

By Brendan Saloner, Daniel Polsky, Genevieve M. Kenney, Katherine Hempstead, and Karin V. Rhodes

Most Uninsured Adults Could Schedule Primary Care Appointments Before The ACA, But Average Price Was \$160

DOI: 10.1377/hlthaff.2014.1258
HEALTH AFFAIRS 34,
NO. 5 (2015): 773–780
©2015 Project HOPE—
The People-to-People Health
Foundation, Inc.

ABSTRACT Provisions of the Affordable Care Act (ACA) allow millions more Americans to obtain health insurance. However, a sizable number of people remain uninsured because they live in states that have not expanded Medicaid coverage or because they feel that Marketplace coverage is not affordable. Using data from a ten-state telephone survey in which callers posed as patients, we examined prices for primary care visits offered by physician offices to new uninsured patients in 2012–13, prior to ACA insurance expansions. Patients were quoted a mean price of \$160. Significantly lower prices for the uninsured were offered by family practice offices compared to general internists, in offices participating in Medicaid managed care plans, and in federally qualified health centers. Prices were also lower for offices in ZIP codes with higher poverty rates. Only 18 percent of uninsured callers were told that they could bring less than the full amount to the visit and arrange to pay the rest later. ACA insurance expansions could greatly decrease out-of-pocket spending for low-income adults seeking primary care. However, benefits of health reform are likely to be greater in states expanding Medicaid eligibility.

Brendan Saloner (bsaloner@gmail.com) is an assistant professor in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland.

Daniel Polsky is a professor of medicine in the Division of General Internal Medicine, the Robert D. Eilers Professor in Health Care Management and Economics at the Wharton School, and executive director of the Leonard Davis Institute of Health Economics, all at the University of Pennsylvania, in Philadelphia.

Genevieve M. Kenney is a senior fellow at and codirector of the Health Policy Center, Urban Institute, in Washington, D.C.

Katherine Hempstead is a director at the Robert Wood Johnson Foundation, in Princeton, New Jersey, and a visiting research assistant professor in the Rutgers Center for State Health Policy, in New Brunswick, New Jersey.

Karin V. Rhodes is director of the Center for Emergency Care Policy and Research, Department of Emergency Medicine, Perelman School of Medicine, and a senior fellow in the Leonard Davis Institute of Health Economics, both at the University of Pennsylvania.

The number of uninsured Americans declined in 2014 following the implementation of the Affordable Care Act (ACA) coverage expansions, which began in late 2013.^{1–3} The uninsured population is projected to decline further in 2015.

However, a sizable number of adults will remain without health insurance even after the full effects of the expansions are felt.⁴ This population will include poor adults residing in states not expanding Medicaid eligibility, undocumented immigrants ineligible for any federal assistance, and adults who believe they cannot find affordable insurance in the new health insurance Marketplaces or who choose to remain uninsured for other reasons.

An important question for policy makers is where the remaining uninsured people will receive their primary care, and at what price. His-

torically, policies have focused on increasing access for the uninsured to federally qualified health centers and other safety-net providers where people can receive low-cost checkups, screenings, and referrals to specialists. Funding for federally qualified health centers nearly doubled in 2001, compared to historical levels—a change that led to significantly improved access for low-income adults living in proximity to those providers.⁵ The ACA also includes a funding increase for federally qualified health centers.⁶

In addition to safety-net providers such as federally qualified health centers, most physicians in private practice provide some charity care, but the amount varies widely across practices and has been declining over time.⁷ Physicians also report making various accommodations for people without insurance, such as offering reduced fees or payment plans.⁸

There is a strong history of charity care in medicine. However, providers may also have profit-seeking motives to treat the uninsured: Providers may be able to extract higher payments from self-paying uninsured patients, compared to the reduced rates available from private insurance companies and from Medicaid and Medicare.

