Understanding and Boosting Enrollment in State Marketplaces and Medicaid

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Testimony for the Maine State Legislature

Joint Standing Committee on Health Coverage, Insurance and Financial Services

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Overview

1) What Drives Insurance Enrollment?
2) Evidence on Medicaid Participation Rates
3) Evidence on Marketplace Enrollment
4) Enrollment in Maine & Policy Options

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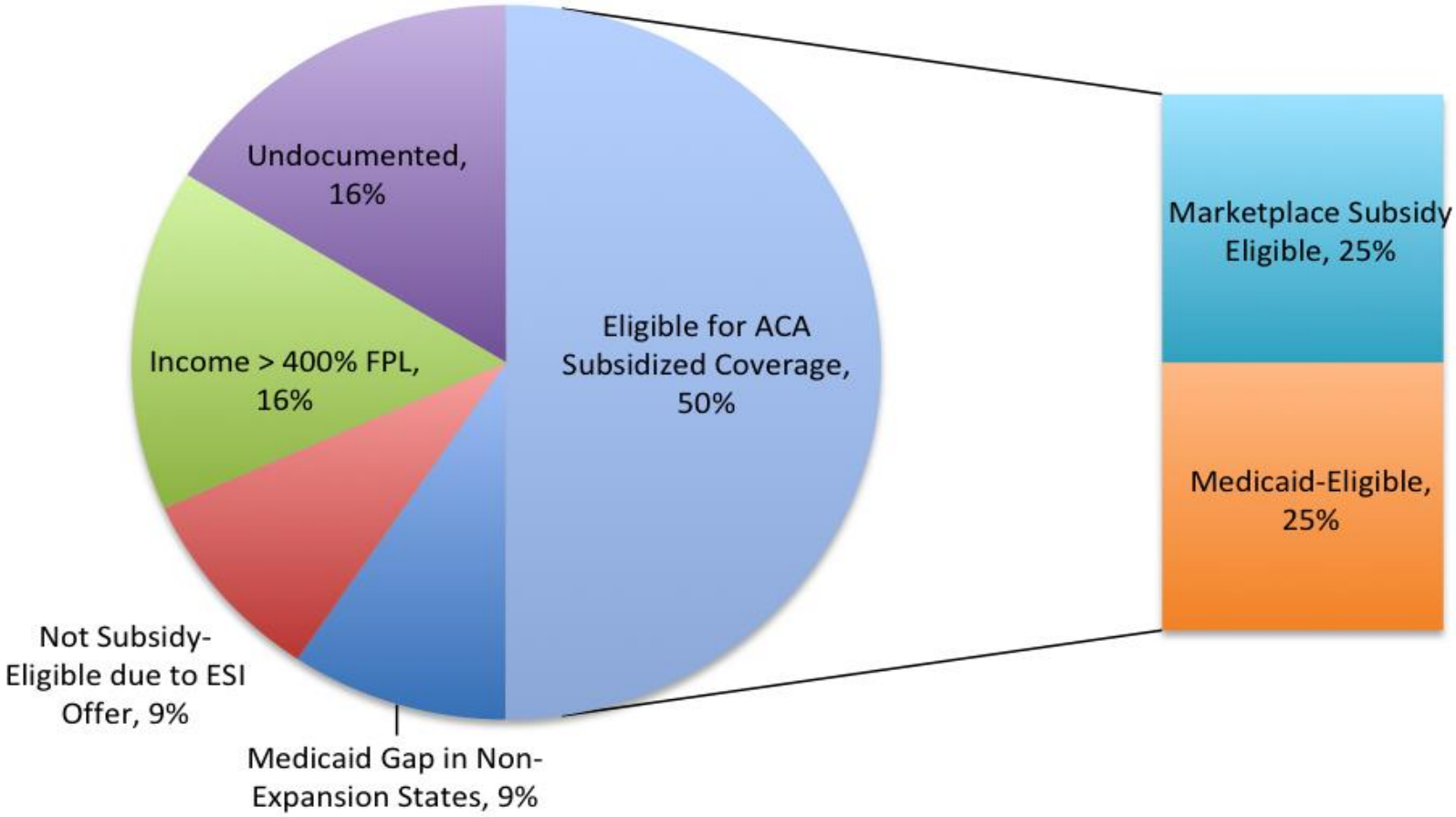
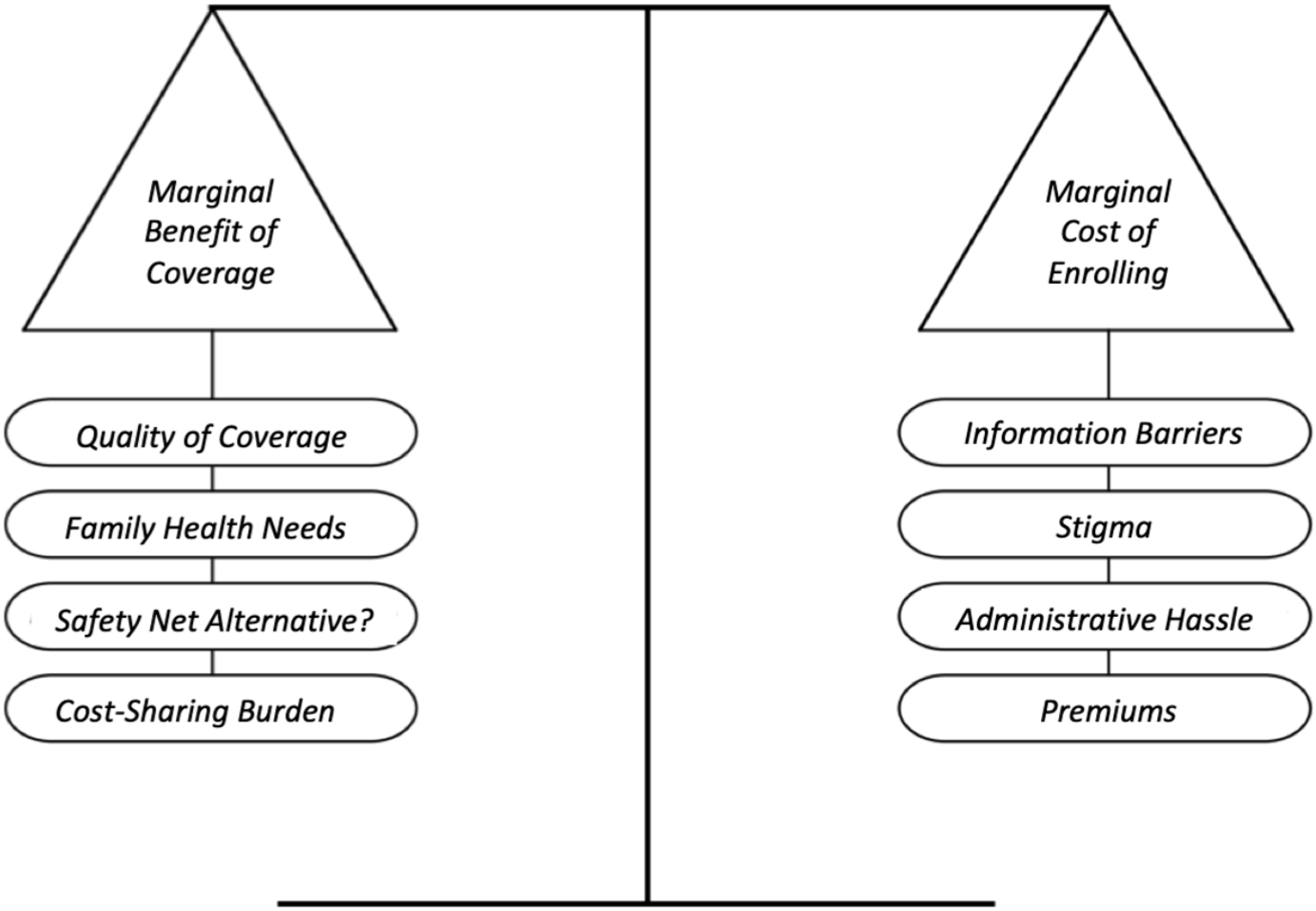
The Remaining Uninsured:
Half of this is an Enrollment Problem



Source: Adapted from Blumberg et al.'s 2018 analysis of the Current Population Survey.

