

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

Emergency Room Visits, Primary Care Access, Hospital Finances and Health  
Outcomes under Medicaid Expansion

A graduate project submitted in partial fulfillment of the requirements  
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By

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## Table of Contents

Signature Page	ii
Abstract	iv
Introduction	1
Literature Review	2
Medicaid and Emergency Room visits	2
Access to Primary Care	5
Medicaid's effect on U.S. Hospital Finances	9
Health related outcomes by Medicaid enrollment	10
Methodology	18
Findings/Analysis	19
Increase in Emergency Department visits	19
Primary care shortage	19
Health disparities	19
Policy Implications	20
Conclusion	22
References	24

## Abstract

### Emergency Room visits, Primary Care Access, Hospital Finances and Health Outcomes under Medicaid Expansion

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The Medicaid Expansion of 2010 under the Affordable Care Act had hoped to improve health care access and improve quality. Since its passage, emergency rooms continue being overcrowded by new Medicaid enrollees. This has created a change in hospital payer mix, which has affected hospital finances (Nikpay et al, 2014). Emergency rooms continue to provide acute care for twenty eight percent of the population (McClelland et al, 2014). The shortage of primary care doctors and locations has further fueled the overcrowding of the ER. A health disparity gap will continue to grow among expansion and non-expansion states as the previously uninsured population start to receive better access to care (Nikpay et al, 2014). As the effects of Medicaid expansion vary from state to state, some state policymakers are using research data to address these issues. This literature review will provide an overview of the findings discovered by empirical research.

## **Introduction**

When former President Barack Obama signed into law the Affordable Care Act (ACA) in 2010, many policymakers saw an opportunity to finally achieve Universal Health Insurance coverage in the U.S. while increasing the quality and affordability of healthcare (Lee & Zhang, 2016). The ACA contains three key mandates: 1. Individual/employer and dependent coverage. 2. Insurance premium subsidy. 3. Medicaid expansion.

Medicaid is the largest provider of health insurance for children and adults in the United States. It provides major financial support to the nation's clinics, hospitals and long-term facilities that serve the poor and uninsured (Lee & Zhang, 2016). Recent data shows that seventy-five million children and more than sixty percent of residents in nursing homes depend on Medicaid to receive health care services (Lee & Zhang, 2016). Currently, federal regulations require states to provide Medicaid coverage for children younger than 6 years of age with a family income of up to 138 percent of the federal poverty level and children ages 6 to 18 years old with a family income at or less than 100 percent of the federal poverty level (Lee & Zhang, 2016). States must also offer Medicaid coverage to pregnant women, vulnerable or disabled adults and low-income elderly persons.

Supporters of the ACA and the expansion of Medicaid had long argued that by insuring this segment of the U.S population, several improvements would be made to the U.S healthcare system. Chief among them were the reduction of emergency room visits, which would give the newly insured more access to other healthcare settings, improve hospital finances, and improve health outcomes among low income households. This literature review will examine if the expansion of Medicaid has helped address these issues.

## Literature Review

### Emergency Room visits:

In a difference-in-differences design study done by Nikpay, Freedman, Levy & Buchmueller, (2017), comparisons were done to illustrate the change between the pre- and post-expansion periods between states that did and did not expand Medicaid in 2014. This particular analysis included 14 expansion states and 11 non-expansion states. The study design assumes that preexisting trends in emergency room use were similar in expansion and non-expansion states, allowing non-expansion states to serve as a control group for what has normally occurred in expansion states. The goal of this study was to determine whether changes in Medicaid eligibility after 2014 were associated with changes in ED use and payer mix. The study compared the changes in total ED visits and the share of ED visits by payer types directly affected by the ACA between states that did and did not expand Medicaid in 2014 (Nikpay et al, 2017). The data collected in this article came from Fast Stats database, an early release version of the State Emergency Department Databases and State Inpatient Databases. These databases are state run and compiled by the Agency for Healthcare Research and Quality (AHRQ), which are available to the general public. The Fast Stats data includes emergency room visits that did and did not end in an admission to the hospital. Data from Fast Stats provides information from four patient categories; Medicare (patients over 65 years old), Medicaid (for patients 19 to 64 years), private insurance (for patients 19 to 64 years) and the uninsured (for patients 19 to 64 years). See Figure 1.

