

THE AFFORDABLE CARE ACT: HOW HAS IT AFFECTED
COMPETITION AMONG PHYSICIANS
IN THE HEALTHCARE INDUSTRY?

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ABSTRACT

The Affordable Care Act is changing the way healthcare is delivered in the United States. The bill, which was signed into law in early 2010, requires everyone to have health insurance in the United States. The full impact of the law has yet to be fully realized because it is not fully implemented and will not be for several years. However, it has driven consolidation within the industry among providers for a myriad of reasons. Providers are consolidating in order meet the bill's requirements regarding quality and spending, which has impacts on spending as well as competition. The Affordable Care Act is affecting the decisions individual physicians make in deciding how they practice. The bill has serious implications for a physician's ability to practice care effectively, and they are choosing to consolidate or to sell their practices to large hospital systems and become employees to hospital systems in order to meet the requirements of the bill. These changes in the way individual physicians practice will have an effect on the way healthcare is delivered as a whole, and it is yet to be made clear whether or not this consolidation will be beneficial or not.

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INTRODUCTION

Affordable healthcare has been a growing issue in America over the last decade. Healthcare costs in the United States have grown disproportionately to Gross Domestic Product, while the global ranking of the United States healthcare system has been steadily dropping (World Health Organization, 2000). The healthcare system is unique to other industries in the United States because of the insurance system that is in place. In other industries, the consumer directly pays for the good or service received. In healthcare, the consumer of healthcare is divorced from the payment for those services because of the insurance system (Wiley et al, 2014). This has historically insulated consumers from the rising costs of care. Shifts in the last decade in the insurance system to higher premiums, copays, and co-insurance have exposed consumers to the financial risk of rising healthcare costs through increasing premiums. This shift has brought healthcare to the forefront of the American public debate. There is also a large portion of the United States' population that struggle with the cost of health insurance, and there are many more that are uninsured. In an effort to control healthcare costs, while attempting to reform the healthcare delivery system, the Obama Administration signed the Patient Protection and Affordable Care Act (also known as the Affordable Care Act or ACA for short) in an attempt to reform healthcare through lowering medical costs and expanding availability of care. There have been attempts to reform the healthcare delivery system during Clinton administration, but it ultimately failed. Like its historical predecessors, the Affordable Care Act is both criticized and praised by Americans across the board. The administration, and much of the American public, believed something had to be done about the way healthcare was being delivered in the United States, but whether or not

ACA is the right solution has yet to be made clear. ACA has affected the infrastructure of healthcare and it will continue to affect all stakeholders involved - large commercial insurance companies, providers of healthcare, and patients alike. This paper analyzes how ACA affects physicians in the healthcare space, specifically how it affects their competition.

The Current Climate of the Healthcare Industry

The healthcare industry is large and complex because of the way healthcare services are financed, delivered and regulated. Healthcare services are delivered by a number of entities such as hospitals, doctors' offices, nursing homes, outpatient surgery centers, and other types of facilities (Hoovers, 2014). The US healthcare sector includes more than 830,000 hospitals, doctors' offices, emergency care units, nursing homes, and social services providers with combined annual revenue of about \$2.2 trillion (Hoovers, 2014). The industry is affected directly by the age of the population, because younger people typically do not need healthcare as much as older people (IBIS, 2014). The United States healthcare sector has seen an increase in physician visits over the last 3 years, and it was expected to see a 6.9 percent increase in 2014 (IBIS, 2014). This trend is due to the aging population in the United States as well as the expansion of care through the Affordable Care Act (IBIS, 2014).

Within the industry, services are typically delivered in two types of settings: inpatient and outpatient. Inpatient services are services performed when a patient has to stay in a hospital for more than 24 hours to receive surgical procedures or medical treatment. Outpatient services are services that are performed when the patient does not

have to stay in a hospital; these visits are less than 24 hours¹. This includes, but is not limited to, office visits to physicians, radiological services, outpatient surgeries, etc. An outpatient visit can become an inpatient visit if the patient needs to be admitted into the hospital after an outpatient procedure. (An example of this would be a CAT scan finding a mass that would need to further testing and would require the patient to stay in the hospital).

The major services of the healthcare industry include hospital care (45% of industry revenue) and care provided by physician practices (20% of industry revenue). The remainder of industry revenue is made up of other services like dental work, urgent care, hospice care, and social assistance (Hoovers, 2014). The United States healthcare system is different from rest of the world because of its unique combination of financing and ownership of its healthcare system. Healthcare in the United States is financed through federal and state governments as well as the private sector, which makes the system very complex. Most doctors' practices and other outpatient facilities are run as for-profit enterprises, in which the practice's net income is the physician's compensation (Hoovers, 2014). This is important to competition between physicians because the amount of patients treated in a given timeframe (or the efficiency) of their practice impacts physician compensation. In most healthcare service payment models, a doctor is reimbursed by insurance providers (private or government) based on the service performed; this reimbursement is net revenue for the practice. This model rewards volume rather than quality because there are few checks in place to ensure quality. There is much debate about this model of reimbursement. The Affordable Care Act attempts to address this deficiency of the current reimbursement model and incentivize reform. Even

¹ Outpatient services can occur in a hospital setting.

though these changes are in their beginning stages, there is movement towards rewarding quality rather than quantity.

