Robert Wood Johnson Foundation

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ACAView

Tracking the Impact of Health Care Reform

Effects of the Affordable Care Act through 2015

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ACAView's Third Report on the Affordable Care Act

In 2015, the ongoing implementation of the Affordable Care Act (ACA) continued to have major effects on the U.S. health care system. Millions of Americans who gained insurance in 2014 have now had more than a full year to experience their new coverage.

Data through the end of 2015 allow us to understand some of the effects of the ACA on physician practice and patient experience more clearly. As politicians and the public continue to debate central elements of the ACA, such timely data on the impact of health care reform will continue to be useful to people interested in understanding changes in the American health care system.

Data through the end of 2015 allow us to understand some of the effects of the ACA on physician practice and patient experience more clearly.

ACAView is a joint effort between the Robert Wood Johnson Foundation and athenahealth, a cloud-based health care technology and services company. Because athenahealth uses a cloud-based network, we can analyze and report rapidly on the effects of the ACA.

For this report we looked at two areas where we felt our data could provide useful information. First, we looked at how the experience of patients in three categories has changed since the coverage expansion of the ACA came into effect: those with Medicaid coverage, with commercial coverage, and without insurance. Second, we considered how the economics of primary care practice have changed since coverage expansion.

Summary of Findings

1. Medicaid Patients

- In states that expanded Medicaid, primary care physicians are seeing substantially more Medicaid patients.
- In many cases, Medicaid expansion has led to the formation of new physician-patient relationships that could lead to better care and outcomes over time.
- The willingness to take more Medicaid patients is spread fairly evenly across physicians.

2. Commercially Insured Patients

- Commercially insured patients are paying only slightly more than in previous years for primary care visits.
- In comparison with costs for primary care, patient obligations for surgery are substantial and rising fast.
- Commercially insured patients are making more free visits to their PCPs under ACA rules on free preventive care. This has shifted the distribution of patient obligations, with patients now paying more for other visits.

3. Uninsured Patients

- Uninsured patients benefit from more free visits than commercial patients, but almost 60% of their visits cost over $40, and 20% cost over $100.
- Uninsured patients on average have slightly shorter visits than insured patients.

4. Economics of Primary Care

- Practice revenues for PCPs in 2014 increased despite a small drop in the number of visits. Both revenue per visit and acuity per visit have increased.
- PCPs, though not facing a large surge in new patients, do appear to be working harder each year – doing more work per visit and managing more complex cases – as part of a longer trend that is probably unrelated to the ACA.

About ACAView

ACAView is a joint effort between the Robert Wood Johnson Foundation (RWJF) and athenaResearch. RWJF is the nation's largest philanthropy dedicated solely to health, working to identify the most pressing health issues facing America today. athenaResearch is a department within athenahealth, a health care technology and services company connecting over 72,000 providers from organizations of all sizes on its cloud-based network.

ACAView seeks to give policymakers, researchers, physicians and the public information on the impact of the Affordable Care Act in physician practices. athenahealth's software manages medical billing, patient health records and other services for physician offices so that doctors can focus on patient care. Given the depth and breadth of athenahealth's network and our ability to access it in near-real time, we are able to track the impact of changes in health care very quickly.

In this report, we looked at the impact of the ACA on provider practices in 2015 (please refer to our previous report for changes through 2014). In 2015, the country reached record lows in the rate of uninsurance, but many patients still struggled with the costs of care. Debates about the virtues and disadvantages of the ACA have continued. We hope that this report provides immediate information useful for all who wish to understand changes in our health care system.

In addition to the full year reports, ACAView has published a series of briefs on topics such as insurance switching and revenue changes for primary care physicians and surgeons. More information on ACAView and its partners can be found at the RWJF website and at CloudView, the athenahealth blog.

Sample Overview

ACAView tracks provider activity among practice locations on athenahealth's network since December 31, 2010. By comparing data over time with a single practice cohort, we are able to capture shifts in patient demographics, payer policies, and practice patterns. The athena sample is broadly representative of the nation's physicians and is very similar in most measures to the national benchmark provided by the National Ambulatory Medical Care Survey.

We have collected data from 21,900 providers at these practices. We focus our analysis in this report largely on 4,900 primary care physicians and approximately 40 million visits that they received from 5 million patients, recorded from 2011 to 2015.[1]

A majority of our physicians are community practitioners, rather than affiliates of academic medical centers, with a larger proportion of visits from the South and a smaller proportion from the West. Compared with all physicians nationally, our cohort also has fewer solo practices and more practices with 11 or more physicians. Please see the Appendix for a more detailed comparison of the ACAView sample to national benchmarks.

