Evaluations of Wisconsin’s Medicaid/BadgerCare Program Reforms

What Can BadgerCare Tell Us About Health Care Reform?

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IRP Partners: Steve Cook and Maggie Darby Townsend
Cross-cutting question:

- How do changes in premiums and eligibility rules affect program enrollment and exit, health care utilization, and program costs?

Project-specific studies focusing on

- Childless adults
- Routes to enrollment
- Crowd-out
- Labor Market Impacts
- Rural and urban impact
Funders

- Robert Wood Johnson Foundation
- Wisconsin Department of Health Services
- U.S. Centers for Medicare and Medicaid Services
- W.E. Upjohn Institute for Employment Research
- UC-Davis Center for Poverty Research
- ICTR-CAP
- UW Partnership Fund
Cost, Coverage, & Access

Overview of Research


Evaluation of BadgerCare Core Plan for Adults without Dependent Children (“Childless Adults”)

- Report #1: Evaluation of Wisconsin’s BadgerCare Plus Core Plan for Adults without Dependent Children: How Does Coverage of Childless Adults Affect Their Utilization?
- Report #2: Evaluation of Wisconsin’s BadgerCare Plus Core Plan for Adults without Dependent Children: The Utility of the Health Needs Assessment (HNA)
- Report #3: Evaluation of Wisconsin's BadgerCare Plus Core Plan for Adults without Dependent Children: Is Early Utilization Distorted by Pent-Up Demand?

Evaluation of Wisconsin’s BadgerCare Plus Health Care Coverage Program
Final Reports, December 2010

- Report #1: Executive Summary Findings on Enrollment, Take-Up, Continuity, Target Efficiency, and Participation in Employer-Sponsored Insurance Coverage
- Report #2: Enrollment, Take-Up, Exit, and Churning: Has BadgerCare Plus Improved Access to and Continuity of Coverage?
- Report #3: Target Efficiency and the Displacement of Private Insurance: How Many New BadgerCare Enrollees Came from the Uninsured?
- Report #4: Wisconsin's Lessons about the Potential of Medicaid Auto-Enrollment
- Report #6: Has Wisconsin Achieved the Policy Goal of 98% Access to Health Insurance?
Data Sets

- Medicaid CARES Eligibility and Enrollment
- Medicaid/BadgerCare Claims
- TPL – Third Party Liability (DHS)
- EVHI – Employer Verification of Health Insurance (DHS)
- Unemployment Insurance (DWD)
- ERISA self-insured employers (U.S. DOL)
- HNA - Health Needs Assessment (DHS)
- ACS and CPS
- Milwaukee County GAMP Claims
- Marshfield Clinic Encounter Data
- Wisconsin Family Health Survey
- Vital Statistics – Birth and Death records
- HMO High Risk Pregnancy Registry
- Wisconsin All Payer Claims Database – WHIO
- National Death Index (NDI)
Prior study: Estimates of Crowd-Out from a Public Health Insurance Expansion Using Administrative Data

Research Question:
- To what degree do new enrollees in public health insurance come from private sector coverage?

What Fraction of Medicaid Enrollees Have Private Insurance Coverage at the Time of Enrollment?
Estimates from Administrative Data
Laura Dague, Thomas DeLeire, Donna Friedsam, Lindsey Leininger, Sarah Meier and Kristen Voskuil
INQUIRY 2014 51:
The Effect of Cost-Sharing

Research Question:
- How do changes in premiums and eligibility rules affect program enrollment and dis-enrollment, health care utilization, and program costs?

The effect of Medicaid premiums on enrollment: A regression discontinuity approach
Laura Dague*
Journal of Health Economics 37 (2014) 1–12
The Effect of Public Insurance Coverage for Childless Adults on Labor Supply

Laura Dague, Thomas DeLeire, Lindsey Leininger

NBER Working Paper No. 20111
Issued in May 2014
NBER Program(s): HE LS

This study provides plausibly causal estimates of the effect of public insurance coverage on the employment of non-elderly, non-disabled adults without dependent children ("childless adults"). We use regression discontinuity and propensity score matching difference-in-differences methods to take advantage of the sudden imposition of an enrollment cap, comparing the labor supply of enrollees to eligible applicants on a waitlist. We find enrollment into public insurance leads to sizable and statistically meaningful reductions in employment up to at least 9 quarters later, with an estimated size of from 2 to 10 percentage points depending upon the model used.
Informing Medicaid Program Design: The Promise of Self-Reported Health Measures

