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STATE HEALTH ACCESS REFORM EVALUATION

Medicaid vs. Marketplace Coverage for Near-Poor Adults: Impact on Out-of-Pocket Spending

December 5, 2017

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- The Robert Wood Johnson Foundation's State Health Access Reform Evaluation (SHARE) grant program



State Health Access Reform Evaluation (SHARE)

- Grant Program Funded by the Robert Wood Johnson Foundation (RWJF)
- At the State Health Access Data Assistance Center (SHADAC)
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Today's Speaker



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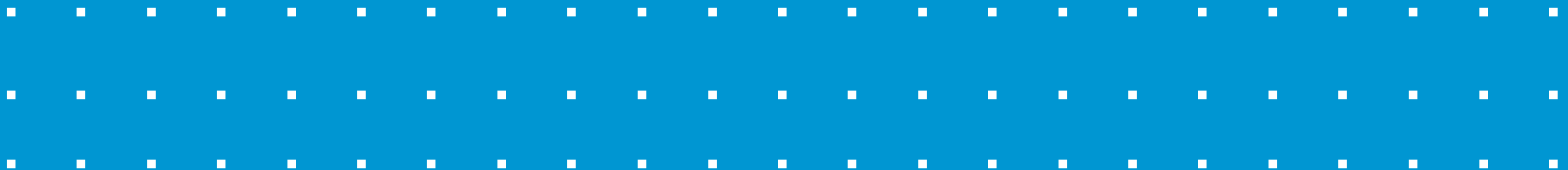


Medicaid vs. Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage

Fredric Blavin, Michael Karpman, Genevieve Kenney, and Benjamin Sommers

SHADAC/SHARE webinar

December 5, 2017



Main Research Question

- Compared with potential access to subsidized Marketplace plans, what is the impact of state Medicaid expansion decisions on out-of-pocket (OOP) health expenses and health insurance coverage among low-income adults with incomes between 100 and 138% of the federal poverty level (FPL)?

How can Medicaid, relative to Marketplace coverage, affect consumer finances?

1. Lower premiums and cost-sharing requirements in Medicaid

- In non-expansion states, tax credits cap Marketplace premiums for the second-lowest-cost silver plan at 2% of income + cost-sharing requirements
- In contrast, little or no premiums and minimal cost-sharing in Medicaid.

2. Higher coverage take-up in Medicaid

- Lower premiums improve take-up, especially among low-income (Chernew et al. 1997; Kenney et al. 2006; Sommers et al. 2012; Dague 2014).
- Other factors

Why is this important?

- Expand or not expand?
- Six states have approved Section 1115 expansion waivers which allow Medicaid to charge premiums for the 100 to 138 percent FPL group (Hinton et al. 2017).
- One state (Arkansas) has submitted a waiver request to lower the Medicaid eligibility level to 100 percent FPL, while at least five others have drafted plans to place other limits on existing Medicaid expansions (McIntyre, Joseph, and Bagley 2017)

Medicaid and Financial Well-Being

- In Oregon, Medicaid reduced the likelihood of borrowing money or skipping bills to pay for medical care by 40 percent and reduced the probability of having a medical collection by 25 percent (Finklestein et al. 2012)
- Medicaid expansion reduced difficulty paying medical bills among low income parents (McMorrow et al. 2017)
- Hu et al. (2016) found that the Medicaid expansion significantly reduced the amount of debt sent to third-party collection agencies by -\$600 to -\$1,000, on average.
- Adults in Kentucky (a traditional Medicaid expansion state) with incomes below 138 percent FPL experienced a greater reduction in trouble paying medical bills than in Arkansas, a “private option” expansion state that features the maximum allowable cost-sharing under Medicaid rules (Sommers, Blendon, and Orav 2016).

