

Healthcare Reform and Medicaid: Patient Access, Emergency Department Use, and Financial Implications for States and Hospitals

By Douglas Holtz-Eakin* & Michael Ramlet

Executive Summary

The Patient Protection and Affordable Care Act expands insurance coverage in the United States. Importantly, the Obama reform's coverage expansions are built around a strategy of expanding Medicaid. These expansions are problematic in a variety of ways. They are likely to dramatically expand the use of emergency room care, as Medicaid's low reimbursement rates limit beneficiaries' access to primary care physicians. In doing so, they will expand – not reduce – the overall economic cost of the U.S. health care system. We estimate that the emergency department impacts alone will generate 68 million visits and add \$36 billion to the nation's healthcare bill. These additional costs will pose a financial threat to state budgets and hospital finances, especially as the reform also reduces funding dedicated to reimbursing hospitals for uncompensated care.

*Douglas Holtz-Eakin is President and Michael Ramlet is Coordinator, Operation Healthcare Choice at the American Action Forum.

Introduction

Insurance coverage expansion is the centerpiece of the Obama Administration’s healthcare reform law. It is less widely recognized, however, that one-half of the thirty-two million Americans expected to gain insurance by 2019 will be covered under an unprecedented expansion of state-administered Medicaid programs.¹ Medicaid expansion is vital to achieving the Obama Administration’s goals for universal coverage. Thus, its budgetary impact and effect on patient access are central to any discussion of the merits of the Patient Protection and Affordable Care Act. This paper is devoted to evaluating the policy implications of expanding insurance coverage through state Medicaid Programs. We begin by reviewing the current state of patient access for Medicaid enrollees. After our current state analysis, we model the likely economic impact of the Medicaid expansion for states, hospitals, and physicians.

Exhibit 1: Projected Medicaid Enrollment (Millions) and Net Federal Budget Impact

| Year | Before | PPACA | Net | Impact |
|--------------|--------|-------|-----|----------------|
| 2010 | 40 | 40 | 0 | \$0 B |
| 2011 | 39 | 38 | -1 | (\$1) B |
| 2012 | 39 | 37 | -2 | (\$2) B |
| 2013 | 38 | 35 | -3 | (\$4) B |
| 2014 | 35 | 45 | 10 | \$29 B |
| 2015 | 34 | 49 | 15 | \$56 B |
| 2016 | 35 | 52 | 17 | \$81 B |
| 2017 | 35 | 51 | 16 | \$87 B |
| 2018 | 35 | 51 | 16 | \$91 B |
| 2019 | 35 | 51 | 16 | \$97 B |
| Total | | | | \$434 B |

Source: Congressional Budget Office Cost Estimate to Speaker Pelosi, U.S. House of Representatives, 2010 Mar 20.

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) requires states to cover individuals with incomes not exceeding 133

percent of the federal poverty level (FPL) who are under age 65, not pregnant, not entitled to Medicare, and not otherwise eligible for Medicaid.²

As with the insurance benefits offered through the forthcoming state insurance exchanges, Medicaid will be subject to new benefit mandates. New federal benefit requirements for state Medicaid programs include offering coverage for prescription drugs and mental health services.

The Congressional Budget Office (CBO) estimates that PPACA’s Medicaid expansion is likely to cost the federal government \$434 billion over the next decade, accounting for more than 40 percent of the healthcare law’s total expenditures. In addition to increasing the federal deficit, the expansion of state Medicaid programs will have a direct impact on state budgets, healthcare provider budgets, and patients’ ability to access care. We turn now to those aspects of the expansion.

Exacerbating the Patient Access Problem

Current State of Medicaid Enrollee Access to Care

America faces a primary care crisis. In a widely cited survey by the Commonwealth Fund, only 27 percent of adults could easily contact their physician over the telephone; obtain care or medical advice after hours, and experience timely office visits.³ Unable to access routine medical care, Americans increasingly turn to the most expensive care delivery setting—the emergency room.

In August of 2010, the Department of Health and Human Services reported that the number of emergency department visits in the U.S. had increased by 23 percent for the most recent

¹ Cost estimate from the Congressional Budget Office to Speaker Nancy Pelosi, U.S. House of Representatives, 2010 Mar 20.