Using an all-payer data set for more than 4.4 million outpatient provider visits to 4,000 physicians, Jonathan Gruber and David Rodriguez found that uninsured patients were typically billed at about 48 percent below the listed charges at a practice. However, the amounts that uninsured patients paid were, on average, about 0.86 percent higher than the amounts paid by private insurers for the same procedures, after 10 percent nonpayment among the uninsured was accounted for.⁹

Moreover, most of the uncompensated care provided to the uninsured was not charity care—it was uncompensated because patients failed to pay for care. Such debts are often sent to collection agencies, which may in turn place financial strain on the uninsured. About 9 percent of the uninsured in the Gruber and Rodriguez study actually paid charges that were more than double the negotiated rates of the privately insured.⁹

Primary care practices are likely to tailor their prices for self-paying customers based on demand in the market.¹⁰ A practice may keep prices for the uninsured relatively high when it is possible to obtain a greater volume of well-paying, privately insured patients. However, a practice may lower prices in markets with a higher uninsurance rate or less affluent patients. Additionally, practices may alter their prices when they have operational efficiencies (for example, mid-level providers who can substitute for physicians) that allow them to schedule higher patient volumes. Given the potential latitude that practices have in setting prices for uninsured patients, it is important to take a close look at variation in prices for the uninsured.

We took advantage of unique data collected from an experimental audit study conducted by our team, in which trained field staff members posing as new patients called primary care offices to request an appointment. The audit included 1,613 completed calls with the uninsurance scenario described below. In 1,281 of these calls the primary care office offered an appointment.

Prior literature underscores the fact that prices for many hospital procedures for the uninsured vary widely.^{11–13} However, there has been little research on prices for primary care visits, a setting in which the uninsured are disproportionately likely to be seen.¹⁴

One advantage of our study is that we were able

to consider prices for the full range of primary care offices willing to accept uninsured patients. This allowed us to compare visit prices quoted from safety-net providers and providers in underserved areas with prices from providers located in more advantaged areas. We benchmarked the range of prices obtained in our study to data on privately insured adults living in the same states.

Study Data And Methods

AUDIT STUDY Data measuring the availability of new patient appointments and prices for office visits for uninsured patients were collected as part of a large-scale audit study conducted in ten diverse states (Arkansas, Georgia, Iowa, Illinois, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas) from November 2012 to March 2013. The audit also collected information on appointment availability for patients with private insurance or Medicaid.

Before the audit, a sample frame of primary care offices was created using the SK&A database, a proprietary database of US office-based physicians that is updated frequently.¹⁵ All of the offices in the sample frame were called in a phone survey to obtain basic information about the office and to verify that it had at least one primary care physician (a practitioner of either general internal medicine or family medicine). Additionally, the survey determined whether or not the office had physicians who would be able to provide ongoing care for new patients, since a sustained relationship is considered critical to primary care.¹⁶ This restriction excluded many free clinics, urgent care centers, and retail clinics.

Trained interviewers posing as prospective new patients called the primary care offices that had been contacted in the pre-audit survey. The callers sought appointments for either a checkup or an evaluation of suspected hypertension (in the second case, the caller stated that he or she had received an elevated blood pressure reading at a pharmacy or health fair). In Arkansas, Massachusetts, Montana, and Oregon, the audit sample included the full census of eligible provider offices. In the other states, calls were disproportionately placed to offices in counties that had higher uninsurance rates. In offices with multiple physicians, callers would ask for an appointment with a randomly selected primary care physician in the office but would accept an appointment with any available provider. Using weights that adjusted for sampling probabilities, our estimates are representative of data from the primary care offices located in communities where the uninsured live.

Callers did not initially provide the scheduler with their insurance status. However, in some cases, the scheduler asked for this information before deciding whether or not to grant an appointment. If the scheduler offered an appointment, the caller would verify that he or she could receive an appointment without insurance. The caller also indicated that he or she would be paying for the appointment entirely out of pocket by asking two questions about price: “How much will this visit cost in total?” and “How much money do I need to bring to the appointment in order to be seen?” The latter question was included to determine whether callers could make a payment arrangement if they could not immediately pay the entire cost of the visit. All appointments were canceled at the end of the call.

Caller scripts are provided in online Appendix Exhibit A1.¹⁷ Additional details about the audit methods have been reported elsewhere.¹⁸

PHYSICIAN AND PRACTICE CHARACTERISTICS In addition to the information collected by the callers, we collected information during a pre-audit survey on the number of physicians and midlevel providers in each office. We also determined whether the office participated in a Medicaid network (either as a contracted provider in a Medicaid managed care plan or as a provider in a Medicaid primary care case management program). We used a federal database of community clinics¹⁹ to determine whether offices were federally qualified health centers and a database of hospitals²⁰ to identify offices located at hospitals.

