Will you financially survive the year?

Critical Decisions

This is the year when everything you have read, heard or thought about the Affordable Care Act (Obamacare) will begin to play out. The decisions you make today and in the next few months about your practice will, most likely, be the most critical professional decisions you ever make. As we stand at the precipice, do you understand the new "geography" of healthcare in 2014 and beyond? There are two items you need to take home from this article:

1. We want to enable you to better understand the landscape you will be living in, so that no matter what decisions you make, your decisions will be educated.
2. We want to introduce you to a new solution that you will find intriguing and should entertain. It just may prove a "practice saver."

Let me introduce you to Obamacare through the eyes of the private practice physician. This is something on which very few have, so I have invested hours of research in piecing this together. I have attempted to minimize any personal opinions and have quoted health sources to back up any statements. After all, our decisions need to be based on facts, not sentiments. But ultimately, do the research yourself. Do not depend just on me! Also, if you are a "speed-reader" or scanner make sure to read the final section. Now, on with the show!

Cancellations of Insurance

So far, approximately 6.1 million individuals lost their health insurance at the beginning of this year because they had purchased their original plans through the individual market place. As of the first of the year, there were about 2 million people who "signed up" for an Affordable Care Act (ACA/Obamacare) plan through an exchanges. However, no one knows if these are actual enrollees

because ACA plans must be paid in January to be effective. (The original deadline of 12/15 was extended to 12/23 and extended again to 1/10/14). An additional 3.9 million individuals have signed up for Medicaid (Medi-Cal in California). You may not think that Medicaid numbers are important if you do not see Medicaid patients, but in order for Obamacare to succeed and pay for itself, it must have young healthy individuals buying plans and, to date, the numbers of "paying customers" appears to be entirely inadequate. As a result, there will be even higher premiums for the insured and lower doctor's pay for all participants.

The next round of cancellations and premium hikes will hit the small business market in the last quarter of this year (2014). It is expected that 50-100 million people will be affected. Therefore, if you think that you are currently immune to the problem because of the "small number" of individual plan cancellations, please reconsider your position.

Definitions

Now let's get to the meat of the matter. Skip this next section if you are familiar with all the terms. If you show this to your patients, or you want a refresher here it is.

Premium – the amount the patient pays for coverage

Deductible - the amount the patient has to pay for covered services before their insurance starts to pay. For instance, if you have a $2,000 deductible, you will pay 100% of your health care expenses until the amount you have paid reaches $2,000.

Copayment - (sometimes called "copay") is a fixed dollar amount that the patient pays for certain health care services. Typically, the patient will have different copayment amounts for different types of service, such as a $25 copayment for a doctor's office visit or a $150 copayment for an emergency room visit. In most cases, any copayments the patients make do not count toward your deductible.

Coinsurance – The patient's share of the costs of a health care. Typically, this is figured as a fixed percentage of the total charge for a service, such as 15% or 30%. Coinsurance kicks in after the patient has met their deductible. For example, assume the patient already met their $2,000 deductible and their plan's coinsurance is 15%. If they have a hospital charge of $1,000 (hahaha – editorial commentary), their share of the costs would be $150 (15% of $1,000). If their coinsurance was 30%, their share would be $300.

Out-of-pocket maximum (or out-of-pocket limit) is the most your patient pays during a policy period (typically a year) before their plan starts to pay 100% of the allowed amount. The money they pay for premiums and health care that their plan doesn't cover (e.g. elective surgery) does not count towards your out-of-pocket maximum. Depending on their plan, their deductible, copayments and/or coinsurance may apply towards the out-of-pocket maximum. The various health care plans have different out-of-pocket maximums; however, under health care reform, the 2014 limits are $6,350 for individuals and $12,700 for families.

What is the Exchange and how does it affect physicians?

As it is currently set up, the marketplace exchange system has been divided up into 4 "metals". The patient is told there are 4 levels of health care as follows:

- A bronze plan will pay 60% of the covered medical costs
- A silver plan will pay 70% of the covered medical costs
- A gold plan will pay 80% of the covered medical costs
- A platinum plan will pay 90% of the covered medical costs

Many physicians and their patients may think this is very straightforward. But please note these numbers are purely from a patient perspective. This represents their "cost". Basically the lower the quality of the plan, the lower the monthly premium and the less it covers of the medical cost. Since the patient is paying anywhere from 10-40% of the cost, how are these costs determined? This is where it gets very complicated and depends on the exact plan, actuarial data and math. Before your head bursts, let's make it simple. The patient share of the cost might come in the form of a large deductible with a low co-insurance in one plan, or it might come with a low deductible and a higher coinsurance. Forbes gives the following example:

Silver Plan A (which generally pays 70% of your health care expenses) offers a high $2,000 deductible and a low 15% coinsurance. Silver Plan B, on the other hand, has a low $250 deductible but a higher 30% coinsurance.

So this should provide a billing nightmare for your staff because NO ONE knows exactly who is paying what, even if they know the type of plan. I find this similar to airline ticket prices, where everyone is probably paying a different fare in each seat of the airplane. There is one major difference though, United or Delta sets its own fees, has tens of thousands of employees and billions of dollars of computers to make it run. You don't set the fees, and you have a few employees and no extra money to make the system functional.

