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Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program

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“Pent-up demand for care appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage.”

SUMMARY: The Affordable Care Act (ACA) has already resulted in expanded eligibility for Medicaid in 27 states, including California, as of 2014. One major concern about the Medicaid expansion is that a high level of need among the newly eligible may lead to runaway costs, which could overwhelm state budgets when federal subsidies no longer cover 100 percent of the expansion population's costs in 2017. Although cost increases as a result of the newly eligible are likely, an even more important question is whether these increases will be temporary or permanent. Evidence from California's Low Income Health Program (LIHP) suggests that cost and utilization

increases among newly eligible Medicaid beneficiaries will be mostly temporary.

This policy brief presents data showing a significant decline in the use of hospital inpatient care and in emergency room visits after one year of enrollment in LIHP, and a stable, not increasing, rate of outpatient service use. Because LIHP provided health care coverage from 2011 to 2013 in advance of the full Medicaid expansion, our findings suggest that early and significant investments in infrastructure and in improving the process of care delivery can effectively address the pent-up demand for health care services of previously uninsured populations.

California's Medicaid Expansion

As of July 2014, California had enrolled 1.5 million newly eligible individuals in its Medicaid program, Medi-Cal, as a result of the Medicaid expansion authorized by the ACA and adopted by the California Department of Health Care Services.¹ The 1.5 million enrollees included approximately 650,000 individuals who were enrolled in California's Low Income Health Program (LIHP) as of December 2013 and who transitioned into Medicaid on January 1, 2014.² LIHP served as a bridge to the Medicaid expansion, providing

potential future enrollees with health care coverage ahead of the legislated start date and facilitating their transition into Medicaid, as described in greater detail below.

Previous lack of affordable coverage, receipt of episodic care, and a high prevalence of chronic conditions among those formerly uninsured are major concerns for Medicaid programs in California and across the nation. Newly eligible Medicaid enrollees are expected to have a significant level of unmet need (pent-up demand) and disproportionately higher rates of costly emergency room visits and hospitalizations. In part, these concerns

appear supported by recently published evidence from the Oregon Health Insurance Experiment that suggests higher expenditures among newly enrolled Medicaid beneficiaries during their first year of enrollment.³ Those findings have been cited as justification for states not to expand their Medicaid programs. Whether increased utilization following Medicaid expansion will be temporary or permanent cannot be answered by the Oregon experiment, however, because no measures were implemented to manage utilization, and the study was limited in both duration and geographic implementation. The question of whether increased utilization and expenditures among newly enrolled Medicaid beneficiaries is temporary or permanent has important implications for the sustainability of national Medicaid expansion. This policy brief addresses the issue directly, using evidence from California's pre-Medicaid expansion programs.

To assess the issue of both the magnitude and duration of pent-up demand among the newly eligible Medicaid population, we examined enrollment and claims data from two consecutive §1115 Medicaid waiver programs in California—the Health Care Coverage Initiative (HCCI), which ran from September 2007 to October 2010, and LIHP, which ran from July 2011 to December 2013. Both programs were designed to provide health care coverage to low-income uninsured adults (income up to 200 percent of the federal poverty level) who were not eligible for Medi-Cal or other public programs at the time, but who would become eligible for Medi-Cal or subsidies through the Health Benefit Exchange in 2014. The programs were funded and administered by participating counties, which received federal matching funds, relied on networks comprised in part of safety-net providers, had defined benefit packages, and met other requirements.^{4,5,6}

