Can Universal Insurance Ensure Access to Healthcare?

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Introduction

Once the Senate passed the Affordable Health Care for America Act (ACA), Barack Obama said, "After a century of striving, after a year of debate, after a historic vote, health care reform is no longer an unmet promise. It is the law of the land."[1] Health care for all American citizens was once a sweet, yet elusive dream, but now it has a chance to meet the needs of an unprecedented number of people. Currently, approximately 20 percent of US citizens lack health insurance – a discrepancy that the American health care reform will reduce in the coming years (figure 1).[2] The ACA promises to cover 30 million more Americans through increasing the size of government-based health insurance programs, providing aid for companies to provide insurance for employees, and supplying help for citizens who cannot afford private health insurance, but who do not qualify for government insurance.[3] Consequently, the ACA will reduce the number of uninsured citizens to 8 percent by the year 2020.[2] Yet, providing health insurance does not ensure equitable access to care. Moreover, all health insurance programs are not alike and the minimal packages may not suffice.

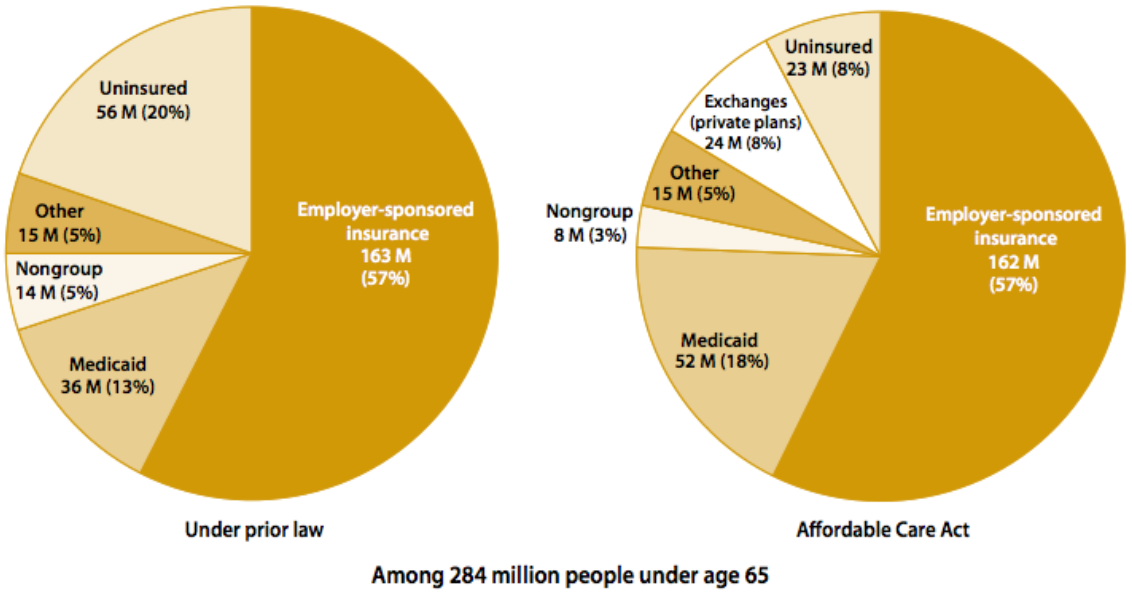

Figure 1: Sources of insurance coverage prior to the ACA and under the ACA in 2020.[2]

In a 2008 Gallup pole, a sample of Americans were asked to identify the most urgent health problem facing the United States. Thirty percent of those interviewed named access to health services as the most significant health problem in the United States.[4] Awareness of healthcare access as a critical barrier to the nation's health has risen dramatically in the past two decades. Inequitable access to medical care poses a substantial threat to receiving proper health care for many citizens. There are several types of access problems, including a lack of health insurance and/or an inability to pay for medical services, a lack of local health service providers, an insufficient amount of health information, and social barriers to receiving health services. Together, these access problems present a many-layered obstacle to providing equitable health care.

Once the ACA diminishes the first barrier to receiving health services by lowering the number of uninsured citizens to 8 percent and making health services more affordable, a critical concern becomes how to provide health services for the newly insured (figure 1).