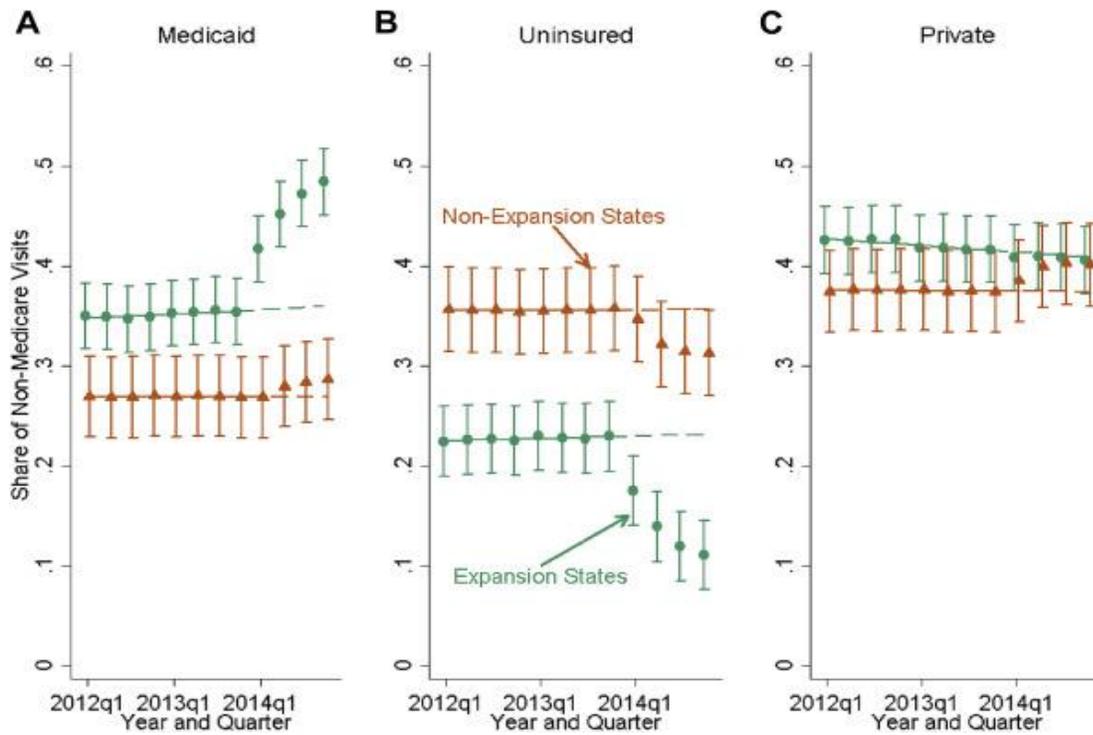


Figure 1. ED payer mix by 2014 Medicaid expansion status. Source: AHRQ Fast Stats ED data. The figure plots the mean seasonality-adjusted share of all non-Medicare ED visits covered by Medicaid (A), with no source of coverage (B), and covered by private insurance (C), along with 95% CIs. Data are weighted by state population in 2014. The dashed vertical line represents the first quarter of the ACA’s Medicaid expansion, Q1. 2014 Expansion states include Arizona, California, Hawaii, Iowa, Illinois, Kentucky, Maryland, Minnesota, North Dakota, New Jersey, Nevada, New York, Rhode Island, and Vermont, and non-expansion states include Florida, Georgia, Indiana, Kansas, Missouri, North Carolina, Nebraska, South Carolina, South Dakota, Tennessee, and Wisconsin.

The article found that total ED use per 1,000 population increased by 2.5 visits more in Medicaid expansion states than in non-expansion states after 2014. Among the visit types that could be measured, increases in ED visits were largest for injury-related visits and for states with the largest changes in Medicaid enrollment. Compared with non-expansion states, the share of ED visits covered by Medicaid in expansion states increased by 8.8 percentage points, whereas the uninsured share decreased by 5.3 percentage points (Nikpay et al, 2016). The study found that Medicaid expansion increased ED visits and shifted hospital payer mix away from uninsured patients toward mostly Medicaid enrollees in 2014.

In an article by authors McClelland, Asplin, Epstein et al, (2015), they discuss the Massachusetts state expansion and how their increase of Emergency Department visits was comparable to other neighboring states. The article further adds that emergency room use was higher among the newly insured population compared with the continuously insured (McClelland, 2014).

Two key takeaways from this peer-reviewed article suggest that the effect on emergency room visits depends on several factors:

1. The type of coverage the patient possesses increases the use of emergency room due to little cost sharing associated with emergency room use and Medicaid.
2. Patients whom acquired state marketplace coverage use the emergency room less because many marketplace plans have large deductibles and cost-sharing requirements. (McClelland et al, 2014).