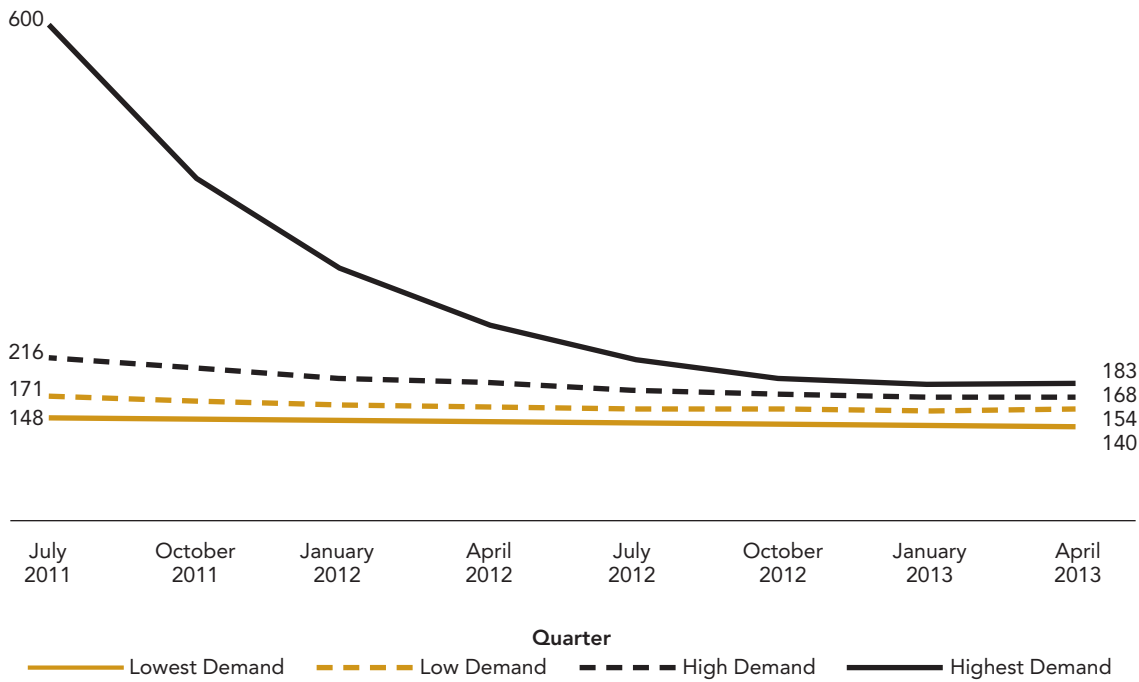
The number of participating counties was 10 under HCCI and increased to 53 under LIHP. LIHP, which was authorized after the passage of the ACA, had more enrollees, more varied income eligibility levels, additional benefits, and a larger provider network per county than HCCI. Both programs used county dollars to leverage federal matching funds, doubling the county-level resources available for caring for the uninsured future Medi-Cal and subsidy eligible populations in participating counties.

We examined data from enrollees during the first year of LIHP who would have been eligible for the Medicaid expansion (up to 133 percent of the federal poverty level). We included 8 of the 10 counties (Alameda, Orange, San Diego, San Francisco, San Mateo, Ventura, Contra Costa, and Kern) that participated in both HCCI and LIHP. We focused on these counties because they reported data for two years prior to LIHP enrollment and two years after enrollment. We then divided 182,443 first-year LIHP enrollees in these counties into four distinct groups based on their expected level of pent-up demand: (1) 69,095 who had not used county indigent services prior to enrolling in LIHP (highest); (2) 16,596 who had used county indigent services prior to enrolling in LIHP (high); (3) 12,033 who had been enrolled in HCCI but had not used services while in HCCI (low); and 84,709 who had been enrolled in HCCI and had used services while in HCCI (lowest). We compared the rates (per 1,000 enrollees) of outpatient visits, emergency room visits, and hospitalizations for each group. We controlled for utilization differences related to county of residence, demographics, number of specified chronic medical conditions, and length of enrollment, using regression models.

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Rates of Emergency Room Visits per Quarter per 1,000 LIHP Enrollees, California

Exhibit 1



Note: Rates of ER visits are adjusted for county and enrollee characteristics.