Information about the sampled primary care physician’s training (in family medicine or general internal medicine) was gathered from the 2012 SK&A file. SK&A was also the source for providers’ National Provider Identifier numbers. We used these numbers to link providers in our sample to data in the Medicare Physician Compare database²¹ (which represents all physicians who received reimbursement from Medicare in 2013) and to obtain demographic characteristics for the providers in our sample. The characteristics included graduation from a foreign medical school.

These variables were available for 1,131 of the 1,281 offices (88.3 percent) that provided price information. We used logistic regression-based imputation methods to fill in missing variables with the MI routine in Stata, version 12.

STATE AND LOCAL CHARACTERISTICS ZIP code-level sociodemographic characteristics—the percentages of the population who had incomes under the federal poverty level and who were unemployed, black, or Hispanic—were extracted from the American Community Survey, 2008–

12, file created by GeoLytics.²² Uninsurance rates were not available at the ZIP code level. They were gathered from the 2012 Area Health Resources Files at the county level.²³

We defined an office as being located in a low-poverty ZIP code if the ZIP code had a poverty rate in the bottom fifth of our sample (lower than 6.2 percent); a high-poverty ZIP code was defined as being in the top fifth (higher than 20.9 percent). We used the same methods in defining counties with low and high uninsurance rates (11.3 percent and 23.1 percent, respectively) and those with low and high density of primary care providers (37.3 and 88.5 primary care providers per 100,000 residents, respectively). We classified three states (Georgia, Montana, and Texas) as not having expanded Medicaid by January 2015, based on a report by the Henry J. Kaiser Family Foundation.²⁴

COMMERCIAL CLAIMS DATA To compare prices quoted to the uninsured with prices paid by private insurers, we examined a custom MarketScan datafile created by Truven Analytics that was specific to the ten study states from 2011. MarketScan represents a large segment of the employer-sponsored insurance market; additional details about its sample and methods have been published elsewhere.²⁵

We analyzed prices for 422,103 primary care evaluation and management visits using codes for visit setting, diagnosis, and allowed amounts (that is, insurer-negotiated prices). Truven suppressed geographic, market-level, and office-level identifiers because of confidentiality concerns. The MarketScan data provide a benchmark for the likely total cost of a new patient primary care visit, similar to the checkup scenario represented in our study. The data also provide information about the cost of services beyond the physician consultation, as explained below.

METHODS Within the sample of uninsured calls, we calculated the percentages of callers who were offered a visit overall and by subgroup (such as size of the office called and location in a high-poverty area), and we compared the percentages with those of privately insured callers. For those uninsured callers who received an appointment, we calculated unadjusted visit prices at the mean and at selected percentiles (twenty-fifth percentile, median, and seventy-fifth percentile) by state and by other physician, practice, and market characteristics. We calculated unadjusted *t*-tests for differences in prices between the subgroup and the rest of the sample.

We examined paid amounts for a privately insured comparison population using the MarketScan data, focusing on any visits to a primary care physician with a new patient evaluation and management code. We also calculated the cost of

18%

Of physician offices

Only 18 percent of offices told prospective patients that they could bring less than the full amount of payment to an appointment and make arrangements to pay the rest later.

additional laboratory and diagnostic exams conducted on the same day as the reference visit.

To examine predictors of receiving an appointment if the patient could bring less than the full amount, we estimated logistic regression models with an indicator for lower price at visit as the dependent variable and the physician, office, and contextual variables described above as predictors.

LIMITATIONS This study was designed to measure the total quoted price for new patient primary care provider visits and the ability of patients to pay less than the quoted price at the time of the visit. It does not reveal whether a lower price might be available to patients who attempt to negotiate one. Schedulers are typically not authorized to make decisions about discounts over the telephone. However, offices may offer discounts, or less aggressively collect unpaid bills, case by case according to the patient's health and financial needs.

The study did not measure the prices of “add-on” services such as laboratory or diagnostic procedures for the uninsured, which are often recommended to patients during a primary care visit. Thus, the prices in this study likely represent only the cost of a physician consultation.

The actual prices for a physician consultation at federally qualified health centers are likely to be lower than those obtained in our study. This is because patients at these centers with incomes below 200 percent of poverty are eligible for discounts on a sliding scale.

