Medicaid on the Eve of the Affordable Care Act: What are the Research Priorities?

Summary of the November 6, 2013, conference held at the Urban Institute in Washington, D.C.
(Released November 2014)

Sponsored by the School of Public and Environmental Affairs (SPEA) at Indiana University and the Urban Institute
Executive Summary

The School of Public and Environmental Affairs (SPEA) at Indiana University and the Urban Institute cosponsored a conference to identify high-priority research questions and gaps in our research knowledge related to changes in the Medicaid program occurring under the Affordable Care Act (ACA). The conference took place in November of 2013, just as the first open enrollment period was getting underway and two months before 26 states were slated to expand Medicaid eligibility under the ACA.

The conference began with a status report on the major policy changes occurring around the country in Medicaid under the ACA and an assessment of pressing research questions. The sessions that followed covered research needs and opportunities in specific Medicaid topic areas including enrollment and coverage; quality of care and outcomes; access to care; and cost impacts. The luncheon panel featured foundations that discussed their priorities and processes related to Medicaid research.

The conference ended with reflections from the day. Two of these speaker summaries form the summary of the conference and appear on p.9, directly after the agenda on p.4. The speakers and participants represented a broad spectrum of perspectives and stakeholders, including those who conduct, consume, and fund research on the Medicaid program.

Speaker biographies can be found on p.162 and the list of participants and their institutions on p.8. Following the synthesis comments, the chapters of this document are organized in the order of the conference. All chapters reflect comments made at the conference, with some small updates made in early to mid 2014.

Synthesis Comments

- Setting Research Priorities for Medicaid on Eve of ACA Health Insurance Expansions (Daniel Polsky)
- Transforming Medicaid through Evidence (Andrew B. Bindman)

Assessment of Where the Nation Stands Currently- ACA Medicaid Implementation

- An ACA & Medicaid Research Agenda: What Can We Learn? (Alan Weil)
- Reactions: Fractious Federalism and the Future of Medicaid (Frank J. Thompson)

Research Needs and Opportunities in Specific Medicaid Topic Areas

Enrollment and Coverage

- Research Needs and Opportunities in the Area of Health Insurance Program Enrollment and Coverage Following ACA Implementation (Thomas DeLeire)
- Research and Data Needs for Monitoring and Implementation of the ACA in 2014 and Beyond: Enrollment and Coverage (Julie J. Sonier)
- Reactions (Sharon K. Long)

Quality of Care and Outcomes

- Improving the Quality of Care for Medicaid Beneficiaries (Sara Rosenbaum)
Andy Bindman, in summarizing the discussion of the day, noted that, “The lack of understanding about the Medicaid program undermines our ability to maximize the return on the public’s investment in this program,” while Dan Polsky commented that, “A theme that was consistent across all topics was the need for data and sufficient research infrastructure to study these questions.” To address that need, Polsky remarked that, “Cooperation and strategizing will be needed ...” and suggested ways to “... begin to create the type of advocacy needed to overcome political and organization hurdles to developing better data for researchers.”

We appreciate the support of our institutions in helping to define a research agenda on this large and growing healthcare program that serves so many of the nation’s most vulnerable populations. SPEA and UI, together with AcademyHealth, are continuing efforts to advance the Medicaid research field by convening a one-day workshop in November 2014, bringing state-based and national evaluation teams together to discuss ongoing and proposed evaluations of Medicaid expansions under the ACA. We plan to continue this effort through annual or biennial meetings.

— Kosali Simon (SPEA) and Genevieve Kenney (Urban Institute)
Medicaid on the Eve of the Affordable Care Act: What are the Research Priorities?
Agenda of Conference Held Wednesday, November 6th 2013
Location: Urban Institute,
2100 M St NW, Washington, DC 20037
Cosponsored by
The School of Public and Environmental Affairs (SPEA) at Indiana University and the Urban Institute (UI)

Schedule

0. Breakfast, registration & seating (8:15am-9am)

1. Welcome— UI President Sarah Rosen Wartell, SPEA Dean John Graham, Genevieve Kenney (UI) and Kosali Simon (SPEA) (9am-9:15am)

2. Assessment of Where the Nation Stands Currently- ACA Medicaid Implementation (9:15-10:00am)
Overview on ACA implementation, with a focus on Medicaid. This opening presentation will frame the discussion for the rest of the day, and provide an up-to-the-moment assessment of Medicaid policy development under the Affordable Care Act (ACA).
Speaker: Alan Weil
Alan Weil
Executive Director
National Academy for State Health Policy

Reactors: Frank Thompson
Frank Thompson
Professor, Rutgers Center for State Health Policy and School of Public Affairs and Administration
Rutgers University

3. Research Needs and Opportunities in Specific Medicaid Topic Areas
In each of these four areas below, speakers will lead discussion of key research questions, data issues, and methodological challenges for assessing the impacts of the ACA in each of four different areas of potential outcomes—enrollment and coverage; quality of care and wellbeing; access to care; and costs. Presenters will kick off the sessions, with reactions following immediately, and with time reserved at the end of each section for ample Q&A.

3.1 Enrollment and Coverage (10:00am-11:00am)
Discussion on expected/possible impacts of the ACA on health insurance coverage with a discussion of the roles of the Medicaid expansion, outreach, enrollment system changes, the mandate, possible variations across states, and of impacts on current and new eligibles, uninsured rates, and rates of nongroup and ESI coverage. Presenters: Tom DeLeire (Georgetown); Julie Sonier (SHADAC); Reactors: Nancy Delew (ASPE); Sharon Long (Urban Institute); Rick Kronick (AHRQ)

Thomas DeLeire
Professor, McCourt School of Public Policy
Georgetown University
Julie Sonier,  
Deputy Director  
State Health Access Data Assistance Center (SHADAC) at the University of Minnesota

Nancy Delew  
Associate Deputy Assistant Secretary for Health Policy  
Office of Health Policy/Assistant Secretary for Planning and Evaluation (ASPE)/ US Department of Health and Human Services (HHS)

Sharon Long  
Senior Fellow, Health Policy Center,  
Urban Institute

Rick Kronick  
Director, Agency for Healthcare Research and Quality (AHRQ)

Break: 11:00-11:15

3.2 Quality of Care and Outcomes: (11:15-12:30)

Discussion on expected/possible impacts of the Medicaid expansion on quality of care and the health and wellbeing of individuals, with a discussion of the roles of service delivery arrangements (i.e. capitated managed care, carve outs, etc.), quality metrics, value-based purchasing and other payment and service delivery innovations, patient incentives, coverage of case management, and other social supports and contextual/social factors that could affect these outcomes. Presenters: Sara Rosenbaum (George Washington University), Robert Kaestner (University of Illinois at Chicago), Reactors: Marsha Lillie Blanton (CMS), Marsha Gold (Mathematica)

Sara Rosenbaum  
Harold and Jane Hirsh Professor of Health Law and Policy  
Milken Institute School of Public Health at the George Washington University  
Department of Health Policy

Robert Kaestner  
Professor, Institute of Government and Public Affairs & Department of Economics  
University of Illinois at Chicago

Marsha Lillie-Blanton  
Director  
Division of Quality, Evaluation & Health Outcomes –  
Children and Adults Health Programs Group  
Center for Medicaid and CHIP Services

Marsha Gold  
Senior Fellow  
Mathematica Policy Research

Luncheon Panel 12:30pm-1:45pm

[networking lunch 12:30-1pm; Foundation perspectives 1-1:30; questions 1:30-1:45; ]
Foundations will discuss current analytic priorities with respect to Medicaid research, describe their process of deciding research priorities, evaluating proposals, what types of work they have funded recently in Medicaid, and the types of research questions they may fund in the near future.

Andrew Hyman (RWJF), Barbara Lyons (Kaiser Family Foundation), Chris Perrone (CA Health Care Foundation)

Andrew Hyman
Senior Program Officer
RWJF

Barbara Lyons
Director, Kaiser Commission on Medicaid and the Uninsured

Chris Perrone
Deputy Director, Health Reform and Public Programs Initiative
Acting Director, Better Chronic Disease Care Program
California Healthcare Foundation

3.3 Access to care (1:45pm-3:00pm)

Discussion on extent to which Medicaid enrollees (both current and new enrollees) will be able to get in to see needed primary care and specialty providers on a timely basis, including a discussion of provider capacity, physician payment issues under Medicaid and implementation issues with respect to the so-called Medicaid fee bump and other relevant policies, in particular capacity through Medicaid managed care networks and of FQHC’s. Role of payment policies and administrative issues in Medicaid, physician participation in Medicaid (for primary care, specialty care, dental care, etc.), geographical location decisions (for practices serving children and/or adults), reactions to the potentially temporary increase in primary care fees, the role of scope of practice and Medicaid payment policies for providers. Presenters: Tom Buchmueller (University of Michigan), Sandy Decker (CDC); Reactors: Anne Schwartz (MACPAC), and Stephen Zuckerman (UI)

Thomas Buchmueller
Professor
Ross School of Business
University of Michigan

Sandra Decker
Distinguished Consultant
National Center for Health Statistics
Centers for Disease Control and Prevention

Anne L. Schwartz
Executive Director
MACPAC - Medicaid and CHIP Payment and Access Commission

Stephen Zuckerman
Co-Director and Senior Fellow
Health Policy Center
The Urban Institute

Break 3:00-3:15
3.4 Cost Impacts (3:15-4:30)

Discussion of both state and federal budget implications of the Medicaid expansion under the ACA and other financing (e.g., block grant) and policy changes, including pros and cons of different Medicaid design options states have proposed to CMS such as the Waivers proposed by Arkansas, Iowa, Pennsylvania; how states react to cost pressures and greater flexibility, etc. Presenters: John Holahan (UI); Deborah Bachrach (Manatt, Phelps & Phillips); Matt Salo (NAMD); Reactors: Judy Solomon (CBPP); Joe Antos.

John Holahan
Institute Fellow
Urban Institute

Deborah Bachrach
Partner
Manatt, Phelps & Phillips, LLP

Matt Salo
Executive Director
National Association of Medicaid Directors

Judy Solomon
Vice President for Health Policy
Center on Budget and Policy Priorities

Joseph Antos
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

4. Reflections and Reactions to Resulting Research Agenda (4:30-5:30)

Designated speakers to give reactions on what they have heard as the highest priority research questions resulting from the discussion, outlining important themes and gaps, as well as prepared remarks from CMS.

A. Research Priorities for Medicaid—the CMS perspective: Cindy Mann (CMS)
B. Reflections from the day

Presenters: —Andy Bindman (UCSF), Dan Polsky (University of Pennsylvania)

Cindy Mann
Deputy Administrator and Director Center for Medicaid and CHIP Services
CMS

Andrew Bindman
Professor of Medicine, Health Policy, Epidemiology and Biostatistics
University of California San Francisco

Daniel Polsky
Professor of Medicine,
Professor of Health Care Management
Director of Research of Leonard Davis Institute
University of Pennsylvania
Other Meeting Participants:

Yaa Akosa Antwi, Indiana University Purdue University at Indianapolis
Joan Alkers, Georgetown University
Heidi Allen, Columbia University
Jessica Banthin, Congressional Budget Office
Samantha Brady, Indiana University
Deborah Chollet, Mathematica
Terri Coughlin, Urban Institute
Brigette Courtot, Urban Institute
James Crall, University of California Los Angeles
Tom Darling, University of Baltimore
Kelly Devers, Urban Institute
Stan Dorn, Urban Institute
Lisa Dubay, Urban Institute
Caitlin Ellis, Indiana University
Arnold Epstein, Harvard University
Alison Cuellar, George Mason University
Sam Flint, Indiana University Northwest
Seth Freedman, Indiana University
Angshuman Gooptu, Indiana University
John Graves, Vanderbilt University
Elizabeth Hall, Wellpoint Inc
Sarah Hamersma, Syracuse University
Jean Hearne, Congressional Budget Office
Ian Hill, Urban Institute
Embry Howell, Urban Institute
Frederick Isasi, National Governors Association
Susan Johnson, Indiana University
Abby Kelly Smith, SVC Consulting
Sean Lyons, Cornell University
Jim Marton, Georgia State University
Heather McCabe, Indiana University
Laura McCloskey, Indiana University
Shannon McMahon, Center for Health Care Strategies
Stacey McMorrow, Urban Institute
Ellen Meara, Dartmouth College
Jordan Millen, Indiana University
Asako Moriya, Indiana University
Christie Peters, DHHS/ASPE
Robin Rudowitz, Kaiser Family Foundation
Lindsay Sabik, Virginia Commonwealth University
Brendan Saloner, University of Pennsylvania
Thomas Selden, Agency for Healthcare Quality and Research
Lisa Simpson, AcademyHealth
Erica Socker, Brookings Institution
Laura Wherry, University of Michigan
Coady Wing, University of Illinois
Carolyn Yocom, Government Accountability Office
Lanlan Xu, Indiana University
Summary Comments

Setting Research Priorities for Medicaid on eve of ACA Health Insurance Expansions

Daniel Polsky

On November 6, 2013, two months before the start of ACA health insurance expansions, a group of researchers and policy makers met for a day to discuss research priorities for Medicaid. I will attempt to synthesize these priorities in this brief article, but before I do, it is worth mentioning three important issues that make prioritizing research for Medicaid particularly challenging.

First, setting research priorities must acknowledge the multidimensional aspects of the policy issues in Medicaid. Medicaid is not simply coverage for qualifying beneficiaries, but particularly given budget constraints for the program, there are issues with maintaining quality of care and addressing its costs. It is difficult for policy relevant research in Medicaid to be focused on one area without an understanding of the context. For example, as we discover changes in coverage, this is directly tied to whether these changes have changed the quality of care delivered or the cost structure of the program. Thus, we should not prioritize research on one aspect over another, but identify priorities within each area of Medicaid and push on multiple fronts.

Second, while there is immediacy to monitoring the implementation of Medicaid expansions to understand what might need to change in the short run, the health insurance expansions offer a number of opportunities to create lasting new knowledge regarding the value of the Medicaid program and best practices within the program. Prioritizing must balance the pursuit of short-term and long-term projects.
Third, answers to some of the most pressing questions are not immediately achievable given the limitations of accessible data or the possible research designs. Research must be accompanied by advocating for the collection of new data or the release of more specific data in addition to pursuing new and novel research designs to study important policy questions.

Next, I will look at research priorities for coverage, quality, and access in four research categories: description, implementation, impact, and policy refinement.

**Coverage**

There is a need to know a top-line number. How many are newly covered by Medicaid? This includes an assessment of how many eligible are newly covered among those newly eligible, but also among those previously eligible. And among those newly eligible, it will be important to track the transitions. How many came from being uninsured and how many had insurance prior to enrolling in Medicaid?

Context is key here. We need to be able to look at coverage in Medicaid in the context of total eligible. Where are the coverage rates the highest and what factors might be most related to high versus low coverage rates? Thus as we count newly covered, tracking those left uninsured is also critical. Among uninsured, how many could be enrolled versus how many fall outside of existing coverage opportunities?

Given the many strange aspects Medicaid coverage, research should not just describe coverage, rather it will be important to call attention to the aspects of the system that have odd and often unanticipated consequences. For example, many enrollees churn in and out of Medicaid over time. This churn includes not only in and out of coverage, but also between
Medicaid and health insurance exchanges. What brings the churners into the system and what sends them out of the system?

The longer-term question is whether coverage through Medicaid for this population is a cost effective way to achieve policy goals. To get at this, it is important to know how Medicaid coverage affects the wellbeing for the population for which this policy is intended. This includes their physical health, their mental health, and their financial stability. Also, embedded in this question is whether there are alternative approaches to achieving the same policy goals and whether those alternatives could be achieved in a manner that was more cost-effective. Studying the crowd out between Medicaid and other forms of insurance is also embedded in this larger question. These are difficult questions to address without experimental or quasi-experimental data. Given the variations between states in implementation of Medicaid expansions, there may exist unique opportunities for research of this type.

A final area to address is research connected more directly to policy refinements. Of highest priority is the design of Medicaid policy in the context of Exchanges and employee health insurance. Research should highlight the ways in which the interaction of the Medicaid system and health insurance exchanges produces suboptimal outcomes. One challenging interaction is related to determining eligibility both at a point in time and over time due to income fluctuations. Understanding the challenges of eligibility determination and the frequency of churning and its consequences could help inform policy refinements. Another challenging interaction is the frequency that families are split between multiple insurance types. It will be important to characterize these circumstances and their impact.

Quality
As coverage changes for Medicaid, the quality of the delivery of care within Medicaid might also be changing and adapting. A top descriptive research priority will be to monitor the quality of care within Medicaid. This includes both measuring the process of care delivery and the outcomes of Medicaid beneficiaries.

As delivery system reform escalates and Medicaid expands, delivery reform for Medicaid beneficiaries will be of growing interest. The opportunities are great and the current evidence base is weak. As a start, implementation research will provide critical information on these processes. Delivery reforms in one state or even one local health care system may not necessarily translate into another state or system. This is true for understanding the value of managed care expansion, the use of accountable care organizations for Medicaid populations, and efforts to monitor or incentivize quality.

Ultimately, we will want to understand not only how the system is changing, but also whether these changes improving quality of care. Evaluations of these changes should look separately at newly eligible and those already eligible. We would expect that the newly eligible will have different severity of disease than those already eligible and we would not want to attribute observed outcomes to what may be changes in underlying severity. Developing an evidence base for the highest quality of delivery to Medicaid populations should focus on the unique needs of this population. For example, Medicaid quality may put a higher return on care coordination versus expensive specialized care.

Monitoring quality and studying quality initiatives are important because providers should be accountable for providing quality care and delivery systems can always be improved. However, the study of quality of care should not be in isolation from other factors influencing Medicaid. Given the federal and state budget constraints and the reluctance of the public to
spend money within Medicaid the goal of this research should be to consider cost-effective care
delivery. That is, given a relatively fixed budget for the Medicaid population, how can dollars
best be stretched to get the most health? It is not sufficient to research quality under the
expectation that quality of care within Medicaid should be at same level as private insurance
unless the same resources were devoted to Medicaid as are devoted to care within private
insurance.

In fact, research on quality may create a more serious conversation around national
willingness to pay for, not only Medicaid coverage, but also for high quality Medicaid coverage.
As a foundation, what is the role of the entitlement of Medicaid and are there alternatives that
would achieve policy aims that include a limited willingness to pay for growth in Medicaid costs.
Research to understand the potential outcomes of alternatives to a Medicaid entitlement will help
inform what may ultimately be a necessary conversation.

Access

The top line descriptive question regarding access is how has access to providers changed
as a result of Medicaid expansions. Researching this question will require comparing current
access levels to an appropriate counterfactual. For example, average access within Medicaid
may in fact decline, but many of the newly enrolled had considerably worse access prior to the
ACA and thus, with appropriate counterfactuals, the lower observed access within Medicaid may
reflect better access for the Medicaid population. An interesting question is whether access is
higher for the newly eligible than those who have been on Medicaid for a long time. Research
on detailed categorization of access will also be helpful. Where do Medicaid patients go for care
and how are they directed to that care?
The deeper question that describing access can help answer is what does coverage really mean? Can recipients access specialty care? Do they have the opportunity to establish a relationship with primary care? Yet this is complicated by the fact that as the system changes access will not be characterized by just measuring whether an appointment with a provider took place.

Because of concerns that Medicaid expansions may stress the ability to provide sufficient access, particularly for primary care, the ACA raised reimbursement for primary care providers serving Medicaid patients to Medicare rates for 2013 and 2014. Yet implementation of this provision has been slow. Studying the impact of this temporary bump in payments will also involve characterizing the implementation of this provision. If the impact of this provision is low, it will otherwise not be clear whether the policy was ineffective or just a result of poor implementation.

Pay increase that ups fees for primary-care doctors serving Medicaid patients to Medicare rates for 2013 and 2014. Moreover, crowd-out matters for providers. Higher reimbursement might not increase the total volume of care provided; shifts in mix might result or income effects may reduce total volume.

Yet as delivery models evolve and the methods of reimbursement change to include shared savings and more managed care, the focus on fee-for-service payment rates becomes obsolete. Do these new models of delivery provide adequate access and, if not, what are the policies that would be most effective to provide adequate access?

Researching policy impact should not only focus on policies to improve access, such as fee increases and easing of scope of practice laws, but on the impact of marginal increases in access on outcomes. On the margin, would it be more cost effective to incentivize access to more primary care or more specialty care for Medicaid patients?
Discussion

A theme that was consistent across all topics was the need for data and sufficient research infrastructure to study these questions. This is because data for many important questions is not readily available. For example, there is no dataset that both provide state level detail and the details for characterizing remaining uninsured. The limitation here is primarily the lack of state-level identifiers in public datasets. But in every area, data limitations are at the center of the gap between many important high priority questions and successfully completed research projects.

There are a number of potential solutions. First, there should be efforts to develop new novel data sources. Survey technology and participant panels being developed through the Internet may offer new opportunities. Second, the government should make administrative data more readily available to researchers in timely way. What is important here is to develop both public use de-identified datasets and protected and restricted access to sufficiently micro detail that may be needed for particular questions. Third, new administrative datasets will have to be adopted by researchers to adequately study the changing landscape of Medicaid research. For example, eligibility criteria may best be studied with IRS data. The increasing interaction between insurance types would increase demand for all payer claims. This leads to a fourth potential solution, which would involve more efforts to organize data aggregation. All payer claims have been one promising development, but other aggregations would yield tremendous opportunities. For example, a fully linked micro-data enrollment dataset including Medicaid, Medicare, exchanges, and employer plans, would allow for a comprehensive study of churning and transitions particularly if also linked to social security data or other employment and income administrative files.
There are huge barriers to achieve many of these potential solutions. Cooperation and strategizing will be needed with well-connected people. Engaging AcademyHealth in these efforts and commissioning an IOM report may begin to create the type of advocacy needed to overcome political and organization hurdles to developing better data for researchers.
Transforming Medicaid Through Evidence

Andrew B. Bindman

The Patient Protection and Affordable Care Act (ACA) is expanding Medicaid as one of the main pillars of coverage in the United States. The Congressional Budget Office (CBO) estimates that there were 72 million people covered in Medicaid in 2013 just prior to the expansion of Medicaid as a part of the ACA, and by 2016 there will be 87 million Americans covered by this public insurance program.\(^1\)

While Medicaid is growing and is already on a scale with Medicare in terms of the number of beneficiaries it covers, our knowledge of how effectively the Medicaid program is performing is much less well developed than it is for Medicare. The lack of understanding about the Medicaid program undermines our ability to maximize the return on the public’s investment in this program.

There are some obvious reasons why Medicare is more thoroughly researched and analyzed than the Medicaid program. First, Medicare’s primary coverage target, the elderly, is a more powerful political voice than are the poor who are covered by the Medicaid program. There is therefore a greater public interest in and expectation for accountability in the Medicare than the Medicaid program.

Second, unlike Medicaid, which is jointly administered by the federal and state governments, Medicare is uniquely the responsibility of the federal government. To manage its responsibility for Medicare, the federal government has made substantial investments in analytic expertise that it has done to a lesser degree in Medicaid. Some of the investment in Medicare has been spent on creating a mechanism for investigators outside of the government to request access

to Medicare’s data so that they can contribute to developing methods for analyzing the program’s performance. Some state governments make similar sorts of investments in their Medicaid programs; but this expertise is not nearly as well developed or coordinated as it is in the Medicare program. States are often less willing or able because of a lack of resources and infrastructure to make their Medicaid data available to researchers than the federal government is with Medicare data.

Third, the data available to understand the Medicaid program is less robust and less available than it is for Medicare. Fee-for-service claims are the main sources of information on health care utilization, costs and quality of care. Medicare has a higher proportion of its beneficiaries than Medicaid in fee-for-service as opposed to managed care. Furthermore, all of Medicare’s fee-for-service claims come to a single site in the federal government, while Medicaid claims are processed within each state program. The federal government receives information from all of its state Medicaid partners, but there are differences in how states report the information and the timeliness with which they do it.

Evidence can become a powerful guiding force for transforming Medicaid programs to achieve the triple aim of improving the delivery of health care at a lower cost that contributes to health benefits. In some ways, Medicaid is a better health care learning environment than Medicare. Medicaid varies in how services are organized and delivered across states while Medicare’s predominantly fee-for-service program is relatively similar across the country. The potential to learn from state variation in Medicaid is high, but policymakers have failed to fully capitalize on this opportunity.

Several steps could be taken to enhance the potential for the research community to contribute toward improving the Medicaid program.
First, since most investigators depend on research grants and contracts for their work, they tend to migrate to where there are available funds. Investigators succeed in a competitive environment by developing expertise in an area in which they can anticipate a reliable source of funding over time. If we expect investigators to invest their time to focus on the Medicaid population, there needs to be a consistent source of funding of sufficient size dedicated to studying the Medicaid population’s health and health care issues over time.

Second, since investigators typically have to perform their work within the limited timeframes of a grant or contract, they need rapid access to timely data. The steps that the Center for Medicare and Medicaid Services (CMS) are taking to speed up reporting between states and the federal government through the Transformed Medicaid Statistical Information System (TMSIS) could make Medicaid data available in a more timely manner than is currently possible from the federal government. If researchers are to be helpful in analyzing these data, they will need to be provided with a process that makes it possible and relatively easy for them to access this information from states or the federal government in a way that is cost-efficient and that protects patients’ confidentiality. CMS has done this effectively with the data it receives for the Medicare program, and it should pursue opportunities to increase the safe distribution of Medicaid data either by itself or in cooperation with states. States will be more likely to participate in this process if they can be assured by CMS and investigators that their data will not be used as a tool to penalize them but rather as a part of an improvement process over time.

Third, it would be valuable and efficient for Medicaid’s policymakers to identify and prioritize their research needs. Investigators are eager to work on the problems that are of the greatest importance to Medicaid programs’ decision-makers. The limited community of investigators and constrained resources in this field makes this all the more important. The process
of prioritizing research needs is most productive if it is done in cooperation with investigators who
could not only learn from policymakers but also contribute to stimulating ideas and help to identify
the sorts of questions that can best be addressed through research.

Finally, if we hope to use evidence to guide improvements in Medicaid, we need to expect
investigators to use rigorous research designs to study anticipated and unanticipated effects of
Medicaid policies. We need to place high expectations on investigators as scientists and to
courage them to be honest brokers, who can objectively report results regardless of whether they
support or undermine a particular policy or a preconceived set of expectations. The quality of the
research and the interpretation of results is improved when informed end users of the information
have an opportunity to engage with investigators. The opportunity for the research to impact policy
is increased through these relationships as well. There are a growing number of examples of states
that have formed partnerships between their Medicaid programs and state universities for just this
purpose.²

² Heller D, Hoffman C, Bindman AB. Supporting the Needs of State Health Policymakers through
Chapters
I am pleased to offer these opening comments at this timely and much-needed conference to discuss the research agenda for Medicaid in the wake of the Affordable Care Act. The tremendous changes in the Medicaid program made by the ACA present a unique opportunity for research to inform our understanding of the program and to guide possible future changes to health policy.

As I considered the topic, I realized there are two distinct ways to build a Medicaid research agenda. The first is the more traditional approach that examines the changes the ACA makes within the Medicaid program and considers what we can learn from them. The second is to place the Medicaid changes in the context of the broader reforms of the ACA and explore Medicaid’s changing role in the health care system. I believe both approaches are valuable, so I consider them in turn.

A Medicaid-Centric Research Agenda

Medicaid—already the largest health insurance program in the country—was slated to provide half of the new coverage made available under the ACA. This may not come to pass with the Supreme Court’s decision allowing states to remain in the existing Medicaid program without consequences even if they do not implement the expansion. Still, the Medicaid

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3 This paper reflects comments I made at the November 6th 2013 symposium, with some data updated in May 2014.

expansion represents a tremendous change in federal and state policy. The great variety in how states have approached implementation begs for a research agenda focused on the reasons for and implications of the varying state decisions. I divide this research agenda into four categories: politics, implementation, coverage and access, and delivery systems.

Politics

The unanticipated choice states face regarding the Medicaid expansion raises a host of political questions. At the simplest level we can look at a map and see which states have adopted the expansion. One such map appears here:
State decisions are the result of complex political dynamics within the states. While eighteen of twenty-one states with Democratic Governors have adopted the expansion, only eight of twenty-nine states with Republican Governors have done so.\(^5\) Governors’ and Legislators’ views on expansion did not always align.

This set of circumstances generates some interesting questions, such as: Will the Medicaid expansion be an important issue in the 2014 elections that include 36 governors’ races? Will incumbent governors’ positions be an asset or a liability in their party primaries and in the general election? Will gubernatorial or legislative partisan positions regarding the Medicaid expansion harden or soften over the coming years? Will there be geographical spread outward from individual states that have taken a position than differs from that of other states in their region?

The politics of the Medicaid expansion decision have been fluid. CMS has approved three state waivers that include variants on the “private option” which calls for the Medicaid expansion to take place through the ACA’s health insurance exchanges, and a few other states are considering this approach. Will the existence of a more conservative model of expansion open the door to additional states expanding Medicaid? Will CMS adopt a more accommodating stance with respect to states’ desires to modify the Medicaid program as a precondition of expansion to bring in additional states? Will the politics of the expansion change in 2017 when states are required for the first time to share in the cost?

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Implementation

The troubled rollout of healthcare.gov has placed a spotlight on implementation—an aspect of public policy that generally receives insufficient attention. The Medicaid expansion involves important implementation issues that are still unfolding and worthy of additional exploration.

One Medicaid provision is off to a disappointing start. The ACA includes a two-year (2013 and 2014) increase in primary care provider rates to equal those of Medicare. States were slow to adopt these provisions—as of May 2013, only three states had implemented them—but a majority of states are now beginning to provide such payments retroactively.6,7 Some of the fault lies with the late release of federal regulations related to these provisions, some with the complexity of those regulations, and some with state capacity to effectuate the change. A better understanding of how this generally popular provision ended up being so difficult would be a good place to start in an analysis of ACA implementation.