Thinking about Insurance Enrollment



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Medicaid Take-Up

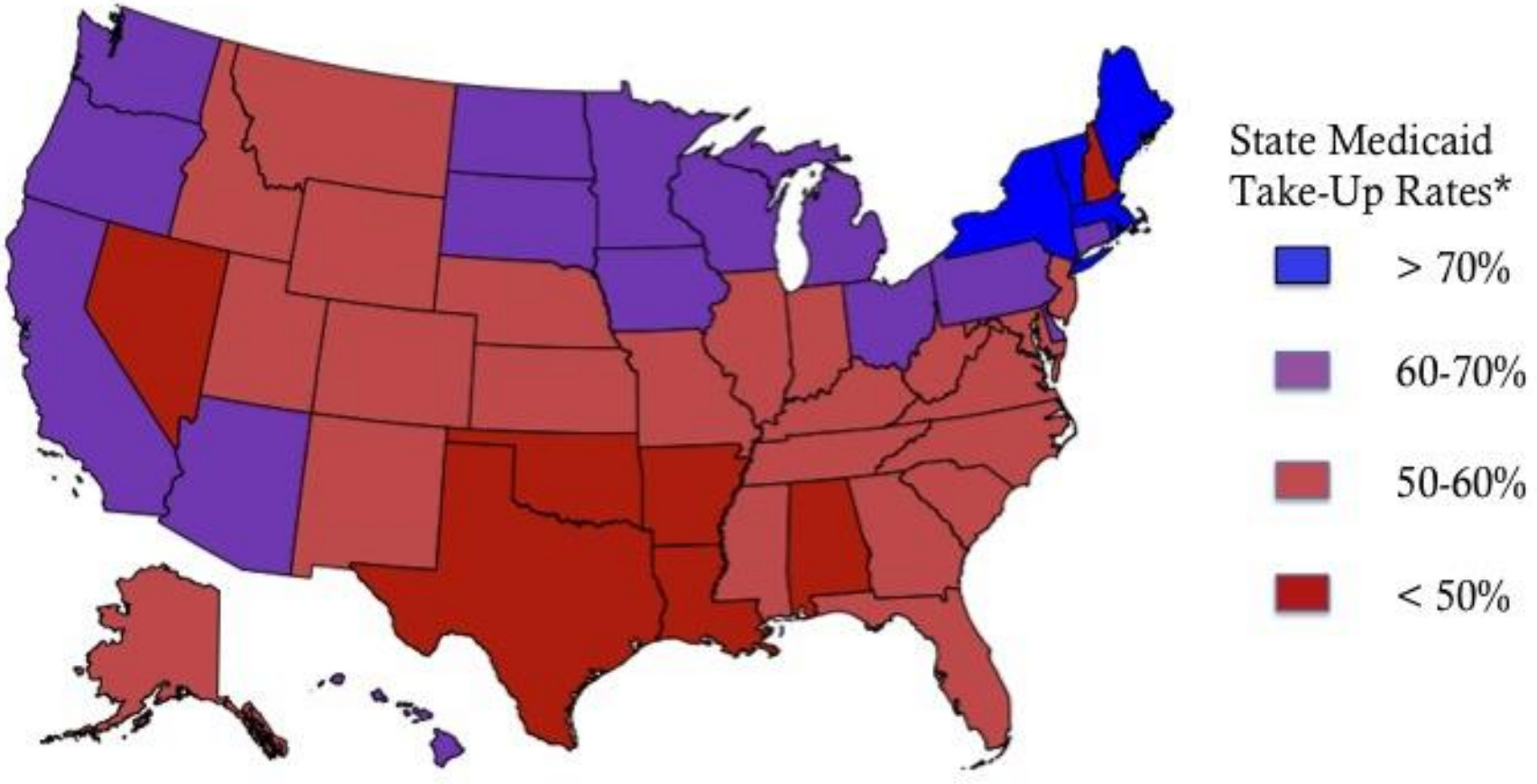
- Medicaid coverage is not automatic for those who are eligible
- Coverage typically involves lengthy application and documentation of residency, income, citizenship and other requirements depending on the state
- Barriers include lack of information, bureaucratic obstacles, lack of time, not valuing the coverage, and stigma

Pre-Expansion Medicaid Take-Up

VARIABLE	Enrollment Among Eligibles without Alternative Coverage
ALL CHILDREN	**86%**
ALL ADULTS	**62%**
Disabled	76%
Parent	57%
Other ('childless adult')	38%

Sources: Kenney et al. 2012; Sommers, Tomasi, et al. 2012;

Medicaid Take-Up, By State



* Pre-ACA participation rates among eligible adults without private insurance. Adjusted for population demographics.

Source: Sommers et al., Health Aff (2012)

What Drives State Differences?

- We studied factors on both sides of the scale
- Marginal Cost of Application:
  - Application length, complexity (reading level), availability of foreign languages
  - Online, phone, and provider-enabled applications; interview requirement
  - Frequency of renewal (every 3, 6, or 12 months)
- Marginal Benefit of Coverage:
  - Provider reimbursement rate in Medicaid
  - Medicaid Managed Care Penetration
  - Covered benefits (dental, others), and cost-sharing requirements

Source: Sommers et al., Health Aff (2012)

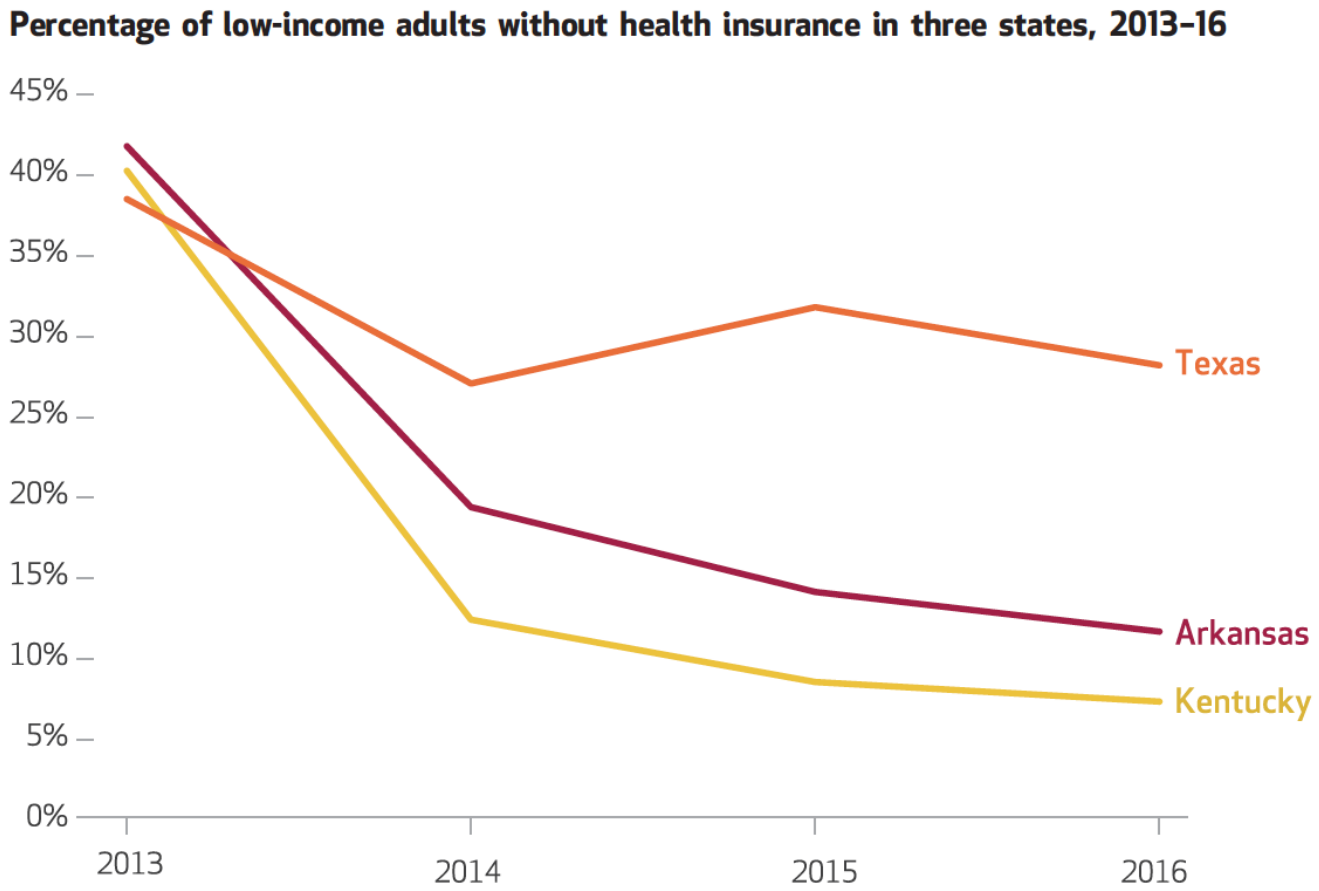
What Drives State Differences?

