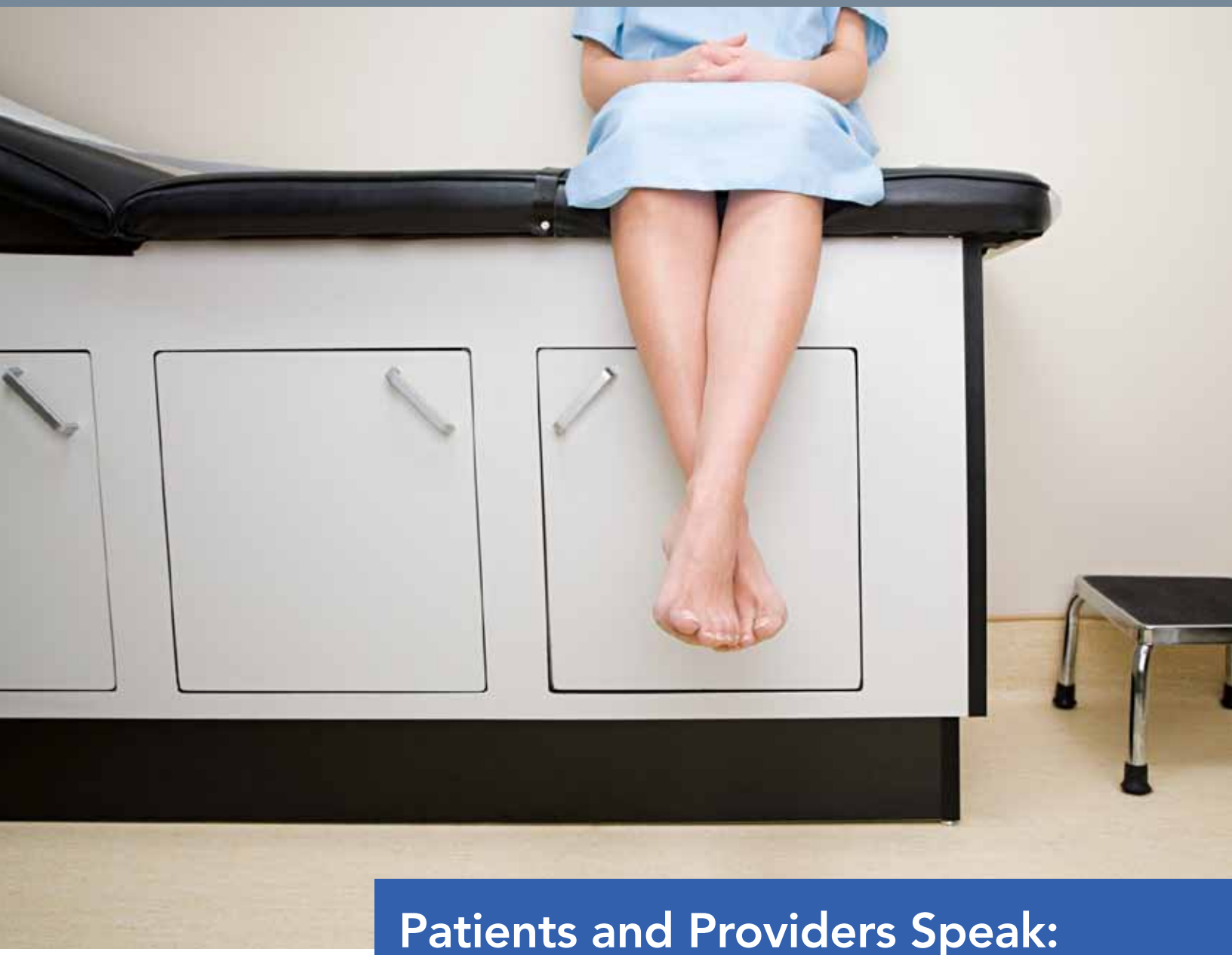
California HealthCare Foundation



Patients and Providers Speak:
Early Care Experiences Under the ACA

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

Introduction

The Patient Protection and Affordable Care Act (ACA) is intended to provide consumer protections and convenient access to a choice of affordable, high-quality health plans for individuals and families, many of whom previously were "locked out" of the health care system due to cost or prior illness.

California was the first state to enact legislation to implement a health insurance marketplace — Covered California — which has the largest number of marketplace enrollees in the country. Covered California was launched in October 2013, and the health plans purchased through it were activated in January 2014. As of April 19, more than 1.4 million Californians have selected a non-Medi-Cal health plan through Covered California, representing over 17% of all Americans covered under marketplace plans.[1]

How successful is Covered California in serving people who seek and receive care under the ACA provisions? This study provides some early insight into the successes and challenges of the ACA from the perspectives of consumers and clinical organizations in California.

Such information will be useful in addressing some concerns associated with health reform. For example, some worry that as the newly insured begin to seek care, provider shortages will reduce access to care.[2] Further, there is concern that newly insured care seekers may have higher-than-average care needs, and may be inexperienced in navigating health insurance coverage.[3] The extent to which these and other potential problems manifest and are overcome will influence ACA implementation and its success.

Methodology

To understand the early care experiences of consumers in Covered California health plans, the American Institutes for Research held focus groups with consumers and interviewed health care providers in four areas of California: the Bay Area (San Francisco and Oakland), Fresno, Los Angeles, and Redding. Data collection occurred from March to May of 2014. A brief survey was also administered to consumers at the start of the focus groups. The four data collection areas represent 5 of the 19 pricing regions Covered California used to price qualified health plans offered through the marketplace. In addition to including both urban and nonurban areas, these four areas maximized recruitment of participants with diverse racial and ethnic identities, political affiliations, and languages spoken, and with and without previous experience in health insurance coverage.

Consumer Focus Groups

Eight focus groups were conducted with 74 consumers who purchased a commercial health plan through Covered California and had used that health insurance at least once to receive care (see Table 1). Medi-Cal recipients were excluded. All participants were required to be age 18 and above. Consumers were recruited to achieve a mix of genders, educational levels, incomes, and racial, ethnic, and linguistic backgrounds.[4] To better understand the care experiences of the Latino population in California, two of the eight focus groups were conducted in Spanish with consumers who self-identified as Latino. Both of the Spanish-language focus groups were held in Los Angeles.

Table 1. Composition of Consumer Focus Groups and Provider Phone Interviews

LOCATION	CONSUMER FOCUS GROUPS		PROVIDER INTERVIEWS
	Groups	Participants	
Bay Area	2	22	19
Fresno	2	17	15
Los Angeles	2	21	12
Redding	2	14	14
Totals	**8**	**74**	**60**

Source: American Institutes for Research, Early Care Experiences Study.

