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HEALTHCARE REFORM AND ITS IMPACT ON PHYSICIANS

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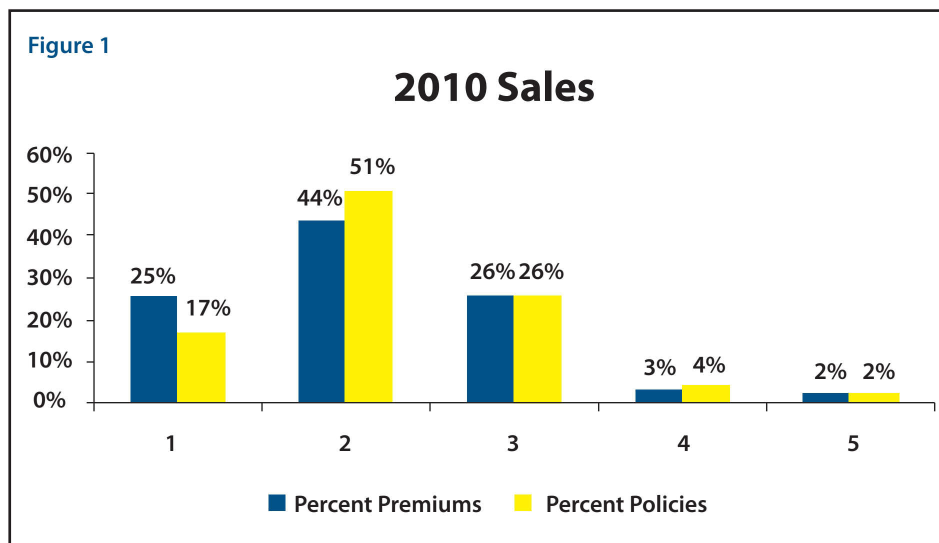
If someone were to ask me, "Who has never heard of healthcare reform?" I would say, "No one." Everyone seems to know something on the topic. A quick Google search proves the overabundance of information currently available on this topic: 26,500,000 results. Because I am part of the disability insurance business, I wonder how much of this information actually discusses the impact of healthcare reform on disability income (DI) insurance.

Disability and the Physicians' Market

In my opinion, looking at the impact of healthcare reform on physicians and their practices provides the most useful lens for evaluating the possible impact of healthcare reform on disability insurance. Sales to physicians make up a significant share of the DI market. Figure 1 from LIMRA shows 2010 DI sales by occupation class.



Source: LIMRA 2010 Annual U.S. Individual Disability income Insurance, Karen Terry, Rob Kanehl (2011) http://www.limra.com/members/abstracts/other/10858s.pdf

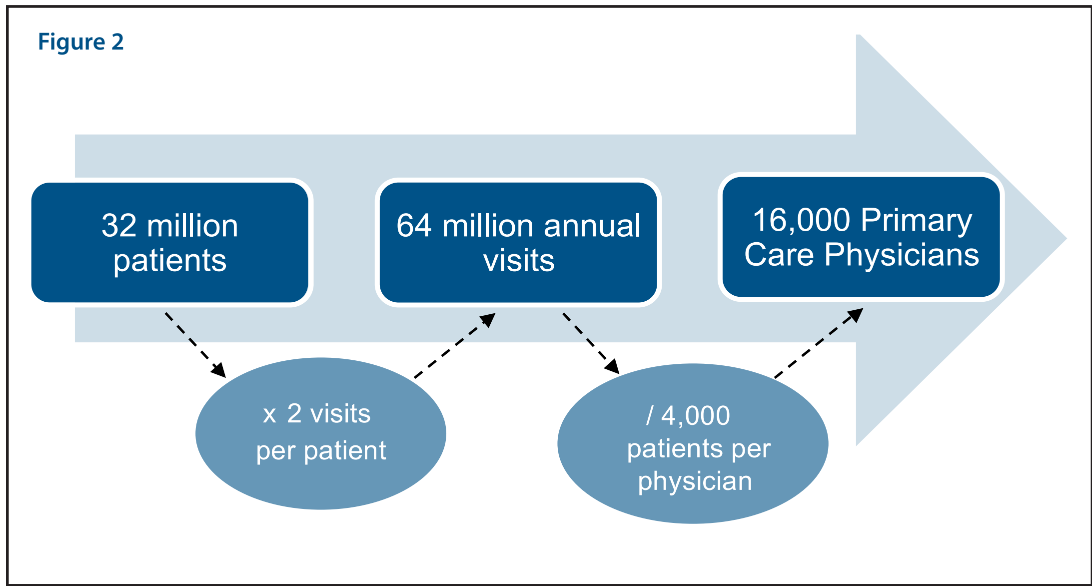
The top two occupation classes (where most physicians and dentists are classified) made up approximately 69% of total sales in 2010. According to LIMRA, 2010 sales to medical classes represented about 25% in terms of policies and over one-third in terms of premiums. The medical market cannot be ignored, especially when the majority of sales are for non-cancellable ("Non-Can") products. The combination of rich benefits and premium guarantees offered in Non-Can products should encourage the disability insurance industry to diligently monitor physicians' experience. As discussed below, this is especially the case in light of the recent healthcare reform legislation.

