

# The Affordable Care Act and California's San Joaquin Valley: A CAUSE Perspective

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# Executive Summary

The US health care system has many resources: our hospitals boast sophisticated equipment, most practitioners are well-trained, and impressive dedication to patient care is the norm. We fund health care more generously than any other nation in the world. Yet, in the midst of this abundance there are at least 52 million people uninsured and many more are underinsured. Lack of basic health care for everyone affects the health of individuals, families, communities, businesses, and our nation. The pressing need for our health care system to become more effective in improving population health is perhaps most evident in high poverty, rapidly urbanizing regions such as California's San Joaquin Valley. In 2010, the US began implementation of historically significant and sweeping legislative reform of the health care insurance and delivery systems. There will likely be important improvements to the system over the next decade. Even with the major changes in policy now being implemented, health care will grow to more than one-quarter of the economy within the decade. We believe the new national policy will not by itself produce excellent, equal opportunity health care for all, both in the United States as a whole and in our region in particular. This report explores the implications of national health reforms for the San Joaquin Valley and highlights policy and program challenges now facing the region.

The remarkably contentious national debate during 2009-2010 resulted in the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152). We will reference the new laws as the "Affordable Care Act (ACA)". Together these bills initiate a series of phased-in changes in health care insurance regulation, new requirements on US taxpayers and businesses, new government subsidies

for the purchase of private insurance, and a broad range of investments in enhancing health workforce, improving care and constraining costs. Yet there is no great sense of national unity or shared relief with its passage. This is not surprising. Although the President, House and Senate, health leaders, and various consumer and industry groups advocated certain goals for health care reform at various points in the debate, the process never came to an agreement on a set of principles that applied consistently as a mission statement in the formulation of health care policy.

ACA begins the most far-reaching effort to improve health care financing and delivery in the US since the passage of Medicare in 1965. ACA includes changes in the existing public health care programs (Medicaid, Medicare, S-CHIP) and the regulation of private insurance, new efforts to increase access to preventive services and improve management of chronic conditions, new funding for practitioner education and demonstrations of new health care roles and other changes. While important elements of the plan are being implemented this year, the most important changes begin in 2014. Over several years, ACA expands Medicaid (Medi-Cal in California) to low-income non-disabled adults, requires all households to acquire insurance, requires most employers to provide insurance, launches new private insurance products for low and moderate income people that are regulated and subsidized through state-administered exchanges, places new restrictions on private insurance, and invests in primary and secondary prevention, health professional education, safety net providers, chronic care coordination, and reimbursement reforms. Figure 1 summarizes some of the key components of ACA.

**FIGURE 1**  
**AFFORDABLE CARE ACT**  
**Key Components and Timeline**

When?	What will ACA change?
This Year 2010	<ul style="list-style-type: none"> <li>▪Persons 23-26 remain on parents' plan</li> <li>▪New federally funded high risk pools for persons denied insurance because of pre-existing conditions</li> <li>▪Tax credit for small employers to purchase coverage</li> <li>▪Private insurance reforms (lifetime cap, cancellations, pre-existing conditions for children, preventive services with no co-pay, reporting on loss ratio and cost increase)</li> <li>▪New requirements on non-profit hospitals</li> <li>▪States receive federal support to establish exchange, adjust Medicaid programs, and implement new insurance regulations</li> <li>▪New investments in safety net infrastructure, health care and public health workforce, primary prevention and public health</li> </ul>
By 2014 and beyond	<p><b>Uninsured/Low Income</b></p> <ul style="list-style-type: none"> <li>▪Medicaid expanded to 133% of FPL with 100% match (match reduced to 90% by 2020)</li> <li>▪State exchange for legal residents, 133-400%, other uninsured, small business employees, and insured employees with unaffordable coverage</li> <li>▪Subsidized coverage with total exposure less than 10% of pre-tax for 133-200% FPL, but less affordable for higher incomes</li> <li>▪Safety net improvements (increased Medicaid rates, FQHC funding, community long-term options, medical home/integrated care options, innovations center)</li> </ul> <p><b>Medicare</b></p> <ul style="list-style-type: none"> <li>▪Reduced subsidy for Medicare Advantage plans</li> <li>▪Phased in elimination of the Part D “donut hole” eliminated by 2020</li> <li>▪Benefit improvements (annual physical, no co-pay for preventive services, transitional care benefits)</li> <li>▪Bundled payments, value-based pricing, primary care team, and other reimbursement reform demonstrations,</li> <li>▪Comparative effectiveness, payment , and quality initiatives</li> </ul> <p><b>Privately Insured</b></p> <ul style="list-style-type: none"> <li>▪States implement individual mandate to hold qualifying insurance.</li> <li>▪Most employers devote at least 68% of payroll to purchasing qualifying insurance, cover most employee premiums or pay a similar amount in tax</li> <li>▪Individual and group market insurance and qualifying plan requirements implemented by states (guaranteed issue, community rating, maximum out-of-pocket at several established levels, minimum benefits, payment increases)</li> </ul>

