

More Uninsured May Visit EDs After Medicaid Cuts

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — More uninsured patients will be seen in emergency departments if states cut back Medicaid programs, Dr. Robert A. Lowe said at the annual meeting of the Society for Academic Emergency Medicine.

A study in Oregon confirmed the assumption that Medicaid cutbacks increase the proportion of patients without insurance among those seeking emergency care, said Dr. Lowe, director of the Center for Policy and Research in Emergency Medicine, Oregon Health and Science University, Portland.

The state's Medicaid program—the Oregon Health Plan—was “the crown jewel of Oregon health policy” in the early 1990s, but a state fiscal crisis led to cutbacks in 2003, he said. Enrollees who missed a premium payment for 1 month were locked out of the plan for 6 months. A new copayment of \$50 for emergency department (ED) visits was added, and the scope of benefits shrank. Within 6 months of the policy changes, 50,000 people lost coverage by the plan.

An analysis of data from before and after the changes showed that the cutbacks produced an abrupt and sustained increase in the number of uninsured patients seeking emergency care, Dr. Lowe and his associates reported.

In 10 urban EDs, the total number of visits remained relatively flat: 31,492 per month in 2002 and 31,910 per month in 2004. The number of patients covered by

the Oregon Health Plan seen in the 10 EDs declined by 5,076 per year (from 7,964 per month in 2002 to 7,541 per month in 2004). The number of commercially insured patients seen fell by 12,144 per year (from 11,020 per month in 2002 to 10,008 per month in 2004). The number of uninsured patients seen in the 10 EDs rose by 18,348 per year (from 4,018 per month in 2002 to 5,547 per month in 2004).

Data from 25 of Oregon's 59 EDs, in-

cluding 16 urban and nine rural hospitals, showed increased numbers of uninsured patient visits in 2004 over those in 2003—differences that were statistically significant in 24 hospitals. The proportion of patients covered under the Oregon Health Plan or by commercial insurance fell significantly in 20 of the 25 EDs.

“The policy implications of this are of concern because almost all states are now undergoing cutbacks in Medicaid, which would lead us to expect substantial in-

creases in ED use by the uninsured nationwide,” Dr. Lowe said.

The decline in commercial insurance coverage probably was a result of the recession and loss of jobs during this time period, he added.

The increase in the number of uninsured patients exceeded the combined drops in patients covered by the Medicaid plan or commercial insurance, which also may be related to the recession, Dr. Lowe said. ■

F Y I

Memory Loss Booklet

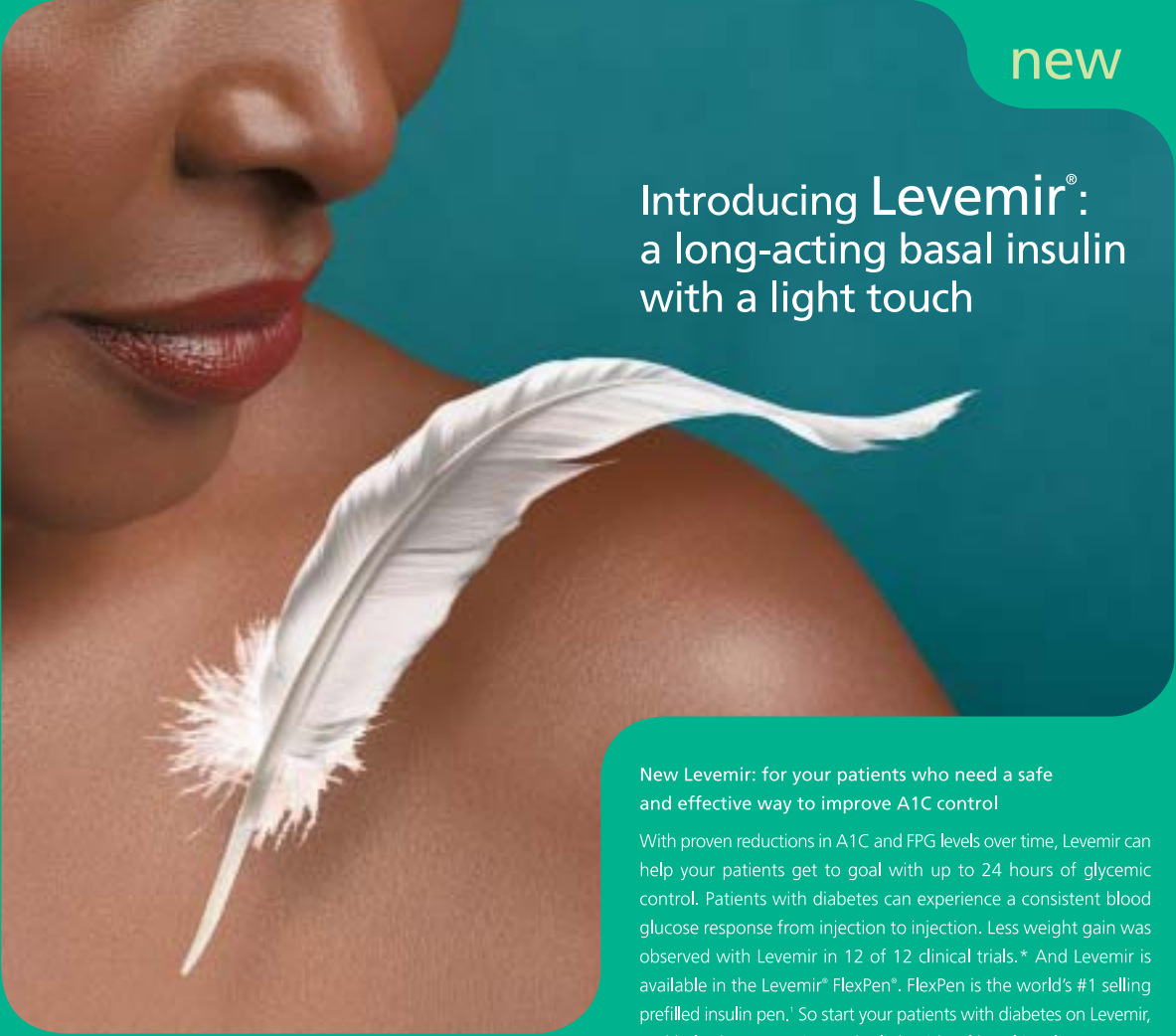
The National Institute on Aging is offering a free booklet designed to help people with limited reading skills learn about memory loss. “Understanding Memory Loss” discusses the range and causes of memory problems, as well as the treatments. To download the booklet, visit www.nia.nih.gov/alzheimers/publications/understandingmemoryloss or order by calling 800-438-4380.

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Families for Depression Awareness, a non-profit organization, offers an online tool to help map family behavior patterns that may be associated with bipolar disorder. The mental health family tree builder provides a printout that people can use to start conversations with their physicians or family members. For more information, visit www.mentalhealthfamilytree.org.

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Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Any change of insulin dose should be made cautiously

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Levemir is not to be used in insulin infusion pumps. Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir from other intermediate or long-acting insulin preparations. The dose of Levemir may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

*Whether these observed differences represent true differences in the effects of Levemir and NPH insulin is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

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