Medicaid Patients

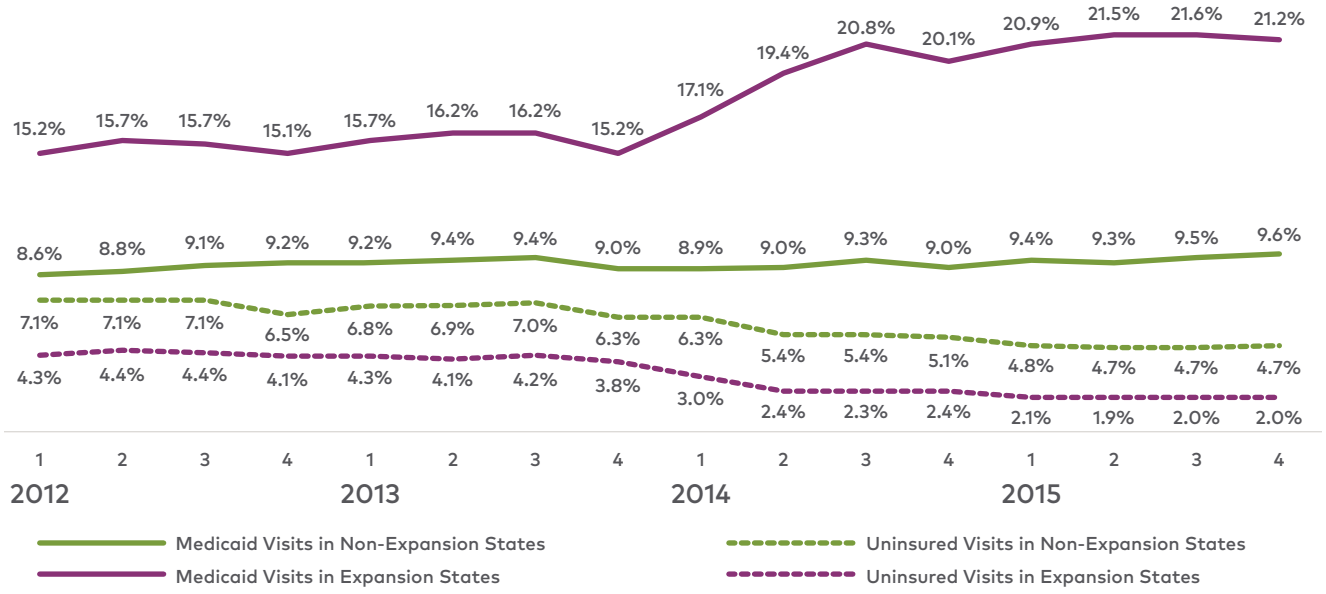
In states that expanded Medicaid, primary care physicians (PCPs) are seeing substantially more Medicaid patients.

One of ACAView's most significant findings has been the rapid increase in the proportion of primary care visits made by Medicaid-covered patients in the states that chose to expand Medicaid coverage. This dramatic shift is a direct result of the Affordable Care Act, which provided strong financial support to states undertaking Medicaid expansion.

The share of visits to PCPs made by Medicaid-covered patients rose rapidly in early 2014 during the implementation of ACA provisions for new Medicaid coverage and reached about one-fifth of the primary care visits in expansion states.[2] For the remainder of 2014 this proportion stayed fairly steady. In 2015 the share of primary care visits made by Medicaid-covered patients in the expansion states stabilized at this new higher level. As shown in Figure 1, the share of PCP visits from patients covered by Medicaid in the expansion states had been approximately 15 to 16 percent through 2012 and 2013, with some seasonal variation. This share then reached 20.8 percent by the third quarter of 2014 and has since stabilized at slightly over 21 percent.

[1] The actual number of patients was over 5.6 million, but this figure includes a small proportion who may have seen physicians in two different practices.
[2] A state's Medicaid expansion status is defined as of 2014. Please see the appendix for the full list of states.

Figure 1. Proportion of PCP Visits From Medicaid and Uninsured Adults (18-64) for Medicaid Expansion States and Non-Expansion States, 2012-2-15*



Sample: Over 3.4 million visits to practices active on the athenahealth network before 2011.
Source: athenaResearch
*States grouped by 2014 expansion status

The increased Medicaid volume during this period is also evident in the increase of new patient visits by individuals covered by Medicaid. In the expansion states, the number of visits in our sample by new patients with Medicaid coverage rose from approximately 132,000 in 2013 to 176,000 in 2014, an increase of roughly one-third. Looking more broadly at visits by both established and new Medicaid-covered patients across the country, we found a 12 percent increase in the total number of visits by Medicaid-covered patients.

Figure 1 also shows the shares of adult PCP visits by uninsured patients in the Medicaid expansion states and comparable data for the states that did not choose to expand Medicaid coverage in 2014. While increases in the share of Medicaid visits were observed only in states that expanded, the share of uninsured visits dropped nationwide. In the expansion states, the share of visits by uninsured patients fell from about 4 percent in 2012 and 2013 to about 2 percent in 2015. In the non-expansion states, the share of visits by uninsured patients fell from about 7 percent in 2012 and 2013 to about 5 percent in 2015.

In many cases, Medicaid expansion has led to the formation of new physician-patient relationships that could lead over time to better care and outcomes.

The goals of the ACA included not only providing health insurance to more people but also promoting better health outcomes. Medicaid expansion readily expanded coverage, but did this new coverage help people establish ongoing relationships with physicians?

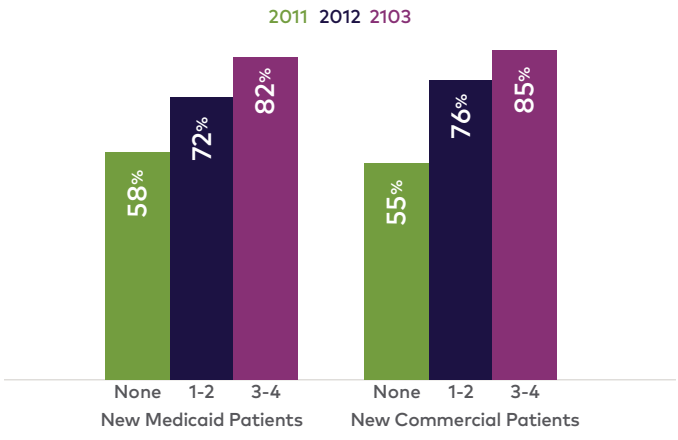
We examined visit patterns for Medicaid patients who visited a PCP for the first time in the first half of 2014. Among these Medicaid-covered new patients, 67 percent returned to the practice within 18 months for a second visit. Some of the new patients with Medicaid coverage who did not return for a second visit within 18 months may not have needed care again so soon after the first visit, or they may have received care at another physician's office or at an urgent care center or emergency department. The rate at which Medicaid patients returned for second visits exceeded the comparable rate for commercial patients, where 60 percent returned for a second visit in 2014.