This issue is especially important in rural areas that tend to have worse health outcomes than urban communities.[5] After adjusting for age differences, rural households have higher rates of mortality, disabilities, and chronic disease than urban communities.[5] Title V of the ACA addresses the second barrier to accessing health services in medically underserved communities by increasing the number of medical professionals across the nation.[6] But the ACA may not be adequate to address the problems of access in rural areas that are as much a problem as insurance in these areas. Lastly, the ACA addresses the final two access problems, mainly through title IV, by increasing access to health information.[7] For without knowledge of medical services, health insurance and access to medical services cannot be vehicles to good health. Thus, ensuring access to care involves not only providing health insurance and medical services, but also health information.

Health Professional Shortage Areas

Currently, 60 million people, which accounts for approximately 20 percent of the U.S. population, live in a health professional shortage area.[8] The federal Health Resources and Services Administration defines a county as a primary care shortage area when its population-to-primary care physician ratio is greater than 3,500-to-1.[8] The U.S. government has identified 6,000 primary care shortage areas.[8] In the same vein, a dental professional shortage area is in one in which there is less than one dentist per 4,000 citizens.[8] More than 4,300 dental health professional shortage areas have been identified according to this criterion.[8] Lastly, a mental health shortage area is defined as one in which there is either less than one core mental health professional per 9,000 citizens or less than one psychiatrist per 30,000 citizens.[5] According to this definition, there are over 3,500

mental health shortage areas.[1,5] While these definitions identify specific communities in need of primary care physicians, dentists, and mental health professionals, there are also shortages of pediatricians, OB/GYNs, and other medical providers. Consequently, this articulation solely reflects the need for a specific subset of health professionals. Without fully accounting for the need to have access to the right kind of medical providers, the U.S. health professional shortage area measure will not accurately illustrate the scope of access problems America faces.

Identifying the Medical Provider Problem in Rural Areas

According to the Association of American Medical Colleges, the nation is expected to have a shortage of approximately 21,000 primary care physicians by 2015.[10] By the year 2020, it is estimated that there will be a shortage of 40,000 primary care physicians.[11] These shortages are based on the large influx of citizens expected to enter the healthcare system because of the ACA and the increasing number of elderly citizens that require more health services.[11] Without expanding the number of primary care physicians in the coming years, this deficit will continue to limit accessibility to health services.

In addition to the insufficient number of primary care physicians, there is an uneven distribution of these medical professionals throughout the nation (figure 2). These doctors typically aggregate in cities with established medical practices rather than in the rural areas that are in dire need of their services. For instance, there are five counties in Minnesota that do not have a single primary care physician.[12] Additionally, these counties tend to house impoverished rural communities whose inhabitants must travel to

[1] The Rockbridge Area currently lacks sufficient access to primary, prenatal, dental, and behavioral health care programs. Additionally, geographic isolation and insufficient transportation options further limit access to health services. It was recently designated as a Medically Underserved Population and is a Mental Health Professional Shortage Area.[9]

neighboring counties for health care. Thus, both the absolute number of primary care physicians and their distribution contribute to the primary care physician shortage.

