



Reports and Research

Table of Contents

March 20, 2014 Board Meeting

- *Reducing Health Care Disparities: Where Are We Now? – The Commonwealth Fund*
March, 2014
- *Medicaid And Marketplace Eligibility Changes Will Occur Often In All States; Policy Options Can Ease Impact – Health Affairs*
March, 2014
- *Insight From Three Obscure ACA Metrics – Jackson Hewitt Tax Service*
March 11, 2014

Reducing Health Care Disparities: Where Are We Now?

Marsha Gold, ScD, Mathematica Policy Research
Issue Brief | March 2014

MATHEMATICA
Policy Research



Robert Wood Johnson Foundation

For many years, the Robert Wood Johnson Foundation (RWJF) has been committed to finding and promoting ways to reduce racial and ethnic disparities. This issue brief gives a general overview of how the field of *health care disparities* has evolved in recent years to identify emerging perspectives, progress and current activity, and outstanding needs. The paper focuses specifically on health care disparities, while recognizing that these are obviously also intertwined with broader efforts to reduce health disparities.

Two major sources of information were used in developing this environmental scan. The first source involved a web-based search for recent literature and ongoing organizational work on this topic. The second source of information was from hour-long telephone interviews with a diverse set of eight key informants, who provided a spectrum of insights into different aspects of disparities work. Interviewees were nationally known policy-makers, researchers, and stakeholders who brought diverse perspectives to the work on disparities. (For additional information on methods, see page 6.)

Relevance of the Issue and Stakeholder Engagement

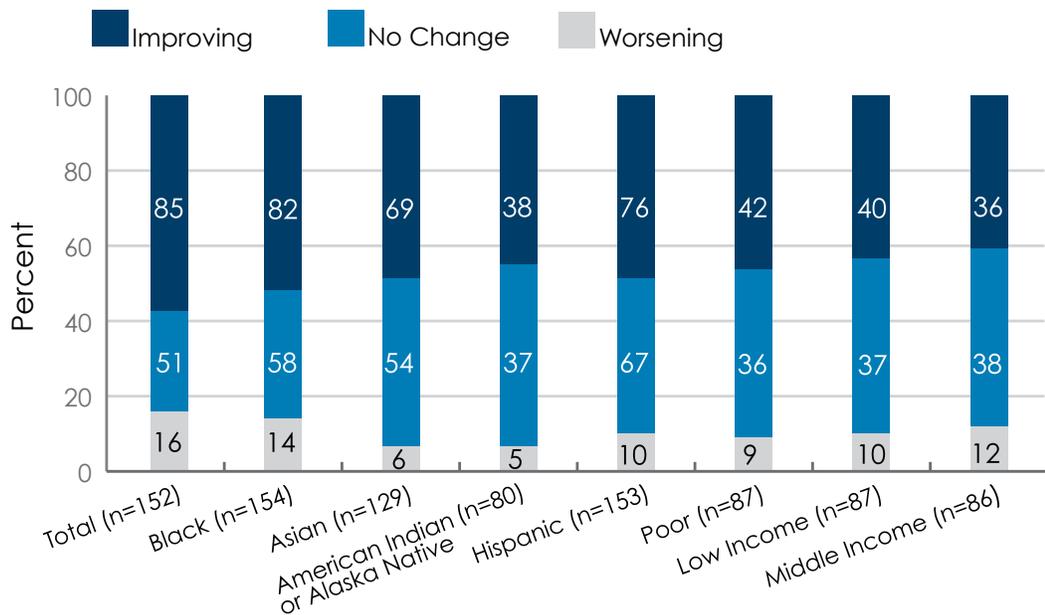
Disparities in Health Care Outcomes Persist

The 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* remains a landmark reference source that raised awareness of health care disparities and the need to reduce them.¹ The IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care defined these disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.” The report found that “racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.”

In 2013, the U.S. Department of Health and Human Services (HHS) released its 10th annual report on this topic.² The National Healthcare Disparities Report (NHDR) includes an integrated highlights section (used in this report and also in the National Healthcare Quality Report (NHQR)),³ which concluded: “health care quality and access are suboptimal, especially for minority and low-income groups.”

While the report reviews results on many types of metrics, the analysis emphasizes results for a subset of summary quality measures, compared across major racial/ethnic and income groups on a longitudinal basis. The findings show that, while overall quality is improving, access is worse and there has been no improvement in lessening disparities (Exhibit 1, page 2).

Exhibit 1. Number and Proportion of All Quality Measures that Are Improving, Not Changing, or Worsening, Overall and for Select Populations



Source: Agency for Healthcare Research and Quality. *National Healthcare Disparities Report 2012.*

Note: For each measure, the earliest and most recent data available to our team were analyzed; for the vast majority of measures, this represents trend data from 2000–2002 to 2008–2010.

Key: n = number of measures

Improving = Quality is going in a positive direction at an average annual rate of greater than 1% per year.

No Change = Quality is not changing or is changing at an average annual rate of less than 1% per year.

Worsening = Quality is going in a negative direction at an average annual rate of greater than 1% per year.

Reducing Health Care Disparities to Achieve More Equitable Health Care Outcomes Remains a Goal of U.S. Public Policy

In its review of where disparities fit into its five-year strategic plan,⁴ HHS identifies three specific goals:

- **Achieve health equity** as outlined in the HHS Action Plan (discussed below) and through actions that help better link patients to a usual primary care source, increase the number of patient-centered medical homes (PCMHs), and enhance support for community health centers.
- **Ensure access to quality, culturally-competent care for vulnerable populations** by improving the cultural competency and diversity of the health care workforce and addressing disparities in access to care.
- **Improve data collection and measurement** of health data by race, ethnicity, sex, primary language, and disability status, as well as other efforts in planning for the collection of additional data.

In 2011, HHS released its *Action Plan to Reduce Racial and Ethnic Health Disparities* under the leadership of the Office of Minority Health.⁵ Its vision is a “nation free of disparities in health and health care.” Overarching secretarial priorities involve heightening the impact of all HHS actions to achieve this goal, particularly by improving the availability, quality, and use of data; measuring disparities in health care; and providing incentives to improve health care for minorities. Concurrent with the release of the Action Plan, HHS also released a national stakeholder strategy to reduce disparities, developed through the National Partnership for Action to End Health Disparities, which it helped convene.⁶

More Tools Now Exist to Support Measuring Disparities and Undertaking Interventions

Enhanced capacity for subgroup analysis. In response to the limitations in available national data for monitoring race and ethnic disparities in health care as well as new Affordable Care Act (ACA) requirements in this area, on October 31, 2011, HHS released new, refined standards for capturing race, ethnicity, sex, and primary language or disability in individual person-level surveys.⁷ The standards for demographic data apply to HHS-sponsored surveys

in which respondents (knowledgeable informants) self-report information. While such standards do not apply to administrative data, providers have additional incentives to collect such data if they want to receive Medicare and Medicaid incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Stage 1 requirements in place since 2010 include, among the core standards, recording patient demographics as structured data. Such demographics need to include preferred language, gender, race, ethnicity, and date of birth.