- Overall, many of the nitty-gritty application details didn't matter much
- Biggest positive factors for enrollment were:
  - Lower cost-sharing in Medicaid
  - More generous optional benefits
  - Higher managed care penetration rates
  - Massachusetts 2006 health reform – more on this later…

Source: Sommers et al., Health Aff (2012)

Medicaid Expansion

- Enrollment is a gradual ramping-up process
- Suggests information barriers, people waiting until they need care



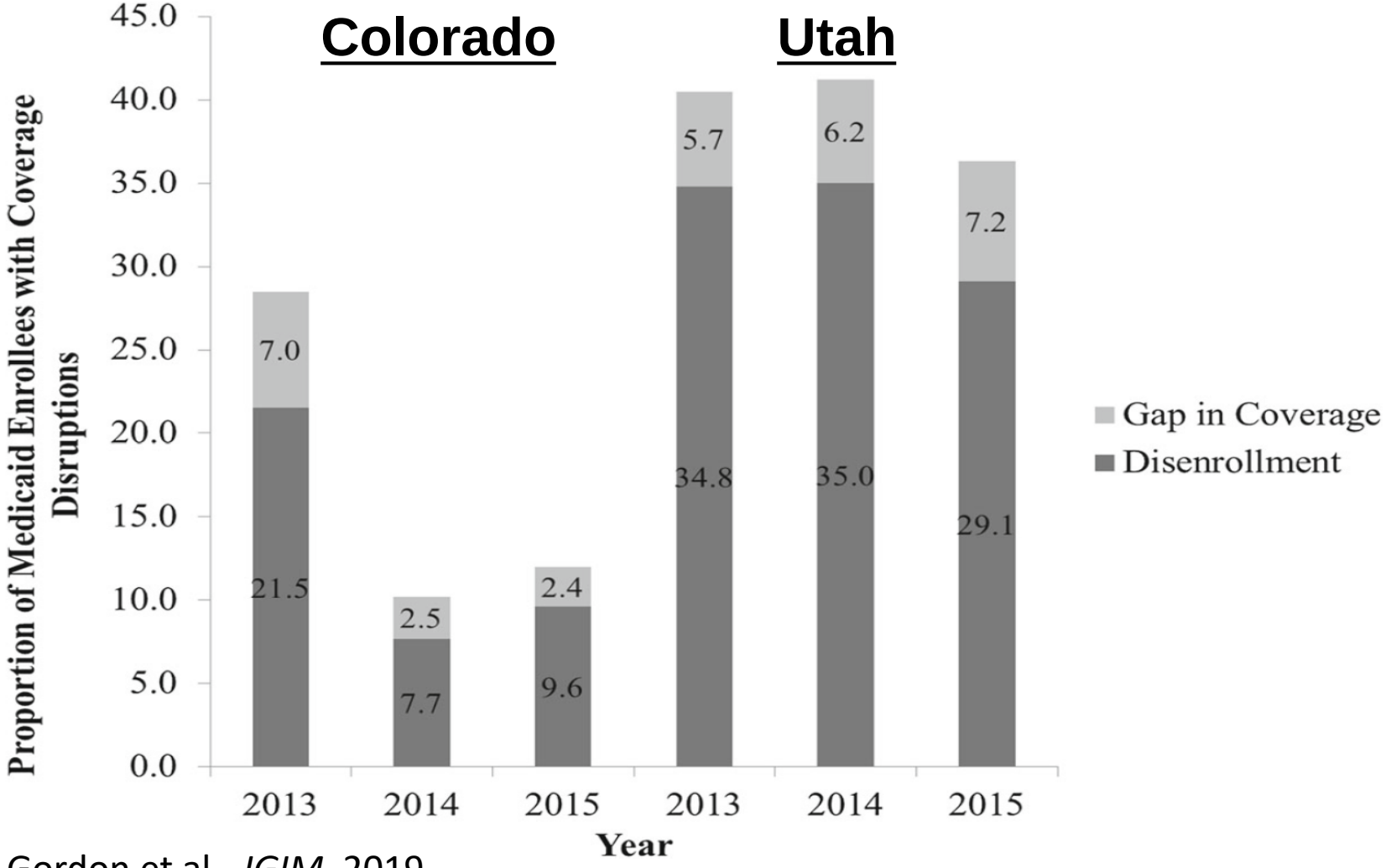
Source: Sommers et al., Health Aff (2017)

Getting in… and staying in

- Coverage in Medicaid – like private coverage – is often unstable over time
- 'Churning' refers to people moving in & out (& often back in) to insurance programs
- Pre-ACA, roughly half of adults lost Medicaid within 18 months of initial enrollment

