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IssueBRIEF

PRIMARY CARE APPOINTMENT AVAILABILITY AND THE ACA INSURANCE EXPANSIONS

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In the current debate in Congress over the Affordable Care Act (ACA), the issue of provider access is a major concern. Fortunately, our 10-state audit study published in *JAMA Internal Medicine* finds that primary care appointment availability for new patients with Medicaid increased 5.4 percentage points between 2012 and 2016 and remained stable for patients with private coverage. Over the same period, both Medicaid patients and the privately insured experienced a one-day increase in median wait times.

Higher appointment availability for Medicaid patients is a surprising result given the increase in demand for care from millions of new Medicaid enrollees. In this Issue Brief, we summarize our study's findings, expand on possible explanations, and extend the analysis by examining the relationship between appointment availability and state-level Medicaid expansions. We find that access to primary care increased for Medicaid patients only in states that extended Medicaid eligibility to low-income, nonelderly adults. Combined, these results suggest coverage provisions in the ACA have not overwhelmed primary care capacity.

Our recently published letter in *JAMA Internal Medicine* finds that access to primary care improved for patients with Medicaid and remained stable for patients with private coverage across 10 study states

Prior to the ACA, concerns were raised about whether the primary care workforce would be able to meet increases in demand for care when previously uninsured populations began seeking health care. Ensuring that appointments are made available to Medicaid patients is particularly challenging because physicians are less likely to accept new Medicaid patients compared to the privately insured, largely due to lower reimbursement rates in Medicaid. Issues with access are not necessarily exclusive to the Medicaid population, however. With more insured adults seeking appointments from a relatively stable supply of primary care providers, privately-insured patients could also be affected.

To assess the ACA's impact on primary care access, we used two waves of data from a study in which simulated patients requested new patient appointments from primary care practices in Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas between November 2012 and March 2013 and January 2016 and May 2016. Trained callers varied by age, sex, and race/ethnicity and were randomly assigned an insurance type (Medicaid or private coverage) and clinical scenario (a check-up or newly-diagnosed untreated hypertension). The methods are described fully here.

We estimated changes in access to primary care between 2012/13 and 2016 for Medicaid and private coverage by measuring the percentage of callers receiving an appointment. For those receiving appointments, we also measured the share of short wait times (7 days or less) and long wait times (more than 30 days) to paint a fuller picture of patients' access. All data were weighted to make them representative to the distribution of people with different insurance types across counties; weights were scaled so that each state contributes equally to cross-state averages.

Our results show that appointment availability increased 5.4 percentage points for Medicaid patients, with no significant change in appointment availability for the privately insured. While the gap in appointment availability between Medicaid and private coverage remains, it fell from nearly 27 percentage points in 2012 to 20 percentage points in 2016. (Figures 1, 2)

Both Medicaid and private coverage patients faced slight increases in wait times, however: Medicaid patients experienced a 6.7 percentage point decline in short wait times and patients with private coverage faced a 4.1 percentage point decline in short wait times, which translates into a one-day increase in median wait times for both groups.

What explains the improved appointment availability during a period of increasing demand?

At least three factors may explain the increase in appointment availability over the study period. First, practices may be extending wait times in order to accommodate a larger group of new patients, as suggested by the increase in wait times.

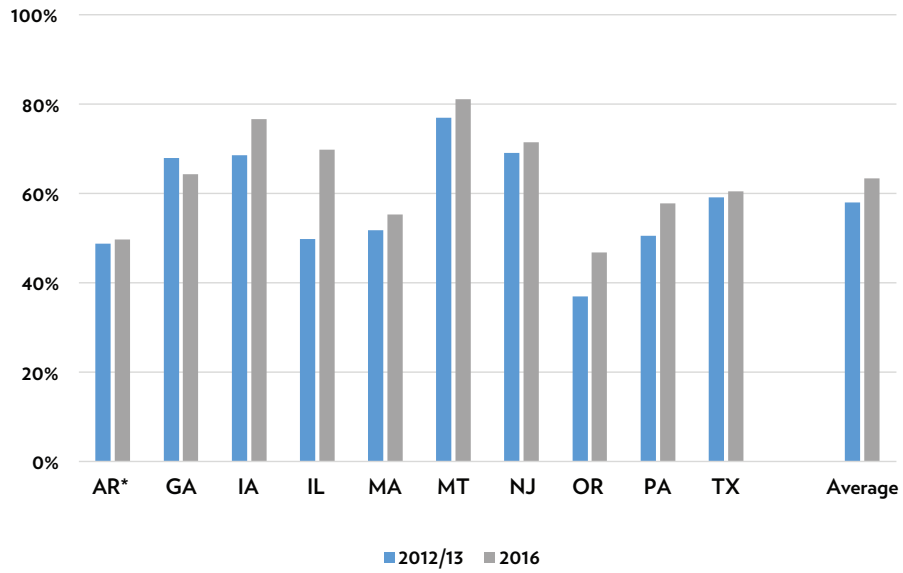
Second, broad investments in primary care and practice redesign could have further improved primary care's ability to accommodate increases in demand. While our study does not provide definitive evidence on the precise mechanisms, it is likely that both policy and market factors are at work. For example, the ACA greatly expanded the capacity of federally qualified health centers and promoted shifts to team-based care, capitated Medicaid managed care, and patient-centered medical homes. There is also a growing trend of retail clinics, which have been linked to a decrease in office-based primary care. During the time frame of our study, there have been other changes in payment models and operational arrangements, including staffing arrangements that increase physician flexibility, consolidation of small practices into larger health systems, and data sharing.

