

Welcome, you're listening to a UC Davis Center for Poverty Research conference podcast. I'm the center's director Ann Stevens. In November 2013, the center hosted the conference The Affordable Care Act and Low Income Populations: Lessons from and Challenges for research. The conference featured top healthcare experts from across the country to discuss the rollout of the Affordable Care Act and what the new system means for poverty in the United States.

In this discussion, panelist Tom Deleer, Peter Cunningham and Ian Hill consider the possible growth and demand for healthcare under the Affordable Care Act, and how our network of hospitals and medical professionals will be able to meet that demand. Delirs, professor of public policy at Georgetown University, Cunningham is a senior fellow, and director of quantitative research at the center for studying health system change, and Hill is a research fellow with the Urban institute.

>> Actually, you know, the FQHCs there, are essentially. More or less the same providers that the insured patients go to. They're just two side of this, of the, the same place, but the you know, that said, it's very, well the FQHCs and the community health centers in Milwaukee are, are.

It's a, my understanding of it, it's a pretty good system in Milwaukee. There's no county hospital in Milwaukee County. It was shut down. We talked about that a little bit earlier today. It was shut down maybe 20 years ago for a variety of reasons, and they replaced it with this system in which the existing hospitals would you know, took on not all equally.

We the biggest hospitals took on that demand themselves and then were reimbursed through this through this you know, they had, they used claims and encounter processing systems in order to seek partial reimbursement from dish payment for you know, there it was a pretty well you know, there once again a lot of the uncompensated care was happening, either F.Q.H.C.s..

More traditionally urban FDHCs. Or in, but the hospitals the patients went to with, you know, were not a county hospital, they were hospitals that also serve, have, private patients, but these are very different, different places, very different systems, and obviously you cant statistically adjust a rural area to look like an urban area.

Area. It doesn't make any sense, and so, even though what we, we try to do in the case mix it's a very different things. Well I can't, I'm not. I think it's the health system that's very different, but, you know, once again, can't really be that sure. Yes.

>> To follow up on that, did you harness the hospitalizations by surgeries versus non?

>> By surgeries.

>> Well, Marshfield did everything for the page stuff whenever you saw, if you were in, if you were in Marshfield and you go to the Hospital, or anything, you're going to the Marshfield clinic, unless you're getting in the car and driving somewhere else, all, in surgeries.

They did everything else. I don't know how much Marsh Field was drawing upon patients from outside their catchment area to get surgeries there, but this population we were looking at were more residence of that area you know, who had been receiving uncompensated care in the area and then might have been receiving so the you know, so I don't know how much of our.

Surgeries and probably not that much but once again this is more of the that we study in large field where people who lived in that area care. While I'm insured, and then we're enrolled in to the badger care four plan for uninsured, for, for low income adults.

>> This is kind of related to that question as well.

But can you just give us some context about how care at.

>> That's a, I don't know how it worked in Marshfield, how they, whether they. How aggressive they were in trying to

bill, but in the, in the sample we had in Milwaukee, the individuals would have basically had a unique iden, ID, and if they, once they received uncompensated care from the.

Participating providers in Milwaukee county which included all the emergency departments and all the hospitals and all the community health centers, but maybe not all the charity care or out patient care that might be provided by private you know private doctors. Then the doctors would submit at the end of the year, to the county.

How many, how many counters they had and they would receive some reimbursement from, from that as a result so they you know, the idea was by participating in the system they were not allowed to go out and bill these patients. So for the patients in Milwaukee County were not getting chased you know, for the providers that were participating in the system.

So do you think, sorry this is a follow up, do you think the increase in utilization then. So, it sounds to me like the patients themselves didn't actually have any change in their out of pocket cost. Do you think this increase in utilization you see is then driven by the providers themselves?

Now that they can get higher?

>> The patients in Milwaukee were on a. In short, for being enrolled in Medicaid. This procedure is a way to reimburse the hospital providers. It's not the same thing as these individuals having insurance. So I think it was a big change in their status.

Now the uninsured in Milwaukee may have had a better deal than uninsured. In other areas, but they were still uninsured. In other areas they're not. You know, other you know, other county health taking assistance there's a lot of, it's not an area that I'm an expert on, but there's some quite decent ones.

I mean, I don't know what the range would be. People in the audience probably know better than me, but maybe from. Okay the decent or maybe there's some excellent ones, but the, you know the state of the baseline for uninsured populations is you know, there's a lot of, probably a lot of hednorgenating out there and the walking's probably pretty good in, in this sense, and so, but still I think the results points towards Medicaid being better in terms their willingness or ability.