Data and Sample – OOP Health Expenses

2010-2016 March Current Population Survey (CPS)

- Includes detailed information on premium and non-premium OOP medical spending, income, state of residence, and demographic and socioeconomic characteristics.
- Sample includes ~6,000 nonelderly adults (per year) with HIU income between 100 and 138% FPL who appear to meet immigration requirements for eligibility (Passel and Cohn 2016).
- Sample excludes late-expanding states (PA, IN, NH, AK) and states with major expansions to childless adults prior to the ACA (DC, MA, VT).
- Shorter pre-2014 period (2013 only) as an alternative specification.

Data and Sample – Health Insurance

- Fundamental redesign of the CPS health insurance questionnaire in 2014 precludes direct comparisons to estimates from prior years (Pascale, Boudreaux, and King 2016).
- We use 2010-2015 American Community Survey (ACS) to assess the impacts of Medicaid expansion on coverage status in this income group.
 - The ACS has approximately 3 million individuals surveyed in each year and includes a consistent set of health insurance questions over the analysis period.
- The ACS sample is also limited to adults ages 19-64 with incomes between 100-138 percent FPL, and excludes noncitizens and residents of the same states excluded from the CPS analysis.

Methods

- Difference-in-differences (DD) models to compare key outcomes for adults 19-64 with incomes between 100 and 138% FPL in Medicaid expansion states vs. those in non-expansion states.
- Models for each key spending outcome (premiums, cost-sharing, and total):
 - OLS model where dependent variable is the level of expenses
 - A linear probability model where the dependent variable is equal to one if the person's family OOP spending exceeds 10 percent of family income (high burden)
 - Two-part linear model to account for the large share of zeros in the data
- RHS controls: age, gender, race/ethnicity, education, work status, citizenship status, family structure, income redesign, and year and state fixed effects.
- CPS replicate weights to generate empirically derived standard errors.
- All spending estimates are in 2015 dollars.

Methods, Cont'd

- The ACS DD approach is consistent with the CPS analysis.
 - Dependent variables are indicators for being uninsured, covered by Medicaid, covered by ESI, and covered by direct purchase coverage.
 - Excludes noncitizens instead of undocumented immigrants and includes PUMA fixed effects to control for fixed differences within and across states.
- Additional models
 - Childless adults and different age and racial and ethnic subgroups
 - Log-transformed models and one- and two-part GLM models
 - Change the income band to address potential measurement error in income.
 - Falsification test: Use higher income bands (150-200 and 200-400 percent FPL) because the ACA coverage provisions for these income groups are, for the most part, the same in expansion and nonexpansion states
 - Change state inclusion/exclusion criteria
 - Tests for parallel trends

ACS Insurance Models, Sample Adults, Expansion vs. Nonexpansion States

	Unadjusted Means		Diff. between periods	Difference-in-Differences				
	2010- 2013	2014- 2015		Unadj.		Adjusted		
<u>Uninsured</u>								
Expansion States	0.352	0.188	-0.164	-0.047	** *	-0.045	** *	
Nonexpansion	0.429	0.311	-0.117					
<u>Medicaid</u>								
Expansion States	0.176	0.294	0.119	0.112	** *	0.111	** *	
Nonexpansion	0.099	0.106	0.007					
<u>ESI/military</u>								
Expansion States	0.394	0.418	0.024	-0.020	** *	-0.023	** *	
Nonexpansion	0.403	0.447	0.044					
<u>Direct purchase</u>								

Total OOP Spending, Sample Adults in Expansion vs. Nonexpansion States

	Unadj. Means		Diff.	Diff-in-Diff			
	'10-'13	'14-'15		Unadjusted	Adjusted		
<u>Average OOP spending</u>							
Expansion States	\$1,014	\$972	-\$42	-\$368	** *	-\$344	**
Nonexpansion	\$1,086	\$1,412	\$326				
<u>High OOP spending burden</u>							
Expansion States	0.211	0.212	0.001	-0.048	** *	-0.041	** *
Nonexpansion	0.229	0.278	0.049				
<u>Any OOP spending</u>							
Expansion States	0.593	0.574	-0.019	-0.089	** *	-0.077	** *
Nonexpansion	0.615	0.685	0.070				
<u>Avg. OOP spending, conditional on any OOP</u>							
Expansion States	\$1,711	\$1,694	-\$17	-\$212		-\$205	

