Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon’s Experiment

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The effect of Medicaid coverage on health and the use of health care services is of first-order policy importance, particularly as policymakers consider expansions of public health insurance.

Estimating the effects of expanding Medicaid is challenging, however, because Medicaid enrollees and the uninsured differ in many ways that may also affect outcomes of interest. Oregon’s 2008 expansion of Medicaid through random-lottery selection of potential enrollees from a waiting list offers the opportunity to assess Medicaid’s effects with a randomized evaluation that is not contaminated by such confounding factors. In a previous examination of the Oregon Health Insurance Experiment, we found that Medicaid coverage increased health care use across a range of settings, improved financial security, and reduced rates of depression among enrollees, but it produced no detectable changes in several measures of physical health, employment rates, or earnings.1-4

A key finding was that Medicaid increased emergency department (ED) visits by 40% in the first 15 months after people won the lottery.3 This finding was greeted with considerable attention and surprise, given the widespread belief that expanding Medicaid coverage to more uninsured people would encourage the use of primary care and thereby reduce ED use. Many observers speculated that the increase in ED use would abate over time as the newly insured found alternative sites of care or as their health needs were addressed and their health improved. One commentator, for example, raised the question, “But why did these patients go to the ED and not to a primary care office?” He hypothesized that “Despite the earlier finding that coverage increased outpatient use, many of these newly insured patients probably had not yet established relationships with primary care physicians. If so, the excess ED use will attenuate with time.”5

We have now analyzed additional data in order to address these questions: Does the increase in ED use caused by Medicaid coverage represent a short-term effect that is likely to dissipate over time? And does Medicaid coverage encourage the newly insured to substitute physician office visits for ED visits? We used the lottery to implement a randomized, controlled evaluation of the causal effect of Medicaid coverage on health care use, applying a standard instrumental variables approach. More detail on the lottery, data, and methods is available elsewhere1-3 as well as in the Supplementary Appendix.
The hypothesis that the 0.17 increase in ED visits attributable to Medicaid coverage in the first 6 months is the same as the 0.15 increase in visits in months 18 to 24. Thus, using another year of ED data, we found no evidence that the increase in ED use due to Medicaid coverage is driven by pent-up demand that dissipates over time; the effect on ED use appears to persist over the first 2 years of coverage. We repeated a similar analysis for hospital admissions and once again found no evidence of any time patterns in the effects of Medicaid coverage over the first 2 years (see the Supplementary Appendix for details).

In our previous work, we found that Medicaid increased both physician office visits and ED use. We estimated separately the effect of Medicaid coverage on whether the person had an office visit and whether he or she had an ED visit; we used these estimates, together with Bayes’ rule, to predict the effect that Medicaid coverage would have on the joint probability of having both types of visits if the increases in the two types of visits were independent of each other. The predicted increase in the joint probability under the assumption of independence is 9.9 percentage points (standard error, 3.5), which is less than the estimate of the actual increase in the joint probability. We thus found no evidence that Medicaid coverage makes use of the physician’s office and use of the ED more substitutable for one another. If anything, the results suggest that it makes them complementary.

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The United States and Cuba — Turning Enemies into Partners for Health

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In June 2016, the U.S. Department of Health and Human Services (HHS) and Cuba’s Ministry of Public Health signed an umbrella accord that promises to make health a cornerstone of the new era of cooperation between the two countries. The memorandum of understanding (MOU), signed by HHS Secretary Sylvia Mathews Burwell and Minister Roberto Morales Ojeda, is the latest expression of goodwill since the December 2014 rapprochement that renewed diplomatic relations and reopened embassies in Washington and Havana. According to the HHS announcement, the MOU “establishes coordination across a broad spectrum of public health issues, including global health security, communicable and non-communicable diseases, research and development, and information technology.” Finally, the door has been opened for bilateral collaboration aimed at preventing and controlling diseases that affect people in both countries — including infectious threats such as Zika as well as cancer and other chronic conditions that are the main causes of death in the United States and Cuba.

Somewhat lost in the attention received by the MOU and the general progress of negotiations — which allow for expanded travel to Cuba for Americans — is the fact that Washington’s six-decade embargo against Cuba is still in place. Although President Barack Obama’s executive actions have reduced its reach, only Congress has the power to end the embargo altogether. Its restrictions seriously hamper the full collaboration promised in the MOU.

Why should Americans care? Although Cuba is relatively poor, it has managed to make prevention-oriented primary care, as well as secondary and tertiary care, available to all its citizens. Today, markers of population health in Cuba compare favorably with those in the United States, and there are fewer geographic and urban– rural health disparities. Cut off from pharmaceuticals, medical devices, and other technology developed in the United States, Cuba has also invested heavily and successfully in biotechnology and related fields, as well as in strategies to address tropical and infectious diseases and chronic conditions common in its aging population.

As a result, the United States can learn a number of lessons from Cuba’s experience — about the organization of medical services, the establishment of community-based programs to pro-

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