Robert Wood Johnson Foundation

athenahealth

ACAView™

Tracking the Impact of Affordable Care

Observations on the Affordable Care Act: Report Two

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About ACAView

ACAView is a joint initiative of the Robert Wood Johnson Foundation (RWJF) and athenaResearch, a division of athenahealth. RWJF is the nation's largest foundation focused solely on improving health and health care. athenahealth is a health care information technology and services company serving more than 59,000 providers in 100 specialties across the country.

The ACAView initiative provides researchers, policymakers, and the public with regular updates on how the Affordable Care Act (ACA) is affecting provider practices. Our emphasis is on the coverage expansion aspects of the legislation, which aim to increase the number of individuals with health insurance by expanding Medicaid eligibility and providing affordable commercial insurance through federal subsidies on new health insurance exchanges.

ACAView reports use data aggregated from athenahealth's ambulatory care software platform, a cloud-based system for managing patient health records, billing, and communication. athenahealth data offers near-real time visibility into patient demographics, clinical services, and practice economics. Our data represents actual patient-provider encounters, and therefore provides greater precision for a larger range of metrics than self-reported surveys permit.

The ACAView initiative provides researchers, policymakers, and the public with regular updates on how the Affordable Care Act (ACA) is affecting provider practices.

Our first report, which was published in July, provided an early description of changes in insurance and health status.[1] This report, which covers data through September, captures some of the effects of the surge in insurance enrollment in March. We will continue to publish regular reports as changes in the health care system become more apparent. athenahealth is also providing monthly updates to RWJF, and additional information is available on the RWJF website[2] and on CloudView, an athenahealth blog.[3]

The relatively rapid pace of this project means that in some cases we provide results before we can confidently explain the underlying phenomena, and in others we have seen only early evidence of a particular trend, which may not persist over time. Our hope is that by sharing data early and at regular intervals, and by acknowledging where we are uncertain, we can help advance an informed dialogue about the early impact of this landmark legislation.

One final note: Although the ACAView project is focused on the impact of the ACA, we will also share–as we do in this report–interesting data and emerging trends that may be only tangentially related to the ACA itself.

[1] Available for download at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414550.
[2] Reports and blog posts online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/athenahealth.html.
[3] Available at http://www.athenahealth.com/blog/.

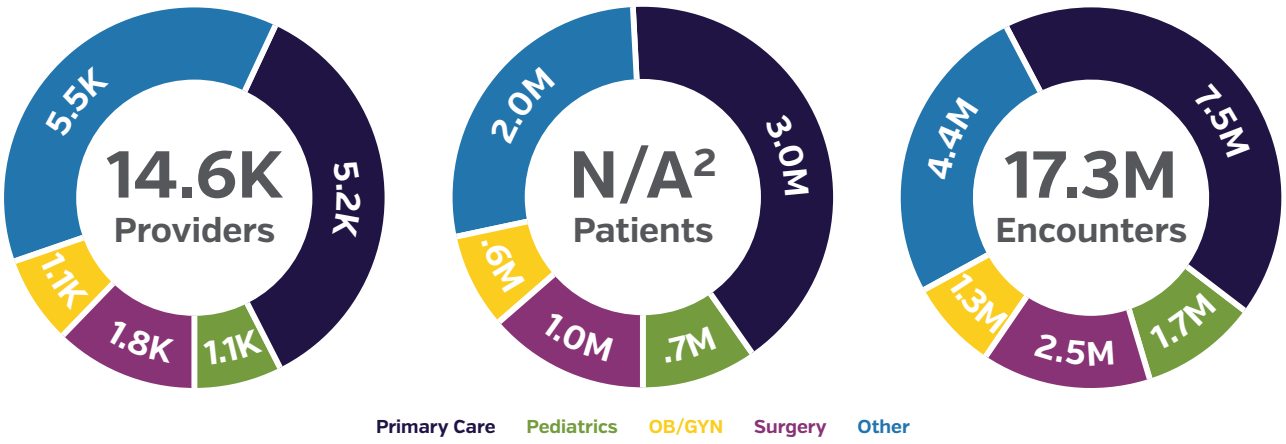
Sample Overview

ACAView tracks provider activity among practice locations that have used athenahealth's cloud-based software continuously since at least December 31, 2010. Comparing data over time within a single practice cohort allows us to capture shifts in patient demographics, practice patterns, and payer policies.

The practices reported in the ACAView metrics include roughly 14,600 providers, of whom approximately 35 percent are primary care providers, 8 percent are pediatricians, 8 percent are OB/GYN, and 13 percent are surgeons. Relative to the nation's practitioners, the ACAView cohort has fewer solo practices and more practices with ten or more physicians, with a somewhat higher proportion in the South and a smaller proportion in the West. Most of the physicians in the sample are community practitioners, as opposed to affiliates of large medical centers. Our sample does not include visits to emergency departments, academic practices, or inpatient settings. The appendix to this report includes a more detailed comparison of the ACAView sample to national benchmarks.

Figure 1. Research Sample

January through July encounters[1] in 2013 and 2014



[1] Practices active before 2011

[2] Unique patients cannot be summed across specialties, since patients may see providers in multiple specialties

Emerging Evidence of More New-Patient Visits

The ACA was designed to dramatically reduce the number of individuals without medical insurance so as to improve their health outcomes. As a result, determining the extent to which the ACA is (or is not) increasing demand for care is among the most critical measures of the legislation's success. In this section, we look at access to provider office visits in ambulatory settings.