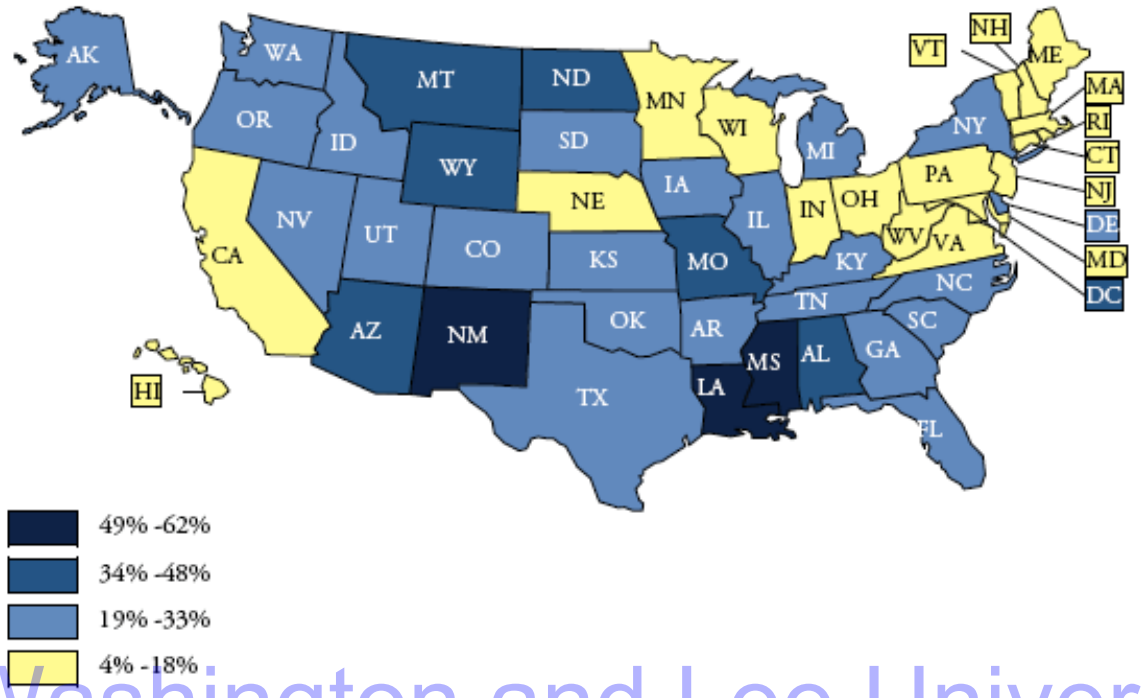

Figure 2: This map identifies states according to how much of their land is defined as a primary care physician shortage area. The dark blue states have 49-62 percent of their state defined as a shortage area, while the lighter blue states have less. The yellow states fare the best, with only 4-18 percent of their state defined as a primary care shortage area.[13]

Currently, 20 percent of the U.S. population lives in rural areas, while only 9 percent of physicians practice in rural communities.[5] Consequently, rural areas of America house 68 percent of the medically underserved.[14] While there are health professional shortage areas throughout the nation, New Mexico, Mississippi, and Louisiana house the largest percentage of shortage areas (figure 2). This trend continues throughout the south and a majority of the western portion of the nation (figure 2). Within these shortage areas, there are 844 counties defined as primary care shortage areas, 525 counties designated as dental shortage areas, and 588 counties identified as mental health shortage areas (figure 3).[5]

More than 60 percent of these shortage areas are in rural settings and are often surrounded by other shortage areas. Consequently, communities within a shortage area are further isolated from health services by surrounding counties that also lack sufficient medical providers. Thus, there are hundreds of rural communities that do not have equitable access to care because they are geographically isolated from health care professionals.

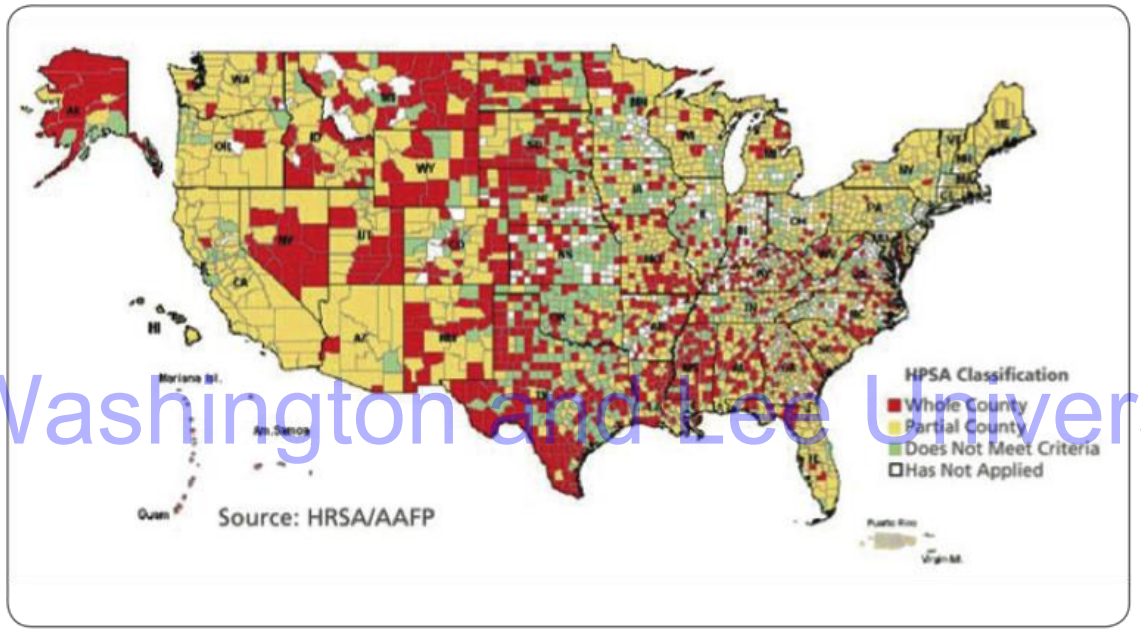

Figure 3: A diagram of the federal health professional shortage areas by county. The red identifies whole counties, yellow for partial counties, green is for areas that do not qualify as a shortage area, and white is for areas that have not applied to qualify as a shortage area.[5] While this diagram highlights provider shortage areas, the deficiencies include both a lack of providers in general, specialized health professionals, and geographical isolation from healthcare.[2]