The return rate for new patients with Medicaid coverage making their first visit in 2014 was the same as it had been for patients making their first visit in the first half of 2013. But because the volume of Medicaid-covered visits has been rising substantially, the continued 67 percent return rate suggests that a larger absolute number of Medicaid patients are beginning ongoing relationships with their PCPs that could lead to improved care and outcomes over time.

Higher Return Rates for Sicker Patients

A closer look at the patients making return visits suggests that more medical attention is being paid to patients in need of care. We found that the return rate for a second visit within 18 months is much higher for patients who are diagnosed with more chronic diseases in the first visit. Figure 2 shows the proportion of new patients who returned for a second visit within 18 months after having an initial visit in the first half of 2014. The data are shown separately for three groups: those patients who had none of the four selected chronic diagnoses in the first visit, those who had one or two of the selected diagnoses in the first visit, and those who had three or four of the diagnoses in the first visit. (The chronic diagnoses were diabetes, hyperlipidemia, hypertension, and mental illness).

Figure 2. Proportion of New Patients in 2014 Who Returned for Second Visit*



Sample: Over 41,000 new Medicaid patients and 130,000 new Commercial patients seen by PCPs at practices active on the athenahealth network before 2011.
Source: athenaResearch
*First visit must have occurred in first 6 months of 2014; 18 months allowed for return visit.
**Chronic diagnoses include diabetes, hyperlipidemia, hypertension and mental illness.

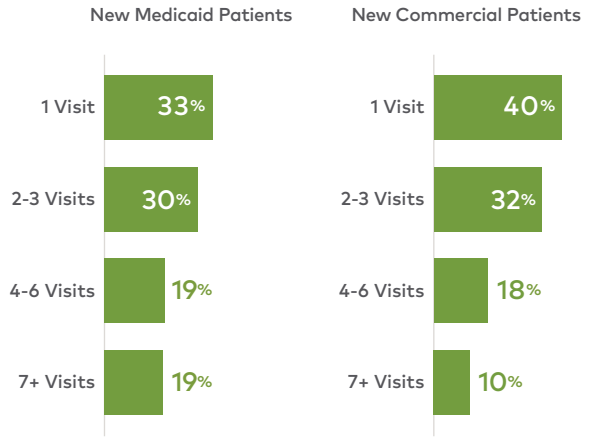
Among the new patients with none of the selected chronic conditions in the first visit, more than half (58 percent) returned within 18 months. The return rate increased to 72 percent among new patients with one or two conditions and 82 percent for those with three or four conditions.

These rates of return for the new Medicaid-covered patients are very similar to those for new commercially insured patients in 2014 in the three categories by counts of the selected diagnoses: 55 percent, 76 percent, and 85 percent. This close parallel between the rates of return visits for Medicaid and commercially insured new patients suggests that Medicaid patients are gaining access to care that is in some respect similar to the access available to commercially insured patients.

Multiple visits

We also found that many of the new patients with Medicaid coverage who returned made multiple visits to the same practice. Figure 3 shows the distribution of new patients who had at least one visit in the first six months of 2014 by their number of visits over an 18-month period. We see that 33 percent visited only once and made no additional visit; 30 percent visited two or three times, including an initial visit and one or two additional visits; the remaining 37 percent of the patients visited four or more times, including an initial visit and then three or more additional visits. This distribution of initial and return visits was very similar to the comparable distribution among new patients with Medicaid coverage in the previous year.

Figure 3. Proportion of New Medicaid Patients in 2014 with Indicated Number of Visits in 18 Months*



Sample: Over 41,000 new Medicaid patients and 130,000 new Commercial patients seen by PCPs at practices active on the athenahealth network before 2011.
Source: athenaResearch
*First visit must have occurred in first 6 months of 2014; 18 months allowed for return visit.

But the number of return visits among the new commercially insured patients was somewhat lower: 40 percent visited only once; 32 percent visited two or three times; and only 28 percent visited four or more times. This difference could be explained by differences in health status and coverage among the Medicaid and commercial populations. Unlike commercially insured patients, Medicaid patients usually pay very little or nothing out of pocket for each visit. In addition, Medicaid beneficiaries include many people with significant disability or chronic illness, so that their health needs are on average greater than those of commercially insured patients.

Overall, we believe that the data on return visits and multiple visits show that the expanded Medicaid coverage is supporting the development of new relationships with physicians, especially for sicker patients. We will look in the future for evidence that these new relationships are contributing to better health outcomes.

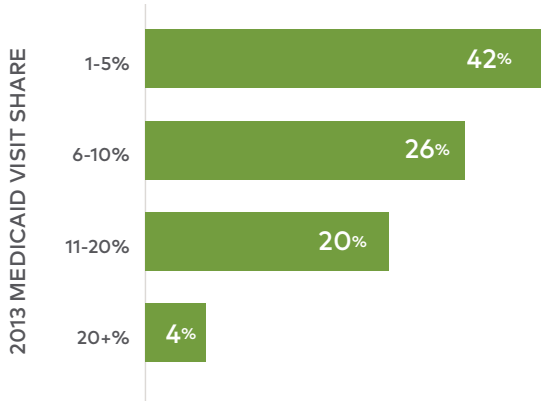
One additional finding of interest is that the average visit time for Medicaid patients is the same as the average visit times for patients with commercial insurance or Medicare. (As shown later, this is not the case for uninsured patients.) Visit times are estimated based on provider interaction with athena software during clinical exams. This equal average visit time for Medicaid patients supports the view that Medicaid expansion may be helping patients to gain relationships and access to care on par with care provided to other patients.

The willingness to take more Medicaid patients is spread fairly evenly across physicians.

