



Health Care Providers are Opting-Out of Obamacare Exchange Plans

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INTRODUCTION

A significant number of American physicians are declining participation in Affordable Care Act (ACA) exchange health plans. A 2014 survey by the Medical Group Management Association, a trade group comprised of multi-physician medical practices, estimated as many as 214,524 American physicians will not be participating in any ACA exchange products.^[i] Doctors are opting out of the exchange plans for many reasons; chief among them is the fact that exchange plans are more likely to offer significantly lower reimbursement rates than private market plans, confusion among consumers about the obligations associated with high deductibles, and fear that patients will stop paying premiums and providers will be unable to recover their losses.^[ii] However, opting-out comes with its own challenges for both providers and patients.

WHY PROVIDERS ARE OPTING-OUT OF EXCHANGE PLANS

Narrow Networks and Low Reimbursement Rates

One of the big selling points of the ACA was that insurers would have to compete with one another for all the new enrollees purchasing subsidized insurance through exchanges. Insurers were able to compete by lowering payments to providers, who in turn make up the difference by increased patient volume due to narrow networks, thereby reducing the cost of the plans.^[iii] The benchmark reimbursement rate is generally considered to be what Medicare will pay for a service, and private insurers have historically paid slightly more than this benchmark.^[iv] However, in order to better compete in the exchanges, private insurers are offering providers reimbursement significantly below that benchmark.

It is estimated that where private plans pay \$1.00 for a service, Medicare pays \$0.80, and ACA exchange plans are now paying about \$0.60.^[v] Many exchange plans are, in fact, pinning their reimbursement rates to the Medicaid managed care schedule, which is significantly below average private market rates.^[vi] For example, Covered California plans are setting their plan fee schedules in line with that of Medi-Cal—California's Medicaid Program—which means exchange plans are cutting provider reimbursement by up to 40 percent.^[vii]

Insurance companies and proponents of the ACA claim that physicians will be able to recuperate this 40 percent cut in reimbursement by working more and taking advantage of the higher volume of patients.^[viii] Primary care providers (PCPs), however, are already overburdened and have too many patients as it is, so the increase in volume will do nothing to offset their losses.^[ix] Furthermore, physicians are worried that exchange plan patients will be sicker than the average patient because they may have been without insurance for extended periods of time, and therefore will require more of the PCPs time at lower pay.^[x]

High Deductibles

There is also concern among health care providers—hospitals and physicians—that patients enrolled in the new exchange plans do not fully understand their benefits, or their obligations. Specifically, providers are hesitating to accept exchange plans because consumers may be pushed towards a higher-deductible plan with a lower premium without understanding what a deductible is. Recent reports estimate that about 22 percent of exchange enrollees have purchased high-deductible Bronze or Catastrophic plans,^[xi] though the MGMA study indicates that for patients with exchange plans that physicians have seen, 75 percent reported those patients were ‘very’ or ‘extremely likely’ to have high deductible plans.^[xii] These patients, on their first series of visits to health care providers, could easily accumulate thousands of dollars in charges that must be paid before the deductible is met. The fear in the provider community is that low-income patients with these plans may rush to get delayed care without the financial ability to pay the high deductible, and while the insurer continues collecting premium payments, the provider will be left uncompensated.^[xiii]

Patients May Stop Paying Their Premium

On March 27, 2012, HHS issued a regulation describing the procedures to be followed should a patient with an exchange plan stop paying his or her premium.^[xiv] Unlike in the private market where an individual loses coverage after failing to pay a premium, exchange plans are required to provide their customers with a 90 day ‘grace period’ to pay their bills.^[xv] During this grace period, the insurer is required to continue coverage for 30 days. After the first 30 day period, the individual’s status is changed to ‘pending.’ Any care provided to a patient whose insurance status is ‘pending’ will be covered by the insurer if the overdue insurance premium is paid by the end of the 90 day period.^[xvi]