Similar results showing an increase in Emergency Room visits was detailed in an article by Beck, (2014). In this article, the author details that Medicaid increased the annual Emergency Room spending by \$120 per covered individual, thus confirming to critics of the health care

overhaul that Medicaid expansion costs more, not less. The author cites the Oregon experiment, which extended coverage to some 10,000 low income residents, as an example of Medicaid enrollees crowding emergency rooms (Beck, 2014). Again, as in the other articles, there is mention of individuals substituting the physician's office for the Emergency Room. The author does note that researchers in Oregon had developed programs intended to change the patterns of ER use (Beck, 2014).

#### Access to Primary Care:

Addressing the need to shift healthcare needs from the Emergency Room to the primary care setting is a topic that was covered by Bhuyan et al,(2016). This article touches on the topic of how the United States is suffering from a shortage and a limited distribution of primary care providers. Even though the expansion of Medicaid gave new enrollees access to health care, not all primary care providers are accepting Medicaid patients due to the low reimbursements by Medicaid. Consequently, these new enrollees end up using the emergency room as a regular source of health care, further straining the system. The article further adds that more than half of the U.S states do not allow non-clinician providers like Nurse Practitioners to practice medicine without physician supervision (Saha et al., 2016). For those states that allow Nurse Practitioners and Physician Assistants to practice, a new trend has developed during the last couple of years according to the article. The emergence of ambulatory care facilities, referred to as retail clinics, have managed to provide convenient, low-cost, and accessible primary care. These retail clinics are mainly staffed by Nurse Practitioners and Physician Assistants. They help serve a population that is badly underserved,

but unfortunately, these retail clinics make up about 2 percent of all U.S. primary care visits (Baha et al, 2016).

Research performed and authored by Winkelman and Chang, (2017), details a study that examines the association between Medicaid expansion and changes in mental health, physical health, and access to care among low-income childless adults with and without chronic conditions. The study's design was a difference-in-differences analytical framework to assess differential changes in self-reported health outcomes and access to care. Participants in this study were childless adults, aged 18–64, with incomes below 138% of the federal poverty level in expansion ( $n = 69,620$ ) and non-expansion states ( $n = 57,628$ ).

Some of the key health measures studied were self-reported general health; total days in past month with poor health, poor mental health, poor physical health, or health-related activity restrictions; disability; depression; insurance coverage; cost-related barriers; annual check-up; and if the patient had a personal doctor (Winkelman & Chang, 2017). The article mentions that data were taken from the 2011–2015 Behavioral Risk Factor Surveillance System (BRFSS), a nationally representative cross-sectional telephone survey of US adults aged 18 and older. Of note, the BRFSS is conducted by state health departments in partnership with the Centers for Disease Control and Prevention (CDC) which aims to provide state-level data on health-related risk behaviors and chronic health conditions. The group sample provided three years of data prior to implementation of Medicaid expansion and two years of follow-up data for most expansion states. Of note, an individual was determined to have a chronic condition if they reported ever being told by a health care provider that they had coronary heart disease (heart attack, angina, or coronary heart disease), stroke, asthma, chronic obstructive pulmonary disease, chronic kidney disease, cancer excluding skin cancer, arthritis, or diabetes

(Winkelman & Chang, 2017). The study in this article evaluated several measures of health care access. Ultimately, after adjusted analysis, the data found that Medicaid expansion was associated with improvement in all calculated measures of health care access among adults without a chronic condition. Medicaid expansion among this group was associated with significant changes in coverage, cost-related barriers to care, check-ups in the last year, and reporting a personal doctor (Winkelman & Chang, 2017).