During all focus groups, consumers were asked to describe their past experience with health care and health insurance coverage as well as share their experiences with their health care and their health insurance since January 1, 2014. Topics of discussion included the ability to see providers when needed, interactions with providers while receiving care, out-of-pocket costs, covered services, physician and specialist networks, and referrals to specialists.[5]

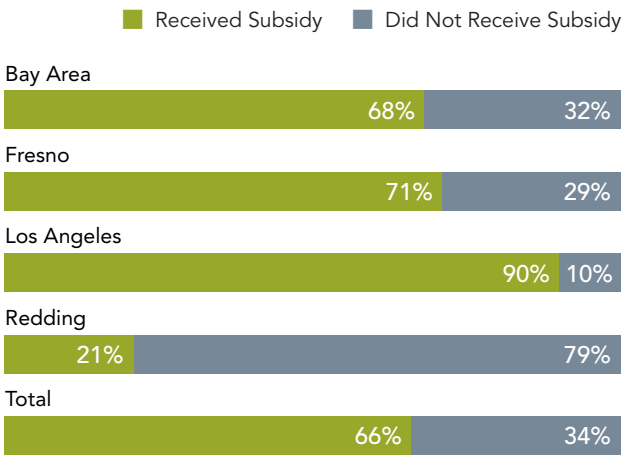
Prior to the start of the focus groups, all participants completed a short survey that contained items from the Consumer Assessment of Health Plans and Systems 5.0 Qualified Health Plan survey.[6] The survey solicits information about participants' general experiences with using their new health coverage and with seeking care.[7]

Consumer Characteristics

Participants ranged in age from 22 to 64 years old, with an even distribution of participants over the oldest three age ranges (see Table 2). Females were more heavily represented than males in the study population, representing 61% of all participants. While participant education level ranged widely by region, the two groups with the highest representation were those with a high school diploma and those with a bachelor's degree. Seventy-four percent of respondents self-identified their race as White, 11% as Black or African American, 6% as Asian or Pacific Islander, and 9% as Other. Forty-six percent of participants self-identified as "Spanish, Hispanic, or Latino," including all of the consumers from the Los Angeles focus groups. Only the Los Angeles focus group participants reported Spanish as the primary language spoken at home. The remaining focus group participants reported English as the primary language spoken at home. Most (66%) participants qualified for the financial subsidy offered through the marketplace. (See Figure 1.)

Thirty-one percent of participants had no health insurance coverage in 2013 before enrolling in a Covered

Figure 1. Consumers Receiving Financial Subsidy for Health Insurance, by Region (n = 74)



Source: American Institutes for Research, Early Care Experiences Study.

Table 2. Consumer Focus Group Demographic Characteristics, by Region (n = 74)

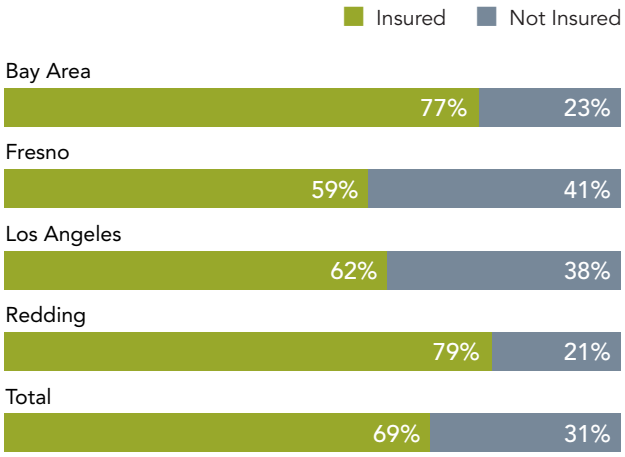
	Bay Area	Fresno	LA	Redding	ALL
Age					
18 to 25	25%	0%	50%	25%	**5%**
26 to 40	38%	21%	25%	17%	**32%**
41 to 54	21%	21%	46%	13%	**32%**
55 and older	32%	32%	9%	27%	**30%**
Gender					
Female	29%	16%	31%	24%	**61%**
Male	31%	34%	24%	10%	**39%**
Education					
Less than high school	0%	50%	50%	0%	**3%**
High school diploma or GED	6%	22%	67%	6%	**23%**
Associate's degree	15%	8%	46%	31%	**18%**
Some college	45%	36%	0%	18%	**15%**
Bachelor's degree	46%	21%	8%	25%	**32%**
Graduate degree	50%	33%	0%	17%	**8%**
Spanish, Hispanic, or Latino					
Yes	18%	21%	62%	0%	**46%**
No	40%	25%	0%	35%	**54%**
Race					
White	36%	28%	*	36%	**74%**
Black or African American	50%	50%	*	0%	**11%**
Asian or Pacific Islander	100%	0%	*	0%	**6%**
American Indian or Alaskan Native	0%	0%	*	0%	**0%**
Other	40%	60%	*	0%	**9%**
Totals	**30%**	**23%**	**28%**	**19%**	**100%**

*No race data were available for Los Angeles.

Source: American Institutes for Research, Early Care Experiences Study.

California health plan (see Figure 2). Reasons cited for being without insurance coverage included unemployment, part-time work status, working for an employer who did not offer health insurance coverage, and the unaffordability of private or individual health insurance plans. These participants described several strategies for getting care. Several consumers stated that their family would take preventive measures to "stay healthy" and avoid seeing a doctor. When faced with medical emergencies or severe illnesses, consumers stated that they would go to trusted doctors, sliding-scale or income-based clinics, or to the emergency department, paying out of pocket for visits, medication, and lab work. One participant in Fresno and two participants in East LA traveled to Mexico to seek lower-cost medical procedures, lab work, and medication.

Figure 2. Consumers' Health Insurance Status by Region, 2013 (n = 74)

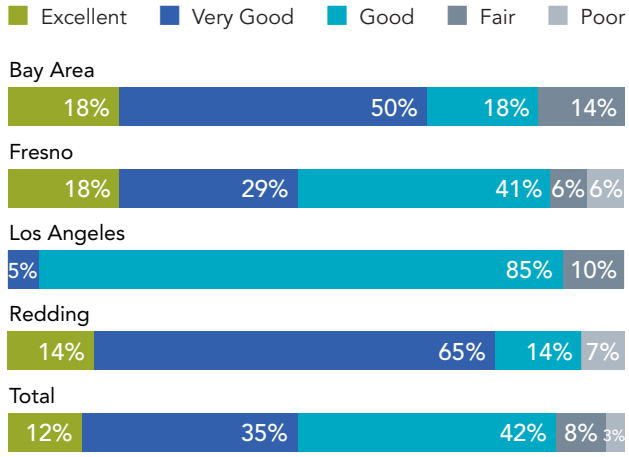


Source: American Institutes for Research, Early Care Experiences Study.

Consumers with health insurance coverage in 2013 were covered through their employers, public insurance programs, a parent's or spouse's employer, or an individual health insurance plan they purchased. The most often cited motivation for enrolling in Covered California health plans was that participants were experiencing premium increases with their prior health insurance coverage and were looking for more affordable options. Other motivations that several consumers offered included the desire to comply with the legal requirement to have health insurance, and employers who, rather than sponsoring insurance for their employees, were requiring them to seek coverage through the marketplace.