Some additional Medicaid implementation questions are: How effectively were states able to convert their eligibility processes to the use of Modified Adjusted Gross Income (MAGI) standards on January 1, 2014, as they were required to do under the law? The move to MAGI requires a major shift in how states approach eligibility calculations, with new data sources and an electronically-driven verification and determination process. How well did systems integrate to provide necessary linkages between Medicaid programs and the federal data services hub, other state data sources, and the state’s health insurance exchange (whether run by the state itself

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or the federal government)? How effectively are states routing people with disabilities to non-
MAGI eligibility pathways after an initial determination of eligibility for a more limited set of
benefits under MAGI rules?

Almost every state is working on major Medicaid eligibility system upgrades. Some
states have chosen to focus exclusively on health programs, while others view the availability of
federal resources as an opportunity to integrate their health and social services programs. How
effectively are states implementing these two design options and are there differences in take-up
rates depending upon which path the state chose?

How effective were new electronic and in-person interfaces with consumers and how
satisfied were consumers with them? How useful were methods such as electronic consumer
accounts, e-notifications through email or text, and navigator, broker, and other in-person
assistance channels? Are the ACA’s goals of “no wrong door” application acceptance and real
time eligibility determinations being achieved? Is there more success in some states than others,
and, if so, what accounts for those differences?

Coverage and Access Effects

The Medicaid expansion offers tremendous opportunities for measuring changes in health
insurance coverage, access, and utilization. The split between states expanding and not
expanding Medicaid offers a unique opportunity to compare similar populations in different
states with different policies.

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8 Kaiser Commission on Medicaid and the Uninsured. Getting into Gear for 2014: Findings from a 50-State
Accessible at: http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf
Myriad research questions come to mind, some of which are: What are the take up rates among populations newly eligible for Medicaid and how do they compare to those traditionally eligible? Do standard measures of access and utilization improve as people gain Medicaid coverage? Are there different access or utilization effects for enrollees in a traditional Medicaid benefit package as compared to an alternative benefit package based upon the essential health benefits? Are there measurable health status improvements as people gain Medicaid coverage? How do estimates of “crowd out” for those made newly eligible compare to those previously eligible for Medicaid?

Many have questioned whether a sufficient number of providers are available to meet the needs of the newly-covered Medicaid enrollees. Research questions include: Do access and utilization measures for new enrollees provide evidence of sufficient or inadequate provider availability? Do those measures vary across states and, if so, are there state characteristics or policies that might explain that variation? Do access and utilization metrics differ between primary care and specialty care? Do initiatives such as support for patient-centered medical homes affect the answers to these questions?

With increased availability and standardization of race, ethnicity and language (REL) data, what will we learn about disparities associated with Medicaid? Will racial and ethnic disparities decline, and will they change differentially in states that do and do not expand Medicaid?

Delivery System Effects

The Medicaid expansion also offers unique opportunities to understand how states define the Medicaid delivery system and how those decisions affect access to care and health outcomes. Some of the questions we might ask are: Do states rely upon the same providers to serve the Medicaid expansion population as they do the previously eligible population? Do states use the
same quality, access, and other performance metrics for the expansion population as for those previously eligible?

Many ACA provisions beyond the expansion affect the Medicaid delivery system. Ten states have memorandums of understanding with CMS to improve care coordination for Medicare-Medicaid “dual eligibles.” Several additional states have proposals pending with CMS. Ten states have received funding from the Center for Medicare and Medicaid Innovation (CMMI) to test the effectiveness of encouraging Medicaid beneficiaries’ participation in chronic disease prevention programs. CMS is also supporting multi-payer reforms with the participation of Medicare, Medicaid, and private health insurers to make medical homes more widely available in eight states. All of these programs have formal evaluation components. Sections 2705 and 2706 of the Act refer to two additional Medicaid demonstration programs: the Global Payment System Demonstration and the Pediatric Accountable Care Organization Demonstration. Both of these demonstrations include an evaluation component, but neither demonstration has yet begun.

Medicaid in Context

While the ACA changes the Medicaid program, a more significant change is the context in which Medicaid operates. Medicaid is now part of a continuum of coverage options that

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stretch across a broad income range (with gaps in states that choose not to expand Medicaid). Medicaid has new relationships with premium assistance tax credits, health insurance exchange enrollment systems, and qualified health plans offered on the exchanges. These changes in context lead me to wonder about an additional set of issues in the four categories I discussed earlier.

Politics

Proponents of the Medicaid expansion now refer to the “coverage gap,” and Ohio’s Governor Kasich based his support for expansion in part on his view that it is unfair to help higher income Ohioans but not support those who are poorer. Arizona’s Governor Brewer argued for the Medicaid expansion in part because, due to the complex interplay between Medicaid and welfare reform, if the state didn’t expand Medicaid, recent legal immigrants would have been eligible for federal tax credits while United States citizens would have received nothing. Do the politics of Medicaid change now that there is a federal program that covers people at higher incomes?

Will state decisions regarding whether or not to build their own insurance exchanges be based in part on how well (or poorly) the federal exchange handles Medicaid eligibility? Will states remain willing to have the federal government determine or assess Medicaid eligibility, or will their preference to control that process translate into a desire to run the exchange themselves?

Will the politics of Medicaid shift as plans on the insurance exchange begin to overlap with Medicaid plans? Will defenders of traditional Medicaid provisions that strictly limit premiums and cost sharing find it difficult to hold the line as other low-income families face significant premiums and cost sharing (even net of subsidies) in their health insurance exchange
products? Will challenges to Medicaid’s efficacy relative to commercial insurance abate as the substance of these two products converges?

Authorization for the Children’s Health Insurance Program (CHIP) expires in 2015. How will perceptions regarding the effectiveness of the CHIP program relative to Medicaid and the new health insurance exchanges affect deliberations regarding its future?

Implementation

The Medicaid expansion and conversion to MAGI that took place January 1, 2014, went off seemingly without a hitch compared to the troubled rollout of the federal exchange in October 2013. State success stories regarding exchange implementation focused almost exclusively on enrollment numbers and mostly ignored the interplay between Medicaid and the exchanges. But in reality, the fate of Medicaid and the exchanges is intertwined. Important questions to ask include: Did people who applied for the “wrong” program get routed to the correct one? If so, was the rerouting seamless, prompt, and accurate? If there was variation across states in this phenomenon, was it attributable to specific state or federal actions? On the whole, were state-based exchanges better at determining Medicaid eligibility than the federal exchange? How did states vary in their ability to transfer Medicaid applications to the appropriate exchange if they determined a person to be ineligible for Medicaid because their income was too high?

Will non-traditional actors, such as financial services firms or tax accountants, play a growing role in the Medicaid program? If so, will they prove to be more effective at implementing various aspects of the law than traditional government partners?
Coverage Effects

As income volatility, changing family circumstances, and the unanticipated eligibility gap left by the Supreme Court’s ACA ruling cause eligibility shifts, many Americans are expected to churn across Medicaid and the exchange. What strategies are states taking to reduce the amount of churn and to minimize the negative effects associated with churn when it occurs? Do various strategies, such as incentives for health plans to participate in Medicaid and the exchange, creation of “bridge plans” to help people move across programs, or creation of a Basic Health Program, have the intended effects? Do access and use measures for people on Medicaid vary by the degree to which they have churned across different forms of coverage, or by whether they participated in one of the mitigating strategies just described?

If, as some expect, employers in low-wage industries begin to encourage their employees to obtain coverage in the exchanges, will there also be enrollment effects for Medicaid? If so, how rapidly will those occur? Will they occur at different speeds in states that expand Medicaid and those that do not?

Delivery System Effects

The ACA creates myriad opportunities for Medicaid to exert its purchasing power in concert with other coverage sources. Will states harness joint purchasing power across Medicaid and the exchanges to demand improvements in cost and quality, and will those efforts demonstrate success? Will states that adopt “private option” approaches to expansion see different results than those that seek purchasing leverage through Medicaid?

As health plans on the exchange use narrow networks to gain a price advantage, will the proliferation of these plans affect networks in Medicaid plans?
Will efforts to help consumers make effective choices among plans on the exchange migrate to Medicaid? For example, will new plan comparison tools created for the exchanges be made available to Medicaid enrollees? Will quality data that must be collected for plans on the exchange also be made available to Medicaid enrollees who have a choice among plans?

Finally, what reforms will states pursue in 2017 when Section 1332’s ‘Waivers for State Innovation’, allowing states to apply to make myriad changes in exchange operations, and joint health care waiver application process become available?

Conclusion

This is an exciting time to conduct research on Medicaid. The ACA modifies the program, and modifies the context in which the program operates. These changes create a robust set of questions that we should seek to answer. And we should then use those answers to improve the program and the U.S. health care system more broadly.
Fractious Federalism and the Future of Medicaid
Comments on Alan Weil’s presentation

Frank J. Thompson¹²

I have planned and moderated many conference sessions on Medicaid over my career. When I do so Alan Weil is usually the first person I call. In his opening presentation, Alan has insightfully illuminated key developments in the states as well as critical challenges and research questions that need to be addressed. Since I agree with virtually all his points, I will refrain from commenting on them and instead amplify the part of his talk dealing with state decisions to participate in the Medicaid expansion. The ability of the Affordable Care Act (ACA) to realize its original coverage goals depends heavily on whether states expand Medicaid. So far about half the states have chosen to do so. As a political scientist, I have a natural proclivity to cite the Federalist Papers. Over two centuries ago, James Madison in Federalist #46 noted “the disposition and the faculty” of the federal and state governments “to resist and frustrate the measures of each other.”¹³ Were he alive today, Madison would hardly be surprised over the tension between the national government and the states over the Medicaid expansion. But what Madison would not have predicted and would likely find disturbing is the degree to which this friction has deep roots in partisan “faction.”

The ACA has become the poster child for a three decade trend toward growing partisan polarization in this country. No Republican in Congress voted for the law and efforts to implement it have occurred in a context of fractious federalism. The defining elements of this

¹²This posting reflects the presentation made at the November 6th 2013 conference. In mid-February, however, I added a few updates.

brand of federalism are: (a) intense attitudinal opposition to the ACA among many state policymakers rooted in their partisan, ideological identities; (b) the active efforts of these state partisans to weaken the ACA through court action and intergovernmental lobbying; and (c) reluctance by state policymakers to implement the ACA.

Given this context a key challenge for ACA supporters is to defuse health reform as a litmus test for partisan loyalty and to persuade Republican policymakers in the states to expand Medicaid. Where does the attempt to break down partisan barriers currently stand? Table 1 provides an overview of state participation in the Medicaid expansion by partisan control of state government during 2013. Unified control signals that one party controls both houses of the legislature and the governorship. Divided governments in turn feature split partisan control. Nebraska receives separate treatment because its legislature is formally nonpartisan. On balance, Table 1 points to the presence of substantial polarization. Only 17 percent of the states with unified Republican governments (Arizona, Michigan, North Dakota, Ohio) have opted to participate while all Democratically dominated governments have. Of some interest given the recent election in Virginia, divided governments have tilted toward expanding Medicaid.

Table 1: States Moving Forward on the Medicaid Expansion
By Partisan Control of State Government (November 2013)

<table>
<thead>
<tr>
<th>Partisan Control</th>
<th>Total</th>
<th>Number Moving Forward</th>
<th>% Moving Forward</th>
<th>States Debating and Deliberating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Republican</td>
<td>24</td>
<td>4</td>
<td>17%</td>
<td>2</td>
</tr>
<tr>
<td>Unified Democrat</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Divided</td>
<td>12</td>
<td>8</td>
<td>67%</td>
<td>1</td>
</tr>
<tr>
<td>Other-Nebraska</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>
While not the focus of this conference, I thought it would also be useful to examine state participation in the insurance exchanges by partisan control of government. Table 2 demonstrates that fractious federalism has again left its mark. Only one Republican-controlled state (Idaho) has pledged to create both health insurance marketplaces while over 75 percent of states with unified Democratic governments have done so (column 3 in the table). When one takes into account other forms of state participation – partnerships or plan management – the overall level of state involvement improves. Still, over 70 percent of Republican-dominated governments have declined any form of participation in the exchanges.

Table 2
States Participation in the Health Insurance Exchanges
By Partisan Control of State Government (November 2013)*

<table>
<thead>
<tr>
<th>Partisan Control</th>
<th>Total</th>
<th>Creating State-Based Health Insurance Marketplaces</th>
<th>% Creating State-Based Health Insurance Marketplaces</th>
<th>Creating Partnerships or Plan Management Options</th>
<th>% Creating Exchanges, Partnerships, Or Plan Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Republican</td>
<td>24</td>
<td>2**</td>
<td>8%</td>
<td>5</td>
<td>29%</td>
</tr>
<tr>
<td>Unified Democrat</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Divided</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td>Other-Nebraska</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>17</td>
<td>34%</td>
<td>14</td>
<td>62%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
The District of Columbia has created its own health insurance marketplace.

Utah will operate its existing small business exchange (called “Avenue H”), while CMS runs the exchange for the individual market.

Two issues strike me as particularly noteworthy in focusing on the Medicaid expansion. The first involves the role of premium assistance waivers as a potential catalyst for participation. Some state policymakers have framed this approach as the “conservative” alternative to traditional Medicaid. While Republican officeholders in several states have evinced interest in the approach, Arkansas has gone furthest. In April 2013, Governor Mike Beebe (D) persuaded both houses of the Arkansas legislature (which the Republicans dominated) to expand Medicaid through premium assistance. With the exception of those with special medical needs, the legislation authorized the state to enroll the ACA’s Medicaid expansion cohort in the insurance exchange. Arkansas officials submitted the waiver request based on this law in August 2013 and federal officials approved it the next month. In a similar vein, Iowa Governor Terry Branstad (R) reached agreement with Republican and Democratic leaders in the legislature to cover a portion of the new Medicaid cohort -- those with incomes from 101 to 138 percent of poverty -- in the insurance exchange. Iowa officials submitted their waiver proposal in late August 2013.

The implications of premium assistance waivers in Arkansas and other states should be a high-priority research target. The ACA assigned a large role to Medicaid primarily because the Congressional Budget Office estimated that it cost 50 percent more per enrollee to insure the targeted group in the exchanges. Presumably, private plans on the exchanges will tend to pay providers more than Medicaid thereby affording enrollees greater access to “mainstream” health care. Use of the exchanges might also reduce churning – people moving between Medicaid and the exchange plans due to fluctuating incomes. It might thereby bolster participation rates among the expansion group and foster continuity of care. Will premium assistance initiatives in fact
enhance take-up rates and promote access to quality care? How much more expensive than a conventional Medicaid expansion will premium assistance be? These and related questions beg for the attention of health services researchers.

For present purposes, however, the role of premium assistance waivers as a catalyst for state participation deserves note. In addition to Arkansas and Iowa, Republican policymakers in such states as Florida, Pennsylvania and Tennessee have expressed interest in this approach. For their part, Democratic legislators in these states have also seen it as a way to bridge the partisan divide. Responding favorably to the Republican premium assistance proposal in Florida, a Democratic state senator observed: “A rose, by any other name, is still a rose.”

A second noteworthy issue involves the expansion decisions of certain resistant states – especially Florida, Georgia, and Texas. These three states are home to over a quarter of all uninsured people in the United States. An estimated 25 percent of the population that stands to benefit from the Medicaid expansion resides in these states. Given their importance, what are the prospects that these three nonparticipating states will reverse course and enlarge Medicaid in 2015? To address this question, I drew on three primary sources of evidence: the partisan patterns in these states, their Medicaid legacies in the period prior to the ACA, and their current policy dynamics. Partisan pattern denotes the percentage of time the Republican Party simultaneously controlled the governor’s office and the legislature in the state since 2000. I also

consider whether President Obama carried the state in the 2008 and 2012 elections. *Medicaid legacy* refers to how the state ranks relative to its peers on two measures of commitment to the Medicaid program – enrollees and expenditures per person below the poverty line. I also assess the degree to which the state’s ranking on these two measures increased or declined in the period from 1992 through 2009.\(^{17}\) To assess *current policy dynamics* concerning prospects for a

\(^{17}\) These data and trends are reported in Joel C. Cantor, Frank J. Thompson, and Jennifer Farnham, “States’ Commitment to Medicaid Before the Affordable Care Act: Trends and Implications.” *Inquiry* 50, #1 (2013):71-84.
Medicaid expansion I primarily relied on phone interviews with key informants in each state. These informants included legislative staff as well as directors of think tanks and university faculty.

For ACA supporters, a decision by Texas policymakers to participate in the Medicaid expansion would be the biggest prize. A quarter of the state’s 25 million residents are uninsured; great numbers of them would qualify for Medicaid under the ACA. Pundits typically label Texas as a very “red” state. President Obama lost the state twice and Republican policymakers have controlled both the legislature and the governorship 86 percent of the time since 2000. In addition Texas has historically evinced less commitment to the Medicaid program than other states. In 2009, it ranked 49th in Medicaid spending per poor person and 48th in enrollees per person in poverty. This ranking essentially remained unchanged in the period from 1992 to 2009. Hospitals, other providers, and an array of advocates for the uninsured have exerted substantial effort on behalf of a Medicaid expansion in Texas. But it is unlikely that the state will expand Medicaid at least prior to the 2014 election. Governor Rick Perry (R), a strong opponent of the ACA, has indicated that he may again seek the Republican presidential nomination. This decision has reinforced his reluctance to reverse course on Medicaid. Governor Perry will not
seek reelection in 2014. Whether or not that election will bring to office a governor and state legislature more open to a Medicaid expansion remains to be seen. In the wake of developments in Arkansas, certain Republican officials have expressed some interest in an expansion via premium support.

Among the “big three” resistant states, Florida offers the most hope for proponents of a Medicaid expansion. But it remains unlikely that any such step will occur before the 2014 election. Florida ranks fourth among states in the proportion of its population without insurance – some 22 percent. Barack Obama carried the state twice but Republicans have dominated all three elected branches of state government since 2000. Historically, Florida has demonstrated somewhat greater commitment to Medicaid than either Texas or Georgia. To be sure, the state ranked 47th in Medicaid spending per poor person as of 2009. But it qualified for 34th place in terms of enrollees per person in poverty. These rankings were basically static in the period from 1992 to 2009. Hospitals and other providers have expressed support for the Medicaid expansion, though some informants claim that other legislative priorities have dissipated the force of their advocacy. Both Governor Rick Scott (R) and the leadership of the Florida Senate supported a Medicaid expansion in 2013. (The senate preferred a premium-support variant based on the state’s experience with the CHIP program.) The Speaker of the state House of Representatives, however, fervently opposed this initiative and the measure died in the last legislative session. This speaker will remain in office through 2014 and appears unlikely to reverse course when the legislature reconvenes. Informants differ on whether Republican legislators in line to succeed the current speaker in 2015 are more open to a Medicaid expansion.

Georgia, with 19 percent of its nearly 10 million residents uninsured, also looms large in importance. President Obama lost the state in the 2008 and 2012 elections. Since 2000,
Republicans have controlled all three elected branches of state government 71 percent of the time. As of 2009, Georgia ranked last among states in Medicaid spending per poor person and 44th on enrollees per person in poverty. Unlike Florida and Texas, the period from 1992 to 2009 witnessed a substantial decline in Georgia’s ranking on the two measures of Medicaid effort relative to other states. On the expenditure metric, the state’s ranking declined by 14 places and on the enrollment indicator, by 16. Hospital associations and other providers have supported the Medicaid expansion although the preeminent Georgia Hospital Association only recently made a strong endorsement. These associations and other advocates have warned that failure to expand Medicaid could cause some rural hospitals to close. Governor Nathan Deal (R) and the Republican-controlled legislature have thus far opposed the expansion. The governor and legislature are up for reelection in 2014. Some informants believe that Republican incumbents are unlikely to invite Tea Party opposition by reversing their position on a Medicaid expansion in an election year.

My pessimistic perspective on the short-term likelihood that Texas, Florida, and Georgia will expand Medicaid should be kept in perspective. Many believe that the federal financial incentives for states to participate in the expansion are so great that even the most reluctant states will eventually come on board. Moreover, premium assistance waivers could, as in Arkansas, allow for a political reframing of the Medicaid expansion in a way that leads to bipartisan endorsement by Republicans and Democrats. The experience with state participation under the original Medicaid program after its passage in 1965 also deserves note. By the end of 1966, 26 states were participating – only one more than plan to expand Medicaid in 2014. States gradually responded favorably to the original law and, by 1970, nearly all of them had Medicaid programs. If states pursued the ACA’s Medicaid expansion at a similar pace, one would expect near
universal participation in 2017. Of course, the past need not predict the future. Partisan polarization was much less present in the late 1960s than currently.

Still, political and policy dynamics seem likely to enlarge the number of participating states. The decision by key Republicans strategists to make opposition to the ACA a defining campaign issue in the 2014 election seems likely to inhibit expansion this year. (In this vein, certain Republican legislators in Arkansas are attempting to rescind the Medicaid expansion authorized in 2013.) Meanwhile, however, states such as New Hampshire and Pennsylvania may well endorse expansion in 2014. Serious deliberation and debate about enlarging Medicaid is also occurring in such states as Missouri, Nebraska, and Utah. In addition to hospital associations and other advocates, local governments in some states are stepping up support for expansion. Mayors and county administrators in these states oversee public hospitals and health systems that disproportionately serve the poor. Moreover, some states require local governments to maintain indigent care programs. The ACA gradually reduces Medicaid disproportionate share funding for hospitals over the next several years. Unless state legislators expand Medicaid, the fiscal stress faced by these local governments in providing safety-net services will increase greatly.18

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Research Needs and Opportunities in the Area of Health Insurance Program Enrollment and Coverage Following ACA Implementation

Thomas DeLeire
May 2014

Summary:

- In order to provide a more complete understanding of the impact of the Affordable Care Act (ACA), research in the following areas should be a priority: the coverage rate, the crowd-out of private insurance, the optimal level of subsidies in fostering the take-up of private insurance among low-income individuals, underinsurance, and effects on employer-sponsored insurance.
- The ACA provides researchers the opportunity to start investing in the creation of large, multi-state, administrative data files that could be used to answer important health services and health policy questions for years to come.
- States are grappling with some key policy questions as the ACA is being implemented on which research could help shed light.

The Affordable Care Act (ACA) set out to transform the health care system and cover millions of individuals while reducing costs. In order to determine how successful the ACA has been at achieving these goals, researchers need to focus on a number of areas. These areas also represent opportunities to examine new populations, use new data, and address new questions that previously have not been possible to answer.

In this brief, I aim to highlight a few of the research questions that should be confronted in order for us to more fully understand how the ACA will affect enrollment and coverage. I also aim to highlight a few opportunities for researchers that the ACA implementation likely will
bring. Finally, I discuss a few possible policy questions that will raise new research opportunities.

I. Research areas in which increased attention should be a priority

A more complete understanding of the impact of the ACA necessitates further research of its impacts on uninsurance (the coverage rate), the crowd-out of private insurance, the effect of premiums of the take-up of private insurance among low-income individuals, underinsurance, and employer-sponsored insurance (ESI) offering.

A. What is the Insurance Coverage Rate and How Has it Changed Following the ACA?

Research questions related to the coverage rate include the following. What fraction of the population is insured and how has this fraction changed over time? How much of the change can be attributed to Medicaid expansion, development of subsidized exchanges, reductions in ESI, and how much is unexplained (and perhaps due to other features of the ACA such as the individual mandate)? To what extent can changes in the coverage rate be causally attributed to the ACA?

There are two primary issues that researchers need to confront when seeking to address these questions. The first is obtaining the data sufficient to determine changes in the coverage rate in a timely and reliable manner. The second is collecting data that might be able to identify the causal impact of the ACA on coverage rates.

Data. There are two types of data that are likely suitable to address this question: survey data and administrative data. Obtaining survey data is relatively straightforward, but challenges remain. The overall coverage rate could be assessed using national surveys from the U.S. Census Bureau (e.g., the Annual Social and Economic Supplement to the Current Population Survey, the
American Community Survey, or the Survey of Income and Program Participation). A comprehensive assessment of survey data suitability for evaluating the impacts of the ACA on coverage and of their timeliness can be found in the chapter by Julie Sonier, “Research and Data Needs for Monitoring and Implementation of the ACA in 2014 and Beyond: Enrollment and Coverage”.

An alternative that researchers should pursue is to construct reliable counts from administrative data (both numbers of individuals enrolled in Medicaid coverage, subsidized exchanges). While aggregate counts should be available from states and Federal sources, constructing reliable and comprehensive administrative panel data on sources of coverage should be a research priority. These data, ideally, would track individuals as they move into and between sources of coverage. To the extent that they represent “all payers”, these administrative data can track movements out of (and potentially into) states of uninsurance. An important and unresolved question is whether reliable administrative measures of enrollment into private insurance coverage outside of the exchanges will become available and whether these measures can be merged with public and exchanged-based insurance enrollment. The availability of private insurance through the exchanges conceivably could displace enrollment in either group or non-group private insurance outside of the exchanges (a phenomenon that is commonly referred to as “crowd-out”). However, the ACA – possibly through the effects of the individual and employer mandates – could encourage enrollment in private insurance outside of the exchanges (“crowd-in”).

Of course, an overarching question is one of the reliability of the measures of coverage in both survey and administrative data. Can precise changes in the sources of coverage (from which we can calculate changes in the percent of the population coverage by Medicaid, covered
by subsidized exchanges, and so on) be obtained from survey data? While, in principle, administrative data represent exact counts of enrollment, in practice data reliability issues also exist (in addition to the issue of whether reliable administrative measures of enrollment into private insurance coverage outside of the exchanges can be developed).

Identification. While documenting trends in the health insurance coverage rate and sources of coverage is highly important, it is also important to determine the extent to which changes in the coverage rate can be causally linked to the ACA. There are a number of methods that have been used in the literature to identify impacts of coverage expansions. These include using variation both across states and within states over time in Medicaid eligibility thresholds, using discontinuities and variations induced by the exchange subsidies, variation in participation in the federal exchange, and other similar variations. Some aspects of the ACA, such as the individual mandate, apply nationally so identifying its impact will be especially challenging. However, despite challenges, the pursuit of knowledge about the causal impacts of the entire law plus its components should represent a top research priority if we are to make any needed adjustments or improvements.

B. Crowd-out. What fraction of enrollees into Medicaid and into subsidized exchanges would have been covered by private insurance in the absence of the ACA?

A related question to understanding the overall impacts of the ACA on coverage is understanding what fraction of enrollees into the new publicly funded forms of coverage (expanded Medicaid and subsidized exchanges) would have been covered by private coverage had these expansions or subsidies not taken place. A very large body of research seeking to determine the extent of crowd-out from earlier Medicaid and CHIP expansions has yielded a wide range of estimates of the extent of crowd-out (see, for example, summaries of the literature in CBO 2007 and Gruber...
and Simon 2008). But the consensus appears to be that at least some crowd-out from the availability of publicly funded insurance should be expected, even if the magnitude of this displacement is highly uncertain (CBO 2014). This research could also determine the fraction of enrollees that were previously uninsured and the fraction that previously had private coverage? Additional questions related to crowd-out that should be addressed include determining what fraction of enrollees into Medicaid would have enrolled into subsidized exchanges had a state not expanded Medicaid and, conversely, what fraction of enrollees into subsidized exchanges would have enrolled into Medicaid had a state expanded Medicaid. There are methodological and data issues that need to be confronted in answering research questions regarding crowd-out effects of the ACA, and these issues are similar to those discussed above. First, there are concerns about whether survey data are sufficiently reliable to measure crowd-out. Administrative data could be used to measure some of these concepts (e.g., as in Dague et al, 2011) to measure some of these concepts, in particular, the fraction of newly covered enrollees that were previously uninsured.

A larger challenge is in identifying the effects of the ACA expansions on crowd-out. Previous studies, (e.g., Gruber and Simon 2008) compare newly covered populations in states that expanded public insurance with similar populations in states that did not expand public insurance, using either a difference-in-differences or simulated instrumented variables approach. In the context of the ACA, this approach is promising in that some states expanded Medicaid and some did not and, further, expansion states differ in their pre-expansion eligibility levels. However, a challenge to identification is that the ACA also affected populations that were not newly covered and that otherwise would have been included in the control group. Finally, it might be of some policy interest to distinguish reductions in private coverage that are intentional
(e.g., a person electing to drop non-group coverage in order to obtain subsidized exchange coverage) versus unintentional (e.g., an employer dropping coverage). However, due to data limitations, distinguishing these pathways can be challenging.

C. Take-up. What fraction of individuals eligible for subsidized exchanges take them up? While it is expected that a large fraction of individuals eligible for subsidized coverage through the exchanges will, in fact, enroll, it is likely that some will remain uninsured. An important research question is the role of premiums and penalties for low-income individuals in affecting this take-up. In particular, are premium subsidies and penalties set optimally? The literature on optimal social insurance (e.g. Chetty 2006, 2008, Chett and Saez 2011) would likely suggest, for example, that the additional take-up from higher subsidies might be weighed against the additional cost and crowd-out from higher subsidies.

How might one identify the effect of premiums on take-up for subsidy-eligible individuals? There are some discontinuities in the schedule of premium caps as a function of the federal poverty level that potentially could be exploited to identify the effect of premiums on take-up. There also may be some idiosyncratic variation in premium setting across regions, especially in the initial years of the ACA. In addition, we know some, perhaps quite a bit, from Medicaid programs that charge premiums for higher income enrollees. Evidence from Wisconsin suggests sensitivity in take-up to movements to small premiums from zero premiums (see Dague, forthcoming).

D. Extent of Coverage / Underinsurance. How does the ACA affect the generosity of coverage?

Generosity might be measured in terms of actuarial value, plan design, coverage of services as well as by traditional measures of underinsurance. One might also seek to compare
the generosity of Medicaid and subsidized exchanges, examine the variation in generosity across plans within a tier of a state’s exchange, compare the generosity of subsidized exchanges and ESI, and so on.