Healthcare Reform Provisions Impacting Physicians

H.R. 3590, commonly known as the "Patient Protection and Affordable Care Act" (PPACA) was signed into law on March 23, 2010. It is a 906-page, single-spaced document. This article is by no means intended to provide a comprehensive list of the provisions; rather, the focus is on the provisions that may impact physicians the most.

Increase in Demand...Insufficient Supply

U.S. citizens and legal residents must obtain qualifying health insurance coverage by January 1, 2014. The white paper and survey "Health Reform and the Decline of Physician Private Practice" (conducted on behalf of the Physicians Foundation by Merritt Hawkins) provides an excellent illustration (Figure 2 on page 8) of how this provision may significantly impact demand for physicians' services.



Source: "Health Reform and the Decline of Physician Private Practice," White Paper and Survey conducted on behalf of the Physicians Foundation by Merritt Hawkins (October 2010)

It is estimated that some 32 million people are currently uninsured and will be required to obtain coverage under the new law. Many of these currently uninsured people do not visit primary care physicians, even if they have serious or chronic conditions, instead using emergency medical facilities when their conditions become acute. As they become covered by medical insurance, more people will look to primary care physicians to take care of their basic health care needs. Although it is a simplistic representation of the demand for care Figure 2 illustrates the estimated number of physicians that will be needed to care for 32 million newly insured people. At the same time, Medicare will begin to cover annual wellness visits, which are typically performed by primary care physicians. So, the 16,000 physician estimate may be low.

Matching demand with supply could be problematic. The white paper mentions that even though the U.S. population grew by 24% in the last two decades, the number of medical residents and fellows trained in the U.S. grew by only 8%. Focusing specifically on family physicians, the number of U.S. medical graduates choosing to become family physicians decreased by 25% between 2002 and 2007. This is reflected in the decline in the proportion of family physicians from 50% of all physicians in the 1950's to 35% today. It remains to be seen just how demand for physicians (or supply) will be affected by healthcare reform; it is interesting, however, to look at Massachusetts' experience.

In 2006, Massachusetts enacted a healthcare reform measure similar to the current national healthcare reform. According to the white paper, the legislation succeeded in expanding health insurance coverage to previously uninsured patients: approximately 98% of Massachusetts' population is now insured, which is the highest among all states. There are unintended consequences, however: as patients have difficulty in scheduling doctor appointments and many doctors in the state are no longer accepting new patients or are restricting the number of patients they will see in certain categories.

Figure 3 below shows the average patient appointment waiting times for seven major cities.

Figure 3

Average Patient Appointment Wait Times

City	Wait time
Boston	50 days
Philadelphia	27 days
Los Angeles	24 days
Houston	23 days
Washington, D.C.	23 days
San Diego	20 days
Minneapolis	20 days

Source: Merritt Hawkins 2009 Survey of Physician Appointment Wait Times

The average patient appointment wait time in Boston is 50 days; more than twice as long as other metropolitan areas. The waiting time for family physicians is even worse--63 days--again longer than that of any other metropolitan area. According to the white paper, these long wait times are despite the fact that, nationally, Massachusetts has the third highest density of primary care physicians. Another indication of insufficient supply is the decrease in new patients' acceptance rate. According to the Massachusetts Medical Society, 40% of family physicians in Massachusetts no longer accept new patients, up from 30% in 2007. Almost 60% of general internists have stopped taking new patients, up from 49% in 2007. These problems could very well be expected to grow as more uninsured people obtain coverage.