[2] Rockbridge County, Buena Vista, and Lexington are identified as a Medically Underserved Population for low-income individuals and is a Mental Health Shortage Area.[9] Because lower income individuals tend to have more mental health problems, providing sufficient mental health services to this area will be critical to ensuring the mental health of this community.

Although primary care physicians are central to maintaining a healthy lifestyle, access to specialists is also important. In 1931, 87 percent of American doctors were generalists, but by 1993 this number had dropped to just over 30 percent.[15] This shift in attention from treatment of the whole person through primary care to healing only specific portions of the body is one factor contributing to lower numbers of primary care physicians. Moreover, the declining interest in primary care has further contributed to the nationwide shortage of primary care physicians. The resulting uneven distribution of specialties diminishes equitable access to care.

Currently, a majority of specialists practice in urban areas and consequently do not meet the health needs of rural communities.[15] Increasing the number of primary care physicians – while important – does not address the lack of specialized doctors, such as OB/GYN physicians, that frequently plague rural areas. For instance, without prenatal care, many pregnant women do not receive proper care and their unborn child's health is at risk. Consequently, the types of the physicians working in rural areas are an important consideration in determining whether or not a community requires more health providers. Despite the great need for certain specialties in rural areas, the ACA focuses primarily on increasing the number of primary care workers.

Inadequate Knowledge of Health Services

In addition to the absolute insufficiency of health professionals, many citizens lack knowledge of medical services in their area or may experience social barriers to equitable access to healthcare. While the medical provider shortage remains a national issue, there is a great need to educate people to enable them to make use of their providers. Through increased health knowledge, newly insured individuals will be capable of making informed

decisions about seeking medical care – rather than avoiding the health care system. Without regular visits to medical providers, treatable illnesses and conditions can become serious health risks that require expensive treatments and often, emergency care. Of the individuals living in rural areas who are admitted into the emergency room (ER), 56 percent lived in the lowest income areas.[16] On the other hand, only 30 percent of non-rural ER visits were made by low-income individuals.[16] This data shows that low-income rural communities tend to rely more heavily on the ER for medical care than non-rural low-income communities. Through educating low-income rural communities about how to maintain good health and seek treatment from primary care physicians when symptoms first present, these communities will be able to effectively access health services before needing costly ER care. Moreover, enhanced knowledge of the health system may break the habit of relying on ER care that so many rural communities have. Thus, in order to improve national health, newly insured citizens must be educated about preventative care and how to utilize primary care services.

In the same vein, 30-day readmission rates for adults covered by public health insurance programs were significantly higher than for privately-insured adults.[17] This finding further suggests that low-income individuals tend to utilize health services less effectively than citizens with private insurance. In addition to a lack of knowledge about health practices, the higher 30-day readmission rates for citizens with public health insurance highlights an absence of follow-up care with a primary care physician.[17] Finally, once the ACA provides health insurance and access to primary care services to more citizens, those that relied on the ER for health services will need to be taught how to seek health care and follow-up services from primary care physicians.

Title V of the ACA Incentivizes the Primary Care Workforce

In its final form, Title V of the ACA has 53 sections aimed at improving the health care workforce across the nation.[6] Title V has numerous provisions for addressing the insufficient number of primary care physicians, geographic isolation from medical services, the uneven distribution of specialties, and other access problems. Through these provisions, Title V plans to increase the primary care physician-to-patient ratio to 1 in every 2,000, increase the dentist-to-patient ratio to 1 in every 3,000, and increase the psychiatrist-to-patient ratio to 1 in every 10,000.[5] To reach these goals, Title V will primarily target the health professional shortages. It will begin by increasing access to currently practicing medical professionals by incentivizing primary care workers to treat more Medicare and Medicaid patients.[6]