E. ESI offering.

Initial modeling, supported by some employer surveys, suggested little employer dropping of ESI coverage (CBO 2014). Much if this was due to “inertia” or caution regarding what the exchanges had to offer. This could change if the exchanges are viewed as attractive places to obtain insurance, given the large subsidies available. There are interesting trade-offs between subsidies, tax benefits of ESI, wage offsets, given the incentives of the ACA. Some modelling (e.g., Burkhauser, Lyons, and Simon 2012) suggests the scope for a fair amount of employees dropping of coverage in response to ACA incentive. However, this is an area in which direct estimates following ACA implementation and modelling based on administrative or linked employer-employee data might be fruitful.

II. Research Opportunities

The ACA will give researchers the opportunity to create multi-state, cross program administrative data files that will include enrollment into Medicaid and subsidized exchanges, with perhaps information on enrollment in ESI and unsubsidized non-group insurance. The marketplace enrollment files (collected by the federal government and by states) hopefully can be made available to researchers and, further, linked to claims at some point in the future. These files may need to include encounter and claims data (which might have to be provided to States or to CMS because of reinsurance or MLR requirements). Ideally, these enrollment files would
also be linked to other administrative data files such as social security earnings, tax records and earning statements, enrollment databases from other social insurance programs, vital statistics, etc. Great strides, in recent years, have been made in linking administrative records to survey data and to making these linked data available to researchers (e.g., the work done by John Abowd and colleagues in linking Social Security earnings records to the Survey of Income and Program Participation and making these data available in a manner that preserves confidentiality).

III. Policy and economic questions

In this section, I highlight three questions (there certainly are more) that non-federal decision makers will be grappling with.

1. Should states expand Medicaid to ACA limits? Should states undo previous Medicaid expansions to ACA limits?

   About half of states are “not moving forward at this time” and about half are “moving forward at this time” on the Medicaid expansion (KFF 2014). As this characterization highlights, the decision whether to expand Medicaid (and to accept the enhanced FMAP) is fluid. In addition, some states, such as Wisconsin has, may consider rolling back previous expansions to ACA (or lower) limits.

2. At what level should premiums and cost-sharing in Medicaid be set?

   States are allowed to charge premiums and impose cost-sharing to most adults with family incomes above 150 % FPL (CMS 2014). As a result, states that previously had expanded their adult Medicaid eligibility thresholds to levels above 150% FPL should consider whether they wish to charge premiums and, if so, at what level. The existence of premiums and cost-sharing
in subsidized exchange-based coverage (even if minimal) for individuals at income levels just above the Medicaid eligibility thresholds may give states an extra incentive to impose similar premiums and cost-sharing among its Medicaid population (both in terms of fairness and to help mitigate any eligibility cliffs).

3. Should firms drop ESI? Which firms should consider dropping ESI?

Once exchanges (and their subsidies) become well-established and functioning, firms may consider whether their workers would be better off receiving subsidized coverage in exchanges rather than tax-preferred covered through ESI, even once employer penalties for not offering are taking into account. Current cost-estimates assume little dropping, but these estimates are sensitive to model assumptions.

IV. Conclusions

This brief highlights a few areas of research that should be a priority as the ACA is being implemented, some areas of opportunity, and some additional policy questions that could be grappled with. Understanding the impacts of the ACA will require increased efforts by researchers and policymakers to use available data, to generate new data, and to design credible research strategies. The period following the implementation of the Act is also a great opportunity for us to broaden and deepen our knowledge of how the public and private insurance markets that serve low-income populations work and how they might work better.

IV. References


Research and Data Needs for Monitoring and Implementation of the ACA in 2014 and Beyond: Enrollment and Coverage

Julie J. Sonier February 2014

Summary:
The Affordable Care Act’s (ACA’s) effects on health insurance coverage in the U.S. will be extensive and will vary substantially across states for a number of reasons. Because of this variation, the use of a state lens is essential to understanding the ACA’s coverage impacts. Unfortunately, among the federal surveys that measure health insurance coverage to date none have included both a state-representative sample design and the depth of content needed to measure key indicators of interest. The American Community Survey (ACS) and Behavioral Risk Factor Surveillance Survey (BRFSS) provide state-level estimates that are lacking in depth, and the Medical Expenditure Panel Survey Household Component (MEPS-HC), National Health Interview Survey (NHIS), and Survey of Income and Program Participation (SIPP) produce estimates that lack the geographic detail and state-representativeness desired by many policy makers. Changes being introduced to the Current Population Survey’s Annual Social and Economic Supplement (CPS ASEC) in 2014 will allow for state-level estimates of many concepts that are essential to understanding the impacts of the ACA, but come at the cost of introducing a break in the CPS ASEC time series which has historically been one of the most widely used data series for tracking state-level trends in health insurance. Key concepts of interest will include monitoring the composition of the remaining uninsured population and stability and consistency of insurance coverage over time and within families.

When the coverage provisions of the Affordable Care Act (ACA) go into full effect on January 1, 2014, they will trigger extensive and wide-ranging impacts on health insurance coverage and access to health care in the U.S., especially for the low-income uninsured. While the full effects will likely phase in over time, a significant portion of the impact is expected to be felt in the short term: current Congressional Budget Office (CBO) estimates are that the number of uninsured will fall by 13 million in 2014, increasing to a cumulative decline of 25 million by 2016.19

Beyond merely measuring reductions in the number of people who lack health insurance as an indicator of the ACA’s impact on coverage, other measures will also be important to track in order to assess and understand the ACA’s impacts (described in more detail below). While there is great usefulness in monitoring these indicators at the national level, it will also be

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critically important to be able to distinguish impacts across states, for several reasons. First, states have significant flexibility in how they choose to implement the law, particularly with regard to their health insurance coverage provisions. State decisions about whether and how to implement the Medicaid expansion, along with whether and how to build a state-based health insurance exchange, are likely to cause variations in impacts observed across states; states are also adopting different strategies for outreach and enrollment of eligible populations, which could also lead to variations in impact. Second, existing variation across states in health insurance coverage and health care financing/delivery systems will also play a role in determining the ACA’s impacts. Finally, other factors that vary by state, such as socioeconomic and demographic characteristics, will also cause variation in the ACA’s coverage impacts across states. All of these factors will need to be taken into account in assessing the ACA’s impacts.

Since enactment of the ACA, much effort has gone into prospectively modeling its impacts on coverage and enrollment. These types of analyses are often done using a microsimulation modeling approach, and Holahan et al. (2012) provide an excellent example of this type of research.20 In 2014 and beyond, however, it is likely that attention will begin to shift away from analyses that predict the ACA’s impacts and toward those that attempt to measure and monitor its impacts over time. It will be important, however, to assess how well these models have performed in order to refine them for future uses. For example, analyses that compare predicted to actual changes in offer rates of employer-sponsored insurance (ESI) or predicted to actual changes in take-up of Medicaid coverage among those eligible to enroll would be particularly useful.

With the shift to a more retrospective approach to understanding the ACA’s impacts, there will be two categories of research questions. The first focuses on monitoring impacts for research purposes (including the questions about ESI offer and Medicaid take-up rates identified above). The second -- not completely unrelated to the first -- focuses on the need for information to support ongoing operational and program decisions being made by policy makers at the state and federal levels (for example, what do states need to know in order to make informed decisions about whether to implement the Basic Health Plan or whether to expand Medicaid?). The

remainder of this paper seeks to address these questions about monitoring the ACA’s impacts for research and policy development purposes, with a focus on two specific topics: 1) the remaining uninsured population and characteristics of the uninsured, and 2) stability and consistency of insurance coverage. Before turning to these two specific topic areas, however, I begin with a discussion of potential data sources.

**Potential data sources**

As described above, there are compelling reasons to monitor the ACA’s impacts at both a national and state level. It will be important to be able to distinguish impacts across states (or groups of states – for example, those that choose to run their own health insurance exchanges vs. those that do not), but also impacts within states in many cases (for example, to help policy makers identify regions of their state that continue to have higher than average rates of uninsurance or identify whether racial/ethnic disparities in coverage are getting bigger or smaller over time). Existing data sources have different strengths and weaknesses with regard to their ability to measure impacts at the state or sub-state level, and so it is likely that depending on the specific research question some data sources will emerge as more well-suited to a given analysis than others.

Given the new landscape of health insurance coverage beginning in 2014, there will also be some new methodological challenges to measuring sources of coverage. To some degree, these have always existed – for example, there is a substantial literature documenting an undercount of Medicaid coverage in population surveys. New challenges added by the ACA include issues such as whether people who purchase subsidized nongroup coverage through an exchange will report it as private or public coverage, and whether people who enroll in Medicaid via an exchange will report it as Medicaid, exchange coverage, or private coverage. Some data sources are likely to collect more detail than others in this area, and as a result may produce more reliable estimates of these measures that will be of keen interest to policymakers. For example, questions are expected to be added to the National Health Interview Survey (NHIS), Medical

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Expenditure Panel Survey Household Component (MEPS-HC), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC) in 2014 to measure coverage through exchanges and distinguish it from Medicaid coverage, while the American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS) will not have any questions related to exchanges. These distinctions in how different population surveys will be adapted to the changing coverage landscape may have important implications for their usefulness to assess the ACA’s impacts. Measuring these concepts well is a complex task that will likely require some adjustment over time as researchers come to better understand how people think about their coverage.

In addition to how well a given data source measures the concept of interest, several other criteria may come into play in determining which data source is best for a particular analysis. These may include, depending on the question at hand, the level of geography at which analysis can be done (state level, sub-state level, or comparisons across states), timeliness of the data so that results can be used to produce actionable analyses for state or federal officials, and availability/accessibility of the data (for example, state-level data from some federal surveys can only be accessed through a Research Data Center).

Figure 1 summarizes how several federal surveys that are commonly used to measure health insurance coverage compare on these criteria. The American Community Survey has the largest sample size among the surveys in Figure 1, and is the only survey from which sub-state geographic estimates are available. These types of estimates have been particularly important to state policymakers as they have created outreach strategies for enrolling the uninsured population, and likely will continue to be important to state officials in the future. The Current Population Survey (CPS) is another widely used data source for state-level estimates, but no sub-state geographic estimates are available and data are usually combined across multiple years to improve the precision of estimates for state-level analyses. For purposes of measuring the ACA’s impacts on coverage, this is a disadvantage of the CPS because it means that state-level estimates of coverage impacts will not be available until at least the fall of 2016 (assuming that 2-year

averages are used to measure change over time at the state level); in addition, while a change in the CPS instrument in 2014 will greatly enhance its usefulness for tracking coverage trends going forward, it will introduce a break in the time series. The Behavioral Risk Factor Surveillance System (BRFSS) also produces estimates of uninsurance rates, but historically has been less widely utilized than the ACS and CPS because it did not include questions about type of coverage (just insured/uninsured) and income is measured much less precisely in the BRFSS, making it difficult to analyze the uninsured population in much detail below the statewide level (e.g., by income). However, new optional questions were implemented in the BRFSS for 2013 (in a majority of states, but not all) that will allow for more detailed insurance estimates by type of insurance coverage and gaps in insurance coverage over a 12-month period.

The three other federal surveys that are included in Figure 1 – the MEPS-HC, NHIS, and the Survey of Income and Program Participation (SIPP) – are not designed to produce estimates that are representative of individual states. State-level insurance coverage estimates from NHIS are published on a limited basis, but state identifiers are not included in the public use file. Researchers wishing to work with state identifiers from the MEPS-HC and NHIS must use the data at an NCHS Research Data Center; the SIPP public use file does include a state identifier, but in many states the sample size is quite small and not representative. 23

Beyond the federal surveys, potential data sources for analyzing the impacts of ACA on enrollment and coverage include surveys conducted by independent research organizations (the Urban Institute’s Health Reform Monitoring Survey24 is one example of a survey that aims to provide timely insights into the ACA’s impacts), and survey data and administrative data from states. At least 16 states have conducted their own health insurance surveys since 2010, with several conducting surveys on an ongoing basis – many are exploring their own ways of asking about marketplace coverage, receipt of subsidies, and other questions important to policy makers in their own states.25 For understanding the size and characteristics of the remaining uninsured population, a survey is required because the uninsured typically do not show up in administrative

23 The 2008 panel of the SIPP was designed to representative of the 20 largest states. (SHADAC, “Monitoring the Impacts of Health Reform at the State Level: Using Federal Survey Data,” March 2011)

24 www.hrms.urban.org

25 A database of state reform survey items, searchable by topic, can be found at http://www.shadac.org/content/state-survey-research-activity.
data; for other concepts of interest (e.g., churn between Medicaid and the exchange – described in more detail below) state administrative data may also be a good choice.

What will the remaining uninsured population look like?

The remaining uninsured population will be comprised of several distinct groups, as depicted in Figure 2 (proportions in this figure are for illustrative purposes only):

- The Medicaid “gap” population, comprised of nonelderly, nondisabled adults in states that have chosen not to implement the Medicaid expansion. Because exchange subsidies will be available for those with incomes at or above 100% FPG, this group will generally consist of parents between current Medicaid income standards\textsuperscript{26} and 100% FPG, and childless adults up to 100% FPG.

- The population that is eligible for Medicaid but not enrolled, as measured by insurance status and family income (with income standards varying by state, for those states that have not expanded Medicaid).

- The population that is eligible for exchange subsidies but not enrolled. This group may be particularly difficult to measure, because eligibility for exchange subsidies is dependent on access to “affordable” employer-sponsored insurance.

- The population with family income above 400% FPG, and thus not eligible for any type of subsidy, that remains uninsured.

- Other uninsured, which may comprise people who are ineligible for public coverage due to immigration status, people who are ineligible for subsidies because they are deemed to have access to “affordable” ESI coverage, and people who are exempt from the insurance mandate for reasons such as religion or hardship. (Although each of these groups would be difficult to measure individually, the size of this group as a whole could be measured as a residual in Figure 2.)

\textsuperscript{26} The lower bound of this range varies by state, and will be a gross standard reflecting the conversion of current net income standards to a Modified Adjusted Gross Income (MAGI) based standard.
Figure 3 illustrates the availability of these measures from the federal population surveys. The measure that is most problematic given existing surveys is the number of people who are eligible but not enrolled in subsidized coverage through insurance exchanges. Measuring this concept requires knowing 1) who has access to ESI coverage, and 2) whether this coverage is “affordable” by the standards of the ACA. None of the federal surveys includes questions that directly measure this second concept (and as a result, researchers will need to continue to impute it). Another challenge that researchers have faced in estimating eligibility relates to immigration status, which also requires the use of imputation strategies.

Looking forward, another key challenge to understanding the characteristics of the remaining uninsured population is that as the number of uninsured individuals falls the sample size of uninsured will also decline in most surveys. This is likely to be more of a concern for researchers interested in state-level trends than national ones.

**Stability and consistency of insurance coverage**

The above discussion of the characteristics of the remaining uninsured population pertained largely to estimates at a point in time, but there is also significant policy interest in understanding how the ACA will change the dynamics of insurance coverage over time. Several concepts are of particular interest to policymakers:

- Churn on and off of coverage, or the degree to which people experience any spells of uninsurance over a period of time (most often a year).

- Churn on and off of Medicaid coverage, and potentially on and off of subsidized exchange coverage. Policymakers are interested in understanding the reasons for churn, especially in identifying which “churn” involves people who continue to be eligible for coverage and are disenrolled for avoidable reasons (such as paperwork problems), and whether the ACA reduces the degree of churn on and off of Medicaid coverage.

- Churn specifically between Medicaid and the exchange, which is a concept that state officials have been particularly interested in, especially as they attempt to understand the implications of a decision about whether to implement the Basic Health Plan that is optional under section 1331 of the ACA. State officials are also interested in
understanding this type of churn in order to make decisions about how benefits and health plan options should be aligned between Medicaid and the exchange.

- Consistency of coverage within families, or the degree to which all family members have coverage through the same source. Because of provisions in the ACA that require maintenance of effort for children in state Medicaid and CHIP programs until October 2019 (assuming that CHIP continues to be funded past its current funding authorization expiration in 2015), there may be many families in which children receive coverage through Medicaid or CHIP and parents receive subsidized coverage through an exchange. Many policymakers are concerned that confusion over multiple sources of coverage, different benefits, different health plans, and different provider networks could result in barriers to accessing appropriate care. Understanding the degree to which the ACA contributes to more (or less) consistency of coverage within families will thus be relevant for policymakers.

To answer these important questions about churn and consistency of coverage, a combination of survey and administrative data likely will be useful. Indicators of churn on and off of coverage and consistency of coverage across all family members will be best measured through population surveys, while it may be the case that the indicators of churn on and off of Medicaid (and/or exchange) coverage and churn specifically between Medicaid and the exchange will be best captured by state administrative data such as program enrollment files. Given variations in state data systems, however, strategies that rely on administrative data may not produce results that are comparable across states: for example, data quality and the level of detail at which reasons for disenrollment are tracked vary substantially across states.

Figure 4 illustrates the availability of these key measures of stability and consistency of coverage from existing federal surveys:

- Coverage dynamics: Historically, the SIPP has been the most common source of estimates of churn because it is the largest of the federal surveys that tracks health insurance coverage on a monthly basis; although much smaller than SIPP, the MEPS-HC also is a good source of national-level information on coverage dynamics. The new CPS ASEC will also allow for month-by-month analysis of shifts in coverage during the
course of the year. NHIS includes questions about gaps in coverage during the year, and new questions were added to BRFSS in most states in 2013 to measure the churn on/off coverage concept. The ACS includes only a point in time measure of coverage and cannot be used to measure churn on and off of coverage over time.

- Consistency within families: Of the surveys included in Figure 4, BRFSS is the only one that cannot be used to measure coverage consistency within families, because it does not gather coverage information about everyone in the family.

**Implications for Monitoring the ACA’s Impacts**

Because of the substantial variation in the health insurance coverage landscape and the decisions of state policy makers, the use of a state lens is essential to understanding the ACA’s impacts. Unfortunately, among the federal surveys that measure health insurance coverage none currently includes both a state-representative sample design and the depth of content needed to measure key indicators of interest. Instead, the ACS, BRFSS, and CPS (historically) provide state-level estimates that are lacking in relative depth, and the MEPS-HC, NHIS, and SIPP produce estimates that lack the geographic detail and state-representativeness desired.

Changes that are being made to the CPS beginning with the Annual Social and Economic Supplement in 2014 will make it the strongest of the three state-representative surveys in terms of ability to measure the concepts described in this paper. The new questions will enable improved measures of all-year insurance coverage, a new point-in-time measure of insurance coverage, new questions to measure exchange participation, and new questions on employer-offered health insurance coverage availability and take-up. As noted earlier, however, because state-level estimates from CPS are typically done using data pooled across multiple years, the earliest time that 2-year estimates measuring a post-ACA implementation period will be available is the fall of 2016. In addition, the switch to the new survey instrument will introduce a break in the CPS time series for uninsurance estimates.

For researchers wishing to compare effects of the ACA across states or groups of states, the lack of state-representative estimates for key measures of interest and restricted access to

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27 Prior to 2013, the BRFSS insurance coverage question was only a point in time question; however, most states have now added questions to determine whether a person had insurance for all of the past year.
state-level data are barriers that may slow analyses of the role that state-specific factors play in ACA’s impacts across states. Short of major redesigns to existing surveys, options for addressing these barriers include:

- Publishing more state-level estimates from NHIS for key indicators where they can be considered reliable, or making available public use files with state identifiers. In recent years, the NHIS sample has been expanded substantially, making it possible to publish more state-level estimates; it is unclear whether this will be sustained in 2015 and beyond.

- To increase the number of state-level estimates, pooling data across multiple years, as has been done routinely with data from the CPS to produce reliable state-level estimates; however, state-representativeness may still be an issue (due to geographic areas within the states that are sampled) and timeliness of estimates would suffer as a result.

- Increased use of small area estimation techniques and multiple data sources to produce state or sub-state estimates from the national surveys that are not designed to produce estimates at this level of geography. Although this would help to fill a gap in knowledge, one potential downside is that policymakers tend to be more skeptical of synthetic estimates, and the analysis may not necessarily be readily reproducible.

Finally, for state officials, the option to field their own surveys may continue to be attractive to those that have invested in developing this infrastructure over time. As noted earlier, at least 16 states have conducted health insurance surveys of their own since 2010, and despite the high cost this may continue to be an attractive option for several reasons, including the ability to oversample specific populations (e.g., by income or race/ethnicity), to have control over survey content, to have direct access to data for analysis of policy proposals, and to obtain and release results in a timely manner.

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28 See, for example, Graves J. and Swartz K. 2013. Understanding State Variation in health Insurance Dynamics Can Help Tailor Enrollment Strategies for ACA Expansion. Health Affairs 32(10):1832-1840. Graves and Swartz re-weighted data from the national SIPP to produce state-representative estimates that were calibrated to ACS state-level controls.
Figure 1
Strengths and Weaknesses of Potential Data Sources

<table>
<thead>
<tr>
<th></th>
<th>ACS</th>
<th>BRFSS</th>
<th>CPS</th>
<th>MEPS-HC</th>
<th>NHIS</th>
<th>SIPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>State representative estimates?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (combine years)</td>
<td>No</td>
<td>No*</td>
<td>Limited^</td>
</tr>
<tr>
<td>Sub-state estimates?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Cross-state estimates?</td>
<td>Yes</td>
<td>Yes, for core survey</td>
<td>Yes</td>
<td>No</td>
<td>No*</td>
<td>No</td>
</tr>
<tr>
<td>Timeliness</td>
<td>9-12 month lag</td>
<td>6-7 month lag</td>
<td>5-6 month lag after collection</td>
<td>Variable</td>
<td>Quarterly releases</td>
<td>9-12 month lag</td>
</tr>
<tr>
<td>Availability/accessibility of data:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>Public use</td>
<td>Public use</td>
<td>Public use</td>
<td>Public use</td>
<td>Public use</td>
<td>Public use</td>
</tr>
<tr>
<td>State</td>
<td>Public use</td>
<td>Public use</td>
<td>Public use</td>
<td>RDC only</td>
<td>RDC only</td>
<td>Public use</td>
</tr>
</tbody>
</table>

*Although not designed for state estimates, the NHIS does publish some state coverage estimates (43 states for 2012).

^2008 panel was designed to be representative of the 20 largest states.
Figure 2
Categories of Remaining Uninsured in 2014 and Beyond

Relative proportions in the figure are for illustrative purposes only.
### Figure 3
**Data Sources for Characterizing Remaining Uninsured Population**

<table>
<thead>
<tr>
<th></th>
<th>ACS</th>
<th>BRFSS</th>
<th>CPS</th>
<th>MEPS-HC</th>
<th>NHIS</th>
<th>SIPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remaining Uninsured:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid &quot;gap&quot; population</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Eligible but not enrolled:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Exchange subsidies</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>- Access to ESI</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>- Affordability of ESI</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Above 400% FPG</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: The table describes whether the data elements are collected by the surveys; other means such as imputation are available to researchers to fill some of the gaps.
## Figure 4

Data Sources for Examining Stability & Consistency of Coverage

<table>
<thead>
<tr>
<th></th>
<th>ACS</th>
<th>BRFSS</th>
<th>CPS</th>
<th>MEPS-HC</th>
<th>NHIS</th>
<th>SIPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stability of coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Churn on and off of coverage</td>
<td>No</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Churn on and off of Medicaid</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Churn on and off of exchange</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Churn between Medicaid and exchange</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td><strong>Consistency of coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All family members have same coverage source</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Not all 50 states.
Reactions to
“Research and Data Needs for Monitoring and Implementation of the ACA in 2014 and Beyond:
Enrollment and Coverage”

Sharon K. Long

Goal: **Track changes in coverage under the ACA to support implementation, policy and evaluation**

- Impacts on insurance coverage
  - Nationally and by state/state groups
  - Overall and for key population subgroups (by income, age, race/ethnicity, urban/rural, etc.)

- Impacts on type of coverage (Medicaid, employer-sponsored, nongroup)

- Impacts on continuity of coverage/churning in coverage type

- Impacts on offers of coverage by firms and take-up by workers
  - Nationally and by state/state groups
  - Overall and for key firm groups (by size, industry)

- Impacts on adequacy of insurance coverage
Resources: National Data Sources

- National survey data
  - ACS
  - BRFSS
  - CPS {Current design or revised design}
  - MEPS-HC/MEPS-IC
  - NHIS
  - SIPP
- Administrative data on enrollment
  - Medicaid/CHIP
  - Exchange/marketplace

Issues with National Survey Data

- Do not necessarily support state estimates
  - Lack of state representative samples
  - Small state sample sizes

- Measurement issues and “missing” variables
  - Limited ability to identify ACA-eligible populations: “family” units, income groups, citizenship status
  - Concerns about accuracy of reported coverage/coverage type, with accuracy likely to worsen over time with increasing complexity of coverage options combined with lack of appropriate questions
• Limited information on changes in coverage over time, particularly by type of coverage

• Limited information on characteristics of insurance coverage: networks, benefits, cost-sharing, financial risk

• *Timeliness of data releases will mean little information in 2014*
Timeliness: When could we document a change in the uninsured rate following ACA policy changes in January 2014?

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Timeliness: When could we document a change in continuity of coverage following ACA policy changes in January 2014?

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Timeliness: When could we document a change in churning between coverage types following ACA policy changes in January 2014?

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**Issues with Administrative Data**

- *Limited to narrow subset of the population: Medicaid or Exchange/Marketplace enrollees*

- New Marketplace and Medicaid reporting requirements starting in October 2013
  - State experiences with reporting requirements not yet known
  - Ability to link data across Medicaid and Exchange/Marketplace not yet known

- Timing and content of data releases by states or CMS/CCIO not yet known

How could we improve national survey data to support ACA implementation, policy and evaluation?

- **ACS:** Try again to add a question on exchanges/marketplaces; Continue to work on strategies for subannual estimates

- **CPS:** Implement revised health insurance questions in 2014; Split-sample fielding of old and new questions in 2014

- **NHIS:** Continue to expand early release measures/populations; Continue to push to expand state sample sizes and content; Expand access to state data/publish more state estimates

- **BRFSS:** Continue efforts to encourage all states to add ACA-related questions; Improve health insurance and income questions

- **MEPS:** Continue to push on expanded content for households and employers; Continue to push for earlier release of the data; Expand access to state data/publish more state estimates
What is needed beyond current national surveys to support ACA implementation, policy and evaluation?

- **Alternative data collection strategies for rapid feedback in 2014**
  - Internet panels: Health Reform Monitoring Survey
  - Follow-back surveys based on 2013 samples: full-year uninsured, individuals with nongroup, employers in small firms
  - “Pop-up” surveys with individuals using exchange/marketplace websites
  - Expand options for state buy-in of expanded sample sizes for national surveys
  - Sentinel surveys using small panels of low-income families or safety net providers as early warning system

- **Data linkage projects for administrative data from Medicaid and exchanges/marketplaces**

- Cognitive research on survey questions related to exchanges/marketplace
  - Targeted surveys with enrollees
  - Test alternative questions with actual enrollees
Improving the Quality of Care for Medicaid Beneficiaries

Sara Rosenbaum, J.D.29

Executive Summary

Medicaid faces three fundamental challenges in the area of health care quality: (1) a perception that the program somehow is not worthy of serious investment; (2) the practical and political constraints that flow from federalism; and (3) the broader politics and practicalities of health system reform, of which Medicaid is only one among many players. Although attention to quality can be found in the program’s earliest statutory and implementation policies, the focus has become much more intense in recent years as Medicaid has grown, as the statutory and regulatory tools for promoting quality have increased, and as the quality of health care has become a matter of systemic concern across multiple payers. Medicaid’s major quality improvement tools can be found in the areas of coverage and benefit design and provider qualification. They also can be found in both macro and micro payment reform initiatives, patient and consumer engagement, and improved data collection and reporting systems.

Questions for future research are how states are utilizing these tools and the challenges they face, how these tools might be used to bring a special focus on the health care safety net on which Medicaid agencies and beneficiaries deeply depend, and how Medicaid might increase its presence in multi-payer quality improvement efforts.

Introduction

The goal of any health service plan must be to promote a healthy population, to prevent illness and premature death, to correct or limit disability, to treat all illnesses and to provide maximum rehabilitation of all persons with impairments. The achievement of these goals involves the fullest possible application of medical knowledge and the use of all health resources . . . . States are expected to set standards that will be appropriate to insure that the services will be of high quality and to adopt methods of administration to assure that the services are furnished in a sympathetic and dignified manner. The emphasis will be focused on medical care as part of a comprehensive plan for services, not just on payment of the medical bill.

HEW, Handbook of Public Administration, Supplement D (D-1000) (1966)

29 Harold and Jane Hirsh Professor, Health Law and Policy, The George Washington University School of Public Health and Health Services
From the time of Medicaid’s enactment, quality – framed in both clinical and patient-centered terms -- has been identified as a focus of the program. For five decades Medicaid has struggled to maintain this focus in the face of three major challenges.

The first challenge has been the enduring image of Medicaid as a failed program of “welfare medicine” that merits far less than the full attention and commitment of the health care system and health policymakers. One recent research synthesis documents Medicaid’s impact on access and health outcomes and provides evidence that patients whose care is funded by Medicaid receive care of comparable quality to that received by other patients.30 (Of course, this does not mean that, at least on a systemic level, the quality of care in the U.S. is particularly good, a problem suggested by a virtual deluge of research). But despite Medicaid’s foundational role in the health care system,31 opponents continue to frame it as a failure for patients, health professionals, and the government, and as an investment that produces poor access and substandard health outcomes.32 That Medicaid continues to struggle under the weight of its “welfare medicine” label is clear from charges by expansion opponents during the recent state Medicaid debates, who constantly have sought to frame Medicaid as an unworthy program for unworthy people. These debates have served to remind us that, to the extent that Medicaid’s supporters had hoped that the welfare medicine imagery had been put to bed years ago and that Medicaid was perceived as worthy of investment, should think again.

