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Expanding coverage
How primary care physicians are accommodating the newly insured

Executive summary

Are there enough physicians in the US to accommodate the millions of newly insured patients? If not, how will the health care system manage its growing (and aging) patient population?

The Deloitte Center for Health Solutions *2014 Survey of US Physicians* shows that 44 percent of physicians are treating more newly insured patients – an important finding for health care stakeholders and decision makers. More primary care physicians (PCPs) (56 percent) experienced an increase in the number of newly insured patients than did surgical specialists (40 percent), non-surgical specialists (38 percent), and other physicians[1] (33 percent). Survey respondents report that this is causing longer appointment wait times and driving PCPs to work longer hours. To cope, some PCPs are adding new physicians and hiring clinical staff to help with care coordination.

How does this compare with the Massachusetts experience with coverage expansion? What impacts will expansion of health care coverage to the newly insured have at national and state levels? What effect will it have on the role of the US safety net system and hospital emergency departments? How will growth in the insured population affect mid-level providers and retail health and urgent care clinics?

Physicians are already experiencing increased demand from a larger patient population. Adapting to that demand is one of the next challenges, not only for physicians, but for many health care stakeholders and decision makers. States and other policy makers may want to consider policy solutions to alleviate physician pressure, including increasing Medicaid primary care service reimbursement rates, sponsoring patient-centered medical homes (PCMH), advancing scope-of-practice standards, and reducing barriers to technology adoption. While physicians will continue to play a critical role in the US health care system, they will likely need to adapt to ever-growing patient numbers and demands. And, they should adapt quickly and prepare to weather the storm. Physician practices should consider redesigning care delivery models, developing new relationships, using data and analytics, and improving patient engagement.

Overwhelming increases

Medicaid expansion and the new health insurance marketplaces have generated a throng of newly insured patients. Gallup's latest poll estimates the US uninsured rate dropped to 13.8 percent in 2014 – the lowest rate in seven years.[2] Medicaid and the Children's Health Insurance Program (CHIP) added 10.8 million enrollees to patient rolls in 2014. This represents an 18.6 percent increase over October 2013, just before most individuals had the opportunity to enroll in new coverage options provided by the Affordable Care Act (ACA).[3]

This coverage expansion could burden the already strained US health care system. In 2010, there were an estimated 205,000 full-time-equivalent (FTE) PCPs. However, the Health Resources and Services Administration (HRSA) estimated that actual demand was 212,500 – a 7,500 shortfall. This imbalance is expected to increase: HRSA estimates that the number of FTE PCPs will grow eight percent by 2020 but demand will outpace that growth, reaching 14 percent by the same year (See Figure 1).[4] More than 65 million individuals live in the 6,100 health professional shortage areas (HPSA) designated by HRSA.[5] These are primarily rural areas, where the typical PCP treats more than 3,500 people.

PCPs in Medicaid expansion states are facing dramatically increasing demand for services. Not only are more people enrolled in the program, the newly enrolled are asking for more PCP visits than the previously enrolled Medicaid population. For example, the Medicaid expansion population in Kentucky is using PCP services 55 percent more than the traditional Medicaid population.[6] As a result, the state legislature passed a bill that expanded nurse practitioners' scope of practice. Under the initiative, nurse practitioners in Kentucky can prescribe medications, which may lead to better disease management in patients with chronic diseases, especially those who live in the state's rural areas.[7]

Finally, insured individuals are more likely to use more services than the uninsured. Deloitte's *2013 Survey of US Health Care Consumers* showed that insured consumers visited their doctor for a well visit or routine check-up (69 percent) more often than their uninsured counterparts (30 percent).[8] The experience of the state of Massachusetts with coverage expansion reinforces this trend.

