Access to Quality Healthcare

Description

The Affordable Care Act (ACA) constitutes the broadest change to American healthcare since the institution of Medicare in 1965. The ACA has had the greatest impact on families and adults aged 18-64, while Medicare primarily (although not exclusively) affects adults 65 years old and older. As a result of the ACA, between January 2012 and March 2016, the number of uninsured American adults is estimated to have declined by between 43% and 48%. As of February 2016, however, there were still between 20.8 and 26.5 million non-elderly uninsured adults, and 19 states had chosen not to expand Medicaid, the vehicle by which the ACA offers health insurance to the poor.

Although the ACA has increased the number of individuals who have insurance, increased access to insurance does not necessarily correlate with increased access to quality healthcare. Many people continue to have high-deductible health plans (HDHPs) and limited networks from which to choose a primary care provider (PCP). By April 2014, 85% of patients who had obtained private health insurance through the ACA marketplace had HDHPs, defined in 2015 as a minimum annual deductible of $1,300 for individuals and $2,600 for families (in 2016, out of pocket expenses were capped at $6,850 per person and $13,700 per family, per year). Deductibles for employer-sponsored insurance rose three times faster than premiums, and seven times faster than wages and inflation combined, between 2010 and 2015, and a 2015 survey found that 75% of insured patients who had problems paying their medical bills stated that it was because they could not afford copays, deductibles, or coinsurance. Others have plans that include up to 50% coinsurance. Medicare-insured patients also face difficulties paying for needed services and medications, whether because of fixed incomes (half of which were less than $23,500 in 2013), annual increases in premiums and deductibles, or difficulty affording medications.

The consolidation of health insurance companies has contributed to this problem. Often touted as good for the consumer because increased market share means increased buying power and lower healthcare costs, consolidation has instead resulted in increased premiums and deductibles. Furthermore, increased competition within the healthcare insurance industry has been associated with decreased costs for patients, but consolidation has resulted in exclusive, non-overlapping market territories and increased barriers to entry for smaller companies. In 2014, private insurance premiums averaged $16,834 per family, and out of pocket spending averaged $800 per individual; the four largest insurance companies commanded approximately 83% of the market share (up from 74% in 2006), and the largest of them recorded $5.6 billion in profits.

This problem of unaffordable healthcare is especially prevalent among those with chronic health conditions and is often compounded by a lack of patient knowledge of helpful resources: 47% of those patients who had problems paying their medical bills were unaware of hospital-fee-reduction programs.
and 37% of patients in another survey did not know that their insurance plan fully covered preventive care services.\textsuperscript{14}

Access to quality hospital-based healthcare is impeded by emergency department (ED) overcrowding, which is associated with increased patient mortality, length of stay, cost, and an overall decreased access to timely treatment, regardless of insurance type.\textsuperscript{15-17} EDs are a major gateway for hospital admissions and by law must provide care to all patients regardless of citizenship, legal status, or ability to pay.\textsuperscript{2,18,19} As a result, EDs have become the healthcare system’s safety net, treating the non-emergent and primary care needs of those who cannot access a PCP, while also being reimbursed poorly or not at all by Medicaid-insured and uninsured patients. The problem of overcrowded EDs is exacerbated by a shortage of PCPs\textsuperscript{20,21} and a dearth of healthcare workers specifically trained to treat those patients with behavioral health problems who comprise 12.5% of ED visits, spend almost 3 times longer in the ED, and are 2.5 times more likely to be admitted than other patients.\textsuperscript{22}

The greater the number of barriers to primary care access, the greater the ED utilization,\textsuperscript{23} and Medicaid-insured patients continue to have more barriers and receive lower quality healthcare than privately insured patients. Contributing factors include:

- Limited physician willingness to accept Medicaid insurance\textsuperscript{23-25}
- Discrimination against and stigmatization of Medicaid-insured patients by healthcare providers\textsuperscript{26}
- Medical and non-medical hurdles associated with lower socio-economic status\textsuperscript{26}
- Barriers to access to primary care and other outpatient services\textsuperscript{21,27,49}
- Significant mental and physical disease burden\textsuperscript{26,49}
- Other barriers specific to the Medicaid population\textsuperscript{28}

The ACA has achieved much-needed reform of the U.S. healthcare system,\textsuperscript{29} but more is needed. The current state of the U.S. national healthcare system, particularly the EDs, is not robust enough to meet the future needs of an aging population, growing racial and ethnic diversity, a mounting income gap, and increasing chronic health problems.

