

The Impact of Health Care Reform on Emergency Departments in the United States: Taking a Lesson from History and Looking to the Future

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Health care costs in the United States (US) have grown to an unsustainable 17% of our Gross Domestic Product (GDP). Although emergency departments are often blamed for the expense, less than 2% of annual health care costs in the US are attributed to emergency care [1]. The Affordable Care Act (ACA) was passed in 2010, which will expand coverage for the uninsured and was intended to reduce overall costs. It is unclear, however, how health care reform will ultimately affect cost, volume in the Emergency Department (ED), and access to primary care.

In 2006, Massachusetts enacted the health care insurance reform law, which subsidized insurance for low-income residents and mandated that everyone in the state maintain some healthcare coverage. The law sought to contain costs by increasing access to preventative medicine through primary care and reducing the “inappropriate” use of the emergency department by uninsured patients with non-urgent complaints. The Massachusetts health reform law is very similar to the Affordable Care Act that will soon take full effect nationwide. History may predict how healthcare reform will impact emergency medicine in the future.

While proponents of healthcare reform hope that emergency room visits will decrease, many physicians believe strongly that patient volume, wait times, and costs will continue to rise sharply [2]. Did the expansion of health insurance coverage in Massachusetts cause a significant change in the number of ED visits? It looks like the answer is no. When Massachusetts’s statistics are compared with nearby Vermont and New Hampshire, it is shown that visits to the ED increased at a comparable rate [3]. Most of this rise in Massachusetts is not an effect of reform, but follows a national trend of growing ED utilization. In Massachusetts, low-acuity ED visits for government subsidized low income patients showed a modest decrease of 2.6% from 2006 to 2008, while the overall number of visits rose by about 17,000 [4]. Perhaps over time this effect will prove to be significant, but it is currently eclipsed by growth in ED utilization that may not be related to insurance coverage. A recent study demonstrated that reducing non-urgent visits to emergency departments will yield little to no savings for the health care system. The real cost savings, however, are in reducing admissions to the hospital [5]. Emergency care itself represents only 2 percent of the nation’s health care. If Massachusetts is any indication, healthcare reform may not do much to decrease costs in the ED unless access to primary care is improved, tort reform is enacted, and the persistent rise in ED utilization is better addressed.

It is important to point out that Massachusetts has about 130 primary care physicians for every 100,000 people, which is the highest in the US. Per capita, Massachusetts has about twice as many primary care physicians as many other states [6]. One could imagine how states with less primary care physicians may have trouble accommodating to a sudden and large demand for primary care services. Many emergency departments may actually see more patients due to higher demand for services in the face of primary care shortages and increasing number of elderly patients.

Massachusetts has shown us that extending insurance coverage did little to improve the trend of increasing ED volumes. Results from the 2011 ACEP member poll suggest that a significant portion of low-

acuity patients presenting to the ED are covered by insurance, but they cannot access primary care providers when they need them. Various reasons for this include inability to find providers that accept the low reimbursements from Medicaid, unacceptably long waiting periods for appointments, and inconvenient office hours. This is a problem that cannot be improved by simply increasing healthcare coverage. Emergency physicians have also reported growing numbers of elderly patients, which are already covered by Medicare and will only increase further as the “baby boomers” age. The same survey shows that many physicians report the fear of lawsuits as a major cause of excessive testing, which is a barrier to cutting spending in the ED and contributes to overcrowding.

The ACA has specifically designated emergency care as a right for US citizens, and prioritizes emergency medicine research with provision for increased funding towards the basic science of emergency medicine, investigating models of delivery, and increasing efficient delivery of services. Academic medical centers will have a unique opportunity to affect policy by influencing directions in research, and will be positioned to address a range of important variables such as the application of information technology, evidence based use of resources, and fair reimbursement for providers in a new episodic care model [7,8].

The impact of health care reform on emergency departments at a national level in the US is yet to be seen. The Patient Protection and Affordable Care Act of 2010 contain at least 11 sections that have direct relevance to academic emergency medicine [7]. Primary care shortages, lack of access to care despite coverage, and legal pressures on physicians are remaining barriers that must be addressed. Opportunities exist for academic emergency medicine providers to influence how this Act will be interpreted and used to provide research, policy making, and medical care for our patients in the emergency department.

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