In general, participants rated their overall health highly. Almost half of consumers rated their health as "Excellent" or "Very good" (see Figure 3). In addition, consumers in this study are high health care users. About 32% reported receiving care three or more times for the same condition in the last three months (see Figure 4).

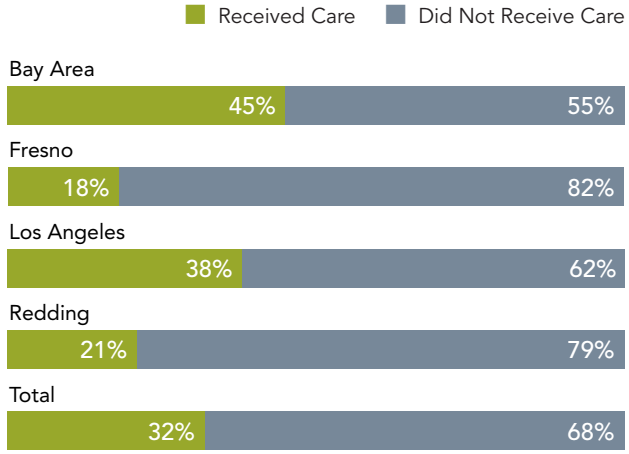
Figure 3. Consumer Self-Reported Health Status by Region (n = 74)



Note: Segments may not sum to 100% due to rounding.

Source: American Institutes for Research, Early Care Experiences Study.

Figure 4. Consumers Receiving Care Three or More Times for the Same Condition, by Region (n = 74)



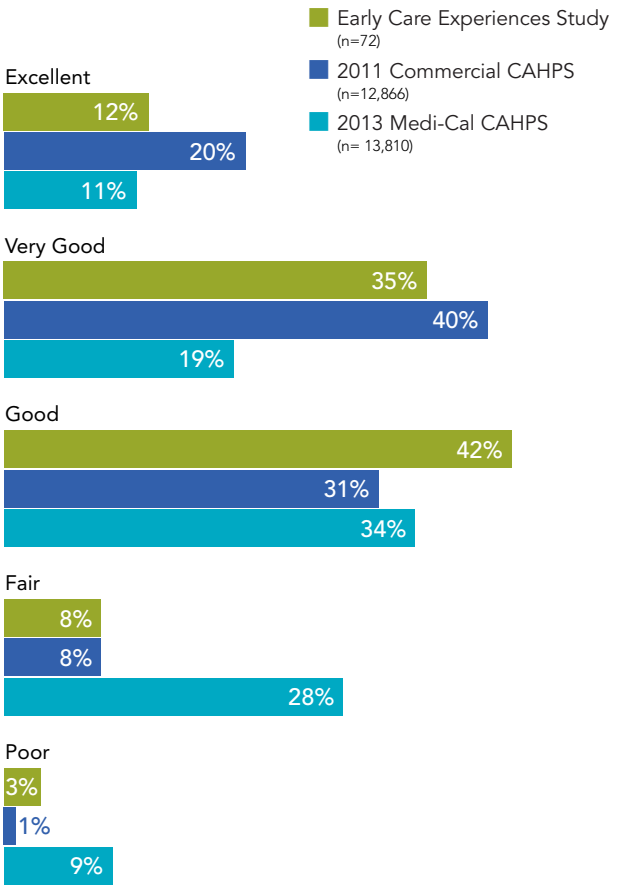
Source: American Institutes for Research, Early Care Experiences Study.

Representativeness of Consumer Sample

The consumers in this study have higher incomes and are less racially diverse compared with Covered California enrollees. Only 66% of consumers in this study were receiving financial assistance for their health plan coverage compared to 88%[8] of Covered California enrollees. Regarding race, 74% of the consumers participating in this study are White, whereas 35%[4] of Covered California enrollees are White. A key group that this study sample underrepresents is Asians. Only 6% of consumers in this study self-identified as Asian compared to 21% of Covered California enrollees.

Based on publicly available commercial and Medi-Cal CAHPS data,[9] consumers in this study perceived their health status more positively than consumers in Medi-Cal plans but less positively than consumers in commercial plans (see Figure 5).

Figure 5. Perceived Health Status for This Study Compared to 2011 Commercial CAHPS and 2013 Medi-Cal CAHPS Respondents



Source: American Institutes for Research, Early Care Experiences Study.

Provider Interviews

Sixty-four semi-structured interviews were conducted with providers in administrative and clinical positions working in clinical organizations in a variety of settings including community health centers, primary care practices, and hospital emergency departments. Specialty organizations and specialists were excluded, as were organizations serving only Medicare or Medicaid beneficiaries. In addition to their perspectives on consumers' experiences using their new health insurance coverage, providers were also asked about any changes in patient volume in their organizations and their organizations' experiences with health plan contracting, reimbursement, and systems changes made to support ACA implementation.

Provider Representative Characteristics

Interviews were conducted with 23 administrative staff, 14 physicians, and 22 other clinical providers (see Table 3). Although these representatives came from a wide range of practice settings, solo or group primary care practices and community health centers were the majority.

Table 3. Provider Characteristics, by Region

	Bay Area	Fresno	LA	Redding	ALL
Role					
Administrative*	26%	35%	22%	17%	**39%**
Clinical†	36%	19%	19%	25%	**61%**
Practice Setting					
Solo / group primary care practice	31%	28%	16%	25%	**52%**
Community health center	30%	25%	25%	20%	**32%**
Hospital emergency department	75%	25%	0%	0%	**6%**
Other	0%	0%	33%	67%	**10%**
Setting Size					
Small (≤10 providers)	26%	29%	24%	21%	**70%**
Large (>10 providers)	56%	25%	19%	0%	**30%**
Totals	**32%**	**25%**	**20%**	**23%**	**100%**

*Examples include office manager, billing clerk, receptionist.

†Examples include physician, physician assistant, nurse practitioner, case manager, social worker.

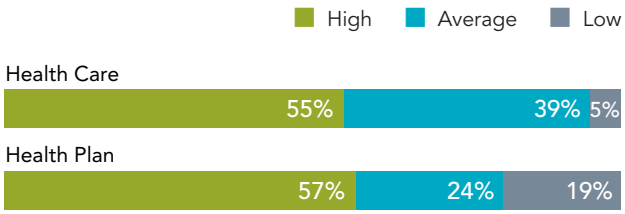
Source: American Institutes for Research, Early Care Experiences Study.

Findings

Consumers' Experiences Under the Affordable Care Act

In general, consumers spoke more positively about the health care they have received since January 1, 2014, than about their new health insurance coverage. When asked to rate their health care and their health plans on a scale from 0 to 10, more consumers rated their health plans lowly than their health care (see Figure 6). Focus group discussions and survey data demonstrate that consumers were highly satisfied with the care they were receiving. However, consumers had a range of both positive and negative experiences with their health plans.