The ACA will take time to implement and, without national and local agreement on health policy goals, the health care industry retains seemingly free rein to pressure for even more favorable treatment during implementation. Because ACA places new responsibilities on states for regulating the health care marketplace and on local providers to increase efficiency and cost-effectiveness of care, much of the debate and maneuvering will occur at the state and local level. In the San Joaquin Valley, important policy and program choices over the next few years will be most effective if made in the context of a local public conversation on health system goals and expectations.

## US Health System Goals

Philosophers and political scientists have long debated the roles and goals of health care policies in democratic societies. Today there is consensus that health care has multiple, varied linkages and impacts across our society. As a result, health care policies have multiple goals. And these goals are intertwined with broader ideological perspectives and political movements. Through much of our recent national debate, these complexities are reduced to contrasting views of health care as an earned privilege, a right and a responsibility. Yet framing US health system goals in terms of choice between private markets and equitable access misses the fact that the US health system already exists with known patterns of financing and access, known achievements and inequalities. It exists as the product of how policies have compromised between privilege and rights perspectives and have interacted over time with technological, social and economic influences on health care systems. The real US health system already represents a heady mix of public and private financing, for-profit and altruistic service delivery, and effective and ineffective care. Not surprisingly this mix produces highly variable local contexts and individual experiences of access, quality and cost. This is particularly evident in the San Joaquin Valley, where differences in health care access and quality as well as broad differences in community access to environments and opportunities that support healthy living result in dramatic variations in life expectancy and disease burdens among zip code-defined communities.

The problems and opportunities for reforming the real US health system were explored in a four-year project

of the prestigious Institute of Medicine, National Academy of Sciences. They convened a diverse and distinguished panel of public health and health care scholars, practitioners, purchasers, and other stakeholders to review and synthesize available research on the causes and consequences of uninsurance in the US.<sup>1</sup> This four-year project estimated the financial and human toll for the nation of having a system of health care and health care financing that leaves so many out. Based on their analyses, the IOM panel achieved consensus on broad principles to shape a national response to the causes and consequence of having so many of our residents without adequate health insurance. In updating these principles to current health care system performance and the current political context, we believe that US policy should seek a health care system that is: 1) Continuous, 2) Affordable, 3) Universal, 4) Sustainable, and 5) Effective.

The CAUSE goals articulate an excellent, equal opportunity health system, where all patients have access to needed health services and can anticipate that necessary preventive and curative services are available in a coordinated way across the life course, and that tax-payers and community members feel secure in knowing that the health system provides the services needed to promote our nation's health while living within our collective means.

## ACA and the CAUSE Principles

Figure 2 offers an overall assessment of ACA using the CAUSE principles.

**Continuous:** The current health system provides neither continuous insurance coverage nor consistent access to health services. In 2009 an estimated 25.7 million in the United States, 3.8 million Californians, and 456,000 San Joaquin Valley residents experienced a lapse in insurance coverage during the prior year. An additional 4.9 million Californians and 582,000 Valley residents did not have health insurance for all of 2009. Persons without insurance or with intermittent insurance are less likely to have any medical care in general, and are less likely to have a usual source of care. While most in the US report having a physician's office or family care clinic that they go to on a regular basis and where they have an established relationship, approximately 44.5 million

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<sup>1</sup> Source: Institute of Medicine, (2004). Insuring America's Health: Principles and Recommendations. Washington D.C. The National Academies Press.



in the US, 6.3 million in California, and 700,000 in the San Joaquin Valley report no usual source of care. There is mounting evidence that even those with insurance often experience in gaps in coverage and lack of primary care coordination of services.