Healthcare providers are reimbursed from private insurance companies or the government through various federal and state programs such as Medicare and Medicaid. The United States operates using what is called a “multi-payer system”, in which different entities reimburse healthcare costs for consumers (Hoovers, 2014). This is a complex process and it can cause uncertainty in how much a physician or a hospital will be reimbursed when it comes to a particular service because that patient has a unique combination of payers. In the United States, 85 percent of the population is covered by private or governmental health insurance and 15 percent is uninsured (Hoovers, 2014). Often times, people are covered by a combination of private and government policies, with about 55 percent of Americans covered by employer-sponsored health insurance. Medicare covers 15 percent and Medicaid covers another 15 percent (Hoovers, 2014).

Hospitals play a vital role in the industry because they are central form of patient care. They typically operate at margins between two and six percent because of the high cost of operating hospitals (Hoovers, 2014). There are some hospitals that have high levels of uninsured patients, which can cause them to operate with negative margins (Hoovers, 2014). Uninsured patients cost a hospital the same amount as an insured patient, but they are typically not reimbursed for the care of these patients. As competition and regulation pressures increase, hospitals are seeking to reduce inefficiencies. Hospitals, as well as ambulatory care providers, are consolidating to gain economies of scale and improve outsourcing abilities for specialty services (Hoovers, 2014). The passing of the Patient Protection and Affordable Care Act is also driving

consolidation among providers in order for them to meet the legislation's requirements. This is causing hospital systems to combine into large systems that span across different geographic areas, and as a result individual practices are being acquired into these larger systems.

The Affordable Care Act

In March 2010, President Obama signed comprehensive health reform, The Patient Protection and Affordable Care Act (Affordable Care Act, or ACA), into law (Kaiser, 2013). This act requires most US Citizens and legal residents to have health insurance (Kaiser, 2013). It plans to ensure this through the American Health Benefit Exchanges, through which individuals can purchase coverage. There are premiums and cost-sharing credits available to individuals and families who have income between 133-400% of the federal poverty level, which was \$19,530 for a family of three in 2013. It also requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange. The original bill expands Medicaid availability to 133% of the federal poverty level, however this was deemed unconstitutional by the Supreme Court, and states are able to opt out of this expansion² (Kaiser, 2013). The goal of these new regulations and requirements is to increase the access of coverage to more people and decrease the healthcare disparities that exist in the United States.

All newly eligible adults are guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges (Kaiser, 2013). The increase of insured patients will be disproportionate to the increase of healthcare providers, which could potentially cause people to lack quality care (Anderson, 2014). Additionally,

² This was deemed unconstitutional by the Supreme Court because it is a Federal Mandate that states were required to do without funding from the Federal Government. States are allowed to opt out if they choose.

government funded programs often pay less to providers than commercial programs, which can drastically affect revenues associated with a physician (in a private clinic or in a hospital setting). Small physician practices sometimes refuse to treat Medicare or Medicaid patients because of this disparity (Hoovers, 2014). This is a large factor in physician competition, because an individual physician practice's payer mix affects that particular physician's compensation. A physician can be seeing a large volume of patients, but if a large percentage of those patients are Medicaid or Medicare patients, those visits might not be generating enough revenue to cover the cost of care and the physician's compensation. For providers that practice charity care, which is providing care for patients who they know cannot afford care, ACA offers the ability to make profit on these previously uninsured beneficiaries. In this aspect, ACA will aid certain physicians. However, practices that do not have high volumes of charity patients could now have an influx of lower paying patients.

ACA is an attempt to make healthcare more affordable by ensuring that everyone has healthcare insurance. It also seeks to increase the quality of care provided through a series of mandates. ACA has allowed the opportunity for more people to have access to the healthcare system, but it has yet to improve the quality of care. ACA is driving massive consolidation by using Medicare payment policies to drive doctors and other medical professionals into a small number of large hospital systems. Hospitals rely on Medicare because it is the largest revenue stream for hospitals due to the types of patients they serve. Because of this, Medicare policies incentivize the consolidation of hospitals and physician practices. This limits the amount of patient choices when it comes to selecting a healthcare provider. Theoretically, the ability for patients to choose

incentivizes physicians and healthcare systems to provide the best quality care they can in order to retain patients. However, this is not always the case in the healthcare system because consumers are not as price sensitive to healthcare services because of the insurance system.