New metrics exist for assessing cultural competency and language services. New consensus metrics are beginning to become available for assessing whether training and other developments are generating changes in the availability of those culturally-competent care and language services viewed as critical to reducing disparities in health care. The National Quality Forum (NQF) is a public-private partnership that works on a consensus basis across stakeholders to agree on appropriate measures for endorsement. In 2012, NQF issued its first endorsements specifically addressing health care disparities and cultural competency. After several years of work, the panel endorsed 12 of the 16 measures under consideration.⁸ These standards cover areas such as office practice communications infrastructure, patient reports on health literacy and cultural competency, patient receipt of language services, and implementation of cultural competency standards. HHS continues to work with its partners on the implementation of policy and practice standards regarding culturally and linguistically appropriate services (CLAS). The National Committee for Quality Assurance (NCQA), a national nonprofit organization that works extensively in the area of health care quality, has developed voluntary accreditation standards for CLAS that include the collection and use of race, ethnicity, and language data.⁹

Stakeholders Are Working to Support Better Capturing of Data Required to Assess Health Care Disparities

Hospitals. In 2007, the Health Research and Educational Trust (HRET) released a toolkit that hospitals can use to collect race, ethnicity, and language data on their patients. The American Hospital Association (AHA) platform for performance improvement is “Hospitals in Pursuit of Excellence,” or HPOE, formed in 2011. An AHA national survey showed that only 18 percent of hospitals in 2011 were collecting race, ethnicity, and language data at the first patient encounter, even though these data are needed to assess gaps in care. Under HPOE, a coalition of organizations—AHA, the Association of American Medical Colleges, the Catholic Health Association of the United States, the American College of Healthcare Executives, and America’s Essential Hospitals (formerly the National Association of Public Hospitals and Health Systems)—are working together with the goal of increasing the collection of race, ethnicity, and language data (REAL) from a baseline of 18 percent (2011) to 75 percent (2020); increasing cultural competence training from a baseline of 81 percent (2011) to 100 percent (2020); and increasing diversity in governance and leadership from 14 percent and 11 percent, respectively, at the baseline (2011) to 20 percent and 17 percent (or reflective of community served), respectively (2020). In August 2013, HPOE released an Equity of Care document aimed at helping hospitals and health systems improve the way they collect and use race, ethnicity, and language data.

Physicians. The American Medical Association (AMA) Commission to End Health Disparities—which first formed in 2004 in collaboration with the National Medical Association and was joined by the Hispanic Medical Association soon afterward—is working to encourage physicians to be concerned with health care disparities. According to its most recent strategic plan, the group has 71 affiliated organizations.¹⁰ Its focus is to educate health professionals on disparities and cultural competency, increase the diversity of the workforce, advance policy and advocacy initiatives in this area, and improve data collection and research to identify and eliminate disparities. The work appears to be a member-led activity, with an agenda that is broad, although not highly resourced.

Health plans. Health plan work centers most visibly around the National Health Plan Collaborative (NHPC). It began with nine large national and regional firms in the industry, whose efforts were co-sponsored by the Agency for Healthcare Research and Quality (AHRQ) and RWJF from 2004 to 2008. The NHPC has been based within America’s Health Insurance Plans (AHIP) since its external funding support ended. As with providers, data collection to identify, monitor, and track progress on health care disparities is an ongoing challenge. While such data collection practices are not tracked routinely, AHIP, with the support of RWJF, has surveyed its members to identify the status and trends of such data collection. The most recent results from a 2010 survey have been profiled to highlight both accomplishments and ongoing challenges.¹¹

Gauging Progress and Accomplishments

Continued Relevance of Capturing Data on Race, Ethnicity, Language, and Other Metrics

Both interviewees and our review of the literature reinforce the ongoing relevance of data collection in seeking to reduce health care disparities. We were told by interviewees that “measurement is still very much an issue” and “this is still a BIG ISSUE.” Even those who sought progress observed that “we have a long way to go.” More progress has been made in capturing disparities data through surveys than in administrative records, including provider and health plan data.

Among the barriers to better data collection on race, ethnicity, and other factors, two appear to have particular policy relevance. First, interviewees said that collecting such data requires an organization to be committed to its pursuit. With many demands on their time and resources, providers and health plans will find the “business case” for such collection to be weaker to the extent that important customers (e.g., regulators, purchasers) do not make collection and use of such data a condition of doing business. Second, inconsistencies and the lack of operational specificity in existing tools limit the usability and quality of the data collected.

A Desire to Move Toward Effective Intervention

Many of the interviewees expressed impatience with data collection that does not lead to intervention, viewing data as just one piece of an ongoing infrastructure for disparities reduction. In addition, in an increasingly multicultural society, interviewees said it is relevant to consider how refined metrics must be, given that individuals vary on so many dimensions. But they also noted that without data, it is very difficult to assess priorities or progress in reducing disparities in quality and outcomes.

Most of those interviewed felt that while more research on effective interventions could always be valuable, sufficient knowledge is available at this point to take steps to intervene effectively; they encouraged progress in this direction. The literature lends some support to this view.¹²

One area of tension around intervention concerns “evidence.” A number of interviewees stressed the contextual dependence of intervention design and strategy. A second issue involves assumptions about causal logic. Our interviews suggest that there is some debate regarding interventions to improve health care disparities over whether the problem is unequal treatment within a practice, or the effect race/ethnicity has on the providers’ availability and quality of care. In reality, both are probably at work.

Linking Disparities to Quality of Care, Delivery System Change, and Payment Policy

Interviewees and the literature clearly link health care disparities to a quality agenda. National tracking efforts now more clearly allow for integrating analysis of quality with a disparities focus because the same metrics are used for both, and a common summary is used across the NHDR and NHQR. Interviewees noted that in delivery settings, disparities initiatives also tend to be located in quality improvement offices. Most interviewees, however, thought that the link was more theoretical than real. The main reason is because stratification of quality metrics by race and ethnicity is not central to most quality improvement or monitoring efforts.

Interviewees had a similar reaction to the role delivery system and payment policy change could have in reducing disparities. In general, interviewees were very supportive of changes in payment policy to reward better separate reporting by race or ethnicity (subject to sample size constraints) but did not see many policy initiatives that do so. Few interviewees believed that disparities were now on the radar screen of PCMHs and accountable care organizations (ACOs), for example. According to interviewees, the Centers for Medicare & Medicaid Services (CMS) is not a major player in the disparities field at this time. However, some expressed the hope that this would change and thought some internal activity might be underway that could expand interest in this area.

Trade-Offs Exist in Expanding the Focus of Disparities Efforts

Our review of current activity makes clear that federal policy, and many organizations across the board, increasingly

view health care disparities broadly. HHS's strategic plan, for example, identifies many groups for attention based on race, ethnicity, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation, gender identity, geographic location, and other factors. There also appears to be a shift from the concept of disparities to one of equity. The shift provides more focus on action and social justice relevant to a wide variety of subpopulations.

Those we interviewed saw advantages in reframing the issue this way. Probably the most relevant from the perspective of race and ethnic disparities is that reframing has the potential to increase relevance and broaden population support because more people could see the relevance of equity to them. There are potential downsides, however. While most interviewees attributed to others the concerns that a broad equity agenda could diffuse the focus on particular subgroups and tax available resources, many of them also mentioned this issue.

There are some practical challenges to a broader definition of disparities, at least in monitoring and interventions. Data to define disparities are currently much more limited for some subgroups than others; LBGT and disability status data lag behind other data. Further, while many people portray a variety of characteristics, the logical chain of processes that leads to disparities based on particular characteristics is likely to differ by particular characteristic. An obvious example relates to disability, where care is challenged by potential physical and other barriers.

Among subgroups, race/ethnicity and income or socioeconomic status have the longest historical link; indeed they often are thought of as interrelated concepts. Some interviewees thought that recent ACA-related eligibility rules for coverage might enhance the availability of income data, at least at the bottom of the distribution. Others said that education could serve as a proxy. In an ACA environment, considerable interest was expressed in looking at the extent to which reduction in disparities might be associated with coverage, and what the remaining disparities might indicate about the role of other factors.

