Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY
Department of Health Policy and Management

Medicaid Expansions Help States Cope with the Opioid Epidemic

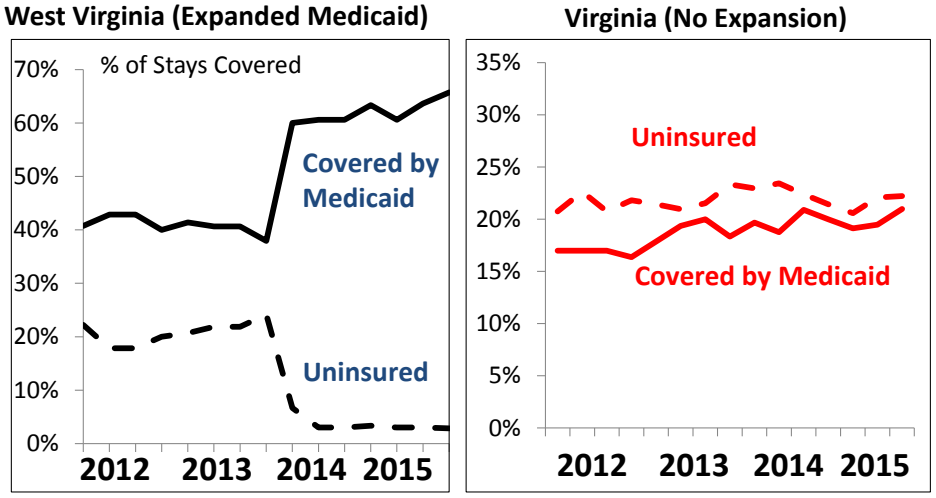
Leighton Ku, PhD, MPH, and Naomi Seiler, JD
July 25, 2017

Recent reports have noted Medicaid's central role in addressing health care treatment needs arising from the opioid epidemic and have raised concerns about the impact of efforts to curtail the Affordable Care Act Medicaid expansion on states' ability to address the opioid epidemic. These observations and concerns are reinforced by new data about opioid-related emergency room visits and inpatient hospital admissions show how states that have adopted the Medicaid expansion protect states, hospitals and consumers.

We examine newly released data from four Southern states, all of which have experienced rapid increases in emergency room visits and hospital admissions related to opioids, such as overdoses, psychiatric problems or acute treatment for addiction.[1] Two of the states (West Virginia and Kentucky) expanded Medicaid in 2014, while the other two nearby states (Virginia and North Carolina) did not.

Opioid-Related Hospital Use. Figure 1 compares the percent of opioid-related hospital stays by payer source from 2012 to 2015 in West Virginia, which expanded Medicaid in 2014, and Virginia, which has not expanded Medicaid. After West Virginia's 2014 Medicaid expansion, the percent of hospital stays for treatment of opioid addiction related problems covered by Medicaid almost doubled, climbing to over 60% by 2015, while the share opioid-related hospital

Figure 1.
West Virginia's 2014 Medicaid Expansion Helped Cover the Costs of Opioid-Related Hospital Stays, While Little Changed in Virginia