The commercial claims data used in this study could not be matched to the specific communities where the audit callers made appointments. Thus, the claims data are not necessarily for care at the same offices as those in our study.

Importantly, the study was conducted in only ten states. Although these states were selected for geographic and health system diversity, our results might not be generalizable to other states.

Study Results

NEW APPOINTMENT RATES Appointment rate data are shown in Appendix Exhibit A2.¹⁷ In total, 79.2 percent of all uninsured audit callers were offered an appointment—slightly lower than the percentage for privately insured callers (83.2 percent). The appointment rate differences between uninsured and privately insured callers existed across most subgroups and settings but were smaller in counties with a high uninsured rate. Approximately 6 percent of uninsured callers who were denied an appointment were told that the denial was due to their insurance status.

As expected, the lowest average prices were at federally qualified health centers.

DIFFERENCES BY CHARACTERISTICS OF PHYSICIAN, OFFICE, AND AREA The mean price for a new uninsured patient visit was \$160, the median was \$125, and the twenty-fifth and seventy-fifth percentiles were \$100 and \$190, respectively (Exhibit 1). Callers who used the hypertension scenario described above were offered less expensive visits, on average (mean \$149), than those who used the regular checkup scenario (mean \$171).

Prices were significantly lower at offices participating in Medicaid networks, compared to those that did not participate. Prices were also lower when providers were in family medicine as opposed to general internal medicine, and when providers had graduated from a foreign medical school instead of a US medical school. Visits were also markedly less expensive at federally qualified health centers than elsewhere. The mean price for a visit at a center was \$109.

There were significant differences in prices based on the poverty rate in the office's ZIP code. Offices located in the lowest-poverty ZIP codes offered new uninsured patient primary care visits at an average price of \$189, compared to \$144 in ZIP codes with the highest poverty.

Interestingly, the uninsurance rate in the county did not seem to be related to an office's price for a new uninsured patient visit. In contrast, visit prices were significantly lower than average (\$134) in counties with a low density of primary care providers. Correspondingly, prices were higher in counties with a high density of such providers (\$173). However, the difference in this case was not significant ($p = 0.214$).

Across the ten study states, the mean prices ranged from a low of \$128 in Pennsylvania to a high of \$188 in Oregon. Prices were not significantly different in states that expanded Medicaid, compared those that did not.

COMPARISON WITH VISIT PRICES FOR THE PRIVATELY INSURED In the 2011 MarketScan data for the ten study states, the mean total amount paid (insurer payments plus patient out-of-pocket payments) for privately insured new patient pri-

mary care appointments was \$200, and the median was \$166 (Exhibit 2). Of the total amount paid, new privately insured patients contributed a mean of \$49 in cost sharing for the visit.

Importantly, the amounts paid for these office visits included both the clinician consultation—typically a fifteen-minute office visit to discuss a health issue of moderate complexity (*International Classification of Diseases*, Ninth Revision [ICD-9], code 99203)—and any additional laboratory or diagnostic exams that accompanied the visit. The mean amount paid for the evaluation and management portion of a privately insured new patient visit was \$118 in the MarketScan data. This was 59 percent of the total payment and an amount comparable to prices quoted to uninsured callers in the audit (\$160).

ABILITY OF PATIENTS TO MAKE A PAYMENT ARRANGEMENT Overall, only 18 percent of offices told uninsured callers that they could bring less than the full amount to the appointment and make an arrangement to pay the rest later (Appendix Exhibit A3).¹⁷ On average, patients able to bring less than the full amount were told that they needed to bring 61 percent of it to the appointment to be seen. Compared to physicians at larger groups, solo practitioners were significantly less likely to offer a payment arrangement (odds ratio: 0.43; 95% confidence interval: 0.28, 0.66). No other office- or physician-level variables predicted receiving a payment arrangement.

Oregon was the state with the highest adjusted odds of a patient's being able to bring less than the full amount to the visit. In other words, although primary care practices in Oregon had higher prices (Exhibit 1), they were more likely to make payment arrangements. The adjusted odds of a payment arrangement were significantly lower in every other state, except for Montana, which has substantial rural and uninsured populations.