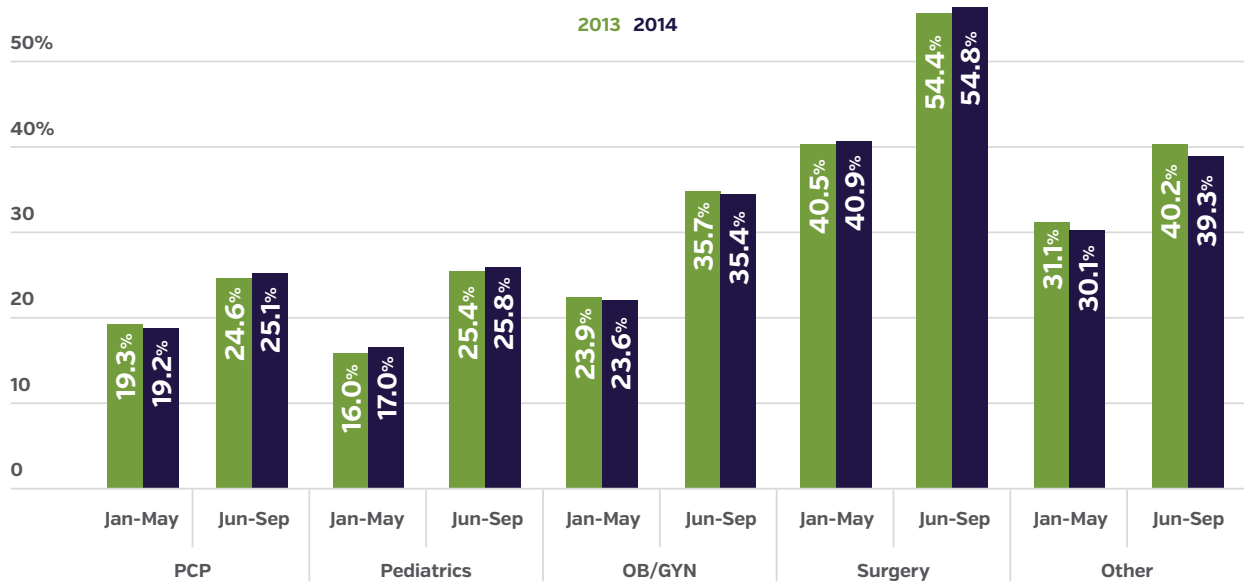
So far, the impact of the ACA on providers in the ACAView sample is mixed. We analyzed two measures of patient access to physician services. One showed no real change year to date; the other showed a moderate increase in the proportion of physician visits devoted to new-patient assessments.

The first measure of access we considered was the proportion of all patient visits accounted for by new patients. If the ACA succeeds in increasing demand, we would expect to see individuals who had not seen physicians in recent years establish new physician relationships, so the proportion of total physician visits with new patients should in theory increase over time. Under this definition, a new patient is considered to be one who has not seen a given provider in at least two years. We carry the new patient designation over throughout the year; a patient who satisfied our new-patient criteria in January of 2013, for example, is considered new throughout the course of 2013. This definition allows us to measure the proportion of total physician work devoted to new patients over the course of the year.

In our previous report we wrote that in spite of the fact that millions of people are newly insured, physicians did not see an influx of new patients in the first quarter. In fact, primary care physicians in our sample saw a slightly *smaller* proportion of new patients in Q1 2014 than in Q1 2013. We see several possible explanations for this observation. For

Figure 2. Proportion of Visits from New Patients, By Specialty Category

January through September



Source: athenaResearch
Sample: Approximately 43 million visits to practices active on the athenahealth network before 2011

example, the surge of enrollees in the health insurance exchanges in February and March meant that these patients were unlikely to show up in physician offices in the first quarter. In addition, it may be that newly covered patients receive care in emergency departments or simply have not had a need for health care services since their coverage began. It is also possible that an appreciable number of physicians in our sample are not accepting new Medicaid or commercially insured enrollees or are out of network for plans sold through insurance exchanges.

The data from the past few months have not significantly changed our perspective. Primary care practitioners, for example, saw slightly fewer new patients (as a proportion of all visits) in the first five months of this year. Between June and September the proportion of visits from new patients was slightly higher for PCPs than during the same period last year, 25.1 percent of all visits compared to 24.6 percent of visits in 2013. Considering the first nine months of the year as a whole, physicians are seeing roughly the same share of new patients as they did last year, given our first definition of new patients.

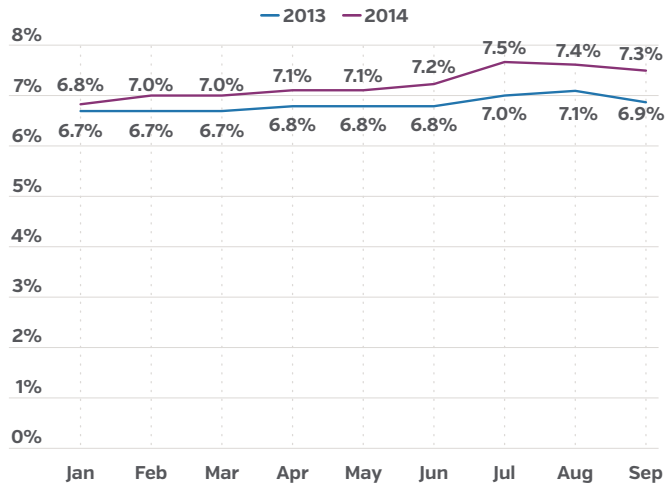
Our second measure of new-patient access looks at provider billing codes for evaluation and management (E&M) services. Under this approach we considered all visits with CPT codes indicating a new-patient visit.[4] These new-patient codes are indicated for patients who have not seen a given provider or a provider with the same specialty in a particular practice in at least three years. The visit must also include three components: a patient history, a physical exam, and medical decision-making. In other words, the criteria for this second definition of new-patient visits are more stringent compared with our first definition, and more likely to indicate visits in which physicians invest in developing new relationships based on a comprehensive understanding of a patient's needs. This measure is also not cumulative. For these reasons, the numbers for new-patient E&M visits are much smaller than our original definition.

The data in *Figure 3* show physicians using new-patient E&M codes more frequently, with the gap growing since the beginning of the year. In January of 2014–the first time physicians might have seen newly insured Medicaid or exchange patients–new-patient E&M codes were used in 6.8 percent of visits, compared to 6.7 percent of visits in 2013. In September, the most recent month for which we have data, 7.3 percent of patient visits included a new-patient code, compared with 6.9 percent during July 2013–a relative difference of almost 6 percent. The growing gap might reflect newly insured patients who received coverage in February or March as well as those who enrolled earlier but did not see a physician until several months after their coverage began. In any case, the numbers suggest that the ACA may be increasing the rate at which physicians are establishing new relationships with patients.

[4] Under this definition, new-patient visits were those with CPT codes of 92002, 92004, 99201-99205, 99321-99328, 99331-99345, and 99381-99387.