The second front is (and always has been) the politics of federalism – not only in the administration of Medicaid but in the realm of health care quality more generally. Traditionally states have been the principal regulators of health care quality, and the federal government has played a decidedly secondary role.33 But as public and private third-party payers have moved to fill the void left by an industry perceived as having failed to self-regulate as well as a lax direct regulatory scheme laden with evidence of industry capture, 34 the quality of care in Medicare and Medicaid-financed has risen to the federal policy forefront. Whenever a Medicaid issue assumes national prominence, an inherent aspect of devising any policy solution is coming up with a power-sharing arrangement that works. In the case of quality, this power-sharing has thus far


31 Medicaid’s foundational role was not lost on the United States Supreme Court. In declaring the adult expansion to be an unconstitutional coercion in NFIB v Sebelius, Chief Justice Roberts grounded his decision in great part in the fact that as a result of the adult expansion, Medicaid had been transformed without adequate notice: “[Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.” 132 S. Ct. 2566, 2606 (2012)

32 See, e.g., Kevin Dayaratna, Studies Show: Medicaid Patients Have Worse Access and Outcomes Than the Privately Insured (Heritage Foundation) (accessed October 17, 2013) http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured

33 Law and the American Health Care System

tipped in the direction of state exceptionalism, at least if one uses as an outcome measure the availability of even a minimal set of national, uniform data regarding program quality and performance. The closest we have come to achieving this outcome can be seen in progress made around quality reporting for children and adolescents, and even here, many states still do not report results.

The third front is the mechanics and politics of change now washing over the underlying health care system, which is in the throes of what arguably may be the most important and fundamental organizational and economic power shifts in the past 75 years. The massive collection of local, fiercely autonomous and powerful fiefdoms that traditionally have characterized the health care system is now undergoing unprecedented market consolidation and re-alignment as large institutions merge into multi-outlet systems, thousands of medical practices are acquired, and payment aligns with service delivery on a grand scale. The large integrated delivery systems that ultimately emerge from this transformation may make it far easier to bring systemic change to the quality of care as a result of the simultaneous aggregation of resources and creation of more rationalized pathways for the diffusion of quality of care improvement practices and mechanisms, such as health information technology. At the same time however, market consolidation has created new tensions, not the least of which is demands for maximum flexibility to effectuate the transformation with only limited external accountability for cost and quality. In the face of transformation, Medicaid, like other payers, has been left to struggle with a pile of quality improvement tools, uncertain how exactly to use them or how to balance partnership and cooperation against enforceable expectations against a standard set of measures. Indeed, in this regard, the diffusion of information technology offers the perfect example of the struggle over when voluntary incentives should turn into fundamental rules of the road. How long should health care systems be induced to cooperate, and when should inducements turn into program exclusion for non-participation in adoption and meaningful use?

This paper focuses on the tools of health care quality and their current use in Medicaid. In truth, the subject of health care quality arguably could swallow every aspect of Medicaid policy, because of the inherent difficulties in separating questions of coverage and access from notions of quality. The Commonwealth Fund frames high performance as a series of interwoven elements: universal coverage that ensures affordable access and continuity of coverage and care; alignment of provider and patient incentives to promote higher quality and efficient care; patient-centered delivery reforms; quality improvement and reporting along with clinical innovation; the use of evidence based medicine and health information technology; and leadership and collaboration.35 In order to narrow the discussion, this paper attempts to focus on tools and strategies for making what exists work better, as opposed to tools and strategies for improving access to any care at all, especially in medically underserved communities. At some point, however, all issues converge.

Key Quality Improvement Levers

In thinking about how to leverage higher quality using available tools, the starting point is federal statute and implementing rules, which determine the nature of the tools, as well as the conditions under which federal funding will be available to pursue quality improvement.

The law contains numerous quality improvement levers; in the main, these levers are long-standing, although some arguably have been enhanced by the Affordable Care Act (ACA), while others, such as state payment flexibility, have received more attention in recent years from CMS. (An agency may cite a new law as a basis for a new initiative -- for example the ACA’s emphasis on payment reform -- when in reality the legal authority to pursue the initiative has existed in the underlying statute all along. In this case, the new law sharpens the attention, even if it really does not add much in the way of new legal authority).

Quality improvement levers operate at both the macro and micro levels, influencing both the structure of health care and the performance of the system for particular patients. All of the levers can be used directly by Medicaid agencies; alternatively, Medicaid agencies can use their powers over health system financing at a broader level, achieving changes by fostering the growth of clinical and financial integration that in turn applies the tools of quality improvement.

Quality levers should not be analyzed in isolation but instead as a suite of tools that works best in combination. That is, changes in coverage and system payment are combined with structural and payment strategies at the specific provider and institutional level whose aim is to improve the interaction between individual patients and providers. Furthermore, the process is not static; the advent of the Center for Medicare and Medicaid Innovation (CMMI) represents the institutionalization of the concept of continuous quality improvement and measurement, an image made enduring in Atul Gawande’s article entitled “Testing, Testing,” which discusses how change comes to health care.36

Coverage and quality

A basic aspect of the quality equation is whether a payer is positioned globally to finance the array of treatments and practice and patient engagement supports identified in the literature as essential to improved performance.37 As the Commonwealth Fund points out, coverage is the first step in the quality improvement equation: not just any coverage but coverage that enables a health care system to deliver the right care in the right place and at the right time.

With its 27 separate service classes38 and its tests of reasonableness in coverage,39 Medicaid arguably offers an unrivaled platform on which to build comprehensive, integrated and high-performing health care delivery arrangements, particularly for patients with extensive health needs. By contrast, private coverage is constrained. Private insurance plans, including those sold through the new Health Insurance Marketplace, are configured by both public law and

38 42 U.S.C. §1396d
39 42 U.S.C. §1396a(a)(17); 42 C.F.R. §440.230(a)-(c)
contract to address a relatively narrow range of health care needs experienced by an essentially healthy population presumed to face none of the health and social challenges that characterize much of the Medicaid population. (Studies suggest that a portion of the premium subsidy-eligible population under the ACA shares these more extensive needs. At the same time, much of the newly eligible population is characterized by younger age and better health).40

The qualified health plans sold in the Marketplace can be expected to operate under a benefit design model that allows extensive treatment limits and exclusions such as fixed caps on days and visits, 41 treatment exclusions, and a medical necessity standard that emphasizes recovery rather than maintenance or avoidance of deterioration in function.42 Although a specified list of preventive benefits is covered without cost-sharing, people covered by qualified health plans can be expected to encounter considerable cost-sharing for the treatment of ongoing health conditions. Cost-sharing reduction assistance will help offset these expectations, but only for lower income populations and far less than completely. Nor is the Act’s non-discrimination clause in coverage of essential health benefits expected to alter this outcome, since the Administration has offered no standards for determining when, if ever, fixed treatment limits might be considered discriminatory against those with the highest burden of illness. Furthermore, while the ACA applies annual and lifetime limits to patients’ out-of-pocket expenditures, these limits are pertinent only to covered services, leaving patients exposed to the cost of medically necessary treatments that fall outside the scope of the contractual promise to pay.43

Unconstrained by traditional insurance coverage norms, Medicaid by contrast offers a potential financial basis for quality improvement that surpasses other payers in the health care market. To be sure, however, while Medicaid operates on a far broader plane than commercial insurance, the program has its limits, and these limits can complicate the task of improving quality for a high-need population. For example, substantial evidence suggests that a combination of medical care, social services, and supportive housing is essential to efficiency

40 Sommers B. and Rosenbaum S. 2011. Issues In health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs 30, 228-36


43 Federal regulation 45 C.F.R. §147.126, bars insurers and plans from imposing annual and lifetime limits. The interaction of this provision with the EHB provision actually is somewhat unclear. Specifically it is unclear whether the prohibition on annual and lifetime dollar limits effectively acts as an override of treatment limits during any enrollment year in the case of patients who reach the dollar limit. 45 C.F.R. §147.126(b) states that while plans can impose condition-based exclusions, if a plan offers any coverage for a particular condition, then the ban on annual and lifetime dollar maximums applies. At the same time, CMS FAQs issued in the wake of the December 2011 EHB Bulletin clarify that fixed treatment limits are permissible without qualifications tied to the ban on annual and lifetime dollar limits. (accessed October 25, 2013) (http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf)
and quality and reliance on community-based solutions to achieve better health outcomes for people with serious mental illness. But as the National Association of Medicaid Directors (NAMD) recently pointed out in comments to the Senate Finance Committee, short of a §1115-sanctioned federal demonstration, current Medicaid policy does not recognize supportive housing (or social services for that matter) as qualifying for federal payments, even in cases in which these essential services are part of a comprehensive quality improvement effort.44

Although Medicaid coverage parameters have their limits, they are broad. Furthermore, in recent years CMS has sought to remove some of the impediments to quality improvement that inadvertently were created by its own unnecessarily narrow interpretation of the law. One such example is the agency’s decision to revise the definition of what constitutes a covered preventive benefit.45 The revised definition broadens the categories of health professionals whose treatments can be financed through Medicaid, thereby enabling health care systems to add professionals with true expertise in the areas of health promotion, patient engagement, and patient communication. In testimony before the Medicaid and CHIP Payment and Access Commission, Cindy Mann, Associate Administrator for Medicaid and CHIP, indicated that her agency believes that it is important to identify other instances in which agency interpretations effectively stand in the way of progress on the quality front.

The ACA expands opportunities to reconfigure Medicaid coverage to better align with quality aims. The law enables the direct coverage of birthing centers, which are associated with improved quality for low income women. Another example can be found in the law’s efforts to expand the scope of preventive services coverage for traditional adult beneficiaries. Although the ACA (unfortunately) does not impose broader preventive services coverage requirements for all beneficiaries, it creates a modest financial incentive for states to align their preventive coverage principles for the traditional adult population with the evidence-based coverage standards applicable to the adult expansion population enrolled in Alternative Benefit Plans. Recent research suggests that the incentive is important, since comprehensive preventive coverage for the poorest adults appears to be lacking in many states.46

Provider qualification standards

Medicaid’s free choice of provider provision47 requires that states allow patients to obtain services from any qualified provider. But the corollary to this right is that freedom of choice extends only to “qualified” providers. As a result, the free choice provision simultaneously establishes the power of state Medicaid programs to establish reasonable, evidence-based provider qualification standards that in turn guide patients to providers and delivery systems

45 42 C.F.R. §440.130, published in final form, 78 Federal Register 42160,42306 (July 15, 2013)
47 42 U.S.C. §1396a(a)(23)
capable of high performance. To be sure, there are limits on this state authority to define the indicia of quality as a qualified provider regulatory standard, the most notable being a prohibition against criteria that arbitrarily exclude qualified providers from participation.\footnote{Planned Parenthood of Indiana v Commissioner of Indiana State Department of Health 699 F. 3d 962 (7th Cir., 2012)} Furthermore, the authority to use the power to define who is a qualified provider inevitably creates a tension between considerations of access on one hand and quality on the other. Given the relatively slow rate at which providers are moving to conform their practices to key, evidence-based indicators of health care quality. Considerable progress has been made but much remains to be done, as can be seen in the case of HIT adoption.\footnote{Furukawa M., Patel V., Charles D., Swain M., Mostashari F. (2013) Hospital electronic health information exchange grew substantially in 2008–12. Health Affairs 32: 1346-1354.} But there obviously comes a point at which the rigor of quality gives way to the reality of access, a dilemma that has plagued Medicaid since its beginnings.\footnote{Access problems are of course nothing new. Robert and Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid, Ch. 6. In the early years of Medicaid, for example, as the authors note, fewer than one-third of dentists, and fewer than half of all optometrists and podiatrists had signed up to participate. Pp. 98-99}

But it is important not to overlook states’ ability to move the field through the use of their power under Medicaid to define who is qualified to treat program beneficiaries. For example, a state might use its legal authority to limit participation among primary care providers to those providers that meet “health homes” criteria that emphasize the use of care teams, decision support tools, care coordination techniques, and patient engagement.\footnote{For a discussion of the key elements of high performance in primary care and practice readiness see Center for Health Care Strategies, Advancing Primary Care: Opportunities to Support Care Delivery Redesign in Practices serving Medicaid and Racially and Ethnically Diverse Patients (Robert Wood Johnson Foundation, August 2012) (Accessed online, October 18, 2013) http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261408} Similarly, a state might require, as a condition of participation, that all providers of primary health care for patients with serious and persistent mental illness either offer a specific range of mental health services or operate as part of a “collaborative care model” that using an evidence-based approach (supported by more than 70 randomized controlled trials), integrates physical and behavioral health services within a Medicaid health home model.\footnote{CHCS and Mathematica Health Policy Research, The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes (CMS, Health Home Information Center, May, 2013) (Accessed online October 18, 2013) http://medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf}

Payment reform

No other issue in health system improvement received more attention under the ACA than payment reform. Payment reform can be thought of as having two fundamental frames of reference. The first is payment approaches such as capitation and global payments that are designed to realign entire delivery systems and to better integrate delivery and financing. This type of payment reform has long been in use in Medicaid through managed care, which now...
accounts for some 60 million beneficiaries. The purpose of managed care is far deeper than simply reducing outlays; what we call managed care is really a strategy of rationalizing health care by creating budgets within which health systems operate and then combining those budgets with other organizational, oversight, and payment tools that can move the providers chosen to be part of the system.

The second type of payment reform is, as noted, meant to work at the point of service. Its purpose, through the use of explicit incentives tied to individual patients, conditions, or practice modalities, is to achieve a better outcome, both one patient at a time and across a patient population as a whole.

Payment reform at the macro level can be used to accelerate health system transformation by encouraging the integration of a fractured delivery system, in effect a re-assembly of disparate points of care into a structure associated with higher performance and quality improvement. The fact that Medicaid managed care has not achieved these results over the years on a large scale does not make the macro intervention a mistake; rather, it suggests the long road that lies ahead as payers, policymakers, and health care providers attempt to figure out what tools will actually work best. But re-assembly of delivery modalities into a more formal system of care that offers beneficiaries a focused point of entry as well as membership in an entity accountable for quality and outcomes is the crucial first step. As these large organizational changes have emerged -- first, for beneficiary populations whose health care needs tend to mirror those of the general population, and more recently, for beneficiaries with higher health needs – the health care system becomes more positioned for the dissemination of micro-level practice improvement changes coupled with payment incentives.

The macro level: ACOs, health homes, and other “integrated care models.”

The move toward greater clinical and financial integration is perceived as so fundamental to quality and efficiency and the achievement of the broad aims of the national quality strategy that lies at the heart of the law that the ACA empowers federal regulatory agencies to modify fundamental principles of antitrust and fraud and abuse in order to achieve these goals. Thus far, the agencies have addressed these issues only in the context of Medicare-funded practice transformation and contracting practices, although their rulings clearly have system-wide implications.

The removal of these regulatory barriers to integration and consolidation has enabled CMS to implement changes in Medicare payment structures and conditions of participation

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54 PPACA §3022

55 For an excellent discussion of legal issues in large-scale practice transformation under Medicaid see Bachrach, D., Bernstein, W., and Karl, A. 2012. High-Performance health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid (Commonwealth Fund) (Accessed online October 18, 2013) http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/High-Performance-for-Vulnerable-Populations.aspx The report reviews the key decisions that states will need to make as well as a series of strategic suggestions for addressing these decisions.
through the Medicare Shared Savings Program that in turn has given rise to the advent of Accountable Care Organizations (ACOs) as a new provider entity. The ACO movement shares many of the characteristics of managed care in the sense of its use of legal and operational tools to organize delivery. At the same time, unlike managed care, the propulsive force is not a third party payer (or administering entity) that attempts to form a practice network to deliver the benefits that are covered. Instead, the forward motion comes from health care providers that affiliate into larger delivery system entities that share joint governance, a more integrated and unified approach to practice, and the power to sanction or exclude members of the group that fail to adapt to its shared goals and practice approaches. In this sense, the ACO movement is one grounded in the traditions of health care rather than the traditions of coverage and financing.

With the exception of pediatric ACOs, the ACA did not formally modify the Medicaid statute to explicitly create this new type of organizational, delivery, and financing tool. But CMS has used its own inherent regulatory powers, coupled with the Medicaid statute’s basic managed care authorities, to create comparable opportunities for Medicaid agencies and providers. The expectation is that by broadening the organizational transformation tools available to Medicaid agencies, the federal government can help further speed the diffusion of delivery system re-alignment. The receptivity of agencies to these new macro quality improvement tools can be expected to be relatively high: the evidence suggests that in addition to the widespread use of traditional managed care, half of all states are pursuing financial alignment or health home strategies, both of which stem from basic managed care purchasing principles.

In broadening Medicaid policy to encompass ACOs, CMS has acted through its general policymaking powers as well as tapping into the CMMI to foster system integration demonstrations that emphasize Medicaid. From a formal legal perspective, CMS’s most important statement of policy to date can be found in a July 2012 State Medicaid Directors letter in which the agency introduces the term “integrated care models (ICMs)” as a concept that encompasses ACOs, “ACO-like models, and other health care delivery and financing models.” The letter effectively enables states to move in the direction of this model, either through direct contracts with emerging entities or via broader managed care arrangements that incorporate these entities into provider networks. In either case, CMS has strongly signaled its

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56 The ACA’s pediatric ACO provisions appear to have fostered the growth of ACOs, both integrated across specialty and single specialty practice. In some cases, the pediatric ACO expansion is driven by children’s hospitals, in others, by the move into pediatrics of general ACOs. More ACOs are forming, but challenges loom with narrower focus. ACO Business News 3:6 (2011) (Accessed online October 25, 2013) http://www.cmpcn.org/pcndocs/ABN0612.pdf

57 Watts, M.O., Musumeci M., and Reaves, E. (2013). How is the Affordable Care Act leading to Changes in Medicaid Long Term Services and Supports (LTSS)? State Adoption of 6 LTSS Options (Kaiser Family Foundation) (accessed online, October 18, 2013) http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf


59 Id. p. 1
interest in broader system alignment for all populations, not only those falling into the traditional managed care target group.

This signal in the Medicaid context parallels CMS’s active efforts to bring integration changes to Medicare by encouraging the growth of ACOs. With more than 250 Medicare-participating ACOs, some of which show remarkably high penetration into their local patient populations, it is natural that CMS would use its authority to attempt to generate the same level of interest in Medicaid. This “bottoms-up” policy shift, coupled with ongoing support for Medicaid managed care and CMS’s move to enable the use of Medicaid premium support models to bring the newly insured into privately-sponsored coverage arrangements tied to practice networks, are all evidence of the agency’s basic desire to steadily move the Medicaid health care environment into line with the rest of the delivery system.

The 2012 CMS letter establishes the ICM framework as a basic framework for Medicaid service delivery. In the spirit of federalism, the letter also creates state options with respect to organization, contracting, and payment (as noted, using existing Medicaid managed care authorities) that obviate the need to apply for federal waivers of otherwise applicable statutory and regulatory restrictions. At the same time, the CMS letter also clarifies the types of state strategies that would trigger the need for waivers, such as compulsory enrollment or the use of selective contracting approaches in which only certain qualified providers are invited to participate in the state program.

The reform directions identified in the CMS letter envision organizational models powered by payment structures that support clinical services (whose scope would be defined by each state), practice support, and a range of patient support services encompassed under the rubric of care coordination. CMS’s implementation approach allows states to use this flexibility in various ways: relatively modestly to focus on advanced primary care and health homes; or more sweepingly to spur formation of more fully integrated delivery models (e.g., medical and clinical practices aligned with hospitals, pharmacies, and a full range of health care professional services). To the extent that states desire more comprehensive risk transfer models, the CMS letter reiterates the need for compliance with the law’s more extensive requirements related to managed care organizations.

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60 For an excellent discussion of state strategies for integrating their own efforts with those of Medicare in the case of ACOs see Bachrach, D., Bernstein, W., and Karl, A. 2012. High-Performance health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid (Commonwealth Fund) (Accessed online October 18, 2013) http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/High-Performance-for-Vulnerable-Populations.aspx The report reviews the key decisions that states will need to make as well as a series of strategic suggestions for addressing these decisions.


62 42 C.F.R. §435.1015
The micro level: provider payment incentives

At the individual provider level, the Medicaid statute affords states considerable flexibility to fashion incentive payments to promote specific types of clinical performance in accordance with evidence-based quality improvement metrics, as well as practice reforms such as adoption and meaningful use of health information technology.

With respect to the adoption and use of electronic records systems, all states have responded to HITECH, enacted as part of the American Reinvestment and Recovery Act (ARRA). The HITECH Medicaid amendments enable (but do not require) states to implement EHR incentive programs that finance both the adoption and meaningful use of health information technology. Information available at the CMS website as of October 2013 shows 50 states, the District of Columbia, and Guam as having programs in place. Reflecting the emphasis on state variation that characterizes Medicaid, CMS notes that states can set their own timelines for both launching programs and moving through the stages of meaningful use, meaning that states can be expected to show variation in the rate of adoption as well as the scope and quality of data exchanged and collected.

Importantly, ARRA did not extend the adoption and meaningful use program to critical parts of the health care delivery system such as long-term care institutional and community-based programs, certain types of essential community providers such as Title X family planning program and Ryan White Care Act clinics, school-based health care providers, or state and local public health agencies delivering clinical services. The extent to which state agencies and these other providers have moved ahead with adoption and meaningful use for other parts of their delivery systems, by employing other sources of funding (e.g., grant programs, state-financed investments) is not clear.

The Role of the Centers for Medicare and Medicaid Innovation

In terms of payment reforms aimed at rationalizing care at the provider level, such as payment bundling and the use of episodes-of-care payment arrangements, states -- as well as providers of special importance to the Medicaid population -- also have shown strong evidence of participation. Through the Center for Medicare and Medicaid Innovation, the ACA established a series of special demonstration programs whose purpose is to test different payment approaches for select populations. The CMMI website shows the range of models undergoing development and early testing stages, including the State Innovation Model program aimed at improving quality and reducing costs for Medicaid and CHIP).
In its 2012 Report to Congress,65 CMMI reported that over 1 million Medicare, Medicaid and CHIP beneficiaries were (or would “soon be”) receiving services from participating providers, whose number was estimated at 50,000. (CMMI also noted that as of the end of 2012, its demonstrations were in too early of a stage to lend themselves to evaluation for their impact on cost and quality).

Several initiatives overseen by CMMI are particularly worthy of note because of their implications for the quality of care for the Medicaid patient population. Chief among these demonstrations is the Strong Start initiative, aimed at reducing early elective deliveries while enhancing prenatal care. The initiative, which encompasses both strong educational efforts to reduce early elective deliveries and enhancements in prenatal care to reduce the risk of pre-term births, reaches nearly 4000 participating institutions. The prenatal care enhancement component specifically tests payment models aimed at peer-to-peer facilitated group appointments, enhanced prenatal care through birth centers, and enhanced prenatal care in “maternity homes.”

Another model, one aimed at a provider group whose performance is of particular importance to Medicaid, is CMMI’s Federally Qualified Health Center Advanced Primary Care Practice demonstration, which entails a special version of the health home practice model. FQHCs serve approximately one in ten Medicaid beneficiaries, and data that all health centers must report to the federal government as a condition of grant funding arguably represents the one national, uniform glimpse into the question of health care quality for low income people.66 The FQHC Advanced Primary Care Practice demonstration, a multi-year, multi-faceted improvement effort, reaches 500 health centers in 44 states.

A third CMMI model is actually a suite of models aimed at the dually enrolled populations. These models focus on care integration, Medicare/Medicaid alignment, and a special initiative to reduce preventable hospitalization among beneficiaries. These special CMMI models (with joint involvement by the Medicare-Medicaid Coordination Office) have attracted multiple states, especially in the case of integrated care and preventable hospitalizations among nursing home residents. In each case, payment reforms are coupled with a focus on practice improvement in order to both improve the quality of care and reduce overall costs to both programs.

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education-demonstration+independence-at-home-demonstration+innovation-advisors-program+pioneer-aco+strong-start-for-mothers-and-newborns-initiative (Accessed online, October 18, 2013). The interactive map indicates both pre-testing and functional models in the following areas: health care innovation; incentives for the prevention of chronic disease; Medicaid emergency psychiatric demonstration; multi-payer advanced primary care; state innovation models (design, model pre-testing, and model testing);

65 (Accessed online, October 18, 2013) http://innovation.cms.gov/Files/reports/RTC-12-2012.pdf

Performance measurement and reporting

Quality measurement generally. As a general matter, and regardless of payer, broad-based quality measurement and public reporting are in their infancy. The ACA seeks to push these quality tools along by establishing public quality reporting on health plans as a core activity within the new Health Insurance Marketplace. Individual state Medicaid agencies also have placed greater emphasis on consumer engagement through public reporting.

Under both CHIPRA and the ACA, national core quality of care measures have now been developed for children and adolescents as well as adults, CMS has coupled these measures with demonstration grants to assist states in implementation.

Health disparities have long been identified as a measure of quality, not simply a measure of inequality, and a good deal has been written on using race and ethnicity data to measure the quality of care to Medicaid beneficiaries. The ACA heightens the focus on race and ethnicity data as an aspect of quality performance measurement, and HHS in 2011 released federal data collection standards as part of this effort to foster the use of such data. A number of Medicaid health plans have used these data to examine trends in care, as have Medicaid agencies.

Of course, all of these data collection and reporting activities – whether on health system performance for children and adults or in the context of disparities measurement, are voluntary. At the same time, there is evidence of widespread state interest in moving to a more national approach to quality measurement. For example, although state quality of care reporting for children and adults is voluntary, as of 2013, all states and the District of Columbia were voluntarily reporting two or more quality measures for children, with a median number of measures reported standing at 14, double the 2010 number of 7. The 2013 Report on the Quality of Care for Children shows further advances in CMS’s and states’ ability to conduct in-depth quality measurement across both the Medicaid and CHIP programs. At the same time, the high level of state variability in the completeness of reporting (22 measures each reported by Florida and Tennessee, compared to 2 measures reported by Nebraska, South Dakota, and Wisconsin) underscores the degree to which uniform, national reporting on core measures of population health are lacking in Medicaid.

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While progress has been made on Medicaid quality reporting in relation to the general population, the Medicaid and CHIP Payment and Access Commission (MACPAC) has concluded that disability remains an area in which information on quality of care is extremely limited. The task of measuring the quality of care for patients with complex needs is a challenging one because of the inevitable limitations of widely accepted quality measures in terms of their utility in measuring quality for people with multiple health conditions. This is not to say that all measurements are complex; for example, it is no less important to know whether women with multiple physical and mental disabilities are receiving cervical cancer screening. Nonetheless, the challenges that come with disability translate not only into unique delivery system considerations but also into the task of measuring performance. Some states have focused specifically on this question.

The absence of a robust system of quality measurement for people with disabilities can, according to MACPAC, be attributed to several factors: the difficulty of identifying patients with disabilities; the lack of accurate or meaningful measures of quality in the context of disability; and the fact that many of the health care delivery arrangements relied on by the patient population (e.g., long term care institutions, home health agencies, supported housing, special needs plans, and other specialty care providers) have not received the type of attention needed to develop comprehensive performance management tools, much less put them into wide use. Nonetheless there are signs of some progress. For example, CMS aims to expand on its performance reporting system for special needs plans using a combination of HEDIS measures and structure and process review. Similarly, the state of California, in its effort to expand the use of managed care into the population of beneficiaries with disabilities, has moved aggressively through its contracting processes to put a more robust quality measurement and improvement strategy into place.

In the case of comprehensive managed care contracts, quality reporting is not optional. Performance review and measurement is a federal requirement, although MACPAC has found that reporting, and enforcement vary widely among the states. Because of this high variability in scope and quality, as MACPAC has noted, it is very difficult to compare states, and national survey systems are quite limited in their sample size, the lag time between performance, performance measurement, and reporting, and the limited range of measures that are reported. An informal MACPAC questionnaire administered over the 2010-2011 time period found that states use a broad array of techniques for monitoring plan performance. Although MACPAC


Moses K., 2012. Raising the bar: how Medi-Cal strengthened managed care contracts for people with disabilities (California Health Care Foundation)

Medicaid and CHIP Payment and Access Commission, Report to Congress (June 2011) Section e.
characterizes the monitoring activities as focused on access, many can be characterized as quality monitoring as well. Examples include complaint monitoring through telephone hotlines, regular communication with system stakeholders, review of utilization data, contractual performance standards, and the use of HEDIS and CAHPS data (whose use is not a federal requirement), and other techniques. The National Committee for Quality Assurance reports HEDIS data nationally, but as MACPAC points out, the data are limited as a result of the methodology (e.g., some measures depend on 12 months’ continuous enrollment) and the small number of measures that are employed as a result. According to CMS, as of 2012, 29 Medicaid programs either required or recognized NCQA accreditation. Of these, 11 states and DC required accreditation of managed care plans using HEDIS measures. In 2011 24 states and the District of Columbia required Medicaid and HEDIS measurement, while 17 states required neither.

External quality review of managed care performance is a requirement of all comprehensive risk-based managed care arrangements. External quality review is designed to measure the quality, timeliness and accessibility of care and must be accompanied by recommendations for improving the quality of services as well as an assessment of plan progress in addressing previous EQRO recommendations. In recent years CMS has made significant improvements in the extent to which state EQRO reports are available for public inspection and analyzed by the government as part of Medicaid quality oversight.

At the same time, challenges remain. MACPAC notes that federal flexibility regarding what states review mean that it is not possible to compare results across states. An extensive review of EQRO in the context of pediatric quality conducted by Mathematica Research for the Commonwealth Fund in 2005 identified numerous recommendations for improving the quality of information about pediatric and adolescent health care quality performance in managed care, but it is unclear whether the recommendations have been acted on at the state level. In 2012 CMS, which maintains a specific EQRO website where managed care quality reports can be viewed, announced a new initiative to improve the quality and depth of the EQRO process, including an updated State Quality Strategy Toolkit, revised CMS protocols, and toolkit supports for EQROs.