**Table 1**

Baseline Demographic Characteristics of Study Population, 2011–2013

Characteristic	Unweighted no. (weighted %)					
	Adults with chronic conditions		P value	Adults without chronic conditions		P value
	Medicaid expansion	Non-Medicaid expansion		Medicaid expansion	Non-Medicaid expansion	
Unweighted no.	27,755	24,759	N/A	18,179	14,095	N/A
Female	17,277 (53.0)	15,796 (53.7)	0.49	8564 (41.0)	6992 (41.3)	0.744
Age, years			<0.001			0.003
18–24	925 (8.3)	654 (6.6)		4082 (35.9)	3032 (32.3)	
25–34	1100 (8.5)	852 (6.6)		2665 (20.6)	1940 (20.2)	
35–44	2144 (10.7)	1820 (11.5)		2030 (12.1)	1564 (13.0)	
45–54	8729 (32.2)	7800 (34.1)		4337 (17.2)	3526 (19.5)	
55–64	14,857 (40.4)	13,633 (41.3)		5065 (14.2)	4033 (14.9)	
Race			<0.001	<0.001		
White, non-Hispanic	18,827 (57.3)	16,245 (57.5)		11,139 (48.4)	8982 (49.8)	
Black, non-Hispanic	3343 (15.2)	5261 (24.4)		2116 (14.1)	2745 (23.9)	
Hispanic	3018 (18.8)	1233 (12.4)		2761 (24.9)	1321 (20.5)	
Other	2567 (8.7)	2020 (5.8)		2163 (12.7)	1047 (5.9)	
Education			<0.001	0.038		
Less than high school	5476 (30.8)	5651 (33.3)		2441 (21.6)	2144 (23.4)	
High school or GED	10,862 (34.1)	10,002 (35.5)		6636 (33.6)	5461 (34.8)	
Some college or more	11,417 (35.1)	9106 (31.2)		9102 (44.8)	6490 (41.9)	
Married	5750 (23.1)	5802 (26.7)	<0.001	3422 (16.0)	2867 (17.2)	0.146
Mean state unemployment rate (%)	8.59 (8.56–8.62)	7.79 (7.76–7.83)	<0.001	8.81 (8.77–8.85)	7.73 (7.68–7.77)	<0.001

### Effects of Medicaid Expansion on U.S. Hospital Finances:

Uncompensated care has always been a hot topic for most hospitals. With the passage of the ACA, hospitals saw reduced payments from Medicare and Medicaid. There was new concern that the ACA would also have a negative impact on urban hospitals that care for a large portion of uninsured, low-income patients (Rosenberg, 2014). In the article by Rosenberg (2014), the author mentions that some hospitals have seen a decline in uninsured patients through the expansion of Medicaid, which has resulted in an increase in revenue for hospitals. In 2013, uncompensated care costs were an estimated \$85 billion, of which, 65% of those costs were offset by government payments (Rosenberg, 2014). The article further details the benefits to Medicaid expansion by highlighting a particular hospital in Seattle, Washington. This hospital saw the number of uninsured patients fall from 12 percent in 2013 to 2 percent in 2014. The hospital's revenue increased by \$20 million that particular year. Other urban hospitals, both safety-net hospitals and investor-owned facilities, reported a similar decrease in uninsured patients (Rosenberg, 2014).

In another study to assess hospital finances between hospitals in states that expanded Medicaid and those that did not, Blavin, (2014), chose to perform an observational study with analysis of data for non-federal general medical or surgical hospitals for fiscal years 2011 through 2014. The study used multi-variable difference-in-difference regression analyses to compare states with Medicaid expansion with states without Medicaid expansion (Blavin, 2014). The sample group included between 1200 and 1400 hospitals per fiscal year in 19 states with Medicaid expansion and between 2200 and 2400 per fiscal year in 25 states without Medicaid expansion. The results showed an increase in Medicaid revenue, decreased uncompensated care costs, and improvements in profit margins compared with hospitals

located in the 25 states that did not expand Medicaid. Also, Medicaid expansion was also linked to improved excess margins but not improved operating margins (Blavin, 2014). Hospital operating margins (defined in percentages) are defined as a profitability indicator showing the income gathered from patient care operations. This measures the extent to which organization is using its financial and physical assets to generate a profit (hfma.org, 2019). Excess margins (defined in percentages) include all sources of income and expenses, other than patient care operations (hfma.org, 2019). The author does note several limitations such as missing values and errors in reporting information for certain measures. The article concludes that future research assessing the impact of Medicaid expansion over a longer time frame is warranted.

#### Health related outcomes by Medicaid enrollment:

An article by Winkelman, Segel and Davis, (2018); examines the impact of Medicaid enrollment on health care costs, utilization, access to care, and general health outcomes among previously uninsured racial/ethnic population. Between 2000 and 2017, the number of Medicaid enrollees increased from 35 million to over 74 million. This, along with expansion in some states and not others, created a natural experiment to perform a population-level impact study of Medicaid. The study used data from 2008-2014 Medical Expenditure Panel Survey (MEPS). The Medical Expenditure Panel Survey is a nationally representative survey that compiles demographic, health insurance, health care costs, utilization, access and self-reported health data. Respondents are surveyed five times over a period of 2 years. The study consisted of two groups: (a) those who remained uninsured throughout the 2-year study period and (b) those who gained Medicaid after a period of no insurance (Winkelman et al, 2018). Multivariable linear regression was used to conduct subgroup analyses by age, sex,

race/ethnicity, marital status, education, region, family size and income. In total, the sample included 10,747 individuals, which included 963 Medicaid gainers of insurance and 9784 individuals who remained uninsured in both years of the MEPS. Health care costs, utilization and access were examined as outcome measures.

