Physician Salaries and the Affordable Care Act: Robbing Peter to Pay for Healthcare

*The goal of the Affordable Care Act (ACA) was to help uninsured and underinsured receive adequate healthcare. How did it affect physician salaries over a seven-year period?*

By Ben Buttars

In 2010, a new socialized form of medicine entered into the American public by way of policy. The main idea: Allow everyone to attain health coverage despite socioeconomic standing, preexisting conditions, or any other incapability. The ACA accomplished a huge shift in the amount of uninsured, reducing that number by over 43% since its implementation (1). However, one of the main concerns among healthcare providers was the capability to maintain income despite new heavy regulation power of insurance groups as well as extra costs to be a qualified physician under the ACA. Although some would argue that the benefit of having more insured outweighs the cost of dissatisfied physicians, the question remains: Would you want your healthcare to suffer because the ACA has increased cost for your physician to operate?

Why would insurers need to regulate payout to physicians?

In order to understand this, it is important to understand a few facets of the ACA.

1. Insurers were no longer able to deny coverage to those who had preexisting conditions.
2. All citizens were required to have insurance under penalty of fines.

With the obligation of coverage on both the citizen and insurer end, the number of insured went up to above 16.9 million according to Goldman Sachs and an analysis from RAND. (3) This means that there were tons of new insurance payouts. Therefore insurance companies needed to find ways to save money and combat those costs. There are two main pathways in which insurers have saved money since the introduction of the ACA:

1. Raising yearly premiums
2. Limiting fee-for-service costs by reducing reimbursement.

**Increased Premiums**

It’s no argument that premiums have increased since the introduction of the ACA in 2010. The Kaiser Family Foundation showed that the average family premium has increased by nearly $4,000 per year. (See figure 1) This is one of the ways that insurance companies have attempted to accommodate for rising insurance payouts. Although this doesn’t directly affect physicians, it’s important to see that insurance companies now need to find ways to cut costs.

![Figure 1: Average Yearly Family Premium since introduction of ACA](https://example.com/figure1.png)

*Source: Kaiser Family Foundation Employer Health Benefit Survey*
Reduced Reimbursements
During the year 2013 and 2014, a rise in Medicaid reimbursement for services was bolstered by the U.S. government. It was expanded to match the payout of Medicare for similar services. However, the support had an expiration date of January 2015 and then turned over the funding to the states. Many states opted not to continue to fund Medicaid and reimbursements fell by as much as 42% in some areas. (5) As Medicaid has assumed 63% of the population, it still remains the least generous in fee reimbursement, at about 50% of private insurers. (6)

Moreover, physician reimbursements are not set from insurer to insurer. Although hospitals and clinics have a list of master prices that set the cost for each procedure, insurance companies almost never pay the price set on that master list. Insurance companies constantly negotiate with care providers concerning overall cost. Each insurance company keeps private the amount that they negotiate with the care provider. Insurance companies then keep negotiated amounts private, creating a multi-level payment system for each individual insurance company. (7)

This has caused physicians to earn a profit while doing a procedure covered by one insurance, but operate at a loss when doing the exact same procedure covered by a different insurance company.

A two-world medical system
Currently there are two types of economic setups for a physician: Private clinic or hospital employee. Under the formation of Accountable Care Organizations (ACO), or groups of selected physicians collaborating with supervision of insurance companies, solo practices are often times having to jump ship and return to larger hospital entities. This was due to reduced reimbursements, cost of health record systems, and increasing regulations. (4)

Quality Reporting Systems
One of the rigid implementations of the ACA included the Physician Quality Reporting System (PQRS). In essence, this has required reporting from each physician group that illustrates they are providing quality care for each individual. The data measured includes proper information given to each individual concerning diagnosis, as well as demonstrating that the physician did everything necessary to assure that the patient made the correct healthcare decision preventing further cost to the insurance company. (8)

This has created a problem when considering autonomy of the patient. For instance, if a diabetic patient refuses to manage insulin levels and ends up needing a leg amputation due to complications with diabetes, the PQRS system has given a poor rating to the physician, lowering reimbursements for the entire year. Although the system strives to provide quality care, it shifts all responsibility to the physician’s shoulders and gives patients minimal responsibility for their own care.

Moreover, many physicians need to hire extra help in order to complete the task of the PQRS evaluations. This adds one more cost to the physician bill in order to provide care. By hiring one extra
employee to dictate PQRS reports, a physician loses tens of thousands of revenue to a new salary. It becomes a lose-lose situation for the physician.

**Patient-Physician Relationships**
Not all physician cost incurred by the ACA is monetary. Since the introduction of the PQRS one of the largest losses has been the amount of time physicians can spend with an individual patient. With the increased demand for care and the decreased reimbursements, physicians have to see more patients than ever. (9) In fact, in order to combat the high physician demand, many Non-Physician Practitioners have been employed and had their duties expanded. (10) Therefore, it becomes less and less likely that physicians spend quality time with their patients inhibiting open and honest communication that allow for open honest communication. Physicians have been pushed to create an in-and-out type of medical care that increases the quantity of patients they see, all while failing to form true intimate relationships. Physicians have needed to herd patients in and out of their clinics like cattle in order to maintain revenue.

**Conclusion**
The ACA was, perhaps, one of the most important healthcare reforms since the introduction of Medicare and Medicaid. It is incredible to know that many more US citizens now have access to care who otherwise wouldn’t. However, in a very “bite the hand that feeds you” sense, the ACA has shifted even more responsibility onto physicians, the men and women on the front lines who are already responsible for saving lives and providing care. The ACA cannot be the end all for healthcare reform. It is currently a very rough illustration of health care’s final picture. Physicians are the very base of healthcare, and a solution needs to be introduced that incentivizes, not threatens or punishes the individuals who are responsible for the healthcare of the nation.

**ENDNOTES**