Source: Sommers, *JGIM,* 2008

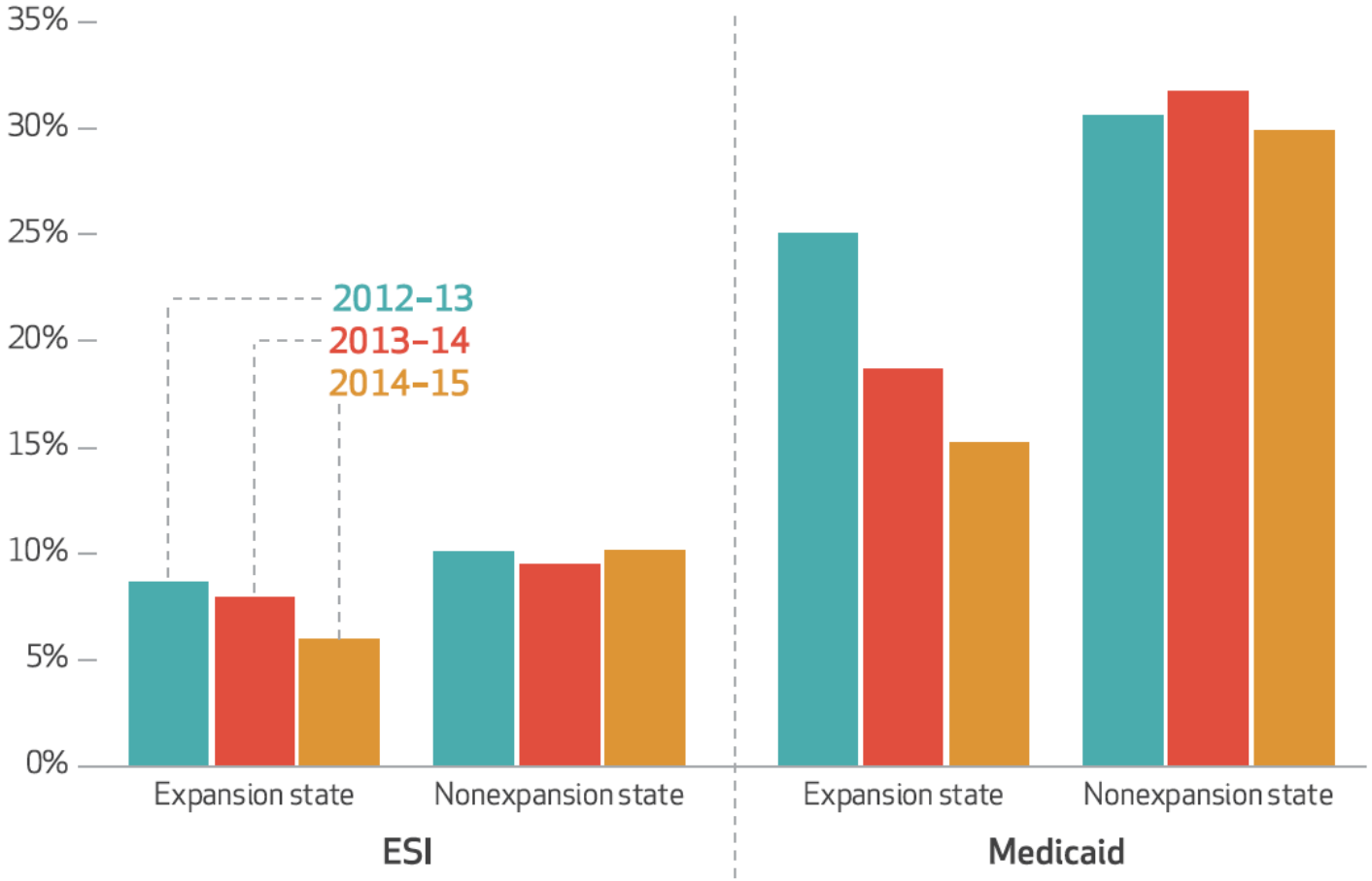
Churning after Medicaid Expansion



Source: Gordon et al., *JGIM,* 2019

Churning under ACA

Percentages of nonelderly adults with at least one uninsured spell of 3 or more months in 2012–13 through 2014–15, by whether their state expanded eligibility for Medicaid



Source: Vistnes & Cohen, *Health Aff,* 2018

Why Churning Matters

Outcome	All Churners	Churners with a Coverage Gap	Churners Without a Coverage Gap
Had to change doctor(s) because of insurance	19.5%	24.1%	14.3%
– Had to change primary care doctor	6.0%	7.3%	4.7%
– Had to change a specialist	2.0%	1.6%	2.4%
– Had to change a specialist and primary care doctor	9.4%	11.2%	7.2%
Had to switch or change prescription medications	17.5%	18.5%	15.9%
Skipped doses or stopped taking prescription medications	33.9%	44.1%	21.9%
Coverage change had a negative impact on overall quality of medical care	39.5%	48.1%	27.8%
Coverage change had a negative impact on overall health	34.5%	43.8%	21.2%

Source: Sommers et al, *Health Aff,* 2016

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Marketplace Enrollment

- Many eligible people don't know they are eligible:
  - 40% of all uninsured adults have not even *heard* of the ACA Marketplaces
- Even among those who go to the Marketplace, only half actually enroll

Source: Collins et al. Commonwealth Fund 2015

Marketplace Enrollment

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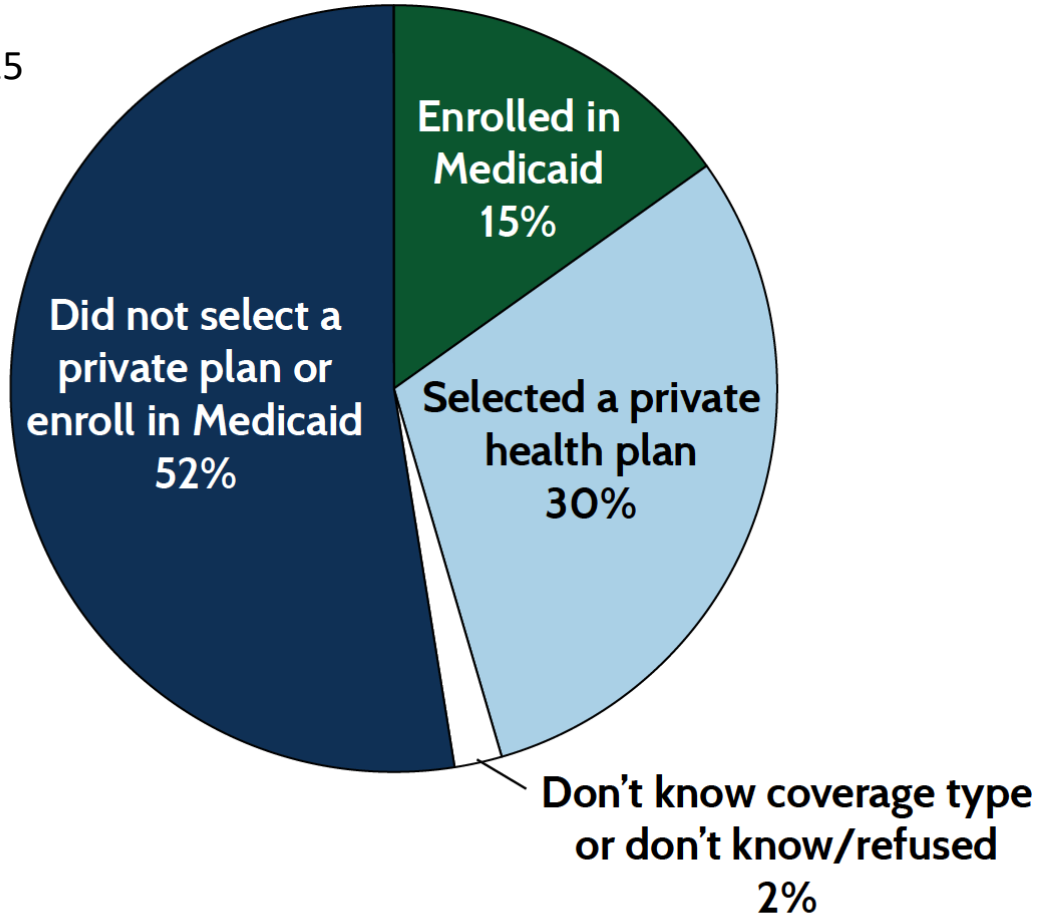


Adults ages 19–64 who went to the marketplace

Marketplace Enrollment

Most Common Reasons for Not Enrolling:

- Could not find a plan you could afford – 57%
- Not eligible for financial assistance – 43%
- Found enrollment process difficult or confusing – 38%
- Couldn't find a plan you liked – 32%
- Decided you did not need insurance – 15%