Health care costs:

This included total health care costs, total out-of-pocket costs for individuals and out-of-pocket prescription drug costs. Each cost measure was adjusted to 2014 dollars by using the Medical Component of the Consumer Price Index. The study showed both Medicaid “gainers” and the uninsured experienced significant increases in **total costs**. An increase of over \$1700 for Medicaid gainers compared to an increase of just over \$100 for the uninsured. The uninsured saw small increases in out-of-pocket costs but those gaining Medicaid experienced a decrease of \$219 in total **out-of-pocket costs** and a decrease of \$142 in total **prescription drug out-of-pocket costs** (Winkelman et al, 2018).

Health care utilization:

Obtained through medical provider records, health care utilization measured emergency room visits, total number of emergency room visits per person, inpatient visits, total number of inpatient visits per person, prescription drug fills and total number of prescription drug fills per person. The data revealed no significant changes in emergency room and inpatient visits among individuals who gained Medicaid compared to those who remained uninsured. Medicaid gainers saw a 10.7 percentage point increase in prescription drug fills while the uninsured saw a decrease of 1.6 percentage points (Winkelman et al, 2018).

Health care access:

Health measures in this survey study assessed issues such as foregone medical care (i.e., “unable to get medical care, tests, or treatments a respondent or a doctor believed to be necessary”), delayed medical care (i.e., “delayed medical care, tests, or treatments a respondent or a doctor believed to be necessary”), or unable to get necessary prescription drugs. The results showed a significant decrease in being “unable to get necessary medical care” for both groups but the decrease was larger for Medicaid gainers (8 percentage points), compared to the uninsured group (1 percentage point). Delayed medical care category saw a 4.5 percentage point decline for Medicaid gainers compared to a decline of 0.5 percentage points for the uninsured group. Both groups reported declines in “unable to get necessary prescription drugs.” Medicaid gainers saw a 3.6 percentage point decline while the uninsured saw a 0.8 percentage point (Winkelman et al, 2018).

Health disparities among race/ethnic groups:

This study, for purposes of subgroup analysis, classified race and ethnic groups as: White, non-Hispanic; Black, non-Hispanic; Hispanic; and other race, non-Hispanic. The study, found total costs increased significantly for White, non-Hispanic and Hispanic individuals but remained rather unchanged for Black, non-Hispanic individuals. Improvements in access to care were significant for each health outcome measure among White, non-Hispanic individuals. Delayed medical care and getting necessary prescriptions were not significant for Black, non-Hispanic and Hispanics. Changes in total prescription drug costs were largest among White, non-Hispanic individuals (Winkelman et al, 2018).

The results of the study suggest that Medicaid is an important tool for improving access to care, prescription drug use, and substantial favorable changes in out-of-pocket costs across racial and ethnic groups. It also has valuable effects on mental health. The authors contend Medicaid alone is unlikely to eliminate racial/ethnic disparities in access to care and health in the United States (Winkelman et al, 2018).

**TABLE 2** Changes in health care costs, utilization, access, and outcomes among nonelderly uninsured adults who gained Medicaid or remained uninsured