Perspectives on Gaps and Useful Future Work

Those we interviewed brought different perspectives to the disparities issue. Their perspectives on gaps and future work were shaped by whether they were based mainly within a national policy, operational and local delivery, or research perspective. Suggestions for future activity often drew upon that individual's experience and organizational base, stressing areas in which support would be useful to their interests in health care disparities. Generally, interviewees tended to see four major gaps in current work.

- ***Cross-Cutting Leadership to “Connect the Dots.”*** While many initiatives are underway in the health care disparities field, interviewees felt that less attention was being paid to the broader context and logic of work to reduce health care disparities regarding how various initiatives or interventions relate to one another, and why they are important.
- ***Aligning Policy and Payment with Disparities Goals.*** While there is more attention than in the past to encourage work around disparities within the operational setting, various interviewees thought that policies stating that such work is both feasible and necessary were still limited. Such policies could be linked to requirements that providers report performance metrics by race and ethnicity. More broadly, interviewees felt that payment is needed to support sustainable interventions. For example, an initiative might pay navigators to improve care for minorities, but the intervention will not be sustainable if the payment system does not generate ongoing support to maintain such a presence after the pilot ends.
- ***Support for Building Infrastructure for Effective Local Interventions.*** Interviewees actively engaged with provider and community-based interventions felt there still was insufficient support for effectively applying local interventions in the marketplace. They also were interested in bringing greater knowledge of social determinants to effective local interventions. Some wished funders would place more emphasis on those efforts oriented toward mobilizing action versus trying to teach researchers how to translate research into action.
- ***Leveraging Opportunities of the ACA.*** With both coverage expansion and delivery reform high on the nation's radar screen as ACA implementation moves forward, some interviewees saw this general awareness as possibly leading to opportunities for focusing on work on health care disparities. For example, given that the ACA is likely to expand coverage, what will be the short- and long-term effects of such change on health care disparities? How will the ACA's expanded payments for primary care affect Medicaid beneficiaries, many of whom are minorities? Will the movement to medical homes encourage work with community organizations and focus more attention on the role of social determinants in affecting health outcomes? Another interviewee saw a need to increase the emphasis on how to implement ACA provisions to improve equity and reduce disparities by encouraging best practices.

In sum, there is a need for work both at the national policy and local care delivery levels in communities. In both cases, there is value in working to integrate disparities into a broader set of goals by encouraging measurement, priority setting, and interventions sensitive to the most vulnerable members of society. Further, community-based interventions will be more effective if they take into account both community and medically focused forces that influence health outcomes, so that the two are self-reinforcing. None of this work is easy, and all of it is likely to require a prolonged commitment.

Methods

The project spanned a four-month period starting on August 15, 2013. The emphasis was on recent activity and perspectives related to health care disparities—generally work from around 2009. Consistent with the thrust of the work of RWJF and many previous efforts in the United States, we placed special emphasis on examining work on racial and ethnic disparities in health care, including efforts at measurement and interventions. The review sought to place this work in the context of health care disparities work in general, however, including recent efforts to broaden its scope to other population subgroups and link disparities to emerging work on quality improvement overall.

Two major sources of information were used in developing this environmental scan. The first source involved a web-based search for recent literature and ongoing organizational work on this topic. The intent was to identify seminal efforts and examples of activity underway by various key stakeholders, rather than provide an exhaustive and comprehensive review of the literature and all ongoing activity.

The second source of information was from hour-long telephone interviews with a diverse set of eight key informants, who provided a spectrum of insights into different aspects of disparities work. We identified those to be interviewed in consultation with RWJF. Interviewees were nationally known policy-makers, researchers, and stakeholders who brought diverse perspectives to the work on disparities. A semi-structured protocol, sent to interviewees in advance, guided the interviews. We told interviewees that the facts regarding their work might be shared in attributed form but the perspectives they provided would not be identified individually. All of those who were solicited agreed to participate.

This project was conducted by Mathematica Policy Research through a grant from the Robert Wood Johnson Foundation.

Endnotes

1. Smedley BD, Stith AY and Nelson AR (editors). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine (IOM), Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press, 2003.
2. Agency for Healthcare Research and Quality (AHRQ). *2012 National Healthcare Disparities Report*. Rockville MD: U.S. Department of Health and Human Services (HHS), AHRQ Publication No. 13-003, May 2013, http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/nhdr12_prov.pdf.
3. Ulmer C, Bruno M and Burke S (editors). IOM. "Future Directions for the National Healthcare Quality and Disparities Reports." Washington, DC: National Academy Press, 2010.
4. U.S. HHS. *Strategic Plan 2010–2015*. Washington, DC: HHS, 2010, <http://www.hhs.gov/strategic-plan/eliminate.html>.
5. U.S. HHS. *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*. Washington DC: HHS, 2011, www.hhs.gov/strategic-plan/eliminate.html.
6. National Partnership for Action to End Health Disparities. *National Stakeholder Strategy for Achieving Health*. Washington DC: U.S. Department of Health and Human Services, 2011.
7. U.S. HHS. *Final Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status Required by Section 4302 of the Affordable Care Act*. Washington, DC: HHS Office of Minority Health, 2011, <http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>.
8. National Quality Forum (NQF). *Endorsement Summary: Healthcare Disparities and Cultural Competency Measures*. Washington DC: National Quality Forum, August 2012, http://www.qualityforum.org/Projects/h/Healthcare_Disparities_and_Cultural_Competency/Healthcare_Disparities_and_Cultural_Competency.aspx.
9. HPOE. *Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data*. Chicago: American Hospital Association, American Medical Association, Catholic Health Association of the United States, American College of Healthcare Executives, and America's Essential Hospitals, August 2013.
10. American Medical Association. *Commission to End Health Care Disparities*. Chicago: American Medical Association, 2013, <http://www.ama-assn.org/resources/doc/public-health/cehcd-strategic-plan.pdf>.
11. Nerenz DR, Carreon R and Veselovskiy G. Race, Ethnicity and Language Data Collection by Health Plans: Findings from 2010 AHIPF-RWJF Survey. *Journal of Health Care for the Poor and Underserved*, 24(4): 1769–1783, 2013.
12. Chin M, Clarke AR, Nocon RS, et al. "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care." *Journal of General Internal Medicine*, 27(8): 992–1000, 2012.

By Benjamin D. Sommers, John A. Graves, Katherine Swartz, and Sara Rosenbaum

Medicaid And Marketplace Eligibility Changes Will Occur Often In All States; Policy Options Can Ease Impact

DOI: 10.1377/hlthaff.2013.1023
HEALTH AFFAIRS 33,
NO. 4 (2014): -
©2014 Project HOPE—
The People-to-People Health
Foundation, Inc.

ABSTRACT Under the Affordable Care Act (ACA), changes in income and family circumstances are likely to produce frequent transitions in eligibility for Medicaid and health insurance Marketplace coverage for low- and middle-income adults. We provide state-by-state estimates of potential eligibility changes (“churning”) if all states expanded Medicaid under health reform, and we identify predictors of rates of churning within states. Combining longitudinal survey data with state-specific weighting and small-area estimation techniques, we found that eligibility changes occurred frequently in all fifty states. Higher-income states and states that had more generous Medicaid eligibility criteria for nonelderly adults before the ACA experienced more churning, although the differences were small. Even in states with the least churning, we estimated that more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months. Policy options for states to reduce the frequency and impact of coverage changes include adopting twelve-month continuous eligibility for adults in Medicaid, creating a Basic Health Program, using Medicaid funds to subsidize Marketplace coverage for low-income adults, and encouraging the same health insurers to offer plans in Medicaid and the Marketplaces.