Research Questions:

- How useful are self-reported health measures in informing benefit design and supporting predictive modeling of future health care costs and utilization for Medicaid?
- How well does the model prospectively classify “at risk” individuals and support risk adjustment and case management?
The ACA Expands Medicaid Eligibility to Include More Low-Income Adults

Impact on Access to Care: Oregon Health Study

- Medicaid significantly increased the probability of having a usual source of primary care, the use of recommended preventive care, and the use of outpatient care, prescription drugs, and hospital care.
- Medicaid adults had lower out-of-pocket medical costs, less medical debt.
- Coverage expansion is followed by a (short-term?) spike in emergency department utilization.

This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain. Baicker, et al, NEJM, 2013.
The Opinion Pages
ROOM for DEBATE

MAY 8, 2013
More Medicaid, More Health?

Almost Any Cost Is Catastrophic if You’re Poor
AUSTIN FRAKT, VETERANS HEALTH ADMINISTRATION
This is just one small study. Evidence shows that Medicaid has been beneficial nationwide and this study shows a range of benefits.

Why Expand Care With No Proven Benefits?
MICHAEL F. CANNON, CATO INSTITUTE
Expenses simply can’t be justified.

Poor People Have the Same Needs as Others
DREW ALTMAN, KAISER FAMILY FOUNDATION
Would you feel comfortable with a catastrophic coverage plan with a deductible of several thousand dollars a year?

Routine Illness Can Be Devastating
ROBERT REICH, FORMER LABOR SECRETARY
Infections and injuries, unattended can cause extended absences or worse. Low-income children need checkups and dental care.

Adding More People to Medicaid Isn’t the Answer
GRACE-MARIE TURNER, GALEN INSTITUTE
We need to modernize the program to free recipients from the Medicaid ghetto so they can have the dignity of private coverage.
Expanding Coverage to Uninsured Childless Adults: Effect on the Use of Health Care

Research Question:

- How does covering the uninsured with public insurance affect their health care utilization?
- Does the new coverage reduce the ineffective and inappropriate use of medical care, increase the use of primary and preventive care, and improve health?
Demand for Care Among Low-Income Childless Adults After Coverage Expansion

**Wisconsin Experience Indicates That Expanding Public Insurance To Low-Income Childless Adults Has Health Care Impacts**

*Health Affairs, 32, no.6 (2013): 1037-1045*

*In press*

Burns M, DeLeire T, Dague L, Leininger L, Voskuil K, Friedsam D. “Expanding Public Insurance to Rural Wisconsin Low-Income Childless Adults Increases the Use of Medical Care.”

*Health Services Research.*
What is the Effect of Coverage Expansion to Low-Income Childless Adult Populations on the Demand for Care/Utilization of Services?
Evaluation of Wisconsin’s BadgerCare Core Plan

- Medicaid-like plan for uninsured adults without dependent children with incomes < 200% FPL
- Wave 1 of enrollment occurred on January 1, 2009
  - Automatic enrollment of individuals participating in Milwaukee County’s safety net program
- Wave 2 of enrollment opened July 1, 2009
  - Open statewide to eligible individuals
  - Enrollment closed suddenly on Oct 9, 2009
  - Subsequent applicants placed on a waitlist
Two Evaluations of the Wisconsin Core Plan

- Study #1: Poor Childless Adults in Milwaukee County
  - Prior users of the county safety net system who were automatically enrolled into the Core Plan
- Study #2: Low-Income Childless Adults in Rural Wisconsin
  - Prior users of Marshfield’s Family Health Center (a community health center) who were subject to substantial outreach and enrollment effort
  - Other low-income individuals in Marshfield area who voluntarily enrolled into the Core Plan
Methods

- Individual level fixed effect poisson models
  - Effectively compares each individual’s use of care when covered with that individual’s use when uninsured
- Regression discontinuity (Marshfield Study)
  - Compare use of care among individuals enrolled into the Core Plan with the use of individuals placed on the waitlist
Data and Measures