So, the first conclusion is that healthcare reform is likely to result in greater demand for physician services but no additional physicians to meet that demand.

Offset...Medicare Payment Incentives

To offset the possible negative impacts of PPACA, the Government offers a couple of Medicare payment incentives including, but not limited to:

- 2011 – 2016: 10% bonus on Medicare payments for "eligible services" as per codes designated in the law. According to the white paper, to be eligible, the charges on office/home and nursing facility visits need to comprise at least 60% of the physicians' total Medicare charges.
- 2011 – 2014: As part of the greater emphasis on health information technology ("Health IT"), incentive payments will be provided for voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI). Starting in 2015, however, there will be penalty for physicians not utilizing Health IT.
- 2013 – 2014: The reimbursement rate for certain services for Medicaid patients will be equal to or greater than the current Medicare rate. Based on the Milliman Healthcare Reform Model, this would improve Medicaid's reimbursement rate from 52% to 70% of private practice. Though improving, it is important to note that this provision only applies to a temporary 2-year period.

Critical Omissions...Reimbursement Issues

Physicians' concerns are heightened because healthcare reform did not address important reimbursement issues. In 1998, a Sustainable Growth Formula (SGR) was introduced to control the increasing spending on Medicare physicians' fees. SGR tracked the spending on Medicare physicians' services against a spending target or budget. If aggregate spending exceeded the target amount, the reimbursement percentage paid to physicians would be cut. Conversely, if aggregate spending was less than the target, the reimbursement ratio would go up. Since 2002 Medicare spending has exceeded the SGR levels and resulted in cuts to physician reimbursement rates. Implementation of the actual cuts has been delayed by short term legislative fixes but a permanent solution has yet to be discussed in Congress. As of January 1, 2011, the accumulated reduction in physician reimbursement rates totals 25%.

As observed by the Texas Medical Association in their article "Medicare Meltdown: Today's Reality," "*Physicians cannot continue to absorb cuts in Medicare fees and maintain viable practices. For the past decade, the cost of running a practice has increased almost 28%. During the same period, physician' payments from Medicare have remained stagnant.*" Figure 4 illustrates how Medicare patients' visits will quickly erode physicians' profitability if the proposed cuts go into effect.

