The Influence of Medicare for All on Reimbursement for Emergency Care Treat-and-Release Visits

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Study objective: Single-payer health care is supported by most Americans, but the effect of single payer on any particular sector of the health care market has not been well explored. We examine the effect of 2 potential single-payer designs, Medicare for All and an alternative including Medicare and Medicaid, on total payments and out-of-pocket spending for treat-and-release emergency care (patients discharged after an emergency department [ED] visit).

Methods: We used the 2013 to 2016 Medical Expenditure Panel Survey to determine estimates of payments made for ED visits by insurance type, and the 2015 National Hospital Ambulatory Medical Care Survey to estimate the proportion of ED visits covered by each insurance type.

Results: We found that total payments were predicted to increase from $85.5 billion to $89.0 billion (range $81.3 to $99.8 billion) in the Medicare-only scenario and decrease to $79.4 billion (range $71.6 to $87.2 billion) under Medicare/Medicaid, whereas out-of-pocket costs were predicted to decrease from $116 per visit to $45 with Medicare and to $36 with Medicare/Medicaid.

Conclusion: In this study of ED treat-and-release patients, a transition to a Medicare for All system may increase ED reimbursement and reduce consumer out-of-pocket costs, whereas a system that maintains Medicaid in addition to Medicare could reduce total payments for emergency care. [Ann Emerg Med. 2020;76:454-458.]

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INTRODUCTION

Despite that more per capita is spent in the United States on health care than in any other high-income country, there remain a substantial number of Americans who lack adequate health insurance coverage. Medicare for All has been proposed as one way to expand health insurance coverage. Previously considered politically untenable, Medicare for All is now supported by 53% of Americans and remains a focus of the 2020 presidential campaign.[1]

Despite controversy in regard to reductions in provider and facility reimbursements, the specific effect of single-payer reform on any particular sector of the health care market has not been well explored.[2] This is particularly relevant to emergency care. If a Medicare for All approach significantly reduces reimbursement to EDs, then the viability of the acute care system may be threatened.

We sought to determine how a transition from the current system to Medicare for All or Medicare for All with preserved Medicaid might affect total payments to EDs for treat-and-release (outpatient) cases. We also sought to understand the effect of these reform scenarios on patient out-of-pocket costs. Because there is no specific single-payer legislation on which to base our projections, this analysis is inherently speculative. However, an examination of the potential effects of single payer on emergency care is vital to informing the policy debate.

We based our analysis on a Medicare for All–type single payer, given the attention it has received from policymakers. We also included a scenario preserving Medicaid because it has largely been left out of single-payer policy discussions. Finally, we further accounted for policy and consumer behavioral uncertainty (ie, consumer response to shifting cost-sharing burdens) by including a range of potential reimbursement changes.

Editor's Capsule Summary

What is already known on this topic

Medicare for All solutions have been proposed by presidential candidates.

What question this study addressed

How would Medicare for All affect emergency department (ED) payments and out-of-pocket costs?

What this study adds to our knowledge

The primary analysis shows that if all patients had Medicare, there would be increased payments to EDs and decreased out-of-pocket costs.

MATERIALS AND METHODS

We used the Medical Expenditure Panel Survey (MEPS) to determine estimates of payments made for emergency department (ED) visits and out-of-pocket expenditures by insurance type, and the 2015 National Hospital Ambulatory Medical Care Survey (NHAMCS) to estimate the proportion of ED visits covered by each insurance type.

Selection of Participants

We used MEPS data from 2013 to 2016 to obtain payment estimates for each insurance subset of the population. Only treat-and-release ED visits were included. We limited our study to adults aged 18 years and older because of substantial differences in the types of insurance and care-seeking patterns in response to changes in insurance.

We excluded admissions (n=1,209) because ED expenditures cannot be attributed for a visit resulting in admission. We also excluded ED visits that, based on having inpatient procedures, were likely misclassified as outpatient (n=1,960), as well as visits with flat-fee payments (n=59) or zero paid/zero charges (n=11). See Appendix E1 (available online at http://www.annemergmed.com) for additional detail.

To adjust ED reimbursements for inflation, the Personal Health Care Expenditure component of the National Health Expenditure Accounts was used, whereas the Consumer Price Indices for medical care were used to adjust out-of-pocket expenditures.[3]

We used the 2015 NHAMCS to determine the national insurance distribution of adult ED visits by primary payer. We used this rather than MEPS for determining the weighted insurance distribution by primary payer because of suspected underreporting of ED visits in MEPS.[4]

Only outpatient visits by adults were included. We used the NHAMCS primary payer variable to create the same classification schema we used for the MEPS data. For visits with only one payer, the sole payer was considered the primary payer. For all visits with multiple payers, we used an algorithm based on schemes developed by the National Center for Health Statistics[5] and Yun et al[6] (Appendix E2, available online at http://www.annemergmed.com). For both MEPS and NHAMCS, the payer categories included Medicare, Medicaid, dual Medicare/Medicaid, commercial, self-pay, and other.