Source: Collins et al. Commonwealth Fund 2015

State vs. Federal Marketplaces

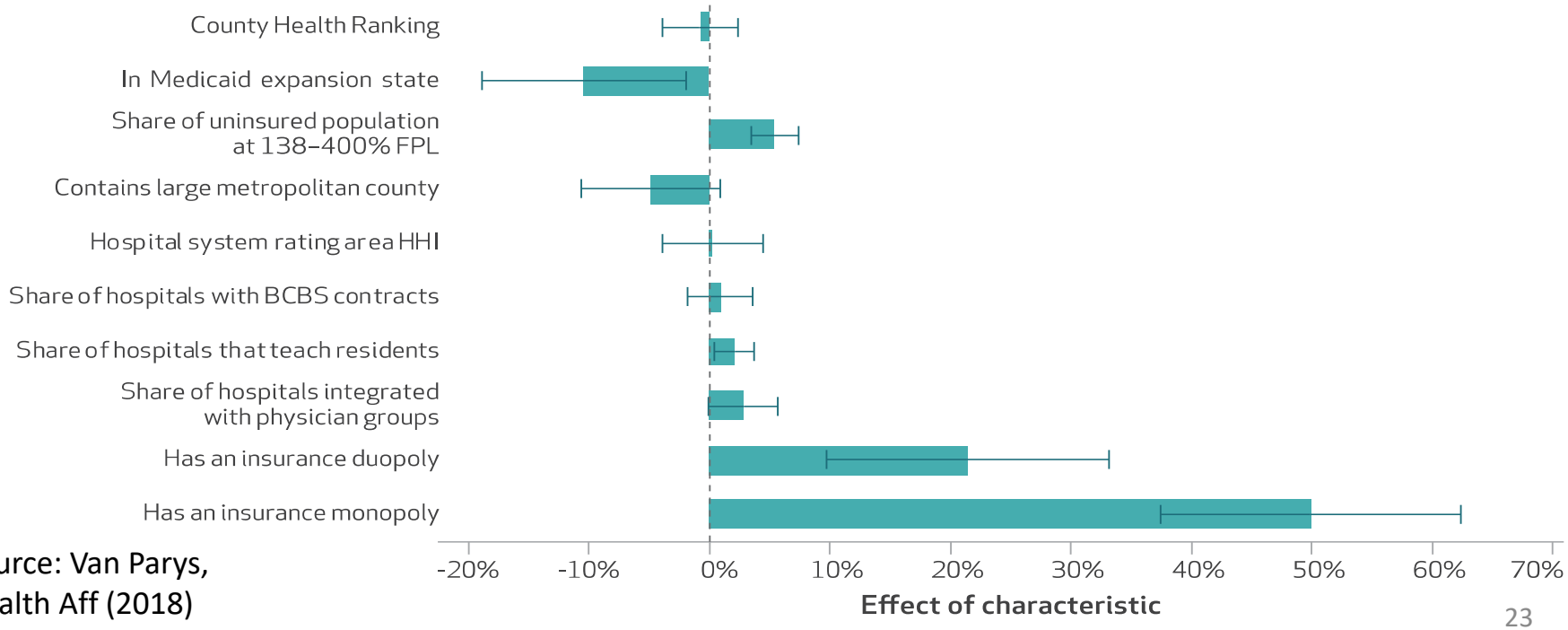
- SBMs vs. Federal Marketplace: each dollar spent on subsidies cut the uninsured by *nearly double* in SBM as in FFM states
- Why? Lots of potential explanations:
  - ✓ More outreach and public awareness
  - ✓ More navigators and enrollment assistance
  - ✓ More likely to have Medicaid expansion too, which also may attract new enrollees

Source: Frean et al. 2017

Keeping Premiums Down

- Multiple payers and more competition
- Medicaid expansion is also associated with lower Marketplace premiums, which can boost enrollment

Rating-area characteristics associated with monthly premiums for the second-lowest-cost silver plan in federally facilitated Marketplaces, 2018



Source: Van Parys, Health Aff (2018)

Enrollment Assistance & Outreach

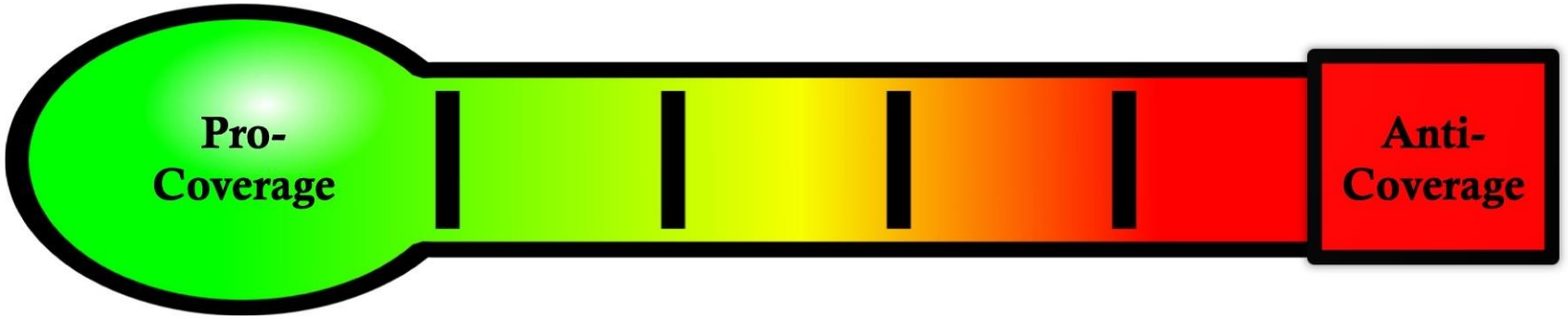
- States have taken widely varying approaches to outreach and enrollment assistance
- Evidence shows this impacts how potential enrollees experience ACA-related coverage & whether they enroll
- We studied 3 states in 2015-2016 to compare these effects

3 States: Marketplace

"KyNect"
State Run, Integrated Medicaid-Marketplace Operations

"Arkansas Health Connector"
Partnership Marketplace

No State Involvement: Healthcare.gov

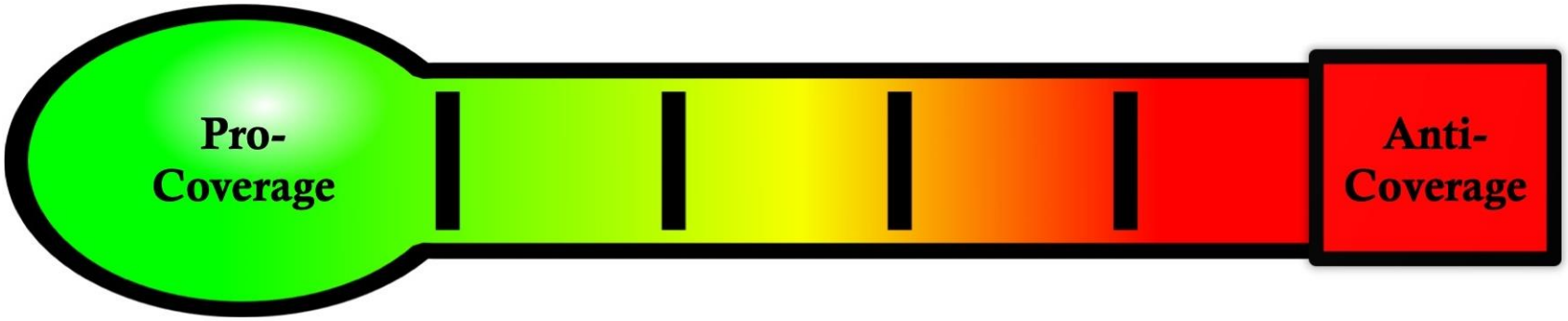


3 States: Outreach

Governor's office led aggressive state-focused outreach effort

SNAP-based enrollment, but 2014 legislative ban on outreach & anti-ACA Senate campaign

