Evaluation of BadgerCare Plus Health Coverage

for

Parents & Caretaker Adults and for Childless Adults

2012 Waiver Provisions

EXECUTIVE SUMMARY REPORT

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by the

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Introduction

This executive summary accompanies a complete technical and scientific report that evaluates the 2012 waiver provisions related to Wisconsin's BadgerCare Plus coverage for non-pregnant, non-disabled adults. It covers two separate waivers: one for parents and caretaker adults, and one for childless adults enrolled in the BadgerCare Plus Core Plan.

The Wisconsin Department of Health Services describes the purpose of the waiver as follows:

> *This [amended waiver] implements additional eligibility requirements on [parents, caretaker adults, and childless adults] with incomes above 133% of the FPL, including those parents and caretakers eligible for BadgerCare Plus through Transitional Medical Assistance. The amended Demonstration will enable Wisconsin to test the effects of increasing premiums on program enrollment, utilization of services, and health outcomes by implementing sliding scale premiums in excess of 5 percent of household income and by permitting a 12 month restrictive re-enrollment policy for individuals who do not pay premiums. The amended Demonstration also tests the effects of the application of the 9.5 percent affordability test found under the PPACA.*[1]

This Executive Summary provides only the primary conclusions from each of eight hypotheses. These hypotheses had been defined by the Wisconsin Department of Health Services in its waiver agreement with the federal Medicaid and Medicare Services (CMS). The UW Population Health Institute was engaged in a contract with the Wisconsin DHS to investigate those hypotheses.

This evaluation was conducted over a 14-month period from July 2013 through September 2014. In that timeframe, the research team needed to study those affected by the July 2012 policy change and exposed to a 12-month restricted-reenrollment period. The study population includes those enrolled in coverage through December 2013. We drew claims data for this study population up to July 2014 to assess their utilization through December 2013. A survey was also fielded from April 1, 2014-August 30, 2014, attaining a 50% response rate from a sample of 2,000 current and former BadgerCare Plus members.

Hypothesis 1.
Is there any impact on utilization and/or costs associated with individuals who were disenrolled, but re-enrolled after the 12-month restrictive reenrollment period (RRP)?

Different impacts occurred in different categories of utilization. Relative to those continuously enrolled, persons who experienced an RRP showed utilization in the period following an RRP (once re-enrolled in BadgerCare) as follows:

- 7% increase in ED visits
  - 3% increase in ACS ED visits
- 1% increase in outpatient visits
  - 13% increase in outpatient visits for preventive care
- 20% fewer hospitalizations
  - 12% decline in preventable hospitalizations

➢ On balance, evidence does not suggest added utilization following reenrollment for the RRP sample.

[1] Wisconsin Department of Health Services. Request for Proposals #3024-R DHCAA-JH. May 8, 2013.

During the RRP, total forgone costs were $134 per month per member of the RRP sample. In addition, during the post-re-enrollment period, there was an additional $48 per month of forgone costs. The forgone costs in the RRP period were mostly the result of averted inpatient and outpatient costs. The forgone costs in the post-reenrollment period were entirely the result of reduced inpatient costs, as there were small offsetting increases in ED and outpatient costs for the RRP sample in the post-re-enrollment period.

The state Medicaid agency, while averting $134 RRP utilization costs, at the same time sacrificed premium revenue that would have otherwise been collected during the members' RRP. An estimated average premium of $86.59 per member per month is foregone by the State from BadgerCare Plus members who enter an RRP.[2] The net monthly savings from the RRP would therefore be approximately $48 per member per month ($134 less $86) during the RRP.

- The RRP did not lead to an increase in costs for the RRP sample following re-enrollment. Results suggest a decline in costs related to decreased hospitalization.
- The State saves approximately $48 per member per month during the RRP, from foregone utilization balanced against lost premium revenue. This does not account for any increased administrative costs to the state that may be associated with implementing or managing this program.

Hypothesis 2.
Are costs and/or utilizations of services different for those that are continuously enrolled compared to those for individuals who have disenrolled and then re-enrolled?

- Continuously enrolled sample uses medical services differently than the RRP sample, even prior to disenrollment.

In particular, the continuously enrolled sample visited the emergency department (ED) 12% less often, but visited the hospital 12% more often and had 24% more outpatient visits than the reenrollment sample in the pre-disenrollment period. These differences were also evident in the period following reenrollment.

The continuously enrolled members visited the ED 42% less often, but had 28% more hospitalizations and 29% more outpatient visits. These differences were also evident for ambulatory care sensitive emergency department visits, preventable hospitalizations, and outpatient visits for preventive care.

- Compared with the continuously enrolled sample, the re-enrolled RRP sample:
  - Uses the ED more often
  - Uses outpatient and inpatient services less often
- These differences are seen both prior to and following disenrollment.
- This analysis compares the two populations, but does not suggest an impact of the RRP itself.