**ENA Position**

It is the position of the Emergency Nurses Association that:

1. All people, regardless of geographical locale or socio-economic status, need equal access to comprehensive healthcare services for critical, acute, and chronic medical conditions, including mental health and substance use disorders.
2. The definition of comprehensive healthcare includes preventive healthcare, wellness promotion, palliative and end-of-life care, and illness and injury prevention.
3. There is compelling evidence that gender, race, ethnicity, and socio-economic class are correlated with persistent and often increasing health disparities that impact and are impacted by diminished access to healthcare.
Position Statement

4. ED staff be knowledgeable about fee reduction programs offered by their facility so that they can refer their patients to support staff and resources that will help them to navigate payment for their care.

5. The use of EDs for primary care and for non-urgent needs can be decreased by expanding primary, preventive, and community healthcare services through a variety of proven strategies, including those listed at the end of this document.

6. Access to primary, preventive, and community healthcare services can be increased by allowing Advanced Practice Registered Nurses (APRNs) to practice to the full extent of their educational preparation, in addition to allowing them equitable reimbursement for services provided.

7. Primary care and non-urgent ED return visits can be reduced through the use of nurse navigators, case managers, and clinical social workers in the ED who assist patients in accessing preventative, primary care, and follow-up resources.

8. Emergency departments and hospital systems can implement evidence-based approaches that increase throughput and reduce patient wait times along with their associated adverse events.

9. Public education and social media initiatives can be implemented to increase public awareness of preventive, community, and primary care resources in an effort to reduce the impact of non-urgent needs on EDs.

10. Our understanding of the ACA’s impact on access to quality healthcare is still evolving; therefore, a commitment to ongoing research and review of the ACA’s impact on access is critical for the future of the healthcare system.

11. Health insurance companies, by virtue of the human object of their business, have an obligation to responsibly balance commercial profit with the thoughtful and innovative provision of affordable healthcare plans that promote wellness, prevention, and the management of chronic conditions.

Background

Over the past half century the utilization of EDs in the U.S. healthcare system has shifted from treating patients with emergent conditions to one of primarily providing care for non-emergent needs. The rate of ED visits over the past 15 years has outpaced population growth, increasing at double the expected rate between 1997 and 2007. In addition, a retrospective study of more than 241,000 ED visits from 1997–2009 concluded that 70% were for primary-care-treatable conditions, and the most recent data from the CDC’s National Hospital Ambulatory Medical Care Survey found that 86% of ED visits in 2011 were triage levels 3, 4, or 5 (i.e., urgent, semi-urgent, or non-urgent). Patients without insurance accounted for more than 21 million of those visits, and only 11.9% of the total visits resulted in admission.

These problems are worse in non-metropolitan areas, where there are lower odds that seriousness of the medical problem will be the reason for an ED visit. Indeed, non-metropolitan ED patients are almost
twice as likely as metropolitan ED patients to indicate that the reason for their visit is that their doctor’s office was not open. Perhaps unsurprisingly, multiple studies have found decreased rates of hospital admission from ED visits in rural and non-metropolitan areas, as compared to hospitals in metropolitan areas. These problems are often magnified by the budget and staffing challenges that many rural and community hospitals face, which impede the implementation of technological and specialized solutions.

The ACA was anticipated to provide solutions to these problems by increasing the number of patients with healthcare insurance, thereby allowing patients to have their non-emergent healthcare needs met by PCPs, while at the same time also providing insurance payment for those patients who still utilize the ED. However, many studies predicted that the ACA would likely cause a slight long-term decrease in ED visits, but would increase ED visits by up to 21% among some patient populations in the first three years after its implementation. A nationwide survey of emergency physicians concluded that ED visits were still on the rise as of March 2015.