Figure 6. Consumer Ratings of Their Health Care and Health Plans (n = 74)



Notes: Low = 0–4; Average = 5–7; High = 8–10. Segments may not sum to 100% due to rounding.

Source: American Institutes for Research, Early Care Experiences Study.

In general, consumers spoke positively about the costs and coverage associated with their health plans. Consumers described a range of positive and negative experiences with other aspects of their health insurance, such as the provider networks, referral processes, and their ability to access their preferred care in a timely manner. Providers' observations of consumers' early care experiences were consistent with the data obtained through focus groups and surveys with consumers. In the sections that follow, consumers' experiences with care, costs and coverage, networks and referrals, and access to care are described in further detail.

Experiences of Care

While their coverage has only been active since January 1, 2014, many consumers reported having multiple instances and types of care. According to survey data, 20% of consumers had gone to a doctor's office or clinic three or more times since January 1, 2014. The types of care consumers described included primary care visits, specialist visits, emergency department visits / hospitalization, lab work, care for chronic conditions (e.g., diabetes), x-rays and other imaging (e.g., CT scan, MRI), acupuncture, therapy, and prescription fills. Almost all consumers spoke very positively about the care they had received, mostly because they found their providers to be respectful and attentive. The sidebar on page 8 lists some of the wording consumers used to describe their care experiences. Of note, Spanish-speaking consumers were happy that they were able to receive care in their native language. Below, consumers' experiences with care are described in more detail.

Consumers are generally happy with the care they have received. Focus group discussions and survey responses indicated that participants were generally happy with the care they have received with their new coverage. In some instances, consumers were receiving care from the same providers they were seeing prior to purchasing health insurance through Covered California. These consumers described their current experiences as a continuation of the high quality care they were accustomed to receiving. With the exception of a few consumers, participants that either switched to a new doctor or for whom it was

Wording Consumers Used to Describe Care Received Since January 1, 2014

"spend more time"

"enough time with me"

"asking questions"

"very nice, very kind, very respectful"

"professional and respectful"

"took care of the problem"

"thorough"

"courteous"

"my doctors speak Spanish"

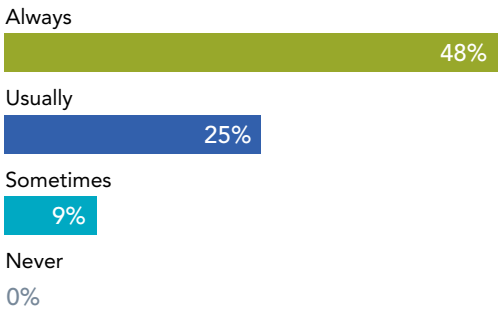
"cordial"

"happy with how they treat me"

"told me my options and explained things more than they did before"

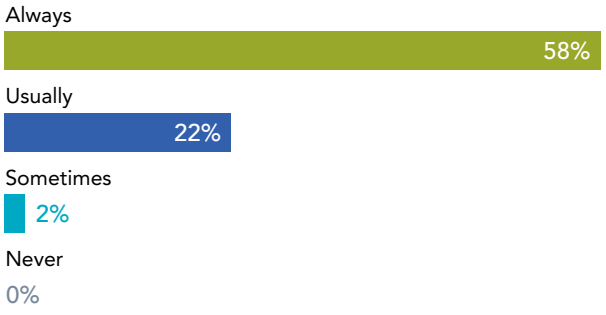
the first time selecting a personal doctor also described having positive care experiences so far. Reasons most often cited in focus group discussions for why the care experience was positive were that doctors spent sufficient time and that they and their staffs were respectful (see Figures 7 and 8). For the few participants that had negative care experiences with their new coverage, the primary reasons cited were that they felt their doctor was rushing through their visit or that their doctor was not being as thorough as they would have liked.

Figure 7. How often did your doctor(s) *spend enough time* with you? (n=55)



Source: American Institutes for Research, Early Care Experiences Study.

Figure 8. How often did your doctor(s) *show respect* for what you had to say? (n=55)



Source: American Institutes for Research, Early Care Experiences Study.

Spanish-speaking consumers have been able to receive care in the language they prefer. Survey data demonstrate that most of the participants who required interpreter services were able to receive those services while receiving care. All six consumer participants who indicated that they needed an interpreter at their doctor's office reported that they were able to receive this service "Always" or "Usually." In addition, focus group discussions indicated that the Spanish-speaking participants valued that they were able to find providers that either spoke Spanish fluently or spoke enough Spanish to communicate with them effectively.

Cost and Coverage

Many consumer participants were thankful to have health insurance coverage, but had difficulty understanding their cost-sharing responsibilities and what services were covered under their health plans. This lack of understanding, coupled with the fact that consumers had only been using their new health insurance coverage for a few months and had uncertainty around income fluctuations, created anxiety among consumers about potential surprise out-of-pocket costs. Nevertheless, most consumers reported being pleased with their premiums and copays, but perceived the deductibles to be too high.

Regarding covered services, the desire to have dental and vision included with their medical insurance came up repeatedly in focus group discussions with consumers. Another health plan weakness, expressed by both consumers and provider representatives, was limited prescription formularies. All of these experiences and perspectives are described in turn below.

"Just the fact that they got coverage, that they have access to a doctor — people become very happy and very grateful."

— Provider, San Francisco

Consumers were thankful to finally have health insurance coverage. As described earlier, many of the consumers in this study had experienced long or short breaks in health insurance coverage — for example, due to life events such as the loss of a job — or had never been insured. These consumers were incredibly happy to finally have health insurance coverage. They described their health coverage using words such as "relief," "security," "tranquility," and "blessing." In discussing why they chose these words, many participants said it was because they were happy and grateful to have access to a doctor. Several provider representatives indicated that they had observed this gratitude in their interactions with patients.

"My overall costs are a third of what they were before. I'm feeling like I got a raise."

— Consumer, San Francisco

Most consumers were pleased with premiums and copays. Many consumer and provider representatives indicated that premiums for Covered California health plans were affordable and lower than expected. In addition, several consumer participants described how their monthly premiums decreased dramatically since being insured through the marketplace. For example, one participant said that they were paying $800 a month for a private health insurance plan and are now paying $20 a month for a plan purchased through Covered California. Even consumers who were previously uninsured and thus not used to making monthly payments for insurance felt the premiums were acceptable. Consumers who are receiving a subsidy and who have pre-existing conditions seemed especially pleased with their monthly premiums.

Like premiums, copays were an area of satisfaction that emerged in focus group and interview discussions. Many consumers said they are paying the same or lower copays with their new insurance. Copays reported for doctor visits ranged from $15 to $60, with most being in the $25 to $40 range. Consumer participants said that copays for prescription medications ranged from $3 to $5 at the lower end and $15 to $20 at the higher end.