While there is much research about how ACA has affected competition between insurers and providers as a whole, there is a gap in research when it comes how it is affecting individual physicians. While physicians are considered in the effects of ACA, little is publicly known that demonstrates exactly what is happening to them and the decisions they are making in the wake of ACA. The government calls for increasing regulation and more patients to be seen and provided for, and hospitals continue to buy out physician practices. Understanding how physicians are affected is important for the population to understand, because physicians are crucial to healthcare. This paper looks at the facts of how ACA is affecting physicians in the industry and develops some understanding on how ACA is affecting the industry as a whole.

Defining Terms: Physicians and Competition in the Healthcare Industry

Providers in the healthcare space are the deliverers of healthcare. The term “provider” is used to describe physicians, hospitals, emergency centers, and so on. Different types of providers have different views of ACA. Hospitals are a large advocate for ACA because of the way they operate. Most hospitals provide charity care, because they care for anyone who comes through their doors, regardless of ability to pay. This causes them to care for patients for which they are not reimbursed. However, with ACA, these previously uninsured patients will now be insured, and thus provide the hospital with revenue. Even though this might be a lesser revenue relative to private insurance, it

is still greater than the revenue they would have otherwise received. Physicians have historically been separate from hospitals, for various reasons, and their relationship was symbiotic. However, the relationship is becoming more integrated. Physicians still practice as independent providers of care. In this form of providing care, physician practices are independent from hospitals, and the physician's compensation is paid out of the practice. If the practice is not doing well, the physician's compensation will be harmed.

The ACA has already drastically changed the Healthcare Industry, and change will continue to happen as the different parts of the ACA continue to be implemented. In particular, competition has been affected because of the implications of ACA. Competition for individual physicians is the ability to attract patients, support their practice, and administer quality care. While there has been an increase in the amount of physician visits in 2014, there is concern from the physician side of how it is affecting their revenues because they are seeing more Medicare and Medicaid patients, which yield lower revenues than patients with commercial insurance payers. Individual physicians are finding it more and more difficult to do all these things well, and ACA has made it harder. ACA is not necessarily making competition worse, but rather changing competition within the industry.

Physicians practice in different locations across the healthcare industry. The largest drivers of industry revenue are hospital care and outpatient care provided by physicians³ (Hoovers, 2014). Physician practices are typically run as for-profit entities because the physician's income comes directly out of the business. The practice's

³ Hospital revenue accounts for 45 percent of industry revenue and outpatient care provided by physicians accounts for 20 percent (Hoovers, 2014).

revenue (and therefore the physician's compensation) is directly tied to how many patients are seen and the quality of those patients' insurance. Hospital systems affect the individual physician, so it is important to understand how they impact each other.

There are a number of different ways that competition among physicians can be analyzed. ACA is affecting individual physician's reimbursement for services, and ultimately their compensation, which could have implications for the industry as a whole. Consolidation in the industry is important to physician competition because it affects the individual physician's market power. In a system with a few number of large providers, the individual physician loses power, both in whom they are seeing, as well as their negotiations with insurance payers. In the industry, compensation means how much money a doctor makes, and reimbursement is what a doctor is paid for a service from an insurance payer. Doctors are largely reimbursed by insurance payers, which factor into their compensation. The two are closely connected, especially when looking at individual physician practices. Reimbursement for services from private payors is typically based off of what Medicare pays for those services. Through ACA, physicians' compensation is being affected because of the nature of government payments for services. ACA is affecting physicians both internally and externally. Externally, ACA is driving massive consolidation in the industry, with large hospital systems emerging, causing many physician practices to be acquired or be forced out of the market. It is also causing physicians to consolidate into physician groups in order to meet ACA requirements. Internally, ACA is affecting physician's reimbursement of services through ACA Exchanges. ACA also failed to address the Medicare physician payment system, particularly the Medicare Sustainable Growth Rate, which could also have large

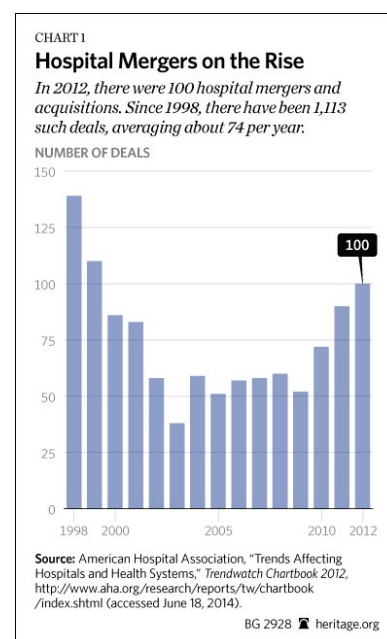
implications for physician reimbursement. All these external and internal factors are changing competition for individual physicians.