[2] The average premium amount is calculated in the following way. We take as reference the FPL in the last period before the RRP. Then we impute the premium level from table 3.1 to each individual according to their reference FPL level. We then take the average of the imputed premium.

The RRP sample's use of the emergency department may relate to the responses by those in the survey sample who had experienced an RRP, when questioned about their attachment to health care.

- Continuously enrolled members constituted a significantly greater share (58%) of those who report having a usual source of care compared to those who had an RRP (42%), while those who had an RRP represented a full 64.1% of those who reported not having a usual source of care.
- Those with an RRP make up the majority (57%) of those who report being without a personal doctor.
- Those who had an RRP significantly more frequently reported that they were unable to get care they needed in the prior 12 months (27.6%) compared to those continuously enrolled (16.7%).
- Those who had an RRP also more frequently reported that they were unable to get medications that they needed in the prior 12 months (28.4%), compared to those continuously enrolled (18.7%)

In the pre-disenrollment period, the continuously enrolled had average monthly costs that were $23 higher than those for the reenrollment sample. This difference was $68 in the post-reenrollment period. In both cases the cost difference was almost entirely due to differences in hospitalization costs. In contrast, there were fairly small differences in costs associated with ambulatory care sensitive (ACS) ED visits, preventable hospitalizations, and outpatient visits for preventive care between the two groups.

- Substantial differences are observed in utilization and total costs, particularly costs associated with hospitalizations, between the unmatched continuously enrolled sample and the reenrollment sample. The continuously enrolled sample incurs greater costs, compared to the RRP sample, in preventable inpatient and outpatient costs, while the RRP sample incurs greater costs for preventable emergency department utilization.

Survey results also find substantially varying self-reported health status, utilization, and needs among these two groups.

- Those who remain continuously enrolled report with significantly greater frequency that a physical, mental, or emotional problem limits their ability to work at a job or business, relative to those who enter an RRP (19.1% versus 11.5%)
- Those who remain continuously enrolled report having at least one chronic condition more frequently compared to those who enter an RRP (64% versus 56%).
- Those who remained continuously enrolled report that they needed some kind of medical care in the last 12 months (80.6%) more frequently compared to those who entered an RRP (75.1 %).

Hypothesis 3.
What impact does the 12 month waiting period for failure to make a premium payment have on the payment of premiums and on enrollment? Does this impact vary by income (if so, include a break out by income level)?

The total number of exits has increased post-policy among both the RRP and non-RRP groups, with the largest increases among the RRP groups. This is true for both the income groups where premiums were previously required and for those for which premiums are newly required.

- Exits due to RRP increased following the July 2012 policy change, and almost all of the increase in exits in July 2012 are associated with the RRP.

The total number of on-time premium payments is higher post-policy than pre-policy, but this is solely due to the increased number of people required to pay premiums between 133-150% FPL and above 200% FPL. For parents and caretaker adults in the income levels associated with premium requirements in the pre-policy period (150%-200% FPL), the number of on-time payments show a decline for the aggregate period through December 2012.

- Important variation appears to occur based on whether the premium change occurs to a member that was previously in a premium-payment category or a non-premium-payment category, rather than the amount of the required premium.

    - The exits immediately following implementation of the new premium payment policies increase substantially but temporarily. This increase is almost entirely due to an increase in RRP exits.
    - The increase in overall number of exits due to RRP is most likely due to the exit of existing enrollees in the program who were not willing or able to pay the new or increased premiums.
    - A large increase in exits occurred among all premium-paying groups associated with the July 2012 premium implementation.
    - Exits have gone up post-policy among both the RRP and non-RRP groups, with the largest increases among the RRP groups. This is true for both the income groups where premiums were previously required and for those for which premiums are newly required.
    - The relative effect of the 12 month RRP combined with the premium was an increase in exits due to RRP for the new premium paying group, but the models suggest a relative reduction in exits due to RRP among the group already paying premiums.

Post-RRP Re-Enrollment

- Re-enrollment rates varied by income both before and following the change in RRP policy.
- Only members within the income group 133-150% FPL show a substantial increase in the frequency, post-policy change, of re-enrollment at twelve months following their exit.
- Re-enrollments decreased among the 150-200% FPL group at both 6- and 12-months.

These trends may be driven by the imposition of new premium payments on the group of parents/caretaker adults, where they had not previously had them, suggesting that they remain eligible and continue to want and need coverage after the RRP. The higher income groups, while facing premium increases along with the longer RRP, had previously participated in some premium cost-sharing. The change in their exit and re-enrollment rates may have, instead, been related to policy changes pertaining to access to affordable employer-sponsored coverage or other circumstances. For those in this group that might have re-enrolled, their entry may have been deterred by the extension of the RRP from six- to twelve months.