- Study #1: Medicaid and prior GAMP claims data
  - Examined use of care as person-level counts of visits at 1-month intervals.
  - Compared 1 year of data pre-enrollment with 1 year of data post-enrollment

- Study #2: Claims, encounter, and enrollment data from the Marshfield clinic and from the Wisconsin Medicaid program
  - Examined use of care as person-level counts of visits at 6-month intervals.
  - Compared 2 years of data pre-enrollment with 2 years of data post-enrollment
Outcomes

Emergency Department Visits

Outpatient Visits

Hospitalizations
Study #1: Milwaukee

- Outpatient visits increased 29%
  - 16.4% increase in primary care
  - 78.2% increase in visits to specialists
  - 55% increase in preventive visits
  - 13.5% increase in episodic visits

- Hospitalizations (inpatient) declined 59%
  - Preventable hospitalizations fell 48%. These declines are large and statistically significant.
  - Declines occurred in 10 out of the 11 measures of preventable hospitalization—conditions, such as hypertension, that can typically be controlled if an individual has access to appropriate primary or specialty care.

- Emergency department visits increased 46%
  - 38.7% increase in ambulatory care sensitive visits.
  - Large percent increase in the number of visits for mental health, drug, or alcohol reasons and for reasons that were unclassified.
Similar to, but not the same as, the Oregon Health Study, which found:

- 35% increase in the probability of having an outpatient visit
- 30% increase in the probability of having a hospital admission
- 15% increase in the probability of taking any prescription drugs

“The results confirm that Medicaid coverage increased overall health care utilization, improved self-reported health, and reduced financial strain.”
Study #2: Marshfield

- Large increase in the mean number of outpatient visits (a 39% increase; \( p=0.026 \)) relative to the waitlist applicants
- Cannot conclude that there was an increase or decrease in ED visits, as the regression discontinuity estimates are inconsistent between specifications
- Increase in the number of inpatient stays (a 124% increase relative to a baseline average of 0.034 visits; \( p\text{-value} = 0.081 \)).

<table>
<thead>
<tr>
<th>Summary of Regression Discontinuity Results</th>
<th>Any Outpatient</th>
<th>Preventive</th>
<th>Behavioral Health</th>
<th>Emergency</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Values for Core Enrollees</td>
<td>2.783</td>
<td>0.275</td>
<td>0.297</td>
<td>0.056</td>
<td>0.034</td>
</tr>
<tr>
<td>Coefficient</td>
<td>1.076</td>
<td>0.256</td>
<td>-0.064</td>
<td>0.060</td>
<td>0.042</td>
</tr>
<tr>
<td>P-Value</td>
<td>0.026</td>
<td>0.000</td>
<td>0.655</td>
<td>0.086</td>
<td>0.081</td>
</tr>
</tbody>
</table>

Notes: All results estimated at a bandwidth of 14 days excluding one week prior to and following the closing date to account for announcement effects.
Coverage Expansions Have Divergent Effects

- **Outpatient visits**
  - Increase in Milwaukee sample
  - Increase in one rural sample
  - No change in one rural sample

- **ED visits**
  - Increase in Milwaukee sample
  - No change in 2 rural samples

- **Hospitalizations**
  - Decrease in Milwaukee
  - Increase in 2 rural samples

- Different patterns of effects on the use of care for different study samples
  - Rural versus urban
  - Integrated health system versus traditional
  - Previous users of safety net system vs. not
So the debate continues about the affects of Medicaid expansions
SURVEY: Milwaukee ER Visits Increase after Obamacare Implementation

Health Policy Brief

Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California’s Low Income Health Program

Nigel Lo, Dylan H. Roby, Jessica Padilla, Xiao Chen, Erin N. Salce, Nadereh Pourat, Gerald F. Kominski
Wisconsin 2012 Medicaid Waiver

- Modeled Premium and ESI Affordability Standards on ACA provisions
- Added sliding-scale premiums for adults starting at 133% FPL
- Changed the eligibility rules regarding persons with offers of employer-sponsored coverage (ESI), aligning the affordability measure to the ACA’s 9.5% standard.
Policy Context

- Reasons for introducing premiums:
  - Limit state program costs
  - Encourage personal responsibility
  - Make public coverage look more like private coverage

- Possible downsides:
  - Increased number of uninsured
  - Adverse health outcomes