HOW ACA IS AFFECTING PHYSICIAN COMPETITION

External Forces: Consolidation in the Healthcare Industry

Hospital Consolidation

The current trend in the healthcare industry is consolidation. There has been an increase in hospital mergers in recent years largely because of healthcare reform. Incentives for physicians and hospitals drive healthcare providers to consolidate in order to benefit from economies of scale and increases bargaining power with insurance providers and physicians (Tcamarata, 2013). This trend is seen in the transaction history in recent years of hospital merger and acquisitions. The chart⁴ provided by the Heritage Foundation



shows the uptrend in hospital consolidation over the last two decades. The original increase in hospital consolidation in the early 2000s was a result of Clinton's attempt of healthcare reform and the introduction of HMOs, which drove consolidation across the industry. A large reason for the unwinding of these conglomerates was the backlash against HMOs. People did not want to spend a lot of money on healthcare, and they also wanted more flexibility when it came to choosing care. People did not like HMOs, in

⁴In the wake of Clinton's failed healthcare reform and the rise of HMO's, hospitals and healthcare systems consolidated. They ultimately failed in consolidation for a few reasons, the main reasons being: backlash against HMOs from the general public and not having the IT to support the large systems and the systems unwound as a result. This is why there is a dip in the early 2000s (Wiley, 2014).

large part because they did not want to be told what to do when it came to healthcare (Wiley, 2014). This poses interesting insight into ACA and the consolidation that is happening as a result of reform. As consolidation and integration of care continues to happen, people could begin to have a backlash against the strict ways care is delivered, as they did in the past.

A large factor in the recent consolidations is the Affordable Care Act, which has driven market consolidation because of its reliance on the Medicare payment system, which is the largest source of revenue for hospitals. Christopher Pope, a PhD and former Graduate Fellow in the Center for Health Policy studies, discusses how ACA has affected the entire industry by being the main driver in hospital consolidation. He argues that ACA advocates anti-competitive arrangements, allowing for the growth of “super healthcare systems” that dominate local markets (Pope, 2014). The healthcare industry is complex and difficult to manage because of its scale and its need; however, Pope believes that ACA has done the opposite of what it claims to do by putting constraints on the free market powers of the industry through regulations and mandates. The policies are in place with the hopes that dominant providers will use their higher revenues to offset the cost of more expensive care (for example, emergency visits). This policy is being enforced through the Medicare program, which favors large healthcare systems because of their ability to generate revenue.

In some cases, hospital consolidation has increased efficiency and decreased the cost of care for consumers. The initial wave of mergers in the healthcare industry yielded 7 percent in price reductions for consumers (Pope, 2014). However, the trend of price reductions among mergers only seems to hold true among small hospitals. In bigger

health systems with fewer providers, there are inflated costs, which hurts the consumer. The largest argument against massive hospital consolidation is that it gives hospitals unfair leverage with consumers, insurers, and physicians. When there are few healthcare providers in a local area, consumers have to choose to go to the most convenient provider, especially if it is an emergency. The consumer is often protected from the cost of care because insurance pays for most of consumers' medical expenses, but what allows providers in healthcare markets to be competitive is the insurance provider's ability to exclude providers from networks. When a hospital system dominates a local area, it is difficult for insurance providers to exclude them if they are imposing price increases (Pope, 2014). This gives large hospital systems more bargaining power with insurance payors, allowing them to contract higher rates than smaller providers, and sometimes these rates are above the cost to provide care. These increases in reimbursement are then passed along to the consumer by insurance companies. This poses a major threat to competition in the industry as a whole because large providers dominate provider networks, thus making the individual physician a very small piece of the picture. When hospitals acquire physician practices, they often buy out the practice from the physician. When a hospital buys out a practice, the physician is given a salary, often times along with a productivity bonus.

Pope's article addresses issues with the Affordable Care Act and competition in the healthcare industry. For his argument, he takes a macro view and focuses on hospitals, rather than the micro level view of how the individual physician is being affected by ACA. He takes the approach that the healthcare system is like any other industry in a capital market and that it should be free to move and adjust prices

accordingly. Under this assumption, the large conglomerate hospitals become like massive companies and individual physician practices become small businesses. Under this assumption, physicians are clearly affected by the massive consolidation trend in the industry. Unchecked by competitive forces, hospitals are able to charge more and are compensated more for their services than smaller facilities (Pope, 2014). However, Pope's argument does not take into account that the healthcare system is not like other markets. The industry is necessary for the population's survival, and the large disparities that existed before ACA were causing massive problems that had to be addressed. Pope's argument addresses the macro effects of ACA without any focus on how it has affected the physician workforce. These implications affect the physician competition, because individually, they do not have market power to match the massive hospital systems being generated by ACA.

The Impact of ACA on the Physician Healthcare Workforce

Thirty million Americans who were previously uninsured are expected to gain health insurance through the Affordable Care Act. While the idea behind increasing the availability of healthcare to those who need it is good, there has to be a workforce to support the increasing amount of patients. Healthcare professionals criticize ACA because it increases the burden on an already fragile system by demanding the care of more patients than the system has the operational capacity to support. The expansion of insurance to these 30 million individuals is not necessarily an expansion of care because it does not guarantee that everyone who purchases insurance will be given the best quality of care available, or care at all (Anderson, 2014).