Title V will support the growth of public insurance programs in order to increase the number of currently practicing physicians that accept Medicare and Medicaid patients. All currently non-Medicare eligible individuals under age 65 that have incomes up to 133% of the Federal Poverty Line will have health care coverage under Medicaid.[18] Consequently, Medicaid coverage will increase from 13 to 18 percent for non-elderly individuals (figure 1). States will receive increased funding in the coming years to manage this influx of individuals newly covered by Medicaid.[18] Moreover, the ACA requires states to extend funding for children in the Children's Health Insurance Program (CHIP).[18] Through increased funding for public health service programs, the ACA provides not only more citizens with health insurance, but also increases the availability of funding health providers receive from Medicaid, Medicare, and CHIP. Thus, the ACA seeks to raise the number of providers willing to serve patients with public health insurance – but the

benefits of these expansions will only be realized with a corresponding expansion of services across the nation.

Strengthening Medicare and Medicaid funding will lend further support to rural medical providers, who often treat more patients with public health insurance. Beginning in 2013, Medicaid payment rates for primary care providers will increase.[6] Enhanced payments for medical providers may increase the number of current health services that accept patients with public health insurance. Consequently, the ACA may expand the number of providers for those with public insurance. Yet, this payment rate increase is only temporary, because the Medicaid payments return to their current rates in 2015.[6] Consequently, this provision may not incentivize more doctors to take Medicaid patients in the long term.

Increasing the Number of Primary Care Workers

After many of the health insurance expansions begin in 2014, there will be a significant demand for primary care physicians. Moreover, this demand will generally be higher in previously uninsured rural areas that tend to constitute medical provider shortage areas.[18] In order to meet these provider needs, there will have to be a significant increase in primary care physicians and their associated colleagues in the immediate future.[18] Within Title V, the Prevention and Public Health Fund will provide $250 million in funding to expand the primary care workforce by increasing the number of primary care residents, physician assistants, and nurse practitioners.[5] This funding should bolster the number of American health professionals that offer primary care – especially in underserved areas.[6] Through supporting primary care workers in underserved areas, Title V hopes to incentivize medical professionals to provide care to those that have the greatest

need. If reached, these goals will expand the medical field dramatically, but such increases may not be sufficient to foster equitable care practices in rural areas. For instance, in the 1970s and 1980s there was an excess of dentists, but many citizens still did not have access to dental care.[5] While the deficiency of dental care was due in part to a lack of dental insurance, an uneven distribution of dentists, a lack of dental facilities in some communities and low Medicaid payments also contributed to this deficit.[5] Consequently, in order to ensure that rural communities have equitable access to care, the government and society must do more than provide temporary payment increases, tax benefits, and loan forgiveness for primary care workers in rural areas.

Training a New Generation of Health Professionals

The ACA also addresses the primary care physician shortage by providing $168 million in funding between 2010 and 2014 for the Primary Care Residency Expansion program.[11] These residents will be encouraged to work in rural areas and in community health centers (CHCs) by the ACA providing financial support to Area Health Education Centers that focus on encouraging health care providers to work in rural areas.[20] Additionally, the ACA will increase the number of Graduate Medical Education training positions by redistributing unused slots to primary care and general surgery slots and to states that have low resident-to-physician ratios.[18] Within other higher education programs, the ACA will support health professional scholarships, loans, and state grants for individuals who will become primary care physicians.[18] Together, these provisions aim to increase the number of health professionals across the nation. Yet, it takes seven years of education and post-graduate training in order to create a primary care physician. Thus,

ACA provisions to support medical education and training may support primary care sector growth in the long-run, but do not address short-term supply issues.

While providing state grants and loans to students who will become primary care physicians will allow for a moderate increase in the number of health professionals in medically underserved areas, it does not ensure that medical students will become primary care physicians. In 2010, most residency programs were completely filled, but the family medicine residency programs only filled to 91.3 percent.[11] Thus, it is not a lack of available primary care positions that limits their number. Simply supplying more funding to medical schools and states to support an increased number of primary care physicians will not solve the medical provider shortage. The negative attitudes toward a career in primary care and the income gap between specialized and primary care physicians must also be addressed.