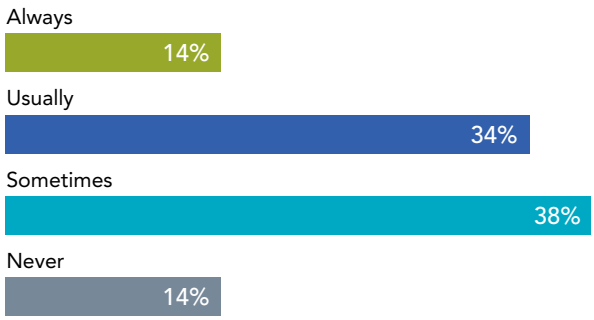
Consumers struggled to understand what services were covered under their health plans, and their cost-sharing responsibilities. Consumer participants repeatedly indicated that they had difficulty using their health insurance because they did not understand their cost-sharing responsibilities or what services were covered under their plans. Understanding how deductibles work was a particular point of confusion for consumers. Provider representatives confirmed that health insurance literacy is a common challenge and shared many stories of consumers not understanding their cost-sharing responsibilities or which services were covered.

"I felt lost because I don't know what is covered, I have no idea what the fees are — all of that."

— Consumer, Los Angeles

Consumers found it challenging to obtain cost and coverage information that was accurate, consistent, and easy to understand. Consumer participants were proactive in trying to obtain and understand information about their costs and coverage. They contacted their health plans via the Internet and phone as well as Covered California if there was a question about whether their coverage was active or not. These information-seeking activities were not fruitful, according to consumers. Consumers found the written materials provided via the website or the mail difficult to understand (see Figure 9). Further, consumers reported receiving conflicting information depending on the method of delivery (e.g., website versus phone) and whom they spoke with. In addition, extremely long wait times on hold with customer

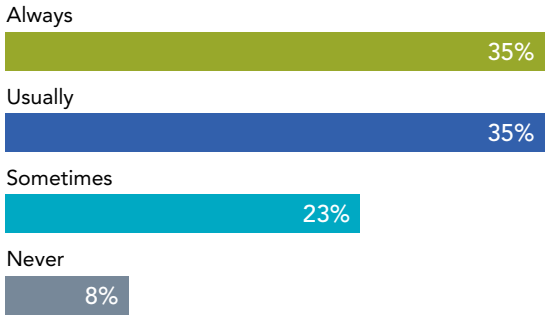
Figure 9. How often did the *written materials or the Internet* provide the information you needed about how your health plan works? (n=50)



Note: Consumers are only asked this question if they have looked for written materials about how their health plan works.

Source: American Institutes for Research, Early Care Experiences Study.

Figure 10. How often did your *health plan's customer service* give you the information or help you needed? (n=40)



Note: Consumers are only asked this question if they contacted their health plan's customer service.

Source: American Institutes for Research, Early Care Experiences Study.

service — up to two hours at a time — and the necessity of multiple contacts to resolve the same issue were commonly reported (see Figure 10 on previous page).

"I don't believe they understand what kind of coverage they have. I think they know that, generally, they can walk in and see a primary care physician, but I don't think our patient[s] are very well-versed about, 'Oh, I can access mental health benefits' or 'I can access dental.'"

— Provider, Los Angeles

"There are a lot of things that are not laid out in clear convention; there are a lot of things that remain confusing. . . ."

— Consumer, Los Angeles

Consumers want dental and vision services covered through their medical insurance. During focus group discussions, consumers were asked to identify what services they wished were covered under their health plans that are currently not covered. The vast majority of participants indicated that they wanted dental and vision services to be included in their medical insurance. Other services that many consumers indicated that they wanted to be covered but are currently not under their health plans include Eastern medicine (e.g., acupuncture) and chiropractic care.

Many consumers had to change medications because of restrictive prescription drug formularies. Many consumers said that a medication that they were taking prior to being insured through Covered California was not covered under their new plan. In some cases this was because the medication was a brand name medication, and their health plan covered only the generic version. Provider representatives also shared stories of patients having to change medications because their usual prescription was not covered under their new health plan. In fact, a couple provider representatives said that coverage of medications has been the biggest coverage weakness that consumers have faced thus far. The perception from providers was that some insurance companies are limiting the drug formularies for Covered California plans in an effort to control costs.

"The one shortcoming I have seen in a few circumstances is the limited drug formulary for some of the companies. For both Blue Cross and Blue Shield, they have shrunk their drug formulary in an effort to reduce cost. So some people's drugs have not been covered and they've had to switch to a different drug."

— Provider, Redding

Networks and Referrals

Experiences with networks and referrals were mixed. Based on focus group discussions, it seemed that about half of consumer participants were satisfied with their health plan networks. These consumers were able to keep their trusted providers or to find new providers without difficulty. The other half of consumer participants reported several challenges with their health plan networks. Two main challenges surfaced during focus group discussions with consumers: (1) finding out that their trusted providers were not in their health plan's network despite receiving information to the contrary when they were selecting and enrolling in the health plan and (2) difficulty identifying providers who accepted their health plans because of ambiguity around network compositions. These issues were echoed in interviews with provider representatives. Below, consumers' early experiences with networks and referrals are described in detail.

"When I got to the doctor, I made sure that [they accepted the insurance]. That took about 30 minutes on the phone. . . . I don't think [finding a doctor] was hard for me."

— Consumer, Fresno

Consumers who were able to keep their trusted doctors or to find an in-network doctor easily were satisfied with their health plan networks. Focus group discussions with consumers indicated that about half of the participants were happy with their health plan networks. These consumers said that they were able to keep their trusted advisors and described the process of finding an in-network provider as seamless. Many said that they received assistance from Covered California or a provider organization that helped them to quickly determine who they could see for care.

Consumers transitioning from Medi-Cal or no health insurance may be the most satisfied with their health plan networks. Several provider representatives said that they interacted with many consumers who were satisfied with their health plans' networks. These consumers, providers said, felt that they now had greater ability to pick providers who would suit their needs. Some providers thought that consumers who were now paying for health insurance felt more empowered to find doctors that met their needs. Other providers felt that Medi-Cal recipients were no longer restricted to county clinics and hospitals to receive care.

"[Consumers transitioning from Medi-Cal] are able to shop on the exchange for a type of plan that allows them to get [a choice of] providers, whereas previously if they were Medi-Cal or county . . . they would have to go to the county clinic."

— Provider, San Francisco

Consumers who encountered inaccurate or ambiguous information about health plan networks were not satisfied with their health plan networks. Consumers who were dissatisfied with their health plans — about half of those in this study — shared two main reasons for their dissatisfaction. First, consumers expressed frustration at learning that their trusted doctors were not accepting their new health insurance despite being told that they would be prior to enrolling in the health plan. Second, consumers expressed frustration at their inability to identify which providers were in fact in-network because of uncertain and conflicting information. For example, consumers told stories of calling provider organizations to see if they would accept their insurance plan and receive a yes or no response only to be recontacted — sometimes after receiving care — and provided a different response.