SUPPLEMENTARY ANALYSIS We calculated regression-adjusted prices, controlling for caller and state fixed effects and physician- and area-level characteristics (Appendix Exhibits A4 and A5).¹⁷ Regression-adjusted prices captured variation in prices across subgroups not otherwise accounted for by other observable differences. However, we found that these prices were broadly similar to the unadjusted prices.

Regression adjustment brought some prices closer to the sample mean. For example, the adjusted prices in New Jersey and Illinois were more than \$19 lower than unadjusted prices. This suggests that some of the higher prices in those states were accounted for by differences in observable characteristics of providers and areas, such as the percentage of offices in low-poverty areas.

EXHIBIT 1

Prices Quoted To Uninsured Callers For A New Patient Primary Care Visit, November 2012–March 2013

	Number of calls	Mean	25th percentile	Median	75th percentile
Full sample	1,281	\$160	\$100	\$125	\$190
CALLER SCENARIO					
Hypertension visit	642	149***	100	125	185
Checkup	639	171***	100	135	200
CLINIC AND PHYSICIAN CHARACTERISTICS					
In a Medicaid network	628	145****	95	125	178
Family practice	700	152**	100	125	185
Foreign trained	417	142***	89	125	165
Solo practitioner	635	152*	90	125	175
Employs midlevels	648	157	100	135	196
Hospital based	59	161	110	126	200
FQHC	72	109***	70	125	135
ZIP CODE					
Low poverty	255	189***	100	150	210
High poverty	262	144*	85	115	150
COUNTY					
Low uninsured	261	157	100	150	200
High uninsured	241	157	95	125	175
Low PCP density	256	134***	95	125	156
High PCP density	260	173	93	130	200
STATE					
Arkansas	129	135*	90	120	160
Georgia	149	167	100	126	180
Iowa	122	166	105	143	200
Illinois	152	155	93	125	175
Massachusetts	78	170	105	150	210
Montana	122	161	125	150	200
New Jersey	162	154	88	125	150
Pennsylvania	102	128**	85	125	150
Oregon	106	188*	125	195	238
Texas	159	177	90	125	175
MEDICAID EXPANSION APPROVED					
No	430	169	100	130	185

SOURCE Authors' analysis of data from the experimental audit study of primary care in ten states, and of information from the sources in Notes 19–23 in text. **NOTES** Acute care visits, "low poverty" and "high poverty" ZIP codes, "low uninsured" and "high uninsured" counties, and "low primary care provider (PCP) density" and "high PCP density" are defined in the text. Medicaid expansion legislation (under the Affordable Care Act) was under consideration in Montana as of March 2015. Midlevels are nurse practitioners and physician assistants. Significance denotes difference from sample mean. FQHC is federally qualified health center. * $p < 0.10$ ** $p < 0.05$ *** $p < 0.01$ **** $p < 0.001$

Finally, as a comparison to prices quoted to potential patients in the audit and to prices in the MarketScan data, we examined amounts paid by actual self-paying and privately insured patients for primary care visits in the 2012 Medical Expenditure Panel Survey (MEPS; Appendix Exhibit A6).¹⁷ Actual patients would be expected to pay less than the amounts quoted to hypothetical patients if they clustered at lower-cost providers or otherwise negotiated for lower prices than initially offered, or if they went without care when faced with high costs. In fact, we found that actual self-paying patients paid an average

EXHIBIT 2

Prices Paid For A New Patient Primary Care Visit From A 2011 Sample Of Privately Insured Patients In Ten States And Comparison Prices From The Audit Study, November 2012–March 2013

New patient visits	Mean	25th percentile	Median	75th percentile
Total cost	\$200	\$126	\$166	\$230
Insurer cost	150	100	125	176
Patient out-of-pocket cost	49	20	25	49
Total cost for E&M portion	118	89	110	140
Comparison price	160	100	125	190

SOURCE Authors' analysis of 2011 data from a custom MarketScan data file created by Truven Analytics for the ten study states. **NOTES** There were 422,103 primary care evaluation and management (E&M) visits in the database and 1,281 calls in the audit study. "Total cost" is all costs associated with an E&M primary care visit and the cost of additional laboratory and diagnostic exams conducted on the same day as that visit. "Total cost for E&M portion" is all costs for the visit related to the physician consultation (that is, costs not related to diagnostics, additional procedures, and testing). Percentile insurer and patient costs do not sum to the total cost because they are calculated separately within each category.

of \$101 for primary care visits (63 percent of the audit study average) and paid even less for visits that had no labs or diagnostics. Amounts for visits with private insurance in MEPS were similar to amounts found in the MarketScan data.