We wondered whether the new Medicaid patients in expansion states were primarily being seen by physicians that had previously seen many Medicaid patients. We found that this was not the case. In fact, the largest increases were seen in practices with small shares of Medicaid visits in 2013. Even among practices that did not see any Medicaid patients in 2013, 13 percent accepted new Medicaid patients in 2014.

Looking at practices that had seen Medicaid patients in 2013, we divided them into groups by the proportion of practice visits that had been Medicaid-covered in 2013: those with very small shares, modest shares, significant shares, and large shares of Medicaid patients.[3] As shown in Figure 4, we found that practices in the first three groups located in states that expanded their Medicaid programs increased their Medicaid volume significantly in 2014: 42, 26, and 20 percent of the absolute numbers that they had seen in 2013. Interestingly, the practices that already had a large share of Medicaid visits in 2013 saw the smallest growth of about 4 percent.

Figure 4. Change in Medicaid Primary Care Visit Volume, 2013 to 2014, at Practices in Expansion States with Indicated Share of Medicaid Primary Care Visits in 2013



Sample: Over 700,000 visits in 2014 at practices active on the athenahealth network before 2011.
Source: athenaResearch

This data suggests that new Medicaid patients were not mostly seen in practices that had previously received many Medicaid patients. Instead, it appears that the new Medicaid patients were spread out among practices with different previous shares of Medicaid patients.

Commercially Insured Patients

Commercially insured patients are paying only slightly more than in previous years for primary care visits.

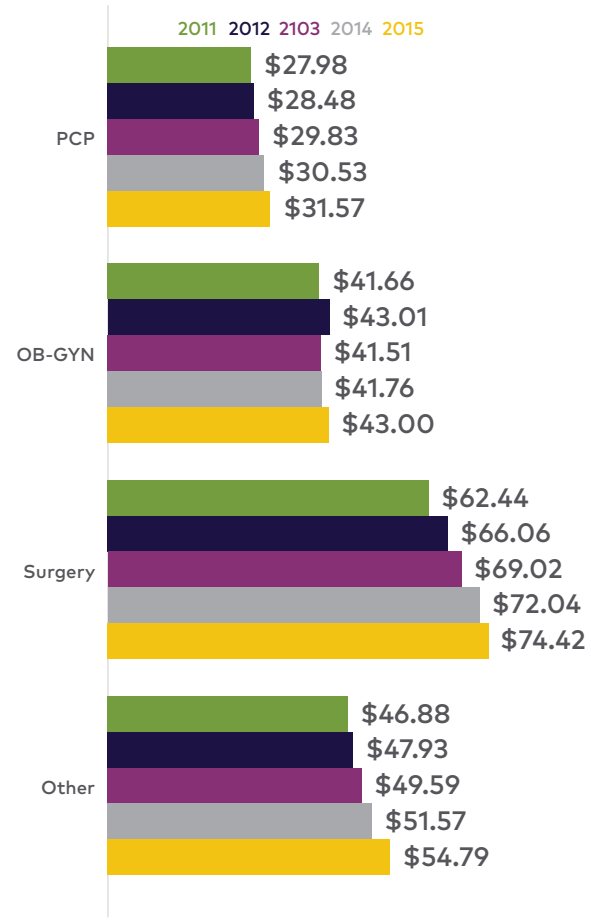
Requiring patients to pay out-of-pocket for ambulatory services can encourage them to use care more conservatively but may also reduce access to needed care. Our findings suggest that patient out-of-pocket obligations for primary care have increased only slightly, continuing a trend that was underway before coverage expansion.

Figure 5 shows the average amounts that commercially insured patients owed for visits to PCPs, OB-GYNs, surgeons, and other specialists from 2011 to 2015. (Visits are drawn each year for the January-August period to keep consistent with the 2015 data, which are not complete for the last months of 2015 until some months later when bills are either fully paid or closed.) In visits to PCPs, the average amount owed by patients increased very slightly by only $3.59 per visit between 2011 and 2015, from $27.98 in 2011 to $31.57. These are mean figures: the patient charge for a visit can range from free up to over $100 if the patient has not yet paid the full annual deductible. Because payments from insurers have also been increasing, patients have been responsible for a relatively consistent share of total provider reimbursement for primary care services–approximately 35 percent.

[3] The ranges for these four groups were 1 to 5 percent, 6 to 10 percent, 11 to 20 percent, and over 20 percent.

Figure 5. Average Patient Owed Amount Per Visit for Commercially Insured Adults (18-64),

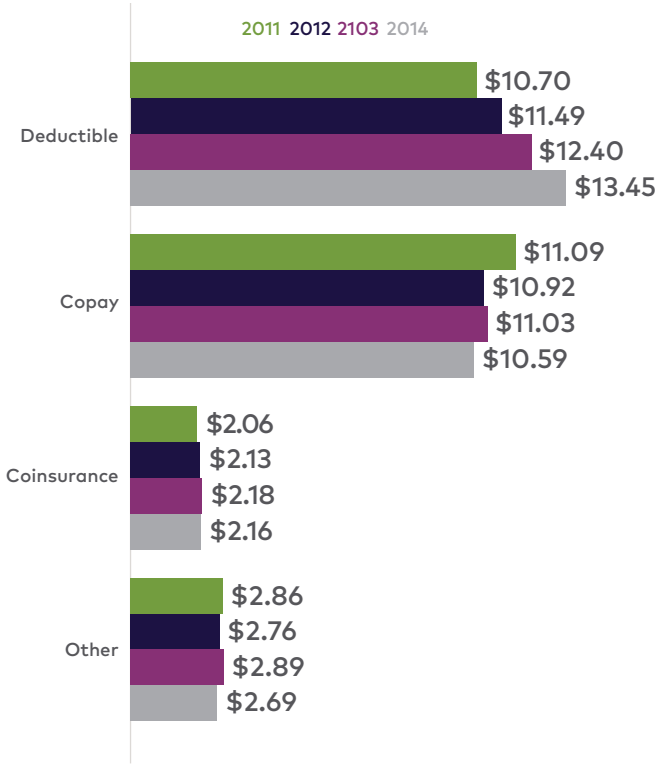
By Specialty Category, January – August



Sample: ~6 million visits per year to practices active on the athenahealth network before 2011.
Source: athenaResearch