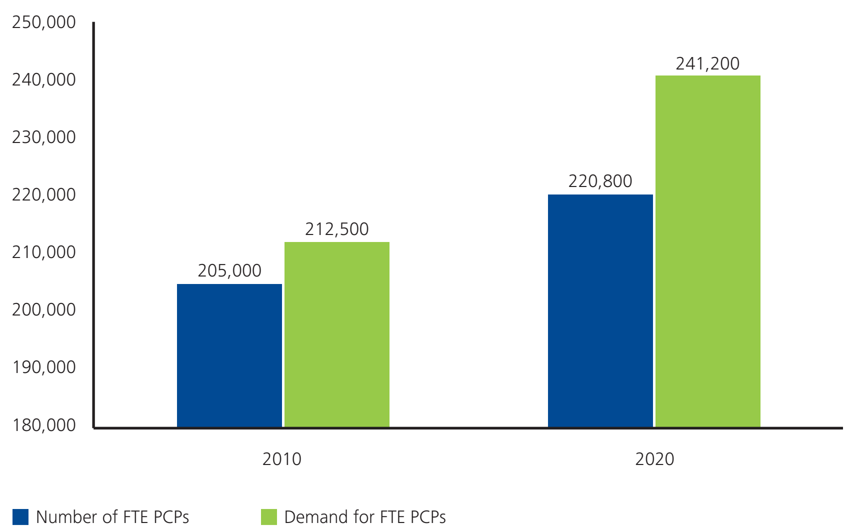
The Massachusetts experience

Massachusetts mandated health insurance coverage and expanded financial support to buy coverage for low-income populations in 2006. As a result, the uninsured rate dropped from 13 percent in the fall of 2006 to seven percent in the fall of 2007.[9]

In the year immediately following the coverage expansion, more individuals reported having a usual source of care and obtaining preventive care in the prior year. However, more people also reported not getting the care they needed, and many had trouble getting an appointment or finding a doctor who would see them.[10]

Massachusetts witnessed an uptick in emergency visits after expanding coverage. There were more than 424,000 visits in 2006 compared with 442,100 in 2008, a four percent growth rate. This trend remained consistent across all ages and geographic areas. Despite the overall increase, low-severity visits among low-income and uninsured patients decreased during the observation period.[11]