Discussion

This study provides a snapshot of prices for a new patient primary care visit for uninsured patients offered by a representative sample of primary care practices in ten states on the eve of the ACA coverage expansions. Almost 80 percent of uninsured callers who indicated that they could pay full price were able to obtain appointments. The mean price quoted to an uninsured caller for a first primary care visit was \$160, with a twenty-fifth to seventy-fifth percentile range of \$100 to \$190.

The mean price quoted for a new patient primary care visit in our study was lower than actual total amounts paid for privately insured new patient primary care visits in the same states (mean \$200). Of those visits, the mean out-of-pocket cost for privately insured patients was \$49.

At least some portion of the higher prices for privately insured patients is attributable to the added costs of new patient testing (such as laboratory, electrocardiograms, imaging, and biopsies). These additional costs add about 40 percent to the total cost of a privately insured patient visit. It is unclear what additional costs uninsured patients would encounter at these practices. However, it is known that uninsured patients receive about the same amount of screenings and tests in primary care that privately insured patients do.²⁶

The prices quoted to uninsured patients in our

study would represent a substantial expense for a typical uninsured adult and may be a deterrent to seeking care. Before the 2014 coverage expansions of the ACA, 27 percent of the uninsured lived in households with incomes below poverty, and an additional 30 percent lived in households with incomes of 100–199 percent of poverty.²⁷ A medical bill of \$100 would represent about one-tenth of the monthly income of a single adult living at the poverty level.

Also before the 2014 expansions, about 30 percent of the uninsured reported that in the previous year they had postponed seeking care because of cost-related concerns, compared to 10 percent of Medicaid patients and 4 percent of privately insured patients.²⁸ Thus, even if uninsured adults are able to find providers willing to see them at prices lower than those quoted to patients in the audit study, such care might not be affordable to many of the uninsured.

In the audit study, quoted prices for a visit were lower in higher-poverty ZIP codes and with foreign-trained physicians. We also found that areas with fewer primary care providers per capita had lower prices, on average, which seems counterintuitive. Economics would predict that a greater density of providers would increase competition and lower prices. The mechanisms underlying this relationship are unclear. However, they could be related to difficulties that physicians in these areas experience in securing adequate revenue from privately insured patients.

As expected, the lowest average prices were at federally qualified health centers: Their average price was about two-thirds of the overall average price at primary care offices. Moreover, as noted above, many patients seeking care at federally qualified health centers are able to receive further discounts because the centers typically set prices on a sliding fee scale, providing the greatest discounts to patients with the lowest incomes. We could not measure these price discounts in the audit.

Retail clinics are another potential source of primary care and have been shown to disproportionately care for underserved populations.²⁹ By design, our study focused on access to care in offices where patients could obtain ongoing primary care. However, for many services such as checkups, immunizations, and treatment of uncomplicated illnesses, patients may find that retail clinics provide a more affordable alternative to traditional care settings.

Retail clinics often accept walk-in patients and advertise prices in a set fee schedule that are typically lower than those charged in traditional provider offices. For instance, in 2014 a prominent retail clinic chain provided blood pressure screenings and counseling for \$65 and ongoing

Our study adds important context to understanding the ACA insurance expansions that are under way.

patient exams for \$79–\$122.³⁰ These prices fall below the averages in our study.

However, a physical exam at a retail clinic may not involve as detailed a clinical history and screening as those offered in many provider offices. Existing evidence indicates that traditional primary care offices and retail clinics provide acute episodic care of comparable quality.²⁹ Nonetheless, there is a need to understand whether retail clinics can provide ongoing care and become “medical homes” for the uninsured that are comparable to primary care offices.

Conclusion

Our study adds important context to understanding the ACA insurance expansions that are under way. Health insurance should reduce the out-of-pocket spending burden among the uninsured. Indeed, 2014 data show declines in the share of households experiencing unmet

need due to cost and problems paying medical bills.³¹

However, because twenty-two states had not expanded Medicaid as of early 2015,²⁴ the benefits of expanded coverage will not be spread to everyone. Adults who have incomes below 100 percent of poverty and who reside in states not expanding Medicaid are not likely to experience any immediate reduction in out-of-pocket spending: These adults have incomes too low to qualify for assistance in the Marketplaces.