ACA has the potential to make marked improvements in continuity of care. Those newly enrolled in state Medicaid programs and private insurance plans through the exchange will have improved access to care and greater potential for ongoing relationships with a primary care provider. Through state implementation of new federal requirements, the potential for privately insured persons to be denied payment for specific services or denied coverage based on pre-existing conditions or other abusive policies will be greatly reduced. Individual who have

changes in work, family, and health needs may still experience gaps in coverage. New Medicare programs will ease elders' level and setting for care transitions and many more will have access to patient-centered medical homes. But those in private health plans may not see these dramatic changes in primary care and there are no proposed changes to private insurance reimbursement for prevention, diagnosis, counseling and coordination services. Significant new investments in medical education and loan repayment programs as well as increased funding for other health professional education may reduce the challenges for low-income persons in accessing primary and specialty care, but there is uncertainty about how well these programs will direct new professionals to underserved communities and regions.

**Figure 2**  
**Assessing ACA Using the CAUSE Principles**

Principle	GRADE	Rational
Continuous	B	1) Reduces risk of private insurance denials of coverage or service, 2) Reduces risk of lost coverage during transitions, 3) More states/delivery systems may offer medical home, 4) Prevention benefit improvements, 5) Only demonstration of payment reform, 6) Workforce investments
Affordable	C	1) Makes health care affordable for under 200% FPL, 2) Does not ensure affordability for 200-400% FPL, 3) Does not limit growth of private premiums for 400+ FPL
Universal	C	1) Reduces demographic and need barriers to coverage 2) Unaffordable coverage may reduce enrollment below 95% estimate, 3) Rural initiatives/safety net expansions/disparity initiatives may not improve access
Sustainable	D	1) Extends Medicare solvency by 6 years, 2) Helps states expand Medicaid, 3) Some effort to "bend cost curve" but not enough, 4) No budget discipline for health care, 5) No FTT
Effective	C	1) Initiative commissions and demonstrations to improve effectiveness, 2) Better consumer information, 4) Health disparity initiatives 3) public health/healthy community initiatives

**Affordable:** Using the current US health system is costly for individuals and families. For many, these costs are increasingly beyond their reach. Before the recession took hold, nearly 20% reported difficulty meeting health care expenditures and more than 60% of bankruptcies were attributed to health care. Mounting evidence suggests that low income and middle class families begin to postpone or avoid needed health services as health as total health care spending (premiums and out-of-pocket) exceed 10% of pre-tax income. For most people, both the ability and willingness to pay for health care seems to be reduced dramatically as their health care costs exceed this threshold.<sup>2,3</sup>

ACA dramatically improves health care affordability for many consumers but the legislation leaves out significant population groups and may still force others to choose between health care and other necessities. An estimated 32 million people nearly 1/10<sup>th</sup> of the US population are expected to receive care subsidized through ACA. In addition, there are an additional \$40 million in tax breaks for small business. For those citizens and documented residents with incomes up to 200% of poverty, Medicaid expansions and the subsidized coverage available through the state exchanges will keep health costs below 10% of pre-tax income. Persons with income 200-400% of FPL (about 88,000/year for a family of 4) will receive subsidies through the exchanges, but they will not keep total health costs below 10% of income. For otherwise uninsured, small-business employees, and the self-insured, selecting a qualifying plan from the exchange will offer clearer shopping, defined levels of financial exposure, and comparable benefit packages, and state oversight of the amount of premium increases. Those offered unaffordable health coverage through their employers also can seek less expensive plans on the exchange. Yet none of these ACA components specifically require that plans be available at 10% or less of pre-tax income or that limits the overall growth in premiums. More than 50,000 San Joaquin Valley residents who qualify for assistance through the insurance exchange and/or subsidies for purchasing care may not be able to find affordable plans in 2014. An additional projected 300,000 persons will be both uninsured and undocumented at that time and not eligible for MediCal or subsidies for purchasing private insurance.

**Universal:** The current US health care system does not provide health care for all. There are an estimated 56 million in the US, 6.4 million Californians, and 1 million San Joaquin Valley residents who were uninsured in 2009. While younger adults are more likely to lack health insurance, 61% of the uninsured adults are over age 30 and nearly one fourth of those in fair or poor health are uninsured. Although rates of uninsurance are higher among noncitizens, about 80% of the uninsured are US citizens.