To the extent that utilization functions as a basic measure of quality, it is important to note MACPAC’s finding in 2011 that while all states required managed care plans to collect encounter data, many states did not report it to the Medicaid Statistical Information System (MSIS), and among those that did, the quality of the data was unknown. CMS reported to

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79 Personal communication with Dr. Marsha Lillie-Blanton, CMS.
80 42 C.F.R. §438.310
83 (Accessed online October 18, 2013)
MACPAC an initiative to improve the rate at which such data were reported and the quality of
the data received.

In 2013 CMS announced an initiative known as the Medicaid and CHIP Business
Information Solutions (MACBIS). This initiative, whose statutory roots can be found in the
Balanced Budget Act of 1997 but which was given a boost under the Affordable Care Act,
entails a number of steps, including a major upgrade to MSIS, which is to be renamed
Transformed MSIS or T-MSIS. According to CMS, T-MSIS will enable improved
programmatic and financial management, “more robust” evaluation of demonstration programs,
and assessments of critical aspects of the health care quality landscape, including beneficiary
attributes in health care encounters as captured in claims, the performance of providers, the
characteristics of enrollees, and the ability to monitor trends over time.

Patient engagement

From its enactment, Medicaid has required states to operate their programs in the best
interest of program beneficiaries. Crucial to this special fiduciary responsibility are efforts to
enhance patient access to clear, accessible, and understandable information about treatment
options, the opportunity for meaningful engagement with their providers. These considerations
of course extend beyond Medicaid; the meaningful involvement of patients in their care is
fundamental to basic notions of personhood.

The fundamental importance of involving low income and medically underserved
patients in care can hardly be overstated. A recent patient survey of low income California
residents conducted by the Blue Shield of California Foundation reports that less than 30 percent
of patients believe they have the information they need to make informed choices about their
health care and that 70 percent of those surveyed are eager for more – and more reliable --
information from their providers and other trusted sources. In other words, low income patients,
like any patients, value engagement in health care and seek the support necessary to make such
engagement possible.

In a recent initiative aimed at improving the health literacy of Medicaid and low income
patients, the Center for Health Care Strategies notes the proven value of certain solutions,
including the use of print, oral and electronic information prepared at the fifth-grade reading
level, provider education to improve literacy skills, and introduction of the types of reforms
found in the Health Home and advanced primary care practice demonstrations that aim directly
at reform of the care delivery system to make care more patient-centered.87 The move toward

84 See State Medicaid Directors Letter #13-004 (August 23, 2013) describing the initiative
2013)


86 Canterbury v Spence 464 F. 2d 772 (D.C. Cir., 1972)

87 Center for Health Care Strategies, 2013. Health Literacy Factsheet Series (Accessed online October 18,
2013) http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711#.UmAleNJQE30
greater patient centeredness includes assessment of literacy, the strengthening of cultural competency within the health care system (including the dissemination and adoption of national standards for culturally and linguistically appropriate services (CLAS)) through techniques such as improved provider-patient communication, care management, improvements in the quality and understandability of health information, and improvements in workforce training.

The ACA advances the theme of patient engagement through the introduction of strategies to improve the quality and accessibility of health information. Part of the CMMI suite of demonstrations, described in its 2012 report, is a special affiliation with the Partnership for Patients, to disseminate evidence of best practices aimed at reducing complications and speeding the healing process through practice improvements that include patient engagement and supports.

Concluding Thoughts and Areas of Further Research

This review of Medicaid and quality underscores the extent of progress toward achieving the program’s original vision as a mechanism for funding high level performance, as measured by coverage and payment across the spectrum of health care need, system integration, use of quality improvement technologies such as HIT, performance measurement and reporting, and patient engagement. These advances have occurred even as Medicaid has faced three major challenges: its perception as a program in which investment in quality improvement is questioned as less than a worthy endeavor; the challenges created by federalism; and the immense challenge of attempting to introduce quality improvement techniques in a rapidly changing health care system. Integration is now well under way. Moreover, the states and the federal government have reached various accords regarding the use of health system improvement tools, including comparative performance reporting across the states. Finally, even as the health care delivery system lurches into its new formation, the system appears to be embracing the idea that techniques for improving the quality of patient care and the health of populations can and should be internalized across care settings.

Much work remains to be done, and the urgency of research into health care quality improvement has never been greater. Some areas for further research are as follows:

First, given the enormous importance of the state role in quality improvement, what do states feel they need to improve quality? A recent Kaiser Family Foundation Study that examined managing Medicaid to improve performance notes the fundamental importance of adequate administrative capacity across all aspects of the program, including quality of care. What do agencies view as the biggest challenges to quality they face? Do agencies believe they have the tools they need? What resources – both human and financial – are necessary to

maintaining high performing quality oversight, and where do agency leaders believe that the greatest investments, both federal and state, are important at this point?

Second, in what directions are states headed, and how are these directions working? The opportunities to engage in health system transformation have never been greater. How effective are the macro tools of quality improvement – coverage design and the purchase of health care delivery systems – working? How are states combining different tools for different populations? What factors might lead a state to remain with traditional managed care contracting options or to introduce new structures such as ACOs and health homes, and for which populations?

A third area is coverage limits. What state options appear to be key to health quality and yet not taken (such as adult dental care)? What might induce change? Relatedly, what types of quality of care investments are barred by limits on what Medicaid will cover and pay for on both the medical assistance and administrative side of things? Should Medicaid agencies, under certain circumstances, be permitted to invest in interventions aimed at improving health even though they address the social conditions of health rather than clinical care per se? For example, under certain circumstances should supportive housing be fundable? These same questions were asked more than 30 years ago in the context of home modifications and respite care for children and adults with severe disabilities, who were being cared for in community settings. This issue also arose in the context of child health some 15 years ago, when the state of Rhode Island was given permission to use Medicaid funds under its §1115 demonstration to remove lead hazards. Given the evidence regarding the interaction between life circumstances and health and the difficulty of achieving good health outcomes – even with high quality health care – for a population facing serious health barriers, should a broader set of interventions be permitted? How is §1115 being used today to foster the integration of health and health care? This issue is very much on the minds of Medicaid agencies as can be seen in New York State’s interest in supportive housing under its transformation proposal.

Patient engagement is a fourth key area. Much attention has been given to the use of higher patient cost-sharing to advance an improved relationship between beneficiaries and the health care system, in the belief that improving this relationship depends on having “skin in the game.” Yet for the poor, “skin in the game” translates into insurmountable barriers to health care, and cost-sharing can simply result in reduced revenues to key health care providers that have a mission or legal obligation to treat the poor. Given the recent findings by the Blue Shield Foundation of California regarding patients’ hunger for a strong relationship with a health care provider and reliable information – both of which are essential to quality, what might be done to advance patient engagement on a larger plane? This is an especially important issue given the simultaneous pressures on providers to increase productivity and the attendant time pressures that result from intense and time-driven practice metrics. Do we need additional measures of patient engagement? Can patient engagement techniques produce good results (such as adherence to treatment plans) even when additional pressures on the provider/patient relationship are not present, such as heightened cost-sharing?

A fifth key area is the experiences of safety net systems, which continue to play an outsized role in Medicaid. Studies of safety net care tend to show a mix of quality performance
and performance shortcomings. What barriers to quality improvement do community health centers, Title X-funded family planning clinics, children’s hospitals, nursing facilities and home health agencies, and public hospitals and health systems experience? Do the barriers relate to funding? To the lack of knowledge about best practices? To competing demands such as the tension between near-term cost reduction and investments that produce long-term improvements in health and health care? How might Medicaid work more closely with these systems to improve quality, considering its dominance as a payer?

Finally, in light of the fact that with some notable variations, Medicaid shares a common system with other health care payers, what might be done to move multi-payer strategies forward? This issue takes on added urgency given the alignment across markets necessitated by the establishment of the new Health Insurance Marketplace and the inevitable transitional challenges that this new marketplace creates. These are of course good challenges to have; previously, an end to Medicaid coverage spelled an end to insurance in most instances. Now, multiple payers have a real opportunity to maintain the connection between patients and health care regardless of who is paying the bill at any given moment.

What specific considerations arise in making Medicaid a more valuable partner? Do its payment discounts inevitably undermine its ability to participate in a multi-payer network that can work in tandem to move the delivery system in a more uniform way? Will adoption of a common core of quality reporting requirements be sufficient to overcome the problem of Medicaid’s relative isolation or might additional steps be taken?
Does Medicaid Improve Health? Lessons from the Past and Recommendations for the Future

Robert Kaestner

Introduction

There is a longstanding debate over whether health insurance, private or Medicaid, and the greater use of medical care that comes with it, improves health. Related to this issue is the equally important question of whether there is substantial waste in the U.S. health care system. If greater use of medical care that stems from gaining health insurance coverage has little effect on health, then this is evidence of an inefficient health care system that can benefit from reform. The public interest in the debate is passionate, as illustrated by the lively discussion that followed the publication of the results from the Oregon Medicaid experiment (Finkelstein et al. 2011; Baicker et al. 2013). The debate is likely to be refueled by a new round of research results from the many studies of the effect of the expansions of Medicaid under the Affordable Care Act (ACA) that will undoubtedly be conducted. Results from analyses of the effect of Medicaid on health from forthcoming studies of Medicaid expansions will become either a “smoking gun” of a problem with Medicaid, or more generally, the entire health care system, or a confirmation of the importance of health insurance and the need to keep everyone, particularly the economically disadvantaged, well insured.

An interesting question is why past research hasn’t already answered the question of whether Medicaid improves health. After all, Medicaid started in the mid-1960s and has been

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90 This paper was partly supported by funding from Indiana University and an early version of the paper was presented at a conference on November 3, 2014 at the Urban Institute and sponsored by Indiana University and the Urban Institute.
expanded several times in recent decades. There has also been a substantial amount of research, but that research has not resolved the issue (Levy and Meltzer 2004; Kronick 2009; McWilliams 2009). The answer lies in the fundamental difficulty of the empirical exercise that is needed, which is to compare the health of those with and without Medicaid. Unfortunately, these two groups differ in many ways besides whether they have Medicaid and these differences confound the association between Medicaid coverage and health. Solving the problem is extremely difficult, which underscores why the two experiments examining this question, the RAND Health Insurance Experiment and the recent Oregon Medicaid experiment, rightly received so much attention and weight in the policy debate. In both experimental studies, the evidence suggests that gaining health insurance coverage, private in the case of RAND and Medicaid in the case of Oregon, had few health benefits. While these studies represent the gold standard from a research perspective, the results of the experiments have not laid the question of the effect of health insurance (Medicaid) on health to rest largely because of a lack of external validity. The RAND study was conducted in the 1970s in six cities and included approximately 2000 families. The Oregon study took place in 2008 in, unsurprisingly, Oregon and was limited to 10,000 adults with incomes below the federal Poverty line.

The debate over whether Medicaid will improve health will undoubtedly continue and the expansions under the ACA will be the focus of much future research. While some of that research may be experimental, although I know of no current efforts to exploit the ACA Medicaid expansions in this way, most of the research will be non-experimental and similar to the type of research that has predominated in the past. The fact that a relatively voluminous amount of past research has not resulted in a definitive conclusion suggests that the approaches used in the past have not been particularly productive. In this article, I provide a brief assessment
of past research and the implications of that research for future study, and recommendations for research going forward. The hope is that my assessment will help to generate new and better research on this important health policy question.

An Important Fact

“Well, the 40 million uninsured, most of them actually won't get sick in any given year. So it's not a problem. Those who do get sick, if they are mildly sick, ah, we let them fend for themselves. If they can afford to go to the doctor, fine. If not, they don't go. When they get really critically ill where it's life-threatening, they have a right, by law, to go to the nearest emergency room. And the emergency room, the hospital is obliged to stabilize them and to take care of them. And so ultimately there is a universal catastrophic insurance policy in force in this country, and it is the emergency room of your neighborhood hospital.” (Uwe Reinhardt)

“One of the things that strikes me when I look at the data is that uninsured people in this country actually get a phenomenal amount of care. The average uninsured person in the United States gets as much care as the average Canadian in dollars. We spend a huge amount of money on these people.” (Sherry Glied)

“I believe if you're poor, you are usually able to get, a fair amount of care, a lot of care in some cases, some of which is very good, some of which is not.” (Gail Willensky)

These three quotes from well-known health policy experts from different sides of the political aisle come from a 2000 Public Broadcasting System (PBS) special entitled Health Care Crisis: Who’s at Risk?91 All of the quotes note the fact that the uninsured often get a substantial amount of care. I verified this fact by measuring the extent of care that the uninsured receive (vis-à-vis the insured) using data from the National Health Interview Survey (NHIS) for the

91 http://www.pbs.org/healthcarecrisis/index.htm
years 2000 to 2009. I focus on a sample of low-educated (High School Degree or less), unmarried persons between the ages of 18 and 64 because this is the demographic group that represents the overwhelming majority of uninsured persons in the US, and a group likely to be significantly affected by the Medicaid expansions. Using this sample, I compared the use of health care for those with and without health insurance.

Table 1 reports sample means by whether a person had health insurance—either public (Medicaid) or private. As the figures in Table 1 indicate, the uninsured consume approximately 60% to 70% of the amount of health care than those who are roughly comparable according to demographic characteristics, but privately insured. The same uninsured-insured differences in the use of services apply if I limit the sample to those in relatively poor health (right hand panel of Table 1). Notably, the uninsured reported about the same level of general health, but approximately 20% fewer bed days than the insured. The estimates in Table 1 are broadly similar with findings from other studies who conducted similar analyses (e.g., Decker et al. 2013) and the experimental analysis in Oregon.92 In fact, evidence from the Oregon Medicaid study indicates that gaining Medicaid increased the probability of seeing a doctor by 37%, increased the number of doctor visits by 57%, and increased the probability of a hospitalization by 31%. These increases in the use of services are not that much different than those implied by estimates in Table 1.

Implications of the Descriptive Evidence

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92 Decker et al. (2103) presented a comparison of the uninsured to those on Medicaid and reported similarly high rates of health care usage among the uninsured. One notable difference between that study and figures in Table 1 is that those on Medicaid are in worse health than the uninsured. However, the Medicaid expansions of the ACA are likely to affect a somewhat healthier population than the current Medicaid population.
While it is possible that the exact magnitude of the estimates are off a little, figures in Table 1 and evidence from other studies, suggest that gaining insurance will increase the use of services somewhere between 25% and 66%. What can we expect in terms of changes in health in response to these increases in care, remembering that the starting point for the increase is a relatively high level of care?

First, it is important to recognize that not all the increase in the use of services that comes with insurance coverage will be effective because of financial incentives to over use care for both the consumer and the provider. Thus, some portion of the additional care is expected to have little effect. Indeed, the over use of health care services is often viewed as one of the major problems of the US health care system (see Dartmouth Atlas for a comprehensive treatment of this hypothesis) and there is no reasonable expectation that state Medicaid programs that expand under the ACA will somehow manage to avoid this problem.

Second, most behavioral theories suggest that uninsured persons, perhaps in consort with their providers, would use the most effective care. Consider the evidence on this point reported in the Oregon Medicaid study (Baicker et al. 2013):

- 72% of the Oregon sample with high Cholesterol was diagnosed without insurance.
- Among the uninsured (control group) 40% more people were using medication to treat high Cholesterol than were diagnosed with high Cholesterol (evidence of overuse even among the uninsured).
- There was a significant increase in the use of medication to treat high Cholesterol, but no change in Cholesterol levels.
- 76% of the Oregon sample with Hypertension was diagnosed without insurance.
Among the uninsured (control group) twice as many people were using anti-hypertension drugs than were diagnosed with hypertension.

There was no significant increase in the use of medication to treat hypertension and no significant change in blood pressure.

Similar evidence as above was reported by Decker et al. (2013) who compared those with Medicaid to those uninsured using data from the National Health and Nutrition Examination Survey (NHANES). However, in that paper, the authors also examined behavioral health and reported that relative to the uninsured, those on Medicaid were more likely to be obese, smoke, drink, and use drugs, and less likely to exercise. While many of these differences may be unrelated to insurance status, there is a possibility that insurance worsens health behaviors because of the availability of relatively cheap medical care and pharmaceutical treatments. In addition, Decker et al. (2013) reported that those on Medicaid were much more likely to be diagnosed with hypertension and diabetes (but not high cholesterol) than those who were uninsured. In the case of hypertension, which is treated with medication, those on Medicaid were also much less likely to have uncontrolled hypertension. In contrast, there was virtually no difference between those on Medicaid and those uninsured in the percentage of persons with uncontrolled diabetes, which has a much greater behavioral component required to achieve a state of controlled disease. Similarly, results from the Oregon Medicaid experiment show that gaining Medicaid increased use of medication to treat diabetes by 84%, but that this increase resulted in no change in glycated hemoglobin.
Overall, these figures suggest that the uninsured are obtaining a substantial amount of care including care that is deemed most effective. In addition, the evidence suggests that insurance will have little effect on health behaviors and may even worsen health behaviors. Therefore, gaining health insurance coverage may have relatively small effects on health, and will largely be ineffective at improving aspects of health that largely depends on health behaviors. The implications of this evidence are that future studies should focus on populations and contexts in which the uninsured are using substantially less care than the insured so as to maximize differences in treatment. In addition, studies should focus on outcomes most amenable to medical treatment because it is unlikely that insurance will change health behaviors and may even worsen them, so outcomes largely dependent on individual behavior, as opposed to medical/pharmaceutical intervention, are unlikely to be affected by Medicaid. While these conclusions may seem obvious, even a cursory review of the literature finds many studies that have done just the opposite.

We Need to Update Our Assessments of What is Known

The debate over whether Medicaid (private insurance) improves health often devolves into a debate over the evidence. While I may not be sufficiently objective, my reading of the evidence is, at a minimum, that past study has not provided adequate evidence to know the answer, or more assertively, that existing evidence indicates that Medicaid has little effect on health (I can hear the groans of disgruntled readers). Here, I will critically assess a few of the articles often cited to support the argument that Medicaid improves health to substantiate my claim. While it is a selective review, it includes prominent studies that are widely considered to be some of the best in terms of research design.
One of the best places to start is with the studies by Lurie et al. (1984, 1986), which are perhaps the most widely cited articles (perhaps because of the publication date) to bolster the claim that Medicaid improves health. These analyses examined the effect of disenrollment from Medicaid on hypertension. Regardless of the quality of this study, which I will assess shortly, the relevance of this study to current (or even past) debate over the effect of Medicaid on health is questionable. Changes in hypertension among 180 poor, older (average age 48), largely black (55%) and female (70%) patients at one UCLA clinic in 1982 are likely to tell us little about the association between Medicaid/insurance and health in recent periods, particularly what will happen in ACA. For this reason alone, this article should take a back seat in the research debate. Moreover, there are legitimate questions about the internal validity of the study. The comparison group was older and sicker than the treatment group, approximately half of the treatment group regained insurance by the one-year follow up, and half of the treatment group received treatment at 6 month follow up for ethical reasons. Overall, the small samples, narrow geographic context, and lack of a strong research design suggest that the evidence in these articles should be interpreted cautiously.

Another set of studies that are often cited as evidence of the health benefits of Medicaid are those by Currie and Gruber (1996a, 1996b). These two studies examined the effect of Medicaid on infant and child health. These studies were carefully conducted and were the first to exploit the “natural experiment” of the 1980s and 1990s Medicaid expansions to answer the important question of whether Medicaid expansions improved health. These two studies spawned a cottage industry of “difference-in-differences” studies of the effects of the Medicaid expansions on many outcomes. These studies deserve much credit and represent a significant advancement of health services research because of the insight to use the changes in Medicaid
policy and the research method. Unfortunately, the “natural experiment” turned out to be not such a good experiment, and therefore, there are legitimate questions about the credibility of the findings from these two studies. Consider the sensitivity analyses conducted by Currie and Gruber (1996a). When state maternal and child health spending were included in the regression model, the estimate of the effect of Medicaid eligibility on low birth weight increased by a factor of five (532%). Clearly, something else was changing in states that expanded Medicaid, which was arguably unmeasured, that was also related to infant and child health. Indeed, many studies have shown that the Medicaid expansions of the 1980s and 1990s were not an ideal “experiment” and results from studies that exploited these changes were quite sensitive to model specification (e.g., Card and Shore-Sheppard 2004; Shore-Sheppard 2008). The lack of a true experiment, the sensitivity of estimates to model specification and the sometimes implausibility of the magnitudes of the effects of these studies should lessen the weight these studies receive in assessing the evidence.93 Clearly, they are not definitive.

While not related to Medicaid, another set of studies that are often cited as evidence that health insurance improves health are those by Card et al. (2008, 2009) who study the effect of gaining Medicare at age 65 on hospitalization and mortality. However, the authors of this study are clear that the findings of the study should not be cited for this reason:

93 Estimates in Currie and Gruber (1996b) imply large, arguably implausibly so, effects of gaining Medicaid coverage on child mortality. Specifically, estimates indicate that a one percent increase in the proportion of children gaining Medicaid coverage reduced the probability of child mortality from internal causes by 2.3 percent.
“The magnitude of the estimated mortality effect of Medicare eligibility is too large to be driven solely by changes among the 8% of the patient population who move from no insurance coverage to Medicare when they reach 65. …Instead our findings point to a more widespread effect of Medicare, including an impact on patients who were insured prior to 65. Given the relatively modest increases in the intensity of treatment we measure at age 65, however, we conclude that the actual mechanism of this effect is unclear.” (Card et al. 2009)

This quote from authors is explicit—the effect found is not solely the result of an insurance-induced shift in demand resulting in greater use of health care and improved health. Indeed, the authors do not even speculate on what may be the cause pointing to “…a more widespread effect of Medicare…” with a “…mechanism that is unclear.”

There are other important articles that are often referred to in the debate over whether Medicaid improves health that I do not review, but none are so compelling that the results would sway the debate toward a conclusion that Medicaid improved health. Indeed, even the recent Oregon Medicaid experiment leaves the question largely unanswered because of the lack of statistical power that characterized the study. For most outcomes, the study did not have the power to detect reliably even moderately sized effects (e.g., 25% effect size). As noted previously, given the considerable amount of care received among the uninsured, large changes in health outcomes as a result of gaining insurance coverage are unlikely. In sum, the extant literature simply does not much provide evidence to support the hypothesis that Medicaid improves health. While it may be true, past research has not established this fact, at least in my opinion. One important explanation for this state of the literature is the difficulty in studying the problem. While more experimental study would be welcomed, there are likely to be few
experimental studies of the effects of the ACA Medicaid expansions on health. So studies of this issue need to learn from the past.

**Some Lessons for Researchers from Previous Literature**

**Difference-in-differences**

It is likely that much of the forthcoming research will use a difference-in-differences (DiD) approach because of the gift bestowed on researchers by the Supreme Court decision that allowed states to opt out of the Medicaid. If the past is a guide to the future, then future studies of the effect of the ACA Medicaid expansions will have to do more than simply group states into two by whether they expanded Medicaid and conduct a DiD analysis. Past Medicaid expansions have not resulted in very good “natural” experiments and as problems in the past literature have evidenced, model specification and choice of comparison group have been important empirical problems to address. These problems are likely to characterize future difference-in-differences studies too, and to be credible, future studies need to address these problems effectively.

First, future studies should adhere to what is now widely viewed as best practice and assess whether the underlying assumption of the DiD research design of equal pre-policy trends for the treatment and comparison states is valid. Two good examples of this are studies of the Massachusetts reform by Courtemanche et al. (2012) and Miller (2012). These studies document that pre-pre-policy trends between the treatment and comparison groups are equal. They also conduct falsification tests using groups that are unaffected by the policy reform to assess whether contemporaneous (to policy change) trends differ between the treatment and comparison groups.
Second, future studies should put more effort into choosing appropriate comparison groups, for example, by making use of the procedure developed by Abadie et al. (2010). This approach selects comparison states based on statistical criteria that have a conceptual justification related to the identifying assumption of the research design. Briefly, Abadie et al. (2010) develop a method to form a comparison group using a weighted average of potential comparison groups (e.g., states) where the weights reflect how good of a comparison a specific group is to the treatment group. The “quality” of the match, or the weight, is based on pre-trends in the outcome variable. While this procedure is relatively easy to implement, particularly because there is statistical software for it, other simpler procedures may also be useful (Dubay et al. 2012; Callison and Kaestner 2013). All of these procedures involve matching the treatment state to comparison states on the basis of baseline characteristics. While none are perfect, they provide a leg up on meeting the key assumption of the DiD approach of equal trends. If baseline characteristics of treatment and comparison states are similar, and/or if pre-trends between treatment and comparison states are similar, then there is more likelihood that the contemporaneous trends that span the implementation of Medicaid expansions will also be similar (in the absence of any policy change).
Third, future studies need to acknowledge that it is sometimes difficult to separate shifts in supply from shifts in demand in response to Medicaid expansions. Consider that some argue that reform in Massachusetts, which affected a small portion of the population, brought forth a change in supply. If so, then ACA-related expansion in Medicaid and other changes that focus on the supply side may have substantial effects that may be confounded with expanded participation in Medicaid. While supply and demand shifts are part of “insurance” effect, we usually think of insurance effects as demand side explanations, and this is the effect that most researchers believe they are identifying when conducting difference-in-differences analyses of the effect of Medicaid. However, the quote from the Card et al. (2009) paper illustrates the potential pitfall of this interpretation. Difference-in-differences analyses of the ACA Medicaid expansions need to address this issue directly. One approach may be to explicitly measure changes in non-Medicaid aspects of the ACA, for example, state enrollment through the federal or state insurance exchanges. This is just one idea, but the larger point is that this issue has to be considered and taken account of in the empirical analysis.
Looking in the Right Places  As noted earlier, the uninsured obtain a considerable amount of care so the scope for insurance to improve health of the uninsured is somewhat limited. There is also evidence that part of the difference in the receipt of care between the uninsured and insured is a result of moral hazard, which implies that some of the extra care the uninsured will obtain when they become insured will have few health benefits. These considerations suggest that future studies should focus on populations with low-baseline use of services. Note that this is usually not the chronically ill, which is the typical sub-group for special attention, because among the uninsured, those in poor health usually get more care than those in better health (see Table 1), although those in poor health have relatively high rates of illness that help identify an insurance effect. The ACA Medicaid expansion group will include near-elderly, and this may be a useful group to focus on because of relatively high rates of illness, although sample sizes become important for sub-group analyses. In addition, given the somewhat narrow scope for insurance to improve health, future studies need to make sure they have sufficient statistical power to detect reliably relatively small effects. For example, future intention-to-treat (ITT) studies that focus on changes in Medicaid eligibility need sufficiently large samples, particularly because of incomplete take-up of Medicaid conditional on eligibility. Similarly, studies estimating the effect of treatment-on-treated (TOT, e.g. instrumental variables) also need large samples because they are based on intention-to-treat estimates. Indeed, one of the limitations of the Oregon Medicaid Experiment was that it lacked statistical power to detect reliably the sizes of effects that were most likely.

It is also interesting to study the effect of Medicaid on the use of services that are known to be quite effective at improving health, such as use of statins, anti-hypertension drugs and some screenings such as colonoscopies. The Oregon Medicaid experiment is a good example of such a
study. However, for many services, the uninsured already obtain these services. For other services, health behavior represents a substantial barrier to obtaining the services and insurance itself will not remedy this problem. How to control for this behavioral confounding is a difficult problem. While identifying whether Medicaid increases use of cost-effective services is an important objective, an even better objective is to link Medicaid to both the use of these services and the outcomes that these services are supposed to affect or prevent. The Oregon Medicaid study is again a good example. Other studies in the context of Medicare are also good examples. These studies link survey data to Medicare claims (Decker and colleagues, McWilliams and colleagues). Similar data exist for Medicaid, for example the linked NHIS-Medicaid claims panel data set, and future studies would benefit from exploiting these data, although the time lag for when this data is available is substantial.

Another line of research that has tried to examine outcomes that are most likely to respond to gaining Medicaid coverage are those that focus on avoidable/preventable hospitalizations, which are hospitalizations that are thought to be preventable with more and more timely primary care of the type that typically is associated with gaining health insurance (Medicaid). Most of these studies do not find evidence to support the hypothesis that Medicaid/insurance is associated with a decrease in avoidable hospitalizations. Almost all of these studies are observational (non-experimental and not based on quasi-experimental approaches). The one study that finds evidence that Medicaid results in fewer avoidable hospitalizations is Aizer (2005), but even in this study the evidence is mixed (e.g., the effect of

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94 See for example: Weissman et al. (1992); Bindman et al., (1995); Pappas et al., (1997); Shi et al., (1999); and Dafny and Gruber(2005). Some disagree with my reading of the evidence and suggest that the results do support a beneficial health effect of Medicaid. Obviously I disagree with these authors.
Medicaid enrollment on all children is larger than on Medicaid children).\textsuperscript{95} In fact, the inconsistency and non-uniformity of evidence is something that characterizes most of these studies.

A recent study by DeLeire et al. (2013) of experience in Milwaukee, WI is a good example. The sample in this study consists of very sick uninsured persons: 75\% with chronic illness; 20\% with alcohol/drug abuse; 25\% with diabetes; and 47\% with hypertension. Prior to enrolling in Medicaid, the uninsured had similar use of outpatient services as those on Medicaid, which again illustrates the fact that the uninsured often receive a considerable amount of care. Results indicated that gaining Medicaid was associated with a 30\% increase in outpatient use, particularly specialty care use. However, gaining Medicaid was also associated with a 46\% increase in Emergency Department (ED) use, particularly for avoidable conditions. Finally Medicaid was associated with a 47\% decrease in avoidable hospitalizations. The messy part of these results is the puzzle of how Medicaid was associated with a large increase in ED visits for avoidable conditions and an equally large decrease in avoidable hospital admissions. How can same physicians prevent hospital admissions, but not ED visits?