Outcome	Unadjusted estimates					
	Medicaid gainers (N = 963)			Remained uninsured (N = 9784)		
	Period 1	Period 2	P value <sup>a</sup>	Period 1	Period 2	P value <sup>a</sup>
<b>Health care costs</b>						
Total costs (\$) <sup>b</sup>	1393	3109	<0.001	605	717	0.052
Out-of-pocket costs (\$) <sup>b</sup>	418	199	0.02	210	240	0.12
Total prescription drug costs (\$) <sup>b</sup>	432	1053	<0.001	146	194	<0.001
Out-of-pocket prescription drug costs (\$) <sup>b</sup>	260	118	0.10	92	109	0.11
<b>Health care utilization</b>						
Any ED visit (%) <sup>b</sup>	18.2	21.1	0.27	8.8	8.8	0.96
ED visits/person <sup>b</sup>	0.27	0.33	0.15	0.12	0.12	0.51
Any inpatient visit (%) <sup>b</sup>	5.2	6.9	0.21	1.8	1.6	0.59
Inpatient visits/person <sup>b</sup>	0.07	0.09	0.20	0.02	0.02	0.93
Any prescription drug fill (%) <sup>b</sup>	50.1	60.8	<0.001	32.3	30.7	0.003
Prescription drug fills/person <sup>b</sup>	6.35	12.67	<0.001	2.86	3.64	<0.001
<b>Health care access</b>						
Have usual source of care (%)	55.5	70.1	<0.001	38.4	40.2	0.03
Unable to get necessary medical care (%)	18.3	10.3	<0.001	10.1	9.1	0.04
Delayed necessary medical care (%)	15.0	10.5	0.01	7.0	6.5	0.23
Unable to get necessary prescription (%)	11.7	8.1	0.050	5.5	4.7	0.01
<b>Health outcomes</b>						
Fair/poor health (%) <sup>b</sup>	39.0	36.7	0.30	23.4	21.0	<0.001
Fair/poor mental health (%) <sup>b</sup>	26.1	24.4	0.31	12.0	12.9	0.06
Severe psychological distress (%)	18.4	14.1	0.01	6.7	6.5	0.48

<sup>a</sup>Regression tests significance of increase between Period 1 and Period 2 while controlling for age, sex, race/ethnicity, marital status, education, region, family size, family income, year, and number of chronic conditions.

<sup>b</sup>Based on Medical Expenditure Panel Survey rounds 1 and 2 (Period 1) and rounds 3 and 4 (Period 2).

**TABLE 3** Changes in health care costs, utilization, access, and outcomes among nonelderly uninsured adults who gained Medicaid by race/ethnicity

Outcome	Unadjusted estimates								
	White, non-Hispanic (N = 260)			Black, non-Hispanic (N = 267)			Hispanic (N = 362)		
	Period 1	Period 2	P value <sup>a</sup>	Period 1	Period 2	P value <sup>a</sup>	Period 1	Period 2	P value <sup>a</sup>
<b>Health care costs</b>									
Total costs (\$) <sup>b</sup>	1816	4254	<0.001	1467	1888	0.31	899	2331	0.02
Out-of-pocket costs (\$) <sup>b</sup>	647	299	0.07	302	73	0.06	184	125	0.18
Total prescription drug costs (\$) <sup>b</sup>	696	1587	0.002	182	540	0.02	245	598	0.001
Out-of-pocket prescription drug costs (\$) <sup>b</sup>	472	159	0.09	65	56	0.62	96	92	0.83
<b>Health care utilization</b>									
Any ED visit (%) <sup>b</sup>	23.3	23.4	0.99	15.6	18.0	0.47	14.0	17.8	0.40
ED visits/person <sup>b</sup>	0.36	0.40	0.65	0.19	0.24	0.29	0.19	0.28	0.16
Any inpatient visit (%) <sup>b</sup>	7.0	9.2	0.41	6.0	5.3	0.73	2.9	5.6	0.11
Inpatient visits/person <sup>c</sup>	0.08	0.11	0.39	0.08	0.07	0.64	0.04	0.10	0.22
Any prescription drug fill (%) <sup>b</sup>	62.6	68.0	0.21	40.1	56.4	<0.001	40.7	53.7	0.001
Prescription drug fills/person <sup>b</sup>	8.7	16.8	<0.001	4.9	10.9	0.002	4.7	8.0	<0.001
<b>Health care access</b>									
Have usual source of care (%)	61.7	76.5	<0.001	56.9	64.7	0.049	46.6	64.2	<0.001
Unable to get necessary medical care (%)	25.9	17.6	0.03	14.0	4.1	<0.001	12.0	3.1	0.001
Delayed necessary medical care (%)	24.2	16.3	0.03	8.9	5.6	0.14	6.6	3.9	0.34
Unable to get necessary prescription (%)	19.1	11.4	0.048	8.4	9.2	0.73	3.5	3.4	0.97
<b>Health outcomes</b>									
Fair/poor health (%) <sup>b</sup>	45.8	42.8	0.40	32.5	30.8	0.57	35.3	35.2	0.85
Fair/poor mental health (%) <sup>b</sup>	35.2	31.7	0.31	20.0	20.6	0.83	18.6	16.6	0.35
Severe psychological distress (%)	23.8	20.4	0.27	13.9	7.8	0.09	14.6	8.7	0.01

ED, emergency department.

