VIEWPOINT

Implications of New Insurance Coverage for Access to Care, Cost-Sharing, and Reimbursement

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The good news for patients is that starting in 2014 the Affordable Care Act (ACA) requires individual and group health plans to issue policies to all applicants, regardless of health status. Through the ACA's individual mandate, insurance exchanges, and Medicaid expansion, guaranteed issue will provide new coverage for millions of citizens. Having insurance, however, does not always guarantee access to primary care.

Lost in the political rhetoric around health reform and technical glitches in the HealthCare.gov website are a set of critical decisions that many physician practices will have to make in the coming years. These decisions may very well contribute to the ultimate success or failure of the ACA.

The ACA and Primary Care

One consistent policy theme throughout the ACA is that, for the coverage expansion to work, additional primary care practitioners will be needed to care for the newly insured. To make primary care more attractive, the law temporarily increases Medicare and Medicaid primary care reimbursement, eliminates co-pays for preventive services, and invests in the primary care workforce through training programs and loan forgiveness. Although these ACA provisions are welcome, private practitioners will nevertheless be faced with difficult decisions about whether to accept new patients.

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The US primary care landscape is changing with fewer small, independent practices, yet the vast majority of primary care is still being delivered by groups of 11 or fewer physicians.[1] Many primary care practices, especially in the population centers expected to account for a large share of the newly insured, are already at or near capacity. Like any other small- or medium-sized business, these practices will have a range of considerations when deciding if the risks associated with increasing patient volume are worth the rewards.

Cost-Sharing on the Exchanges

As the federal and state health insurance exchanges emerge, understanding of how these products will pay for services is becoming clearer. The ACA provides income-based subsidies to help pay for out-of-pocket costs, but the lowest-premium bronze and silver plans cover only 60% to 70% of medical expenses and require cost-sharing of up to $6350 for individuals and $12 700 for families. High deductibles, co-pays, and coinsurance in the exchange products may shift some of the collection burden from the insurer to the practice.

The exchanges, at least early on, are most likely to attract the uninsured, persons who qualify for subsidies or Medicaid, and individuals with preexisting conditions. Many of these persons could struggle to pay out-of-pocket costs; nonhospital collection on medical debt was only 16.7% in 2012.[2] Practices will have to determine what level of collection risk they are willing to incur and whether they will require payment at the time of service or extend credit through billing.

Medicaid Reimbursement

Twenty-six states to date have decided to "opt in" to the ACA's Medicaid expansion, with 5 others still considering options, including using the funds to pay for private insurance. Although estimates of new Medicaid enrollees have declined, the ACA's expansion of Medicaid to cover persons with incomes up to 138% of the federal poverty level is still projected to add more than 12 million persons to the program by 2022.[3]

Medicaid reimbursement rates have been a perennial concern for physician practices. Medicaid pays only 59% of Medicare primary care rates on average, and even less when compared with private insurance.[4] Reimbursement rates and practice participation vary significantly between states. For example, in New Jersey, only 46% of primary care physicians accepted new Medicaid patients in 2011-2012 compared with 53.7% in California, 74.8% in New York, and 85% in Wisconsin.[5] In addition to reimbursement, physicians have cited payment delays, administrative burden, and missed appointments as reasons for not accepting new Medicaid patients.

To increase practice participation during Medicaid expansion, the ACA increases Medicaid primary care rates for 2013-2014 to 100% of Medicare physician fees. During this period, Medicaid primary care reimbursement will experience its largest increase in the program's nearly 50-year history. Depending on their capacity to accept new patients, practices will have to decide whether the 2-year rate increase is worth the risk of adding staff and additional space to accommodate new Medicaid patients.

Aside from financial and administrative considerations, practices are also guided by a set of legal and ethical standards that accompany patient care. While patients can terminate a relationship with a clinician or practice at any time, physicians cannot simply stop seeing a patient when, as will be the case with the temporary Medicaid payment increase, their reimbursement rate is reduced. Continuity of care regulations requiring practices to ensure an ongoing source of services as well as ethical guidelines that forbid physicians from neglecting existing patients will be important considerations.

Quality Measurement

Primary care practices are increasingly being required to report a host of quality measures as conditions of participation in both government and private insurance programs. Several provisions of the ACA adopt this approach and provide both incentives and penalties for meeting quality benchmarks.

Beginning in 2015, the ACA transitions the Medicare Physician Quality Reporting Initiative (PQRI) from a voluntary program to a mandatory one, requiring that by 2017 all physicians report on the 138 individual quality measures applicable to their practice. Physicians who elect not to participate will see a payment reduction of 1.5% beginning in 2015, increasing to 2.0% in 2016 and beyond.[6] The ACA also allows Medicare to use quality data to reward and penalize clinicians and practices through the Value-Based Payment Modifier program.

Outcomes and performance-based payment initiatives have shown mixed results in terms of quality improvement.[7] These initiatives could also have the unintended consequence of creating disincentives to accepting some newly insured patients. Clinicians may avoid seeing patients with complex health issues whom they fear might reduce their overall performance scores.[8] Transportation problems and socioeconomic status are among the factors associated with missed appointments and link nonattendance to poorer outcomes.[9] If physicians perceive, rightly or wrongly, new patients insured through Medicaid or exchange products as less likely to adhere to treatment recommendations or to keep scheduled appointments, the number of practices not accepting these new patients could increase.

Conclusion

Whether the goal of the ACA in providing access to care for millions of uninsured US citizens is realized depends largely on the current primary care system to treat newly insured patients. The reimbursement and regulatory structure of the US health care delivery system makes decisions about accepting new patients particularly complicated for physicians, other clinicians, and practices. Practice consolidation, investment in health information technology, and development of new care models are under way, but the current primary care infrastructure still consists of tens of thousands of small- and medium-sized businesses. Although it is uncomfortable to consider lack of access to care and unmet human needs in economic terms, these small primary care practices must weigh the opportunity of absorbing newly insured patients against the financial and regulatory risks. How, how much, and how long clinicians and practices will be paid for their services under Medicaid and the exchanges will be important considerations. It may well be that the ACA's temporary reimbursement increases coupled with high cost-sharing insurance products and payments tied to quality measurement are simply not an attractive enough business proposition.

ARTICLE INFORMATION

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