I know the next question you are probably asking is, "what will be my payment for services rendered?" I have spent hours of research attempting to find the answer. The answer is NO ONE seems to know yet. But I have quoted several sources below to give you an idea of what is known.

- ***Kaiser Health News:*** information cobbled together from interviews suggests that if Medicare pays $90 for an office visit of a complex nature, and a commercial plan pays $100 or more, some exchange plans are offering $60 to $70.

- ***Time 1/1/2014:*** When Blue Shield of California was designing the new health plans it would offer individuals under the Affordable Care Act (ACA), the insurer made a simple request to doctors and hospital in its network — lower your prices or get left behind. The insurer asked providers to accept reimbursement rates as much as 30 percent lower than what Blue Shield previously paid through plans sold on the individual market.

- ***Power Your Practice***: In Connecticut, two private insurers planning to be part of the state's HIX sent doctors letters proposing reimbursements that were between 30% and 40% below what they currently pay.

- ***Medical Group Management Association***: More than half of physicians who received payment rate information from ACA exchange insurers report those rates were lower than average commercial payer rates offered in their area, according to the MGMA Legislative and Executive Advocacy Response Network's ACA Insurance Exchange Implementation Report. Around 33.2 percent reported the rates were much lower while 36.2 percent said the rates were somewhat lower. Only 26.8 percent said they were equal and 3.8 percent reported higher rates.

As you can see, no one has the exact answers. Taking the numbers as a whole, it appears that on average, physicians may be seeing a 20%-40% decrease in reimbursement, depending on the health insurance company, the choice of plan, the type of practice and geographical location. This represents 20-40% off your already deeply discounted rates. This assumes that the patient pays their full 10-40% of the covered health care cost and pays their deductible. These are truly spurious assumptions.

Now take a deep breath because I have one more piece of bad news. You also need to realize there is a little noticed provision of the ACA which gives exchange participants a 90 day grace period to pay premiums. Insurers have to pay all claims incurred by the patient in the first month, but guess what? In the second month if the patient is delinquent; all claims are held as pending. By the third month if the patient has still not paid, the insurer can terminate him or her….and THE PHYSICIAN has to collect payment for all outstanding claims.

This is not what many of us were expecting, but this is the hard cold reality. I do not gain any pleasure in passing this news to you, but we private practice physicians must deal with the facts as they exist in 2014.

A suggestion

I have personally asked over 50 fifty physicians if they are accepting Obamacare insurance in their practice. Not one person stated they were taking this insurance. This news is not getting into the press! Slowly but surely patients are discovering that their insurance card is little more than an ATM card that does not access an ATM machine. I know for a fact that many physicians are seeing Obamacare patients but don't know it. Once you agree to accept the patient under an exchange plan and bill the patient's insurance, you will have tacitly agreed to participate and accept the marked discounts. Please be careful.

Potential Answers

Many solutions currently exist for the weeks, months and years that lay ahead. No one solution will fit every physician but I have had extensive conversations with many physicians about how they are coping. No doubt you have been privy to some of these solutions but here is a short list that some physicians have contemplated or instituted.

- Cash only practice – This is self-explanatory
- Flat fee concierge based medicine – A group of patients are asked to pay, usually, a several thousand dollar flat fee for extra special care and attention, above and beyond the norm.

- Variable fee concierge based medicine – Patients are offered a menu of value added services: the more comprehensive the service, the higher the concierge fee. No payment usually results in cutting back of services such as phone calls, lab results, etc.
- Administrative fee based medicine – All patients incur an administrative fee usually in the range of a few hundred dollars for all the non-medical care necessary on their behalf.
- Selling of practice to large institution – This is self-explanatory
- Hope and prayer- For those with a more religious bent.
- Ignore the problem and hope it goes away – For those who don't have a religious bent.

The Solution

In times of great change, there are those who make the right decisions and thrive as well as those that make the wrong decision and fade away. What is the perfect solution for one practice is not the remedy for another. Each practice population is different. Each specialty is different. Each physician is different.

To come up with a solution that fits all is a truly difficult task and is impossible. But there is a solution that will help many if not most physicians.

That solution is one that will:

- Place additional funds in the pockets of all participants in an equitable manner.
- Bring patients comfortably into physician's offices without burden on the physician.
- Place minimal disruption on how the physician currently practices.
- Allow new patients to rapidly accept this new system.
- Allows primary care physicians and specialists to benefit.
- Be the difference between survival and failure for you and your colleagues.

Our Suggestion

As many of you are aware, we have started meeting with primary care physicians and specialists in small groups to assess their needs. Through these discussions, we believe that a "total care" group concierge service will benefit our members. This concierge service will, for the first time, include a cohesive network of primary care physicians ***and*** specialists whose care is coordinated by a "total care" liaison. We are currently holding focus groups to better direct this effort to the needs of all our physicians. To date we have met with approximately 50 physicians, but we would like YOUR input. If you find this idea appealing and wish to join us in this effort, please contact one of the physicians below to learn more.

Primary Care Physicians please contact:

William Stanford at williampstandford@hotmail.com or Rachael Gordon at rgordon@keyway.net

Specialty Care Physicians please contact:

Arnold Cinman at cinman5676@towerurology.com or Martin Hopp at marty@towerent.com

We believe that a comprehensive total care concierge practice is a time whose day has come. We are currently at work on the fundamental business structure and patient flow. We look forward to working with each of you.