<sup>a</sup>Regression tests significance of increase between Period 1 and Period 2 while controlling for age, sex, race/ethnicity, marital status, education, region, family size, family income, year, and number of chronic conditions.<sup>b</sup>Based on Medical Expenditure Panel Survey rounds 1 and 2 (Period 1) and rounds 3 and 4 (Period 2).

Another article addressing the health disparities among U.S. adults by state Medicaid expansion status was authored by Akinyemiju, Jha, Moore and Pisu, (2016). The article mentions of a cross-sectional study of U.S. adults using data from the 2013 Behavioral Risk Factor Surveillance System (BRFSS) dataset. This random telephone survey collects data on health risk behaviors, chronic diseases and conditions in all U.S. The data was collected from over 483, 865 participants aged eighteen years and older (Akinyemiju et al, 2016). This study analyzed this dataset to determine the socio-demographic and geographic distribution of chronic diseases in the U.S. and assess whether states with a higher prevalence of comorbidities decided to participate in the Medicaid expansion program. The results to this study showed expanded states had a lower proportion of Blacks compared with non-expanded states (7.8 % vs. 12.6%). Expanded states had a higher proportion of adults with at least a college degree (37.5% vs. 32.6%). Expansion states had a lower proportion of adults with no health insurance coverage compared with non-expansion states (15.2% vs. 20.3%). The expansion states also reported lower proportion of adults with no regular medical doctor (15.3% vs. 17.1%) and who reported not visiting any doctor for at least 5 years (7.9% vs. 9%), (Akinyemiju et al, 2016). The authors of this study concluded that states who did not participate in the ACA Medicaid expansion program experience a higher burden of adults with chronic diseases compared with states that did. The article also adds this health gap may widen further as individuals in expansion states obtain better health care access (Akinyemiju et al, 2016).

Adding to the importance of improving health care inequalities, the article by Rodriguez, (2018), focuses on socio-economic status (SES), and how low SES groups have a low survival and participatory disadvantage over the higher SES groups. The author details

how democratic societies organize in hierarchies and their participation in politics determine the distribution of public goods and services that shape social determinants of health (Rodriguez, 2018). The article helps explain how low political participation has become key for the maintenance and perpetuation of inequality among low socio-economic status groups (Rodriguez, 2018).

## **Methodology**

Qualitative analysis of archival research data was gathered through California State Northridge's Oviatt online library. The peer-reviewed articles that were searched contained key phrases, such as "Medicaid enrollment", "Medicaid expansion", "ACA and Medicaid enrollment", "Medicaid expansion states", "Medicaid and emergency room visits" and "Medicaid health disparities by race & ethnicity". The inclusion criteria I used in this research focused on the most recent articles on the Affordable Care Act (ACA) and the impact of Medicaid coverage/enrollment among expansion and non-expansion states was the main criteria used on this research paper. The literature on emergency room visits was from a difference-in-difference analysis survey study taken from calendar years 2010-2014 and theoretical peer-reviewed article. The same methodology was used in the literature on access to primary care. Observational study with analysis of data for hospitals in fiscal years 2011-2014 and a theoretical peer-reviewed article was used on Medicaid Expansion and U.S. Hospital finances. The literature on Medicaid enrollment and associated outcomes used 2008-2014 Medical Expenditure Panel Survey (MEPS) data. This national survey collects data on demographics, health insurance, health care costs, utilization, access and self-reported health data. With my exclusion criteria, research data on cancer disparities among the uninsured and Medicaid's effect on physician fees were omitted. This information was excluded due to the limited research data available.

## **Findings/Analysis**

The purpose of this literature review paper was to evaluate the effects of Medicaid enrollment among expansion and non-expansion states. The increase of emergency room visits, addressing primary care shortages among the newly insured population and health outcomes among low socio-economic status (SES) groups will be discussed in these findings:

### **Increase in Emergency Department Visits:**

Many studies have evaluated how the changes in insurance coverage have affected emergency department usage. Emergency room use has been of interest to policymakers because emergency room care, especially low-acuity ER use—serves as a community barometer for access to care in outpatient settings (Pines et al, 2019). The literature reviewed shows that Medicaid expansion has increased ED visit and shifted hospital payer mix. The states that increased their Medicaid eligibility experienced the largest increase in ED usage (Pines et al, 2019). As the previous author Beck, (2014), cited in her research, “the increase in ER visits wasn’t surprising because Medicaid made them free.” (Beck, 2014). The ER has become the provider of low acuity care unscheduled care and is generally seen by the public as a last resort for healthcare. This public perception will most likely not change any time soon. The shortage of acute care locations with convenient hours has further strained Emergency Rooms.