The focus on avoidable hospitalizations has much intuitive appeal and is a seemingly good strategy. However, the inconsistent evidence of the past literature suggests that this outcome may not be as ideal as presumed. Ambulatory Care Sensitive (ACS) conditions may not be what they are supposed to be, or are not reliably related to the conceptualization that underlies

\textsuperscript{95} Two related and recent studies are Kolstad and Kowalski (2010) and Miller (2012). Kolstad and Kowalski examined the Massachusetts health care reform and found that gaining insurance was associated with a decrease in hospital admissions through emergency department, an increase in hospital admissions through other channels, and no change in total hospitalizations. Miller (2011) examined Massachusetts reform and found that reform was associated with a decrease in outpatient emergency room visits, particularly those that are preventable with primary care.
their appeal. The potential lack of validity of the current measures of avoidable hospitalization was raised in a 2009 AHRQ report\textsuperscript{96}, and the following quotes describe the skepticism:

“The Prevention Quality Indicators grew out of work led in the early 1990’s by John Billings and Joel Weissman. ….While studies continue to show a link between area level access to care and potentially avoidable hospitalization rates in some populations, no studies have reassessed the face validity of these indicators since their original inception, despite advances in clinical medicine and changes in practice patterns.”

“Panelists expressed some concern regarding the usefulness of the indicators even for area level application. Since the panelists generally represented experts in clinical care, rather than community or public health, it is difficult to draw conclusions from their concerns other than to note that clinicians in general seem to be cautious about attributing hospital admission rates to poor access to quality outpatient care.”

Overall, the 2009 AHRQ report revealed much disagreement among clinicians on the indicators of avoidable conditions. Future research in this area should refine and tighten the empirical approach underlying analyses of avoidable conditions to focus on clinical links between insurance, use of services and outcomes (e.g., Oregon Medicaid study).

\textsuperscript{96} (http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/PQI%20Summary%20Report.pdf)
Conclusion

The intuition underlying the hypothesis that obtaining health insurance through Medicaid will improve health is strong, and it is unlikely that Medicaid will not have some positive health benefits, but they may be small and/or difficult to detect empirically. Future studies need to confront this fact and design studies that are based on credible research designs, that use best practices in implementing and testing the validity of the research design, that have sufficient statistical power, and that examine outcomes most likely to be affected. While these seem like simple rules that should have characterized past research, the facts are otherwise. Much past research on the effects of Medicaid on health have deviated from these simple rules and the result has been a bounty of not very useful studies, which is not only my conclusion, but also of others (Levy and Meltzer 2004). Indeed, the great attention that the RAND and Oregon Medicaid experiments receive is because of the poor quality of much of the literature and the inadequacy of the evidence to answer the question of whether Medicaid improves health. I hope my assessment of this literature and recommendations for future study help to improve what I expect will be another round of studies that assess whether the ACA Medicaid expansions affected health.

References:

Table 1
Comparison of Insured and Uninsured
Sample (90% of Uninsured): Non-elderly Adults, Low-Educated, Not Married
NHIS 2000 to 2009

<table>
<thead>
<tr>
<th></th>
<th>Full Sample</th>
<th>Poor Health (Self-reported Health&gt;2)</th>
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<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
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<tr>
<td>Hospital Stay</td>
<td>0.10</td>
<td>0.06</td>
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<tr>
<td>Doctor Visit</td>
<td>0.84</td>
<td>0.58</td>
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<td>Delayed/No Care</td>
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<td>ER Visit</td>
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<td>0.25</td>
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<tr>
<td>Self-reported Health</td>
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<td>2.5 (1.1)</td>
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<tr>
<td>Bed Days</td>
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<td>5.4 (26.3)</td>
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<td>Employed</td>
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<td>0.65</td>
</tr>
<tr>
<td>Medicaid</td>
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<td></td>
</tr>
<tr>
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<td>Full Sample</td>
<td>Poor Health</td>
</tr>
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<tr>
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<td>0.65</td>
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Table 2

Comparison of Privately Insured and Uninsured Sample (90% of Uninsured): Non-elderly Adults, Low-Educated, Not Married

NHIS 2000 to 2009
<table>
<thead>
<tr>
<th>Num. of Observations</th>
<th>24,738</th>
<th>12,853 (34%)</th>
<th>9,587 (34%, Ins)</th>
<th>6234 (49%, Un)</th>
</tr>
</thead>
</table>
Commentary: Research on ACA’s Effect on Medicaid Quality and Outcomes

Marsha Gold

What is/are the “right” questions?

“Would you tell me, please, which way I ought to go from here?”

“That depends a good deal on where you want to get to,” said the cat.

“I don’t care where,” said Alice.

Then it doesn’t matter which way you go,” said the cat.

--Lewis Carroll

Quality: Three Views on an Elephant

☐ Rosenbaum: the ultimate outcome(s) of a system that leverages tools of coverage, benefits, standards, payment incentives, metrics, and patient engagement.

• Key Concern: Getting the tools “right” to support equitable outcomes

☐ Kaestner: Defining appropriate outcome(s): what can/should we realistically expect from expanded coverage and where should our spending be directed?

• Key concern: cost effective outcomes that add “value”

My “Bias” or Perspective

☐ We could spend our money a lot more wisely and effectively in this nation.

☐ This argument is old. Change is hard and unlikely to happen--at least fully.

☐ Until then: Access to “standard” care as a right—should anyone be denied this human right in a just society?

☐ The question: where does quality “fit” in assessing changes in Medicaid under the ACA and its expanded coverage?

Do the Uninsured Use A Lot of Care Now?

☐ Is 60-80% a lot or a little—and are the dollars as effectively or ineffectively used as for the privately insured or Medicaid?
• Late care costs more—over time, coverage could generate some offsets in cost for more effective care (versus less effective, not “overtreated”)
• Uninsured pay more out of pocket—coverage should reduce stress and financial vulnerability
• Insurance matters—pretty robust research
□ Uninsured are a highly diverse group: how do effects vary by subgroup?
• Risk adjustment challenging
• Subgroup specific effects valuable

Quality in Medicaid: Today and Tomorrow
□ Appropriate benchmarks: “right” care versus same care as everyone else—and improve along with the average with all in system?
□ Delivery: how can coverage be integrated with appropriate outreach, behavioral education and community to enhance results?
□ Disparities: Does coverage lessen gaps?
□ Focus: Everyone versus newly insured?

Some Reactions to Methods Issues

□ Delivery of intervention a precondition for assessing effects—intention to treat right standard but coverage must change.
□ Needs matter (80/20 rule): Effects more likely for those most needy. The rest: prevention, comfort, insurance effects (rare events)
□ Incomplete/faulty data complicate analysis.
□ Outcomes other than health are relevant—both to people and economics
□ Access and distributional issues are critical outcomes for assessing coverage expansions
Medicaid Research Priorities

Chris Perrone

CHCF Program Areas

• Better Chronic Disease Care
• Innovations for the Underserved
• Market and Policy Monitor
• Health Reform and Public Programs

Health Reform & Public Programs

Objectives

• Inform statewide efforts to expand public and private coverage
• Support the evolution of Medi-Cal

Approach

• Provide technical assistance
• Advance innovative thinking
• Monitor performance

How We Decide

(or Venn do we fund?)
Recently Funded Monitoring Projects

ACA with Medicaid components

• Impact of ACA on coverage, access and affordability
• Early experiences with the ACA

Medicaid-specific

• Access to care for Medi-Cal enrollees
• Managed care performance dashboard
• Transition of SPDs to managed care

Initiative to Monitor Access

• Establish framework and measures
• Analyze existing administrative and survey data
• Measure specialty access
• Advance understanding of access as new models of care emerge

What’s Next?

ACA Implementation: Consumer experience with Medicaid enrollment; uptake; churning.

Medicaid Transformation: Expansion of populations and services to managed care; integration of care.

SIM Plan: Public reporting; P4P; maternity; palliative care; workforce.
The Affordable Care Act and Access to Care: Existing Research and Open Questions

Thomas C. Buchmueller

Abstract: The insurance coverage expansions of the Affordable Care Act will only improve access to health care if there is an adequate supply of providers willing to treat the newly insured. This chapter summarizes recent studies on how providers responded to past coverage expansions. Compared to the large number of studies focused on patients, the literature on the supply side is relatively small and is limited in terms of the outcomes analyzed. Studies focusing on physicians suggest that the expansion of public insurance changes the mix of patients that physicians treat though may have little effect on the total supply of services, particularly when public reimbursement rates are significantly lower than private market fees. However, other research points to the importance of mid-level health providers—nurse practitioners and physician assistants in the case of medical care, dental hygienists in the case of dental care—and community health clinics as important sources of increased capacity.

When the Affordable Care Act (ACA) was enacted, it was projected that the law would cause Medicaid coverage to increase by 10 million people in 2014, rising to 16 million in 2019. In the wake of the Supreme Court ruling that made the ACA’s Medicaid expansion optional for states, the immediate increase in coverage will be lower than originally projected, though will still be substantial. More recent estimates from the Congressional Budget Office are that Medicaid enrollment will increase by 12 million in 2016. Private insurance coverage, mainly in the form of subsidized coverage purchased through the newly formed health insurance marketplaces, is projected to increase by the same amount (CBO 2014).

A primary goal of the coverage expansions is to improve access to health care. The recent Oregon Health Insurance experiment provides compelling evidence of such an effect (Finkelstein et al 2012; Baicker et al. 2013). Adults who gained coverage through the Oregon expansion were substantially more likely to report having a usual source of care than otherwise similar uninsured individuals and Medicaid coverage led to large increases in the use of outpatient visits and preventive screening. Other research using quasi-experimental methods finds positive effects of health insurance coverage for other populations. Studies on the expansion of Medicaid eligibility for children find significant increases in outpatient visits (Currie and Gruber 1996; Card and Shore-Sheppard 2004; Currie, Decker and Lin 2008) and a decline in ambulatory care sensitive admissions (Aizer 2007). Similarly,
research on Massachusetts’s 2006 health reform finds that the expansion of health insurance coverage led to an increase in overall health care utilization, a reduction in unmet need and a reduction in the use of hospital emergency departments for primary care (Long and Masi 2009; Miller 2012; Kolstad and Kowalski 2012).

In these studies and many others in the literature, the patient is the unit of analysis and the results can be interpreted as reflecting mainly demand-side effects. Because the coverage changes studied were relatively small, it is probably safe to assume that there was adequate supply to meet the increase in demand induced by the coverage gains. However, the ACA coverage expansions, comprising substantial increases in both public and private coverage, are much larger than previous ones in terms of the percent of the population expected to gain insurance. Thus, there is a concern that, in some parts of the country at least, there will not be adequate provider capacity to meet the increase in demand. If this is the case, newly insured individuals may still experience access problems. In areas with acute excess demand, increased crowding may cause access to deteriorate for previously insured patients.

To understand how coverage expansions might or might not translate to improvements in access to care, it is important to understand how providers respond to demand shifts resulting from changes in population insurance coverage. In this chapter, I briefly summarize recent studies shedding light on how providers respond to health insurance coverage expansions. Given that a large fraction of the ACA coverage gains will come from Medicaid and low Medicaid fees are often cited as a factor that limits access to care, it is important to understand also the effect of payment rates on the supply of services to Medicaid patients. Therefore, I summarize studies in this area as well. Of course, not all providers will be affected by the coverage expansions to the same degree. The impact is likely to be greatest for safety net providers that serve low-income communities and treat a disproportionate share of publicly insured and uninsured patients. In the case of primary care, community health clinics (CHCs) are important safety net providers. The last section of the paper discusses recent studies on the role that CHCs play in providing access to care for disadvantaged patients.

**Provider Responses to Public Insurance Expansions**
A useful theoretical framework for analyzing provider responses to public insurance expansions and changes in payment rates is a model by Sloan, Mitchell and Cromwell (1978), which assumes that providers face a downward sloping demand curve for private patients and a fixed unit price for treating Medicaid patients. As illustrated in Figure 1, this combination produces a kinked marginal revenue curve. At low levels of output, providers will treat only private patients for whom the marginal revenue curve slopes down. When that curve equals the fixed Medicaid price, that price becomes the relevant marginal revenue. If there is a limit to the number of publicly insured patients in the market, at some level of output the marginal revenue curve may become downward sloping again. Providers are assumed to choose a level of output such that marginal revenue equals marginal cost. Therefore, the mix of patients treated depends on where the marginal cost curve falls relative to this kinked marginal revenue curve. For a provider with a high marginal cost or a strong private demand—illustrated by the marginal cost curve MC_A—the point of intersection will be on the downward-sloping portion of the curve, which means that only private patients will be seen. In contrast, a provider with a marginal cost curves like MC_B and MC_C will see a mix of public and private patients.

This model predicts that the response of providers to a public insurance expansion will depend on the mix of patients they are seeing before the expansion and the extent to which the increase in public coverage represents an overall gain in coverage—i.e., the extent of crowd-out. When crowd-out is minimal, an expansion of public insurance can be seen and an extension of the horizontal portion of the marginal revenue curve. Such a change will have no effect on providers like those represented by MC_A and MC_B because it does not change the point where their marginal cost and marginal revenue curves intersect. On the other hand, for a provider with a marginal cost like MC_C, an expansion of public insurance represents an increase in marginal revenue that should lead to an increase in public patients treated (NC to NC’). A case of significant crowd-out can be seen as an inward rotation of the downward sloping portion of the marginal revenue curve. A provider like B will see the same number of patients but the share with public insurance will increase. For a provider like A, the new marginal revenue curve will intersect marginal cost at a lower level of output—i.e., fewer patients will be treated.
Three recent empirical studies on the response of physicians to public insurance expansions interpret their results in the context of this model. Baker and Royalty (2000) use two years of panel data (1987 and 1991) from the American Medical Association’s Survey of Young Physicians to examine the impact of Medicaid eligibility expansions for pregnant women on the percentage of a physician’s patients who are poor or on Medicaid. An important feature of their analysis is that they are able to distinguish between physicians in private practice and those in public health settings. They find that increased Medicaid eligibility leads public health physicians to see a greater percentage of poor patients and patients covered by Medicaid. In contrast, they find that an expansion of Medicaid eligibility has no significant impact on physicians in private practice.

Garthwaite (2011) uses data from two sources—panel data from the Community Tracking Survey (CTS) and two years of cross-sectional data from the National Ambulatory Medical Care Survey (NAMCS)—to study the response of pediatricians to the insurance coverage changes caused by the implementation of CHIP. In both analyses he uses other physicians as controls. In the CTS, he finds that the implementation of CHIP led to an increase in the percentage of physicians reporting that they accept Medicaid patients, an increase in the share of revenues from Medicaid, and a decrease in weekly hours worked. He and White (2013) also use the CTS and find that the CHIP expansion coincided with a reduction in hours worked by pediatricians. One possible explanation for this result is that a substantial share of children who gained CHIP coverage previously had private insurance and that because of this crowd-out, the main effect of CHIP on physicians was a reduction in fees, which induced physicians to work less.97

One problem with this interpretation is that while there was a high degree of crowd-out, the CHIP expansion did lead to a net increase in insurance coverage (LoSasso and Buchmueller 2004; Gruber and Simon 2008). Based on the large number of studies showing a positive effect of coverage on utilization, we would expect this to have led to an increase in physician visits among children.98 One possibility is that more children were

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97 According to He and White (2013), average reimbursements for an office visit are roughly 40 percent lower for children covered by CHIP than for children with private insurance.

98 Direct evidence on the effect of the CHIP expansion on utilization is mixed. Selden and Hudson (2006) and Lurie (2009) find that the CHIP expansion led to an increase in physician visits for children, though White (2012) obtains results suggesting that the CHIP expansion had little effect on utilization.
seeing physicians, but the average length of the visit was falling. Garthwaite uses the NAMCS data to test this hypothesis, using a difference-in-differences (DD) model to compare changes between 1993 and 2002 for pediatricians and other types of physicians. The DD results do imply that the CHIP expansion coincided with a reduction in visit length and an increase in the percentage of visits that were shorter than 10 minutes, though none of these effects are statistically significant at conventional levels. Garthwaite also estimates a triple difference (DDD) model that adds an additional contrast between publicly and privately insured patients. This specification yields slightly stronger evidence of a decline in visit length.

Taken together, the results of these studies suggest that the capacity of private practice physicians did not expand to meet the increased demand caused by an expansion of public health insurance, and in fact it may have decreased. This raises the concern that large scale coverage expansions may result in excess demand for primary care services. The “crowding” that results from this excess demand might not only limit access to care for those individuals gaining coverage but may also have negative spillover effects on patients who were previously insured, though these papers provide no direct evidence on this question.

However, an important limitation of these studies for understanding how coverage expansions affect access is that by focusing exclusively on physicians, they provide an incomplete picture of primary care capacity. As shown in Figure 2, since the 1980s, there has been a steady growth in the number of nurse practitioners (NPs) and physician assistants (PAs). In the US, there are currently more than 150,000 NPs and 85,000 PAs eligible to practice. Combined, this is greater than the number of general and family practice physicians (Stange 2014). The extent to which these mid-level providers can provide the necessary capacity to meet the increased demand for primary care depends on scope of practice regulations, which vary at the state level. Stange (2013) examines how the expansion of NP and PA supply and scope of practice laws affected health care utilization. He finds that in states where NPs are allowed greater autonomy, increases in NP supply lead to modest gains in primary care office visits.
Most studies on the effect of health insurance coverage on health care utilization focus on medical care. Less attention has been paid to dental care, which is an important aspect of primary care.\(^9^9\) Although state Medicaid programs are required to cover dental services for children, adult dental coverage is optional. Most states do not cover dental care for adults and many have added or dropped coverage in the past 10 years. These policy changes provide useful variation for investigating how providers respond to changes in insurance coverage. Given that the average dentist is located in a county where Medicaid covers 9 percent of the adult population, state decisions to add or drop adult dental benefits lead to non-trivial demand shocks.\(^{10^0}\) Three recent studies using household data show that Medicaid coverage of dental services has a strong positive effect on dental visits for adult enrollees (Choi 2011; Nasseh and Vujic 2013; Brodsky 2013).

Buchmueller, Miller and Vujicic (2014) examine how dentists responded to the demand shocks that occurred when states added or dropped dental coverage. The study uses data from the American Dental Association’s annual Survey of Dental Practice (SDP) to estimate the effect of Medicaid adult dental coverage on several supply-side outcomes: participation in the Medicaid program; the number of visits by patient insurance status and type of visit; dentists’ labor supply; and the employment of dental hygienists. The survey also includes two measures related to crowding: the average number of days it takes for patients to get an appointment and the average number of minutes spent in the waiting room.

We find that the expansion of Medicaid dental coverage to adults increases the percentage of dentists who report treating publicly insured patients and public patients as a percentage of the practice’s patients. Of course, such results do not necessarily indicate a change in the behavior of providers. It could simply be that when Medicaid does not cover dental care for adults, Medicaid enrollees will be self-pay patients from the perspective of

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\(^{9^9}\) According to data from the 2010 MEPS, 38 percent of non-elderly adults reported a dental office visit in the last year. This is comparable to the 39 percent who reported a physician visit. Overall, dental care represents 6.3 percent of total health spending for non-elderly adults, compared to 14 percent for outpatient primary care.

\(^{10^0}\) Because private dental insurance is less common than private health insurance, especially for low-income individuals, crowd-out is much less of an issue in the case of dental care. Therefore, changes in Medicaid coverage policy translate to changes in insurance coverage overall.
dentists. However, we also find that the expansion of Medicaid dental coverage leads to an increase in the number of visits per week and that this increase is driven by care provided to publicly insured patients.

The analysis of dentist labor supply and employment practices suggest that dentists meet the increased demand for care by working slightly more hours per week and by making greater use of dental hygienists. We also find that these coverage expansions lead to modest increases in the number of days it takes to get an appointment and the number of minutes spent in the waiting room. However, these crowding effects are concentrated in states with more restrictive regulations regarding the scope of practice for dental hygienists. We find no significant increase in wait times in states allowing hygienists greater autonomy. This latter result underscores the importance of mid-level providers as a source of primary care capacity.

The Effect of Medicaid Provider Payments on the Supply of Services

Because low payment rates are commonly cited as an important factor that limits access to medical care for Medicaid patients, the ACA includes a provision that temporarily raises Medicaid payment rates for primary care to Medicare levels. A number of studies have examined the relationship between Medicaid fees and provider participation in the program. Cunningham and Nichols (2005) and Decker (2007) find that higher Medicaid fees are positively associated with the willingness of physicians to treat publicly insured patients. Baker and Royalty (2000) find such a response for private physicians in their sample. Their results suggest that higher Medicaid payments shift the site of care for low-income patients from public health settings to private physician practices. Gruber, Adams and Newhouse (1997) find a similar result when studying the effect of increased Medicaid payments in Tennessee.

Because of the way that changes in payment policy can shift the site of care, increasing payment rates may or may not increase overall utilization. Some studies using cross-sectional data find a significant relationship between Medicaid payment rates and the site of care, but find no significant relationship between payment rates and overall utilization (Long, Settle and Stuart 1986; Rosenbach 1989; Cohen and Cunningham 1995). However,
other studies that analyze changes in fees suggest that access to physician services improves when Medicaid
payments are increased (Gabel and Rice 1985; Shen and Zuckerman 2005; Decker 2009; White 2012).

Access problems attributed to low Medicaid fees are a significant concern in the case of dental care.
Several recent studies suggest that increases in Medicaid dental fees improve access by inducing more dentists to
participate in the program. An innovative program in Michigan called Healthy Kids Dental provides useful
evidence on this effect. Under this program the state contracts with Delta Dental, which pays dentists according to
its regular commercial fee schedule. The program was introduced in several rural counties in 2000 and has been
periodically expanded on a county-by-county basis since then. An evaluation of the initial roll-out found that the
program led to significant increases in dentist participation and utilization (Eklund, Pittman and Clark 2003).
Other studies using national data also find that higher Medicaid fees lead to increases in dental visits for children
on Medicaid (Decker 2011; Buchmueller, Orzol and Shore-Sheppard 2013).

*The Role of Public Health Providers*

Baker and Royalty’s (2000) results on both the effect of coverage expansions and Medicaid fee changes
suggest that physicians in public health settings, such as Federally funded community health centers (CHCs), meet
the residual demand for care not supplied by physicians in private practice. Federal funding for CHCs has
increased significantly since the 1990s (LoSasso and Byck 2010). Much of this funding increase came as a result
of a Bush Administration program, the Health Care Center Growth Initiative which provided grants to support over
1000 new or expanded health centers (McMorrow and Zuckerman 2013). The ACA includes $11 billion in
appropriations for a further expansion of CHC capacity. Therefore, CHCs and other safety net providers are likely
to play an important role in meeting the increased demand for care resulting from the ACA insurance expansions.

Several recent studies document a correlation between proximity to a community health center and various
proxies for access to care (Hadley and Cunningham 2004; Gresenz, Rogowski and Escarce 2007). However, to the
extent that CHCs locate in areas of greatest unmet need, cross-sectional correlations are likely to understate the
extent to which an increase in the number of safety net providers improves access. This type of endogeneity bias is reduced, though not eliminated, in analyses that use fixed effect methods to examine the effect of changes in funding on changes in access. A recent example of this type of work is a paper by McMorrow and Zuckerman (2013) examine the effect of changes in market-level health center funding on medical care utilization and unmet need. Their results suggest that the expansion of CHC capacity caused by increased funding translated to increased office visits for low income patients. At the same time, they obtain the counterintuitive result that increases in CHC funding are associated with increases in the probability that a poor patient reports delaying medical care for reasons of cost.

A recent study by Bailey and Goodman-Bacon (2012) uses historical data on the establishment of CHCs in the 1960s and early 1970s to investigate not only their effect on access to care but also the long run effect of this access on mortality among older adults. The analysis exploits variation in the timing of CHC rollout which they argue is essentially random because of “administrative confusion” in the way the program was established. Their results suggest that CHCs improved access to care and reduced mortality for older adults.

Directions for Future Research

Compared to research that uses data on patients to study the effect of health insurance on utilization of care, there is much less research that analyzes coverage expansions from the perspective of providers. Given concerns about whether there will be adequate primary care capacity to meet the increased demand for care caused by the ACA, this is an important area for future research.

At the same time, it is a difficult research area. There are fewer data sources that provide information on provider behavior and some that do provide such information do not have information on all types of providers. In particular, an exclusive focus on physicians runs the risk of overlooking the extent to which other health professionals can meet the needs of the newly insured. Another limitation of many existing data sources is a lack of detailed information on geographic location. Much of the research on prior public insurance expansions exploits
cross-state policy variation to estimate causal effects. States are too large a geographic area for identifying issues of crowding and inadequate capacity.

References


Nasseh, Kamyar and Marko Vujic. 2013. “Health Reform in Massachusetts Increased Adult Dental Care Use, Particularly Among the Poor,” Health Affairs, 32(9): 1639-1645.


Figure 1. A Simple Model of Provider Decisions to Treat Public and Private Patients
Figure 2. Aggregate Trends in Health Care Providers, 1980-2008

Source: Stange (2013)
How will the ACA affect access to care for Medicaid enrollees?

Reactions by Stephen Zuckerman

Decker presentation

- Highlights the new opportunities offered by the changes to NHIS questions
  - Focus on access and use, not provider participation
- Establishes baseline clinical differences between Medicaid and uninsured
- Provider attention on physicians and CHCs
- Excellent job of pointing to some of the major outcomes that should be studied

Buchmueller presentation

- Introduces some theoretical context for studying responses to the ACA expansion
  - Focus of models on provider responses
- Highlights need to consider primary care fee increase, responses of mid-level providers and the role of CHCs

ACA Medicaid expansion is not a randomized controlled trial

- Not a researcher’s dream, but still plenty to be grateful about
  - 7 justices made the Medicaid expansion optional
- State decisions seems to be driven by factors other than the need for coverage
  - Reduces endogeneity concerns, but still need to consider baseline differences in modeling effects
- Medicaid policy changes and context go beyond the ACA eligibility expansions
Percentage of the Current Uninsured Eligible for Medicaid/CHIP in 2014

Average Medicaid Fee Increases for ACA Primary Care Services in 2013, by State

Note: TN has no Medicaid FFS program.
SOURCE: 2012 KOMU/Urban Institute Medicaid Physician Fee Survey
Dimensions of provider response (1)

- More providers participate – on their own, through their healthcare systems, or by contracting with managed care plans
- Participating providers see more Medicaid patients
  - Shorter visits, expand use of mid-level providers
- States relax scope of practice laws to allow more discretion to mid-level providers

Dimensions of provider response (2)

- Primary care is evolving beyond physicians, NPs or PAs toward team-based care (e.g., PCMH)
  - Nutritionists, social workers, comm hth wrkrs, care coordinators
  - eHealth techniques could also play a role
- Specialists may see a new source or patients
  - But, demand higher fees to expand services
  - Could be a key component to improving health
  - Telehealth may change the way some specialty care is provided
The Financial Impacts of Health Reform

John Holahan

Figure 1
State Decisions to Expand Medicaid and Medicaid Enrollment
Percentage Increase in Enrollment, 2016

Expanding

Not Expanding

If these states had not expanded Medicaid


Figure 2
State Decisions to Expand Medicaid and the Uninsured
Percentage Reduction in the Uninsured, 2016

Expanding

Not Expanding

If these states decide to expand Medicaid

Figure 3
Federal Expenditures in Expanding and Not Expanding States, Relative to No Reform Baseline
2013-2022
Percentage Increase in Expenditures

Expanding

Not Expanding

If these states had not expanded Medicaid

If these states decide to expand Medicaid


Figure 4
State Expenditures in Expanding and Not Expanding States, Relative to No Reform Baseline
Percentage Increase in Expenditures
2013-2022

Expanding

Not Expanding

If these states had not expanded Medicaid

If these states decide to expand Medicaid

Sources of Savings to States

Programs that support uncompensated care at hospitals and other safety net providers; indigent care programs

Medically needy; many pregnant women

Low-income adults with disabilities

State funded mental health and substance abuse treatment; public health services

### Estimated Macroeconomic Effects of Medicaid Expansion

<table>
<thead>
<tr>
<th>State</th>
<th>Estimator</th>
<th>State Fiscal Year</th>
<th>State G.P. (millions)</th>
<th>Earnings by State Residents</th>
<th>Employment</th>
<th>State General Revenue (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>University of Alabama at Birmingham</td>
<td>2014-20</td>
<td>$16,097</td>
<td>-</td>
<td>-</td>
<td>$1,706</td>
</tr>
<tr>
<td>Colorado</td>
<td>Charles Brown Consulting</td>
<td>2005-26</td>
<td>$4,400</td>
<td>$608 per household</td>
<td>22,386</td>
<td>$128</td>
</tr>
<tr>
<td>Maryland</td>
<td>Hilltop Institute</td>
<td>2020</td>
<td>$3,283</td>
<td>-</td>
<td>26,970</td>
<td>$237 (includes local revenue and premium taxes)</td>
</tr>
<tr>
<td>New Mexico</td>
<td>University of New Mexico</td>
<td>2020</td>
<td>$719.5</td>
<td>$268.4 million (statewide)</td>
<td>6,001</td>
<td>$60.6</td>
</tr>
<tr>
<td>Oregon</td>
<td>OHSU, Manatt, OHA</td>
<td>2020</td>
<td>$3,782</td>
<td>$1,664 million (statewide)</td>
<td>29,100</td>
<td>$80.6</td>
</tr>
<tr>
<td>Virginia</td>
<td>Omura Economics &amp; Analytics</td>
<td>Annual average, 2014-19</td>
<td>$3,032</td>
<td>-</td>
<td>23,998</td>
<td>$29.0</td>
</tr>
</tbody>
</table>

Note: Maryland estimates were for the ACA at a wave, not limited to the effects of the Medicaid expansion. Estimates with multiple scenarios, including various take-up levels, are shown with high-level take-up. If only low and high levels are available (as with New Mexico), the table shows the low level. For the Hilltop, University of New Mexico, and OHSU, et al. studies, this table displays all results for the final estimated year, even though the studies also include multi-year estimates for state GDP, earnings, and state general revenue.
Expansion States

• More enrollment in Medicaid
• More reduction in the uninsured
• More federal dollars
• Higher state expenditures
• Less uncompensated care
• Various sources of state savings
• Positive or neutral macroeconomic effects

Non Expansion States

• Fewer new Medicaid enrollees, but woodwork effect
• Much less effect on uninsured
• Much less reduction in uncompensated care
• Still have lower Medicare rates, Medicare and Medicaid DSH cuts, new taxes
• Less increase in state expenditures, but need to maintain many current programs
• Negative macroeconomic effects
• Seems politically unsustainable

Block Grants

Problem with current financing

• States don’t have strong incentives to contain spending
• State shift costs to federal government though practices such as use of provider taxes

Policy Option

• Set a predetermined rate of growth in federal expenditures; states make policy within budget constraint

Issues

• Medicaid spending not really out of control – well contained by comparison with other metrics; problem has been enrollment growth

• If rate of growth set low enough to achieve federal savings and states have already achieved low levels and rates of growth in spending per enrollee, states need to come up with new funds or cut enrollment
• States are at very different starting places in terms of spending; block grants would vary enormously
• Block grants don’t deal well with recessions
• Block grants would address problems with provider taxes but that can be done other ways

Private Insurance Plans

The Arkansas Model
Premise is that private plans can do better—improve access at lower costs
• Evidence doesn’t support this; Medicaid beneficiaries do well on several measures of access, Medicaid is less costly and has lower rates of growth
• Could improve access at a higher cost
• Exchange plans are looking a lot like Medicaid plans in many states i.e. narrow networks, lower provider rates

But Arkansas may be different
• State does not have managed care
• There is little competition in private market; state is Blue Cross dominated
• State sees their reform as a way to mainstream new Medicaid enrollees and foster competition in exchange marketplaces
Medicaid Expansion: State Approaches. Considerations and Questions
Deborah Bachrach

- Coverage Model
- Benefits
- Personal responsibility

☐ Premiums and cost sharing
☐ Health incentives

- Crowd out of ESI
- Enhanced FMAP

- Payment and Delivery Model
- Reform reimbursement policies and plan/provider delivery mechanisms

☐ Lower costs
☐ Improve outcomes

- Medicaid as lever

☐ State employees
☐ Marketplace

### Maximum Allowable Medicaid Premiums and Cost-Sharing

<table>
<thead>
<tr>
<th></th>
<th>&lt; 100% FPL&lt;sup&gt;1&lt;/sup&gt;</th>
<th>100% - 150% FPL</th>
<th>≥ 150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate cost-sharing cap</td>
<td>5% household income</td>
<td>5% household income</td>
<td>5% household income</td>
</tr>
<tr>
<td>Premiums</td>
<td>Not allowed</td>
<td>Not allowed</td>
<td>Permitted, subject to aggregate cap</td>
</tr>
</tbody>
</table>

### Maximum Service-Related Co-pays/Co-Insurance

<table>
<thead>
<tr>
<th>Service Type</th>
<th>&lt; 100% FPL&lt;sup&gt;1&lt;/sup&gt;</th>
<th>100% - 150% FPL</th>
<th>≥ 150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services</td>
<td>$4</td>
<td>10% of cost the agency pays</td>
<td>20% of cost the agency pays</td>
</tr>
<tr>
<td>Non-emergency ER</td>
<td>$8</td>
<td>$8</td>
<td>No limit</td>
</tr>
<tr>
<td>Rx Drugs</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: cost the agency</td>
</tr>
<tr>
<td>Institutional</td>
<td>$75 per stay</td>
<td>10% of total cost the agency pays for the entire stay</td>
<td>20% of total cost the agency pays for the entire stay</td>
</tr>
</tbody>
</table>
Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room.