Although the Congressional Budget Office projects that 95% of the US population will have health insurance when ACA is fully implemented, so-called undocumented immigrants are excluded from the exchanges or subsidies. In addition, groups defined by specific health service needs (mental health, long-term care, abortion) may still experience significant gaps in coverage, access, and care coordination. Further, the projected number of newly insured persons may be lower than anticipated. Massachusetts' experience with mandatory enrollment and subsidies has found that many people, particularly younger adults, find the cost of qualifying insurance much higher than the tax penalty for not enrolling. Depending on how states design and operate exchanges and insurance reforms, healthier young adults in California may make similar choices as ACA is implemented and reduce the proportion of the whole population that is insured. While more than two thirds of the persons in the San Joaquin Valley projected to be uninsured in 2014 without ACA will be eligible for subsidies or assistance through the insurance exchange, at least some of these persons may remain uninsured because insurance will still be unaffordable. Further, those who are undocumented immigrants---about 1/3 of the region's uninsured---will be excluded from coverage under the new law.

**Sustainable:** The current US health care system is not sustainable. Total health expenditures reached \$2.3 trillion in 2008, which translates to \$7,681 per person and 16.2 percent of the nation's Gross Domestic Product (GDP). The spending on healthcare has grown faster than the overall economy since the 1960s and is projected to reach 19.5% of the GDP by 2017. Without policy changes, total (public and private) national spending on health care could reach 49 percent of the GDP by 2082. Private insurance

<sup>2</sup>Source: Blumberg LJ, Holahan J, Hadley J, Nordahl K, "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs*, Web Exclusives [Epub, June 4, 2007], Vol. 26, No. 4, July/August 2007, pp. w463-w473.

<sup>3</sup>Source: Banthin JS, Cunningham P, Bernard DM, "Financial Burden of Health Care, 2001-2004," *Health Affairs*, Vol. 27, No. 1, January/February 2008, pp. 188-195.

cannot afford to take care of the oldest and sickest patients because the premiums they would need to charge are too high. Policy makers cannot shift excess cost burden to the states which face rising costs with limited resources. California is an example of a state ill equipped to financially support health care services. The 2009-2010 California budget included a 13% (about \$4 billion) reduction in Health and Human Services despite almost 5% growth in Medicaid enrollment. For the budget year 2010/11 the governor has proposed a 6.3% cut to health and human services, on top of continuing cuts from previous years.

A central hope for ACA is that it will increase the sustainability of the US health system. The ACA invests in a needed array of national panels, new comparative effectiveness studies, and reimbursement reform demonstrations. These initiatives may offer important improvements in both care quality and cost-effectiveness, but it is unclear how quickly these innovations will be more broadly adopted or if states will innovate regulatory and reimbursement frameworks that hasten a drive toward efficiency in health care. Primary prevention and preventive service enhancements are believed to increase population health and thus reduce long-term cost escalation, but it is unknown whether or not the scale and design of the ACA investments in public health and health equity are sufficient to create important impacts on the cost curve in the near term. But the legislation does not establish a pathway to budget discipline at national or other levels for health systems or populations. Without some kind of consensus limits on health care costs, we just do not know if the evolution of administration and practice approach in ACA will bring sufficient incremental reductions in the growth of health care costs compared to other economic sectors so that health care remains part of the social safety net of our society.

It is also important to find the most fair and painless way to distribute the burden of paying for health care. In order to finance new costs in ACA, the program obtains revenues from increased Medicare premiums for the very wealthy, new taxes on so-called “Cadillac health plans,” fees on the health care industry, a tanning tax, savings from Medicare Advantage program changes and additional Medicare savings from unspecified reimbursement reforms.

This financing strategy may limit long-term stability of the program: health care industry fees may contribute to increasing prices and premiums and employers may pull away from the most costly plans more quickly than expected. More importantly, because of several political compromises ACA avoided finding financing sources outside of the health care industry and it also needed to set subsidy levels at the less affordable levels noted above. In a political compromise, ACA does not establish a single national insurance exchange with nearly monopsony purchasing power and more capacity to inspire insurance price reductions. Putting this together, ACA may end up making US health care affordable for fewer people than anticipated and curbing the growth of health care less than needed.

**Effective:** Despite devoting a larger share of its resources to health care than other industrialized countries, the US does not lead the world in the delivery of safe, efficient, and effective care. Surprisingly, when the US health care system's performance is compared to those of other industrialized nations, it lags behind in a number of important benchmarks, including safety, effectiveness, efficiency, access, and equity. For example, on the measure of the number of deaths that could have been prevented with timely and effective care the US now ranks last among the industrialized countries. Ineffective health care in the US has devastating consequences throughout the life course: we have higher rates of infant mortality than our peer nations and only one-half of adults receive all age-appropriate preventative care. Concerns with the effectiveness of US health care arise in all sectors.

