Health Care

Are Montana's Primary Care Providers Ready for the Affordable Care Act?

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The Affordable Care Act (ACA) will change the way Montanans use the health care delivery system. According to American Community Survey three-year estimates, approximately 172,000 Montanans are uninsured. Exactly how many will gain health insurance either through the Medicaid expansion or Montana's Federally Facilitated Exchange is subject to debate. Certain, however, is that Montana's health care delivery system will experience an increase in the demand for health services of all types.

While the Medicaid expansion is an option for states – and it may not happen in Montana – many of the uninsured will qualify for subsidized health insurance in the exchange beginning in 2014. The uninsured tend to use primary care less and hospital emergency departments more than the privately insured. As the uninsured gain access to health care coverage, their utilization of the health care system will change. Particularly for primary care, can Montana's existing primary care workforce accommodate the increase in demand that will follow the newly insured in Montana? Nationally, the primary care system is strained since many physicians now become specialists, and among those who remain in primary care, an aging workforce may soon mean that shortages will appear.

Current Demand for Primary Care Office Visits

Before the impact of the newly insured can be assessed, the current levels of ambulatory care use need to be addressed. Montana's number of primary care physicians in the state per 100,000 people (51) falls well below the generally accepted national threshold of 60 to 85 primary care physicians per 100,000. The National Association of Community Health Centers estimates that 150,000 Montanans are without access to a primary care provider. Many primary care practitioners are now older and closer to retirement, a demographic that parallels the population in general. In addition, more practitioners are now practicing part time.

The insured use primary care at nearly three times the rate of the uninsured, and hospital emergency departments at half the rate of the uninsured. This is important because as the uninsured gain access to health care coverage, use of the hospital emergency department should fall. Emergency departments are one of the most expensive points of entry in the health care system. Under the expansion of Medicaid to individuals with incomes under 138 percent of the federal poverty level ($15,000), sizable increases in the use of all ambulatory care settings will occur as the uninsured transition to health care insurance. Particularly for primary care, the demand for office visits will increase almost four-fold as individuals go from uninsured to insured under Medicaid (Table 1).

Data on the health insurance status of the Montana population from the American Community Survey is combined with the 2007 National Ambulatory Medical Care Survey to estimate the current demand for five different ambulatory care services: primary care offices, surgical specialty offices, medical specialty offices,

Table 1
Office Visits per 100, by Expected Source of Payment

	Primary Care	Surgical Specialty	Medical Specialty	Hospital Outpatient	Hospital Emergency Dept.
Private Insurance	192	55.1	61.5	17.3	22.5
Medicaid/CHIP	254.7	33.1	44.9	84.9	82.1
No Insurance	65.3	17.2	30.1	19.2	41.5

Sources: 2007 National Ambulatory Medical Care Survey; U.S. Department of Health and Human Services; National Center for Health Statistics.

Table 2
Current Demand for Primary Care Office Visits by Expected Source of Payment

	– Source of Expected Payment –						Total Primary Care Office Visit Demand
	Employer-Sponsored Insurance	Private Insurance	Medicare	Medicaid/CHIP	Uninsured	Unknown	
Montana	742,310	295,037	415,287	141,863	94,653	47,382	1,736,533
Cascade	57,145	19,173	35,625	13,201	7,520	4,589	137,253
Flathead	64,414	26,243	36,229	9,989	12,281	4,015	153,171
Gallatin	78,021	34,120	23,278	5,901	8,279	4,664	154,264
Lewis & Clark	61,198	15,759	25,354	6,581	4,202	2,504	115,598
Missoula	89,937	33,335	36,019	14,480	12,871	3,298	189,939
Ravalli	26,003	13,709	23,627	7,733	4,088	488	75,647
Silver Bow	27,199	8,963	16,448	7,488	3,185	317	63,599
Yellowstone	120,837	37,503	58,811	22,182	15,857	5,302	260,492

Sources: 2007 National Ambulatory Medical Care Survey; American Community Survey; Bureau of Business and Economic Research, The University of Montana.

Table 3
Estimated Increase in the Demand for Ambulatory Care Office Visits

	Primary Care	Surgical Specialty	Medical Specialty	Hospital Outpatient	Hospital Emergency Dept.	Total Office Visits
Private Insurance	131,999	39,485	32,713	(1,979)	(19,795)	182,423
Medicaid/CHIP	128,283	10,853	10,102	44,846	27,713	221,797
Total Change	261,281	50,338	42,815	42,867	7,919	405,220

Sources: 2007 National Ambulatory Medical Care Survey; American Community Survey; Bureau of Business and Economic Research, The University of Montana.

hospital outpatient and hospital emergency department visits.

Table 2 summarizes the current demand for primary care office visits in Montana and select counties. The number of office visits is calculated by type of payment (insurance) and also includes the demand by the uninsured.