Hypothesis 4.
What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?

Overall, comparing enrollee's experience pre- and post-policy, there was a downward trend in total enrollment among premium-paying categories after the July 2012 changes, but total enrollment recovered at the end of 2013 before eventually again trending down in 2014. Comparing across income groups, roughly 80% of parent/caretaker enrollees were in families with incomes below 133% FPL, with smaller fractions in the higher income groups. TMA enrollment trended up during 2011, but began to decline at the beginning of 2012 and then dropped in July 2012 across all of the newly premium paying income categories, but not in the non-premium-paying category. The childless adult program was closed to new enrollment, and so the total enrollment is decreasing across all income groups. An accelerated decline occurred among the highest income group associated with the time of the premium implementation.

Parents and Caretaker Adults:

The overall level of exits increased after July 2012, by 14-21% depending on the specification. The new premium-paying group, those with incomes 133%-150% FPL, had exit rates that were 2.8-3.1 times higher than the comparison group once they were required to pay premiums. Those in the 150-200% FPL group facing increased premiums had exit rates 1.7-1.8 times higher than previously, relative to the comparison group. For parents/caretakers, the size of the effect is, for the most part, decreasing in income, and is significantly larger for the new premium-paying groups than for those already required to pay premiums. Within the already paying premium income ranges, the largest effects on exit rates are for the highest income enrollees.

TMA adults:

The post period was associated with an exit 1.6-1.8 times higher overall. All income groups >133% FPL were new premium payers, and the premium requirement was associated with 2.6-3.8 times higher exit rates, depending the group and specification. The smallest increases were for the above 200% FPL group, who were paying the highest premiums. This could be explained by higher income enrollees being most able to pay the premiums, or by selection -- only high-need members may remain enrolled at that income level.

Childless adults:

The post period was associated with slightly lower exit rates overall. However, the new premium-paying enrollees in the post policy period showed a substantial increase in exits rates, increasing by a factor of 4.2-6.4, depending on the exact specification and group. Similar to TMA adults, the smallest effect appears to be for the >200% FPL group. Here again, childless adults in income categories that previously did not have a premium are more likely to exit than are those parents/caretaker adults who previously had a premium and then face higher premiums with the change in policy.

Effects of Premiums on Exits

- 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.

Survey responses indicate varied impact of premiums and reasons among sub-groups for leaving BadgerCare Plus coverage:

- Respondents were, in all eligibility categories, less likely to report that they dropped their coverage because of the premiums.
- Childless Adults much more frequently reported that they dropped their BadgerCare Plus coverage because of premiums increased (34%) than did Parents/Caretaker Adults (11.2%).
- Respondents most frequently cited loss of eligibility due to a change of income as their reason for leaving BadgerCare. They also frequently cited other insurance as a top reason. This may reflect that change in the way the BadgerCare Plus program measured affordability of employer-sponsored insurance, although it is not certain given the lack of comparable data from prior to the policy change.
- Persons who had been subject to an RRP were significantly more likely to report having dropped their BadgerCare Plus coverage due to premiums (10.9%), compared to person who had been continuously enrolled (4.7%).
- Those who had been continuously enrolled were significantly more likely to report leaving BadgerCare Plus because of an income change (29.3%) relative to those who had been subject to an RRP (24.3%), and the continuously enrolled were more likely to cite "other reasons" (29.6%) for leaving BadgerCare, compared to those who had been on an RRP (25.2%) .

Hypothesis 5.
How are enrollment, retention, and access to care affected by the application of new, or increased, premium amounts?

Hypothesis 4 addresses enrollment and retention. The analysis under Hypothesis 5 focuses on the effects of the premium policy on utilization and access to care. The relationship of premium changes to changes in utilization could be driven by differential selection in those who leave. In other words, those with the lowest health care needs may exit the program because they are the least willing to pay the new or increased premiums. Average health care use would then appear to be increasing among those who remain enrolled in the program (since those with lower than average usage are leaving at a higher rate).

Parents/Caretaker Adults:

- Overall, no change occurs in the average healthcare use by enrollees who remained enrolled in the program before and after the premium policy change. This is consistence with the enrollees who exited having similar healthcare needs, on average, to the enrollees who remained in the program, or alternatively, premiums having no effect on health care use.
- Within the newly premium required income levels, the post-July 2012 period was associated with a 5% increase in outpatient visits relative to the pre-period baseline. The difference appears to be coming purely from selection effect.

TMA:

- Average use increased for outpatient, ER, and hospital visits. This would suggest that healthier enrollees are disproportionately likely to leave the program, or alternatively, premiums have a negative effect on health care use.
- Adjusting for within-person differences, there is no evidence of across-the-board increases or declines in health care utilization for the TMA population, but there are some observed differences for certain income groups.