Figure 1. Number of FTE PCPs compared with demand, 2010 and 2020



Source: HRSA

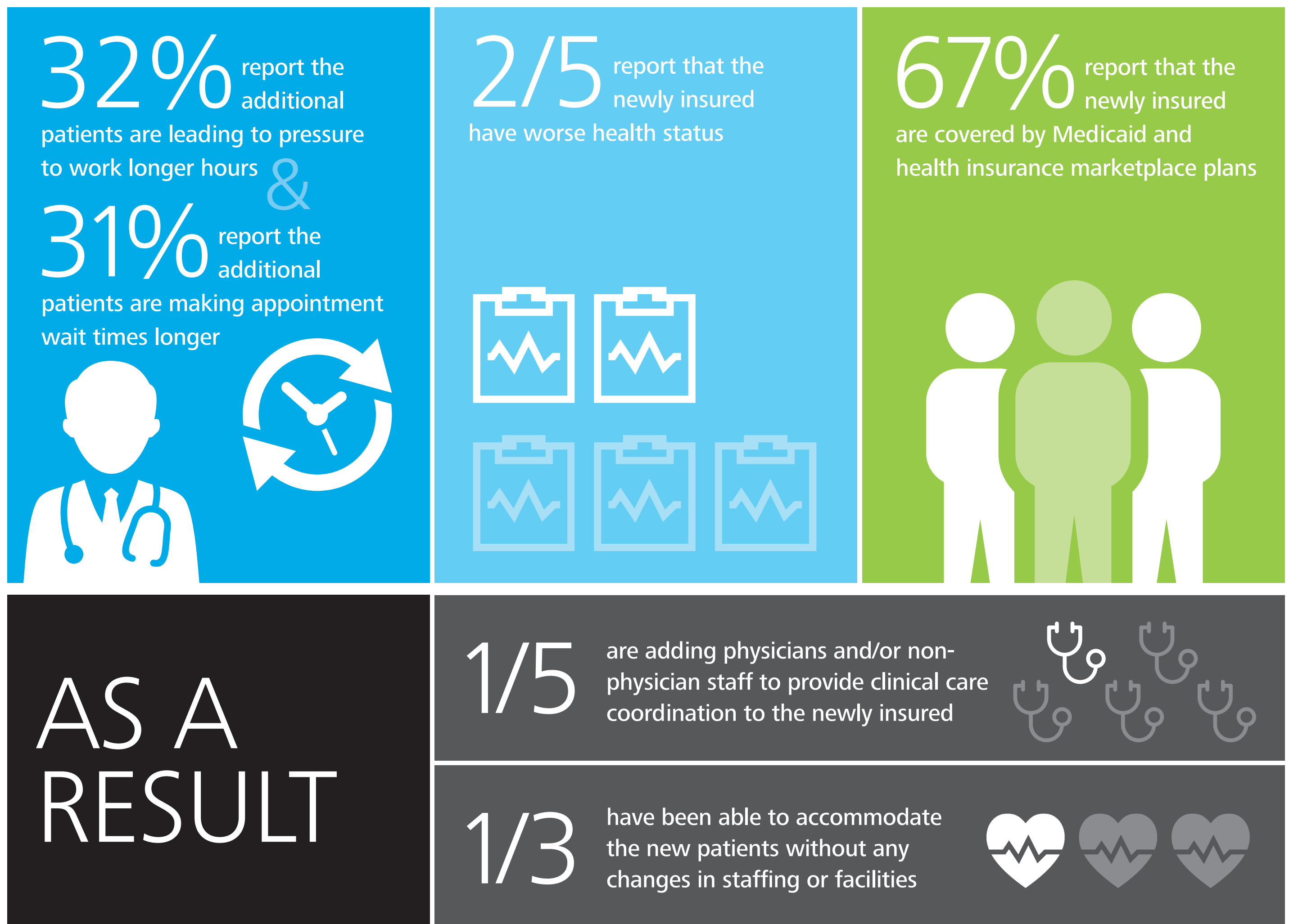
The impact on physicians

The Deloitte Center for Health Solutions *2014 Survey of US Physicians* is a nationally representative survey of 561 physicians. It was fielded in 2014, shortly after the national coverage expansion. This early glimpse into the expansion shows that US physicians, especially those in primary care, feel the effects.*

Patient demand is swelling. Forty-four percent of all surveyed physicians have seen an increase in patients that were previously uninsured. However, the increase in those patients varies by specialty: PCPs (56 percent) are more likely to report seeing seeing increases in newly insured patients than surgical specialists (40 percent), non-surgical specialists (38 percent), and other physicians (33 percent).

Among PCPs with an increase in newly insured patients, many report that the patient influx is straining resources. Nearly one-third of PCPs report that this has resulted in them working more hours and patients having longer appointment wait times. Twenty percent of PCPs say their work setting has added physicians and/or non-physician staff to provide clinical care and care coordination to newly insured. Nearly two in five PCPs with an increase in newly insured patients report that these patients have lower health status and more chronic conditions. And sixty-seven percent state that these patients are covered by Medicaid and health insurance marketplace coverage (See Figure 2).

Figure 2. PCPs with increased newly insured population: Observations and reactions



Source: Deloitte Center for Health Solutions, 2014 Survey of US Physicians

* See appendix for survey objectives and methodology.

The impact on safety-net clinics, emergency departments, and non-traditional players

PCPs are not the only health care providers dealing with the impact of expanding numbers of newly insured consumers. Others include safety-net clinics, emergency departments (ED), and non-traditional providers such as retail health and urgent care clinics.

Safety-net clinics: These health care facilities provide important services for low-income individuals, a situation that is not likely to change in the near term. After 25 states and the District of Columbia expanded Medicaid, researchers observed an overall increase in patient visits to safety-net clinics. However, rates of uninsured patient visits are declining, even in non-expansion states. In expansion states, Medicaid appears to be making up the difference – Medicaid patient visits to safety-net clinics increased during this period but remained stagnant in non-expansion states.[12]

Emergency departments: In 2013, seven of the 10 busiest EDs in the US saw an increase in patient visits over 2012. More recent data from the second quarter of 2014 indicates that Medicaid expansion states had greater increases in ED visits (5.6 percent) than non-expansion states (1.8 percent). The rise in ED visits following the coverage expansion may be explained by consumers' continuation of past behavior patterns – many may continue to view the ED as their primary means of access to care. Now, however, the newly insured have a lower threshold to cross before seeking medical care – their new plans protect them from previous high out-of-pocket costs and the anxiety of not being able to pay. As Medicaid and marketplace plans educate enrollees about the availability and value of obtaining health services in a primary care setting, it could lead to a migration away from EDs to PCPs and free-standing urgent care centers.

