Obamacare Rushed to the ER

Medicaid expansion much costlier than expected — and not curtailing expensive emergency room visits

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A pair of reports this month on Medicaid spending undercut predictions that Obamacare would reduce costs while expanding coverage to the working poor.

The first report, from the government itself, shows that expanding Medicaid under the Affordable Care Act is turning out to be far more expensive that originally anticipated. The Centers for Medicare and Medicaid Services said in a report to Congress that the cost of covering new recipients came to $6,366 per patient in 2015 — 49 percent higher than previously estimated.

The second report comes from a study by George Washington University researchers who determined that states that expanded Medicaid did not experience a statistically significant difference in emergency room use than states that did not expand. The study found that ER visits in expansion states grew by less than 3 percent in 2014 compared with 2012-13 — roughly the same as states that did not expand.

Hospitals in expansion states did see a 27.1 percent increase in Medicaid-paid visits, while visits by people without insurance decreased by 31.4 percent. The findings suggest that taxpayer funds merely shifted from money paid to compensate hospitals for uninsured patients to Medicaid. The study's authors presented the findings as good news because ER use did not increase with Medicaid expansion as some had feared.

Critics of the Affordable Care Act suggested that interpretation is akin to looking at the glass as half-full rather than half-empty.

"We're spending an awful lot of money not to make things worse," said Michael Tanner, a senior fellow at the libertarian Cato Institute. "This is largely a case of shifting money around."

Jesse Pines, one of the authors of the George Washington University study, said many experts had expected a big increase in hospital use with an increase in Medicaid recipients. That was the experience in Oregon, which expanded its program prior to Obamacare and used a lottery to determine who got access. ER visits increased among that group by 40 percent over those who had applied but were not accepted.

But Pines said it is difficult to forecast the long-term impact on hospitals, which are losing federal funding to compensate for uninsured patients and are facing a decline in the number of patients with private insurance, which generally pay higher reimbursement rates.

“It’s not clear what the economic impact is on hospitals,” he said.

One of the most significant pieces of the ACA was expanding Medicaid eligibility to people making up to 138 percent of the federal poverty line — about $16,390 for a single person, or $22,540 for a family of four. From 2014 through this year, the federal government is paying 100 percent of those costs. After that, the share paid by states will gradually rise to 10 percent.

The Congressional Budget Office projected in April 2014 that the expansion would cost the federal government $68 billion in 2015. The actual costs exceeded that by roughly $26 billion. Brian Blase, a senior research fellow at George Mason University’s Mercatus Center, estimated that $7 billion of that overrun was due to higher-than-expected enrollment, while $19 billion resulted from higher payouts.

“The experts have made a lot of bad predictions about Obamacare, but this is one of the worst,” he said.

Blase said there are only two possible explanations for why new Medicaid enrollees are costing more money. The first is that population has, on average, sicker people than previously eligible Medicaid recipients. Blase said he believes that is unlikely; indeed, many experts predicted the costs would be *lower* for new enrollees because they are relatively wealthier than people who previously were eligible.

Blase said be believes the second explanation is more likely — that states are setting higher reimbursement rates for medical providers. States provide an average of 43 percent of the funds for the traditional Medicaid program, giving them an incentive to keep costs low. With the feds picking up 100 percent of the costs for new enrollees, Blase said, states are more likely to succumb to lobbying efforts from hospitals and doctors for higher payments.

“They have an incentive to set high reimbursement rates,” he said.

Blase called for congressional oversight.

“There needs to be an investigation into that — where is the money going,” he said.

Tanner, the Cato Institute expert, said the Medicaid recipients have little incentive to use less expensive care or moderate their health care consumption — since the government pays the entire cost. The Obama administration has rejected states’ requests to charge small copayments to Medicaid recipients.

“You have to think through what you’re making free,” he said.

It remains something of a mystery why Medicaid recipients continue to use emergency departments at hospitals rather than go to doctors when they are sick. Some have speculated that

it is because many a Medicaid recipient has never had a primary-care physician and goes to the hospital out of habit.

Part of the reason, according to Tanner, is that many Medicaid recipients simply cannot find doctors who accept Medicaid patients. Many doctors decline Medicaid patients because of low reimbursement rates. What's more, Tanner noted, the United States has a shortage of doctors totaling an estimated 150,000.

"A lot of it has to do with the fact that we still haven't solved the problem of primary care physicians," he said.

Tanner said part of the shortage is due to the fact that fewer foreigners educated in American medical schools are remaining in the United States. In many cases, he said, those medical students are finding opportunities in their home countries that did not previously exist.

"We're not getting the same number of doctors," he said.