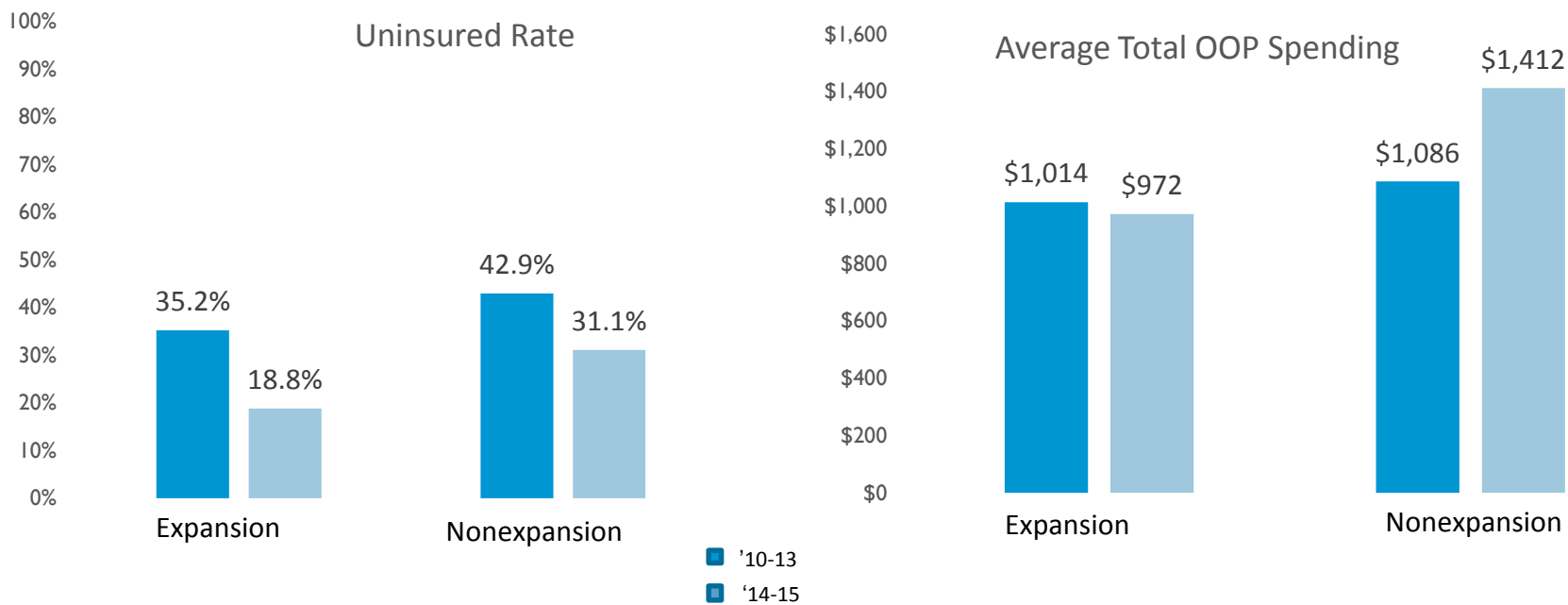
OOP Premium Spending, Sample Adults in Expansion vs. Nonexpansion States

	Unadj. Means		Diff.	Diff-in-Diff			
	'10-'13	'14-'15		Unadjusted	Adjusted		
<u>Average OOP spending</u>							
Expansion States	\$544	\$579	\$36	-\$141	**	-\$125	**
Nonexpansion	\$546	\$722	\$176		*		
<u>High OOP spending burden</u>							
Expansion States	0.117	0.124	0.007	-0.030	**	-0.026	**
Nonexpansion	0.127	0.164	0.037		*		
<u>Any OOP spending</u>							
Expansion States	0.211	0.253	0.042	-0.081	**	-0.075	**
Nonexpansion	0.231	0.354	0.123		*		*
<u>Avg. OOP spending, conditional on any OOP</u>							
Expansion States	\$2,571	\$2,289	-\$282				