Figure 3. Proportion of Visits with New-Patient E&M Code

2013 vs. 2014



Source: athenaResearch
Sample: Approximately 43 million visits to practices active on the athenahealth network before 2011

In short, the signals on new-patient volumes are mixed. Physicians do not appear to be seeing an appreciably higher proportion of new patients this year than last when new patients are defined as those who the physician has seen in the last two years and when volumes are computed in cumulative terms. However, physicians are using new-patient E&M codes more frequently than last year. This may suggest that–despite the apparent lack of a surge in new-patient volumes–physicians are establishing new relationships with patients at a higher rate this year than last. We will continue to monitor these metrics in the coming months to see whether a consistent trend emerges.

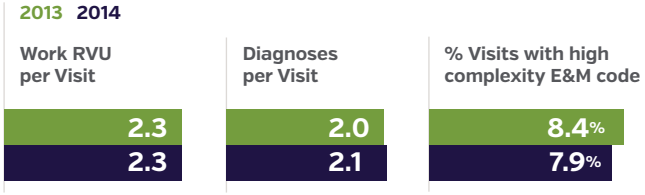
Similar Visit Intensity and Chronic Disease Rates for New and Existing Patients

Some health care industry observers expected a groundswell of new patients with uncontrolled chronic disease after Medicaid expansion and health exchanges went into effect. This would imply a significant change in work intensity, measured by relative value units (RVUs), with physicians working harder to treat more complex patients.

However, we have seen no change in work RVUs for new patients this year relative to last year, and the number of diagnoses per visit has increased only slightly (*Figure 4*). The proportion of new-patient visits with high-complexity E&M codes has in fact fallen slightly from last year, from 8.4 percent to 7.9 percent of new-patient visits.[5]

Figure 4. Work Intensity Metrics for New Patients

2013 vs. 2014, January through September



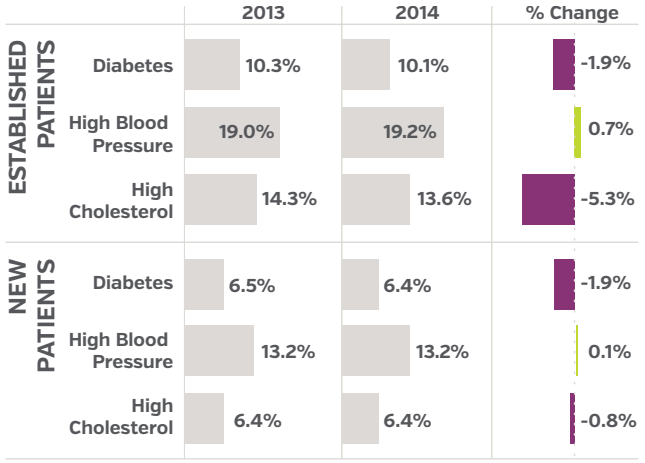
Source: athenaResearch
Sample: Over 12 million visits to practices active on the athenahealth network before 2011

Another important measure of overall health–chronic disease incidence–shows a similar pattern (*Figure 5*). Looking specifically at adults (18-64) visiting primary care physicians (PCPs)–the group most likely to be affected by the ACA–any changes in chronic disease rates have been modest and inconsistent, increasing slightly for high blood pressure and decreasing for diabetes and (especially among established patients) for high cholesterol, rather than revealing an underlying change in overall health status. In fact, the changes in chronic-disease rates among new patients were smaller than those among established patients.

These numbers suggest that physician offices have not been overwhelmed by previously underserved patients with significant health needs. These individuals may not yet have filtered into office settings in sufficiently large numbers to affect chronic-disease rates or may be receiving care in more intensive settings, such as emergency departments, rather than physician offices.[6]

Figure 5. Chronic Disease Rates*

PCP Visits for Adults 18-64, January - September



* Percentage of encounters with diagnosis
Source: athenaResearch
Sample: Approximately 10 million visits to practices active on the athenahealth network before 2011

[5] We define high-complexity E&M encounters as those with claims billing for CPT codes that are valued more highly within a cluster of E&M codes. For example, within the group of E&M codes 99211-99215, we classify the codes 99214 and 99215 as high-complexity.
[6] http://newsroom.acep.org/2014-05-21-ER-Visits-Up-Since-Implementation-of-Affordable-Care-Act

Medicaid Enrollment has Risen in Expansion States; the Uninsured Rate is Falling

In broad terms, we are seeing evidence that previously uninsured patients are responding to the coverage options their states present. In states with expanded Medicaid access, newly enrolled Medicaid patients (whether or not they had previous relationships with their physicians) appear to account for most of the reduction in the uninsured. In states without expanded Medicaid eligibility, the reduction in the proportion of uninsured is more modest and seems to be resulting from more patients receiving care through the health insurance exchanges.

Figure 6 summarizes payer mix changes for primary care physicians providing over 10 million office visits between January and September 2014 (compared with the same period in 2013). Different shifts can be seen in expansion states compared with non-expansion states. Physicians in non-expansion states are seeing a higher proportion of commercial visits and lower proportions of all other insurance categories. This suggests they may be opening their practices to patients newly insured through the commercial exchanges. In expansion states, PCPs are seeing a higher proportion of Medicaid patients, reflecting the expanded number of Medicaid beneficiaries. The rate of visits from uninsured visits is falling across the board, but there is a sharper decline in expansion states compared to non-expansion sates, likely reflecting the effects of greater Medicaid coverage and possibly more frequent and positive publicity around new enrollment options in these states.