Patient costs for visits result mostly from deductibles and copayments, with small amounts from coinsurance and other expenses.[4] Figure 6 shows the average annual amounts owed by patients for visits to PCPs from 2011 to 2014 broken out into amounts for deductibles, copayments, coinsurance, and other expenses. Costs for deductibles have risen substantially, starting at approximately $10.70 per visit in 2011 and rising to $13.45 per visit in 2014, for an average annual increase of 7.9 percent.[5] Following payment data through August 2015, we continue to see a large annual increase in the amount owed because of deductibles; comparing patient payments in the January-August periods of 2011 and 2015, we find an average annual increase of 8.3 percent.

Figure 6. Average Patient Owed Amount for Commercially Insured Adult (18-64) PCP Visits



Sample: ~3 million visits per year to practices active on the athenahealth network before 2011.
Source: athenaResearch

In comparison with costs for primary care, patient obligations for surgery are substantial and rising fast.

In contrast to lower patient responsibility for primary care services, patient responsibility for visits to some specialists is significant and has risen at a higher rate. In visits to surgeons, the average patient payment increased from $62 in 2011 to $74 in 2015, an increase of $12 per visit overall and 4.5 percent annually. For visits to OB-GYNs, patient costs were roughly flat over the period, and for visits to other specialists patient costs rose at an average annual rate of 4.0 percent. The proportion of patient responsibility for surgical services increased from 31 percent in 2011 to 38 percent in 2015.

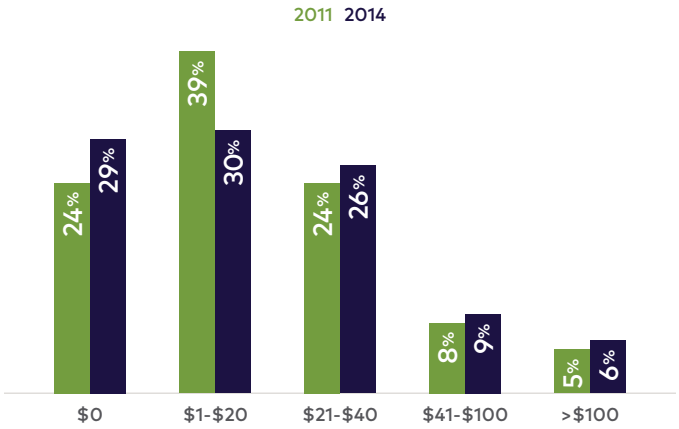
[4] The deductible is an annual amount, sometimes large, that patients must pay before insurance coverage begins; a copayment is typically a small fee, for example $20 for an office visit, that patients must pay to help cover costs of care. The other category includes expenses billed to the patient but not specified as deductible, copay, or coinsurance.
[5] These costs for deductibles, mostly incurred earlier in the year, are averaged over all the visits for the entire year.

Commercially insured patients are making more free visits to their PCPs under ACA rules on free preventive care.

Although patient financial obligations for primary care services is increasing only slightly, the distribution of what patients owe for care is changing more significantly. An important ACA provision requires insurers to pay fully for preventive care recommended by the U.S. Preventive Services Task Force, so that patients face no costs in accessing these services. In our sample, visits with no charge increased 11 percent, from 1,110,000 in 2011 to 1,235,000 in 2015. We have not yet analyzed how many of these visits are for preventive services, but we speculate that the ACA mandate on free preventive services is an important factor driving this increase. At the other end of the spectrum, visits costing more than $100 have increased 30 percent, from 119,000 in 2011 to 155,000 in 2015.

The rising numbers of free and high-cost primary care visits have shifted the distribution of patient costs across the fee scale. As shown in Figure 7, the proportion of adult visits to PCPs that were free increased from 24 percent in 2011 to 29 percent in 2014. This pattern was not observed in visits to surgeons where the share of visits with no cost rose by only 1 percentage points from 2011 to 2015. In addition, the proportion of visits to surgeons costing over $40 rose even more, with an increase of 8 percentage points, from 25 percent in 2011 to 33 percent in 2015.

Figure 7. Distribution of Patient Owed Amount for Commercially Insured Adult (18-64) PCP Visits, 2011 and 2014



Sample: ~3 million visits per year to practices active on the athenahealth network before 2011.
Source: athenaResearch

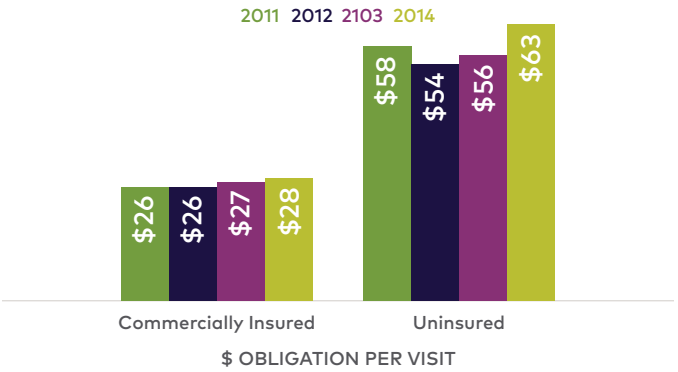
Uninsured Patients

Uninsured patients benefit from more free visits than commercial patients, but almost 60% of their visits costs over $40, and 20% cost over $100.