### **Primary Care Shortage:**

The studies show that the shortage of primary care physicians remains a growing problem. Physician assistants (PAs) and nurse practitioners (NPs) are often seen as part of the solution to the looming shortage of primary care physicians (Peterson et al, 2013).

Unfortunately, a large and growing number of PAs and NPs now work outside of primary care, which suggests that more innovative policymaking is needed to increase primary care health access. Some factors that influence physicians to choose subspecialty careers may have similar effects for NPs and PAs, including student debt and income gap disparities. Physician Assistants and Nurse Practitioners play important roles in many health care fields, including the delivery of primary care services. The lack of consistent and comprehensive data on how many NPs and PAs are clinically active or where they practice directly needs to be addressed.

### **Health disparities:**

The literature studied suggests that states that did not participate in the ACA Medicaid expansion program experienced more reported chronic diseases and other health related problems compared to those states that did enroll. Those individuals that qualified under the Medicaid expansion have benefitted with more access to care, lower prescriptions costs and less depression than those that remain uninsured (Akinyemiju et al, 2016). This improvement has been reported among most racial/ethnic groups. As more lower socio-economic status groups start to receive appropriate care for their chronic illnesses, non-expanded states may show a significant health gap in the next coming decades as individuals in expanded states obtain better health care access (Akinyemiju et al, 2019).

### **Policy Implications:**

Initially, policymakers projected that insuring Americans on Medicaid would reduce costly emergency room visits by giving this population greater access to healthcare through other settings. As noted in the literature, Emergency Room visits increased in states that expanded Medicaid. Long delays and over-crowding of the ED remains a big problem among

many cities. Some remedies that were mentioned to alleviate the overuse of the ER included redesigning the ED intake process and increasing hospital efficiency. Other Emergency Departments are expanding social work and case-management intervention programs for high-cost users (McClelland et al, 2014). The studies also report many patients who have a regular source of care often use the ER because of lack of timely access (McClelland et al, 2014). By addressing the low acuity cases and working in conjunction with other community providers, the Emergency Departments and hospitals can improve the flow of patients through a continuum of care. Other forward-thinking organizations have embraced the “Hospital at home” concept. This idea uses a home-based approach to deal with acute care compared to the traditional inpatient admission, thereby reducing ER use. These ideas along with recruiting more Physician Assistants and Nurse Practitioners to work in primary care centers will help incorporate an integrated health delivery system that would greatly benefit the low socio-economic groups. Reducing the health disparities among this vulnerable population would make the ACA’s goals a reality.

## **Conclusion**

The passage of the Affordable Care Act in 2008 marked a major milestone in the battle to curb healthcare costs and address health disparities among low-income households. The provision to expand Medicaid coverage by increasing the eligibility requirements reduced the number of uninsured from 49 million to 29 million according to estimates (Nikpay et al, 2017). A health care economist from the Department of Veterans Affairs, Austin Frakt, once mentioned, "...being insured itself is not a sufficient condition for using the system effectively" (Beck, 2014). Mr. Frakt cited more walk-in clinics and better access to care as solutions to address the overcrowding of emergency rooms. Hospitals have had to do more with less in regards to federal and state funding. This and several other factors have hindered the success of Medicaid expansion. As with most government policies, improvements need to be made to improve the product. Political partisanship will keep playing a major role in the ACA's success or failure in addressing health disparities, quality of care and lowering the cost of healthcare.

### **Recommendations: Areas for Future Research**

There is a good amount of literature on the ACA and Medicaid expansion. The amount of research on the effects on ED visits and primary care access is considerable but research gaps still exist. Aside from the few individual state studies on emergency room visits, very little information exists on the financial impact on emergency rooms. Normally, Medicaid pays a lower percentage of charges than other payers (Nikpay et al, 2017). In 2018, a large reduction in hospital payments was set to occur, further reducing Medicaid revenues to hospitals. Further research is needed on the topic of Medicaid's effect on hospital finances. As mentioned previously, some hospitals have adopted the home based approach for acute care.

Limited data exists in addressing the success of this concept. Also, future research needs to be made available in the area of primary care shortages and the reasons why only fifty percent of Physician Assistants and Nurse Practitioners choose to work in primary care centers.

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