Even with copayments for nonurgent care, Medicaid patients still rely on ERs

January 26 2015

How can states and federal government provide adequate health care to poor people, without overburdening taxpayers or leaving health care providers with billions in unpaid bills? That thorny problem is especially challenging in the aftermath of a recession and congressional mandates expanding Medicaid eligibility. To help control rising costs, in 2005, Congress gave states the option of charging copayments for Medicaid recipients who get nonurgent care in hospital emergency departments, where care is much more expensive than in most doctors' offices.

But a study conducted by researchers at the Johns Hopkins University School of Medicine and the Johns Hopkins Bloomberg School of Public Health suggests these copayment provisions do not significantly reduce Medicaid recipients' use of emergency rooms.

The study, published Jan. 26, 2015, in *JAMA Internal Medicine*, tracked how often Medicaid recipients visited emergency rooms under two different scenarios—in eight states that authorized hospitals to collect copayments for nonurgent care and in 10 states where hospitals were not authorized to collect the copayments. The study, which covered the years 2001 to 2010, found no significant difference in emergency room visits by Medicaid recipients in states with and without copayments, says lead author Mona Siddiqui, M.D., M.P.H. , an assistant professor of internal medicine at the Johns Hopkins University School of Medicine.

"As states are expanding Medicaid, they are looking for ways to control costs," says Siddiqui, who is serving on the White House Social and

Behavioral Sciences Team through August 2015 as a Science and Technology Policy Fellow of the American Association for the Advancement of Science. "Our study suggests they will need to look at other strategies besides requiring copayments. There was little evidence that cost-sharing would have any impact on the use of emergency rooms by poor people, who often have few other health care options."

Federal law guarantees emergency health care to everyone regardless of their ability to pay, but by 2004, the unpaid Medicaid emergency room bills owed to community hospitals nationwide totaled $40.7 billion. Hospitals absorb some losses, and others fall on the states. In 2002, some states began setting copayments for Medicaid patients whose emergency room visits turned out not to be urgent. But it wasn't until the Deficit Reduction Act of 2005 that states could legally tell hospitals to turn away Medicaid patients who didn't make a copayment for nonurgent care.

The Johns Hopkins study is the first one to examine the effect of the law while these changes were being phased in and for several years afterward. The researchers looked at data from Medicaid recipients aged 19 to 64 who participated in the nationwide Medical Expenditure Panel Survey. From survey data and billing records, the researchers calculated the rate of emergency room visits per person in each state studied.

The researchers sampled about 3,000 Medicaid recipients in eight states—Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina and Washington—that set copayments ranging from $3 to $15 per nonurgent emergency room visit. They also sampled about 7,500 Medicaid recipients in 10 states—California, Colorado, Connecticut, Georgia, Louisiana, Maryland, Michigan, North Carolina, Virginia and Texas—that did not set copayments.

The researchers found the states with the highest initial rates of emergency room use were also the ones that sought copayments from

Medicaid recipients for nonurgent care. But once the copayments went into effect, those states' emergency room use rates went down less than one-tenth of 1 percent. The data did not show any increase in the rate of Medicaid patients' visits to doctors' offices, suggesting they were not switching away from the emergency room and toward primary care physicians.

Senior author Craig E. Pollack, M.D., M.P.H. , an associate professor of medicine at the Johns Hopkins University School of Medicine and an expert in health services research, says the findings may reflect some hospital staff members' reluctance to deny care in cases where Medicaid patients can't make the copayments. Staff members may also be unsure which cases are true emergencies and which are not.

"The question of whether a need for care is urgent or not is a difficult one, for patients and clinicians," says Pollack. He and Siddiqui say a lack of access to primary care physicians may be one reason why Medicaid patients continue to seek emergency room care in spite of copayments.

There simply aren't enough doctors practicing in poor communities to give these patients a real choice, Pollack says. "This is a really vulnerable population," he says, "and there are questions about whether personal financial responsibility can play a role in improving their health care, or whether a financial requirement restricts their access to health care even further.

"The states are hungry for ways to control costs and expand access to care, and copayments are one attractive option," Pollack says. "But unfortunately, this may not be the tool to help accomplish that."

Provided by Johns Hopkins University School of Medicine