Retail health and urgent care clinics: The growing prevalence of non-traditional providers for primary care could disrupt existing PCP-patient relationships but they also could help PCPs by handling excess demand generated by the newly insured. Retail clinics are often open after PCP office hours and typically do not require an appointment or a pre-existing relationship. Additionally, both retail clinics and urgent care centers may be more conveniently located than PCP offices and charge less for basic health services. This reality is not lost on PCPs; many believe that convenience and affordability drive consumers' use of retail health clinics. Another potential benefit of clinic growth for PCPs is a reduced volume of low-severity cases. PCPs that are not overwhelmed with low-severity cases may have more time to focus on engagement and care management strategies for their patients with chronic conditions.

Many urgent care and retail centers currently have limited ability to manage chronic conditions or provide continuity of care. Some physicians also believe that these settings may increase the likelihood of medical errors because retail health clinics' and physicians' electronic health records (EHR) systems sometimes are not in sync. Retail health clinics are trying to correct some of these issues through focused initiatives on chronic disease management of specific populations.

What does it all mean?

States and other policy makers may want to consider policy solutions

Some of the pressure on health care providers that is being generated by the newly insured may be alleviated by state governments. Governors, legislatures, and departments of health and human services could consider adopting solutions that support PCPs. These may include increasing Medicaid reimbursement rates for primary care services, advancing scope of practice standards, sponsoring PCMHs, reducing barriers to health technology adoption, and monitoring narrow networks. New payment models, such as bundled payments, shared savings, and shared risk, also may support physicians as they transition into caring for new patient populations.

Raising payments for Medicaid physician visits is one approach. Many stakeholders remain concerned that reimbursement levels are too low to attract PCPs to programs like Medicaid. The ACA's mandatory increase of Medicaid primary care payments to match Medicare levels expired at the end of 2014. The Urban Institute estimated that, as a result, the average primary care service fee in Medicaid was reduced by 42.8 percent starting in 2015.[14]

Before the policy expired, an American College of Physicians survey found that approximately 40 percent of physicians said they would accept fewer Medicaid patients if the program was not extended.[15] It is too early to tell what the results of this expiration will be, but recent data from Health Pocket suggests that fewer physicians accepted Medicaid patients in 2014 than in 2013.[16] State-level delays and confusion about the policy may have influenced these results. In states that successfully implemented the policy, more physicians may have been inclined to accept Medicaid patients, spreading the financial and clinical pressure of increasing patient loads across more physicians.

Higher PCP reimbursement levels also may have allowed some physician practices to hire mid-level providers (e.g., nurse practitioners, physician assistants). Research suggests that mid-level providers could help alleviate some of the pressure by assisting with care coordination and chronic disease management. Several states have begun initiatives to allow these clinicians to practice at the top of their license.

State efforts to improve care efficiency through PCMHs also may help to address the needs of the newly insured. Medical homes provide team-based, comprehensive, ongoing, patient-centered care. As of early 2013, the National Association for State Health Policy reported that 43 states have policies and programs that aim to advance the use of medical homes by private health plans, Medicaid, and CHIP.[17]

Technology could play a significant role in reducing physicians' burden. Remote health monitoring, telemedicine, mobile health, and other technology-centric strategies can help PCPs respond to increased demands. Early examples of health systems that have implemented these strategies show that patients who use online services had fewer primary care or urgent care visits than before they had online access.[18] States may need to consider enhancing or updating telemedicine policies, however, as many barriers to adoption currently exist; among them, state licensing practices, privacy and security concerns, and continuity of care.

Policy makers and regulators should consider advancing solutions that enable newly insured patients to access the care they need. One example is oversight of narrow provider networks, especially in the health insurance marketplaces where health plans continue to face pressure to reduce premiums and other costs for consumers. The increase in narrow networks could explain why some physicians (those included in those networks) have been seeing greater surges in demand than others. If health plans are required to build larger networks into their plans, consumers may be able to access more PCPs, thus dissipating demand. Regulators, researchers, and patient advocacy groups may wish to monitor the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey to gauge whether consumers report access problems.