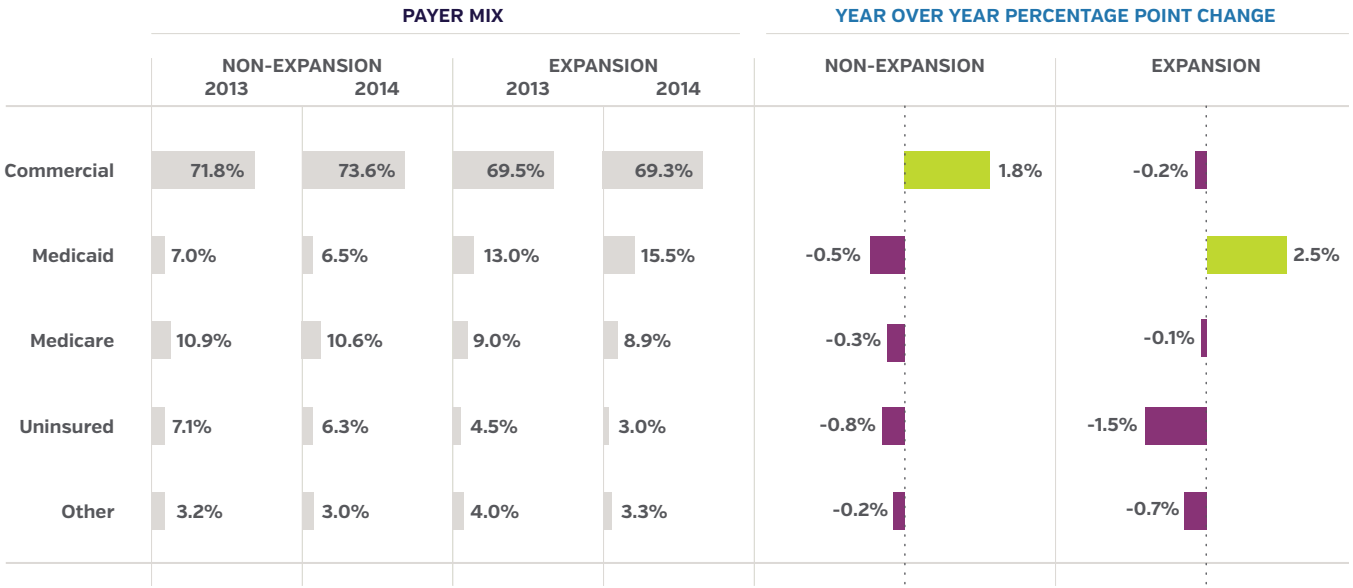
Previously uninsured patients are responding to the coverage options their states present.

Contrary to our expectations, we are not seeing an increase in the share of visits from commercially insured patients in expansion states, despite the millions of individuals covered through the exchanges. One conjecture is that part of this trend reflects some patients switching from commercial plans with high deductibles to Medicaid. It is also possible that individuals in expansion states with new, high-deductible commercial coverage may not yet have sought physician care.

We have also not seen an increase in the proportion of visits from Medicaid patients in non-expansion states. Although Medicaid eligibility in these states has not changed, many non-expansion states are reporting growth in Medicaid enrollment as more eligible individuals have "come out of the woodwork," presumably due to media coverage around the ACA in general and Medicaid in particular. These new Medicaid enrollees do not yet appear to have visited the physicians in our sample in significant numbers.

Figure 6. Payer Mix for Adult (18-64) PCP Visits

January through September
Medicaid Expansion States vs. Non-Expansion States

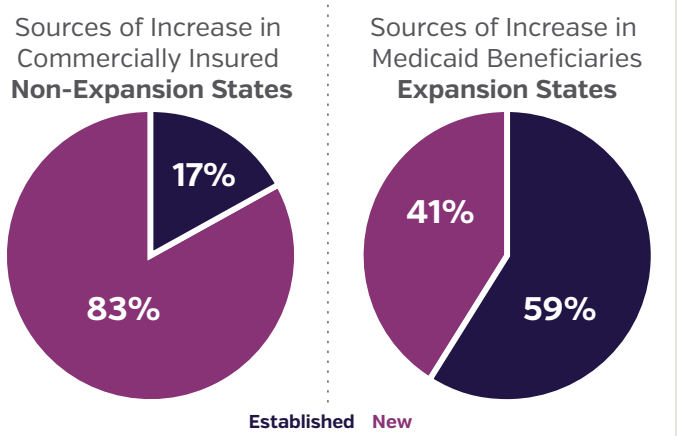


Source: athenaResearch
Sample: Approximately 10 million visits to practices active on the athenahealth network before 2011

Figure 7 examines this change for two key segments: commercial patients in non-expansion states and Medicaid beneficiaries in expansion states. In non-expansion states, more than 80 percent of the additional commercial visits consist of new patients with commercial insurance. Conversely, in expansion states, only 41 percent of the increase in Medicaid volumes is explained by new patients, while the other two thirds reflects a change in insurance status among established patients (who may have previously had employer-sponsored insurance or been uninsured) or increased utilization from existing Medicaid beneficiaries.

Figure 7. Percentage of Payer Mix Increase Attributable to New vs. Established Patients

January - September, 2014



Source: athenaResearch
Sample: Approximately 8 million visits to practices active on the athenahealth network before 2011

The data in *Figure 8* provide another perspective on how coverage options have affected payer mix. In non-expansion states, visits by commercially insured new patients (between January and September) as a proportion of all visits increased by eight percent over last year. The rate increased by only three percent in expansion states. However, states with expanded Medicaid eligibility have seen a 33 percent jump in the proportion of all PCP visits from new Medicaid patients (although the baseline figure is small); in non-expansion states, new Medicaid visits declined by 10 percent as a proportion of PCP visits. In other words, providers in non-expansion states are seeing fewer new patients with Medicaid and more with commercial coverage, while those in expansion states are seeing far more new patients with Medicaid coverage.

Our data show only a small increase in the share of visits from commercially insured patients in expansion states overall (and a small decrease in share of visits among commercially insured new patients) despite millions of enrollees in exchange-based commercial plans in these states. This may be a result of low-income individuals previously covered by commercial insurance who have now opted for Medicaid coverage instead. Alternatively, new commercial enrollees in expansion states may have been less likely than those in non-expansion states to seek physician services this year, in which case they would not appear in our data. This result may also be specific to our sample of physicians.

The timing of payer-mix changes, shown in *Figure 9*, is also revealing. In states expanding eligibility, Medicaid visits have increased as a proportion of all primary care visits each month this year, rising from 12.2 percent of all primary care visits in December of 2013 to 16.7 percent

Figure 8. Distributiuon of Adult (18-64) PCP Visits

January - September, 2014

Patient Type	Insurance	Non-Expansion States			Expansion Staes		
		2013	2014	Change	2013	2014	Change
New	Commercial	16.3%	17.5%	8%	14.3%	14.7%	3%
	Medicaid	1.9%	1.7%	-10%	2.8%	3.7%	33%
	Other	5.9%	5.3%	-11%	4.6%	3.7%	-20%
Established	Commercial	55.8%	56.0%	1%	55.5%	54.7%	-1%
	Medicaid	5.1%	5.0%	-3%	10.2%	11.5%	13%
	Other	15.0%	14.5%	-3%	12.6%	11.7%	-7%
	Total	**100%**	**100%**	-	**100%**	**100%**	-

Source: athenaResearch
Sample: Approximately 10 million visits to practices active on the athenahealth network before 2011

in September of this year. The proportion of visits from uninsured patients, similarly, has fallen in both expansion and non-expansion states.