Uninsured adults in all states who have incomes of 133–400 percent of poverty are now eligible for subsidized coverage in federal and state-based Marketplaces. Enrollment has been relatively strong through early 2015. However, the ultimate status of coverage expansion within this population will depend on a range of factors, including out-of-pocket expenses after subsidies, tax penalties for nonenrollment, and the continued availability of safety-net care.³²

On the provider side, an increase in the number of privately insured new patients could theoretically either raise or lower the price of care for the uninsured, depending on the rates that insurers offer physicians and other primary care providers to see insured patients and the decisions physicians make regarding their labor supply (such as the number of hours they work). The cross-sectional data in the current study did not allow us to infer how prices will change, but they do indicate that local market conditions are correlated with prices for the uninsured. Future studies are needed to better understand the determinants of prices faced by the uninsured, and how those prices may affect enrollment in coverage and population health outcomes. ■

Primary data collection for this study was supported by a grant from the Robert Wood Johnson Foundation (Grant No. 70160). Brendan Saloner acknowledges funding support from the Robert Wood Johnson Foundation Health and Society Scholars Program.

NOTES

- 1 Cohen RA, Martinez ME. Health insurance coverage: early release of estimates from the National Health Interview Survey, January–March 2014 [Internet]. Hyattsville (MD): National Center for Health Statistics; 2014 Sep [cited 2015 Mar 2]. Available from: <http://www.cdc.gov/nchs/data/nhis/early-release/insur201409.pdf>
- 2 Levy J. In U.S., uninsured rate sinks to 12.9%. Gallup [serial on the Internet]. 2015 Jan 2015 Jan 7 [cited 2015 Mar 2]. Available from: <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>

- 3 Long SK, Karpman M, Shartzter A, Wissoker D, Kenney GM, Zuckerman S, et al. Taking stock: health insurance coverage under the ACA as of September 2014 [Internet]. Washington (DC): Urban Institute; 2014 Dec 3 [cited 2015 Mar 2]. Available from: <http://hrms.urban.org/briefs/health-insurance-coverage-under-the-aca-as-of-september-2014.html>
- 4 Kenney GM, Huntress M, Buettgens

- M, Lynch V, Resnick D (Urban Institute, Washington, DC). State and local coverage changes under full implementation of the Affordable Care Act [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2013 Jul [cited 2015 Mar 2]. Available from: <https://kaiserfamilyfoundation.files.wordpress.com/2013/07/8443-state-and-local-coverage-changes-under-full-implementation.pdf>
- 5 McMorro S, Zuckerman S. Expanding federal funding to commu-

