Expanding Coverage to Low-Income Childless Adults in Massachusetts: Implications for National Health Reform

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MEDICAID EXPANSION UNDER THE ACA

- The Patient Protection and Affordable Care Act (ACA) will extend Medicaid eligibility to nearly all adults with family income up to 138% of poverty in 2014.

- The largest expansion population will be adults without dependent children ("childless adults") as few states provided public coverage to this population prior to the ACA.

- Massachusetts expanded public coverage to childless adults as part of its 2006 health reform initiative.
  - Provided fully-subsidized coverage for adults up to 150% of poverty.
HEALTH REFORM IN MASSACHUSETTS

- Legislation passed in April 2006, with implementation beginning in July 2006
- Major goals:
  - Near-universal health insurance coverage
  - Improve access, affordability, and quality of health care
- Included expansions of public coverage, subsidies for private coverage, health insurance exchange, expansion of dependent coverage, individual mandate, and more
- Provided the template for many of the elements of the 2010 ACA
DATA—Massachusetts Treatment Group

- Massachusetts Health Reform Survey
  - Sample of non-elderly adults 19-64 years old
  - Baseline survey in 2006, follow-ups in 2007 to 2010
  - Oversamples of the lower-income and uninsured adults who were targeted by reform
  - Sample size ~3000 each year
  - Funded by BCBSMA Foundation, with additional funding in earlier years by RWJF and the Commonwealth Fund

- Sample: Childless adults with family income less than 100% of poverty in 2006, 2008, and 2009
  - Sample size is relatively small: 1,089
DATA—Comparison Groups

- National Health Interview Survey (NHIS)
  - Annual survey of 35,000-40,000 households (75,000-100,000 individuals)
    - More detailed questions for random adult in the household—“sample adult”
  - Use NHIS data from the Integrated Health Interview Survey (IHIS) from the Minnesota Population Center

- Samples:
  - (1) Childless adults with family income less than 100% of poverty in 2006, 2008, and 2009 (sample size: 3,705)
  - (2) Childless adults with family income between 200% and 300% of poverty in 2006, 2008, and 2009 (sample size: 3,559)
OUTCOME MEASURES

- Health insurance coverage
- Access to care/barriers to obtaining care
- Use of health care services
METHODS

- Examine changes in insurance coverage, access and use in Massachusetts using the MHRS and a pre-post framework
  - Estimates capture impact of reform plus other changes over period, including recession and health care cost trends
  - However, other studies have shown consistency in pre-post and difference-in-differences models for Massachusetts over this time period
- Compare the MHRS findings for MA with comparable estimates of changes over the same time period for similar adults in other states using the NHIS to approximate difference-in-differences estimates
METHODS

- Estimate linear probability models, controlling for demographic characteristics, health and disability status, and socioeconomic characteristics.
  - Underlying assumption is that the trends over time for similar adults in the other states provide the counterfactual for what would have happened in the absence of health reform in Massachusetts
  - “Other states” includes all states outside of the northeast region
  - Used multiple comparison groups to assess the sensitivity of our findings across models
- Outcomes are limited to measures that were comparable across both surveys
CHANGES IN INSURANCE COVERAGE, 2006 TO 2008/2009: Any Insurance
Percent reporting insurance coverage at the time of the survey

**Note:** These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN INSURANCE COVERAGE, 2006 TO 2008/2009: Employer-Sponsored Insurance (ESI)
Percent reporting ESI coverage at the time of the survey

Note: These are regression-adjusted estimates.
* (***) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN ACCESS TO HEALTH CARE, 2006 TO 2008/2009: Usual Source of Care

Percent reporting that they have a usual source of care

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2008/2009</th>
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</thead>
<tbody>
<tr>
<td><strong>MA</strong></td>
<td><strong>73%</strong>*</td>
<td><strong>85%</strong>*</td>
</tr>
<tr>
<td><strong>LOWER-INCOME US</strong></td>
<td>68%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>HIGHER-INCOME US</strong></td>
<td>75%</td>
<td>75%</td>
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</table>

Note: These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN USE OF HEALTH CARE, 2006 TO 2008/2009: Any Doctor Care

Percent reporting a doctor care visit over the prior year

Note: These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN USE OF HEALTH CARE, 2006 TO 2008/2009: Any Dental Care

Percent reporting a dental care visit over the prior year

Note: These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN USE OF HEALTH CARE, 2006 TO 2008/2009:
Any emergency department visit
Percent reporting an emergency department visit over the prior year

Note: These are regression-adjusted estimates.
* (***) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN USE OF HEALTH CARE, 2006 TO 2008/2009: Emergency department visit for non-emergency care

- The MHRS asked about ED visits for non-emergency conditions
  - Between fall 2006 and fall 2008/2009, this fell from 32% to 23% for low-income childless adults in MA
  - Perhaps reflecting gains in access to dental care
- Do not have a measure for this in NHIS, but suspect based on other results that this outcome remained unchanged in other states
CHANGES IN UNMET NEED FOR HEALTH CARE DUE TO COSTS, 2006 TO 2008/2009: Medical Care

Percent reporting unmet need for medical care over the prior year

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<tr>
<th>Region</th>
<th>2006</th>
<th>2008/2009</th>
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<tbody>
<tr>
<td>MA</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>LOWER-INCOME US</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>HIGHER-INCOME US</td>
<td>15%</td>
<td>17%</td>
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Note: These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN UNMET NEED FOR HEALTH CARE DUE TO COSTS, 2006 TO 2008/2009: Dental Care

Percent reporting unmet need for dental care over the prior year

<table>
<thead>
<tr>
<th>Region</th>
<th>2006</th>
<th>2008/2009</th>
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<tbody>
<tr>
<td>MA</td>
<td>22%</td>
<td>6%**</td>
</tr>
<tr>
<td>LOWER-INCOME US</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>HIGHER-INCOME US</td>
<td>14%</td>
<td>18%*</td>
</tr>
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</table>

Note: These are regression-adjusted estimates.
* (**) Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
CHANGES IN UNMET NEED FOR HEALTH CARE DUE TO COSTS, 2006 TO 2008/2009: Prescription Drugs
Percent reporting unmet need for prescription drugs over the prior year

Note: These are regression-adjusted estimates.
* (**): Significantly different from fall 2006 at the .05 (.01) level, two-tailed test.
SUMMARY OF KEY FINDINGS

• Evidence from Massachusetts suggests a strong response by low-income childless adults under health reform:
  – Increases in insurance coverage, with employers continuing to play an important role
  – Gains in access to and use of health care, including increased likelihood of having a usual source of care, visiting doctors, specialists, and dentists, and reductions in unmet need for care due to cost
SUMMARY OF KEY FINDINGS

- Evidence from our comparison groups of lower- and higher-income childless adults in other states suggest changes in Massachusetts are due to health reform
  - Coverage, access and use in other states all either remained unchanged or worsened over the same period during which Massachusetts experienced gains
EXPECTATIONS UNDER THE ACA

• Large increases in coverage and commensurate gains in access to and use of health care for low-income childless adults under ACA

• Ramifications:
  – Increased demand for health care, which may be a challenge in states with current stresses on provider supply
  – Potential for more appropriate care, leading to reductions in inappropriate ED use (and associated costs)
  – Providing more secure financial situation for vulnerable population as burden of health care costs is eased