This trend seems to suggest a lag of several months between when patients receive coverage and when they receive services. This may occur due to long wait times for appointments, a delay in sorting out benefits, limited availability of new-patient primary care visits, or the fact that newly insured patients may not have immediate health needs.

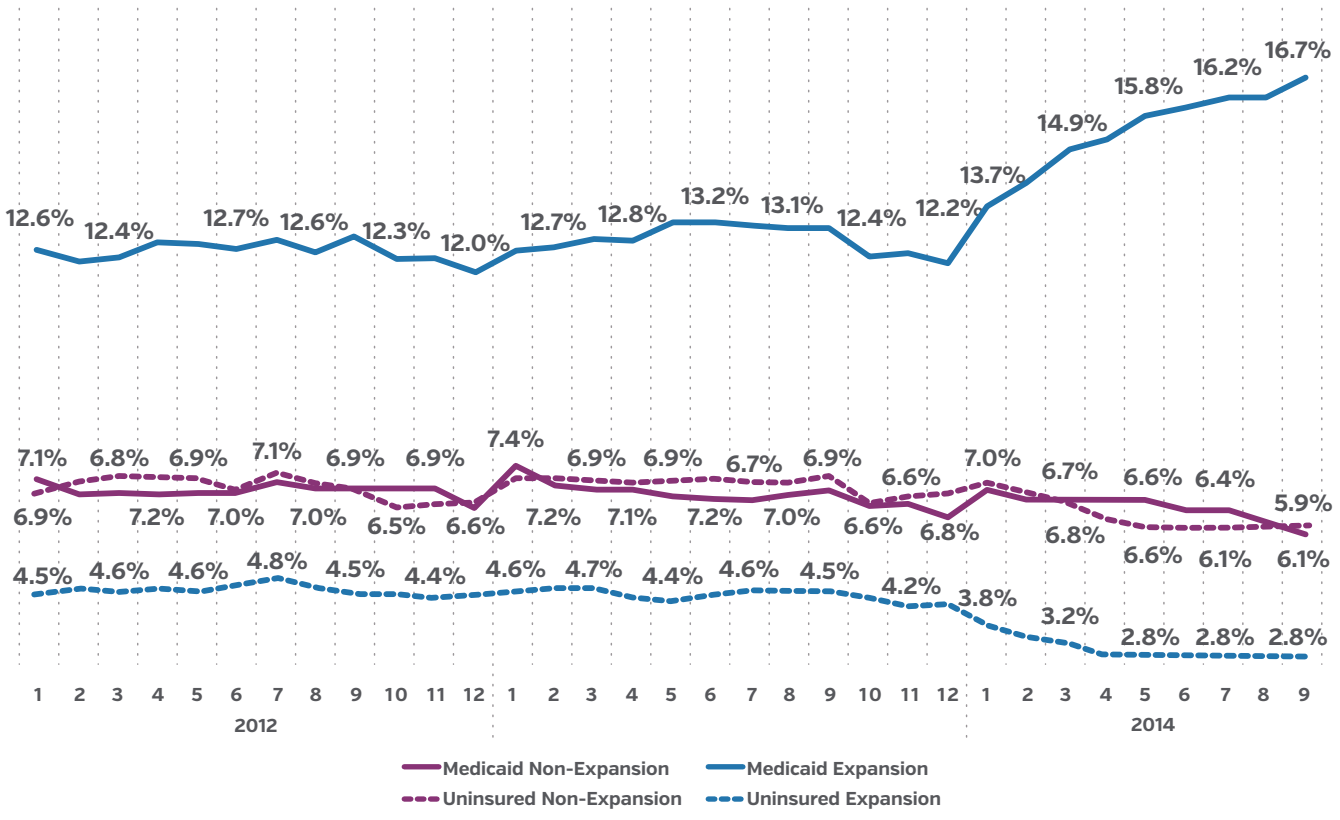
Chronic Diseases Among New Patients Vary by Payer Class

Chronic disease rates for new adult patients remained relatively consistent between 2013 and 2014 (see *Figure 5*). However when the overall figures are broken down by payer type and Medicaid expansion status, some interesting differences are evident. In most segments, rates of diabetes, high blood pressure, and high cholesterol have increased at least slightly.

Commercially insured new patients have slightly higher rates of diabetes and high blood pressure this year than in 2013, which may in part be the result of patients with chronic diseases enrolling in exchange-based plans. Similarly, in states with expanded Medicaid eligibility, disease rates for Medicaid beneficiaries have increased as the number of beneficiaries has grown. For example, 12.7 percent of Medicaid enrollees in expansion states had diagnoses of high blood pressure year-to-date, up from 12.1 percent during the same period last year.

Medicaid patients in non-expansion states are a notable exception to this trend, with rates of diabetes and high blood pressure falling between 10 percent and 15 percent in relative terms as the number of beneficiaries in these states has increased. One consequence of this shift is that chronic disease rates among new Medicaid patients in non-expansion states are now closer to rates in expansion states, whereas previously beneficiaries in expansion states had substantially lower rates of chronic disease.