Childless Adults:

- As for parents/caretakers, there Is no or limited evidence of utilization effects any effect of premiums. Any observed differences in visits for childless adults appear to be driven by healthier childless adults being differentially likely to exit when required to pay premiums.

Survey responses show varying experience across groups over the year since the new policy took effect:

- TMA adults more frequently report needing care and less frequently report getting the care they need, whle Childless adults report less frequently needing care compared to other the other groups, and also less attachment to health care.
- All three groups are substantially less likely to report having a usual source of care and getting the care they need, compared to the Wisconsin overall population reported by Wisconsin's 2010 Family Health Survey.
- All three groups heavily cite, as the reason that they did not get needed care, that the care "costs too much" or they "didn't have insurance."
- Childless Adults and TMA adults more frequently report that their health has become worse over the past 12 months, compared to Parents/Caretaker Adults. (19%, 16%, 11%, respectively)

Hypotheses 6. Are there discernible characteristics with respect to individuals and/or the policies that are available to them, who have been determined to have affordable coverage, e.g., part-time/full-time, large/small employer, etc.?

Hypotheses 7. How many individuals have met the affordability test? What is the margin by which they have met the test?

- 70% of members appearing in the Unemployment Insurance data worked for an employer with an EVHI match, suggesting that approximately 30% of eligible adults work for employers who have not submitted data to EVHI data.

- Approximately one-quarter of members with an EVHI match had missing data regarding availability and cost of employee ESI coverage.

Determination of whether a BadgerCare Plus applicant had access to affordable employer-sponsored coverage typically required an EVHI verification. Item missing-ness regarding the employee-specific insurance generosity measure is three times higher for members lacking access compared to those with access (9% versus 28%, respectively).

- Given the high levels of missing data, and the differential missing-ness across groups, the findings related to Hypotheses 6 and 7 require caution.

- Sex, mean wages, and household income were the demographic characteristics that differed the most across the two groups

- Women comprise a larger share of the lacking access to ESI group (75% versus 65% of group with access)

- Higher wage earners and higher-income households populate the group with access (mean wage $5,669 vs. $4,176 of group lacking access; mean household income 103% FPL for group with access vs. 90% FPL for group lacking access).

CORE plan members comprised 8% of the group lacking access and less than 1% of those with access, which is unsurprising given the ESI eligibility restrictions specific to CORE. Parents and caretakers and, especially, extension members had greater representation in the group with access. Notably, the percentage of members with an EVHI match was fully 10 percentage points higher among the group determined to have access relative to the group lacking access (85% vs. 75%). Those determined to have access to *affordable* ESI and those determined to lack such access had similar sociodemographic profiles.

Hypothesis 8.
Has the application of new premiums to this population served as a cost-savings measure to the State?

- The new premiums have served as a cost-savings measure to the State, by increasing collection of premium dollars and in some cases resulting in exit from coverage. The findings from Hypotheses 1-5 suggest that these savings are not offset by pent-up demand upon re-enrollment.

    - The cost savings over a 12-month period, from averted utilization summed with the additional revenue collected, results in a total estimated savings of $69,152,851

    - The increase in premiums accounts for 60% of total program savings. while 40% of the savings accrue from the averted utilization costs of those who exit BadgerCare Plus coverage.

    - Parents/Caretaker Adults account for 56% of total program savings, as they account for the predominance of enrolled members and of those affected by the policy changes.

    - The policy change results in an estimated savings to the BadgerCare Plus program of $139 per-member-per-month

Limitations and Caveats

These estimates require several cautions in their interpretation:

1. These estimated savings accrue to the BadgerCare Plus program specifically, and not to the health care system overall.

2. Missing claims and encounter data will result in understatement of cost savings from averted utilization.
3. Savings to the BadgerCare Plus program may be offset by additional administrative costs, which this evaluation does not assess.
4. The measure used here of re-enrolment allows for re-entry only at six months after the exit. Those who exited without an RRP could potentially re-enroll at any time that their circumstances allow; in this case, the savings estimates would be overstated.

Any utilization and costs averted from the BadgerCare Plus program may be incurred by other safety net programs if those who leave BadgerCare Plus become uninsured. The foregone utilization costs averted from the BadgerCare Plus program due to program exits or RRP may be incurred in the form of uncompensated care. Such utilization costs would ultimately be absorbed across payers.

The subsequent insurance status of those who leave BadgerCare Plus coverage is a matter outside the scope of this evaluation. However, the survey respondents who report no longer having BadgerCare Plus coverage offer some information about the degree to which they gained other coverage upon leaving. About 48% of Parents/Caretaker Adults, 56% of Childless Adults, and 57% of TMA Adults report having access to other insurance as a reason for no longer being on BadgerCare.

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