The uninsured account for 5 percent of all office visits for primary care. By far the biggest demand placed on primary care providers comes from the Medicare population. Medicare enrollees account for more than 415,000 of the total 1.7 million office visits for primary care, or 24 percent of the total demand for primary care services (Table 2).

By contrast, in Gallatin County, one of the youngest populations in the state, Medicare enrollees account for only 15 percent of total primary care demand in Gallatin County.

Estimated Increase in the Demand for Primary Care Office Visits

Approximately 68,000 uninsured Montanans with incomes below 138 percent of the federal poverty level may become insured under the Medicaid expansion. The remaining uninsured, 104,000, are left to shop for health insurance in Montana's Federally Facilitated Exchange. Assuming all 172,000 previously uninsured become insured either through Medicaid or private insurance, an additional 261,000 primary care office visits are expected statewide (Table 3).

The increase in emergency department use by the Medicaid population (27,713) is partially offset by the decrease in emergency department use by the privately insured. Recall that as the uninsured transition to Medicaid, emergency department use increases two-fold while emergency department use by the privately insured decreases by half.

By far, the greatest impact of the ACA is on the demand for primary care office visits, which account for 64 percent of the total ambulatory care office visits resulting from increased insured rates. Adding the incremental increases for primary care (Table 3) to the estimated current demand for primary care (Table 2) provides

a snapshot of the total anticipated demand for primary care office visits as a result of the ACA and its provisions to increase insured rates.

Total statewide demand for primary care is almost two million office visits per year (Table 4).

Primary Care Capacity

The capacity of the primary care system to accommodate additional demand may be modeled by the number of primary care practitioners and the number of office visits primary care providers can offer each year. In a study by Davis, Roberts, and White (2009), 495 primary care physicians were identified in the state of Montana. Other studies contrast drastically with this number, and range from 629 primary care providers (Stenseth 2009) to 862 primary care providers (Rivard 2009).

The U.S. Department of Health and Human Services uses a guideline of 4,200 office visits per year for primary care physicians, much lower than the American Medical Association guideline of 5,400 office visits per year for family practitioners. The lower threshold is used in this analysis. Table 5 estimates primary care capacity for the state and by select county. By comparing primary care capacity to estimated total demand, the ability of the primary care system to accommodate the increased demand for primary care services can be estimated.

Overall, it appears that Montana can accommodate the increase in demand for primary care office visits that result from the uninsured acquiring health insurance. This may not be the case for all Montana counties, though. Particularly for Flathead, Missoula, and Ravalli counties, Montanans may find access to primary care providers difficult. Efforts to increase primary care providers are needed in order to accommodate some of the changes brought about by passage of the ACA.

Table 4
Total Estimated Demand for Primary Care Office Visits, Montana and Select Counties

County	Total Additional PC Office Visits	Total Demand for PC Office Visits
Montana	261,281	1,997,814
Cascade	17,854	155,107
Flathead	28,252	181,423
Gallatin	18,631	172,895
Lewis & Clark	9,424	125,022
Missoula	30,745	220,684
Ravalli	11,300	86,947
Silver Bow	7,482	71,081
Yellowstone	35,736	296,228

Source: Bureau of Business and Economic Research, The University of Montana.

Table 5
Estimated Shortages/ Surpluses of Primary Care Office Visits, Montana and Select Counties

Locale	Primary Care Supply	Primary Care Demand	Shortage (-)/Surplus (+) Office Visits per Year
Montana	2,079,000	1,997,814	+81,186
Cascade	163,800	155,107	+8,693
Flathead	176,400	181,423	-5,023
Gallatin	226,800	172,895	+53,905
Lewis & Clark	147,000	125,022	+21,978
Missoula	201,600	220,684	-19,084
Ravalli	58,800	86,947	-28,147
Silver Bow	71,400	71,081	+319
Yellowstone	508,200	296,228	+211,972

Source: Bureau of Business and Economic Research, The University of Montana.

Conclusion

Major medical markets, such as Missoula, Great Falls, and Billings, serve areas well beyond the county boundaries. Although primary care is usually delivered locally, it is reasonable to assume that primary care demand is still underestimated to a considerable degree. More illustrative perhaps are the counties with low surpluses of primary care capacity, or in some, shortages of primary care capacity. Ravalli County in particular appears to have a severe shortage of primary care capacity given the additional burdens to be placed on their providers.

Even legislative initiatives nationally and at the local level may not fix the primary care workforce shortage because of the long period of time required to train doctors, nurse practitioners, and physician assistants.

Missing in this analysis is the role that payment to the provider serves in seeing certain payer mixes, particularly Medicaid. As payments fall to the marginal cost of providing services to these patients, doctors will have limited options. Some may decrease the number of Medicaid patients seen, some may simply retire earlier. Many primary care physicians are now employed by local hospitals and federally funded clinics. Hospitals and these clinics receive higher payments from government sources than an independent physician receives for the same services. How this trend affects overall costs is not apparent, but it does provide some support to keep primary care physicians in our communities. 13