The healthcare industry's workforce is already under great stress. According to experts and medical economists, shortages are projected for every profession in the healthcare space. The impact of ACA will only increase the demand for these providers' services, while the supply of the physician workforce remains the same as it has historically. The system is also under stress because of the aging population. This poses a threat both within the physician workforce as large numbers of physicians approach retirement, but also because the demand for medical services increases as the population ages (Anderson, 2014). As this trend is realized, availability of medical services will decrease as providers of healthcare services retire and demand for medical services will increase as the aging population will need more medical services. These trends already pose a strain to the healthcare industry, and ACA is increasing this strain because of the increasing demand.

Another issue with the supply of healthcare providers is the disproportionate number of primary care providers and specialists. In the healthiest countries, around 40 to 50 percent of providers are primary care providers. Currently, the United States' provider base is only about one third primary care providers. The ACA relies on the healthcare system having enough primary care providers to deliver services to the newly insured population. An additional 8,000 primary care physicians would be needed to support the added amount of insured people under the ACA (Anderson, 2014). There is also a lower incentive for medical students to study to become a primary care physician because their compensation is less than that of a specialist, so the cost of going to medical school to become a primary care provider is not as appealing compared to specializing (Anderson, 2014). While the ACA is seeking to improve the health of the population, it is not taking

into account the physicians who support the healthcare system. While insuring a larger amount of people, it does not seem to consider the number of physicians who will provide the services.

The Affordable Care Act was created with the intention of expanding insurance to the entire population, while also increasing the quality of care and decreasing the cost of care through incentives. The ACA will not be able to increase the quality of patient care because the physician workforce will be strained (Anderson, 2014). Increased regulation means added paperwork for healthcare workers, which adds to the problem of not being able to meet patient needs sufficiently. According to Anderson, the ACA will only increase the workload of the workforce, both in sheer number of patients that need to be seen, and in the amount of additional paper work that must be done to meet the ACA's regulation requirements (Anderson, 2014). By increasing the amount of insured patients and increasing the amount of regulation that providers must do impedes physician's ability to provide quality care. In order to keep up with the benchmarks set by the ACA, providers will have to find ways to balance it all or risk of having negative profit margins.

The Affordable Care Act relies heavily on mandates, penalties, and bonus reimbursements in order to enforce compliance, which has proven to do more harm than good. Over the past few years, penalties have totaled \$227 million for hospitals and facilities that failed to meet the ACA's standard. A large proportion of the hospitals and facilities affected were located in rural regions with low-income patients (Anderson, 2014). Providers are experiencing reductions in revenue, while also trying to increase the quality of care to maintain the ACA standards to avoid penalties. This is resulting in a

vicious cycle that is detrimental to the providers that the ACA is supposed to help. Physicians escaped a reduction in Medicare reimbursement rates in 2013, but are expected to see a 25 percent reduction in 2014 (Anderson, 2014). This reduction in Medicare reimbursement will make it increasingly more difficult for providers to break even. The ACA penalizes them for not meeting the quality of care, but also puts downward pressure on their revenues and bottom lines. This may put increasing pressure on physicians to not consolidate in order to avoid these risks.

In order to remain competitive in the healthcare industry, providers have to plan to stay ahead of the ACA regulations and requirements. This trend is causing a change in the infrastructure of healthcare practices. Consolidation data on the healthcare industry indicates that hospitals, individual physicians, group practices, and other healthcare businesses are merging and consolidating to remain strong and competitive in the marketplace. Consolidating can reduce overhead costs for billing and claims by taking advantage of economies of scale, and it also spreads out the financial risk of the entities' market share (Anderson, 2014). While it is necessary for these parties to consolidate to remain competitive, it is adversely affecting fair competition in the market. As the number of healthcare systems in the market decreases, those individual systems' ability to leverage against insurers increases. This trend could result in a decrease in the quality of care because the competitive checks that ensure that providers are meeting quality of care requirements are eliminated.

Furthermore, independently owned physician practices are decreasing in number within the industry. Rather than keep up with the increasing regulations, costs, and workloads created by the ACA, physicians are choosing to consolidate or sell their

practices. By 2011, 50 percent of physicians were no longer working independently and were employed by a hospital or corporation (Anderson, 2014). When a physician practice is acquired by a hospital, the hospital takes on that practice's overhead and the physician is then paid as an employee of the hospital. There are mutually beneficial reasons for this occurrence, one of which being the practice being able to take advantage of the hospital's economies of scale in operational areas, like the billing and collection systems. However, physician's being on payroll increases the hospitals' operating costs, which puts downward pressure on hospitals' bottom line, increasing the price to insurers and patients alike as hospital systems grow in size (Anderson, 2014). While consolidation has the potential to increase efficiencies, it can adversely affect the price to consumers and reduce the quality of care.