Primary Data Analysis

The goal of this analysis was to estimate the difference in total payments for ED care between the current multipayer system and 2 Medicare for All scenarios. We calculated total payments for the current system as follows. We multiplied the average payment rate per visit (identified from MEPS) by the weighted number of visits for each insurance category (identified from NHAMCS). We then summed the total payments for all payers to estimate the total payments for emergency care under the current system.

We separated the calculations of payment changes into 2 postintervention "single-payer" scenarios. The first was a Medicare for All scenario, in which all ED visits were covered by traditional Medicare. The second scenario, Medicare plus Medicaid, transitioned all visits to Medicare, with 2 exceptions: individuals currently enrolled in Medicaid, and 36% of the uninsured who were assumed to be eligible but not enrolled in Medicaid. For these exceptions, Medicaid payments were left intact (see Appendix E3, available online at http://www.annemergmed.com, for details).[7]

To determine total payments under the proposed scenarios, we determined the mean payment rate for Medicare beneficiaries by using MEPS. We multiplied this mean payment by the projected number of ED visits, adjusted for changes in utilization.

Because reimbursement in a future Medicare for All system depends on whether total ED visits increase, decrease, or stay constant, we modeled utilization changes for each scenario according to the anticipated influence of each insurance category moving to coverage by Medicare or Medicare and Medicaid. Literature on the price elasticity of demand suggested a range of –0.04 and –0.30, and in accordance with the available evidence for emergency care we used –0.17 as our primary analysis.[8-12] In other words, for every 1% increase in the cost of emergency care to the consumer, the demand for emergency care would decrease by 0.17%.

Table 1. Prereform total visits, average reimbursement rates, and out-of-pocket expenditures, adults only, inflation adjusted to 2016 US dollars.*

Visit/Reimbursement Amount	Medicare	Medicaid	Dual Enrolled	Commercial Insurance	Other	Self-pay Only
Total weighted visits (n)	13,778,939	22,269,058	3,566,429	26,729,890	3,241,783	11,159,058
Facility average reimbursement, $	832	492	745	1,521	1,168	245
Professional average reimbursement, $	153	116	134	258	160	57
Combined average reimbursement, $	984	608	879	1,779	1,327	302
Out-of-pocket expenditures per visit, $	45	20	4	175	73	299

*Reimbursement and expenditure figures obtained from MEPS panels 18 to 20, spanning 2013 to 2016; total visits weighted to the US population were obtained from the 2015 NHAMCS.

Furthermore, in the hypothetical Medicare for All scenario, the change in expected demand for emergency care was modeled under 2 different cost-sharing possibilities. We first relied on the preintervention average Medicare cost sharing as our primary analysis because this involves less change from the status quo, and then included 0% cost sharing.

RESULTS

Characteristics of Study Subjects

A total of 21,594 ED visit records were extracted from MEPS. After application of the exclusion criteria, the final sample size from MEPS included 13,649 visits representing 130.3 million weighted visits. A total of 21,061 ED visits were included from 2015 NHAMCS. After application of the exclusion criteria, our final sample included a total of 12,917 visits, representing 80,745,157 weighted visits, of which 17% were Medicare, 28% Medicaid, 4% dual coverage, 33% commercial, 4% other, and 14% uninsured. Average per-visit reimbursement was $984 for Medicare, $608 for Medicaid, $879 for beneficiaries with dual Medicare and Medicaid eligibility, $1,779 for commercial insurance, $1,327 for other, and $302 for the uninsured (Table 1). We calculated $85.5 billion in total payments for treat-and-release emergency care visits under the current system, composing 3% of total health care expenditures in 2016.[13]

Main Results

In our primary reform scenario, in which all visits had Medicare as a payer—using our range of utilization changes and assuming that cost sharing for Medicare remained unchanged from the prereform scenario—the total number of ED visits was predicted to increase by 9.66 million (range 2.27 million to 17.05 million), which corresponds to an estimated increase in the total payments for emergency care of $3.53 billion (range –$3.74 billion to $10.81 billion) (Table 2) (see detailed calculations in Appendix E4, available online at http://www.annemergmed.com).

We then performed the same analysis under the assumption of no cost sharing. In this scenario, the estimated increase in total payments for the provision of emergency care was $9.63 billion (range –$2.30 billion to $21.57 billion) (Table 2) (see detailed calculations in Appendix E4, available online at http://www.annemergmed.com).

In the hypothetical Medicare/Medicaid reform, our primary analysis again retained the same out-of-pocket cost sharing of Medicare and Medicaid. This yielded a predicted increase in visits of 11.03 million (range 2.59 million to 19.46 million) but an estimated decrease in the total payments to the emergency care system of $6.10 billion (range –$13.86 billion to $1.65 billion) (Table 3) (see full details in Appendix E5, available online at http://www.annemergmed.com).

Finally, we performed the same analysis under the assumption of no cost sharing. The estimated change in total payments for the provision of emergency care was –$1.69 billion (range –$12.82 billion to $9.44 billion)

Table 2. Net change in total payments for emergency care in Medicare for All system, adults only, inflation adjusted to 2016 US dollars.