While the ACA has substantially increased the numbers of people with insurance, tens of millions still lack coverage. Some adults over age 65 and some children lack coverage, but non-elderly adults have the highest rate of uninsurance. The rate of uninsurance among non-elderly adults in the first quarter of 2015 was about 13 percent.[6] Our data support several observations about their costs of care and their visits.

Uninsured patients continue to face much higher average bills for primary care visits than do insured patients. Figure 8 shows for 2011-2014 the average obligation per visit to a PCP for commercially insured patients and for uninsured patients.[7] In 2014, commercially insured patients owed $28 per visit; uninsured patients owed an average of $63 per visit, more than twice as much.

Figure 8. Average Patient Owed Amount for Adult PCP Visits by Commercially Insured and Uninsured Patients

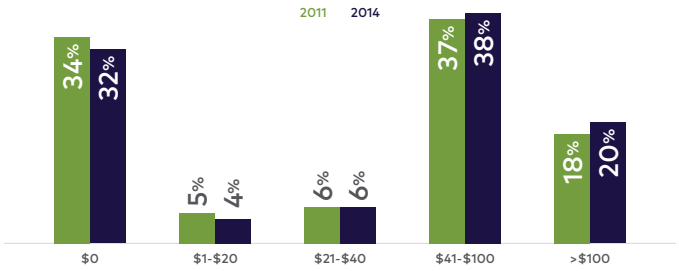


Sample: Approximately 3 million commercially insured and 200,000 uninsured visits per year to practices active on the athenahealth network before 2011.
Source: athenaResearch

The average patient obligation of $63 masks a great variation in what uninsured patients owe for care. As shown in Figure 9, uninsured patients pay nothing for many of their primary care visits, but for 58 percent of the visits patients are asked to pay more than $40 and for 20 percent of the visits patients are asked to pay more than $100. It is important to note that these are the amounts patients are asked to pay, not necessarily what they do pay – we will be looking at collections for uninsured patients in future work.

[6] http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/. Its Figure 2 includes estimate of 13 percent of nonelderly still uninsured.
[7] For insured patients, the obligation is the amount due from the patient after the insurer's contribution. For uninsured patients, the obligation is the amount billed.
[8] http://iom.nationalacademies.org/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx "America's Uninsured Crisis: Consequences for Health and Health Care, Report Brief Feb. 2009," p. 4.

Figure 9. Distribution of Patient Owed Amount for Uninsured Adult (18-64) PCP Visits, 2011 and 2014



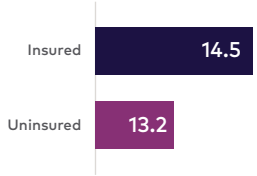
Sample: Approximately 200,000 visits per year to practices active on the athenahealth network before 2011.
Source: athenaResearch

Uninsured patients on average have slightly shorter visits than insured patients.

Uninsured adults face important obstacles to getting health care. They are more likely than insured people to have cancer that is caught in later stages, more likely to die of heart attacks or strokes, and more likely to suffer bad health and early death from a wide range of chronic diseases.[8] One might expect that the significant needs of uninsured patients and their reduced access to services beyond primary care would cause them to have longer visits when they do see PCPs.

Our data, however, show that the average visit time for uninsured patients was slightly shorter than the average visits for insured patients. By analyzing the time stamps of physician computer entries, we can estimate visit duration. While this methodology is not without limitations, we believe it provides a good way to estimate differences in visit time for different physicians or patient groups. Figure 10 shows average encounter time for adult visits to PCPs in 2013-2015 for insured and uninsured patients. The insured patients have a visit average of 14.5 minutes, while the uninsured patients have an average of 13.2 minutes, or on average 9 percent less time.

Figure 10. Average Encounter Time (in minutes) for Primary Care Visits by Uninsured and Insured Adults, 2013-2015



Sample: Over 5.3M insured visits & 190K uninsured visits each year to over 800 primary care providers using athenaClinicals software.
Source: athenaResearch

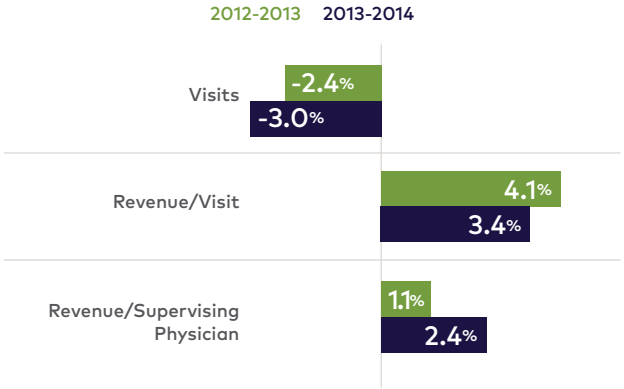
Economics of Primary Care Practice

Practice revenues for PCPs in 2014 increased despite a small drop in the number of visits. Both revenue per visit and acuity per visit have increased.

Overall revenue per supervising PCP increased from 2013 to 2014 by 2.4 percent. Revenue for PCPs depend on the number of visits and the revenue per visit.[9] Looking at visits for 2012, 2013 and 2014, we see that the number of visits fell somewhat: down 2.4 percent in 2013 and 3.0 percent in 2014, as shown in Figure 11. But the revenue per visit climbed steadily, from $93 in 2012 to $96 in 2013 – a year-to-year increase of 4.1 percent – and to $100 in 2014, a year-to-year increase of 3.4 percent.

Eighty-eight percent of the increase in payment per visit was due to higher reimbursement per work RVU, and 12 percent from slightly greater work RVUs per visit. (The work performed during visits to PCPs is measured by work RVUs, the "relative value units" used to measure the time and intensity of physician work for setting Medicare procedure payments.)