The ACA seeks to increase the availability of care to the uninsured by providing them with the ability to purchase insurance. While the ACA increases the amount of insured, it does not guarantee care. The increasing demand for medical services is met with downward pressure on the supply of medical services in many different ways. While there are different opinions about the ACA, there are trends generated by its implementation that cannot be denied. Consolidation is happening across the board as providers plan to meet the ACA benchmarks in order to remain competitive. By doing so, massive health conglomerates are emerging that dominate their local regions. These conglomerates have unfair advantage in regards to patients, insurers, and the government. As the cost of care increases and providers struggle to meet the ACA requirements, physicians are attempting to remain competitive by participating in acquisitions and mergers.

Internal Forces: Physician Compensation and Reimbursement

ACA Exchange Products

Traditionally, physicians have been reimbursed under a fee-for-service model, which reimburses the physician for each service performed. Reimbursement from commercial payers is based off of what Medicare will pay for a service⁵. Typically, commercial payers will pay more than Medicare, depending on the contract the physician has with that particular payer. This gives doctors an incentive to have patients that have insurance from commercial payers because it guarantees that they will have better revenue with those patients than they would with patients who have Medicare or Medicaid. Under ACA, uninsured people are able to purchase insurance from exchanges that are set up in the marketplace. Like the other government funded insurance, these insurance plans yield lower levels of reimbursement for physicians.

Exchange insurance yields lower reimbursement for physicians, which is proving to be an issue for physicians in the United States. In a 2014 nationwide survey of ACA implementation done by Medical Group Management Association, physicians have expressed their issues associated with ACA products and how it is affecting their practices. Of the 40,000 physicians that participated, 23.5% will not be participating with any health insurance products sold on ACA exchanges (MGMA, 2014). Based on this sample size, American Action Forum estimates that 214,524 physicians of the 893,851 physicians nationwide are not participating (La Couture, 2014). This service provides

⁵ Medicare is the benchmark for reimbursement for medical services across the industry.

insight into why physicians are opting out or choosing to participate. Physicians that are opting out of exchange products have given clear reasons for why they are opting out. There are three main reasons physicians are opting out: narrow networks and lower reimbursement rates, high deductibles on exchange products, and the risk of patients not paying premiums (MGMA, 2014).

The narrow networks⁶ that are created by insurers for exchange products, partnered with lower reimbursement rates, is a large factor in why physicians are choosing to opt out of ACA exchanges. Insurers compete with one another to sell the subsidized insurance by lowering payments made to physicians, which lowers the cost of the plan. There are antitrust laws in place that make it difficult to acquire hard data on what a physician's rates are, but it is estimated that for every \$1.00 that commercial plans pay, Medicare pays \$0.90, and the exchange plans offer as low as \$0.60 or \$0.70 (Rabin, 2013). Insurers paying this low amount to physicians argue that physicians will make up the lack of reimbursement from larger volumes as a result of narrow networks. Theoretically, primary care physicians will be seeing patients with exchange insurance – however, there is already a massive shortage of primary care physicians due to the higher reimbursement rates of specialized physicians (HRSA, 2013). Primary care physicians report being strained as it is, and there is projected to be an increase in the demand for primary care physicians as the population ages. This potential increase in volumes of patients that will yield less revenue to already overburdened physicians is causing them to opt out of exchange products.

⁶ Narrow networks are created by insurers that only allow exchange products to see a “narrow” network of physicians, thus guaranteeing that those patients see the physicians on that plan.

Another reason physicians are opting out of participating with exchange products is the concern that the patients on these plans do not fully understand their benefits or their obligations of payment (La Couture, 2014). According to the 2014 MGMA survey of ACA implementation, 75 percent of treated patients on the exchange plans were ‘very’ or ‘extremely likely’ to have high deductible plans, meaning that the exchange plans have higher deductibles to offset the lower premiums. The concern among healthcare providers is that patients on the exchange plans do not understand that they are obligated to pay their deductibles when receiving care, and these deductibles are high. There have already been reports of patients on exchanges realizing they are obligated for the deductible amount for services and have been unable to pay or have cancelled appointments because of it (La Couture, 2014). Providers also fear that these patients will rush to get ‘delayed care’, in which they are still obligated to receive care despite being not having paid the deductible. This action leaves the physician uncompensated for administering that care.

The number one reason physicians are opting out of exchange plans is the fear that patients may stop paying their premiums. In private markets, individuals lose coverage if they stop paying premiums (La Couture, 2014). In exchanges, there is a 90-day grace period where the patient has time to pay their bills, but still is guaranteed care. If the individual does not pay the premium by the end of the 90-day grace period, the insurer does not reimburse the provider for that patient, and the provider does not recover the cost for caring for that patient. For these reasons, physicians are choosing to opt out of exchange plans, and it is proving to be problematic in some areas of the country. In California, it is estimated that 70 percent of physicians have opted out of Covered California Plans, which demonstrates the gravity of this situation (La Couture, 2014).

Similarly, 11 out of the top 18 hospitals nationwide are only accepting two or fewer of the exchange plans, while continuing to service private plans, for the same reasons physicians are opting out (Richards, 2013). This is an alarming trend, and it appears that for these groups of providers, ACA is actually doing the opposite of what it was intended for.