Cost sharing cannot be mandatory for individuals with household incomes < 100% FPL.

If non-preferred drugs are medically necessary, preferred drug cost sharing applies.

- CMS extended Indiana’s HIP waiver for 2014 while State considers Medicaid expansion for new adult group
- HIP covers adults < 100% FPL not otherwise Medicaid eligible
- Each enrollee has an HSA-like account (Personal Wellness Responsibility or POWER account) of $1,100
- Enrollee contributes up to 2% of income on a sliding scale basis; State makes up the difference
- Enrollee receives $500 of free preventive care; balance up to $1,100 paid out of POWER account
- MCO covers medical costs after $1,100; benefits are comprehensive
- If enrollee receives all appropriate preventive services, unspent funds in POWER account roll over to next year; if not, only individual contribution rolls over

Under a three-year 1115 Waiver, Arkansas will purchase coverage for its expansion adults (all childless adults and parents >17% of FPL) through QHPs in the Marketplace

- Medically frail adults are excluded from the demonstration
- In 2015, State will seek to include children & lower income parents
- Only one significant provision of federal Medicaid law waived; enables Arkansas to make premium assistance mandatory
- The Arkansas demonstration (“private option”) is intended to
- Promote continuity of coverage
- Smooth seams across the continuum of coverage
- Equalize reimbursement and increase provider access
- Drive long term premium stability
- Advance quality improvement and delivery system reform
Arkansas will comply with Medicaid benefit requirements for the new adults, providing NEMT and EPSDT (for 19 and 20 year olds) through Medicaid FFS wrap

Arkansas will comply with Medicaid cost sharing rules.

No cost sharing below 100% FPL in 2014; may be added in 2015

For individuals between 100% FPL and 133% FPL, Arkansas Medicaid will cover QHP premiums costs, pay CSRs and cover the deductible for the high value silver plans (94% AV)

Arkansas will delegate appeal authority to the insurance agency, aligning public and private appeal rights

Arkansas evaluation plan must demonstrate cost-effectiveness considering short and long term costs and improved beneficiary access and outcomes

Iowa Wellness Plan

Individuals with incomes below 100% FPL

Commercial-like benefits tied to state-employee plan

Informed by State Innovation Model (SIM) planning initiative/grant

Medicaid will align with other payers to establish ACOs

Medicaid and Wellmark cover 70% of Iowans

Marketplace Choice Plan

Individuals with incomes between 100% and 133% FPL

Premium assistance waiver to purchase QHP coverage with no wraparound benefits

Employer Sponsored Coverage

Members will be enrolled in ESI if available and cost-effective

No co-pays except non-emergency use of ER

Monthly premiums for individuals >50% FPL

Premiums are waived for completion of health behaviors such as health risk assessment, physical, smoking cessation and preventive examinations

Iowa is seeking to adopt a strategy that incents healthy behaviors and to move away from co-pays which are unpredictable, can deter care access and are difficult for providers to collect
Under 1115 Waiver, Iowa Medicaid is seeking to purchase coverage for its expansion adults with incomes between 100% and 133% of FPL through QHPs in the Marketplace.

- Medically frail adults are excluded from proposed demonstration
- One goal is to bring more plans into Iowa Marketplace
- Iowa is seeking to waive several provisions of federal Medicaid law in order to
  - Make premium assistance mandatory
  - Charge monthly premiums ($20); waived if meet health improvement activities or for hardship
  - Not contract or reimburse FQHCs per current law
  - Not cover out-of-network family planning providers, EPSDT & NEMT
  - Not provide retroactive coverage

Michigan legislation expands Medicaid conditioned on obtaining two waivers and maintenance of enhanced FMAP

- Waiver #1 must be obtained before implementation of expansion and include cost-sharing
- Require co-pays up to 5% of income, designed to encourage use of high-value services
- Co-pays to be paid in advance
- Co-pays reduced for meeting healthy behavior standard
- Waiver #2 must be obtained by 12/31/15 and allow the State to impose certain requirements on beneficiaries between 100% and 133% FPL enrolled in Medicaid > 48 months
- Purchase coverage through the marketplace using APTCs/CSRs or
- Remain in Medicaid with cost-sharing capped at 7% of income

Under proposal advanced by Governor Corbett, PA would expand Medicaid using premium assistance to purchase QHP coverage for all newly eligible adults

- Medically frail adults would have option to participate
- Includes monthly premium for individuals > 50% FPL
- Sliding scale basis
- Maximum of $25/mo for individual and $35/mo for family
- May be reduced if participate in health and wellness programs
• Eliminates all co-pays except for non-emergency use of ER
• Unemployed individuals must engage in job search/training
• Seeks federal commitment to work with State to “prevent further erosion of private commercial insurance market.”

• In October, the NH Medicaid Expansion Study Commission recommended expansion under certain conditions; Legislature now debating
  • Recommendations include
  • Mandatory premium assistance for Medicaid eligible individuals with access to employer sponsored coverage
  • Mandatory premium assistance for individuals between 100% and 133% FPL to purchase QHP coverage in the Marketplace
  • In 2014, only Anthem is participating in the NH Marketplace
  • Individuals not eligible for premium assistance would be required to enroll in Medicaid managed care plans

• Will premium assistance in the Marketplace improve coverage and care for Medicaid beneficiaries by
  • increasing provider access and capacity?
  • decreasing coverage gaps?
  • decrease churning and improving continuity of coverage and care?
  • improving enrollee satisfaction?
  • decreasing non-emergency use of ERs?
  • Will premium assistance in the Marketplace be cost effective considering access, cost and quality?
  • Will increased cost-sharing encourage or discourage appropriate use of care? Where do premiums fit in?
  • Is CMS flexibility key to increasing the number of Medicaid expansion states?
Cost-Impacts
Matt Salo

1) Medicaid, as payer, must better influence/change behavior. How can this be best accomplished?

- Providers
- Beneficiaries
- Health Plans/Systems
- Other Agencies
  - Federal (CMS/HRSA/SAMHSA)
  - State (Public Health, Corrections, Education)
  - Local (City/County, Mental Health)

2) Alternatives to traditional Medicaid in the ACA Expansion Option

- Arkansas model – necessary to prevent death spirals in the marketplace?
- Partial expansions
- Models that encourage more personal responsibility

3) Value-Based Purchasing

- Financial incentives to drive quality/outcome measures
  - Which measures bring the most “bang for the buck”
- Health technology assessments/comparative effectiveness
4) Alternative Delivery Models

- Increased cost sharing
  - HSAs
  - Premiums
  - Co-pays (enforceable and more than nominal)

5) Payment Reforms

- Capitation

- Shared savings
  - Withholds vs. bonuses

6) Long Term Services and Supports

- Financing
  - Balance of federal vs. state vs. private (How to we avoid crowd-out?)

- Delivery
  - Is HCBS always a cost saver?
    - Cost/quality impact of DoL regulations on overtime and minimum wage
  - Value of MLTSS

7) Dual Eligibles

- What are the true costs and quality implications of maintaining the current fragmented FFS system?

- Establishing state-by-state baselines to best determine crosswalk implications for state led reforms?
8) FQHCs

- Future of PPS
  - Post Medicaid/marketplace subsidy expansion
  - Interaction with state delivery system/payment reforms
- Relationship between payment and access

9) Pharmacy

- Sustainability of the Drug Rebate Program
  - Open/closed formularies
  - Tiered cost-sharing
  - Future of biologics/genetic design products
- Role of P&T Committees, other evaluative measures to determine cost effectiveness

10) Behavioral Health

- Impact of untreated needs on current Medicaid spending
- Cost and quality implications of removing “carve-outs”
- Examination of the populations currently served in IMDs
  - Who are they?
  - How do we best serve their needs?
Cost Impacts
Judith Solomon

Supreme Court Decision Changed Everything

• Instead of new uniform eligibility limit for adults, states vary in who will be covered (and when they will be covered)

• Emerging variation in how people are covered
  — Use of premium assistance to expand coverage
  — Non-expansion states want to add new twists as they consider expansion

Variation Multiplies Potential Areas of Research

Expansion States

• Who gets covered and when?
• Characteristics of new enrollees
• Outreach strategies: What works for different groups?
• Impact on other state spending
  — Mental health and substance abuse spending
  — Other uncompensated care

Non-expansion States

• Impact of the mandate on enrollment
• MAGI effects on eligibility
• Impact of DSH cuts
• State spending on mental health and substance abuse services and other uncompensated care

“Waiver” is a Misnomer

• Section 1115 of the Social Security Act provides authority for demonstration projects
• Allows waivers of certain statutory provisions but only to the extent needed to further the objectives of
the demonstration

- Budget neutrality required
  - Costs to federal government no more with the waiver than without

- Transparency requirements added in the ACA

“Skin in the Game” and “Healthy Behaviors”

- What do we know already regarding impact of co-pays and premiums on low-income people?
  - Healthy Indiana enrolled older and sicker population
    - Many participants had no premium obligation
    - Allowed payment of premiums by non-profits
  - Iowa abandoned premiums in earlier demo

- If premiums deter enrollment of younger and healthier people, are they consistent with purpose of the ACA?

1115 Does Not Authorize Waivers of Cost-Sharing Provisions

- Statute provides flexibility particularly for beneficiaries with incomes above the poverty line
  - Co-pays for non-emergency use of the emergency room
  - Co-pays for non-preferred drugs

- Research needed on impact of cost-sharing on access to care

Arkansas “Private Option”

- Will it be cost-effective?
  - “Medically frail” remain in traditional Medicaid
State defining as cases with highest expenditures

- Demonstration project approved without an evaluation plan

- Hypothesis in proposal that better care in private option but what is the comparison group?

- Does it really limit churn?

- *Families v. single individuals*

- Is it budget neutral to the federal government?

Iowa Is Really a Four-Part Strategy

- Traditional Medicaid for the “medically frail” in addition to Wellness and Marketplace Choice Plans and premium assistance for employer coverage

- Impact of the complexity

  - Changes in income

  - Changes in availability of employer coverage

  - Changes in health status

- Will premiums be allowed for people with incomes below the poverty line?

Evaluation Should Drive Decisions at State and Federal Level

- AR model should be evaluated not just on private option but for its impact on traditional Medicaid

- Are demonstrations of premiums and cost-sharing really needed?

- Need short- and long-term evaluation plan because expansion decisions being made in “real time”
Medicaid Expansion Under the ACA: Dollars and Sense?

Joseph Antos

The Affordable Care Act (ACA) is a national test of our political and technical ability to reshape health financing in the United States.\(^{101}\) The principal objective of the legislation is to expand health insurance to millions of people who previously did not have the resources or access necessary to obtain coverage. The ACA established uniform national eligibility standards for Medicaid that were intended to guarantee health coverage to every low-income American. A subsidy program was established for individuals who did not already have access to private health insurance through their employer and new rules were imposed requiring insurers to extend coverage to all who apply, regardless of their health status.

Despite its substantial detail, the 2010 legislation provided only a crude sketch of what was to come. Thousands of pages of regulations and other guidance have more often than not obscured both the likely response of the health sector to the ACA and its impact on individuals. The Supreme Court upheld the constitutionality of the ACA, but determined that Congress had overstepped its authority by threatening to withdraw funding from any state that did not fully expand Medicaid coverage to the federal standard.\(^{102}\) Ongoing court cases could substantially alter the way the ACA operates.\(^{103}\) Health care providers, plans, and insurers are adapting their operations to meet the new requirements and changing business conditions. It will be years before the market stabilizes—assuming no substantial changes in legislation or regulation in the intervening period.

Even if the ACA’s provisions are not fully implemented, such sweeping legislation massively redistributes both resources and power in the health sector and the general economy. There will be winners and losers, but who wins and who loses—and by how much—was far from certain when the ACA was enacted and remains fluid. Research is needed to understand the complex interactions of federal, state, and private actions that have been triggered by the legislation. Such analysis can help identify the impact of the ACA on health care costs, the distributional consequences for individuals, the changing financial incentives created by the ACA for health plans and providers, and could provide insights into new policies that can promote efficiency, effectiveness, and value in our health care system.

Supporters of the ACA are unmistakably unhappy that the states have been given the authority to decide whether to expand eligibility to their Medicaid programs. States that do not expand will leave a coverage gap for those who do not qualify for Medicaid under existing state eligibility rules but have too little income to qualify for subsidies through the health insurance exchanges. Some states quickly expanded program eligibility to all whose incomes are less than 138 percent of the federal poverty level. Others may expand eligibility in future years, at least part way to the federal standard, and some states may decide not to expand. That creates variation, if not a completely natural experiment. But unless states are also given more flexibility to shape their programs to meet the needs of their populations—and continue innovations that have proven valuable—opportunities to improve the health system in a cost-effective manner for low-income families will be lost.

**Why Expand Medicaid to 138% of Poverty?**

\(^{101}\) What is commonly referred to as the Affordable Care Act consists of the Patient Protection and Affordable Care Act, enacted March 23, 2010, and the Health Care and Education Reconciliation Act, enacted March 30, 2010. Our discussion refers to the combined impact of those two acts.


All too often, Congress passes legislation that includes provisions that do not seem to make sense. Sometimes those inexplicable provisions are simply mistakes. The complexity of the ACA and the chaotic legislative process that disgorged the bill undoubtedly account for many problems that are now beginning to emerge.

Other inconsistent aspects of the ACA reveal the thinking that motivated the policy. A case in point is the overlap between income eligibility for the subsidies for private insurance on the exchange, which begins at the federal poverty level, and the ACA Medicaid eligibility standard, which tops out at 138 percent of poverty. Keep in mind that these provisions were written more than 2 years before the Supreme Court gave states the authority to decide whether to expand their Medicaid programs.

Had the ACA’s coercive tactics remained in place, the overlap in income eligibility would have been a minor issue because individuals who are eligible for subsidized insurance outside the exchange (whether from Medicaid or an employer) are not eligible for the exchange subsidy. Now that states can decide how much to expand Medicaid, individuals above the federal poverty level can be eligible for exchange subsidies while those with lower incomes may not be eligible for any subsidy at all.

Careful draftsmanship would have one subsidy program seamlessly ending where the other subsidy program begins. Corrections could have been made in a conference committee or through a corrections bill after the legislation was signed into law, but that was not politically possible.

That leaves us with a version of the bill that reveals negotiations over the cost of expanding coverage. By increasing the upper income limit for Medicaid eligibility, fewer people would be eligible for exchange subsidies and CBO would reduce the estimated budget cost of the bill.

One can understand the lure of what seems to be cheap insurance coverage for both the federal and state governments. The federal government in 2014 will pay about 58 percent of the cost of benefits for individuals who are eligible for Medicaid under the pre-ACA rules. The match rate jumps to 100 percent for those who become eligible under expanded ACA rules. Eventually the enhanced match drops to 90 percent of the cost of benefits, which is significantly higher than the current top rate (73.4%, which goes to Mississippi).

Even with full federal payment, the budget cost of an additional Medicaid enrollee is less than it would be if that person received an exchange subsidy. According to estimates from the Congressional Budget Office (CBO), the average federal cost of enrolling an adult in Medicaid under expanded ACA rules will be about $3,677 in 2014—higher than the $2,132 federal cost for enrollees under pre-ACA rules but significantly lower than the $6,348 average federal cost to subsidize individuals who enroll in the exchanges rather than in Medicaid.\(^\text{104}\)

From that perspective, expanding Medicaid under the ACA looks like a bargain. Perhaps 25 percent of new Medicaid enrollees will be people who qualified for the program under pre-ACA rules (the “woodwork effect”).\(^\text{105}\)

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\(^\text{105}\) CBO assumes that one-quarter of the 6 million people who will not have Medicaid coverage in 2022 as a result of the Supreme Court’s decision would have qualified under pre-ACA rules. See CBO, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, July 24, 2012,
That leaves about 6 million people enrolling in 2014 under the expanded rules. The federal government saves $16 billion in 2014 by shifting them to Medicaid rather than to the exchanges.

If the ACA Medicaid income level had been set equal to a more plausible figure, such as 100 percent of the poverty level, more than $100 billion would have been added to the estimated cost of an already expensive piece of legislation. By keeping one-third of newly-insured individuals out of private insurance, bill sponsors could claim that the ACA was not a trillion dollar spending bill.\(^{106}\)

The CBO score applies only to a 10-year budget window, but the commitment of taxpayer resources is permanent. The original estimate of the federal cost of insurance coverage provisions in the ACA was $788 billion for the period 2010 to 2019, which includes the 4 years prior to full implementation of the law.\(^{107}\) By now the cost has ballooned to $1.4 trillion for 2014 to 2024, a period over which the exchange subsidies and Medicaid expansion are fully implemented.\(^ {108}\) Unless there are significant changes in the subsidy programs, those costs will continue to rise over time.

### Is ACA’s Medicaid Expansion a Good Deal for States?

Medicaid is the single largest component of state expenditures, accounting for 23.5 percent of the $1.7 trillion spent by states in 2013.\(^ {109}\) Given other demands on state budgets and the political ramifications, the decision to expand Medicaid eligibility is not one that can be taken lightly.

From a purely budgetary standpoint, whether or not to expand Medicaid may be a wash during the years of full federal funding.\(^ {110}\) In either case, citizens who were previously uninsured gain coverage at little or no cost to the state. But beginning in 2017 the federal match rate drops to 95 percent and continues to decline to 90 percent by 2020. States that expand Medicaid coverage to obtain “free” insurance in the near term face mounting costs over time.

States have a strong incentive to take advantage of the overlap in subsidies that was left in the ACA by the legislative drafters. By not expanding Medicaid eligibility, individuals with incomes between 100 and 138 percent of the federal poverty level gain comprehensive private insurance coverage at no cost to the state.

States have been discouraged from partially expanding Medicaid to those with incomes up to the poverty level. The administration’s position is that any partial expansion would receive only the regular match rather than the

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\(^ {106}\) Assuming that 25 percent of new Medicaid enrollees were qualified under pre-ACA rules, 9 million of the 12 million people who have Medicaid coverage due to the ACA in 2016 would be eligible for 100 percent federal funding. Those 9 million constitute somewhat more than one-third of the 25 million people CBO estimates gained insurance coverage from all sources in that year. See CBO, Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline, May 2013, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf).


\(^ {109}\) National Association of State Budget Officers, *Fiscal Survey of States, Fall 2013*, [http://www.nasbo.org/sites/default/files/NASBO%20Fall%202013%20Fiscal%20Survey%200f%20States_0.pdf](http://www.nasbo.org/sites/default/files/NASBO%20Fall%202013%20Fiscal%20Survey%200f%20States_0.pdf).

enhanced federal matching payment.\footnote{111 Kathleen Sebelius, Progress Continues in Setting up Health Insurance Marketplaces, December 10, 2012, http://www.hhs.gov/healthcare/facts/blog/2012/12/marketplaces121012.html.} That is intended to encourage state to fully expand their programs, but it also discourages states from any expansion at all. Particularly in states that have tightly limited access to Medicaid coverage, the additional cost of an expansion would be substantial.

The budgetary impacts vary across states depending on the generosity of their current programs.\footnote{112 Drew Gonshowroski, “Obamacare and the Medicaid Expansion: How Does Your State Fare?” The Heritage Foundation, The Foundry, March 5, 2013, http://blog.heritage.org/2013/03/05/obamacare-medicaid-expansion-state-by-state-charts.} New York, which already provides support for people through state-only programs, could save as much as $33.8 billion over the next decade by shifting those costs into Medicaid. In contrast, Georgia could be faced with $1.8 billion in higher state costs by expanding Medicaid to 138 percent of the poverty level.

Largely as a consequence of the ACA, state and local spending for Medicaid is projected to double over the next decade from $188 billion in 2013 to $340 billion in 2022.\footnote{113 Gigi A. Cuckler, Andrea M. Sisko, et al., “National Health Expenditure Projections, 2012–22: Slow Growth Until Coverage Expands And Economy Improves,” Health Affairs, October 2013, http://content.healthaffairs.org/content/32/10/1820.full.pdf+html.} Even after the initial cost increase as a result of expanded coverage, however, state and local Medicaid spending is projected to grow about 7 percent a year—substantially faster than the economy or state revenues.

As the baby boom generation ages, more people will become eligible for Medicaid and will need long-term care and other expensive services covered by the program. Those costs will add to budget challenges at all levels of government whether or not states expand their programs.

That adds an additional uncertainty to what is already a complex decision. The federal government could respond to its own fiscal pressures by cutting back on the enhanced matching rate for new Medicaid enrollees, leaving states with a larger bill. By the same token, there is no reason to think that the exchange subsidies would not be reduced to help with a federal budget problem, although that might wait until after 2016.


Subsidized health plans on the exchanges are likely to be no better. The ACA requires exchange plans to offer generous benefits but limits the ability of plans to manage patient costs. Consequently, narrow networks are common among exchange plans, triggering complaints from consumers who are faced with costly premiums, high deductibles and other cost-sharing requirements, and restricted access to physicians and hospitals.\footnote{116 Darius Tahir, Narrow-Network Health Plans Expected to Proliferate Under Obamacare, National Journal, October 9, 2013, http://www.nationaljournal.com/innovations-in-health/narrow-network-health-plans-expected-to-proliferate-under-obamacare-20131009.}

For persons with incomes between 100 and 138 percent of poverty, the cost of premiums, deductibles, and other cost-sharing requirements is largely covered by the exchange subsidies—but only for lower-cost “silver” plans that
have limited provider networks. The plans are lower cost but enrollees are likely to lose access to their neighborhood hospital and their physicians.

**Reform, With or Without Expansion**

Medicaid serves different populations with sharply different needs, and reforms must account for that diversity as well as varying conditions in each state. Regardless of individual state decisions on whether to expand eligibility, there are opportunities to make Medicaid more responsive to the populations it serves without driving costs to unsustainable levels.

Medicaid reform should seek to restore to beneficiaries a sense of ownership and responsibility that all too often is taken away by poverty, disease, and bureaucracy. That means ensuring that our scarce resources serve those most in need of public help. It means removing the disincentives that discourage poor Americans from joining the middle class. And it means returning power and responsibility to states, localities, and families.

As America’s largest means-tested entitlement program, Medicaid operates philosophically like welfare programs of old. Individuals with sufficiently low income are entitled to benefits with no further obligation or responsibility to contribute in some way to the greater good, even if they are able. Moreover, Medicaid beneficiaries have little opportunity to be active consumers of health services, a long-standing problem in the health sector.

Welfare reform in the mid-1990s changed the way we think about cash assistance to the poor. As a condition of receiving support through Temporary Assistance for Needy Families (TANF), able-bodied adults are now required to meet a work requirement. The objective is to wean families from welfare dependency and, in so doing, reduce the chances that they will continue to need help years from now. By any reasonable measure, we are on our way to achieving that goal.¹¹⁷

In contrast, Medicaid operates without work requirements. This is particularly relevant to the expansion population who will become Medicaid beneficiaries as a result of the ACA. If all states expanded their eligibility limits, 82 percent of the new eligibles would be adults not living with dependent children.¹¹⁸ Moreover, more than half would be below the age of 35. Many of them are working, but many who are not could seek employment.

There are two sides to every contract, even a social contract. Both sides should have responsibilities that they must meet.

We should also integrate medical assistance with mainstream health insurance. The vast majority of us participate in health plans sponsored by our employers. Medicaid coverage should be converted into a premium assistance program to subsidize the cost of private insurance, including high-deductible plans with health savings accounts. Medicaid beneficiaries should not have to choose between a job and health care for their children.

By mainstreaming healthy children and adults and providing temporary assistance to purchase health insurance when it is needed, we can focus Medicaid on beneficiaries with chronic infirmities who are dependent on government assistance for their survival. The latter group has multiple needs that may include mental health and addiction services, housing, social services and other activities provided across a number of state and local agencies. Better coordination among those agencies, and between the agencies and charitable organizations and families, can yield more effective use of limited funds.


To make such reforms work, we need to shift decision-making authority back to the families and state and local governments who actually manage—or cope with—the Medicaid program on a day-to-day basis. Shifting from the current financing system, in which the federal government pays at least half of the cost of the state’s program cost, to a block grant would reverse the incentives that drive up spending.

There is a built-in inflationary bias in Medicare financing. Because the states pay a percentage of the costs of Medicaid with the federal government paying the rest, state policymakers can take credit for expanding Medicaid coverage without having to pay the full cost. Moreover, actions to reduce spending yield no more than 50 cents on the dollar in Medicaid savings to the state. Sensible cost-cutting policies are less likely to be adopted if the state keeps only part of the savings but incurs all of the political opposition.

When a state does decide to adopt a new policy or adjust an old one, it must seek permission from the Centers for Medicare and Medicaid Services (CMS). That additional layer of bureaucracy can be enough to stop a good idea before it can be tried.

To address both issues, Medicaid should be converted from an open-ended entitlement to federal dollars to a form of defined contribution. Federal subsidies to the states should be set a fixed amount that does not increase as a result of state actions designed to shift cost out of their budgets. This is essentially a block grant, although the precise form of the grant could account for inflation, population growth, and other circumstances outside direct state political control that influence the cost of Medicaid.

A block grant approach gives states incentives to reduce unnecessary spending and focus their resources on those most needing help. States should be given wider authority to make program changes without having to seek approval from the federal government. Since states would be fully responsible for any spending in excess of the grant, regulatory restrictions can be loosened without exposing the federal budget to unexpected costs. This also requires a clear set of rules establishing the general expectations we should all have for an effective medical assistance program that can operate within reasonable budgetary limits.

Waivers and State Experimentation

Despite substantial barriers to innovation, many states have pioneered Medicaid reforms through waivers granted by CMS. The lesson of these experiments is that one size does not fit all. The different populations served by Medicaid have varying needs for services and capabilities to navigate the health system. Some states are eager to try new approaches, and others face political and technical challenges that make innovation difficult. Limited fiscal capacity is a problem for all states.

An important theme of state initiatives is promoting more active consumer decision-making and aligning incentives to reduce waste and inefficiency. For example, the Healthy Indiana Plan provides a benefit package modeled after a high-deductible health plan and health savings account. The combination of significant cost-sharing requirements and a subsidized personal account is intended to make enrollees more cost-conscious than beneficiaries of traditional Medicare.

The plan, which began in 2008, expanded Medicaid eligibility to adults with incomes up to 200 percent of the federal poverty level. The deductible is $1,100, which is substantial for a low-income population. A Personal Wellness and Responsibility (POWER) account is used to cover the cost of the deductible. An individual contributes a modest income-related amount to the account, with the remaining cost of the deductible covered by a

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government subsidy. Enrollees with no income do not pay into their POWER accounts and the program covers the full contribution. This gives everyone in the plan personal responsibility for how that money is spent.