At the heart of both of these frustrations is inaccurate and ambiguous network information. Consumers received this information from multiple sources including Covered California, health plans, and provider organizations. Interview discussions with provider representatives suggest that bad network information is due to providers not knowing if they are contracted with particular health plans, and Covered California and carrier websites and lists that were simply incorrect.

"I talked to [a person from the health plan] about the list of doctors, and he said, 'It's a mess.' He said, 'We don't know who's on it.' He said, 'We don't hear back from a lot of doctors. Hopefully, it will all straighten out.' He said, 'For now, we know it's just a mess.'"

— Consumer, Redding

Finding in-network specialists was more difficult than finding in-network primary care physicians. As with primary care, experiences and perspectives on specialist networks were mixed. Some consumers were able to receive referrals quickly and easily from their primary care physicians. However, many consumers struggled to secure referrals to specialists for needed care. The core challenge with referrals, according to both consumers and provider representatives, is that available specialists were not accepting Covered California plans.

". . . my doctor can't refer me to whatever specialist that they choose if they aren't on the list. . . . When I looked for a doctor, they sent me a list, but the majority of the doctors didn't accept the plan. . . ."

— Consumer, Los Angeles

Access to Care

Several successes and challenges regarding access to care emerged in focus group and interview discussions, as well as the survey data. In general, it appears that wait times for appointments for specific health issues and routine care have not increased and are acceptable to consumers. However, wait times for specialty care have increased slightly compared to pre-ACA implementation. In addition, consumers may be traveling farther for specialty care because of limited specialist networks. In fact, several of the network challenges identified above appear to be having an effect on access to care. Difficulty identifying in-network providers has meant that some consumers are not receiving care from their preferred providers. This challenge, as well as high deductibles, has led some consumers to delay care. The following sections describe these access-to-care findings in turn.

Appointments for specific conditions and routine care were easy to get quickly, while specialty care appointments took longer. While a few consumers described slightly longer wait times, most participants indicated that they were able to be seen for specific health conditions and routine preventive care within a time frame that seemed typical and acceptable. For some participants this meant the same day; however, most reported a day or two for specific health concerns and a couple of weeks to a month for routine preventive care. Other participants did not specify a time frame but used phrases such as "no waiting," "took me right away," and "very fast" when describing the time period in which it took to be seen.

Specialty care, on the other hand, was more challenging to obtain quickly. Several consumers reported longer wait times to be seen by specialists. Provider representatives also indicated that wait times for specialty appointments were taking longer for their patients to get.

". . . about 60% of my referrals that I did over a month ago still [do] not have an appointment date. . . . Family practice [patients] are seen in no time at all. It's the specialty [appointments] that we have a hard time [with] in this case."

— Provider, Redding

"I have to pay out of pocket for all my prescriptions, which is about $250 per prescription, per month. And it all comes out of my deductible because I need to pay that first before I actually get any coverage, basically. I'm afraid to go to the doctor because what I normally get done is really expensive."

— Consumer, San Francisco

High deductibles led to delays in care. Several consumers indicated that their deductibles were so high that they avoided receiving necessary services. A couple of providers also indicated that they had observed consumers avoiding getting services unless they are absolutely necessary because they cannot afford their deductible. It is not clear from the study data what deductible amounts were considered too high. However, consumers and provider representatives described deductibles as high as $6,500. In addition, one provider representative noted that the lowest deductible her practice has seen so far has been $2,500.

"I had a doctor that I had made an appointment with for early in this year, and he said, 'We're renegotiating our contract with Anthem. . . . So if you want to come in, you'll have to pay the full price for a visit, or we can schedule for when our negotiations are back together again.' I said, 'I'll wait.'"

— Consumer, San Francisco

Consumers delayed care while sorting out network scope and information challenges. In addition to delaying care because of high deductibles, some consumers delayed needed care because of the ambiguity of provider networks. In some instances, consumers faced delays in care because they had not been able to find an in-network provider. For example, one consumer was waiting to refill a prescription until after she found the in-network specialty doctor she needed to write the

prescription. Her previous specialist was not accepting her health plan. In other instances, consumers were intentionally delaying care until they were clear whether their current physicians were in or out of network. For example, one consumer described canceling a scheduled appointment with a primary care physician because the physician was still negotiating their contract with the health plan the consumer purchased through Covered California.

Inaccurate provider network information meant that consumers received care from providers who were not their first choices. As described above, many consumers found that their trusted providers were not accepting the plans they purchased through Covered California. These consumers were forced to find new providers. These new doctors were described as "second or third choices," and consumers lamented having to start over in building treatment plans and rapport with the new providers. Providers expressed frustration by these circumstances as well and noted that many of their long-term patients who they could no longer see because the patients were now out of network asked the providers for in-network recommendations.

". . . but that's our only choice because my husband's doctor is not on this list. Now . . . we can't go to him. We got somebody new that we don't know, and he's our only choice."

— Consumer, Redding

Consumers, particularly in nonurban areas, may be traveling long distances to see in-network specialists. As described above, finding specialists who accept Covered California health plans has been especially challenging for the consumers in this study. It appears, based on interview discussions with primary care provider representatives, that to find in-network specialists, consumers must travel longer distances. For example, a Redding provider described finding the closest in-network specialists for their patients in Chico, which is an hour from their office. A couple of consumers also reported traveling long distances — an hour or more — to see in-network specialists.

Clinical Organizations' Experiences Under the Affordable Care Act

In general, providers said that it was too early to understand how ACA implementation would affect their organizations. However, some providers began preparing for anticipated effects prior to January 1, 2014, by hiring new staff and updating billing systems. The effects that providers did report experiencing included lack of clarity in processes for contracting with health plans offered through Covered California, changes in reimbursement rates, and increases in patient volume. The following sections describe in detail the systems changes that providers made to support ACA implementation, changes in health plan contracting and payment, and changes to care demands.

Systems Changes Made to Accommodate ACA Implementation

Some providers attempted to increase capacity and infrastructure to manage changes under the ACA. Most of the providers that were interviewed stated that their organization had not made any major systems changes to accommodate the ACA. Providers cited many reasons for this, including lack of funds for widespread systems changes, lack of knowledge about what to expect after implementation of the ACA, or that their organizations' patients were not affected by ACA implementation. One representative described their organization as having adopted a "wait and see plan."

Of the organizations that did describe specific systems changes in anticipation of ACA implementation, the most commonly mentioned changes were hiring new clinical staff to accommodate anticipated increased patient volume, hiring new or training existing staff to assist consumers with identifying their health insurance options and enrolling in plans, and updating billing systems to help with processing claims.

"We hired more staff . . . including doctors, clerical staff, MAs, RNs, because we knew we were going to see more volume of people. We knew that once people have insurance, everybody would come start getting care."