According to the MGMA 2014 ACA Implementation Survey, 23.5 percent of providers surveyed are opting out, but the other 76.5 percent are continuing to participate in exchange products. The number one reason for providers to remain with exchanges is to remain competitive in their local market (57.6 percent of providers surveyed), and the second highest reason is charity (39 percent) (MGMA, 2014). The largest reason physicians are choosing to participate in exchanges is to remain competitive in their markets, which may indicate that the participation could be fragmented geographically. A large reason for physicians opting out of exchange networks is the difficulty of operating in narrow networks, which are controlled by insurance providers. Physicians have expressed concern about how these narrow networks will work (MGMA, 2014). There is also concern among providers about availability of information regarding who is in the narrow network. This puts the burden on the provider to find out whether or not they are in the narrow network or not, which can be more difficult than it sounds because the federal exchange websites are confusing and vague (La Couture, 2014). Narrow networks can make it difficult for physicians to administer proper care because it limits whom a physician can refer a patient to if they need to see a specialist or need a certain procedure completed. If a physician is unaware what other providers are in their narrow network, it can make the process of administering care more difficult. For physicians, it is also much

harder to determine patient eligibility, cost-sharing information, and the plan's provider network for ACA exchange patients (MGMA, 2014). The MGMA 2014 Survey also found that it was difficult for physicians to determine whether or not the patient was on an ACA exchange product or not. But of the physicians surveyed that are participating in ACA exchange products, 80 percent are only participating with between one and five exchange products, and according to the MGMA Survey, there are more than 20 exchange products. Even though the majority of physicians surveyed are participating, it is in a limited capacity.

The reality of the situation is that it is too soon to really know how ACA will affect physicians in the long run. There seems to be a disparity in the amount of information available to providers, and this is affecting how providers feel about ACA exchanges. According to the MGMA 2014 Survey, providers as a whole do not see ACA affecting the volumes of their practice in the near future. However, the majority of physicians surveyed were specialty physicians, and it has already been determined that primary care physicians' volumes will be affected the most by ACA. Narrow networks also pose a problem in that primary care physicians have expressed their difficulty in trying to get a proper referral visits for exchange patients because of the narrow networks (MGMA, 2014). This puts physicians in a bind, because it limits, or at least hinders, their ability to service ACA exchange patients.

While ACA has given insurance to a huge population of previously uninsured people, it is still indeterminable how ACA has truly affected providers. Time and more data will be needed to determine this. The reality is that ACA puts pressure on the provider to increase the quality of care and the number of patients they see, while also

lowering the cost of care. ACA's exchange products provide lower reimbursement for each service provided, thus putting the physician's reimbursement at risk. With individual physicians already struggling to practice independently, the risk of lower reimbursement is causing physicians to consolidate their practices, or sell their practices to hospitals. By doing this, they go from having their money paid out of the practice to being paid a salary. By being employed by the hospital, they are held harmless to fluctuations in reimbursement payments.

Medicare Sustainable Growth Rate

A large issue among the healthcare industry is the Medicare physician payment system, namely, the Medicare Sustainable Growth Rate (SGR). The SGR was established by the Balanced Budget Act of 1997 as a means to control Medicare spending on physician services. Medicare creates a Fee Schedule⁷ made up of reimbursement fees for each medical service. The reimbursement fee is calculated using a formula⁸ that consists of relative values for a physician's work⁹, geographic modifier, and a monetary factor. This monetary factor is what converts the equation into money, which is what each service is reimbursed; it is also what the SGR affects. The SGR sets a growth rate target for Medicare expenditures based on enrollment, economic growth, and provider efficiency (Ryan, 2015). There is another formula that predicts whether or not actual spending will or will not exceed the target, and adjusts the conversion factor accordingly (Ryan, 2015). At the time of its creation in the late nineties, it seemed like a satisfactory way to control medical spending because the economy was doing well and Medicare

⁷ The Fee Schedule is a matrix that details each service that can be performed by a physician and its calculated reimbursement.

⁸ Not to be confused with the SGR Formula. This formula was created by Harvard researchers in 1988.

⁹ Relative Value Units: Measure of value for each service provided by a physician based on the work performed.

spending met the expected targets each year. However, as the economy began to contract, medical costs continued to rise. As a result, the SGR called for a 4.4 percent annual cut to the conversion factor (Ryan, 2015). This was widely unpopular, and since then Congress has delayed implementing the SGR factor conversion happen. As a result, the gap between target spending set by SGR and actual spending has been cumulatively increasing over the last decade. If the conversion factor were to be cut as a result of the SGR formula, reduction in Medicare spending would be as much as 26 percent, which would have catastrophic effects across the healthcare industry.