Providing Incentives for Primary Care Physicians

Currently, primary care physicians receive a significantly lower salary than specialists. In fact, there is a $135,000 yearly salary difference between primary care physicians and specialists.[11] This salary disparity makes in more difficult for primary care physicians to repay medical school loans once they begin practicing. In addition to the lack of incentives in terms of future salaries, the allure of specialized medicine and a desire to work at large practices all contribute to the physician distribution issue. The ACA incentivizes primary care medicine by allocating $5.6 billion over the next decade to bonuses for primary care workers and general surgeons that practice in defined health care shortage areas.[7] Additionally, this funding will help in the redistribution of unfilled residency positions in the primary care area, allow for increased flexibility in residency

training programs, and promote the expansion of teaching programs within primary care residencies.[7] Together, these Title V provisions help to support development of the primary care workforce and diminish the long-standing negative attitudes toward a career in primary care.

Yet, temporary bonuses may not be enough to lessen the salary gap between primary care and specialized physicians in the long term. It takes 7 years to finish medical school and complete a residency program, and consequently, a newly trained primary care physician practicing in a rural area will only receive a bonus from the ACA provision for 3 years. Without a long-term solution to the salary deficit between primary care and specialized physicians, it will be difficult to motivate medical students to enter into the primary care workforce. In conjunction with federal loans and scholarships supported by Title V, increasing primary care physician salaries and benefits may serve to make the field more attractive for medical students.

Expanding Community Health Centers Through Title V

Community Health Centers (CHCs) currently provide primary care services to approximately 20 million uninsured US citizens at more than 8,000 sites across the nation (figure 4).[21] The CHCs offer primary care services to individuals – regardless of their insurance or financial status. Services include not only primary care, but also dental, behavioral, and social services.[22] All CHCs accept Medicaid, Medicare, and most insurance plans.[23] In 2010, 35 percent of CHC patients had Medicaid, 25 percent had Medicare, and others were either uninsured or had private insurance. Moreover, 70 percent of CHC patients have incomes below the Federal Poverty Line.[22] Because of their mission to provide health services to all individuals, patients pay for services based on a reduced

sliding scale that accounts for both income and family size.[23] These provisions have allowed CHCs to offer healthcare to a wide variety of individuals since the late 1960s when the first CHC was established.[22] Despite the important role they play in offering medical services to underserved populations, 43 percent of health professional shortage areas do not have a CHC.[22]

Through investing $11 billion in CHCs, the ACA will help expand health services to up to 20 million more patients.[21] Beginning in 2011 and continuing through 2016, the ACA will utilize this funding to support the growth of CHCs in medically underserved communities.[21] Moreover, Title V will aid CHCs in the development of community-based collaborative care networks that support information sharing and referrals between CHCs and private medical providers.[21] By establishing a network involving CHCs and other medical providers, referrals can occur among network participants, which will expedite the referral process and ensure more efficient care practices. Additionally, prior to the ACA, CHC patients needing specialized care typically could not afford services at private medical centers. Yet, the ACA will allow CHC patients to receive treatments they otherwise could not afford by providing them with public insurance and increasing access to specialized care through primary care physicians. Thus, Title V supports collaboration among medical providers to expand the efficacy of CHCs and provides aid for patients so that they can benefit from these collaborative care networks.

Although these provisions aim to increase the efficiency and effectiveness of health services through CHCs – especially in rural areas – there still exists significant barriers to these medical providers. Because CHCs traditionally maintain their independence from the broader health community, new relationships among health providers will take time to

establish.[21] Moreover, many CHCs are geographically isolated from specialty providers. Thus, it will be difficult for CHC patients in rural areas to utilize referrals to far-away providers unless they receive help with transportation.

CHCs are currently providing services to mostly uninsured and impoverished patients that do not contribute financially to CHCs.[22] Additionally, CHCs will serve approximately 20 million newly insured citizens once the personal mandate is fully in effect. While their patient load will grow substantially in the coming years, an increased number of insured patients may provide them more economic security. Yet, reimbursement policies currently undervalue primary care services.[22] Insufficient payments for primary care combined with an increased number of patients may actually diminish the financial security of CHCs and their ability to offer high quality health services. Thus, while Title V focuses on utilizing CHCs to increase access to health services, their financial security must be ensured in order for them to continue providing sufficient medical care.