Benjamin D. Sommers (bsommers@hsph.harvard.edu) is an assistant professor of health policy and economics in the Department of Health Policy and Management, Harvard School of Public Health, in Boston, Massachusetts.

John A. Graves is an assistant professor at the Vanderbilt University School of Medicine, in Nashville, Tennessee.

Katherine Swartz is a professor of health economics and policy at the Harvard School of Public Health.

Sara Rosenbaum is the Hirsh Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services, in Washington, D.C.

Beginning January 1, 2014, the Affordable Care Act (ACA) established two pathways to health insurance for nonelderly US citizens and legal residents. The first was an expansion of Medicaid coverage for people with annual incomes of up to 138 percent of the federal poverty level in states that elected to expand their programs. The second pathway was subsidizing private coverage purchased via health insurance Marketplaces for people with incomes of 138–400 percent of poverty who do not have an offer of affordable coverage through an employer. The pathways are designed to work in tandem, but a major challenge is how to promote continuity of coverage and health care for

people when their incomes and life circumstances cause them to transition between Medicaid and subsidized private coverage.

In states that opt out of the ACA’s Medicaid expansion, changes in income or family circumstance will lead many people to lose coverage entirely unless they qualify for coverage under one of the traditional categories of Medicaid eligibility: pregnancy, disability, or being the impoverished parent of a minor child. A less stark problem that presents a different set of challenges will occur in states that do expand Medicaid: the potential for moving between Medicaid and Marketplace coverage.

Both of these types of “churning”—loss of coverage and frequent transitions in the source of

coverage—can cause difficulties. The total loss of coverage raises the most serious problems in terms of access to care, but frequent transitions across coverage pathways also raise important issues for beneficiaries, health plans, providers, and policy makers. From one year to the next or during any given year, many individuals and families will experience changes in eligibility either for Medicaid or for Marketplace coverage. These eligibility changes could lead to both gaps in coverage and disruptions in the continuity of care, because people might have to find new providers or change their existing health treatments if their new insurance plan uses a different provider network or covers different services than their old plan did.

Previous research has estimated that approximately half of low-income adults might experience a change in income or family circumstances leading them to transition from Medicaid to Marketplace coverage (or vice versa) each year.¹ Policy makers continue to explore various options to reduce the frequency of churning or at least mitigate its adverse impact on the continuity of health care.

Because churning is the result of many factors, it may be a larger issue in some states than in others. To date, there is little evidence about which states are most likely to experience churning. In this context, state-level estimates of potential churning rates among people likely to participate in Medicaid and the Marketplaces would be extremely valuable.

A major limitation to analyzing state-specific churning is that the most commonly used source of data on changes in insurance coverage and income over time—the Census Bureau's Survey of Income and Program Participation (SIPP)—was not designed to provide samples of people that are representative of every state's population.² The survey's sample is relatively small and disproportionately includes lower-income people and people in particular localities.³ We overcame these limitations by combining information on income and family changes from the SIPP with state-specific weights that we developed using a much larger survey, the American Community Survey (ACS).⁴

Our study objectives were to provide detailed estimates of the potential extent of churning between Medicaid and Marketplace coverage under health reform in each state and to identify state-level factors associated with higher rates of churning.

Study Data And Methods

DATA SOURCES We used data from two sources. First, information on changes in eligibility over

time came from the 2008 SIPP. Following previous research,^{1,5} we identified all adults ages 19–62 (thus excluding adults who would age into Medicare during the survey's follow-up period) who were likely to enroll in Medicaid or subsidized Marketplace coverage. We defined this sample as those adults with family incomes estimated to be up to 400 percent of poverty (incomes that made them eligible for Medicaid or tax credits for Marketplace coverage) who did not have Medicare, employer-sponsored insurance, or military health insurance. These criteria yielded a sample of 11,898 people.

For each month in the survey, we estimated family income as a percentage of poverty,⁶ using the concept of the health insurance unit (see the online Appendix for details).⁷ We tracked the number of adults experiencing a change in income that would result in a shift in eligibility (based on crossing the Medicaid expansion income threshold of 138 percent of poverty) during the subsequent twelve months.

Annual income is used to calculate the proper tax credit for people who have coverage in the Marketplace and has been studied previously in the context of reconciliation payments.⁵ However, eligibility for Medicaid is based on monthly income, and eligibility for Marketplace subsidies is contingent on not being eligible for Medicaid. Therefore, monthly income was the relevant measure for this analysis.

We were also more interested in coverage changes than in the receipt or extent of tax credits. Therefore, we did not analyze how often people had income changes that crossed alternative thresholds, such as 250 percent of poverty (the ACA threshold for receiving cost-sharing subsidies) or 400 percent of poverty.

Our second data source was a three-year sample of 9,204,447 people in the 2009–11 ACS. These data were used to construct state-specific weights for the SIPP sample, following the method developed by Allen Schirm and Alan Zaslavsky.⁸ Specifically, state weights were developed using a Poisson regression model that calibrated SIPP state population totals to match a set of forty-three control totals from the ACS. If, for example, based on the ACS there were 35,000 people working in the manufacturing industry in North Dakota, then our SIPP estimate also yielded an estimate of 35,000. State-level control totals included demographic characteristics, income, family composition, insurance coverage type, and employment measures (both status in the labor force and industry).

Using the approach employed by John Graves and Katherine Swartz,⁹ we restricted the construction of state weights so that only people in contiguous states and states with similar eli-

gibility policies for public programs could contribute information to an estimate for a given state (see the online Appendix for details).⁷ The information for each person in the expanded state sample was then weighted by the appropriate state-specific weight to yield representative estimates for each state.

ANALYSIS Using the methods outlined above, we estimated rates of churning for each state. Our two primary outcomes were the percentages of adults with continuous eligibility for the same insurance program over a six-month period and over a twelve-month period. We limited our sample to people for whom we had complete income data for the first twelve months in the survey.

After producing state-specific estimates of rates of continuous eligibility over time, we analyzed whether churning rates varied by states' poverty rates or the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults.

For the state poverty rate analysis, the sample was divided into three groups based on the rate in each state (as derived from the Census Bureau's 2009 Current Population Survey), using natural breaks in the distribution to produce similar-size groups (people whose incomes were less than 11.0 percent, 11.0–14.5 percent, and greater than 14.5 of poverty). We also tested the impact of categorizing states by per capita income or median household income.

For the analysis of the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults, the sample was divided into three groups based on the share of a standardized national population that would be eligible for Medicaid under each state's laws (see the online Appendix for details).⁷ This approach was similar to methods used in previous research.¹⁰

We used *t* tests to identify differences in churning rates across these classifications for all fifty states and the District of Columbia. We also ran bivariate linear regression models in which each state's percentage of adults with twelve months of uninterrupted eligibility was the outcome and the state poverty rate, per capita income, and Medicaid eligibility measure were separately used as continuous predictor variables.

Our goal in these analyses was not to present an exhaustive model of predictors of coverage stability. Instead, we sought to identify simple state-level measures that offer a straightforward way to conceptualize what kinds of states experience more or less churning. For this purpose, we selected measures that vary widely across states and might plausibly affect income mobility, program eligibility, or both over time.

LIMITATIONS Our study has several important

limitations. First, we used self-reported income data, which might correspond imperfectly with income as it will actually be assessed by state Medicaid programs and the Marketplaces. The impact of this imprecision on state-level churning rates is unclear.