In order to promote improvements in effectiveness, ACA calls for establishing a national strategy for health care quality, a national comparative effectiveness research effort, bundled payment and value-based pricing demonstrations, demonstrations program around new health care roles and technologies to improve effectiveness, and new investments in health care and public health work force. ACA also includes an annual physical exam benefit and elimination of preventive service co-pays in Medicare and coverage for preventive services in qualifying private insurance plans. Several ACA elements also address racial/ethnic disparities in care quality, including new data collection, new community health teams, and targeted workforce development programs. Over time these initiatives

may establish new policies and professional consensus on clinical and administrative practices that promote health care effectiveness. Yet it remains to be seen whether these initiatives will produce improvements in care for persons in private insurance or whether providers in underserved areas will have the resources to adopt recommended practice changes. Because many believe that greater health care effectiveness and population health are as much shaped by living conditions and health education efforts launched by public health and community equity advocates, ACA contains significant new investment in public health to support primary prevention and community transformation grants aimed at inequitable living conditions and primary prevention.

### **ACA Implementation: San Joaquin Valley Concerns**

California is on track to become one of the first states to develop the insurance exchange and insurance regulation changes required by ACA. By October 2010 a bill authorizing the exchange had been signed. Government and provider groups are diligently exploring their roles in implementing the new law. Despite early efforts to implement ACA by 2014, California's short-term is harder to gauge. Still mired in the recession, the state seems poised for another round of draconian cuts in Medi-Cal and other safety net programs. The recession has had even more dire consequences for the Valley, where unemployment and lack of health care access have grown even more than statewide, while county and city budgets for health and human services have been slashed. Valley safety net hospitals face huge losses linked to uncompensated care and inadequate Medi-Cal rates, while other safety net providers are reeling with massive increases in demand. Meanwhile, several Valley counties are in the thick of planning or implementing Medi-Cal and indigent care changes, and a new multi-county Medi-Cal managed care program is just getting started. In this context, Valley health care stakeholders focus on maintaining and enhancing our under-funded and over-stretched health system, even while preparing to implement the new law. Using the CAUSE principles, we describe at least six issues that need to be addressed through Valley advocacy for state policy choices and local efforts to participate in federally-administered components of ACA.

- **Finance Care for the Undocumented:** At least 232,000 people or 8% Valley residents are both

undocumented immigrants and uninsured. Although these persons make up 42% of the uninsured in Valley, they are excluded from ACA's Medi-Cal expansions and private insurance subsidies. Inadequate access to continuous and effective care for this population has a significant negative impact on the overall health of our region. Because so many Valley children nearly 1/3 ---live in a home with at least one undocumented adult, it is in the best interest of all residents to ensure access to basic health care for this population.

- **Consider Valley Context in Medi-Cal Expansion** Given our relatively higher dependence on Medi-Cal than other portions of California and a relatively higher proportion of residents living near Federal poverty limits, the ACA expansion of Medi-Cal will be particularly important for our region. State eligibility determination and enrollment policies can dramatically shape the degree to which new patients are brought into the health care system. The Central Valley will need these systems to be culturally and linguistically responsive and geared to the needs of rural and urban fringe residents. Ongoing and enhanced attention to member participation in decision-making in existing and new managed care plans and administrative and clinical enhancements to support high volume service access sites will be crucial during ACA implementation. Finally, California has the opportunity to develop policies that direct a higher proportion of ACA increases in Federal support for Medi-Cal to the most under-served communities.
- **Medical Homes/Care Coordination:** The strong network of Federally Qualified Health Centers and related community clinics in the region have been noteworthy leaders in demonstrating components of the patient centered medical home approach. But most Valley safety net primary care providers are under-funded and have faced few past fiscal or regulatory incentives to fully develop these approaches. Given our vast geography, poverty and historic shortages and mal-distribution of health care resources, rapid progress toward patient-centered medical home programs is more important here than in other regions and coordinated multi-institutional and regional efforts to support these programs should be pursued. California will have the option to develop a Medi-Cal medical home program and Valley stakeholders can encourage adoption of this approach.