² Section 2001 of the Patient Protection and Affordable Care Act (P.L. 11-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

³ Beal A, Dotty M, Hernandez S, Shea k, Davis K. Closing the divide: how medical homes promote equity in healthcare. New York (NY): Commonwealth Fund; 2007.

reported decade, topping off at 177 million visits in 2007.⁴

Nowhere is this costly problem more acute than among Medicaid enrollees. The National Hospital Ambulatory Medical Care Survey revealed that Medicaid enrollees access care through the emergency room at twice the rate of the uninsured and privately covered populations. In part, greater emergency room use among Medicaid patients reflects low reimbursement rates in the state programs. In 2008, Medicaid reimbursements averaged only 72 percent of the rates paid by Medicare, which are in turn below the rates paid by private insurers.⁵

| Exhibit 2: ER Visits (Millions) By Payer Type | | | |
|--|----------------|-----------------|------------------|
| | <u>Private</u> | <u>Medicaid</u> | <u>Uninsured</u> |
| Covered Population (M) ^a | 174.1 | 36.2 | 43.3 |
| Total ER Visits (M) ^b | 45.580 | 29.379 | 17.926 |
| ER Visits Per Person | 0.3 | 0.8 | 0.4 |
| Percentage of Annual U.S. ER Visits ^b | 39.0% | 25.2% | 15.3% |

Source: National Health Statistics Reports - U.S. Department of Health and Human Services
 a. Health Insurance Coverage Trends, 1959 - 2007; NHSR #17; July 2009
 b. National Hospital Ambulatory Medical Care Survey, 2007; NHSR #26; August 2010

Primary care physicians in many states have simply stopped seeing Medicaid enrollees. In August, Texas doctors threatened to drop Medicaid in the face of even steeper reimbursement reductions.⁶ The cost of limited access to primary care is especially apparent in Massachusetts; ironically the state model for the Obama Administration’s healthcare coverage expansion. Medicaid patients from July 2007 through March 2008 visited the emergency room at a rate more than three times that of privately insured patients.

The Obama Administration’s decision to push insurance coverage through a major expansion of Medicaid ensures a greater number of emergency room visits. What remains open to investigation is the exact rate at which patients will access care in the most costly care setting. In addition, as patients grapple with even more crowded emergency rooms, what will be the negative impact on their access to life-saving care in a real emergency?

Healthcare Reform’s Impact on Patient Access - And At What Cost?

Few physicians expect the Patient Protection and Affordable Care act to improve patient access or reduce the over utilization of the emergency room. In a recent survey of 1,800 emergency room physicians, 71 percent of respondents expect emergency visits to increase, and nearly half (47 percent) anticipate that conditions will worsen for patients.⁷ This sentiment is supported by historical utilization rates and the Congressional Budget Office Medicaid enrollment projections.

Beginning in 2014 with the mandated expansion of Medicaid eligibility, the historical rates of emergency department utilization indicate that policymakers should expect a substantial increase in annual emergency room visits. In the next decade, hospital administrators and emergency room physicians can expect to see 68.1 million more Medicaid patients in emergency departments as a direct result of the Obama reform.

Treating patients in the most costly care setting will raise, not lower, national health expenditures. In 2005, the RAND Institute conducted an economic investigation of care delivery in the emergency room. RAND found that in most instances, the costs are underreported with the

⁴ Niska R, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary. National health statistics reports; no 26. Hyattsville, MD: National Center for Health Statistics. 2010.

⁵ Zuckerman S, Williams A, Stockley K. Trends in Medicaid Physician Fees, 2003-2008. Health Affairs, 28, no.3 (2009).

⁶ Garret R. Texas doctors threaten to drop Medicaid out of fear of more fee cuts. The Dallas Morning News.

⁷ ER Docs Predict Jump in Emergency Room Visits. US News and World Report. 17 May 2010.

implication that emergency room visits have an even higher impact on healthcare expenditures than was previously believed.

Using RAND’s estimate of the economic cost for each emergency room visit, Exhibit 3 shows the total projected economic cost of the Obama Administration’s Medicaid expansion. The economic cost estimate includes overhead costs booked to the emergency department as well ancillary services used by patients and the administrative cost of retaining emergency room physicians. In 2010 dollars, the weighted economic cost of visiting the emergency room is about \$525 per visit. In 2016, the estimated 42.2 million Medicaid visits to the emergency room will have an economic cost of \$22.2 billion.

Exhibit 3: Projected Medicaid ER Visits (Millions) and Net Emergency Room (ER) Costs Under PPACA

| Year | Before | PPACA | Net | ER Costs |
|--------------|----------------|----------------|---------------|-----------------|
| 2010 | 32.463 | 32.463 | 0.00 | \$0.0 B |
| 2011 | 31.651 | 30.840 | -0.81 | (\$0.4) B |
| 2012 | 31.651 | 30.028 | -1.62 | (\$0.9) B |
| 2013 | 30.840 | 28.405 | -2.44 | (\$1.3) B |
| 2014 | 28.405 | 36.521 | 8.12 | \$4.3 B |
| 2015 | 27.594 | 39.767 | 12.17 | \$6.4 B |
| 2016 | 28.405 | 42.202 | 13.80 | \$7.2 B |
| 2017 | 28.405 | 41.390 | 12.99 | \$6.8 B |
| 2018 | 28.405 | 41.390 | 12.99 | \$6.8 B |
| 2019 | 28.405 | 41.390 | 12.99 | \$6.8 B |
| Total | 296.224 | 364.396 | 68.172 | \$35.8 B |