— Provider, San Francisco

Some primary care providers have to refer their patients to new specialists. Many primary care providers interviewed as part of the study described having to find new specialists to refer their patients to because the specialists that they typically refer to are not accepting Covered California plans. This was a source of frustration for providers because they spent a lot of time calling around to find in-network specialists for their patients. Also, providers did not like that they were referring patients to specialists whose care they were not familiar with.

"I think we have figured it out who in this town takes which insurance plan. If it's an endocrinologist, or a dermatologist, or the one that we use quite a bit, a GI doctor [gastroenterologist], I'm having to send my patients out of the county, which is a really big disservice for our patients."

— Provider, Redding

". . . we've had to call so many doctors until we actually find a doctor that takes it. A lot of times, honestly, we're not even familiar with this doctor. . . . It's gotten to where we just hand our patients to basically anybody that will take that insurance because nobody is taking it. So we can't even guarantee patients are going to get good care."

— Provider, Fresno

Health Plan Contracting and Payment

While provider representatives reported that health plans were processing claims in roughly the same time as prior to the ACA, provider representatives reported spending a significant amount of time getting pre-authorizations for patients' medications prior to writing prescriptions. Another challenge that clinical organizations expressed was that contracting with qualified health plans (QHPs) was much more complex and less transparent than prior to ACA implementation. Specifically, providers had difficulty distinguishing which of the plans offered by carriers they were contracted to accept and noted that some plans were being selective in their contracting with providers rather than opening it up to all who were interested. Once contracted, many were satisfied with the reimbursements they were receiving, especially community health centers that received lower reimbursement from Medi-Cal. Provider representatives' perspectives on health plan contracting and payment are described in further detail in the sections that follow.

Claims processing was occurring more smoothly than expected, and administrators are optimistic for further improvement. Several provider representatives indicated that prior to the implementation of the ACA, they expected there to be challenges with processing claims for QHPs. However, since January 1, 2014, the provider representatives in this study indicated that claims processing has been smooth. No provider representatives reported excessive delays in reimbursement. Instead, reimbursement turnaround was comparable to other plans. In cases where administrators did encounter difficulty with claims processing, they expressed confidence that the problems would be resolved over time. When one provider in Fresno began billing to a Covered California plan, they were surprised how seamless it was.

"Wow. Okay, they paid a little less, but that wasn't difficult at all."

— Provider, Fresno

Administrative staff found the pre-authorization process for medications labor-intensive. A specific challenge brought up by multiple providers was difficulty identifying which prescription medications their patients' health plans covered. Accommodation of pre-authorization requests took up substantial office staff time, administrative staff reported. In one office, a staff person had to devote a full day, on a weekly basis, to handling prior-authorization paperwork. Prescribing was further complicated by changes in formularies. In many cases the formulary for products offered through Covered California plans was different than the one for products by the same plan outside of Covered California.

". . . [the pre-authorization process] is very time-consuming for both the doctor and myself. . . . Sometimes it's approved, sometimes it's not. If it isn't, the insurance will come back and say, 'Can you try this, a generic?' Then we give the generic to the patient, and then it's ineffective."

— Provider, San Francisco

Provider representatives found the processes for contracting with QHPs offered through the marketplace confusing and lacking in transparency. As was mentioned earlier in this report, there was confusion over which providers were in Covered California plans' network. Interviews with provider representatives confirmed that they were unsure of whether they were contracted with the Covered California health plans for several reasons. One challenge was that some practices were contracted with a particular health plan, but they did not realize that they were not contracted with the health plan's Covered California product. Another reason for provider confusion was that providers did not realize that in some instances, contracting was not simply a matter of waiting for paperwork to go through, but rather executed only when invited by the plan. Provider representatives said this method was frustrating because they were not notified that this would be the process when they sought a contract with a particular plan.

"Here's the issue — the patients wanted to choose who they were currently seeing as their provider, and we couldn't even tell them who we were contracted with because we weren't really sure which product of theirs we had actually contracted with because it wasn't explicit on the contracts."

— Provider, San Francisco

"It's not like we either accepted or declined because they cherry picked which physicians they wanted to be part of it, and we apparently did not make the cut somehow."

— Provider, San Francisco

Satisfaction with reimbursement rates varied by type of clinical organization. Some providers expressed concern about lower reimbursement rates from Covered California plans. These provider representatives, and some consumers, speculated that low reimbursement rates were to blame for limited specialist networks. In addition, a few provider representatives said that they may not continue to accept Covered California plans because it would not be financially sustainable.

While many providers complained of lower reimbursement, a greater number reported that it was either higher or comparable to non-marketplace plans. Provider representatives who spoke positively of reimbursement rates tended to be in clinics that were nonprofits, free, or served primarily Medi-Cal patients. Covered California plans, from their perspective, provided reimbursement for services that typically generated little revenue, such as routine physical exams.

"They are already losing money [because of EHR adoption] and can't take more of a hit because of low reimbursements."

— Provider, Fresno

"I keep telling the doctors, 'You guys have to keep putting in those physicals. Remember, now we have somebody paying us, reimbursing us, so please be aware of that.' That's why I have to make them aware that now with this new process coming along, they're being reimbursed at a higher rate."

— Provider, Los Angeles

Changes in Care Demands

In general, provider representatives reported that it was too early to tell if significant changes in care demands would occur as a result of ACA implementation. Many reported increases in patient volume but were reluctant to attribute it to the ACA at this early stage. There were a few reports of increased care seeking from individuals with chronic conditions. Provider representatives attributed this uptick to patients' previous inability to afford care or denial of coverage. Providers in this study noticed few changes in the demographic composition of the patient population. However, a few provider representatives reported more requests for services in languages other than English. The sections below describe in further detail the changes in care demands observed by provider representatives.

Provider organizations were experiencing increases in patient volume. A substantial number of providers reported an increase in calls for appointments, and in patient volume. While many providers believed these increases to be directly attributable to care seeking under the ACA, others were uncertain. Provider representatives described the increases as positive because they believed it would help grow their organizations. They also reported that they were able to accommodate the demands without much impact on wait times for appointments. The increased volume varied in magnitude from slight upticks to noticeable increases. In addition, a couple of providers reported decreases in patient volume because their patients were being absorbed into Medi-Cal, and these providers did not accept public insurance.

"Before, we were only seeing maybe one or two patients a day. And some days she has a full schedule of seeing 8 to 10 patients a day at the most. So it just depends on the day, but yes, since January 1, we've definitely seen an increase."

— Provider, Fresno

Provider representatives noticed more patients with chronic conditions accessing care. Similar numbers of providers reported seeing an increase in patients with chronic diseases seeking care, and not seeing such an increase. The chronic conditions most frequently mentioned by provider representatives were diabetes, hypertension, and high cholesterol. Several provider representatives also reported an uptick in patients with severe depression and other mental health disorders. Increases in patients with these conditions, provider representatives observed, seemed to be due to two circumstances. First, consumers with undiagnosed chronic conditions were receiving these diagnoses now that they were seeking care. In these instances, providers believed that previously uninsured patients had been ignoring symptoms because they were unable to afford care.