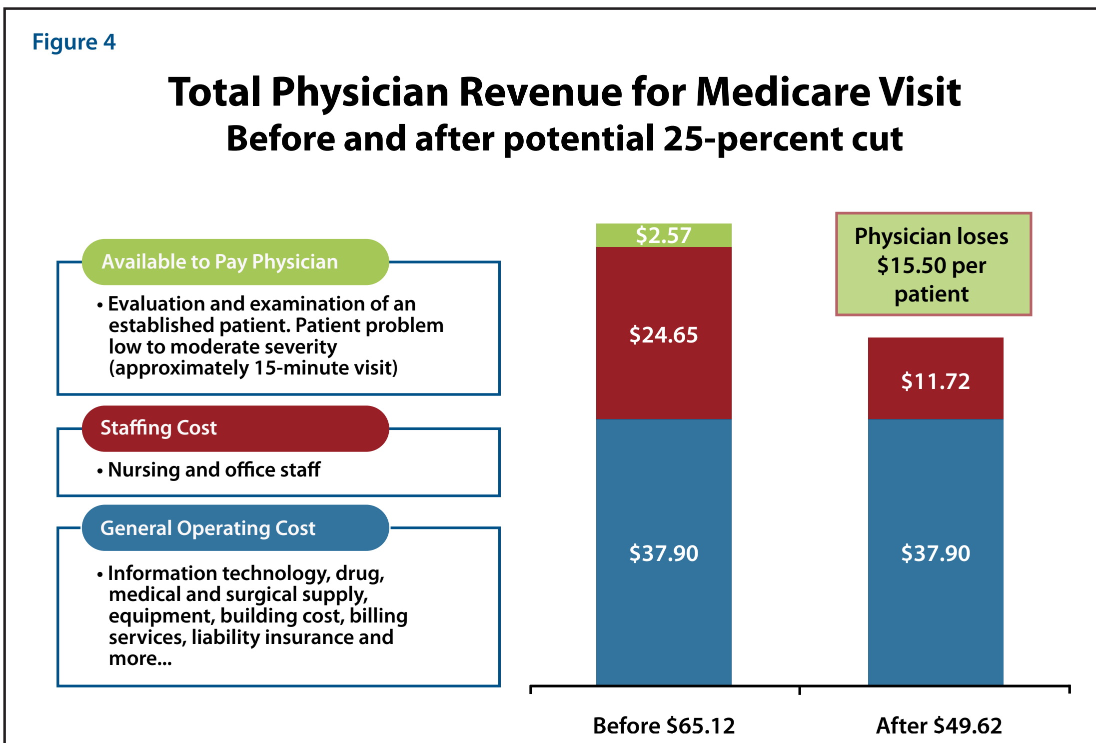
Physicians' Reactions

With the upcoming changes expected from the healthcare reform legislation, it is important to consider how physicians might react. Merritt Hawkins performed a survey published in 2010 to gauge physicians' reactions toward healthcare reform by comparing their initial reaction and their reaction three to four months after enactment. Their responses are shown in Figure 5 on the next page.

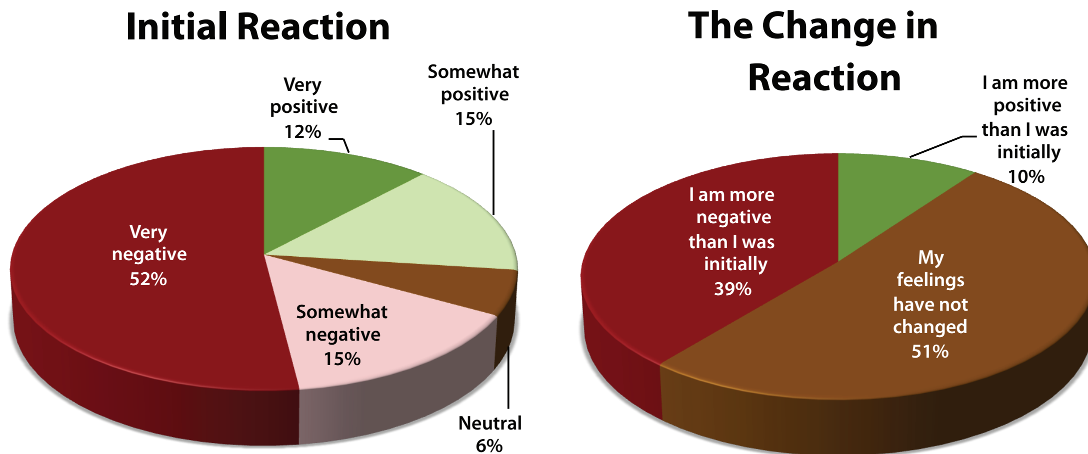
In their initial response, approximately two-thirds of physicians were either somewhat or very negative about the new law, as compared to 27% who were somewhat or very positive.

It seems clear that most physicians think unfavorably about the new law as very few of them felt more positively when surveyed three to four months later. Anecdotally, it appears that increased demand for services coupled with financial uncertainty, as discussed on the next page, are the most worrisome to physicians.

Figure 4



Source: Medicare Meltdown: Today's reality, Texas Medical Association (2010)



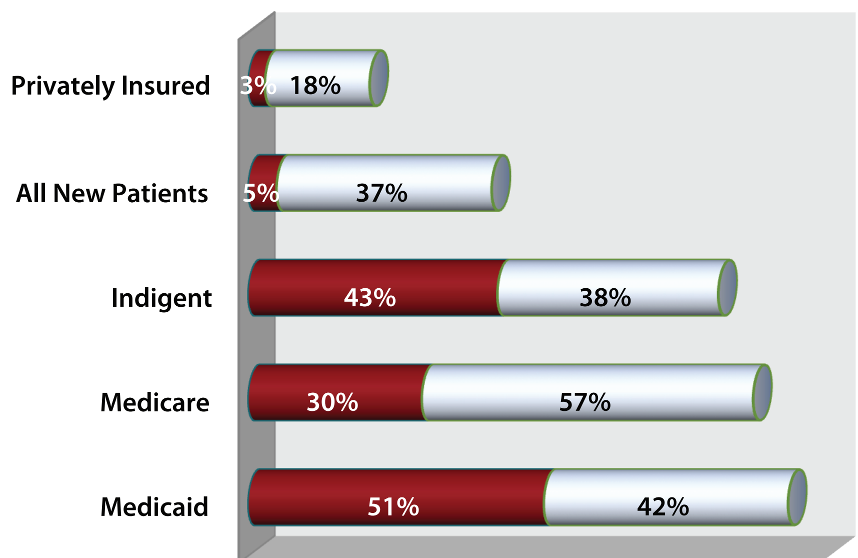
Source: "Health Reform and the Decline of Physician Private Practice," White Paper and Survey conducted on behalf of the Physicians Foundation by Merritt Hawkins (October 2010)