Figure 4: Distribution of Community Health Centers in 2008.[22]

Funding Title V

In its final form, Title V has fifty-three sections aimed at improving the health care workforce.[7] Many of these sections are critical to ensuring efficient progress in the health field, yet only a few have reserved funding. Consequently, numerous sections will fight for funding in appropriations each year. The central oversight tenet of Title V is the establishment of The National Health Care Workforce Commission (NHWC), which is a commission that will analyze health care workforce needs and offer advice to Congress and the White House about how to allocate funding to the health system.[7] This oversight commission has the potential to dramatically increase efficiency and progress in the health system. Additionally, it addresses the inherent decentralization present in America's mainly privatized health care system.[7] Despite its potential to focus national resources on current health issues, the commission is funded through the appropriations committee.

Without a stable funding source, the NHWC may not be able to perform its function adequately because its continued funding depends on a dynamic political atmosphere.[7]

While the ACA offers incentives to students and universities to expand the number of primary care physicians and workers, these workforce provisions are eclipsed by ACA support for coverage expansion and CHC investments.[19] For instance, ACA funding for physician training programs is determined by the appropriations committee and thus does not have guaranteed funding.[18] Without funding, training programs and other agendas that expand the primary care workforce cannot support future health workers and increasing the number of primary care physicians will be impossible. Only after developing the primary care sector and distributing these workers equitably across the nation will the ACA be able to effectively improve access to health services.

Title IV: Providing Health Education

While Title V of the ACA addresses the medical provider shortages specifically, Title IV supports the development of health education programs that will enable citizens to effectively utilize their health insurance and medical providers.[24] Under Title IV, each state will design a public awareness campaign to educate Medicaid patients about preventative services.[7] Through these education programs, Medicaid patients can begin to utilize medical services more effectively and learn to seek care early. In the same vein, Medicare patients will have access to Annual Wellness Visits that will allow patients to develop and/or update a personalized prevention plan.[25] Such planning will not only allow Medicare patients to more fully use their health system, but it will enable their doctors to become better acquainted with their patients and their health needs.

Additionally, a grant program will support school-based health clinics to provide both preventative and primary care to underserved families not covered by Medicare.[7] These programs will educate both children and their families on how to maintain good health and brings healthcare into the school system, which further increases access to health knowledge. While these provisions will incorporate health information into health services, knowledge does not imply capability. Programs that not only educate but also support families during the process of learning how to utilize the health system and manage their own health are also necessary. Only through learning how to care for one's own health will an individual have the capability to utilize medical providers.

Beyond simply increasing knowledge of health services, Title IV will promote a healthier American lifestyle in order to prevent disease.[24] A National Prevention, Health Promotion, and Public Health Council will utilize a $13 billion Trust Fund to create a national prevention program that will support a healthy American lifestyle.[24] Through this Council, programs that focus on promoting proper nutrition and require chain restaurants to post the caloric content of their foods will become commonplace.[24] While these lifestyle provisions do not directly increase access to medical providers, they do reinforce knowledge of nutrition gained in the doctor's office. Thus, Title IV has the capability to increase society's ability to make healthy decisions both inside and outside the doctor's office.

Policy Suggestions

The ACA addresses numerous healthcare access problems through providing health insurance programs, bolstering the number of primary care physicians, and preventative care education programs.[7] Although Title V has provisions that will increase access to care

overall, its programs may be too diffuse to properly diminish the expanding problem of the health care workforce shortage.[25] Consequently, supplemental programs are crucial to ensure its effectiveness. A central issue regarding the primary care workforce shortage involves the negative opinion of primary care as a career. Only through strengthening public opinion of primary care physicians and providing the proper incentives to primary care doctors will more medical students enter into primary care practices. Moreover, because the workforce shortage is a multifaceted problem, additional provisions that more thoroughly confront geographical, educational, and other barriers to maintaining a sufficient number and distribution of health care workers are necessary. Yet, tackling so many disparate problems may slow overall progress by having such a diffuse solution. Thus, a balance between creating programs that address the medical provider shortage in rural areas and ensuring their effectiveness must be found.

While Title V does have provisions for increasing the number of midlevel medical providers in rural communities, its central focus is on primary care doctors and CHCs.[6] This shortcoming may limit the efficacy of Title V and diminish its ability to increase access to health providers in medically underserved areas. In the long-term, bolstering the primary care workforce will lead to more favorable health outcomes overall, but it does not adequately address the need for certain specialized health providers in rural areas. Only through incorporating more incentives to train and employ alternative health workers, such as midwives and nurse practitioners, will the ACA effectively diminish the unequal distribution of specialties across the nation. Nurse practitioners take less time to train, but are capable of serving as a patient's primary health care provider. Additionally, nurse practitioners are trained to focus on prevention, wellness, and education in conjunction

with treating the patient. Because they are trained to treat patients in a multi-dimensional manner that is more welcoming to individuals that are unfamiliar with the health system, nurse practitioners may be more accessible to rural communities. Thus, by training more alternative health workers such as nurse practitioners, it may be easier to address the medical provider shortage in rural areas.