- nity health centers slows decline in access for low-income adults. *Health Serv Res.* 2014;49(3):992–1010.
- 6 Health Resources and Services Administration. The Affordable Care Act and health centers [Internet]. Rockville (MD): HRSA; [cited 2015 Mar 2]. Available from: <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>
 - 7 Cunningham PJ, Hadley J. Effects of changes in incomes and practice circumstances on physicians' decisions to treat charity and Medicaid patients. *Milbank Q.* 2008;86(1):91–123.
 - 8 Fairbrother G, Gusmano MK, Park HL, Scheinmann R. Care for the uninsured in general internists' private offices. *Health Aff (Millwood).* 2003;22(6):217–24.
 - 9 Gruber J, Rodriguez D. How much uncompensated care do doctors provide? *J Health Econ.* 2007;26(6):1151–69.
 - 10 Sloan FA. Effects of health insurance on physicians' fees. *J Hum Resour.* 1982;17(4):533–57.
 - 11 Rosenthal JA, Lu X, Cram P. Availability of consumer prices from US hospitals for a common surgical procedure. *JAMA Intern Med.* 2013;173(6):427–32.
 - 12 California HealthCare Foundation. Price check: the mystery of hospital pricing [Internet]. Oakland (CA): CHCF; 2005 Dec [cited 2015 Mar 3]. Available from: <http://www.chcf.org/publications/2005/12/price-check-the-mystery-of-hospital-pricing>
 - 13 Hsia RY, Kothari AH, Srebotnjak T, Maselli J. Health care as a “market good”? Appendicitis as a case study. *Arch Intern Med.* 2012;172(10):818–9.
 - 14 Ferrer RL. Pursuing equity: contact with primary care and specialist clinicians by demographics, insurance, and health status. *Ann Fam Med.* 2007;5(6):492–502.
 - 15 SK&A. Fact sheet: healthcare profiling data verified at the source daily [Internet]. Irvine (CA): SK&A; [last updated 2012 Mar 1; cited 2015 Mar 3]. Available from: http://www.skainfo.com/research_center-fact-sheet.pdf
 - 16 Saultz JW. Defining and measuring interpersonal continuity of care. *Ann Fam Med.* 2003;1(3):134–43.
 - 17 To access the Appendix, click on the Appendix link in the box to the right of the article online.
 - 18 Rhodes KV, Kenney GM, Friedman AB, Saloner B, Lawson C, Chearo D, et al. Primary care access for new patients on the eve of health care reform. *JAMA Intern Med.* 2014;174(6):861–9.
 - 19 Health Resources and Services Administration. Health center data [Internet]. Rockville (MD): HRSA; [cited 2015 Mar 3]. Available from: <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>
 - 20 American Hospital Association. AHA data viewer [Internet]. Washington (DC): AHA; [cited 2015 Mar 3]. Available from: <http://www.aha.org/dataviewer.com/>
 - 21 Medicare.gov. Physician Compare [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2015 Mar 3]. Available from: <http://www.medicare.gov/physiciancompare/search.html>
 - 22 GeoLytics. American Community Survey (ACS) data files [Internet]. Somerville (NJ): GeoLytics; [cited 2015 Mar 3]. Available from: <http://www.geolytics.com/USCensus,AmericanCommunitySurvey,Products.asp>
 - 23 Health Resources and Services Administration. Area Health Resources Files (AHRF): national, state, and county health resources information database [home page on the Internet]. Rockville (MD): HRSA; [cited 2015 Mar 3]. Available from: <http://ahrh.hrsa.gov/>
 - 24 Henry J. Kaiser Family Foundation. Status of state action on the Medicaid expansion decision [Internet]. Menlo Park (CA): KFF; 2015 Jan 27 Dec [cited 2015 Mar 3]. Available from: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>
 - 25 Danielson E. Health research data for the real world: the MarketScan databases [Internet]. Ann Arbor (MI): Truven Health Analytics; 2014 Jan [cited 2015 Mar 3]. (White Paper). Available from: http://truvenhealth.com/Portals/0/Users/031/31/31/PH_13434%200314_MarketScan_WP_web.pdf
 - 26 Bruen BK, Ku L, Lu X, Shin P. No evidence that primary care physicians offer less care to Medicaid, community health center, or uninsured patients. *Health Aff (Millwood).* 2013;32(9):1624–30.
 - 27 Henry J. Kaiser Family Foundation. Distribution of the nonelderly uninsured by federal poverty level (FPL) [Internet]. Menlo Park (CA): KFF; 2013 [cited 2015 Mar 3]. Available from: <http://kff.org/uninsured/state-indicator/distribution-by-fpl-2/>
 - 28 Kaiser Commission on Medicaid and the Uninsured. The uninsured and the difference health insurance makes [Internet]. Washington (DC): The Commission; 2012 Sep 1 [cited 2015 Mar 3]. Available from: <http://kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>
 - 29 Mehrotra A, Wang MC, Lave JR, Adams JL, McGlynn EA. Retail clinics, primary care physicians, and emergency departments: a comparison of patients' visits. *Health Aff (Millwood).* 2008;27(5):1272–82.
 - 30 Walgreens. Price menu [Internet]. Deerfield (IL); 2014 [cited 2015 Mar 3]. Available from: <http://www.walgreens.com/topic/health-care-clinic/price-menu.jsp>
 - 31 Collins SR, Rasmussen PW, Doty MM, Beutel S. The rise in health care coverage and affordability since health reform took effect [Internet]. New York (NY): Commonwealth Fund; 2015 Jan [cited 2015 Mar 3]. (Issue Brief). Available from: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf
 - 32 Herring B. The effect of the availability of charity care to the uninsured on the demand for private health insurance. *J Health Econ.* 2005;24(2):225–52.