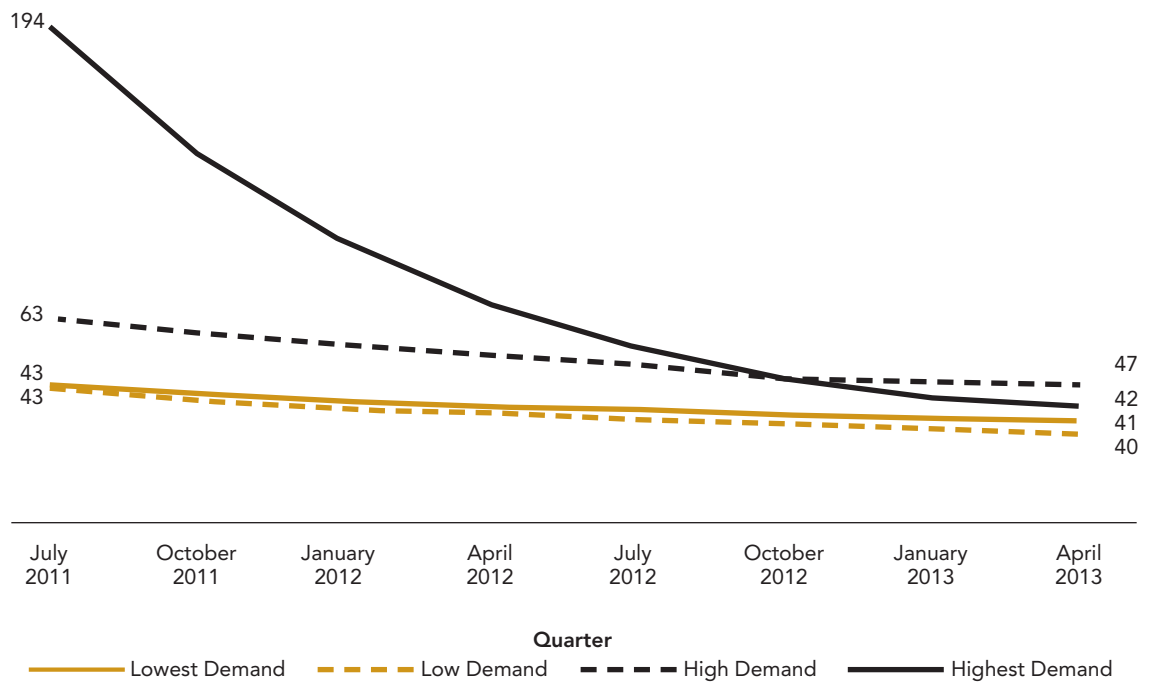
Rates of Emergency Room Visits and Hospitalization Declined Among Those with Highest Pent-up Demand

LIHP enrollees with the highest demand (who had not previously used county services) had 600 emergency room visits per 1,000 enrollees in the first quarter of the program. This rate declined rapidly during the first year of the program and remained relatively constant during the second year of LIHP,

reaching a low of 183 per 1,000 at the end of the second year (Exhibit 1). Those with high demand also showed a significant but smaller decline in the rate of ER visits, from 216 per 1,000 enrollees in the first quarter to 168 per 1,000 enrollees at the end of the second year. The rate of emergency room visits remained low and did not change significantly for those with low or lowest pent-up demand.