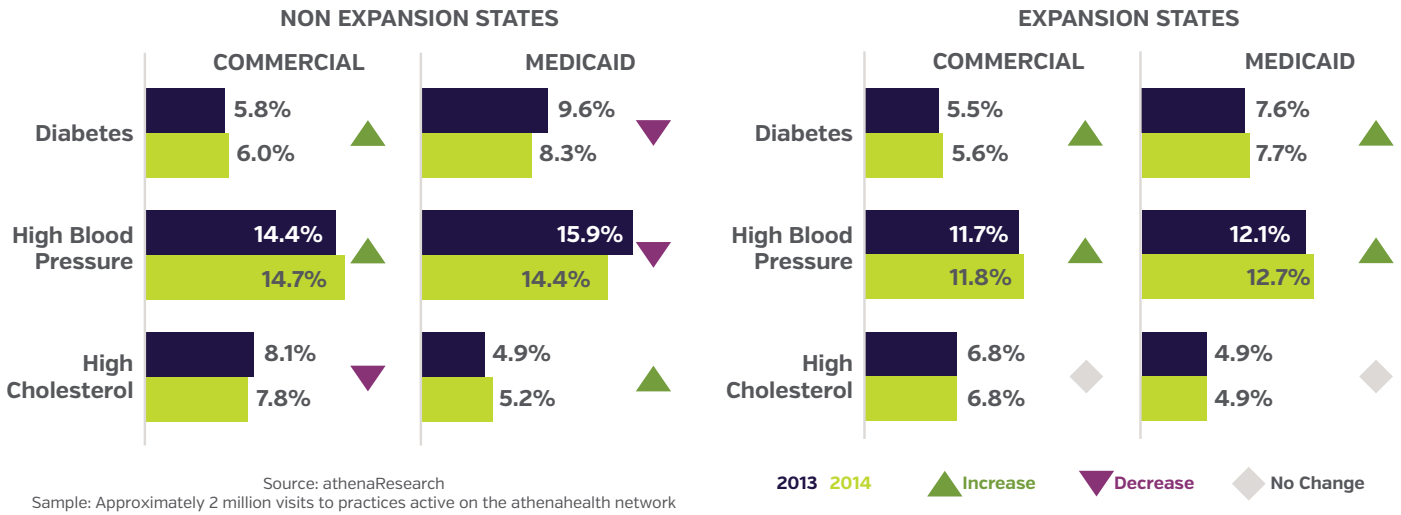
Figure 9. Proportion of Adult (18-64) PCP Visits From Medicaid and Uninsured Patients
Medicaid Expansion States vs Non-Expansion States



Source: athenaResearch
Sample: Approximately 19 million visits to practices active on the athenahealth network before 2011

Figure 10. Chronic Disease Diagnosis Rates for New Adult (18-64) PCP Visits by Expansion Status and Payer Type

January through September



Source: athenaResearch
Sample: Approximately 2 million visits to practices active on the athenahealth network before 2011

Payment Rates Stable or Down, but Patients Paying More Out of Pocket

We see two important trends in provider reimbursement. First, average nominal payment rates are growing slowly overall and are actually declining for certain specialties. Insurers are adjusting payment rates to increase reimbursement to primary care practitioners (who have historically been paid lower rates than specialists), while insurer payments are down for surgery visits.[7] Second, patients are bearing a greater portion of costs for physician services. Here, too, we see differences among specialties, with patient obligations increasing more for surgery than for primary care. Some of these trends appear more pronounced for new patients.

Reimbursement rates are growing slowly overall, declining for some specialties

Figure 11 shows reimbursement rates for commercial insurers by specialty, where reimbursement reflects actual payments received by providers from insurers. Reimbursement per visit is higher for new patients than for established patients in part because new patients require more intensive care (in

Figure 11. Average Primary Payment Per Visit for Commercial Patients

January through July

Metric	2013		2014		2013-2014 Change	
	Established	New	Established	New	Established	New
All Visits	$118.15	$161.13	$120.39	$162.50	1.9%	0.8%
PCP	$89.32	$121.61	$91.84	$125.78	2.8%	3.4%
Pediatrics	$117.91	$172.03	$124.28	$176.36	5.4%	2.5%
OB/GYN	$175.99	$166.02	$179.87	$164.51	2.2%	-0.9%
Sugery	$180.21	$204.00	$176.50	$199.90	-2.1%	-2.0%
Other	$122.35	$163.88	$121.25	$165.74	-0.9%	1.1%

Source: athenaResearch
Sample: Approximately 19 million visits to practices active on the athenahealth network before 2011

[7] Payment data are reported per visit. In our year-end report we will provide payments per RVU, which adjusts for differences in acuity.
[8] Payment data are reported for January through July. Because the process of adjudicating payments can take several months, reliable data for August and September are not yet available.

other words, RVUs per visit are higher). Overall, commercial reimbursement rates for the ACAView sample grew by only 1.9 percent per visit for established patients in 2014.[8]

Changes in reimbursement rates were uneven across specialties. Primary care physicians saw increases of 2.8 percent and 3.4 percent for established and new patients, respectively. Surgeons were hit hardest, with per-visit declines of 2.1 percent and 2.0 percent for established and new patients this year. These figures are based on average payments per visit from the primary insurance carrier, and do not control for potential shifts in procedure mix.

We believe that the rebalancing of reimbursement dollars reflects insurers' changing strategies. More private payers are prioritizing primary care services as a means of encouraging wellness and limiting downstream acute-care costs, while also reducing surgical reimbursement by offering narrower networks that exclude high-cost hospitals and surgeons.

Reimbursement differences between new and existing patients are also revealing. Overall payment rates for commercial payers have increased by 1.9 percent for established patients but by only 0.8 percent for new patients. This may reflect a shift toward the narrow-network plans that are common in the new insurance exchanges.

Patients bearing a greater financial burden

Faced with mounting pressure from employers to control premiums, commercial insurers have not just kept reimbursement growth in check–they have also shifted a greater portion of the financial burden onto patients. Although the change in patient obligation varies to some degree from one specialty category to another, obligations have gone up for most patients and specialties.

Figure 12 shows the change in payments by type for established and new patients through July of this year relative to the same period last year. Overall, patient obligations–including co-pays, co-insurance, and deductibles–have increased significantly faster than primary insurance payments, by 3.6% and 4.7% for established and new commercially insured patients, respectively.

The increase in patient out-of-pocket payments is driven almost entirely by higher deductible obligations. Co-pays are up slightly, but they represent a relatively small portion of total patient obligations. Deductible obligations have increased by 8.5% and 9.5% per visit for established and new commercial patients so far this year, while co-insurance obligations have remained about the same. This level of increase is unlikely to be sustainable over time.