Providers may need to change to weather the storm

Approximately 11.4 million individuals enrolled in health plans in the marketplaces during the second open enrollment period.[19] Medicaid, CHIP, and marketplace enrollment growth is projected to continue over the next decade – by 2025, the Congressional Budget Office expects 27 million fewer people to be uninsured in the US.[20] Primary care visits are also projected to increase by 20.3 million annually.[21]

Are there enough physicians to accommodate the influx of newly insured? There may be if provider organizations, especially PCP practices, implement key operational changes to help them weather the storm. Among possibilities:

- **Redesign care** – As demand continues to grow, physician practices should consider using health technologies, expanding the role of non-physician clinicians, and employing team-based approaches to care. New care models such as health coaches and group visits may help support some of these initiatives. Also, care coordination and disease management capabilities likely will be required.
- **Develop new relationships** – Americans will likely continue to access retail and urgent care facilities, so PCP practices should consider planning for and adopting new business models. These models may include partnerships outside of the traditional scope of their business. For example, collaborating with retail pharmacists may help organizations successfully adopt population health approaches.
- **Anchor practices in technology, data, and analytics** – PCP practices that employ innovative health technologies, big data, and analytics that focus on outcomes measures could be better positioned to enhance care quality and accommodate more patients in their daily schedules. This will likely require greater adoption of EHRs.
- **Improve patient engagement** – Ongoing patient education and engagement will likely be needed to continue transforming patients into informed consumers who know when to seek care and how to manage their conditions. As part of this process, PCPs should consider focusing on customer service and social support initiatives.

Conclusion

There is a great deal of anxiety about how the US health care system will deal with its growing patient population. But, evidence suggests that this anxiety could fade over time. By 2010, fewer patients in Massachusetts reported not getting the care they needed.[22] As PCPs make greater use of technology, mid-level providers assume a larger role in care coordination and chronic care management, and retail and urgent care facilities increase in number and use, the gap between patient demand and physician capacity may shrink.

Ultimately, some things will not change: People will still get sick and they will still need health care. Physicians will continue to play a critical role in the US health care system. But, physicians and other health care stakeholders will likely need to adapt to ever-growing patient numbers and demands. And, they should adapt quickly and prepare to weather the storm.

Appendix: Survey objectives and methodology

Since 2011, the Deloitte Center for Health Solutions has annually surveyed a nationally representative sample of the US physician population to assess experiences, actions, and attitudes about health care. The 2014 survey examines value-based care, the future of medicine, the impact of health reform, and health information technology (HIT).

In 2014, a random sample of US primary care and specialist physicians was selected from the American Medical Association's (AMA) master file of physicians.

Invitation letters describing the nature of the survey and honorarium were mailed to physicians via postal mail (Appendix Figure 1). Those interested in participating were directed to a website where the web-based questionnaire was completed online. The survey took approximately 22 minutes to complete. Survey data were collected June 2-23, 2014, and 561 physicians completed the survey. Data are weighted to reflect the national distribution of physicians in the AMA master file by years in practice, gender, region, and medical specialty. The margin of error is +/- 3.89 percent at the .95 confidence level.

Appendix Figure 1. Survey sample composition

	PCPs	Surgical specialists	Non-surgical specialists	Other*	TOTAL
Total completed surveys	105	140	196	120	561
Total invitation letters sent					
Letters mailed	3,261	5,211	7,296	4,839	**20,607**
Post office returns†	80	171	213	233	**697**
Additional information					
Surveys completed over quotas	0	45	44	0	**89**
Incomplete surveys	11	20	28	4	**63**
Ineligible surveys	5	6	35	25	**71**

†as of July 9, 2014

* Other physician type is comprised of Anatomic/Clinical Pathology, Occupational Medicine, Public Health and General Preventive Medicine, and Other (i.e., some other specialty not listed)

Endnotes

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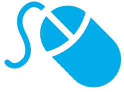

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