Exhibit 2

Rates of Hospitalization per Quarter per 1,000 LIHP Enrollees, California

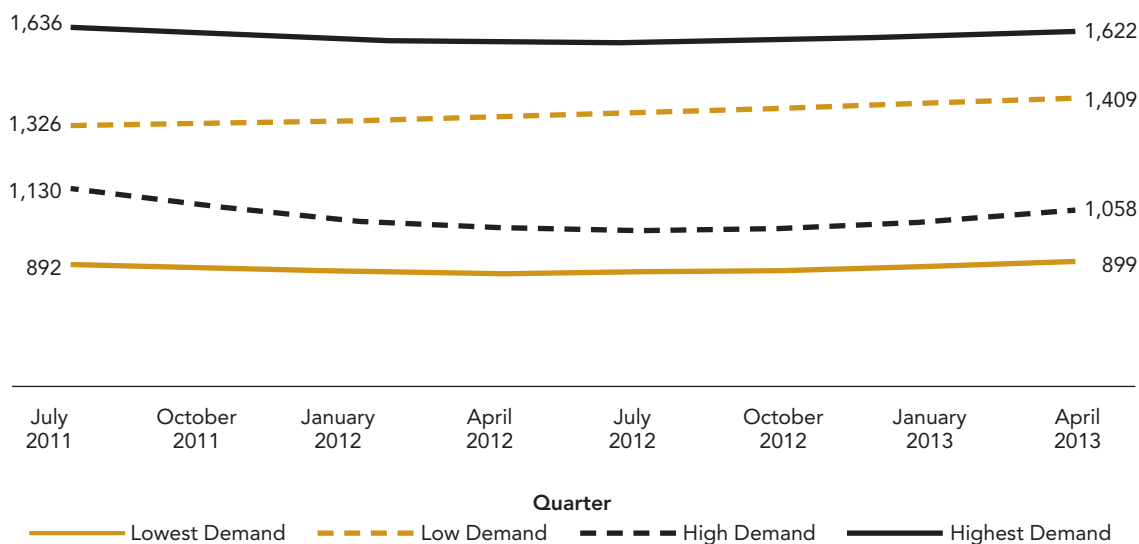


Note: Rates of hospitalization are adjusted for county and enrollee characteristics.

Similar to ER use, LIHP enrollees with the highest demand had a significant and rapid decline in hospitalization rates, from 194 to 42, from the first to the last quarter studied (Exhibit 2). A slower but significant decline also occurred among those with high demand, from 63 to 47 hospitalizations per 1,000 enrollees. The hospitalization rates for those with low or lowest pent-up demand remained virtually the same during the first two years of the program.

Rates of Outpatient Visits per Quarter per 1,000 LIHP Enrollees, California

Exhibit 3



Note: Rates of outpatient visits are adjusted for county and enrollee characteristics.

Rates of Outpatient Visits Remained Relatively Constant Among All LIHP Enrollees

The rate of outpatient visits by LIHP enrollees with highest demand was 1,636 per 1,000 enrollees in the first quarter, decreasing only slightly to 1,622 by the end of the second program year (Exhibit 3). The trend among enrollees with high demand and those with the lowest pent-up demand was

essentially constant during the two years, and both groups had fewer visits than the group with the highest demand. Those with low pent-up demand (previously enrolled in the HCCI program but had not used services) had a slight increase in visit rates, with 1,326 per 1,000 enrollees in the first quarter and 1,409 by the end of the second year.

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Policy Implications

As of January 1, 2014, 650,000 LIHP enrollees had been transitioned into Medi-Cal in California, accounting for about 34 percent of newly eligible Medi-Cal enrollees in the state. All new Medi-Cal beneficiaries were enrolled in participating managed care plans, but LIHP enrollees were able to retain their primary care providers if those providers participated in the Medi-Cal managed care network(s) available in their county.

The findings reported here have two significant implications for California and the nation. First, although newly eligible Medicaid enrollees have pent-up demand for care, this demand appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage. Second, for populations who were “pre-enrolled” in coverage programs prior to Medicaid expansion in January 2014, much of the pent-up demand for expensive emergency room and hospital care has already been met.

The HCCI and LIHP programs required counties to develop several enhanced care processes that may have been responsible for the decline in emergency room and hospitalization rates reported in this policy brief. These enhanced processes included: (1) mandatory assignment of enrollees to a medical home; (2) care coordination

and teamwork training for primary care providers; (3) health risk assessments to stratify enrollees into varying intensities of disease and case management; (4) improved access to specialty and other services required to prevent deterioration of patients with ambulatory care sensitive conditions; and (5) culturally competent self-care to help diverse populations maintain and improve their health.^{5,6}

Although our results are not directly comparable to those of the Oregon Health Insurance Experiment,³ they suggest that the higher costs and utilization among newly enrolled Medicaid beneficiaries is a temporary rather than permanent phenomenon. To the extent that California’s experience with the pre-ACA HCCI and LIHP programs is generalizable to other states, policymakers and service providers can expect a reduction in demand for high-cost services after the first year of Medicaid enrollment.

The LIHP program was part of the early implementation of the ACA in California. This early implementation was expected to address the pent-up demand among LIHP enrollees prior to their transition into Medi-Cal, thus reducing the anticipated surge in program expenditures and crowding of emergency rooms. Our findings indicate that these program goals have been achieved.

Methods

We used data only for the first two years of LIHP because data for the entire LIHP program were not available at the time of this study. We used evaluation and management visits to assess outpatient care and excluded other services, such as labs and imaging. We excluded Contra Costa and Kern counties from these outpatient visits due to missing procedure codes or other data limitations.

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Endnotes

- 1 California Department of Health Care Services
- 2 "Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California," from Covered California. <http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html>
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