Second, our sample underrepresented people who dropped out of the SIPP sample. Such people are likely to have less stable circumstances than those who remain in the survey, so our approach could underestimate the extent of churning.

Third, our sample contained all adults who were potentially eligible for Medicaid or subsidized Marketplace coverage. Many eligible people have not enrolled in public coverage programs in the past,¹¹ but our sample design implicitly assumed full participation rates. However, it is unclear whether people who do not enroll are more or less likely to experience income changes than those who do sign up for coverage.

Fourth, some people in this income range may have declined an offer of affordable employer-sponsored insurance (that is, insurance costing less than 9.5 percent of the employee's income), which would have precluded their receiving Marketplace tax credits.¹² SIPP does not supply information on employees' potential premium obligations, which prevented us from accurately identifying such people in the data set.

Consistent with the ACA, our approach assumed that people could lose eligibility for Medicaid or subsidized Marketplace coverage in any given month based on changed economic or family circumstances. Whether interruptions will be as frequent as the law contemplates is unclear, since families might fail to report changed circumstances each time they occur. Moreover, the Centers for Medicare and Medicaid Services (CMS) has used Section 1115 waivers under the Social Security Act to enable states to apply to adults a policy of twelve-month continuous eligibility for Medicaid—an option that already exists for children.¹³ State Medicaid agencies and the Marketplaces also may vary in how quickly they respond to reported changes in eligibility.

For the purpose of estimating rates of churning, we assumed that all states would expand Medicaid eligibility to 138 percent of poverty. As of January 2014, however, only twenty-five states and the District of Columbia had elected to do so.¹⁴ Furthermore, the landscape of the Medicaid expansion is changing rapidly, and it is possible that some states will scale back higher-income (above 138 percent of poverty) eligibility for Medicaid once Marketplace subsidies become available. Therefore, we felt that a simplifying assumption using the same income

cutoff for all states would produce the most plausible comparisons across states.

The state-based weighting approach also has limitations. Our reweighting method was designed to strike a balance between the biased and imprecise direct state estimates yielded by small samples and the also potentially biased but more reliable indirect state estimates produced by appropriately weighted larger samples. As noted above, we also limited out-of-state “borrowing” to respondents in contiguous states and states with similar public program eligibility policies. This might result in less statistically reliable estimates for states with few neighbors.

Study Results

Exhibit 1 shows eligibility continuity curves for selected states representing the upper and lower bounds, the median, and selected percentiles of adults experiencing continuous eligibility for Medicaid or Marketplace coverage. Appendix Exhibit 2 lists the specific values for each state and 95% confidence intervals for the estimates.⁷ The curves are clustered in a fairly narrow band. Across all states (not including the District of Columbia), an estimated 63–72 percent of adults did not experience any changes in eligibility through the first six months, and in all but two states, 40–55 percent of adults did not experience any changes during the full twelve-month

period.

Two states’ estimates were outliers, with little churning at six months but marked churning at twelve months; thus, we did not include those states in Exhibit 1. Hawaii and Maine experienced more churning at twelve months than any other state—with only 40 percent and 42 percent of adults, respectively, having stable eligibility. However, those states’ estimates at six months were fairly high, at 70 percent and 67 percent, respectively. As discussed above, our weighting approach may be less reliable in states with few or no neighboring states, such as these two outliers.

Appendix Exhibit 3 shows the values by state for people whose incomes were initially below 138 percent of poverty versus those with incomes between 139–400 percent of poverty.⁷ Although the precise pattern varied across states, the median rate of continuous eligibility at twelve months was slightly higher for those with initial incomes in the range of 139–400 percent of poverty than for those whose incomes were initially below 138 percent of poverty (53 percent and 47 percent, respectively).

We found that eligibility continuity was lowest (that is, churning rates were highest) at twelve months in states with the lowest poverty rates (Exhibit 2). Each percentage-point decrease in a state’s poverty rate was associated with a 0.29 percent increase in churning at twelve months (Exhibit 3). However, it is important to note that this relationship is not exactly linear: Churning rates were quite similar across states with low and medium levels of poverty, in contrast to high-poverty states.

We found a similar pattern—higher-income states having more churning—when we used alternative groupings of states by their poverty rates and when we used per capita income or median household income instead of poverty rates (Appendix Exhibit 4).⁷ Continuity of eligibility was also lower in states that had more generous Medicaid programs before the ACA (Exhibit 2).

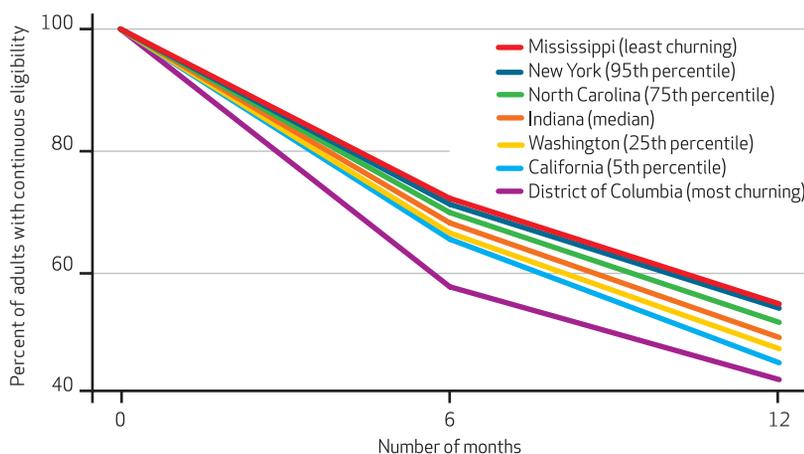
Discussion

Beginning in January 2014, the pathways to affordable insurance expanded significantly in all states as a result of the ACA’s insurance Marketplaces, especially in states that have expanded their Medicaid programs. The ACA was designed to ensure coverage continuity for US citizens and qualifying residents, with a pathway available to everyone—regardless of income or life circumstances.

In states that fully implement the ACA with expanded Medicaid programs, this vision will

EXHIBIT 1

Estimated Percentages Of Adults In Selected States Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage



SOURCE Authors’ analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text). **NOTES** The sample contained adults ages 19–62 with family incomes of less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey ($N = 11,898$). A change in eligibility was based on a change in the family’s monthly income as a percentage of poverty that moved the income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit.

be realized. There, the challenges become how to ensure that eligibility translates into actual enrollment, and how to make transitions in coverage as smooth as possible. In states that do not expand Medicaid, these transitions will be starker and more painful.

Previous research^{1,12} has demonstrated that millions of Americans will face circumstances that cause them to transition among coverage pathways during a year. Our study estimated how such churning might vary across states. Our results have three primary implications.

First and most important, transitioning among pathways to coverage has the potential to be a major issue in every state. Medicaid—and state health policy more generally—is typically characterized by differences across states in numerous domains.^{11,15–17} However, we found that if all states were to expand Medicaid, most would experience relatively similar rates of changes in eligibility for Medicaid and premium subsidies over six or twelve months.

We estimated that approximately half (plus or minus 5 percentage points) of adults likely to be eligible for Medicaid or subsidized Marketplace coverage will experience an eligibility change within twelve months. Our estimated churning rates are slightly higher than those in one previous analysis of four large states.⁵ However, our approach used more robust state-level weighting than the previous study and measured income based on the health insurance unit, instead of the family.

Second, although churning rates were likely to be high everywhere, we found some small differences in the rates across states. States with lower poverty rates and higher per capita incomes were likely to experience higher rates of churning between eligibility for Medicaid and eligibility for premium subsidies.