Objective: to measure how the ACA-like premium structure affects Medicaid exit rates for parents and non-elderly, non-disabled adults without dependent children (“childless adults”)
Background

- Little research exists on the effects of premiums for adults in Medicaid, and none on childless adults.
- Wisconsin’s BadgerCare Plus Program in 2012 covered parents and caretakers, as well as some childless adults, up to 200% FPL
- In June 2012, more than 225,000 parents/caretakers and 25,000 childless adults were enrolled
- Effective July 2012, some current enrollees had premiums increased or faced new premiums depending on income as a percent of the Federal Poverty Level (FPL)
## Changes in Premium Cost-Sharing

<table>
<thead>
<tr>
<th></th>
<th>Prior to July 2012</th>
<th>Effective July 2012</th>
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<tbody>
<tr>
<td></td>
<td>Childless Adult</td>
<td>Parent/Caretaker</td>
</tr>
<tr>
<td></td>
<td>($/month)</td>
<td>($/month)</td>
</tr>
<tr>
<td>&lt;133%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>133-140%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>140-150%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>150-160%</td>
<td>0</td>
<td>$10</td>
</tr>
<tr>
<td>160-170%</td>
<td>0</td>
<td>$27</td>
</tr>
<tr>
<td>170-180%</td>
<td>0</td>
<td>$68</td>
</tr>
<tr>
<td>180-190%</td>
<td>0</td>
<td>$122</td>
</tr>
<tr>
<td>190-200%</td>
<td>0</td>
<td>$188</td>
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</tbody>
</table>

For reference, 133% FPL in 2014 was ~$2194/month for a family of 3, so premiums would start at ~$66/month for such a family in July 2012.
Data

- Administrative enrollment data from the State of Wisconsin
- February 2008 to December 2013
- Eligibility records contain:
  - Gender, age, race, household composition, employment status
  - Monthly enrollment status and premium requirements, including whether premiums were paid
  - Exact determination of family income at application
Methods: Effects of Premiums on Enrollment

- Use a natural experiment from Wisconsin’s BadgerCare Plus Programs
- Difference-in-differences models
  - For parents/caretakers, compare those who faced new premiums (133-150% FPL) and increased premiums (150-200% FPL) to those who saw no change, before and after July 2012
  - For childless adults, compare those who faced new premiums to those who saw no change, before and after July 2012
- Specifications:
  - Cox proportional hazard models, a form of discrete-time hazard model.
  - Ordinary least squares regression /Individual fixed effects regression
Methods: Effects of Premiums on Utilization

- Examine utilization outcomes by type of service (emergency department, inpatient, and outpatient), and stratify by income level and corresponding monthly premium amount.
- Use the structure of the premium requirement to create comparison groups.
- Compare utilization of members with incomes just above and just below the premium thresholds, yielding estimates of the relationship between premium policy changes and service utilization.
- Regression-adjust the average visits by individual.
- Cannot be interpreted as the causal effect since likely differential selection in those who leave.
Findings Currently Under Review by State Agency
Summary of Findings: The Effect of Premiums on Exit

- More significant than the amount of the premium is the application of new premiums where there had previously been no premiums.
  - Parents: Exit rates vary by income groups, with the increase in exit rate much larger for the 133-150% FPL group than 150-200% FPL group.
  - TMA: The premium requirement was associated with 2.6-3.8 times higher exit rates, depending the group and specification.
  - Childless Adults: Exit rate were 4.2-6.4 times higher, depending on the income category.
Childless Adults much more frequently reported that they dropped their BadgerCare coverage because of increased premiums.
How are access to care and utilization affected by the application of new, or increased, premium amounts?
Differential Selection among Leavers? Parents and Caretaker Adults

- Parents/Caretaker Adults show no change in the average healthcare use of enrollees who remained enrolled in the program before and after the premium policy change.
- Enrollees who exited had similar healthcare needs, on average, to the enrollees who remained in the program, or
- Alternatively, premiums had no effect on health care use.
Differential Selection among Leavers? TMA Adults

- TMA enrollees, average health care use higher for enrollees in the post-policy period.
- This would suggest that healthier enrollees are disproportionately likely to leave the program, or
- Alternatively, premiums promote increased health care use.
Differential Selection among Leavers? Childless Adults