Sources: Authors Calculations; Bamezai A, Melnick G, Nawathe A. The Cost of an Emergency Department Visit and Its Relationship to Emergency Annals of Emergency Department Volume. Annals of Emergency Medicine. Volume 45, Issue 5, May 2005, Pages 483-490.

By 2019, the increased overutilization of the America’s emergency departments stemming from the Obama reform will increase national healthcare expenditures by \$35.8 billion compared to prior law. These costs will pose a real threat to bankrupt states, hospitals, and physicians.

The Threat to States from an Underfunded Mandate

Expanding national insurance coverage through state Medicaid programs may have served to limit the apparent federal budget cost, but it comes at a precarious time for state budgets. Prior to the President signing a \$26 billion emergency relief package earlier this month, forty-six states faced budget shortfalls that add up to \$112 billion for the fiscal year ending in June 2011.⁸

The Patient Protection and Affordable Care Act’s \$434 billion dollar commitment to expanding state Medicaid programs is best viewed as a partial payment on the full cost of expansion. State budgets will be exposed to the remainder of the full costs, including costs from increased emergency room utilization.

States are just beginning to learn of the healthcare reform law’s hidden costs as they conduct independent studies to determine the implementation steps need to meet the 2014 Medicaid and insurance exchange mandates. For example, Nebraska Governor Dave Heineman was confronted with the stark budget realization that the reform is likely to cost his state between \$526 million and \$766 million. This a \$400 million discrepancy from initial analyses conducted by PPACA supporters.⁹ Facing historic budget deficits, the underfunded healthcare reform mandates will force states to make difficult decisions like cutting funds to education programs or safety net healthcare institutions. More than a fifth of the nation’s hospitals are owned by state and local governments, which could further squeeze patient access for Medicaid enrollees.

⁸ Robinson E. States of Crisis for 46 Governments Facing Greek-Style Deficits. Bloomberg News. 25 June 2010.

⁹ Lillis M. Nebraska governor says health reform a threat to state education funding. The Hill. 30 August 2010.

Hospitals: An Ominous Financial Storm?

Coinciding with the expansion of state Medicaid programs are aggregate reductions in the disproportionate share hospital (DSH) payments to states for 2014 through 2020. The aggregate reductions total \$500 million for FY 2014, \$600 million each for 2015 and 2016, \$1.8 billion for 2017, \$5 billion for 2018, \$5.6 billion for FY 2019, and \$4 billion.

In effect, just as hospital emergency rooms begin to swell with Medicaid enrollees, the federal government will be cutting a program dedicated to compensating hospitals for Medicaid's underpayments. This is coupled with \$156.6 billion in Medicare reductions over the next decade. Hospitals will need carefully review how their emergency departments treat Medicaid enrollees or financial peril at the hands of overcrowded emergency departments.

Physician Incentives: Doctors Offset Emergency Room Dependency?

The Patient Protection and Affordable Care Act requires states to pay physicians for primary care services furnished in 2013 and 2014 at a rate that is no less than 100 percent of the Medicare payment rate, thus raising the tantalizing prospect that fewer Medicaid beneficiaries might rely on

emergency departments in the future.

Unfortunately, this provision is both temporary and expected to have limited improvement on Medicaid enrollee access to primary care. A May 2010 poll of primary care physicians found that just 10 percent of respondents believed new Medicaid enrollees in their area would be able to find a suitable primary care doctors. In contrast, 67 percent of primary care physicians believed new Medicaid enrollees would be unable to gain physician access.¹⁰

Conclusion

The Obama reform's coverage expansions are built around a strategy of expanding Medicaid. These expansions are problematic in a variety of ways. They are likely to dramatically expand the use of emergency room care, as Medicaid's low reimbursement rates limit beneficiaries' access to primary care physicians. In doing so, they will expand – not reduce – the overall economic cost of the U.S. health care system. We estimate that the emergency department impacts alone will generate 68 million visits and add \$36 billion to the nation's healthcare bill. These additional costs will pose a financial threat to state budgets and hospital finances, especially as the reform also reduces funding dedicated to reimbursing hospitals for uncompensated care.

¹⁰ Trapp D. New Medicaid patients will lack access, most doctors say. American Medical News. 3 May 2010.

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