To see why this might be the case, consider two states, one with a poverty rate of 10 percent (and a relatively high median household income) and the other with a poverty rate of 15 percent (and a relatively low median household income). The richer state has a larger share of its population with incomes of 100–250 percent of poverty, while the poorer state has a larger share of its population with incomes of below 50 percent of poverty. The richer state has more people close enough to the eligibility cutoff that they are likely to transition between Medicaid and Marketplace coverage as their incomes rise. Fewer people in the poorer state will be able to raise their incomes above 138 percent of poverty.

Third, states with more-generous eligibility criteria for their Medicaid programs before the ACA also had higher churning rates. In part, this is a result of the fact that these states tended to

EXHIBIT 2

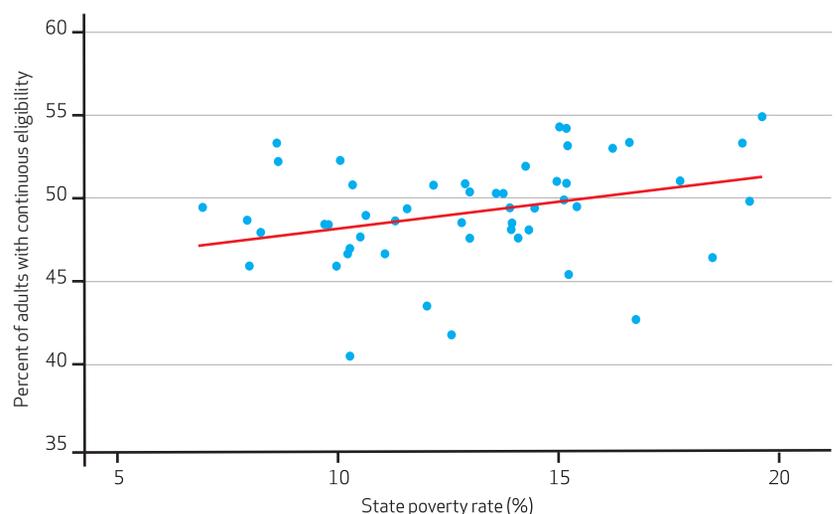
Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage, By State Characteristic

State characteristic	Percentage of adults with continuous eligibility at:			p value ^a
	0 months	6 months	12 months	
POVERTY RATE				
Low (n = 16)	100.0	67.9	48.4	0.03
Medium (n = 19)	100.0	67.6	48.5	0.03
High (n = 16)	100.0	68.9	50.8	Ref
MEDICAID ELIGIBILITY CRITERIA BEFORE THE AFFORDABLE CARE ACT				
Most generous (n = 17)	100.0	68.0	48.1	0.005
Moderately generous (n = 17)	100.0	67.2	48.4	0.01
Least generous (n = 17)	100.0	69.1	51.1	Ref

SOURCE Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text), using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state characteristics, of data from the 2009 Current Population Survey and of eligibility data from the Kaiser Family Foundation. **NOTES** The sample contained fifty-one state-level estimates (for the fifty states and the District of Columbia), based on an analysis of adults ages 19–62 with family incomes less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey (N = 11,898). A change in eligibility was based on a change in the family's monthly income as a percentage of poverty that moved the family's income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit. ^ap values for difference at twelve months were based on a t test comparing the twelve-month estimate across the groups as indicated.

EXHIBIT 3

Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage At Twelve Months, By State Poverty Rate



SOURCE Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state poverty rates, of data from the 2009 Current Population Survey. **NOTES** The red line shows the following regression equation: twelve-month continuous coverage = 45.4% + 0.29% × state poverty rate (p = 0.04). See Exhibit 2 Notes for additional information.

have lower poverty rates. But, in addition, states whose pre-ACA Medicaid enrollment included people at higher income levels were likely to have a larger population in Medicaid with incomes at or near the threshold of 138 percent of poverty. That increases the likelihood that many of them would transition between Medicaid and the Marketplace during a year. In contrast, in states without generous Medicaid eligibility, some of the people in this income group likely have employer-sponsored insurance instead of Medicaid, which makes them less likely to have Medicaid or Marketplace coverage in 2014.

It is important to recognize that the eligibility changes we have analyzed are the result of an effort to expand pathways to affordable coverage for all Americans. Churning has often been used to describe the negative outcome of moving into and out of insurance coverage and becoming uninsured. In contrast, we are discussing changes that are a by-product of a system that allows for transitions among insurance pathways. These transitions increase the risks of disrupting care continuity and of having short gaps in coverage. But they represent a different (and less problematic) form of churning than that between having Medicaid or Marketplace coverage and being uninsured.

However, when low-income adults in states that opt not to expand their Medicaid programs experience a loss of income that drops them below 100 percent of poverty, most will not be eligible for subsidized coverage in the Marketplace or for Medicaid. Most nonexpansion states restrict Medicaid eligibility for adults to pregnant women, certain low-income adults with disabilities, and parents of minor children with incomes of no more than 35 percent of poverty on average.¹⁸ In other words, most adults who lose Marketplace subsidies in nonexpanding states will become uninsured, as has traditionally happened to adults who lose Medicaid eligibility.¹⁹

Policy Implications

Our findings indicate that every state is likely to experience significant rates of eligibility changes over time. A number of policies have recently been proposed to mitigate the effects of churning between Medicaid and Marketplace coverage, and state policy makers should consider them in the light of our findings.¹²

One option is for states to adopt twelve-month continuous eligibility periods in Medicaid as a means of overcoming the churning effects of periodic income fluctuations. As noted above, CMS has offered states a fast-track option to adopt this approach, using Section 1115 waivers.¹³ In addition, legislation that would enable

Most adults who lose Marketplace subsidies in nonexpanding states will become uninsured.

states to choose such an option without a waiver is now pending in Congress.

A second, more incremental option offered in CMS's 2012 regulations allows states to assess people's ongoing eligibility for Medicaid using projected annual income instead of current monthly income. This option could reduce rates of eligibility changes, particularly for workers whose earnings vary seasonally.²⁰

A third option for states is to use Medicaid funds to purchase coverage in qualified health plans in the Marketplace for people with incomes below 138 percent of poverty. This is similar to what Arkansas proposed in its waiver application, which was approved by CMS.²¹ Previous estimates have suggested that such premium support could reduce churning by as much as two-thirds in those states whose pre-ACA eligibility standards were very restrictive.²² In effect, people covered through premium support arrangements could maintain their enrollment in the same health plan regardless of the source of subsidy. However, people whose income rose above 138 percent of poverty would face monthly premiums and additional cost sharing that could lead some to drop coverage entirely. Thus, even a premium support model is unlikely to eliminate churning entirely.

A fourth approach is the Basic Health Program, an option under the ACA that enables states to combine their Medicaid expansions with Marketplace subsidies into a single program for individuals and families with incomes of up to 200 percent of poverty. This option has been estimated to reduce churning by 4–5 percentage points per year and to push the churning point to a higher income level, where employer-sponsored coverage is more likely to be an option.⁵ However, the impact of the Basic Health Program on churning depends on the population affected and assumptions made about who will sign up for coverage.^{5,12,23} In any case, the option will not be available until at least 2015: CMS has not yet issued regulations on how the Basic Health Program will work.

Eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues.

A fifth option relates to how and when income changes are verified. Previous research has found that some Medicaid churning is the result of administrative errors or misunderstandings of the application process by beneficiaries when they attempt to reenroll.^{24,25} This suggests that using state administrative data to verify eligibility might produce errors. Safeguards such as automatically continuing eligibility for an extra three months or until the next period of open enrollment for the Marketplace could help minimize inappropriate changes in coverage and reduce unnecessary reenrollments.²⁶ Similarly, integrating Marketplace and Medicaid eligibility determination could help eliminate the possibility of gaps in coverage associated with changes in eligibility. Unfortunately, many states using the federal Marketplace do not plan to allow it to determine people's eligibility for Medicaid, which will increase the risk of bureaucratic delays.