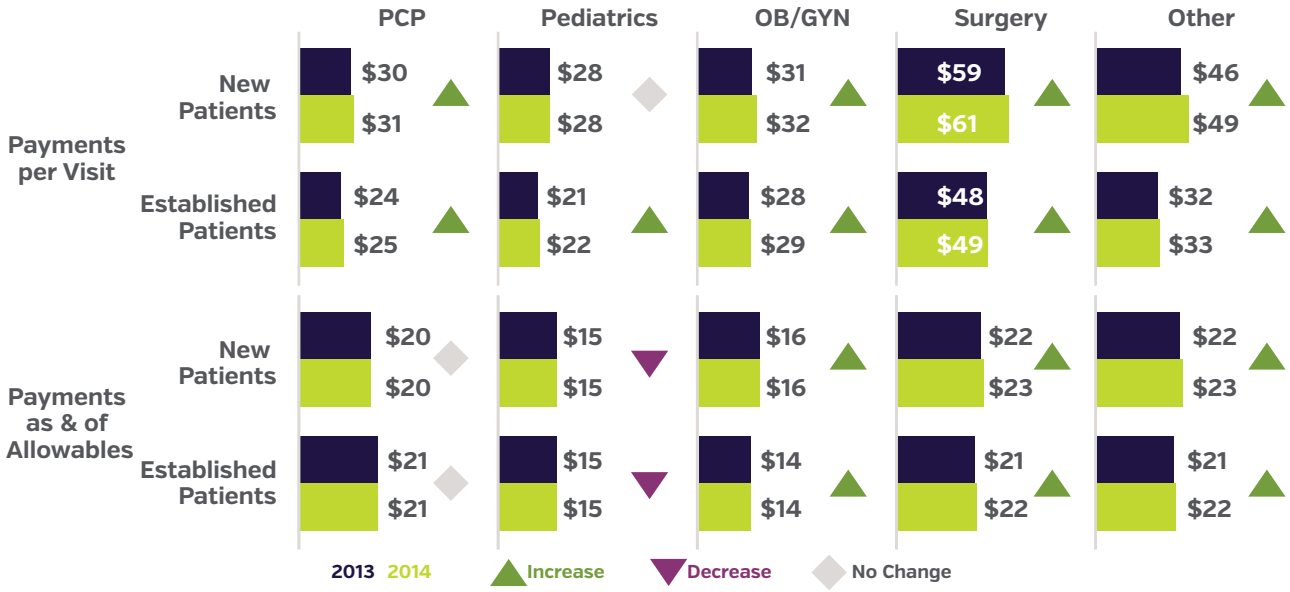
Figure 12. Average Primary Payment and Patient Obligation Per Visit

Commercial Patients, January through July

Metric	2013		2014		2013-2014 Change	
	Established	New	Established	New	Established	New
Primary Payment per Visit	$118.15	$161.13	$120.39	$162.50	1.9%	0.8%
Total Patient Obligation per Visit	$28.19	$40.80	$29.20	$42.74	3.6%	4.7%
Co-Pay Obligation per Visit	$10.35	$10.72	$10.16	$10.53	-1.8%	-1.7%
Coinsurance Obligation per Visit	$3.87	$7.31	$3.87	$7.28	0.1%	-0.5%
Deductible Obligation per Visit	$13.97	$22.77	$15.16	$24.93	8.5%	9.5%
Patient Obligation as % of All Payments	19.3%	20.2%	19.5%	20.8%	1.3%	3.1%

Source: athenaResearch.
Sample: Approximately 19 million visits to practices active on the athenahealth network before 2011

Figure 13. Patient Obligation per Visit for Commercial Patients, By Category
January through July



Source: athenaResearch
Sample: Approximately 19 million visits to practices active on the athenahealth network before 2011

The changes in insurance benefits that these obligations reflect are more pronounced among new patients, who we believe are more likely to have the high-deductible, narrow-network plans common on exchanges. New patients had slower growth in primary payments and greater increases in total obligations and deductibles across the year to date, consistent with a more pronounced shift in plan benefit design.

Although these trends are more or less consistent across specialties, there are some notable differences. As *Figure 13* shows, patient obligations are lowest for pediatrics and primary care and highest for surgery and other specialties. For example, established patients owed $25 per visit for primary care and $49 for surgery. Although part of this differential is attributable to greater intensity (higher RVUs per visit), patient obligations as a percent of allowables are also higher for surgical specialty care than for primary care. New patients pay more out of pocket for care, largely due to greater acuity of services.

Relatively low out-of-pocket costs for primary care services benefit low-income individuals, for whom the financial burden of visiting a doctor—even while insured—might represent a significant hurdle to obtaining care. But as patient obligations for primary care have remained manageable—even for financially secure patients who could pay for a greater portion of their care—out-of-pocket costs for surgeries and other specialties have increased significantly. Refocusing on chronic disease management and prevention is a worthy goal, and doing so may indeed reduce downstream costs in the future. However, reducing patient obligations for primary care at the expense of surgical and medical specialty care has a flip side as well: low-income patients with costly surgical needs may find their financial obligations too onerous even with insurance.

We will continue to look closely at each of the areas discussed in this report with a particular emphasis on reimbursement rates and patient obligations. One area of particular interest will be adjusting this data by relative value units (RVUs). We welcome your comments and questions.

We look forward to publishing a year-end report on ACAView in early 2015.