If the individual does not become current on insurance premiums by the end of the 90 day period, the health care provider will be left to recover any charges incurred between the 31st and 90th day of the grace period directly from the patient. If the patient is unable to pay, the provider will remain uncompensated.^[xvii] This was reported as the number one reason for providers deciding not to participate in exchange plans.^[xviii]

Though final numbers are not available yet, current estimates indicate that nearly 1 million individuals enrolled in exchange plans have failed to pay their premiums to date. Those plans have been canceled, but any of the enrolled individuals who failed to pay premiums may have obtained health care that will be uncompensated by their insurance company.^[xix]

HOW PROVIDERS MAY OPT-OUT OF EXCHANGE PLANS

Many exchange plans are keeping costs low by only offering narrow network plans. These plans are built around providers already in the insurers’ networks who provide care at the lowest cost. McKinsey has estimated that in 2014, 48 percent of all plan networks are narrow, and 40 percent of those are considered ultra-narrow (30 percent or less of area hospitals participate).^[xx]

Providers in the network who are typically more expensive may not be included in these narrow network plans.^[xxi] Those providers who are included are not necessarily told that they have been^[xxii]. Many contracts between insurers and providers allow insurers to unilaterally add providers to new plans’ networks, and adjust reimbursement rates without notice.

Doctors that are included in the narrow networks as a result of these contract provisions are typically able to opt

out of new plans by informing the insurance company in writing that they will decline the new insurance plans.
[xxiii]

Unfortunately for many newly insured Americans, this is precisely what is happening. When the ACA went into effect in January 2014, it was estimated that 70 percent of California's 104,000 physicians were not participating in Covered California plans.[xxiv] Likewise, 11 of the top 18 hospitals nationwide were accepting only two or fewer exchange plans, while continuing to accept insurance from dozens of private market plans.
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WHY PROVIDERS OPTING-OUT IS PROBLEMATIC

Doctors who may want to opt out of exchange plans face several obstacles. Most insurers are under no obligation to inform providers when they have been added to a new plan within the carrier's network, as discussed above. This leaves many providers in the dark as to whether they have been selected to participate in the narrow network plan, or whether an insurer with whom they have contracted is even selling such a plan. With no actual knowledge of being included in these plans, it falls to the providers to seek out this information from carriers directly or through their websites.[xxvi]

Those websites, however, may be misleading or confusing. The federal exchange website provides no information as to which providers are participating in offered plans.[xxvii] Some state-based exchanges fail to provide this information as well. Other states, like California, do provide information on which providers are in each carrier's network, but this information may do more harm than good.[xxviii]

Though it would seem like a useful tool, exchange websites that provide information about which providers are in carriers' networks can confuse consumers who do not understand that providers in an insurer's broader network may not be part of the exchange's narrow network plan.[xxix] In fact, this misleading information has caused such confusion that physician groups have petitioned Covered California to remove provider network information from its website entirely.[xxx]

CONCLUSION

Health care providers face many new obligations and restrictions as a result of the ACA, as do insurers. Because of the pressure placed on insurance companies to keep the cost of exchange plans unrealistically low, providers are being reimbursed at financially unsustainable rates. This reduction in payment rates has caused many physicians and hospitals to decline to accept insurance plans issued through the exchanges, and thereby negating the intended effect of providing individuals with affordable care by virtue of eliminating their access to care. What results is a market where not only hospitals and physicians are opting-out of exchanges plans, but individuals and families are opting-out as well. Some families who were insured before the ACA went into effect are finding that it is in fact more reasonable to pay the individual mandate penalty and pay for health care out of pocket than it is to pay a monthly premium for insurance coverage that leaves them unable to access care.
[xxxi] Unfortunately, the stated goals of the law fly in the face of the actual results that it produces.

[1] Medical Group Management Association, MGMA ACA Exchange Implementation Survey Report, May 2014; available at http://www.mgma.com/government-affairs/issues-overview/aca/aca-exchange-implementation-report/aca-surveyreport_online_2?ext=.pdf

; Kaiser Family Foundation, Total Professionally Active Physicians, September 2014; *available at* <http://kff.org/other/state-indicator/total-active-physicians/>.