You know, to access care, because they seem to go out and do it.

>> I just got one word, sort of follow-up question on that whole comparison in Wisconsin and then with Oregon, about the patients, and how they got enrolled. So, it seemed like in Oregon, they did the lottery.

30,000 that had the opportunity to enroll but only 10,000 enrolled. Is that right? So what happened to the other 20,000? I mean did they open up so that more people could enroll or did they just say oh great for us. We only have to pay for, for 10,000 or how did, how did that work?

>> In Oregon, nine thousand people said, put me on the wait list. I'd like to get what's essential Medicaid for, for, for adults. 30,000 of them were randomly selected to say, hey, here's an application, go ahead and apply. A whole bunch of them didn't even bother to apply, probably because they got jobs, and their incomes went up, or they moved out of state or they moved and they never got contacted.

They have no idea, really, but I think a lot of it was because they were no longer eligible. And they knew it so they didn't bother to apply. A whole bunch of people applied but their incomes were too high now and they didn't get on. And then a whole bunch of other people, you know, they had pri-,

that meanwhile had private health insurance, and so, and so that's why only 10,000 of the 30, they would've enrolled all 30,000 of them, potentially, but they only enrolled 10,000 because 20,000 were ineligible or did not apply, and

>> And they didn't expand that beyond that, to say that

>> No, they. So we're gonna invite another 20,000
>> Yeah. They didn't. They, all right, so maybe they, were anticipating that
>> Okay.
>> or, or who knows? But I don't know why.
>> And then in Wisconsin, in Milwaukee they got,
>> Yeah. So completely different, in some states.

>> In, in, in Oregon, these 90,000 people, wanted insurance, right? They went and took the effort to sign up. The people who signed up actually took the extra effort of actually signing up. In Milwaukee the thought was well we know about these folks and you know, actually this program, the Badgercare poor plan only 65,000 got on then they shut it down, they ran out of money, no more people are allowed to apply, they got their waiver, they had to be budget neutral, they only.

So if they hadn't these uninsured, people. From Milwaukee, who had been receiving services from the at the front of the line. They probably would have never So it was a group that they worried wouldn't have signed up. Maybe wouldn't have learned about it, and they knew that the state wanted them on the program.

At least I thought they did, and I think they did want them on the program. And they put them on the front of the line. They, they got on the program six months before everyone else, and so, but I don't know how many of them would have been on the program if they had just done, been a first come, first serve the way other places were.

It was more the traditional way of, but the Marshfield Clinic asserts, they tell us that they, because they have this captive. They are basically a monopolist up there. They had the incentive to go sign up. They tried hard to do it. I don't have statistics of how successful they were.

>> If I could draw a connection to the earlier talks on Massachusetts, and one of the reasons there was such a stark immediate drop in uninsurance was because of an auto-enrollment strategy, and. There are real lessons for the ACA going forward. In, in Massachusetts, it was a, it was a public program called COMCARE.

They already had from the safety net system in their data system, information on everyone who had enrolled in that program, and at the flip of a switch, literally overnight, thousands of people were suddenly covered and enrolled and it wasn't even put out as an option. Come on, you know, apply.

And you know, we're in a position to do something similar with the ACA, but I'm afraid we're not. Things like the SNAP program. Any adult on SNAP is gonna qualify under 138% of poverty, and, there have been a lot of people, some, some of whom I work with are really advocating for more auto enrollment.

And I don't think we're. We're as poised as we should be to do that. Cuz you could really achieve meaningful gains very quickly.

>> So, reaching out to those SNAP people

>> It's true.

>> Using the data to contact them.

>> It's true, but we just finished actually an evaluation of express lane eligibility which is, is most often draws on the SNAP program, and the difference between the states that took SNAP rolls and auto enrolled versus one's that just said we know you're eligible, here.

Here's a letter and they would get five, ten percent response rate. Maybe. To those letters. So just the idea of chaotic lives, Doctor Katz talked about some of the folks that, that we're talking about. Getting people to take action to apply is, is a barrier in itself. What did you think that because I know that we don't know what we're going to do.

>> There are others who might feel know a bit more about this than I comment. The surveys I've seen from folks like

Kaiser shot that this is a, this younger population. Values insurance quite a lot and values the notion of coverage quite a lot, and so this, this picture of them as being you know, don't bother me maybe an overstatement and so I think, I think there's hope for, for for reasonable levels of enrollment plus the penalties go up pretty fast,.

You know, it's nom, nominal the first year but, but within a couple of years you're looking at real money.

>> Plus you have to remember that young adults at least younger than 26 can now get on their parent's policy, and at least I've heard anecdotally that even if young adults who can't get on their parent's policy and aren't particularly motivated.