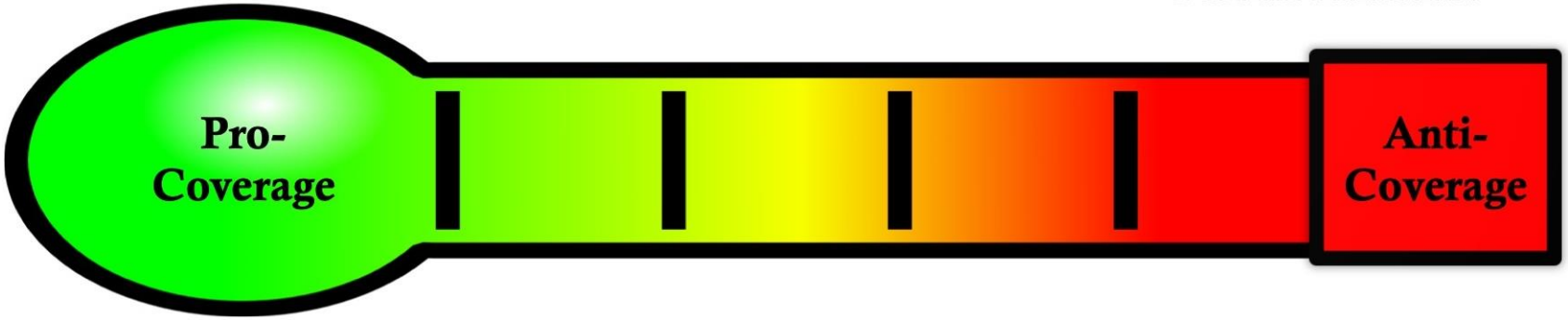
No state-based outreach



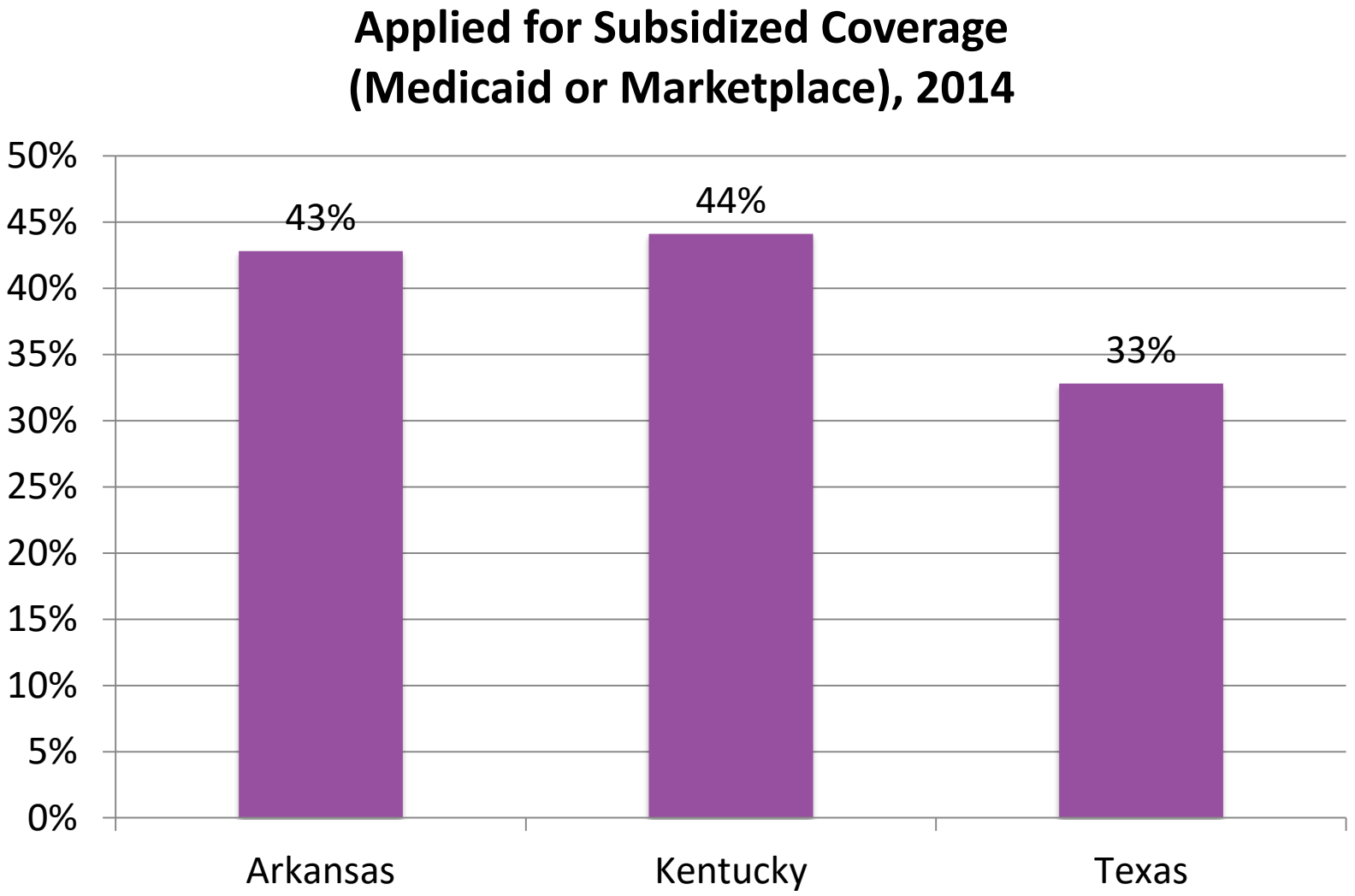
3 States: Enrollment Assistance

In-Person Assistors & Navigators

Onerous regulations on Navigators; no In-Person Assistors



State Choices Matter



Navigator Assistance

- At the state level, highest in SBM state without restrictions on navigators – 46% in Kentucky vs. 32% in Texas

- Navigators boosted application rates, successful applications, and consumer-rated experience among applicants

Source: Sommers et al *HA 2015*

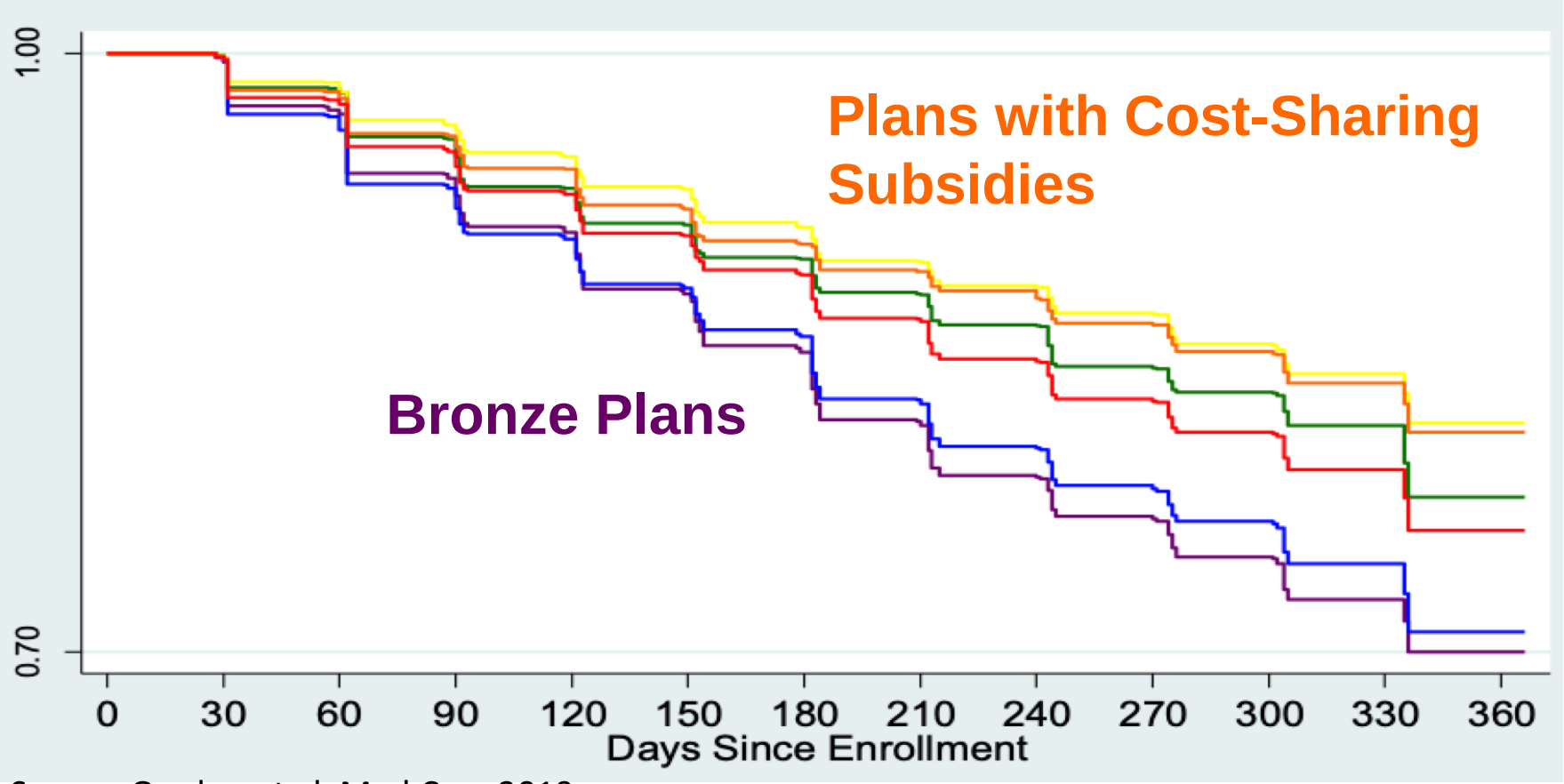
Effects of Mandate?

