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Calling All Doctors: What Type of Insurance Do You Accept?

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Invited Commentary

Calling All Doctors
What Type of Insurance Do You Accept?

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Through coverage expansion, the Patient Protection and Affordable Care Act (ACA) is expected to reduce a major barrier to health care access, the cost of care. However, the law does not ensure that an adequate number of physicians are available and willing to accept a patient's form of coverage.

One of the main ways that the ACA expands coverage is through the Medicaid program. One particular concern has been whether enough physicians are available to meet the demands for the care of these patients.[1] Some of the greatest increases in Medicaid coverage are projected to occur in geographic areas that already have practitioner shortages regardless of payment type. Low Medicaid reimbursement rates further compound the problem. In general, Medicaid programs pay physicians less than Medicare and commercial insurers.[2] Physicians are not required to accept Medicaid patients, and research indicates that physicians are less willing to accept these patients in states with lower payment rates.[3]

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There is no systematic monitoring of whether physicians are willing to accept patients with Medicaid coverage. A common approach is to ask physicians through a survey. However, physician nonresponse and inaccurate reporting can undermine the validity of the results.

In this issue, Rhodes et al[4] describe a strategy for determining physicians' willingness to accept new patients with different types of insurance that closely reflects patients' experiences. They used a simulated patient methodology, which relied on trained staff using a script to call primary care offices in 10 states and request a new patient appointment. By using a reproducible clinical scenario and varying the expected payer information, the investigators were able to estimate the willingness of a sample of practices to accept privately insured, Medicaid, and uninsured patients.

The study was performed during the year before the expansion of Medicaid as a part of the ACA. The findings confirm what physician surveys had previously suggested: there is variation in physicians' willingness to accept new Medicaid patients across states, and in all states this rate is lower than the rate for privately insured patients. On average, callers with Medicaid coverage were only 68.4% as likely as privately insured callers to obtain a new patient appointment from a primary care physician for the same clinical problem but almost 4 times as likely as uninsured callers with a limited ability to pay. Among callers obtaining an appointment, wait times did not differ by insurance status.

The simulated patient methodology offers some advantages over physician surveys. It is not subject to nonresponse

or recall bias, and it provides a way to determine whether a physician's willingness to care for patients with varying types of insurance results in differences in the wait time for care. Physician groups have complained that this methodology creates an unnecessary burden on practice staff, but institutional review boards have generally approved these projects with a waiver of consent so that investigators can replicate as closely as possible real-world interactions between persons seeking medical appointments and physician offices.[5] Because the implementation of the ACA will create a heightened need to monitor access to physicians, it would be useful to know the relative costs and agreement in results between simulated patient studies and physician surveys.

Neither physician surveys nor simulated patient studies can answer all questions about access to care. For example, neither method lends itself very well to judging the quality of an available physician or studying disparities in physicians' willingness to care for patients based on patient race or ethnicity. More important, these approaches alone may not answer the fundamental question about whether individuals, and Medicaid patients in particular, have adequate access to care.

Although the findings of Rhodes et al[4] and those of physician surveys[3,6] suggest that a smaller proportion of physicians care for Medicaid beneficiaries than for patients with private insurance coverage, the medical needs of the Medicaid population could still be adequately met if participating practices were conveniently located near where Medicaid beneficiaries live and if they served enough Medicaid patients. However, study findings suggest not only that physician participation in Medicaid is low but also that those who do participate care on average for a small number of Medicaid beneficiaries.[6]

The combination of the low participation rate and the low numbers of Medicaid patients in the practices that do participate suggests that there is a real shortage of physicians available to care for Medicaid beneficiaries, resulting in inadequate access to care. Safety-net clinics provide a disproportionate amount of care to patients covered by Medicaid, which helps fill some of the void, but this approach is insufficient on its own, particularly for meeting the needs for specialty care. Furthermore, the health reform experience in Massachusetts, which served as the template for the ACA, suggests that these sites could be overwhelmed by the rapid increase in Medicaid beneficiaries that is likely to occur in states that have chosen to expand Medicaid eligibility.[7]

The interpretation of physician availability for a new patient appointment as a sign of access also depends on the size of the population at risk. This metric becomes less meaningful as the percentage of patients without a regular source of care decreases. For example, Massachusetts has the highest percentage of its population reporting having a regular source of care (91.3% vs the national mean of 71.7%).[8] This high degree of bonding between physicians and patients is an indication that Massachusetts provides access to primary care for the overwhelming majority of its residents. The results reported by Rhodes et al,[4] however, suggest that the small percentage of individuals in Massachusetts who still lack a primary care practitioner may have more difficulty finding one than their counterparts in other states and will wait longer for an appointment when they do. As states approach the goal of providing all residents with a regular source of primary care, the capacity of practitioners to accept new patients is likely to decrease. There is a risk that the limits on primary care practitioners' capacity to expand their practices combined with their preference for privately insured patients could crowd out opportunities for Medicaid patients.

Legislators drafting the ACA anticipated the need to expand access to primary care for Medicaid patients by requiring states to increase their payment rates to primary care physicians for these patients to at least what Medicare pays. Although the federal government is covering the additional cost, states have been slow to implement this policy, and without congressional action the federal requirement and financial support will expire at the end of 2014.

There is little indication as to whether primary care practitioners will meet the access challenges associated with implementing Medicaid expansion as a part of the ACA. Timely monitoring of physician participation in Medicaid and the number of Medicaid patients in participating practices could inform federal and state policy makers regarding the need to extend and potentially expand payment policy incentives and other reforms to ensure adequate access to care for the expanding population of Medicaid beneficiaries.

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