The ACA mandated states to expand their traditional Medicaid programs to everyone with income up to 138 percent of poverty, but it did not create new opportunities for state innovation. The Supreme Court put the decision to expand Medicaid back in the hands of the states, but it too failed to give states more authority to run their own programs.

Several states have proposed to expand eligibility by incorporating premium assistance in their Medicaid programs. Premium assistance allows public funds from Medicaid or the Children’s Health Insurance Program to be used to purchase private coverage, which could include plans offered by employers or by insurance exchanges.

Arkansas received approval to shift its entire Medicaid population into the exchange, starting with all newly eligible beneficiaries but eventually including currently eligible beneficiaries as well. This step was taken in part because of concerns that the exchange market would otherwise not attract enough enrollees to be viable. Persons likely to have high medical costs—including those who are medically frail, pregnant women, and dual eligible beneficiaries (who are typically elderly and in need of long-term care services)—are excluded.

The Arkansas project, which was approved for 3 years, transfers Medicaid’s requirements and inefficiencies into the insurance exchange. The Department of Health and Human Services (HHS) has stated that all Medicaid beneficiaries who are transferred into the exchanges “remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.”

At least for beneficiaries under the poverty level, the only change is the name of their health plan: they will have full Medicaid coverage with no responsibility for premiums or cost-sharing. For beneficiaries between 100 and 138 percent of poverty, cost sharing will be minimal, reflecting existing Medicaid rules.

Under the terms of the waiver, the cost of this project is supposed to be no greater than current program costs. Although organized health plans might reduce the cost of care and improve the care that is delivered, it is more likely that the exchange plans will operate like Medicaid with little change in access to or quality of care.

Other states have adopted a more ambitious approach to expanding Medicaid using premium assistance. Iowa and Pennsylvania require beneficiaries to pay modest income-related premiums, but reduce the cost for beneficiaries who participate in healthy behavior activities. Pennsylvania also reduces the premium for beneficiaries who

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123 Arkansas has said that they plan to impose some cost-sharing on beneficiaries with incomes between 50 and 100 percent of the federal poverty level, subject to approval by CMS.

actively look for employment. Unlike Arkansas, both states also provide premium assistance for employer-sponsored insurance when available.

States could do more to develop better ways to provide Medicaid coverage if the federal waiver process were simplified and improved. The Bipartisan Policy Center’s Governors’ Council recommends 5 improvements, including:

- Establish a clear, detailed process for establishing budget neutrality for Medicaid waivers and for evaluating waiver applications,
- Convert successful waivers into permanent innovations,
- Develop templates for state plan amendments,
- Design waiver templates to allow states to respond rapidly to requirements in the ACA, and
- Make technical guidance available and accessible to states and the public.125

The Republican Governors Public Policy Committee takes a broader view, offering proposals that would in some measure address long-standing problems in Medicaid.126 They argue that states are in the best position to design systems based on their own needs, culture, and values. Specific proposals include:

- More flexible financing mechanisms, which could include a block grant or capped allotment in place of the federal matching formula;
- Allowing states to negotiate performance targets with CMS rather than holding them to the detailed and complex rules that currently dictate how states run their programs;
- Eliminating the need to seek federal approval for even small changes in state Medicaid programs;
- Allowing states to tailor payments to providers that promote quality and performance, in place of fee-for-service payment methods;
- Streamline and simplify the eligibility process to ensure that those most in need are served;
- Enforcing reasonable cost-sharing rules; and
- Offering a choice of health plans to beneficiaries.

Rep. Fred Upton (R-MI), chairman of the House Energy and Commerce Committee, and Sen. Orrin Hatch (R-UT), ranking member of the Senate Finance Committee, similarly propose changes in Medicaid that allow states to test and implement patient-centered reforms that meet the needs of beneficiaries while reducing costs.127 Their comprehensive agenda addresses a large number of concerns, and includes:

- Encouraging individualized benefit designs, which could include premium assistance, value-based insurance designs, account-based plans, and other consumer incentives;
- Increased provider transparency and value-based purchasing;
- Improved access to coordinated care;

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• Reduced barriers to state innovation, including requiring CMS to respond promptly to waiver requests and waiver reciprocity (which requires HHS to approve waivers similar to those already in force); and
• Shifting from the current federal matching payment system to federal per capita allotments tailored to the specific population categories served by Medicaid.

Responsible reforms can improve the value of Medicaid coverage while placing program spending on a path that is sustainable both for the federal government and the states. A reasonable first step is to remove the bureaucratic barriers to state experimentation.

Conclusion

Medicaid spending will increase dramatically as a result of the Affordable Care Act. Millions of people will become newly eligible in states that choose to expand their programs. Millions more who were eligible under previous rules have been encouraged to enroll as well. That will bump up total Medicaid spending by over 12 percent in 2014—almost double the average annual rate of increase in spending over the past decade.\textsuperscript{128}

Beyond the immediate surge in enrollment and cost, Medicaid spending will continue to grow very rapidly in coming years, averaging about a 6.7 percent annual increase from 2015 to 2022. Even if the recent slowdown in the growth of overall health spending continues, Medicaid will have a rising proportion of elderly and disabled beneficiaries who use expensive services that drives up program cost.

Those spending trends make Medicaid a growing problem for policymakers at all government levels. They face many competing demands for resources, and there is only limited capacity to expand revenue. New ways must be found to reduce the cost of Medicaid while improving the value that the program provides to those most in need.

The Affordable Care Act represents a lost opportunity to take on the daunting challenge of reforming Medicaid. Given the complexity of the program and the sensitivity of the politics, it may be asking too much for the federal government to take on that task. States are in a better position to understand the specific challenges faced by their Medicaid programs, and to assess their fiscal and political capacity to make changes.

We should adopt incremental policies that open the program to greater state innovation. States are on the front lines of Medicaid and the battle to control spending. They need relief from the straitjacket of excessive federal regulation and more flexibility to try local solutions for local problems.

Changes at the federal level are needed to give a stronger impetus to state-led reforms. The number one problem is the perverse system of matching payments, which promotes inefficient and unnecessary spending. A shift to a defined contribution-style federal subsidy would reverse 5 decades of perverse incentives. Implemented carefully, vulnerable populations would be protected and their care would be improved. Without fundamental financing reform, states and the federal government will continue to have conflicting policy objectives.

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Genevieve M. Kenney, Ph.D. is Co-Director and a senior fellow in the Health Policy Center of the Urban Institute. She received a doctorate in economics and Masters in Statistics from the University of Michigan and has been conducting policy research for over 25 years. She is a nationally renowned expert on Medicaid, The Children's Health Insurance Program (CHIP), and the broader health insurance coverage and health issues facing low-income children and families.

She has led a number of Medicaid and CHIP evaluations and published over 100 articles and briefs on insurance coverage and access to care for low-income children, pregnant women, and other adults. In her current research, she is examining the implications of the Affordable Care Act, Medicaid coverage of family planning services, and state efforts to enroll more children and adults in Medicaid and CHIP.

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Kosali Simon is a Professor at SPEA, IU, and a Research Associate of the National Bureau of Economic Research (NBER). Prior to joining SPEA in 2010, she was an Associate Professor at Cornell University. She teaches classes in health economics and health policy at graduate and undergraduate levels, and her primary research area is economic analysis of health insurance and health care policy. She is a Board Member of the American Society of Health Economists (ASHEcon) and the American Economic Association Committee on the Status of Women in Economics (CSWEP) where she coordinates the national mentoring program for junior female economists. She serves as the health Co-editor for the *Journal of Policy Analysis and Management*, an Associate Editor of *Health Economics*, an editorial board member of the *American Journal of Health Economics*, a member of the National Advisory Council for the Robert Wood Johnson Foundation Health Policy Fellowship program, and an Affiliated Scholar of the Urban Institute. She received her PhD in Economics from the University of Maryland at College Park.

**Alan Weil**  
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Alan Weil has been the executive director of the National Academy for State Health Policy (NASHP) since September 2004. An independent, non-partisan, non-profit research and policy organization, NASHP is dedicated to excellence in state health policy and practice. Prior to joining NASHP, Mr. Weil served as director of the Urban Institute's Assessing the New Federalism project, one of the largest privately funded social policy research projects ever undertaken in the United States. He previously held a cabinet position as executive director of the Colorado Department of Health Care Policy and Financing, was health policy advisor to Colorado Governor Roy Romer, and was assistant general counsel in the Massachusetts Department of Medical Security.
Mr. Weil is a frequent speaker on national and state health policy, Medicaid, federalism, and implementation of the Affordable Care Act. He is the co-editor of two books, publishes regularly in peer-reviewed journals, has testified before Congress more than half-a-dozen times, and is called upon by major media outlets for his knowledge and analysis.

He is on the editorial board of the journal Health Affairs, and is a member of the Institute of Medicine's Board on Health Care Services, the Kaiser Commission on Medicaid and the Uninsured, as a member of The Commonwealth Fund's Commission on a High Performance Health System. He is a member of the Board of Trustees of the Consumer Health Foundation in Washington, DC, and of the Board of Directors of the Essential Hospitals Institute (formerly the National Public Health and Hospitals Institute). He is a graduate of the University of California at Berkeley, the John F. Kennedy School of Government at Harvard University, and Harvard Law School.

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Dr. Frank J. Thompson is a nationally renowned scholar of politics and administration, implementation, public management, and health policy. In 2007, he received a Robert Wood Johnson Investigator Award to study the evolution of Medicaid during the Clinton, G.W. Bush, and Obama administrations. The research led to Thompson’s forthcoming book, Medicaid Politics: Federalism, Policy Durability, and Health Reform (Georgetown University), which is a thorough examination of the genesis and expansion of Medicaid and its impact on the American health care system.

Thompson is a fellow of the National Academy of Public Administration, a past president of the National Association of Schools of Public Affairs and Administration, and the former executive director of the National Commission on State and Local Public Service (Winter Commission). He has received several awards including the Donald C. Stone Distinguished Scholar Award for his accomplishments in the field of intergovernmental relations and management.

In 2008, Thompson joined the School of Public Affairs and Administration at Rutgers University in Newark and concurrently became an affiliated faculty member of the Rutgers Center for State Health Policy in New Brunswick. Prior to his tenure at Rutgers, he served as dean of the Rockefeller College of Public Affairs & Policy at the University at Albany, State University of New York. Thompson is an alumnus of the University of Chicago where he earned his bachelor’s degree in political science and the University of California, Berkley, where he received his doctoral and master’s degrees in the same discipline.

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Julie Sonier is Deputy Director of the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota. She has over 15 years of experience in the development and implementation of state-level health reforms, with a particular focus on using data to understand state-level trends and to inform policy decisions that improve health care cost, access, and quality. She assists states with modeling the state-level impacts of health care reforms, designing and implementing multipayer health care payment reform initiatives, creating frameworks for measuring the impacts of reforms, and implementing Medicaid-related provisions of the Affordable Care Act. Prior to joining SHADAC in 2010, Ms. Sonier served as director of the Health Economics Program at the Minnesota Department of Health. Ms. Sonier holds a masters degree in public affairs with a concentration in economics from Princeton University and a B.A. in economics from Amherst College.
Thomas DeLeire
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Thomas DeLeire is professor of public policy. His research focuses on labor and health economics. His most recent work has comprised an evaluation of recent expansions to Wisconsin’s health insurance programs for low-income families. DeLeire has twice taken leave from his university appointments to work in government. From 2005 to 2007, he was a senior analyst at the Congressional Budget Office, and from 2002 to 2003, he was senior economist for labor, health, and education for the Council of Economic Advisers.

Sharon Long
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Sharon Long, a senior fellow in the Health Policy Center at the Urban Institute, is an applied economist with over 25 years of experience conducting timely research on health care issues, including work addressing state and national health reform. Dr. Long was recently awarded AcademyHealth's 2012 Health Services Research Impact Award for her research evaluating the impacts of health reform in Massachusetts. While Dr. Long has spent most of her career at the Urban Institute, she was a Professor in the School of Public Health at the University of Minnesota from 2010 to 2012, where she worked with states on health reform issues as a senior economist at the State Health Access Data Assistance Center (SHADAC). Dr. Long holds a Ph.D. in economics from the University of North Carolina at Chapel Hill.

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Rick Kronick
Director, Agency for Healthcare Research and Quality (AHRQ)

Dr. Kronick joined the Department in January 2010 as Deputy Assistant Secretary for Planning and Evaluation, overseeing the Office of Health Policy. In that role, he has conducted and coordinated research on policies relating to public health; health care delivery; health insurance; and health care financing programs, including Medicare, Medicaid, State Children's Health Insurance Program, and private insurance coverage. His work, and that of the Office of Health Policy under his leadership, has been integral to the implementation of the Affordable Care Act. Additionally, his team has provided insight and information critical to our effort to improve the health of the nation. Prior to joining HHS, Dr. Kronick conducted health policy research in academia as well as in federal and state government, including as Director of Policy and Reimbursement for the Medicaid Division of the Massachusetts Department of Public Welfare, and most recently, as a Professor and Chief of the Division of Health Care Sciences in the Department of Family and Preventive Medicine at the University of California, San Diego. "AHRQ has important work ahead, and I look forward to continuing to work with Dr. Kronick in this new role," Secretary Sebelius said in a statement.

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Department of Health Policy
Sara Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University, Milken Institute School of Public Health. She also holds a Professorship by Courtesy in the GW Law School and is a member of the faculty of the School of Medicine and Health Sciences.

A graduate of Wesleyan University and Boston University Law School, Professor Rosenbaum has devoted her professional career to issues of health justice for populations who are medically underserved as a result of race, poverty, disability, or cultural exclusion. An honored teacher and scholar, a highly popular speaker, and a widely read writer on many aspects of health law and policy, Professor Rosenbaum has emphasized public engagement as a core element of her professional life, providing public service to six Presidential Administrations and fifteen Congresses since 1977. Professor Rosenbaum is best known for her work on the expansion of Medicaid, the expansion of community health centers, patients' rights in managed care, civil rights and health care, and national health reform. Between 1993 and 1994, she worked for President Clinton, directing the drafting of the Health Security Act and designing the Vaccines for Children program, which offers near-universal coverage of vaccines for low income and medically underserved children. Professor Rosenbaum also regularly advises state governments on health policy matters and has served as a testifying expert in legal actions involving the rights of children under Medicaid. Professor Rosenbaum is the leading author of Law and the American Health Care System, 2d ed., published by Foundation Press, May, 2012, a landmark textbook that provides an in-depth exploration of the interaction of American law and the U.S. health care system. She has received national awards for her work, serves on governmental advisory committees, private organizational and foundation boards, and is a past Chair of AcademyHealth. She is a member of the CDC Director's Advisory Committee, the CDC Advisory Committee on Immunization Practice (ACIP), and a Commissioner on the Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress on federal Medicaid policy.

Marsha Lillie-Blanton
Director
Division of Quality, Evaluation & Health Outcomes –
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Robert Kaestner
Professor
Institute of Government and Public Affairs
University of Illinois
Department of Economics
University of Illinois at Chicago

Dr. Kaestner is a Professor in the Institute of Government and Public Affairs and a Professor in the Department of Economics of the University of Illinois at Chicago. He is also a Research Associate of the National Bureau of Economic Research and serves as a co-editor of the Journal of Policy Analysis and Management. Dr. Kaestner's area of expertise are health, labor and social policy. He has authored more than 100 scholarly publications and has been awarded several research grants from the National Institutes of Health.

Marsha Gold
Senior Fellow
Mathematica Policy Research
Marsha Gold is a senior fellow at Mathematica in Washington, DC. She is a nationally known expert on health care delivery and financing, especially in managed care and public programs such as Medicare and Medicaid. Her expertise covers trends in the organization and financing of medical care and its implications for access to care.

Current studies include the Medicare Advantage Monitoring Program, which has been tracking the use of private plans in Medicare, the Global Assessment of HITECH for the Office of the National Coordinator for Health Information Technology, and several studies that aim to monitor emerging models (e.g. accountable care) and support policymakers (e.g. the Medicaid Access and Payment Commission). Recent projects have involved support for Mathematica’s work with AHRQ on the patient centered medical home, analysis of the Consensus Development Process used by the National Quality Forum, and evaluations of the National Health Plan Collaborative to reduce racial and ethnic disparities.

Katherine Hempstead
Senior Program Officer
RWJF

Katherine Hempstead, PhD, MA, joined the Robert Wood Johnson Foundation in 2011 as a senior program officer in the Research and Evaluation unit. She brings her exceptional experience in government, research, and academia to her work with the RWJF Coverage team, and relishes the “opportunity to start new projects and learn more about the world of philanthropy.”

Previously, Hempstead was director of the Center for Health Statistics in the New Jersey Department of Health and Senior Services. She also served as statistician/analyst in the Office of the Attorney General, New Jersey Department of Law and Public Safety, an assistant research professor, Rutgers Center for State Health Policy, and an adjunct assistant professor, School of Public Health, University of Medicine and Dentistry of New Jersey.

Hempstead’s early career included work as a research scientist and assistant professor at the Center for Health and Public Service Research, Wagner School of Public Service, New York University. She was an instructor at the New School for Social Research, New York, a post-doctoral training fellow at the Office of Population Research at Princeton University, and an assistant professor at Catholic University, Washington, D.C. She has published extensively in the areas of mortality by ethnicity and migration.

Born in New Jersey, Hempstead received a PhD in Demography and History from the University of Pennsylvania, where she also earned an MA in Demography and a BA in Economics and History.

Hempstead presently resides in West Windsor with her husband. They have three children.

Barbara Lyons
Director, Kaiser Commission on Medicaid and the Uninsured

Barbara Lyons is a leading expert on Medicaid and health policy issues affecting low-income and vulnerable populations. She conducts policy research, testifies and has published widely on health insurance coverage, access to care, health care delivery and financing, dual eligibles and long-term care. She is Director of the Kaiser Commission on Medicaid and the Uninsured, a major initiative of the Foundation that serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform.

Prior to her position with the Kaiser Commission, Dr. Lyons served on the policy staff of The Commonwealth Fund Commission on Elderly People Living Alone where she specialized in economic, health coverage and financing issues facing elderly people. Dr. Lyons received her doctoral degree in health policy from the Johns Hopkins University, Bloomberg School of Public Health.
**Chris Perrone**  
Deputy Director, Health Reform and Public Programs Initiative  
Acting Director, Better Chronic Disease Care Program  
California Healthcare Foundation

Christopher Perrone is acting director of the foundation's Better Chronic Disease Care program, which focuses on improving clinical outcomes and quality of life for Californians with chronic diseases. Perrone is also deputy director of the foundation's Health Reform and Public Programs Initiative.

In that capacity, he leads CHCF's efforts to improve the policies and practices that shape Medi-Cal and other publicly funded health care programs, and to promote greater transparency of, and accountability for, the performance of these programs.

Prior to joining CHCF, Perrone served as director of planning for the Massachusetts Division of Medical Assistance. He was the first external recipient of the Globe Award, given by the Office of Strategic Planning at HCFA (now CMS), for his work to improve the delivery and financing of acute and long term care services for low-income seniors. Perrone has also held positions with The Lewin Group, the American Psychological Association, and the Center for Health Policy Studies at Georgetown University.

Perrone received a bachelor's degree from the University of California, Berkeley and a master's degree in public policy from Harvard University.

**Anne L. Schwartz**  
Executive Director  
MACPAC - Medicaid and CHIP Payment and Access Commission

The Medicaid and CHIP Payment and Access Commission (MACPAC) named Anne L. Schwartz, Ph.D. as its executive director in February of 2013. Dr. Schwartz joined MACPAC as deputy director for policy and analysis in October and has served as acting executive director for the past four months. She comes to MACPAC from the journal *Health Affairs* where she served as deputy editor.

Dr. Schwartz has served in leadership positions in both government and nonprofit settings. Prior to *Health Affairs*, she was vice president of Grantmakers In Health, a national nonprofit organization providing strategic advice and guidance to private foundations and corporate giving programs working in the health sphere. Among her responsibilities there were efforts to build bridges between policymakers and health grantmakers. Earlier, she was special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a predecessor to the Medicare Payment Advisory Commission. She began her career serving on personal and committee staff in the U.S. House of Representatives.

Dr. Schwartz is a graduate of Brown University and earned her doctorate in health policy from the School of Hygiene and Public Health at The Johns Hopkins University.

**Sandra Decker**  
Distinguished Consultant  
National Center for Health Statistics  
Centers for Disease Control and Prevention

**Stephen Zuckerman**  
Co-Director and Senior Fellow  
Health Policy Center
Stephen Zuckerman, Ph.D. is Co-Director and a senior fellow in the Health Policy Center of the Urban Institute. He received his doctorate in economics from Columbia University in 1983 and has studied health economics and health policy for almost 30 years. He is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services.

He has also published extensively on a wide range of other topics, including the determinants of geographic differences in Medicare spending, Medicaid managed care, state coverage expansions for adults, changes in Medicare benefit design that could protect the most vulnerable beneficiaries, hospital rate setting, and the impact of undocumented immigrants on the U.S. Health care system. Other issues he has worked on include Medicaid financing arrangements, crowd-out of private coverage by SCHIP, the health care safety net, and survey approaches for measuring insurance coverage.

Dr. Zuckerman also co-directed the development of the Geographic Practice Cost Indices used in the Medicare physician fee schedule. Prior to joining the Institute, he worked at the American Medical Association's Center for Health Policy Research.

Thomas Buchmueller
Professor
Ross School of Business
University of Michigan

Tom Buchmueller is a health economist whose research focuses on the economics of health insurance and related public policy issues. His recent work has examined the relationship between employer-sponsored insurance and labor market outcomes, interactions between the public sector and private insurance markets and consumer demand for health insurance.

Before joining the Ross School faculty, Buchmueller was Professor of Economics and Public Policy at the Paul Merage School of Business at the University of California, Irvine. He was a Packer Policy Fellow at the University of Technology, Sydney (2006-2007) and was a visiting researcher at the Federal Reserve Bank of San Francisco (2005-06), INSEAD (2001-2002), the Centre de Recherche d'Etude et de Documentation en Economie de la Sante' (2001-2002) and the University of York (1997).

John Holahan
Institute Fellow
Urban Institute

John Holahan has a wide range of research interests, including state health policy, Medicaid, and issues on federalism and health. He has written on Medicaid block grants and other proposals on changing the financing of Medicaid. He has been interested in changes in insurance coverage and rising numbers of uninsured, particularly on the role of changes in income distribution and changes in the number of uninsured. He is currently involved in a major project looking at a wide range of cost containment options. He helped developed the Massachusetts health care reform law.

Dr. Holahan has written several books and served on editorial boards of a number of journals - Health Affairs, Health Services Research, and Inquiry.

Deborah Bachrach
Deborah Bachrach has more than 25 years of experience in health policy and financing in both the public and private sectors and an extensive background in Medicaid policy and healthcare reform. She works with states, providers, plans and foundations in implementing federal health reform and Medicaid payment and delivery system reforms.

Ms. Bachrach has served as an advisor to the Center for Health Care Strategies, the Medicaid and CHIP Payment and Access Commission (MACPAC), the Robert Wood Johnson Foundation and the Kaiser Family Foundation as well as state Medicaid agencies, foundations, healthcare providers and other healthcare organizations. She is an adjunct professor of law at the New York University School of Law, where she teaches a seminar on federal health reform.

Most recently, Ms. Bachrach was the Medicaid Director and Deputy Commissioner of Health for the New York State Department of Health, Office of Health Insurance Programs. In this capacity, she was responsible for coverage, care and payment policies for over 4 million children and adults enrolled in New York’s Medicaid and Child Health Insurance Programs and led reforms to streamline Medicaid’s eligibility and enrollment process and to improve its purchasing strategies.

Ms. Bachrach was a partner at Manatt from 1992 to 2006, serving as co-chair of the Healthcare Practice Group. She provided legislative, regulatory and strategic counsel to academic medical centers, safety net hospitals, community health centers, health plans and other healthcare companies.

Prior to this, Ms. Bachrach served as Vice President, External Affairs, at St. Luke’s-Roosevelt Hospital Center. She also worked for four years as New York State Chief Assistant Attorney General and for three years as Chief of the Civil Rights Bureau in the Office of the New York State Attorney General.

**Matt Salo**  
Executive Director  
National Association of Medicaid Directors

Matt Salo was named the first Executive Director, and at the time, only staff member of the National Association of Medicaid Directors (NAMD) in February 2011. This was a bit of a homecoming, as his first real job out of college was working for the Medicaid Directors from 1994 to 1999.

Matt formerly spent 12 years at the National Governors Association, where he worked on the Governors’ health care and human services reform agendas, and where he firmly believes he was responsible for securing the entire tobacco settlement for the states, getting more than $100 billion in state fiscal relief, and in modernizing the Medicaid program.

Matt taught high school for two years at T.C. Williams High in Alexandria, VA, which actually bears no resemblance to the school they profiled in the Disney movie, Remember the Titans. He holds a BA in Eastern Religious Studies from the University of Virginia, and is still trying to find ways to explain how that got him to where he is today.

**Judy Solomon**  
Vice President for Health Policy  
Center on Budget and Policy Priorities
Solomon is Vice President for Health Policy at the Center on Budget and Policy Priorities, where she focuses on Medicaid and the Children’s Health Insurance Program and issues related to the implementation of health reform, particularly policies to make coverage available and affordable for low-income people.

She has testified before state legislatures and spoken extensively to national and state nonprofit groups and is often cited by national and state media, including the New York Times, USA Today, Wall Street Journal, and Washington Post.

Previously, Solomon was a Senior Policy Fellow at Connecticut Voices for Children and Executive Director of the Children’s Health Council. She directed the Council’s work on policy analysis, outreach, education and training, and independent oversight of health care services provided through Connecticut’s Medicaid managed care program.

She has also worked as a legal services attorney specializing in the area of public benefits and taught at the Yale University School of Medicine.

Solomon is a graduate of the University of Connecticut and Rutgers University School of Law in Newark.

**Joseph Antos**  
Wilson H. Taylor Scholar in Health Care and Retirement Policy  
American Enterprise Institute

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), where his research focuses on the economics of health policy — including the Affordable Care Act, Medicare, the uninsured, and the overall reform of the health care system and its financing. He also studies the impact of health care expenditures on federal budget policy.

Before joining AEI, Antos was assistant director for health and human resources at the Congressional Budget Office (CBO). He has also held senior positions in the US Department of Health and Human Services, the Office of Management and Budget, and the President’s Council of Economic Advisers. He recently completed a seven-year term as health adviser to CBO, and two terms as a commissioner of the Maryland Health Services Cost Review Commission. In 2013, he was also named adjunct associate professor of emergency medicine at George Washington University.

Antos has a Ph.D. and an M.A. in economics from the University of Rochester and a B.A. in mathematics from Cornell University.

**Cindy Mann**  
Deputy Administrator and Director Center for Medicaid and CHIP Services  
CMS

Cindy Mann, J.D. has served as the Director of the Center for Medicaid and CHIP Services (CMCS) within the Centers for Medicare & Medicaid Services (CMS) since June 2009. As CMS Deputy Administrator and Director of CMCS, Ms. Mann is responsible for the development and implementation of national policies governing Medicaid, the Children’s Health Insurance Program (CHIP), including working closely with States.

Prior to her return to CMS in 2009, Cindy served as a research professor at the Georgetown University Health Policy Institute and was the Executive Director of the Center for Children and Families at the Institute. Her work at Georgetown focused on health coverage, financing, and access issues affecting low-
income populations and States. Cindy served as Director of the Family and Children’s Health Programs Group in the CMS (then HCFA) Center for Medicaid and State Operations from 1999-2001, where she played a key role in implementing the SCHIP program and led the Center’s broader work on Medicaid policies affecting children and families. Before joining HCFA in 1999, Cindy directed the Center on Budget and Policy Priorities' federal and State health policy work. She also has extensive State-level experience, having worked on health care, welfare, and public finance issues in Massachusetts, Rhode Island, and New York.

Cindy holds a law degree from the New York University School of Law.

**Andrew Bindman**  
Professor of Medicine, Health Policy, Epidemiology and Biostatistics  
UCSF

Andy Bindman, M.D., is Professor of Medicine, Health Policy, Epidemiology & Biostatistics, at the University of California San Francisco (UCSF). He is Director of the University of California Medicaid Research Institute and Director of UCSF’s Primary Care Research Fellowship. From 1995-2010 he served as the Chief of the Division of General Internal Medicine at San Francisco General Hospital where he helped the Division to become a nationally recognized leader in developing physicians and scholars caring for and improving the care for some of the nation’s most vulnerable patients. He has practiced and taught at San Francisco General Hospital for over 20 years. Dr. Bindman has published more than 110 peer-reviewed scientific articles evaluating the impact of health policies on low-income patients’ access to and quality of care. During 2009-2010, he was a Robert Wood Johnson Health Policy Fellow working with the US House of Representatives Energy and Commerce Committee chaired by Congressman Henry Waxman. In that role Dr. Bindman actively participated in the policy process that resulted in federal health reform through the passage of the Patient Protection and Affordable Care Act.

**Daniel Polsky**  
Professor of Medicine  
Robert D. Eilers Professor of Health Care Management  
Executive Director, Leonard Davis Institute  
University of Pennsylvania

Daniel Polsky, Ph.D. is the Executive Director of the Leonard Davis Institute of Health Economics, Professor of Medicine in the Perelman School of Medicine and the Robert D. Eilers Professor of Health Care Management in the Wharton School. His research areas include access to health care, workforce, and economic evaluation of medical and behavioral health interventions. He currently serves on the Congressional Budget Office’s Panel of Health Advisers and the Institute of Medicine's Board on Population Health. He was the Senior Economist on health issues at the President’s Council of Economic Advisers in 2007-08. He received a Ph.D. in Economics from the University of Pennsylvania in May 1996 and a Master of Public Policy from the University of Michigan in 1989.