Third, more providers may take Medicaid patients if Medicaid enrollees become a larger portion of the pool of insured individuals. In pediatrics, over one in three children is insured by Medicaid/CHIP and the vast majority of pediatricians accept public insurance. We explore this third possibility by assessing how the increases in appointment availability relate to state-level decisions to expand Medicaid.

What about the Medicaid expansions?

The ACA's Medicaid expansion provided funds and gave states the option to extend Medicaid eligibility to nonelderly adults with incomes below 138 percent of the federal poverty level. As of February 2017, 25 states and the District of Columbia have expanded Medicaid using the program structure of traditional Medicaid, six states have expanded with a Section 1115 waiver which can allow for more cost-sharing

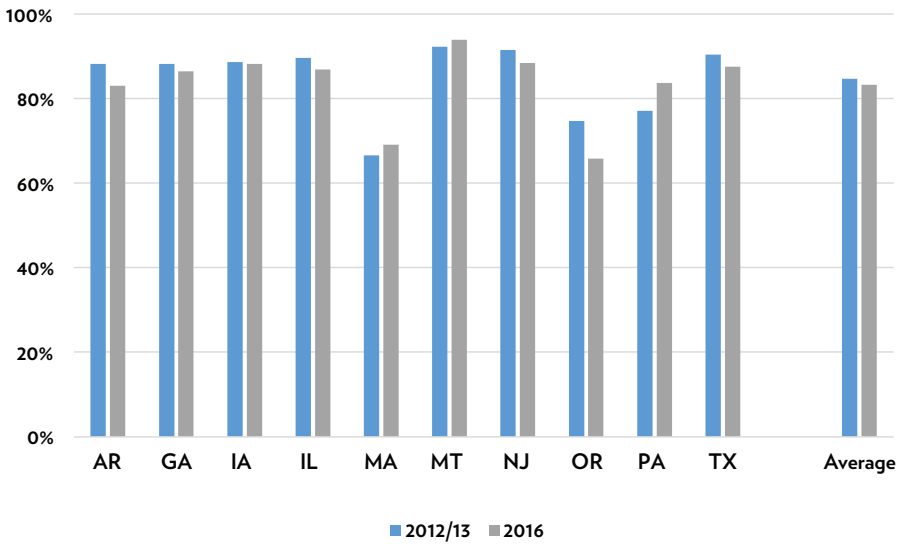
FIGURE 1.
Availability of New Patient Primary Care Appointments for Medicaid Enrollees



Notes: Because AR expanded Medicaid via a private option, the Medicaid group in 2016 includes medically frail enrollees that stayed on traditional Medicaid.

Source: Polsky D, Candon M, Saloner B, Wissoker D, Hempstead K, Kenney GM, Rhodes K. Changes in Primary Care Access between 2012 and 2016 for New Patients with Medicaid and Private Coverage. *JAMA Internal Medicine*. 2017; 177(4), doi:10.1001/jamainternmed.2016.9662.