If the cuts called for by the SGR were to happen to Medicare spending, physician payments through Medicare would be reduced by more than 20 percent. This has large implications for providers, especially individual physicians. The cost of providing care would far exceed Medicare reimbursement for services, which could potentially cause many individual physicians to have to leave the Medicare system because they simply would not be able to cover their costs with Medicare (Ryan, 2015). If large amounts of physicians were to leave the Medicare system, it would affect access and delivery of care, particularly for senior citizens who rely on Medicare and Medicaid for much of their healthcare. These cuts would also affect people under exchange insurance, and people who had Medicare extended to them under ACA. Another issue with the large potential cut in Medicare spending is reimbursement for services from private payors. Reimbursement from private insurance companies is based on what Medicare pays for each service. If SGR were to make cuts to Medicare spending, physician reimbursement would decrease across the board, which is why the SGR is at the forefront of current political debate.

The ACA did nothing to address the SGR, which is a large issue in healthcare reform. The Medical Group Management Association did not support the health care reform package because of its failure to address the Medicare Physician Reimbursement, particularly the SGR¹⁰ (Jessee, 2009). MGMA believes that the Physician Reimbursement system needs to be completely fixed, and the SGR done away with. ACA's failure to address the SGR has implications on the healthcare industry, particularly on individual physicians. With the potential threat of reimbursement cuts on Medicare, individual physician's reimbursement is highly at risk. This threat of a 26 percent cut in reimbursement could be driving physicians to consolidate further in order to hedge their risk against the dip in reimbursement. As discussed earlier, by being employed by a hospital, individual physicians are paid a contracted amount, and are held harmless to fluctuations in Medicare reimbursement. ACA's omission of SGR has left physicians more at risk financially, which is inevitably driving further consolidation in the healthcare industry. Although ACA did not address the SGR, Congress is finally addressing the Medicare payment system as of late March, 2014.

CONCLUSION

ACA has driven consolidation in the Healthcare Industry; a continuing trend that is being accelerated by the mandates put forth from ACA. Consolidation concentrates the market and affects the cost of care. Individual physician practices are decreasing in number because of this. Individual providers are choosing to sell their practices or consolidate into groups. In some situations, individual providers who become salaried

¹⁰ MGMA has Healthcare Reform Principles that are believed to be necessary for healthcare reform. The number one principle is "Fix the Medicare Physician payment".

employees by hospitals become hard to manage in terms of the cost of care they are providing, because they are now held harmless to business risk they were previously exposed to. This has shown to drive up the cost of care, thus affecting the individual. ACA's goal is increase quality, while also decreasing the cost of care. ACA has allowed for movement towards quality improvements, but it leaves the individual provider at a disadvantage against the massive conglomerates in the industry. Most individual providers are joining with other providers, or choosing to be acquired by the health systems. This lowers competition among physicians in local areas, because it decreases the amount of independent providers. The individual is affected because these trends could affect the cost of care. ACA already affects individuals trying to acquire insurance, and consolidation could further affect the cost and quality of care.

ACA also affects individual provider's compensation through the lower reimbursements of exchange products. Physicians are accepting these lower reimbursements in order to remain competitive. This threatens physician competition because it causes physicians to work harder to get paid less, which could deter people from wanting to be doctors. The narrow networks, of which physicians have little information about, also affect providers. These providers are typically lower cost, meaning they are more efficient. These more efficient practices are now unknowingly being added in networks in which they will get lower reimbursement rates for the services they are providing. ACA is built on the healthy, young people of America paying more to cover the unhealthy uninsured. If young people begin opting out, people who were previously uninsured and receiving financial assistance will be unable to pay for care because of increased premiums. If these people are treated and not paying, providers

will be losing money. In this way, ACA could prove to be a vicious cycle that only increases the individual's cost of care without actually covering the uninsured. ACA also adds a huge number of uninsured individuals to an already burdened system. What is not understood is that these newly insured people are not all guaranteed care.

Whether or not the consolidation trends that are a result of the Affordable Care Act are beneficial has yet to be determined. The reality is that the way individual physicians practice is changing as a result of ACA. The regulations and mandates set forth in ACA are causing physicians to consolidate into groups in the forms of entities like Accountable Care Organizations. The effects of ACA on physician reimbursement are also driving the integration of physicians into hospital systems, eliminating the individual physician practice from the healthcare industry. This could potentially be a good thing, as hospitals are able to provide better management of poorly run physician practices. However, large hospital systems have more market power in their ability to negotiate higher rates with insurance companies, which are ultimately passed along to the consumer in the form of higher premiums. Based on consolidation trends in since the last attempt at United States healthcare reform, consolidation happens as a result of reform, which is in many ways counteractive to what reform is attempting to create. It is yet to be made clear whether ACA will bring about the change that Clinton's reform did not. However, based on the similar trends seen in the industry, this consolidation could ultimately prove detrimental, and cause providers to dissolve into smaller groups again. Ultimately, ACA is reshaping competition for the individual physician by incentivizing them to consolidate to keep up with ACA regulations and prevent losses in reimbursement.

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