Payments	Primary Analysis, Current Medicare Out-of-Pocket Costs*	Secondary Analysis, 0% Out-of-Pocket Costs*
Combined change in total payments, $ (in billions)	3.53 Range −3.74 to 10.81	9.63 Range 2.30 to 21.57
Out-of-pocket expenditures per visit, $	45	0

*Range was created with a price elasticity of −0.04 as the lower bound and −0.30 as the upper bound in accordance with preexisting literature.

Table 3. Net change in total payments for emergency care in Medicare for All with preserved Medicaid, adults only, inflation adjusted to 2016 US dollars.

Payments	Primary Analysis, Current Medicare and Medicaid Out-of-Pocket Costs*	Secondary Analysis, 0% Out-of-Pocket Costs*
Combined change in total payments, $ (in billions)	−6.10 Range −13.86 to 1.65	−1.69 Range −12.82 to 9.44
Out-of-pocket expenditures per visit, $	36	0

*Range was created with a price elasticity of −0.04 as the lower bound and −0.30 as the upper bound in accordance with preexisting literature.

(Table 3) (see full details in Appendix E5, available online at http://www.annemergmed.com).

In our primary analysis with current Medicare and Medicaid cost-sharing levels, both reform scenarios resulted in a decrease in out-of-pocket costs for individuals currently commercially insured and self-pay. In the Medicare for All scenario, average per-visit out-of-pocket costs decreased by $71. In the hypothetical Medicare/Medicaid scenario, average per-visit out-of-pocket costs decreased by $80 (Tables 2 and 3).

LIMITATIONS

First, we included only adult treat-and-release ED visits for reasons we explored earlier and consistent with similar methods by Yun et al[6] and Galarraga and Pines.[14] MEPS may also underestimate the total number of visits resulting in admission despite our exclusion criteria.

We assumed Medicare and Medicaid reimbursement rates would remain constant after reform. The Centers for Medicare & Medicaid Services could seek to change reimbursement rates. Medicaid reimbursement rates also vary, with states playing a role in setting them. It is therefore likely that Medicaid reimbursement rates would change, but the direction and magnitude of these changes remain unknown. Furthermore, the acuity of ED visits determines the reimbursement and may affect our estimates. Additionally, this study provides an estimate of the average change in emergency care at the national level, which may differ from the effect observed for individual health systems and regions.

Finally, our single-payer scenarios did not preserve supplemental insurance. Retaining supplemental insurance could lead to higher reimbursements and lower out-of-pocket costs, although more research is needed.

DISCUSSION

Our primary analysis demonstrates that Medicare for All could increase total payments for emergency care and reduce out-of-pocket cost sharing on treat-and-release visits for adults. This result is a consequence of the number of patients shifted from Medicaid or uninsured—both of which currently reimburse lower than Medicare—into Medicare. In this scenario, consumer out-of-pocket spending was predicted to decrease, given the significantly lower cost sharing for Medicare outpatient ED visits compared with private insurance or the uninsured. Conversely, a system that preserves Medicare and Medicaid under current eligibility criteria, cost-sharing levels, and reimbursement levels could lead to a reduction in total ED payments and a reduction in consumer out-of-pocket cost sharing for adults. The reduction in total payments for emergency care is a consequence of the transition of higher-paying private insurance plans to Medicare without the transition of lower-paying Medicaid and dual-enrolled plans to Medicare.

Because we accounted for a potential wide range of changes in demand for emergency care (which depends on levels of cost sharing in a Medicare for All system), our results include a similar wide range of potential changes in reimbursement under both the Medicare for All and the Medicare/Medicaid scenarios. These ranges suggest it is possible to have either an increase or decrease in reimbursement in both reform scenarios. However, the primary analysis based on the best available evidence suggests an overall increase in total payments under Medicare for All and a decrease in total payments under Medicare/Medicaid.

Our results also suggest that the ultimate effect of any reform on total payments depends on the eventual Medicare or Medicaid reimbursement rates because both programs reimburse substantially less than commercial insurance for emergency care. Furthermore, the effect of any particular plan would not be uniform across hospitals. Although we predict a net increase in total payments for ED care when all ED visits are covered by Medicare, there may be a negative influence on hospitals currently with a payer mix that is heavily commercially insured and positive influence on hospitals with a predominantly Medicaid or uninsured payer mix.

As expected, cost sharing for emergency care would decrease under both reform scenarios, an anticipated effect, given the higher cost sharing within commercial plans. We were conservative in our approach to modeling cost sharing, keeping the average out-of-pocket expenditures constant for both Medicare and Medicaid from the current

state to a future reform scenario. Higher cost sharing would likely further reduce ED utilization.

Our findings suggest that a transition to a Medicare for All system may increase total payments for treat-and-release emergency care as well as reduce out-of-pocket costs. Conversely, a system that keeps Medicaid and its low reimbursement structure intact may reduce total payments. Policymakers must be cognizant of the structure and balance of reimbursements in a future single-payer system and their potential effect on the provision of emergency care. This modeling exercise is based on numerous assumptions about the structure of future single-payer proposals. However, our methods, calculations, and examination of a potentially vulnerable sector of health care should contribute to the ongoing policy discourse.

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