Finally, a state option that combines enrollment and marketing strategies is to encourage certified Medicaid managed care plans to enter state Marketplaces. In recent months it has become clear that a number of companies with historic roots in Medicaid managed care have decided to pursue such certification because they realize that their members will experience income fluctuations and thus might have disruptions in coverage and care. The use of multimarket plans could promote continuity of coverage. However, states will need to ensure that Medicaid managed care plans have adequate financial reserves before allowing them to sell coverage in the Marketplace.

The "bridge plan" option created by CMS in 2012 is essentially a partial version of the multi-market plan strategy.²⁷ It allows plans to operate in both markets under limited circumstances, such as covering only people who have experienced a change in eligibility in the previous year.

Conclusion

Our findings add to a growing body of literature that documents the potential for changes in eligibility for health insurance coverage among low-income families under the ACA. In particular, our study demonstrates that if all fifty states and the District of Columbia were to expand Medicaid under the ACA, a substantial number of people in every state would experience income changes over the course of a year that would change their eligibility for Medicaid or the subsidized health plans sold in the Marketplaces.

We found that higher-income states might be particularly prone to churning between Medicaid and plans sold in the Marketplaces, but the differences between higher- and lower-income states were small. The implication is that eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues. Of course, the disruptions in care resulting from churning are even more serious in states that are not expanding Medicaid in 2014: Those states will have large gaps in eligibility for many low-income adults whose incomes will be too high for Medicaid but too low for tax credits.

Large government programs such as Social Security, Medicare, Medicaid, and the Children's Health Insurance Program typically do not start operating with all of their policies already perfectly tuned. The transition issues raised here will require attention in the coming years, and our key conclusion is that every state will need to address them.

Fortunately, during the past two years an increasing number of feasible policy options have emerged that could mitigate the effects of such changes in eligibility. State officials should consider using these options to reduce inefficient transitions that are a by-product of multiple pathways to insurance and fluctuating incomes. Reducing such churning will greatly increase the likelihood of stable coverage and improved quality of care under the Affordable Care Act. ■

Benjamin Sommers's work on this project was supported by the Agency for Healthcare Research and Quality (Grant No. K02HS021291). John Graves received funding from the Robert Wood Johnson State Health Access and Reform Evaluation program for the construction of the sample weights. The

content is solely the responsibility of the authors and does not represent the official views of the Agency for Healthcare Research and Quality or the Robert Wood Johnson Foundation. The authors are grateful for research assistance from Juliana Stone. Sommers currently serves part time as an adviser

in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS). This article does not represent the views of HHS. [Published online March 12, 2014.]

NOTES

- 1 Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Aff (Millwood)*. 2011;30(2):228–36.
- 2 Census Bureau. Poverty: description of income and poverty data sources [Internet]. Washington (DC): Census Bureau; [cited 2014 Feb 21]. Available from: <http://www.census.gov/hhes/www/poverty/about/data-sources/description.html>
- 3 Census Bureau. Survey of Income and Program Participation [Internet]. Washington (DC): Census Bureau; [last revised 2014 Feb 3; cited 2014 Feb 21]. Available from: <https://www.census.gov/programs-surveys/sipp/methodology/sampling.html>
- 4 Census Bureau. American Community Survey [home page on the Internet]. Washington (DC): Census Bureau; [cited 2014 Feb 19]. Available from: <http://www.census.gov/acs/www/>
- 5 Hwang A, Rosenbaum S, Sommers BD. Creation of state basic health programs would lead to 4 percent fewer people churning between Medicaid and exchanges. *Health Aff (Millwood)*. 2012;31(6):1314–20.
- 6 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Prior HHS poverty guidelines and Federal Register references [Internet]. Washington (DC): HHS; [cited 2014 Feb 21]. Available from: <http://aspe.hhs.gov/poverty/figures-fed-reg.cfm>
- 7 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 8 Schirm AL, Zaslavsky AM. Re-weighting households to develop microsimulation estimates for states. Alexandria (VA): American Statistical Association; 1997.
- 9 Graves JA, Swartz K. Understanding state variation in health insurance dynamics can help tailor enrollment strategies for ACA expansion. *Health Aff (Millwood)*. 2013;32(10):1832–40.
- 10 Cutler D, Gruber J. Does public insurance crowd out private insurance? *Q J Econ*. 1996;111(2):391–430.
- 11 Sommers BD, Tomasi MR, Swartz K, Epstein AM. Reasons for the wide variation in Medicaid participation rates among states hold lessons for coverage expansion in 2014. *Health Aff (Millwood)*. 2012;31(5):909–19.
- 12 Buettgens M, Nichols A, Dorn S. Churning under the ACA and state policy options for mitigation. Washington (DC): Urban Institute; 2012.
- 13 Mann C. Facilitating Medicaid and CHIP enrollment and renewal in 2014 [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2013 May 17 [cited 2014 Feb 19]. Available from: <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-003.pdf>
- 14 Kaiser Family Foundation. State health facts: status of state action on the Medicaid expansion decision, 2014 [Internet]. Menlo Park (CA): KFF; [cited 2014 Feb 19]. Available from: <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- 15 Arellano ABR, Wolfe SM. Unsettling scores: a ranking of state Medicaid programs. Washington (DC): Public Citizen; 2007.
- 16 Heberlein M, Brooks T, Guyer J, Artiga S, Stephen J. Holding steady, looking ahead: annual findings of a 50-state survey of eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP, 2010–2011 [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2011 Jan [cited 2014 Feb 19]. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8130.pdf>
- 17 Kenney GM, Lynch V, Haley J, Huntress M. Variation in Medicaid eligibility and participation among adults: implications for the Affordable Care Act. *Inquiry*. 2012;49(3):231–53.
- 18 Kaiser Commission on Medicaid and the Uninsured. Where are states today? Medicaid and state-funded coverage eligibility levels for low-income adults [Internet]. Washington (DC): KFF; 2009 Dec [cited 2014 Feb 21]. Available from: <http://www.scha.org/tools/files/where-are-states-today-medicaid-state-funded-coverage-eligibility-levels-for-low-income-adults-kff1209.pdf>
- 19 Sommers BD. Loss of health insurance among non-elderly adults in Medicaid. *J Gen Intern Med*. 2009;24(1):1–7.
- 20 Kaiser Commission on Medicaid and the Uninsured. Medicaid eligibility, enrollment simplification, and coordination under the Affordable Care Act: a summary of CMS's March 23, 2012, final rule [Internet]. Washington (DC): KFF; 2012 Dec [cited 2014 Feb 19]. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8391.pdf>
- 21 Tavenner M. Letter to Andy Allison [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2013 [cited 2014 Feb 21]. Available from: <http://posting.arktimes.com/media/pdf/arkansassignedapprovalltr.pdf>
- 22 Rosenbaum S, Sommers BD. Using Medicaid to buy private health insurance—the great new experiment? *N Engl J Med*. 2013;369(1):7–9.
- 23 Graves JA, Curtis R, Gruber J. Balancing coverage affordability and continuity under a basic health program option. *N Engl J Med*. 2011;365(24):e44.
- 24 Hill I, Lutzky AW. Is there a hole in the bucket? Understanding SCHIP retention. Washington (DC): Urban Institute; 2003.
- 25 Sommers BD. From Medicaid to uninsured: drop-out among children in public insurance programs. *Health Serv Res*. 2005;40(1):59–78.
- 26 Swartz K. Minimizing churning and coverage gaps between Medicaid and subsidized qualified health plans. Paper presented at: AcademyHealth Annual Research Meeting; 2013 Jun 25; Baltimore, MD.
- 27 Centers for Medicare and Medicaid Services. Frequently asked questions on exchanges, market reforms, and Medicaid [Internet]. Baltimore (MD): CMS; 2012 Dec 10 [cited 2014 Feb 20]. Available from: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>

