
- **Robert Wood Johnson Foundation** http://rwjf.org
- **US House Ways & Means Committee (for summary of House bill)** http://waysandmeans.house.gov/MoreInfo.asp?section=52
- **US Senate Finance Committee** http://finance.senate.gov/
- **US Senate HELP Committee** http://help.senate.gov/index.html

For additional experts and websites on this and other subjects, go to www.allhealth.org

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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