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# Health Reform: A Work in Progress

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# Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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## Editorial

### Health Reform: A Work In Progress

By David B. Nash, MD, MBA

Editor-in-Chief

It has been 5 years since we, in partnership with Eli Lilly and Company, introduced *Prescriptions for Excellence in Health Care (PEHC)*, a unique newsletter series devoted to the evolving national quality improvement agenda. Since its launch in 2007, the newsletter has been provided as a supplement to our *Health Policy Newsletter (HPN)*. This issue marks 2 important beginnings – a new 4-part series on the present and future impact of health care reform and, as *HPN* goes exclusively electronic, the debut of *PEHC* as a stand-alone publication.

Like many of our readers, I have followed the implementation of the Patient Protection and Affordable Care Act (ACA) with keen interest, some trepidation, and a certain amount of optimism. As we go to press, it is almost 2 years since the passage of this historic, game-changing legislation that promises to influence how health care is delivered and reimbursed in the United States for decades to come.

Debates continue to rage about the ACA's design, its intended effects, and whose way is best. But, lawsuits and court challenges by some states notwithstanding, the ACA and

the overwhelming majority of its provisions are here to stay.

Although the popular media tends to focus on the few hot-button issues (eg, charges of amendment violations, “death panels”), an astounding array of provisions have already gone into effect across the entire industry. In the first year alone (2010), insurers faced a variety of new requirements, such as: increased mandatory reporting of administrative data, continued coverage of adult children under their parents' policies (until the 26<sup>th</sup> birthday), strict limits on reasons for discontinuing coverage, and free preventive screening services for adults. Nonprofit insurers were required to maintain a medical loss ratio of 85% or higher in order to take advantage of Internal Revenue Service tax benefits. Other provisions that went into effect in 2010 include new tax credits available to small businesses (those with 25 or fewer employees) to help with employee premium costs and the expansion of Medicare to small, rural hospitals and facilities.

In January 2011, Medicare beneficiaries began to receive free preventive care as well as a 50% discount on the cost of covered

brand-name prescription drugs for the Medicare Part D coverage gap (donut hole). Grants became available to states to develop programs aimed at delaying the onset and reducing the prevalence of chronic conditions among Medicaid beneficiaries.

Hospitals, too, have begun to feel the impact of ACA as the federal government ceased making payments to states for Medicaid services related to certain hospital-acquired infections – a precursor to a reduction in Medicare payments for preventable hospital admissions scheduled to take effect in 2012.

On the policy front, the Centers for Medicare and Medicaid Services has met its deadline for developing the CMS Center for Medicare and Medicaid Innovation, the body that will oversee testing of innovative payment and delivery models.

In the summer of 2011, we convened a symposium to get a snapshot of how various provisions of the ACA have begun to affect health care quality and population health. With presentations from a cross section of stakeholder groups, we had an opportunity to learn how things are going on the front

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lines, from primary care to long-term care to policy making. Three of these presentations form the basis of the articles in this issue.

The first article, *“The Role of Primary Care in Health Care Reform,”* examines 3 current ACA-related initiatives that have the potential to reinforce primary care as the foundation for assuring the success of health care reform.

Prevention plays either a starring or supporting role in many ACA provisions. The second article, *“A*

*New Model for Integrating Clinical Preventive Medicine into Patient Care,”* describes one residency program’s approach to improving how preventive medicine specialists are prepared to meet the expectations of health reform.

The third article is one that certainly piqued my interest. Exploring another key component of health reform, *“Leveraging Electronic Health Records in Comparative Effectiveness Research”* translates a complex sounding concept into terms that are easily understood and thought provoking.

I hope that this issue and others in this series will shed new light on some of the changes that are occurring as health care reform unfolds. As always, I welcome questions and comments from readers. I can be reached at: david.nash@jefferson.edu.

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