- Childless adult post-policy utilization increases.
- Healthier childless adults differentially likely to exit when required to pay premiums but, even so, differences are limited.
- Differences in visits for childless adults appear to be driven by selection effect.
What’s Next: Wisconsin’s 2014 Waiver
<table>
<thead>
<tr>
<th>Federal Poverty Level</th>
<th>Premiums start at 200%</th>
<th>300%</th>
<th>300%</th>
<th>100% No premiums</th>
<th>100% No premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>300%</td>
<td></td>
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<td>Former coverage of parents/caretaker adults up to 200% FPL</td>
<td>Former Core Plan wait list for childless adults up to 200% FPL</td>
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<tr>
<td>200%</td>
<td>CHILDREN (up to age 19)</td>
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<tr>
<td></td>
<td>- Youth exiting foster care (up to age 26)</td>
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<tr>
<td>100%</td>
<td>PREGNANT WOMEN</td>
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<td></td>
<td>ADULTS WITHOUT DEPENDENT CHILDREN (“childless adults”)</td>
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</table>
To what degree do people between 100-133% FPL take up ACA QHP enrollment and sustain their premium payments over time?

How does the utilization compare to prior utilization under Medicaid/BC coverage?

What is the churning experience at the 100% FPL level, relative to the churning at the 138% FPL level?

How does this policy affect continuity of coverage and care? For those with chronic conditions? Pregnant women, who will gain categorical eligibility up to 300% FPL, and then return to QHPs post-partum.

How does the access to providers compare for those in QHPs relative to those in Medicaid at these income levels?
WI DHS BadgerCare 2014 Evaluation Hypothesis: Childless Adults

By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:

- Improve health outcomes
- Reduce the incidence of unnecessary services
- Increase the cost effectiveness of Medical Assistance services
- Increase the continuity of health coverage
WI DHS BadgerCare 2014 Evaluation Hypothesis:

TMA Adults

Cost-sharing provisions on lower-income families above the poverty line will

- Reduce the incidence of unnecessary services
- Slow the growth in health care spending
- Increase the cost effectiveness of Medicaid services

The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the FFM.
Parents and caretaker BadgerCare enrollment has declined 24%.

Enrollment of Childless Adults has increased more than five-fold (564%).

- Wisconsin’s monthly average Medicaid enrollment has increased 1.6% since pre-ACA open enrollment, compared to a 3.3% increase in other states that did not participate in the ACA Medicaid expansion, and a 15.3% increase in Medicaid expansion states.

- Some of this difference in growth reflects Wisconsin’s higher eligibility levels relative to other states prior to the ACA, while some of the difference reflects the current Wisconsin Medicaid reforms.
Enrollment of People Below the Poverty Level into Medicaid/BadgerCare

- Enrollment has increased 9.4% for parents and caretaker adults below 100% FPL.
- Enrollment of children below the poverty line has increase 4.5%.
- Combined enrollment of parents/caretakers and children with incomes below the poverty line increased 6.2% — perhaps bringing in people previously eligible but not enrolled.

Note: This does not include enrollment declines from the TMA/Extensions program, depicted in slide #12.
Children’s Pre– and Post–ACA Medicaid/BadgerCare Enrollment

Change from September 2013 through June 2014

- Enrollment for children 100-250% FPL—who remain eligible for coverage but whose parents and caretakers have lost eligibility for BadgerCare coverage— has declined 5% since September 2013, with a drop-off of 5,993 children in this eligible group.

- Children above 300% FPL are no longer eligible for BadgerCare after April 1, 2014, which may account for much of the drop off noted in the <250% FPL category.

- Enrollment of children below the poverty level has increased by 13,477 children.

Note: This does not include changes in coverage extensions under “Transitional Medical Assistance” (TMA)
Wisconsin DHS tracked the enrollment status as of June 30, 2014 of 62,776 adults who became ineligible for BadgerCare under Governor Walker’s entitlement reform rules that took effect April 1, 2014.

- 18,801 (30%) selected an ACA Qualified Health Plan via the Marketplace as of June 13, 2014
- 4,867 (8%) were redetermined eligible for BadgerCare
- Insurance status of 62% of those removed from BadgerCare (38,116 people) remains unknown
Contact

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