Second, provider representatives reported that patients whose chronic conditions had been previously diagnosed were re-entering care after long absences. These absences, provider representatives reported, were typically because they had been denied health coverage or could not afford health coverage in the past. Interview discussions contained several stories of patients who had not been seen by a provider in years now coming in with their new health coverage to refill prescription medication and get a checkup.

"Like I said, so many of these patients haven't seen a doctor in so long. They have so many health issues that they don't even realize. They didn't realize that they had diabetes because they just felt thirsty. They didn't realize they had high cholesterol because you have to have lab work to see that. They delay their health for so long because of cash pay. It's like a car that you never repair."

— Provider, Fresno

"[The patient said], 'I need to schedule my appointment. I need to see a doctor because I don't know where I'm at right now. I don't know if my cancer is in remission, or if it's come back.' She was like, 'Now that I have it, here's my card.' Very proudly, she showed it to me. 'Here's my card.'"

— Provider, Fresno

There has been an increased demand for preventive services. Provider representatives described an increase in patients seeking preventive care, such as routine physical exams, since January 1, 2014. One provider reported a 15% to 20% increase in patients requesting such services. Providers often expressed excitement that they could provide physical exams and screenings to their patients. They felt this was the first step in diagnosing illnesses early on and keeping patients healthy.

"I've seen the influx and just people taking responsibility for their own health in a preventative approach — to me, that's a huge success."

— Provider, San Francisco

A few provider representatives reported slight changes in race/ethnicity and primary language of patients being seen. The majority of providers did not see a change in patient population demographics. Many organizations in the study said that future changes in patient demographics were not likely to be significant because they already served a diverse racial, ethnic, and linguistic patient population. A few provider representative saw differences, including more Latino patients and more patients whose first language was Korean, Japanese, Mandarin, or Spanish.

"We're seeing higher volume of patients that are calling and asking if certain languages are spoken here by the providers."

— Provider, Los Angeles

Discussion

Study findings suggest that some of the commonly anticipated challenges associated with ACA implementation — such as difficulty accessing care and low health insurance literacy — are occurring, but that there are successes as well.

Access-to-care concerns were a result of limited and ambiguous provider networks and high deductibles. Specifically, some consumers were unable to see their preferred trusted providers because of inaccurate network information. In addition, they delayed care while network uncertainties were sorted out and because they could not afford the out-of-pocket costs associated with high-deductible health plans. Specialty care was particularly challenging to access because few local providers were accepting Covered California health plans.

Finally, low health insurance literacy was a problem for many consumers. Whether or not these literacy issues are more severe among the Covered California population is unclear. Many study participants reported that all consumers, regardless of insurance status or experience or socioeconomic status, struggle to navigate health insurance.

In addition to anticipated challenges, a few unanticipated challenges seem to be emerging as well. For example, little attention has been given to the lack of transparency and the complexity of the processes by which health plans contract with providers for the products offered through the marketplace. However, these issues were central to the ambiguity surrounding provider networks that has led to reduced access to care, according to provider representatives in this study. Another unanticipated finding was that some providers are losing patients because of Medi-Cal expansion. Only challenges related to increased demand, rather than decreased demand, are commonly discussed.

A potential but unobserved challenge involved delivery of care to those who may be sicker than the average patient or who are members of a racial, ethnic, or linguistic minority group. Provider representatives reported slight upticks in chronically ill patients but were able to accommodate these needs right away. Moreover, many provider representatives noticed that more people were also seeking preventive care such as routine physical exams. Thus, many marketplace consumers may be

using their health insurance coverage to seek care that will allow them to diagnose illnesses early on or to remain healthy in addition to treating chronic illnesses. Few providers reported increases in racial, ethnic, or linguistic minority group members seeking care, with the exception of a few providers who said that more patients were seeking Spanish-, Korean-, and Japanese-speaking providers. Focus group discussion and survey data with Spanish-speaking consumers indicated that these participants were able to have their language needs met via interpreters or Spanish-speaking providers.

This study revealed several early benefits of the ACA as well. In general, consumers had positive experiences with their health care providers, were grateful to be covered by health insurance at all, and found their premiums and copays to be not only affordable but much lower than what they were used to paying. In addition, some provider organizations prepared for the implementation by making administrative, staffing, and technological changes. Many of these changes were intended to help consumers choose and enroll in the health plans that were best for themselves and their families, receive the care they needed in a timely manner, understand their cost-sharing responsibilities, and process claims quickly and efficiently.

In sum, while consumers are experiencing some challenges obtaining care through new ACA plans, many benefits are evident as well.

It is important to note that this study sample is small and non-random, and thus should not be taken as representative of the Covered California enrollee population or of the California population. In addition, the findings presented here represent the perspective and perceptions of consumers and providers only. Other important stakeholder perspectives, including health plans and Covered California, were not included and are not represented in the findings. Further, the study team aimed to speak to representatives from both small and large clinical settings; however, given the demographics of the four regions, recruiting individuals from large practices was a significant challenge.

This study offers early insights from consumers and providers regarding the process of obtaining care through plans newly available under the ACA. Going forward, it will be important to continue to monitor ACA implementation, engage key stakeholders in identifying solutions to overcome challenges as they emerge, and assess the efficacy of these solutions in improving consumers' experiences.

Endnotes

1 "Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations, and County Workers Credited as Reason for High Enrollment in California," Covered California, news.coveredca.com.

2 S. M. Petterson et al., "Projecting US Primary Care Physician Workforce Needs: 2010–2025," *Annals of Family Medicine* 10, no. 6 (2012): 503–509, www.rwjf.org. See also: op.bna.com.

3 Health Insurance Exchanges: Long on Options, Short on Time, PwC Health Research Institute, October 2012, www.pwc.com; *A Profile of Health Insurance Exchange Enrollees — March 2011 Brief,* Kaiser Family Foundation, 2011, www.kff.org.

4 See screener used to recruit consumers, www.chcf.org.

5 See interview guide, www.chcf.org.

6 The American Institutes for Research is contracted by the Centers for Medicare & Medicaid services to develop a CAHPS survey for the qualified health plans offered through the marketplaces. The survey contains original and revised items from the CAHPS 5.0 Medicaid Health Plan survey and the CAHPS 4.0 Commercial Health Plan survey as well as new items developed specifically for the CAHPS QHP survey. The items included on the questionnaire for this study were taken from the OMB-approved version of the CAHPS QHP survey, which is currently being field-tested.

7 See consumer survey, www.chcf.org.

8 "CAHPS Database," Agency for Healthcare Research and Quality, www.cahps.ahrq.gov.