OOP Cost-Sharing, Sample Adults in Expansion vs. Nonexpansion States

	Unadj. Means		Diff.	Diff-in-Diff				
	'10-'13	'14-'15		Unadjusted		Adjusted		
<u>Average OOP spending</u>								
Expansion States	\$470	\$393	-\$78	-\$227	*	-\$218	*	
Nonexpansion	\$540	\$689	\$149					
<u>High OOP spending burden</u>								
Expansion States	0.091	0.082	-0.008	-0.012		-0.009		
Nonexpansion	0.111	0.115	0.004					
<u>Any OOP spending</u>								
Expansion States	0.543	0.500	-0.042	-0.082	**	-0.070	**	
Nonexpansion	0.555	0.595	0.040		*			
<u>Avg. OOP spending, conditional on any OOP</u>								
Expansion States	\$867	\$785	-\$82	-\$268		-\$274		
Nonexpansion	\$972	\$1,158	\$186					

Uninsured Rates and Average Total Out-of-Pocket (OOP) Spending of Adults 19-64 with Family Incomes Between 100-138% FPL in Medicaid Expansion versus Nonexpansion States, 2010-2015



Source: Authors' analysis of American Community Survey data and Current Population Survey Annual Social and Economic Supplement data.

Notes: Figures include unadjusted means in Medicaid expansion and nonexpansion states. The regression-adjusted estimates are similar and are shown in Exhibits 1 and 2.

Additional Findings

- Results not driven by pre-2014 differential trends in expansion vs. nonexpansion states
- Estimates from childless adults sample similar to those among the full sample
- No evidence of differential impacts by race/ethnicity
- Medicaid expansion significantly reduced average total OOP spending among 19 to 34-year-olds, but did not have a significant impact among the 35 to 64-year-old subgroup.
- Estimates from various robustness models are consistent with the main model findings. These robustness checks include:
 - Limiting the analysis period to 2013-2015
 - Estimating log-transformed and one- and two-part GLM models
 - Including/excluding different combinations of states from the sample
 - Using various time-related model specifications

Conclusions

- Medicaid expansion relative to Marketplace coverage was associated with a 5-percentage point reduction in the probability of being uninsured.
- Medicaid expansion lowered OOP health spending burdens for those between 100 and 138 percent FPL relative to not expanding Medicaid.
- Reduced average total OOP health spending by \$344, high OOP spending burdens by 4 percentage points, and the probability of nonzero OOP spending by 8 percentage points.
- The impact of those who newly enrolled in Medicaid (relative to marketplace) could be much higher, particularly among those with high OOP expenses prior to the ACA.
- Spending findings likely driven by lower OOP cost-sharing requirements in Medicaid, combined with higher coverage take-up in expansion states relative to nonexpansion states.

Policy Implications

- These findings are important given the greater flexibility that states may have in shaping their Medicaid programs.
- Policy options to increase take-up and lower spending burdens in expansion and nonexpansion states
 - Reduce or eliminate premium requirements
 - Increase targeted outreach efforts
 - Increase the value proposition of Medicaid coverage relative to being uninsured
- Moving forward, several factors could influence coverage take-up and OOP spending among this population

Limitations

- There is potential for recall error and other forms of measurement error in annual income e.g., churn.
- Between March '13 and March '14, there were some wording changes for the OOP questions and the imputation process of missing responses.
- The 2013 income data for the portion of the sample receiving redesigned income questions can be consistently compared with income data from 2014 and 2015, but not with earlier years.
- As with any quasi-experimental analysis, time-varying unobservable factors might bias our estimated effects.

Question & Answer

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