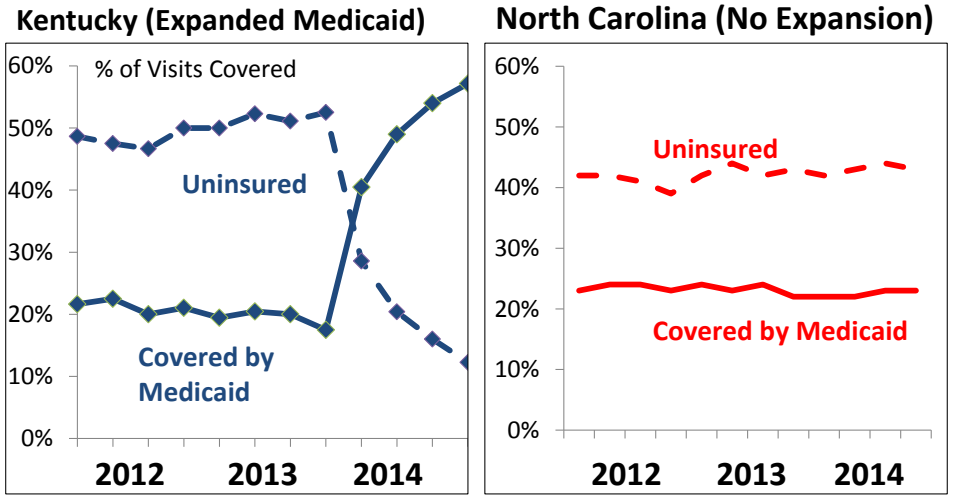


Source: GW analysis of HHS, Healthcare Cost and Utilization Data, July 2017. Data for Medicare and Private Insurance Not Shown

visits by uninsured patients plummeted to 3%, thereby reducing hospitals' uncompensated care burdens. By contrast, Virginia opioid-related inpatient hospital discharges experienced almost no change in coverage patterns among admitted patients and thus continued to be burdened by high uncompensated care costs. In West Virginia, the additional Medicaid revenue and the reduction in uncompensated care costs helps these hospitals – urban and rural – remain solvent and staffed, so that they can continue to address patients' health problems. (The pattern of increasing receipt of Medicaid revenue and falling uncompensated care use after 2014 exists more broadly for West Virginia, not just for opioid-related hospital stays.)

Opioid-Related Emergency Room Visits. Similarly, Figure 2 compares the insurance status for emergency room visits related to opioid abuse from 2012 to 2014 in Kentucky, which expanded Medicaid eligibility, and North Carolina, which did not. In 2012 and 2013, Medicaid covered about one-fifth of the opioid emergency visits, while about half of the emergency visits were from those who were uninsured. (The remainder were Medicare and privately insured patients, whose trends did not change). In 2014, as emergency room visits rose, the share of visits covered by Medicaid climbed sharply, accounting for over half (57%) by the end of 2014, while the share for the uninsured plunged to 12%. The result was a significant decline in the proportion of emergency room services that were uncompensated, a key factor in enabling hospitals to maintain staffed, functioning emergency departments that serve entire communities.

Figure 2.
Kentucky's 2014 Medicaid Expansion Helped Cover the Costs of Opioid-Related Emergency Room Visits, While Little Changed in North Carolina



Source: GW analysis of HHS, Healthcare Cost and Utilization Data, July 2017. Data for Medicare and Private Insurance Not Shown

In contrast, in North Carolina, about two-fifths of the patients remained uninsured while only about one-quarter of all visits were insured through Medicaid. In these states, hospital emergency care departments experienced no relief in their uncompensated care burdens.

Conclusions. While we illustrate the findings from four states, similar patterns occurred in other states with opioid crises such as Ohio, another Medicaid expansion state, or Maine, another state that has not expanded Medicaid. Medicaid expansions are a critical form of support for states, hospitals and patients that help them address calamities related to the opioid epidemic.

In states that expanded Medicaid coverage, millions of people gained health insurance, including those in need of care and treatment to deal with opioid abuse. Because insurance plays such a significant role in access to health care, particularly the types of high-cost rehabilitation services needed to address opioid addiction, the ACA Medicaid expansions enable hospitals and their communities to provide care for longer-term treatment of those addicted. Finally, by reducing the proportion of uninsured patients, the Medicaid expansion has reduced the level of wholly uncompensated care hospitals must manage, a particularly serious problem for small rural hospitals located in and serving low income communities facing elevated health risks. Congressional proposals to end Medicaid expansions would undercut a proven and successful strategy to help address the ongoing opioid epidemic.

Endnote:

[1] These are data reported by states to the Healthcare Cost and Utilization Project of the Department of Health and Human Services. Opioid-related visits are determined based on diagnoses, like overdoses, reported in the emergency room or hospital reports. They do not include cases in which opioids are prescribed for another problem, e.g., to relieve pain due to injury or illness. Due to limitations in the data, data about emergency room use are not available for West Virginia and 2015 data are not available for emergency room use in Kentucky.