To sign up for the exchanges their parents will pick up the tabs for that as well. So I think it's, I think for some young adults they're still getting support one way or the other from their parents. But I, I agree with Ian I think this sort of dichotomy that we've kind of created or I, frankly that it's media driven that you've got the young invincible's on the one hand.

And, and then you got everybody, you know, in my age group that's old, old and decrepid. And it's gonna drive up the premiums. It's, you know, it's an exaggeration, because, I think, there are a lot of young adults who value insurance, who I think if they get the right price maybe with a little help from mom and dad will sign up.

And then there's, there's a lot of people in the older groups that yeah okay maybe you know maybe the premiums are gonna be higher, but they're still pretty healthy, they're not gonna, you know they're not gonna break the bank or, or destabilize the insurance market if they enroll disproportionately.

>> Okay, I think the con for those people right now had asked. Assets develop into low premiums. You need to market to young people that are choosing not to enroll. So I mean what.

>> Yeah.

>> The market worked pretty good for 25 year old single men.[x] in this market.

It was sorta, that was their market

>> RLight.

>> So.

>> Yeah, I mean, there, there, there's going to be [x], there's, there's going to be a little niches like that where, and, and unfortunately, the media tends to focus on, I mean, when you talk about, now, now you hear a lot about all the policies are being cancelled, and that sounds horrible, but, you know, you have to wait, okay, well what kind of coverage are they going to get?

Instead, maybe the premiums are going to be a little bit higher, but maybe they're also going to get better coverage. And so you kind of have to wait to see how things kind of shake out. With all of that.

>> I just had a question for Tom. So I understand kind of think about the results that you got particularly from and if I understand that correctly your outcome was you really need two years?

>> In Milwaukee we looked one year. Here, and in Marshfield we looked two years, and that only had to do with the timing of the stud when we finished our

>> So I guess my question is, is, is your study ongoing? Watch these friends over, over time and I ask that because I think about

>> Are you a funder?

>> How much of what you're seeing is some of the noise of people getting access to something they've never had before and seeking care for you know, these chronic disease and things that fits along their tow and I wonder if some of that will even out over time and start.

Long term trend, kind of your thoughts on that interpretation.

>> The the results in middle, in, in Wisconsin, in Milwaukee were certainly, and I should have emphasized this more, one year following enrollment. So, certainly some of the the fact of these are such large increases in emergency department visits.

Part of that could be that does even you know, for the best of us who you know, when we change jobs and have good private insurance takes some time to integrate ourselves into a new health system and find a new primary care doctor. Might these changes be even larger for this group that was enrolled in the floor plan and so receiving care at the emergency department.

For, which is not necessarily, it's not efficient, but it's not bad care. They might have just continued to do that, and whether that was a temporary or, you know, whether things might have shifted from more primary care and less care, in, in the longer run I think remains to be seen, and so I would like to followup on this, but we will see.

This is not, this is not inexpensive stuff to do if there are funders out there.

>> I guess I want to, maybe I'll round out with one last question, which is that as I listen to just the relatively small number of papers we've heard today, it's very clear, and people have made this point, there's a lot of variation.

If you look at Oregon versus different parts of Wisconsin and it strikes me that given the complexities and the, the baseline conditions matter and the populations matter and implementation matters. We are gonna end up, down the road, with a lot of very well done studies that reach different conclusions and I think there is gonna be a really high payoff.

To doing some sort of analyses that group the studies, and as I think Tom very nicely did, compare and see what's different and try to make some sense of it. The cynical part of me says well at least in academic publishing, there's not, even though I think those are super-important, there's not a huge return to that, and so I wonder if anyone has any thoughts on how, as a research community.

We can sort of make sure that happens in the next decade around the ACA.

>> It's people like her and then your point is that.

>> I think that's

>> Right, right.

>> That there's good work to be done by the center of

>> And

>> They are Right and there are groups like Robert Johnson that are committed to the issue.

So I think I think there's hope there, yeah yeah, and I think that, I think that politics more than any of us could've dreamed maybe are gonna confound the story. More than, more than anything, I mean, I think there's such a clear haves and haves not taking shape in terms of the 17 states that are setting up their own exchanges, that are really trying to make it work versus states where it's being actively, opposed.

You know, I think the estimates were that five or six states might have to rely on federally facilitated exchange, but it's 35, and the idea of dealing with 35 different arcane Medicaid systems. And, hundreds of insurers in 35 states. I mean it's not at all surprising we see healthcare.gov, you know, having so many problems.