The majority of patients receiving new healthcare insurance under the ACA did so under Medicaid, and although multiple studies have shown an increased use of preventive care among Medicaid recipients, early studies also revealed that Medicaid patients visited EDs up to 46% more frequently than patients with other types of insurance or with no insurance at all. The most recent data from the CDC’s National Health Interview Study, which looked at ED visits in 2013-2014, found that adults with Medicaid had the highest prevalence of both a single ED visit and multiple ED visits in the previous 12 months, when compared with patients with private insurance and patients without insurance, and almost four times the odds of having one or more ED visits in the previous 12 months when compared with privately insured adults.

One of the ways that the ACA pays for itself is by offering tiered plans that trade lowered monthly premiums for cost-sharing approaches to payment. Such health plans and their high out-of-pocket costs are a burden for households with incomes between 100% and 250% of the Federal Poverty Limit (FPL), 80% of which do not have the assets to meet the high deductibles required by their healthcare plans. They are also a burden for households with incomes between 250% and 400% of the FPL, which do not benefit from the ACA’s provisions for subsidized insurance. HDHPs are particularly prevalent in the private healthcare market, in part because this cost-sharing approach allows employers to reduce their portion of their employees’ coverage. In 2013, 58% of companies with fewer than 200 workers offered insurance that had an average annual deductible of at least $1,000. Some studies have found that the ACA’s elimination of out-of-pocket costs for preventative services has improved screening among patients with HDHPs; however, HDHPs also force patients to stop essential treatment, decrease the dosage of or cease taking prescribed medications to reduce costs, and schedule expensive diagnostic procedures late in the calendar year in order to minimize out-of-pocket costs. Many are simply unable to pay their medical bills.

As mentioned above, the problem is compounded by insurance companies’ established track record of decreasing competition through consolidation and driving down healthcare costs through the power of volume bargaining, while at the same time increasing premiums and deductibles rather than passing those savings on to the patient. The degree of consolidation within the healthcare industry can be
appreciated by comparing it with the airline industry. In 2014 the market share of the top four insurance companies was 83%, while the market share of the top four airlines was only 62%.\textsuperscript{60} The consequences of HDHPs and insurance company consolidation for hospitals and providers include decreased reimbursement from insured patients who are nevertheless unable to pay their portion and increased acuity and number of comorbidities in patients who have avoided treatment to cut costs.

Some of the changes brought about by the ACA improved benefits to Medicare patients (e.g., closing the gap in Part D prescription drug coverage by 2020), but many patients with Medicare still struggle to pay for needed services and medications. In 2016, Part B premiums and deductibles for 16 million Americans rose by 16% and 13%, respectively, and both premiums and deductibles are projected to rise by up to 8% per year between 2016-2024.\textsuperscript{56,57} Perhaps more problematic, the Medicare system can be incredibly complex and difficult to navigate, and an inability to understand it can lead to poor decisions and lost healthcare access.\textsuperscript{58} The potential for insolvency of the program, increased eligibility age, and increasing numbers of eligible Americans constitute future potential barriers to access to quality healthcare that are yet to be solved.

The use of EDs for primary care and non-urgent needs can be decreased by expanding primary, preventive, and community healthcare services through a variety of proven strategies, including:

- Increasing access to local community health centers, neighborhood and specialty chronic disease clinics, and nurse-managed health clinics
- Expanding evidence-based community prevention and wellness programs
- Increasing the use of mobile integrated health and community paramedicine programs
- Increasing the use of advanced practice nurses and allowing them full practice authority in all states
- Eliminating barriers that prevent triaging of patients from the ED to primary care health facilities
- Collaborating with community-based programs to build and maintain a coordinated system of services that advance a continuum of quality care for patients with mental illnesses and substance use disorders
- Increasing the use of case managers and clinical social workers in the ED who can help patients access non-ED resources whenever possible\textsuperscript{52,53}

EDs can also help combat the problem of overcrowding by adopting practices that more efficiently treat all patients, including those requiring specialized care,\textsuperscript{22} thereby improving ED patient flow.\textsuperscript{48}

**Resources**


Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?: Hearings before the Committee on the Judiciary, Senate, 114th Cong. 1 (2015) (Testimony of Leemore S. Dafny).


References


Position Statement

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