It is no surprise that the categories of patients that will be most affected will be Medicare, Medicaid, and indigent patients. On the other hand, patients with private insurance are likely to be least impacted due to the higher reimbursement levels in private insurance. These changes in the medical practice may lead physicians to overwork, stress, depression, and ultimately dissatisfaction with their job.

It is expected that healthcare reform will increase the number of patients looking for care from a primary physician, especially when mandatory coverage becomes effective. Without more available physicians, the amount of time a physician can spend with any one patient is likely to be reduced. The combination of inadequate numbers of primary care physicians and less time spent with patients, will likely translate to diminished quality of the services provided to patients.

Most physicians are not optimistic about the potential effect of healthcare reform on the financial position of their practices. Approximately 68% of the physicians surveyed by Merritt Hawkins believe that healthcare reform will diminish their financial viability. Healthcare reform should reduce the number of uninsured patients; everything else equal, this should improve physicians' financial stability. However, the uncertainty of the reimbursement levels going forward offsets this favorable impact.

What does this mean to patients? This is likely to impact physicians' availability to patients going forward, as we have seen happen in Massachusetts. Figure 6 summarizes the impact to physician accessibility. The Merritt Hawkins' survey found that 60% of responding physicians believe that they need to either stop receiving new patients or establish significant restrictions on certain categories of patients.



Source: "Health Reform and the Decline of Physician Private Practice," White Paper and Survey conducted on behalf of the Physicians Foundation by Merritt Hawkins (October 2010)

Predicting the Future...by Looking Back

Looking Back at Managed Care

Another way to estimate the impact of healthcare reform may be to look back at the impact of managed care. Before the widespread use of managed care, physicians were paid on a "fee-for-service" basis. The sicker the patient is (thus the more services a physician provides), the higher the physician's income. Technological advances at the same time made many new procedures and tests available, but came at a price. These costs translated into significant increases in healthcare costs, which opened the door to the rapid expansion of managed care in the 80's and 90's in an effort to control cost. Managed care changed the "fee-for-service" philosophy. Under managed care, the healthier the patient is (thus the fewer services a physician performs), the higher the physician income. This approach was successful in slowing the escalation of healthcare costs.

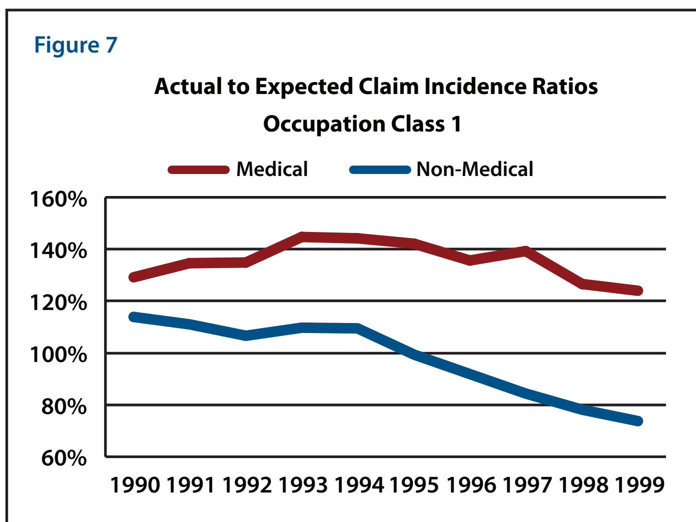
In general, physicians did not respond favorably toward the imposition of managed care regimes. From their perspective, managed care lowered the quality of patient care while reducing their income and autonomy. For example, typically under managed care plans, all courses of treatment or prescription drugs suggested by physicians need to adhere to certain procedures and managed care protocols. In addition, the personal relationship between physicians and their patients was eroded. New patients were attracted to (or turned away from) a physician based on their network status. All these factors are components in increasing physician dissatisfaction.