FIGURE 2.
Availability of New Patient Primary Care Appointments for Private Coverage Enrollees



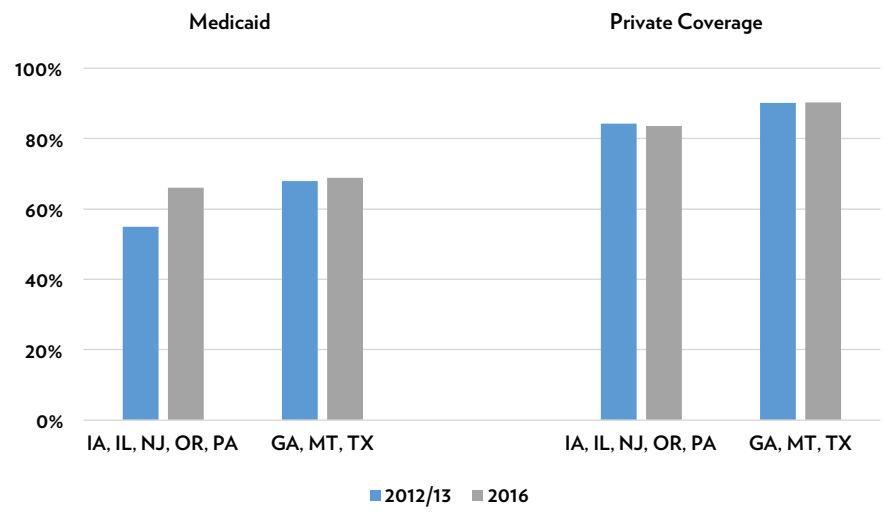
Source: Polsky D, Candon M, Saloner B, Wissoker D, Hempstead K, Kenney GM, Rhodes K. Changes in Primary Care Access between 2012 and 2016 for New Patients with Medicaid and Private Coverage. *JAMA Internal Medicine*. 2017; 177(4), doi:10.1001/jamainternmed.2016.9662.

TABLE 1.
ACA Medicaid Expansion Status of 10 Study States as of February 2017

ACA Medicaid Expansion in 2014/15	No ACA Medicaid Expansion
• Illinois[a] • Iowa[a,b] • New Jersey • Oregon • Pennsylvania (2015)	• Georgia • Texas
Private Option Expansion	**ACA Medicaid Expansion Not Implemented in 2014/15**
• Arkansas	• Massachusetts (2006) • Montana (2016)

[a]Illinois and Iowa both transitioned from primary care case management to Medicaid managed care during the interim.
[b]Iowa had a private option for small portion of the Medicaid expansion population in 2014 only.

FIGURE 3.
Availability of New Patient Primary Care Appointments for Medicaid and Private Coverage by 2014/15 Medicaid Expansion Status



Notes: IA, IL, NJ, OR, and PA expanded Medicaid eligibility to low-income, nonelderly adults in 2014 and 2015. MT didn't expand Medicaid until 2016. As of February 2017, GA and TX have not expanded Medicaid. AR and MA are excluded from the key comparisons because of the uniqueness of their Medicaid expansions and the difficulty identifying them as a traditional expansion state or a plausible comparison.

and other features than Medicaid typically permits, and 19 states have opted out. Between 2013 and 2016, the number of individuals with Medicaid coverage increased over 35 percent in states that expanded Medicaid and only 12 percent in states that did not expand Medicaid.

In our sample, some states chose to expand Medicaid under the ACA and others did not. (Table 1) To examine the effects of extending Medicaid eligibility on primary care access, we grouped states according to the timing and nature of their expansions. Our treatment group included Illinois, Iowa, New Jersey, Oregon, and Pennsylvania, all of whom initiated their expansions in 2014 or 2015. Because Montana's expansion began during data collection in 2016, we placed them in our control group alongside Georgia and Texas, states that have not extended Medicaid eligibility as of February 2017. Our results are robust when Montana is treated as an expansion state.

We exclude Massachusetts from our analysis because it officially adopted the ACA's Medicaid expansion, but had already began to cover low-income adults through its state-led reform effort in 2006. Between 2012 and 2016, appointment availability did not change in Massachusetts and, notably, it was the only state to experience a decrease in wait times.

We also exclude Arkansas because it expanded Medicaid in 2014 using an 1115 private option waiver, with the vast majority of newly eligible Medicaid enrollees obtaining coverage through the new marketplaces created under the ACA and the medically fragile remaining on Medicaid. Recent work explores Arkansas's expansion in depth. Between 2012 and 2016, there was no change in access for Medicaid enrollees, but private coverage enrollees faced lower appointment availability and longer wait times.