- **Health Care Workforce:** ACA devotes new funding to physician and other health professional education and provides new incentives for emerging practitioners to begin their careers in under-served communities. Establishing a medical school (at University of California, Merced) in the region, and supporting enhancements to post graduate training are importance elements of a comprehensive strategy. New funding for community health workers, public health, telemedicine and electronic health records also suggest the need for increased local education and professional development options.
- **Insurance Exchange and Insurance Regulation:** While California has made important first steps in establishing the insurance exchange and regulating private plans, there are many more decisions to make. New California legislation establishes the basic structure of the exchange, but does not include a specific plan for its financing after initial federal funding, nor does it lay out expectations for the exchange in terms of public engagement in decision-making and communications. Communication strategies used by the exchange need to be responsive to the cultural and language needs of Valley residents, and the governance process for the exchange needs to include representation of Valley communities and populations. The new legislation does not establish any clear guidance on the criteria to be used in selecting and regulating plans within the exchange. Valley patients and others could advocate for restrictions on plans that raise rates excessively or fail to adapt benefit and coverage decisions to special needs in rural and under-served areas. California has yet to seriously debate other changes in health insurance regulation as required by the ACA. As these debates develop, there will be opportunities to strengthen or water down other key insurance reforms in the national law, such as the use of community rating, limitations on loss ratios, consumer disclosure, and denials of coverage.
- **Behavioral Health:** All Valley counties are facing a growing gap between demands for mental health and substance abuse services and the availability of such care. Despite the Mental Health Services Act, behavioral health services have been more developed as a specialty service sharply separated from traditional primary care. Targeted initiatives to expand behavioral health in the Federally Qualified Health Centers and other settings can offer more appropriate service options for this

population and relieve pressure on over-burdened hospital emergency rooms and public safety settings.

## **Can We Do Better? Towards an Excellent Equal Opportunity US Health Policy**

The important advances in health policy represented by ACA will expand health care access for many and make important steps towards improving the quality and efficiency of health care in the United States. We have also described a range of implementation strategies and incremental changes that can further improve the health care system. However we believe it is a worthwhile endeavor to achieve better than a “C” grade in fulfilling the goals of continuous, affordable, universal, sustainable and effective (CAUSE) health care in this country. This will require additional changes in US health policies and practices that go further than ACA does in satisfying the principles of CAUSE. Recognizing that our national conversation about health care will become more focused as elements of the ACA are implemented, we describe six areas of change most consistent with the CAUSE goals.

### **1) Break the Link between Employment and Health Care:**

The ACA builds upon the present system of employment-based, primarily private coverage. ACA does not include a publically financed alternative such as Medicare-for-All that would allow employers a choice for purchasing something other than private insurance. Offering Medicare-for-All plans would provide competition to keep premiums in line. Having a national back-up plan available for all would free employees to seek a change in employment without worrying about the consequences of losing their health insurance.

### **2) Eliminate the Concept of Shopping for Insurance:**

Even as ACA improves the continuity of coverage, some gaping holes in the medical safety net will remain. The concept that one must shop for insurance and wait 90 days for it to be in effect is different than having a publically supported plan that offers a core of benefits that are always available should one lose coverage due to a change or loss of employment. Development and incremental implementation of a Medicare-for-All plan would insure that all persons

always have access set of core benefits.

### **3) Bend the Curve: Reduce the Rate of Health Care Cost Increases:**

Although ACA includes some initiatives to slow health care spending increase, several additional actions could be taken to reining in health care costs: a) Create new incentives to strengthen primary care so it provides all components of the patient centered medical home; b) Let go of the tenet that the government or private insurance must pay for all care simply because it is technologically feasible and available; c) Implement health care budgets. National, state, and sub-state democratically elected health boards can monitor utilization and re-shape coverage based on local experiences and values.

### **4) Provide Economic Incentives to Promote Health:**

While the ACA provides some important new investments in public health and primary prevention and new initiatives around the nation seek to create policies and environments that support healthy lives, individuals still have responsibility for doing what they can to improve their own health. We can use existing employer/employee connections to offer tax credits to employers that engage employees in

managing these risk factors. Employers can also offer wage or benefit enticements for meeting personalized goals.

### **5) Consolidate Overlapping Health Coverage:**

While ACA includes aggressive initiatives to reduce fraud and abuse in health care, it does not address the unnecessary expenditures associated with workers' compensation and automobile insurance. Both systems could be reformed to separate the financial compensation from the health care component of these plans.

### **6) Medical Malpractice Reform:**

ACA includes funding for state demonstrations of medical malpractice reform, yet the new law does not feature a consensus on the shape of this reform and the national patchwork of inconsistent policies is likely to remain in place for years. We can enact a national malpractice approach based on alternative dispute resolution principles. An effective national policy would empower professional panels, chosen in consultation with state health boards, to review malpractice claims that cannot be resolved through mediation.