Impact of Managed Care on Disability Income

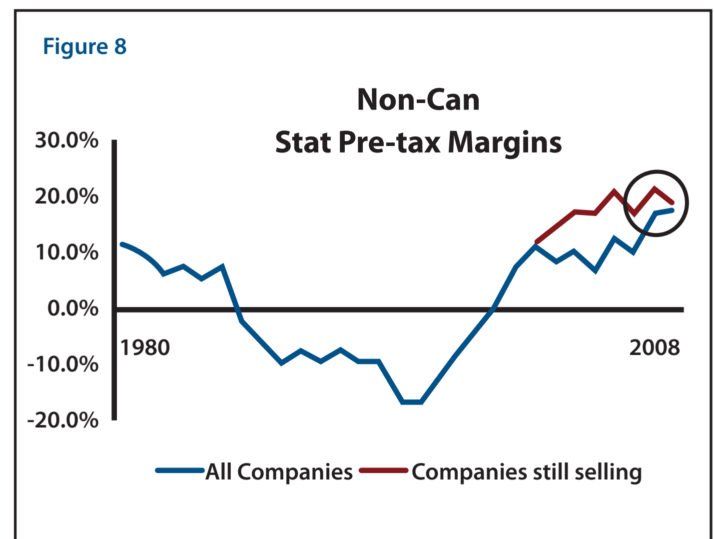
Physician dissatisfaction exacerbated structural deficiencies in the disability income insurance market at the time. Physicians had always been a key target market for disability income business and this was even more so during the 70's and 80's when there was a constant increase in physicians' income. However, as managed care networks continued to expand, the trend of increasing physicians' income was halted or even declined in some cases. This became an issue for DI carriers when physicians' disability benefits stayed unchanged even though their incomes had declined. The problem became even more apparent when physicians became employees of managed care networks or large physician groups and were eligible for group disability benefits (in addition to their individual benefits). The over-insured problem became unavoidable and claims filed by physicians increased. The fact that most policies at the time were issued with liberal benefits like lifetime benefits, pure own occ, and unlimited mental nervous further aggravated the problem.

Over-insurance problems and liberal benefits combined with loose underwriting (no financial documentation, limited medical questions), improper pricing (far underpriced for the risks taken), and ineffective claim adjudication led to an increase in claims. The Actual to Expected Claim Incidence ratio (A/E) from IDEC, during the peak of managed care (1993 – 1995) is shown in Figure 7. Note that the A/E's were higher in this period than in other years. As expected, this led to the drop in pre-tax margin as pictured in Figure 8. The pre-tax margin for disability income hit the bottom roughly around this period.

Disability income carriers responded by limiting the richness of benefits. During this time, lifetime benefits were eliminated. Mental/nervous claims were limited to a 24-month lifetime maximum and the rich pure own occ definition was eliminated. Underwriting procedures were tightened: blood and urine tests were performed, medical history was asked in the application, income documentation became necessary, and carriers began to issue policies with exclusions and modifications. These steps, combined with better claim adjudications, led to a turnaround in profitability.



Source: Society of Actuaries, Individual Disability Experience Committee (IDEC) 1990-1999 (published in 2005)



Source: Milliman Disability Newsletter (October 2009)

Predicting the Future

Healthcare reform will certainly impact the medical industry as a whole and physicians specifically. It is too early to predict the actual impact on physicians; however, it should be noted that the root of the dissatisfaction expressed by many physicians stems from their reaction to its increased demands on physician services without addressing their main concerns in regards to reimbursement issues. With the expected increase in demand and insufficient supply, healthcare reform may cause physicians to be overworked, stressed, and depressed which can generate even more frustration with their profession.

This is where disability income insurers need to stay alert. The current state of the disability income insurance business is nowhere near that of the period prior to managed care. We have improved our pricing and introduced tighter underwriting and a better claim adjudication process. We must remain careful in our product offering as well. Over the last few years, product features have become more aggressive with the reintroduction of unlimited mental/nervous and pure own occ provisions at several companies. We have to make sure that these features are priced appropriately. We should not forget that disability income business cycles between good and bad times. We certainly do not want to return to the market of the 1980's and early 1990's. As one physician puts it, "There is a limit to how far we [physicians] can be pushed and this is it!*"

*Physician's comments from "Health Reform and the Decline of Physician Private Practice," white paper and survey conducted on behalf of the Physicians Foundation by Merritt Hawkins (October 2010).

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