But I think, and, and a few of you have talked about my colleague Jenny Kenny. Some of the work she's done. Massive numbers of people uninsured currently are living in those states that aren't expanding Medicaid. So we've got this absurd situation of creating new coverage for working poor, but leaving the destitute out of that.

So it's just gonna be a crazy picture for a while.

>> But, but, let me just dissenting, maybe you could say somewhat cynical. The only thing I worry about is gi, given how politically toxic the affordable care act is I, I do worry about you know and I, I'm not sure, and whether you're talking about public funders or whether you're talking about private funders.

Is there gonna be, is there gonna be a funder? Are there funders out there who are gonna be willing to fund something

that that say, that says in some way, big or small, something with the ACA doesn't work very well? Because the consequences of that. You know I mean, and it's not just well but we can fix it, it's not, you know, I mean that kind of finding is taken by, you know, those who don't want the affordable care act and then they want to use it to undermine it, and so it's a very difficult, I just kinda view it.

Maybe for the next year or two is a very difficult political environment for both funders and researchers to be operating in, because I think there's just enormous pressure whether you're pro-ACA or negative ACA, that you know, not, not to just let the results. Tell what they, tell what they are.

But what, what is the interpretation of that in terms of, in terms of, legislation itself?

>> Okay, we'll take one last comment.

>> I just want to another sort of interesting comparative experiment, related to the fact that all mistakes Cuz what Impacting for, for them on their safety net.

hospitals and their in most states, compared to the states where, they potentially, with those particular institutions, stand to really benefit, and improve who they serve how they're able to serve them, and that might be a really interesting, sort of study to look at

>> I mean, my, my crystal ball was cloudier than usual, a year or so ago.

I would never dream that the, that politics would be so toxic that this many states wouldn't expand, but I, but I still believe, pretty firmly that it's only a matter of a few years before governors and legislators are gonna be crushed by hospital association and physicians associations and safety net hospitals.

I mean they are just, they are leaving millions and millions on their table.

>> And they

>> And they, and they

>> Yeah. Do their own Medicaid expansion

>> Yeah, yeah and, and, and they already are I mean I think, I think in Ohio which has, which has a very Republican well has a Republican governor I think the legislature they sort of flipped on medi, they did expand Medicaid and a lot of that has to do with.

With pressure and lobbying from, from the hospital association because they're telling them you wanna see hospital start closing down in this state. If you don't expand medicate, and I know they are doing the same in Texas but, you know, again it's, it's just the political resistance in some states is so severe that it doesn't really matter.

In fact the governor in Texas. It says he thinks it's okay, then. Emergency rooms provide, you know, providers of last resort, that's not a bad way to do your health care system. So I think that is happening, and, and Ian's right, I think over time it is going to, I, you know, it's, they're just not gonna be able, what, especially if they see.

Some of their, their big hospital sys, cuz it's not just the state government, it's other hospitals in the system, in the community, that don't want to see their public hospital or safety net hospital go under, because they know what that's gonna mean for them. So there's, there is a lot of, yeah, there, there, there is a lot of.

Pressure to, to do this, and I think over time it will

>> So.

>> Yeah.

>> Really this time the last comment we'll have from back here, and then we'll take a break.

>> Here you kind of took my breath away when you talk about finders not being interested in parentage.

>> Oh, no, not even troubled.

>> But a heavy turnover for funder before.

>> Right.

>> And I know exactly what you're saying, but do you think that extends also to CMS because of.

- >> Absolutely.
- >> Because of inconvenient truth that we got out of Oregon?
- >> Ab, absolutely.

I, I mean, and again I'm not pointing my finger at any single funder, but you know, all I'll say is, I, I have. Experienced a few things myself in the past year, and seen a few other things where it is very difficult for fun, for some funders to want to put out something that could be even mildly construed as negative towards that ACA.

And that concerns me going forward because you know, again as a researcher, you know it's not a black, you know it's not a black and white world. You know, not, you know, it's not gonna be while the ACA is spectacular or the ACA is a big flop. It's gonna be some things work well as planned, some things didn't work well as planned, and so, how do we fix this?

But, I, I just, I'm just concerned in the current environment that it may be difficult to get that kind of research done.
>> We're gonna take a short break till three and then we will meet for our final session.
>> Yeah. I'm Ann Stevens, the Director of the Center for Poverty Research at UC Davis, and I want to thank you for listening.

The Center is one of three federally designated poverty research centers in the United States. Our mission is to facilitate nonpartisan academic research on domestic poverty, to disseminate this research, and to train the next generation of poverty dollars. Core funding comes from the U.S. Department of Health and Human Services.

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