Medicaid Expansion Causes Surge In ER Visits

Brian BlaseContributor
The Apothecary
Contributor Group
Policy
I was a Special Assistant to the President at the White House's National Economic Council from 2017-2019. I now head Blase Policy Strategies.

Most health care experts agree that the emergency room is a poor place to receive non-emergency care. It's extremely expensive and ER providers do not specialize in treating routine health issues. ER crowding can also produce problems for people with true health emergencies. One of the main selling points for the Affordable Care Act (ACA) was that it would produce cost savings since newly insured people would secure a usual place of care and reduce their use of ERs.

On March 3, 2010, a few weeks before the ACA passed Congress, President Obama said, "taxpayers currently end up subsidizing the uninsured when they're forced to go to the emergency room for care…. You can't get … savings if those people are still going to the emergency room." A few months after passage of the law, then-Speaker of the House of Representatives Nancy Pelosi said, "the uninsured will get coverage, no longer left to the emergency room for medical care."

A new study released yesterday in the New England Journal of Medicine suggests that the assumption that the ACA would lead to lower ER use was wrong as Medicaid expansion in Oregon produced a spike in ER visits. A surge in ER use will likely produce adverse health consequences for many and may be contributing to skyrocketing Medicaid expansion spending, which was 49% higher per enrollee in 2015 than the government expected.

Medicaid Expansion Increased Emergency Room Visits

The new study resulted from the Oregon Medicaid experiment, in which Oregon expanded Medicaid to a limited number of lower income non-disabled adults using a lottery. The expansion's design, which involved random assignment, allowed researchers to draw more reliable conclusions about the impact of Medicaid eligibility than observational studies. Here is the way the authors describe their central findings:

> Medicaid coverage resulted in significantly more outpatient visits, hospitalizations, prescription medications, and emergency department visits. Coverage significantly lowered medical debt, and virtually eliminated the likelihood of having a catastrophic medical expenditure. Medicaid substantially reduced the prevalence of depression, but had no statistically significant effects on blood pressure, cholesterol, or cardiovascular risk.

Of crucial importance, the study also found that "[a]cross a variety of alternative specifications, we consistently find that Medicaid's value to recipients is lower than the government's costs of the program, and usually substantially below." They estimated the "benefit to recipients from Medicaid per dollar of government spending range from about $.2 to $.4."

The new study provides additional evidence on the impact of Medicaid coverage on ER use. This study was conducted, in part, because many observers speculated that the increase in ER use would decline over time as the newly insured found alternative sources of care or their needs were addressed and their health improved. This speculation was wrong.

According to the authors' findings:

- Medicaid increased ER visits by 40% in the first 15 months.
- There is no evidence that the increase in ER use is driven by pent-up demand that dissipates over time; instead, the effect of Medicaid on ER use persists over at least the first 2 years of coverage.
- There is no evidence that Medicaid coverage makes use of the physician's office and use of ERs substitutes for one another.

Increased ER Visits Has Adverse Health Outcomes

When a person uses the ER for non-emergency care, at least two problems result. First, the person doing this is receiving care in an extremely inefficient setting—the costs are much higher and the providers have not specialized in treatment of non-emergency health care services. Second, the person is contributing to crowding in the ER, which can affect the access to care of other people, including those experiencing genuine health emergencies.

A 2014 study that reviewed 11 previous studies concluded that ER crowding "is a major patient safety concern associated with poor patient outcomes." Of the 11 studies reviewed, three found a significant positive relationship between ER crowding and mortality either among patients admitted to the hospital or discharged home, and five found that crowding was associated with higher rates of patients leaving the ER without being seen.

These conclusions were consistent with a 2009 study on the same topic. The authors reviewed 41 previous studies, concluding that ER crowding "is associated with an increased risk of in-hospital mortality, longer times to treatment for patients with pneumonia or acute pain, and a higher probability of leaving the ER against medical advice or without being seen."

ACA Medicaid Expansion Much More Expensive Than Projected

The government's most recent Medicaid Actuarial Report contained the striking finding that government spending on Medicaid expansion enrollees was roughly $6,366 per enrollee in fiscal year 2015, 49% higher than the predicted amount of $4,281. In July, I wrote that the much

higher-than-expected spending was largely the result of the federal government's 100% reimbursement of state spending on expansion enrollees.

While the government forecasters failed to anticipate how states would respond to the 100% federal reimbursement, states had an incentive to pay insurance companies very high payment rates for the expansion population. High payment rates make insurers and hospitals happy, and the cost is dispersed to federal taxpayers. Based on the new Oregon study, Medicaid expansion enrollees' high use of ERs—potentially because of an inability to find physicians accepting new Medicaid enrollees—is likely a contributing factor to the large Medicaid expansion cost overrun.

Another Reason Against Medicaid Expansion

The Oregon Medicaid experiment continues to produce substantial evidence that Medicaid expansion is a poor use of taxpayer dollars. From the Oregon Medicaid experiment, we know that Medicaid expansion does not seem to produce better physical health outcomes, that expansion enrollees receive low benefit relative to the cost, and that ER use surges. Since a spike in ER use likely produces adverse outcomes for other people with emergency health needs, this secondary effect also needs to be part of state lawmakers' decisions as they weigh the wisdom of either adopting or reversing Medicaid expansion.

Brian Blase

I was a Special Assistant to the President at the White House's National Economic Council from 2017-2019. In that capacity, I advised key policymakers including the president, I developed administrative priorities, policies, and strategies, and I coordinated the development and finalization of several key regulatory changes, including rules to expand Association Health Plans, short-term plans, and health reimbursement arrangements. I now head Blase Policy Strategies, a research and consulting firm focused on market-based health care solutions. I am a senior research fellow with the Galen Institute, the Texas Public Policy Foundation, and the Foundation for Government Accountability. From 2011-2015, I worked on Capitol Hill, serving first as a senior professional staff member for the House Committee on Oversight and Government Reform and then as the health policy analyst for the Senate Republican Policy Committee. I have also worked at the Mercatus Center and the Heritage Foundation. I have a PhD in Economics from George Mason University, completing a dissertation on Medicaid financing.