

Relationship of Affordable Care Act Implementation to Emergency Department Utilization Among Young Adults

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Study objective: The 2010 provision of the Patient Protection and Affordable Care Act (ACA) extended eligibility for health insurance for young adults aged 19 to 25 years. It is unclear, however, how expanded coverage changes health care behavior and promotes efficient use of emergency department (ED) services. Our objective was to use population-level emergency department data to characterize any changes in diagnoses seen in ED among young adults since the implementation of the ACA dependent coverage expansion.

Methods: We performed a difference-in-differences analysis of 2009 to 2011 ED visits from California, Florida, and New York, using all-capture administrative data to determine how the use of ED services changed for clinical categories after the ACA provision among young adults aged 19 to 25 years compared with slightly older adults unaffected by the provision, aged 26 to 31 years.

Results: We analyzed a total of 10,158,254 ED visits made by 4,734,409 patients. After the implementation of the 2010 ACA provision, young adults had a relative decrease of 0.5% ED visits per 1,000 people compared with the older group. For the majority of diagnostic categories, young adults' rates and risk of visit did not change relative to that of slightly older adults after the implementation of the ACA. However, although young adults' ED visits significantly increased for mental illnesses (2.6%) and diseases of the circulatory system (eg, nonspecific chest pain) (4.8%), visits decreased for pregnancy-related diagnoses and diseases of the skin (eg, cellulitis, abscess) compared with that of the older group (3.7% and 3.1%, respectively).

Conclusion: Our results indicate that increased coverage has kept young adults out of the ED for specific conditions that can be cared for through access to other channels. As EDs face capacity challenges, these results are encouraging and offer insight into what could be expected under further insurance expansions from health care reform. [Ann Emerg Med. 2016;67:714-720.]

Please see page 715 for the Editor's Capsule Summary of this article.

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INTRODUCTION

Young adults represent a unique population with distinct health care needs. Although they are generally healthy, they also have high rates of preventable diseases and injuries.¹ Studies suggest that young adults rely heavily on emergency department (ED) care for their health care needs, and in California adults aged between 19 and 34 years had a 15% increase in ED visits from 2005 to 2010.^{2,3} High ED utilization among young adults could reflect many factors, including lack of insurance, limited access to primary care, and redirection from other care facilities. As EDs face cost containment⁴ and crowding issues,⁵ it is increasingly important for policymakers to address high ED utilization across all populations to improve the efficiency and quality of the health care system.

In September 2010, the Patient Protection and Affordable Care Act (ACA) enacted a specific provision geared toward young adults aged 19 to 25 years to expand insurance coverage, the dependent coverage expansion. This provision enabled young adults to remain as dependents on their parents' private health insurance policies. Studies suggest that the 2010 provision increased the proportion of health care visits covered by private insurers,⁶⁻⁸ with non-Hispanic whites demonstrating greater net gains in coverage compared with other race or ethnic groups.⁹

Other studies indicate that dependent coverage expansion was associated with an overall decrease in ED utilization among young adults compared with an older population.^{10,11} However, these modest decreases in ED utilization provide little insight on how expanded insurance

Editor's Capsule Summary*What is already known on this topic*

The Patient Protection and Affordable Care Act (ACA) has expanded insurance coverage, especially for young adults under their parents' private insurance policies.

What question this study addressed

Using administrative databases from 3 large states, the authors analyzed the change in emergency department (ED) utilization before and after implementation of this ACA provision.

What this study adds to our knowledge

After coverage expansion, there was a slight decrease in ED visits for conditions treatable in an ambulatory setting, but an overall increase in ED utilization.

How this is relevant to clinical practice

This study demonstrates ED utilization changes possibly related to increased insurance access for a relatively healthy patient population.

coverage affects overall changes in health care use behavior and in which medical conditions these reductions occur. Specific knowledge distinguishing the medical conditions for which young adults continue to seek care in the ED from those for which use has decreased can shed light onto how the health care system is addressing the underlying needs of young adults and guide future policies targeting this population.

This study examines changes pre- versus post-ACA in rates of diagnosis-specific ED visits by young adults aged 19 to 25 years in 3 US states compared with adults aged 26 to 31 years during the same period who were unaffected by the 2010 provision. For each diagnosis group, we estimated both the change in the number of ED visits per year and the change in the risk of ever visiting the ED for young adults compared with the control group pre- versus post-ACA. Given previous reports of racial disparities in the expansion coverage,^{9,10} we also sought to explore these changes across race and ethnic groups.

MATERIALS AND METHODS**Study Design and Setting**

We performed a retrospective analysis of 2009 to 2011 ED visits to determine how the use of ED services changed for discrete clinical categories before versus after the ACA's dependent coverage expansion among young adults

aged 19 to 25 years. We compared service use with that of a control group of slightly older adults aged 26 to 31 years, who were unaffected by the ACA provision. ED visits were obtained from all-capture longitudinal state ED databases and state inpatient databases in California, Florida, and New York, thus capturing ED encounters that resulted in discharge or admission to a hospital. The state inpatient database and state ED database are distributed by the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project.¹²

Selection of Participants

A pre-ACA period was defined from September 1, 2009, through August 31, 2010, 1 year preceding the provision's implementation, and a post-ACA period from January 1 through December 31, 2011. We excluded the period from September 1 through December 31, 2010, to avoid uncertainties about when insurance plans renewed, as other studies have done.^{8,10} We extracted 11,413,240 ED encounters made by patients aged 19 to 31 years in these 2 periods. We excluded records that did not have a visit linkage number (9%) or were from out of state (3%).

Methods of Measurement

Each visit was categorized by primary discharge diagnosis into one of 18 diagnostic groups, using the Clinical Classifications Software provided by the Agency for Healthcare Research and Quality.¹³ The software collapses more than 14,000 *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes into 18 discrete, clinically meaningful categories. Two Clinical Classifications Software categories were excluded from the analysis, conditions originating in the perinatal period and residual and unclassified codes, because one category was not applicable to our population and the second could not provide meaningful information about the reason for the ED visit.

For each period, we counted the number of ED visits a person had for each of the Clinical Classifications Software categories. We used Healthcare Cost and Utilization Project's anonymized person-specific linkage identification to aggregate across visits. Next, we used census data to calculate the number of people in each state who did not visit the ED during each period. Specifically, we first counted the observed ED visitors aggregated by race or ethnicity, sex, age, and state. For race or ethnicity, we used the following categories: non-Hispanic white, black, Hispanic, and other. Using Census Bureau population data,¹⁴ we estimated the number of residents in each demographic group. Finally, to estimate the number people

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