Figure 11. Changes in Measures Related to Primary Care Revenue



Sample: ~8 million visits each year to practices active on the athenahealth network before 2011.
Source: athenaResearch

The combined effect of fewer visits and greater revenue per visit was a modest increase in revenue. Revenue for each supervising physician was $246,000 in 2012; $249,000 in 2013; and $254,000 in 2014.[10] Thus, practice revenue for each physician rose by 1.1 percent from 2012 to 2013, and by 2.4 percent from 2013 to 2014. It is important to note that revenue per physician is not equivalent to total physician billings. Physicians may be part-time and may work in multiple practices, some with and some without athenahealth information systems.

[9] Our accounting of revenue includes payments from the patient and from primary and secondary insurers. These revenues do not include any fixed salary or bonus payments that physicians may receive.
[10] Revenues include those from medical assistants and registered nurses working with the "supervising physicians."

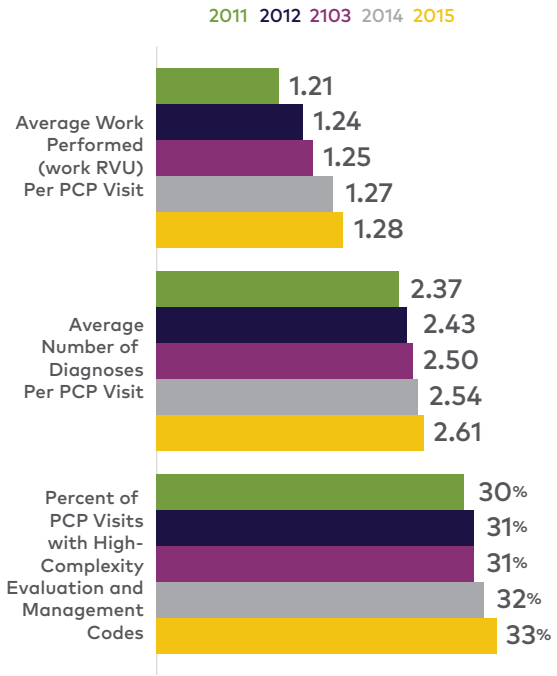
PCPs, though not facing a large surge in new patients, do appear to be working harder each year as part of a longer trend that is probably unrelated to the ACA.

We found last year that PCPs were not overwhelmed by a large increase in the number of new patients that they cared for in 2014. Analyzing data for 2015, we again see that the number of new patients seen by PCPs has remained largely unchanged at about 17 percent.

Work RVUs for PCP visits increased only slightly in 2014, but several measures in our data suggest that over the period 2011-2015 acuity per visit has increased. This trend is evident through three measures: average work performed per visit to PCPs, average number of diagnoses recorded during these visits, and the share of visits for evaluation and management that included high-complexity procedures. Our data indicate that this trend of increasing work has been ongoing for at least four years, and does not appear to have accelerated during ACA implementation of Medicaid expansion and the individual mandate.

The increased intensity of PCP visits is shown in Figure 12. Over four years, work RVUs per visit have increased by 6 percent, the number of diagnoses per visit increased by 10 percent, and the proportion of visits with high complexity evaluation and management codes increased by 12 percent.

Figure 12. Changes in Measures Related to Primary Care Intensity



Sample: ~8 million visits each year to practices active on the athenahealth network before 2011.
Source: athenaResearch

While these three measures taken together suggest that PCPs are working harder to care for patients with greater acuity, conclusions must be drawn cautiously. One interpretation might be that physicians are recording more rather than working harder. It is possible that physicians, under more pressure to document diagnoses and their work with patients, are recording more diagnoses and procedures independent of significant increases in morbidity or work performed.

But this documentation of conditions and treatments is itself an element of work. Physicians must satisfy themselves that a diagnosis is merited and must spend additional time to record diagnoses and procedures. Though we can't firmly establish how much different factors have driven the recorded increase in work, the data indicate that at minimum physicians are working more to document diagnoses and procedures.

* * *

Our findings have highlighted important experiences of patients and physicians under the ACA thus far. We plan to continue our attention to the experience of physicians and patients as part of our work on ACAView.

The experience of Medicaid-covered patients will be important, particularly as some states debate the merits of Medicaid expansion. Our findings so far suggest that physicians at practices with different degrees of Medicaid experience have been willing and able to take on new Medicaid-covered patients. Physicians appear to be developing new relationships with many of these patients, especially those with greater needs for care. They also are seeing Medicaid-covered patients for visits that are on average just as long as visits with other insured patients even though Medicaid payments are lower than commercial rates. Altogether, these findings suggest that physicians have been willing to take on this increment of new work and have done so without apparent harm to their revenue.

For commercially insured patients, the ACA appears to have neither accelerated nor slowed rising primary care bills due to increasing deductibles. Rising payments by insurers have kept the patient *share* of cost steady. For surgical visits, however, patient share of cost has risen substantially. At the same time, under the ACA rules on free preventive care, commercially insured patients have made more free visits to PCPs.

Despite the ACA's successes in increasing coverage, millions remain uninsured but may be affected by the shifting health care environment. Our findings so far indicate that uninsured patients benefit from more free primary care visits than do insured patients, but they face much higher bills than insured patients when they are asked to pay. On average, the visits of uninsured patients are shorter than those of insured patients, with fewer diagnoses made. We hope to continue our work in understanding the experiences of uninsured patients.

As always, we welcome responses from our readers about this report and suggestions on topics of future work.