In the five study states that expanded Medicaid in 2014 or 2015 (IL, IA, NJ, OR, PA), Medicaid appointment availability increased by 9.5 percentage points, from 54.9 percent to 64.4 percent (Table 2, Figure 3). Illinois experienced the largest increase in appointment availability for Medicaid (20.0 percentage points), followed by Iowa (8.1 percentage points) and Pennsylvania (7.2 percentage points). For private coverage enrollees, appointment availability declined in Oregon (-8.9 percentage points) and increased in Pennsylvania (6.5 percentage points). In the three study states that did not expand Medicaid in 2014 and 2015 (GA, MT, TX), there were no significant changes in appointment availability for either insurance type. (Figure 3, Table 2)

While surprising, these results are consistent with an audit in Michigan that found increased Medicaid appointment availability, particularly in areas with the largest gains in Medicaid patients and a second study that found improved access and affordability for adults targeted by the expansion.

The relationship between changes in wait times and state-level Medicaid expansions is less clear. In 2014 and 2015 expansion states, Medicaid enrollees faced a 9.1 percentage point decrease in the share of short wait times, but no change in the share of long wait times. Among privately insured patients, there was no change in the share of short wait times,

TABLE 2.
Analysis of Medicaid Expansion State Changes from 2012/13 to 2016 in Primary Care Appointment Availability Rate and the Share of Short and Long Wait Times for New Simulated Patients

	2012/13	2016	Percentage Point Difference	# of calls
APPOINTMENT AVAILABILITY				
Medicaid				
Medicaid Expansion in 2014/15 (IA, IL, NJ, OR, PA)	54.9%	64.4%	9.5***	4,173
Comparison States (GA, MT, TX)	68.0%	68.4%	0.4	2,071
Private Coverage				
Medicaid Expansion in 2014/15 (IA, IL, NJ, OR, PA)	84.3%	82.5%	-1.8	4,717
Comparison States (GA, MT, TX)	90.2%	89.2%	-1.0	2,389
SHORT WAIT TIME (7 DAYS OR LESS)				
Medicaid				
Medicaid Expansion in 2014/15 (IA, IL, NJ, OR, PA)	58.6%	49.5%	-9.1***	2,536
Comparison States (GA, MT, TX)	59.6%	50.8%	-8.8**	1,361
Private Coverage				
Medicaid Expansion in 2014/15 (IA, IL, NJ, OR, PA)	57.7%	55.5%	-2.2	3,990
Comparison States (GA, MT, TX)	59.8%	51.6%	-8.2***	2,122
LONG WAIT TIMES (30 DAYS OR MORE)				
Medicaid				
Medicaid Expansion Initiated in 2014/15 (IA, IL, NJ, OR, PA)	8.5%	10.5%	2.0	2,536
Comparison States (GA, MT, TX)	7.9%	12.6%	4.7*	1,361
Private Coverage				
Medicaid Expansion Initiated in 2014/15 (IA, IL, NJ, OR, PA)	5.8%	8.5%	2.7**	3,990
Comparison States (GA, MT, TX)	5.3%	11.5%	6.2***	2,122

Notes: * p<0.05, ** p<0.01, *** p<0.001. AR and MA are excluded from the key comparisons because of the uniqueness of their Medicaid expansions and the difficulty identifying them as a traditional expansion state or a plausible comparison.

and a 2.7 percentage point increase in the share of long wait times. In states that did not expand Medicaid in 2014 and 2015, both insurance types experienced an overall increase in wait times.

Since this audit was restricted to in-network offices, our estimates do not reflect changes in the size of Medicaid networks or for established patients. Some changes to health care delivery, such as Iowa and Illinois moving to capitated managed care, may confound our ability to link Medicaid expansions to changes in appointment availability. Finally, we only include 10 states and 27 percent of the national nonelderly population – though states were selected to provide geographic, demographic, and health care-related variation, our results may not be generalizable to other settings.

Policy Implications

As policymakers from across the political spectrum consider changes to the current health care system, it is crucial to understand the ACA's full impact. Our 10-state audit study asks whether primary care access is changing as more people gain health insurance under the ACA. Overall, we find increases in primary care appointment availability for new patients with Medicaid in states that expanded Medicaid, with no offsetting decline in appointment availability for patients with private coverage. Our findings suggest that the influx of millions of newly-insured patients under the ACA has not overwhelmed primary care capacity, which should allay concerns that capacity constraints would compromise access to care, particularly within Medicaid.

ABOUT LDI

Since 1967, the Leonard Davis Institute of Health Economics (LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation's health and health care. Originally founded to bridge the gap between scholars in business (Wharton) and medicine at the University of Pennsylvania, LDI now connects all of Penn's schools and the Children's Hospital of Philadelphia through its more than 250 Senior Fellows.

LDI Issue Briefs are produced by LDI's policy team. For more information please contact Janet Weiner at weinerja@mail.med.upenn.edu.

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