- Evidence is mixed on how much this drove consumer enrollment behavior
- Study of survey data shows size of mandate penalty had no impact on enrollment
- Other studies have found effects, but small - and more likely among higher-income groups who are not subsidy-eligible
- BUT – Massachusetts take-up rates jumped after 2006 mandate passed

Sources: Frean et al. 2017, Saltzman 2019, Sommers et al. 2012

Marketplace Churning

- Not just signing people up, but keeping them enrolled
- People in skimpier plans drop out at higher rates



Source: Gordon et al. Med Care 2019

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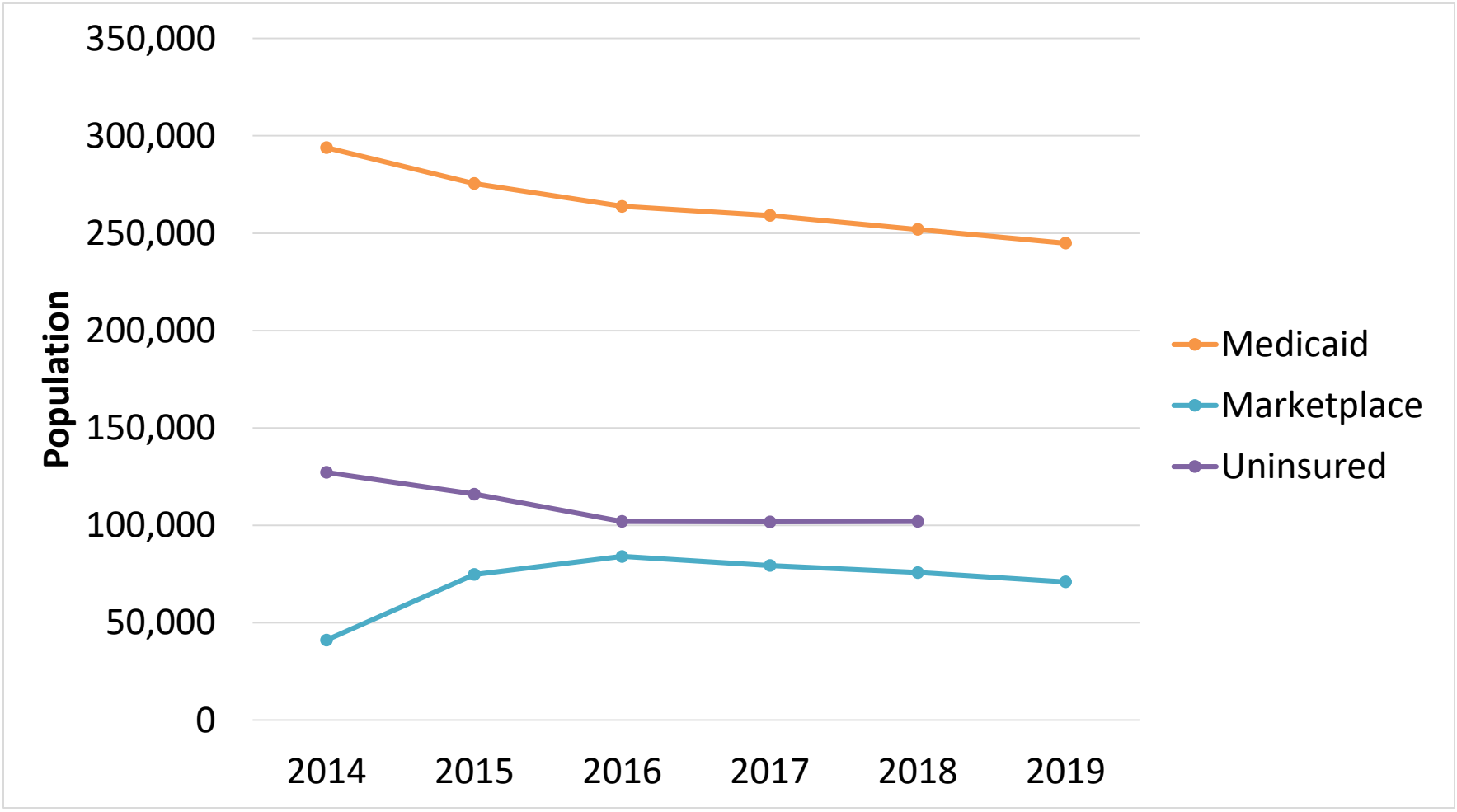
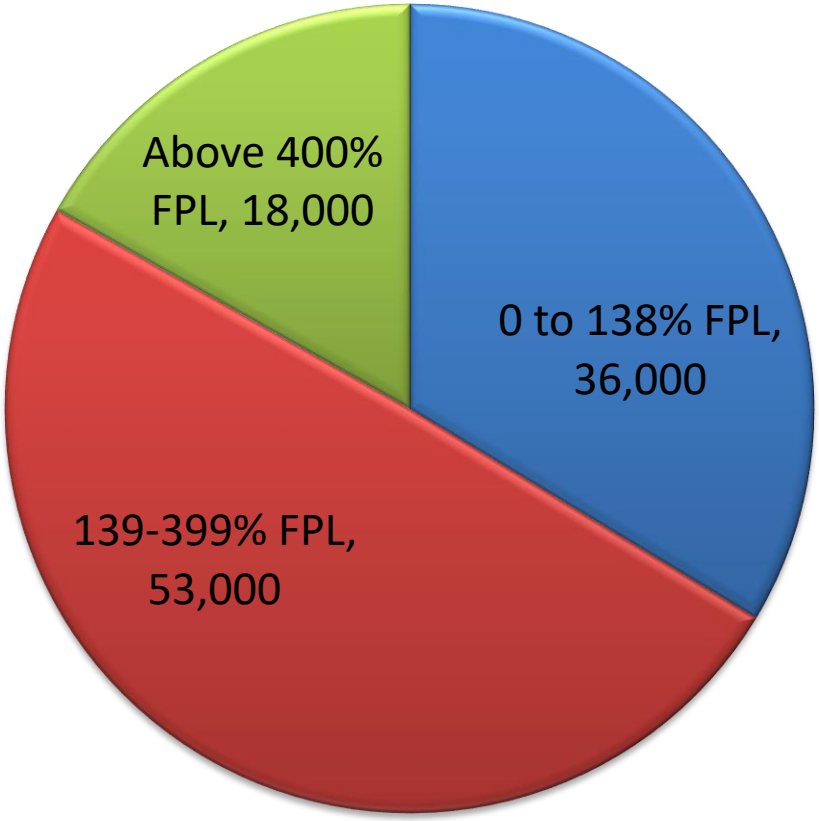
Enrollment Update: Maine