Appendix

Medicaid Expansion Status, 2014

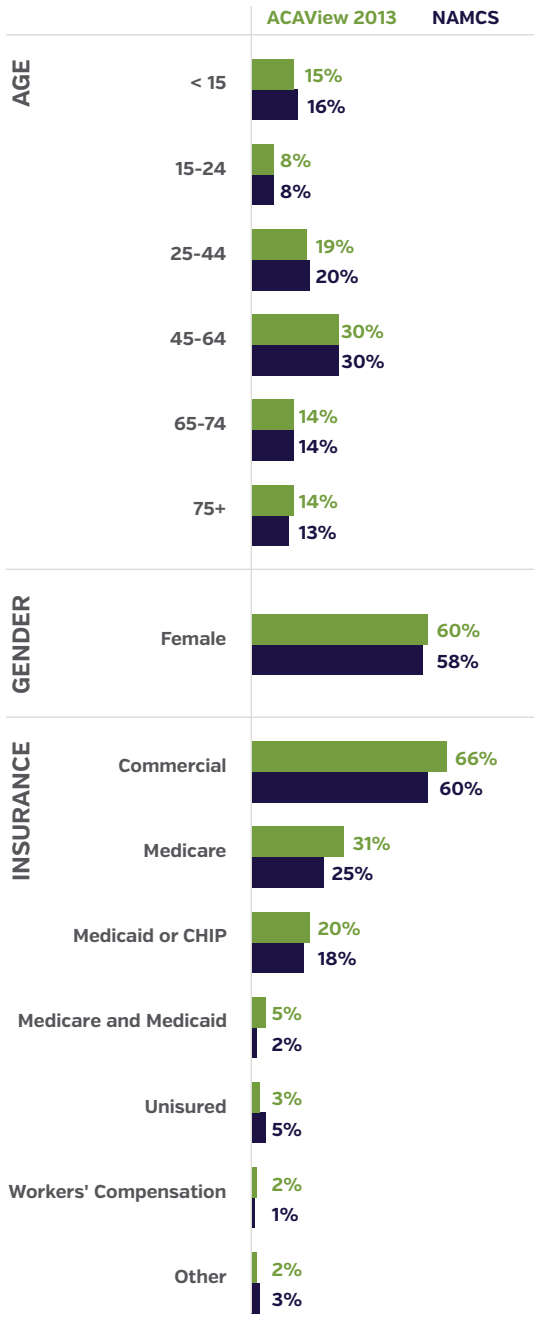
Expansion	Non-Expansion
Arizona	Alabama
Arkansas	Alaska*
California	Florida
Colorado	Georgia
Connecticut	Idaho
Delaware	Indiana*
District of Columbia	Kansas
Hawaii	Louisiana
Illinois	Maine
Iowa	Mississippi
Kentucky	Missouri
Maryland	Montana
Massachusetts	Nebraska
Michigan	New Hampshire*
Minnesota	North Carolina
Nevada	Oklahoma
New Jersey	Pennsylvania*
New Mexico	South Carolina
New York	South Dakota
North Dakota	Tennessee
Ohio	Texas
Oregon	Utah
Rhode Island	Virginia
Vermont	Wisconsin
Washington	Wyoming
West Virginia	

* These states expanded their Medicaid programs either late in 2014 or in 2015. For this analysis, we have used the state's 2014 Medicaid expansion status to define the two comparison groups.

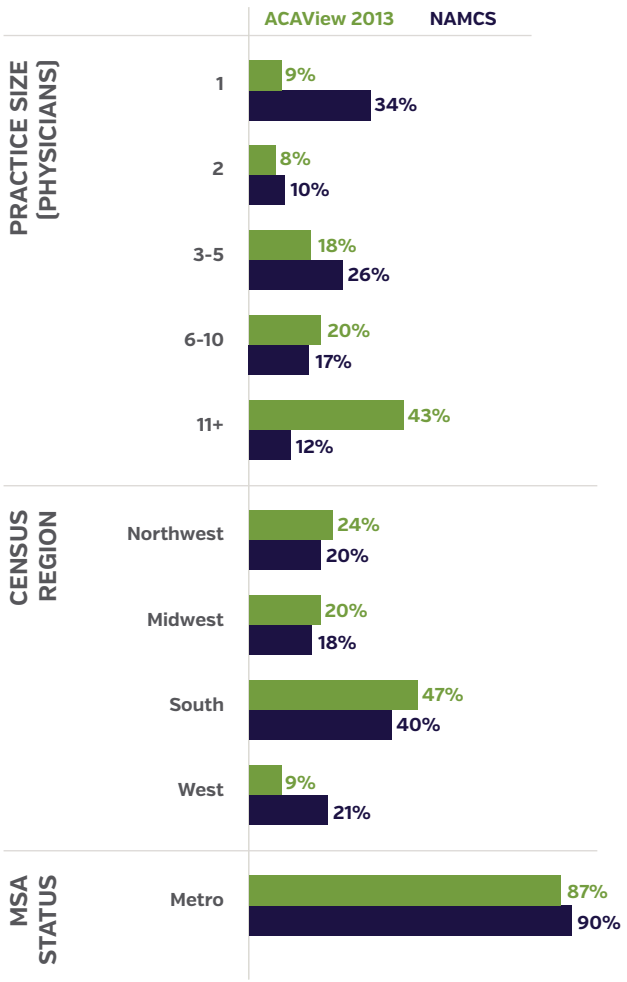
Athenahealth ACAView Practice Cohort vs. NAMCS

The following practice visit characteristics compare ACAView's sample with data from the National Ambulatory Medical Care Survey (NAMCS). NAMCS is administered by the Centers for Disease Control and Prevention and provides an authoritative statistical profile of ambulatory medical care in the United States. ACAView's sample is based on 130 million ambulatory visits to practices that have been on athenahealth's network since December 31, 2010. Given the similarity in distribution of patient demographics and ACAView's robust representation across provider demographic segments, we believe our data provides a reliable reflection of community ambulatory practice patterns in the United States.

Office Visit Characteristics: Patient Demographics athenahealth ACAView Practices vs. NAMCS



Office Visit Characteristics: Provider Demographics athenahealth ACAView Practices vs. NAMCS



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