Beyond primary care, other alternative health workers such as "dental therapists" and "community paramedics" may also increase access to health services in rural communities.[12] In rural Minnesota, training midlevel providers to perform services typically offered by dentists and paramedics increases access to medical services. For instance, licensed dental therapists can fill cavities and pull baby teeth under the supervision of a certified dentist.[12] In the same vein, a physician-supervised community paramedic can treat minor injuries and chronic illnesses without taking patients immediately to the ER.[12] Together, these midlevel medical providers can work in underserved, rural areas to bring increased access to health services. Because these lower-level health professionals take less time to train and demand a smaller salary, impoverished communities will be better able to support them.

Finally, the current distribution of and specialization of physicians constitute two of the central problems of the medical provider shortage. Despite this knowledge, Title V focuses on the primary care workforce shortage. While Title V increases access to primary care medicine, it fails to address the need for cardiovascular, prenatal, endocrine, and other medical services in rural and medically underserved areas. These other needs have become secondary to primary care because the ACA could not meet every health need without becoming too diffuse to be effective. Additionally, providing health insurance, increasing

access to primary care, and the development of collaborative care networks will allow primary care physicians to refer patients to specialists. By focusing on primary care, Title V has created primary care workers as the stepping-stone to specialized care. This will allow an increase in access to specialists for those without the capability to do so before the ACA. Yet, in order to be effective, it must be feasible for rural communities to utilize specialized care. Until the ACA or other reforms can offer a means for rural communities to meet their multidimensional health needs, providing health insurance and primary care will not effectively increase access to healthcare overall.

Conclusions

Medical delivery needs to evolve. Through the ACA, numerous modifications will fundamentally amend the healthcare system in order to increase access to health services. The ACA reaches out to the rural areas of America that currently house 68 percent of the medically underserved.[14] First, the ACA has expanded Medicaid funding in order to include more individuals, which not only increases access to medical services, but also provides a more significant funding source for doctors.[6] Second, Medicaid payment rates for primary care services will be at least 100 percent of current Medicare payment rates from 2013 through 2014 in order to incentivize more doctors to treat Medicaid patients.[6] Despite this increased funding, Medicaid payments will return to their current level in 2015, which may prevent primary care practices from treating Medicaid patients in the long-term. Third, Title V will increase the number of primary care workers through improved payments in the form of tax breaks and bonuses for primary care workers that practice in rural areas.[6] Fourth, Title V will also expand the number of primary care workers through the Primary Care Residency Expansion program, scholarships, and loan forgiveness for medical

professionals who intend to work in medically underserved areas.[6] Together, these provisions should increase the number of primary care workers where they are most needed – in rural communities. While these programs address several of the underlying reasons for medical provider shortages, much of their funding is allocated for in appropriations and thus there is no guarantee that they will increase access to medical services for a significant period of time. Fifth, a central tenant of Title V focuses on enlarging the number of CHCs across the nation – especially in rural areas that do not have equitable access to medical services.[6] This provision should open up a large number of previously isolated communities to healthcare. Sixth, Title IV of the ACA focuses on preventative care through expanding knowledge of health services and health planning that will increase access to medical providers by making society more aware of treatments and how to maintain a healthy lifestyle.[24] In addition to numerous other health programs, these provisions should expand access and knowledge of the American health system.

While the healthcare reform allocates funds and increases access to medical providers, it will nonetheless struggle to reach all Americans and improve national health without becoming more cost-efficient. Policies that directly address the reasons for the current medical provider shortage must not only involve financial considerations that lessen the income gap between primary and specialized physicians, but also address the underlying causes for the medical provider shortage. On a broader scale, sustained support of many Title V provisions will be necessary to see the long-term benefits and inefficiencies of the ACA. Although Title V addresses numerous barriers to healthcare access in rural areas, future reforms will be necessary to ensure the effectiveness of the ACA. Finally, while the ACA cannot address all inequities in medical service distribution and gaps in the

provision of care throughout America, the healthcare reform has taken the first step towards a more unbiased and efficient system.

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