Sources: HHS Enrollment Reports, Census Bureau

The Uninsured in Maine



Source: Adapted from SHADAC 2019 Report – Note: Data from pre-Medicaid expansion

Policy Options: Medicaid

- Data matching from other state programs, either for targeted outreach or directly using information for enrollment (e.g. Express Lane eligibility in CHIP)
- 12 month continuous eligibility in Medicaid (requires 1115 waiver for adults – see NY, MT)
- Bolster community-based enrollment assistance programs
- Marketing and outreach

Avoid Policies that *Worsen* Enrollment

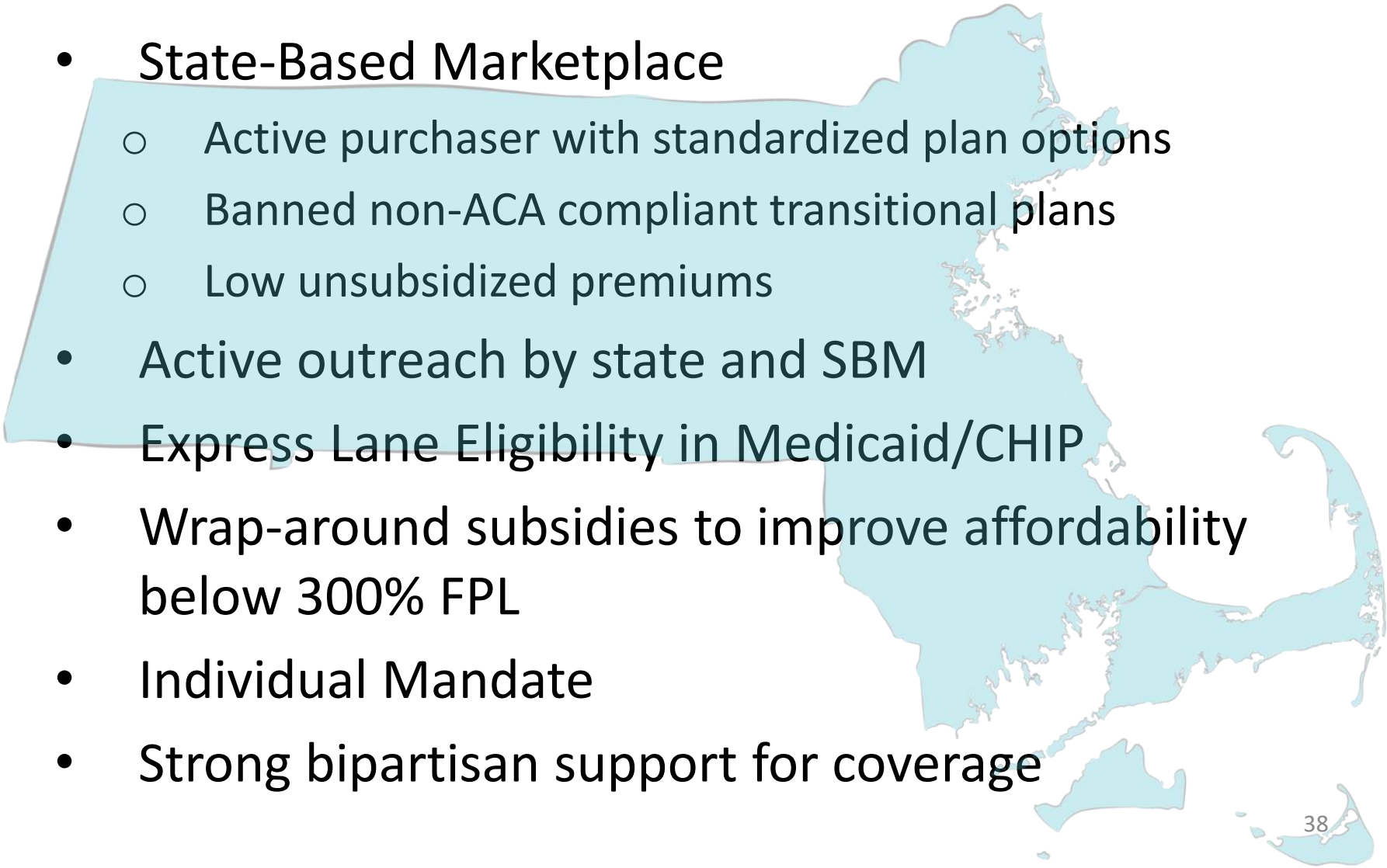
- Work Requirements – 18,000 lost coverage in Arkansas, no change in employment, 1/3 didn't even know about the policy
- More frequent eligibility checks – linked to decreasing Medicaid enrollment between 2017 and 2019
- Eliminating retroactive eligibility in Medicaid

Source: Sommers, Goldman, et al. NEJM 2019

Policy Options: Marketplace

- Auto-enrollment for zero-cost plans – see Dr. Linke Young's testimony
- Bolster community-based enrollment assistance programs (again)
- Marketing and outreach (again)
- Wrap-around subsidies for cheaper coverage
- Active-purchasing SBM and possibly standardized plans to improve affordability and transparency for consumers

Case Study: Massachusetts - 97% Covered



- State-Based Marketplace
  - Active purchaser with standardized plan options
  - Banned non-ACA compliant transitional plans
  - Low unsubsidized premiums
- Active outreach by state and SBM
- Express Lane Eligibility in Medicaid/CHIP
- Wrap-around subsidies to improve affordability below 300% FPL
- Individual Mandate
- Strong bipartisan support for coverage

Final Thoughts

- Maximizing impact of the ACA and Medicaid expansion in Maine require substantially improving current enrollment rates
- Enrollment is Step 1; Retention is Step 2
- Multifaceted approach is needed, using public-private partnership
- While these nuts & bolts issues aren't splashy, they determine whether the programs are ultimately able to succeed and improve health

Final Thoughts: Why this Matters

VIEWPOINT

Medicaid Expansion and Health
Assessing the Evidence After 5 Years

Heidi Allen, PhD, MSW
School of Social Work, Columbia University, New York, New York.

Benjamin D. Sommers, MD, PhD
Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, Boston, Massachusetts; and

Studies have shown that Medicaid expansion has been associated with greater access to care, more preventive care, and improved chronic disease management.[1] Medicaid expansion has also improved financial well-being among low-income families.[2] While these are important findings, they are process measures that precede any potential changes in health. The critical question posed by many policy makers is whether Medicaid expansion improves health. Five years after implementation of the expansion an evidence base has begun to emerge.

To examine the relationship between Medicaid expan- associated with improved control of hypertension, but not diabetes.[5] While improved blood pressure control is an important outcome, the long-term effects of expansion on cardiovascular disease are less certain. Researchers using hospital registry data analyzed patients admitted with congestive heart failure, finding increased coverage but no change in in-hospital mortality associated with the Medicaid expansion.[6]

Another high-risk condition that has been studied is end-stage renal disease (ESRD). Although Medicare provides insurance to most patients with ESRD, this cov-

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Health Insurance Coverage and Health — What the Recent Evidence Tells Us

Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D.

The national debate over the Affordable Care Act (ACA) has involved substantial discussion about having health insurance improves financial security. The strongest evidence comes from the Ore-

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