Insight from Three Obscure ACA Metrics

March 11, 2014

When HHS releases its next enrollment update in the coming days, the media will likely focus on three numbers: (1) total sign-ups for qualified health plans; (2) the proportion of enrollees between ages 18 and 34; and (3) state-specific numbers relevant for local constituencies. And all three are great numbers! HOWEVER, we believe that three other (and more esoteric) metrics also provide important insights into enrollment trends, and we summarize these data below. Further, at least two of the three numbers are consistent with the view that most marketplace enrollees through February 1, 2014 previously had insurance and have simply transitioned from earlier coverage to subsidized policies.¹

Stand-Alone Dental Plans: Strong Interest in FFM States

We noticed a fascinating number in the most recent enrollment report from HHS.² Of the 1.9 million served by the federally-facilitated marketplace (FFM) by February 1, 2014, some 422,000 consumers (21%) have purchased stand-alone dental policies. Interestingly, the coverage isn't for children: 96% of the policies were for adults age 18-64. And adults age 26-44 were disproportionately likely to buy stand-alone dental coverage. The geographic distribution is also a bit surprising: in 17 of the 36 FFM states, more than one in five adult QHP enrollees selected stand-alone dental products (including the larger states of Georgia, Texas, Virginia, Pennsylvania, New Jersey, Illinois, and Florida). Unfortunately, though, the enrollment report doesn't show the timing of the purchase, so it is not possible to discern any change in enrollment trends before and after the New Year. We also don't have data yet on the state-based marketplaces (SBM), so we may not yet have the full picture. Even so, these data are evidence of the early demand for ancillary dental coverage.

Bronze Plan Selection: Undersubscribed?

Bronze plan selection seems surprisingly low with fewer than one in five consumers choosing this metallic tier. Given reports that perhaps one in four subsidy-eligible adults may qualify for a "zero dollar" plan,³ we might have expected the bronze selection rate to be higher as such coverage is essentially "free". These numbers may lend additional evidence to support the conclusion that signups to date are disproportionately from the ranks of the previously insured. That said, the rate of bronze plan selection may well increase as more uninsured individuals enter the marketplaces in the 20 days remaining of open enrollment.

Overall, males were slightly more likely than females to select bronze coverage (17% and 15%, respectively). However, in twelve of the 36 FFM states, more than 20% of adults selected bronze plans (including Illinois, Texas, Montana, Alaska, Indiana). We also know that the rate of bronze selection was on average higher in SBM relative to FFM states (23% and 16%, respectively) – with relatively higher rates of bronze selections in Washington, Hawaii, Colorado, Maryland, and DC. (The higher rates of bronze selection in SBM may be a product of the different way in which these marketplaces present health plans to consumers relative to the presentation in the FFM.) Still, bronze signups appear relatively low across most marketplaces.

(cont'd)

Catastrophic Plan Selection: Enrollment Trending Light

Catastrophic or “cat” plans had relatively low enrollment (approximately 36,000) across all states and both sexes. Data for the approximately 19,000 cat plan enrollees in the FFM are only partly revealing. While cat plans are by definition limited to persons age 29 or under or with very low incomes, 54% of enrollees are between ages 26-34 -- and only a very small fraction (3%) are 18 or under. Because of the format of the HHS reporting, we cannot tell the proportion of persons age 26 to 34 who qualified on the basis of their income rather than their age. The relatively low interest in cat plans is perhaps unsurprising if you believe that persons transitioning from coverage make up the majority of current Marketplace enrollees.

Note that enrollees in cat plans cannot claim the § 36B premium assistance tax credits for such coverage, though cat plans do count as minimum essential coverage for purposes for the § 5000A tax penalty. One related statistic: Among the approximately 322,000 enrollees in the FFM states **not** receiving subsidies, 30% chose bronze plans and an additional 6% chose catastrophic plans.

Implications

If most marketplace enrollees to date previously had insurance, then the tax industry’s work with enrollment has become even more important. In short, the tax industry helps uninsured individuals enroll by leveraging the 1040 information to streamline the application process. Since 88% of the uninsured who are eligible for the tax credits are already filing taxes,⁴ the tax filing moment may be the best opportunity to enroll these Americans. We take this role seriously and will continue to help – now and again during the open enrollment period for 2015, which, we are happy to report, now extends through February 15, 2015!

We will update this analysis when HHS shares February enrollment data in the coming days. Please feel free to contact me at brian.haile@jtax.com or 615-761-6929 if I can be helpful in any way.

Brian Haile

Senior Vice President for Health Policy

Jackson Hewitt Tax Service Inc.

(615) 761-6929 | brian.haile@jtax.com | Twitter: @haile_brian



¹ See generally, Laszewski, Bob, “Survey Data and Market Reports Say the Uninsured Are Not Signing Up for Obamacare,” January 19, 2014 blogpost, available at http://healthpolicyandmarket.blogspot.com/2014/01/survey-data-and-market-reports-say.html?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+HealthCarePolicyAndMarketplaceBlog+%28Health+Care+Policy+and+Marketplace+Blog%29; Nather, Dan, “Obamacare stats still hard to nail down,” *Politico*, February 24, 2014, http://www.politico.com/story/2014/02/obamacare-enrollment-numbers-103828_Page2.html. By way of background, the February enrollment report noted that about 82% of qualified health plan enrollees (which translates to about 2.6 million people) receive financial assistance. This in itself is a small

number: the pre-2014 individual market alone served roughly 11 million enrollees. See Kaiser Family Foundation, "Individual Insurance Market Competition," (2011), available at <http://kff.org/other/state-indicator/individual-insurance-market-competition>. Over 44% of individuals with "direct purchase" insurance in Census Bureau surveys reported incomes between 125%-400% of the federal poverty level. While some individuals may retain grandfathered plans and others may not be eligible for a substantive tax credit, it is very likely that the 2.6 million enrollees receiving assistance transferred from a plan for which they were paying "full freight." Author's calculations of data from Current Population Survey 2012-13 from U.S. Census Bureau.

² The general source for enrollment data analyzed here is: U.S. Department of Health and Human Services, "Health Insurance Marketplace: February Enrollment Report," ASPE Issue Brief, February 12, 2014, available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf.

³ For estimates on the availability of zero-dollar bronze products, see recent reports from McKinsey and Credit Suisse at http://www.mckinsey.com/~/media/McKinsey/dotcom/client_service/Healthcare%20Systems%20and%20Services/PDFs/McKinsey_Reform_Center_Exchanges_go_live_Early_trends_in_exchange_dynamics.ashx and https://doc.research-and-analytics.csfb.com/docView?sourceid=em&document_id=x531093&serialid=QVESvNa9T%2bFOVahl%2fzKL5CWJ8Ce%2f8bybAHq1HuKQ4zw%3d, respectively.

⁴ Dorn, Stan, Matthew Buettgens, and Jay Dev, "Tax Preparers Could Help Most Uninsured Get Covered," Urban Institute and Robert Wood Johnson Foundation, February 18, 2014, available at <http://www.urban.org/publications/413029.html>.