Appendix

Provider Practice Metrics to be Tracked through ACAView

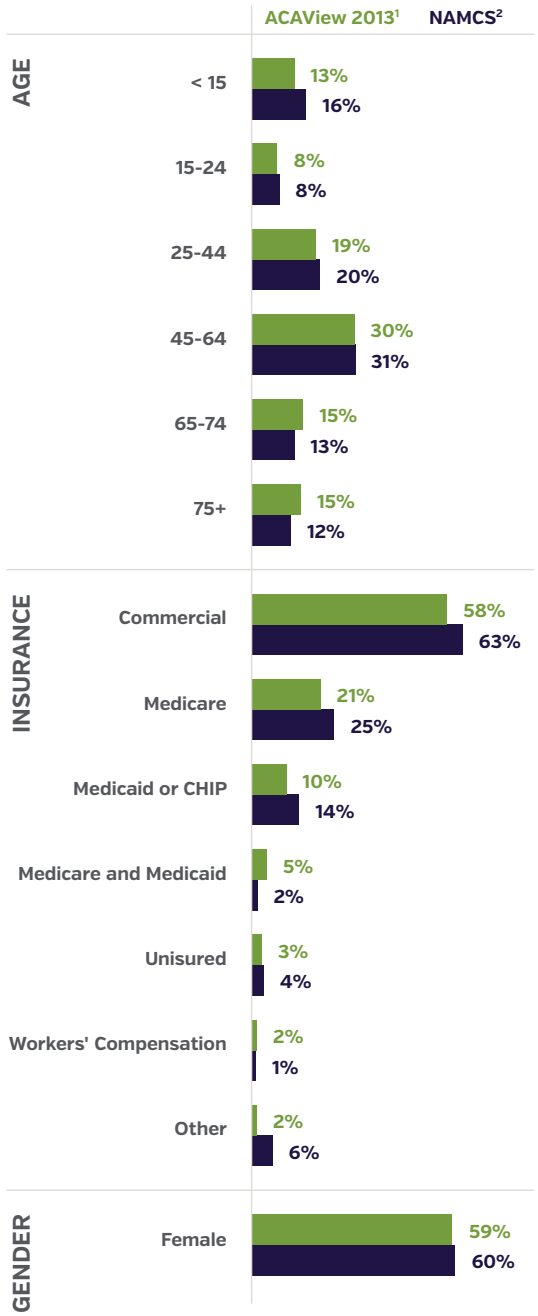
Metrics in **magenta** are currently tracked.

Category	Measures
Patient Access	**New-patient visits as a percentage of total patient visits for primary care providers (PCP)s, pediatricians, specialists**
	Number of days between when appointment was made and when patient was seen by PCP for new and established patients
	Schedule density by proportion of PCP slots used out of slots available
Patient acuity	Number of problems selected in the patient problem list – new and established patients
	Number of diagnoses per visit – new and established patients
	Percent of evaluation and management visits with code of 4 or higher – new and established patients
	Scripts per visit for new and established patients
	Obesity rate for new and established patients
	Referrals per visit, new and established patients
	Percent of new and established patients with a diagnosis of diabetes
	Percent of new and established patients with HbA1C levels < 7
	Percent of new and established patients with a diagnosis of hyperlipidemia
	Percent of new and established patients with LDL levels < 100 mg/Dl
	Percent of new and established patients with a diagnosis of high blood pressure
	Percent of new and established patients with blood pressure levels exceeding threshold
Physician work intensity	**wRVU[10] per visit, new and established patients**
	Documentation time per visit for new and established patients
Workload distribution	Percent of visits performed by physicians, nurse practitioners, and physicians' assistants
Patient financial burden[11]	**Patient financial responsibility per PCP visit for new and established patients**
	Patient financial responsibility per specialist visit for new and established patients seeing specialists
	Patient out-of-pocket payments per PCP visit for new and established patients
	Patient out-of-pocket payments per specialist visit for new and established patients
	Percentage of what a patient owes he or she has paid at 90 days for PCP visits – new and established patients
	Percentage of what a patient owes he or she has paid at 180 days for PCP visits – new and established patients
	Percentage of what a patient owes he or she has paid at 90 days for specialist visits – new and established patients
	Percentage of what a patient owes he or she has paid at 180 days for specialist visits – new and established patients
	Proportion of charges going to collections
Physician practice burden	First pass rate[12] for new and established patients
	Denials for new and established patients
	Proportion of charges going to collections
Physician Reimbursement	Percentage change in allowables per RVU[13] – PCPs – new and established patients
	Percentage change in allowables per RVU – Surgeons – new and established patients
	Percentage change in allowables per RVU – Ob-Gyns – new and established patients
	Percentage change in allowables per RVU – Medical specialists – new and established patients

[10] Work RVUs (Relative Value Units), measure the relative time, skill, and effort required for a service.
[11] Patient financial responsibility is what a patient owes for his her care after primary and secondary insurance is taken into account. Out-of-pocket payments is what a patient pays.
[12] First pass rate refers to the percentage of claims that are submitted and reimbursed without a denial or partial payment after the first submission.
[13] Allowables refers to the amount that a physician should be paid for services rendered, assuming full payment from the insurer and the patient.

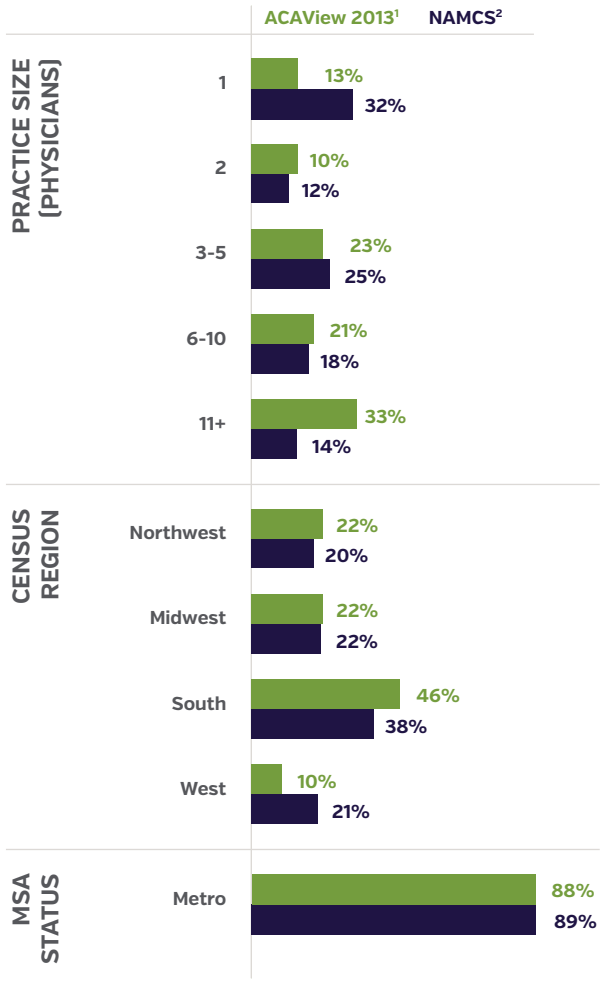
Athenahealth ACAView Practice Cohort vs. NAMCS

Office Visit Characteristics: Patient Demographics Athenahealth ACAView Practices vs. NAMCS



Source: athenaResearch
1: 30 million visits to practices active on the athenahealth network before 2011
2. http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf

Office Visit Characteristics: Provider Demographics Athenahealth ACAView Practices vs. NAMCS



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