Welcome. You're listening to a UC Davis Poverty Research Center 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 health care experts from across the country to discuss the roll out of the Affordable Care Act.

And what the new system means for poverty in the United States. In this presentation, Tom DeLeire discusses his research on how the Affordable Care Act might effect how childless adults use health care. DeLeire is a professor of public policy at Georgetown University.
>> One of the largest pieces of expansion under the Affordable Care Act in Medicaid, is to extend Medicaid to all adults.

And this is, obviously, depending on how many states take up the Medicaid expansion of the Affordable Care Act. But this is the new population that, to a large degree, is gonna be covered under Medicaid in the United States. So, what do we know about the effect of extending Medicaid coverage to childless adults will be on, on, use of healthcare?

Turns out that despite the fact that, as this graph might this picture might suggest, we haven't had a lot of experience covering childless adults under Medicaid. We do know a little bit now, because a few states have started expanding their, their, you know, state only expansions, have started expanding their programs to childless adults.

And we have a little bit of experience now seeing what has happened in those states. So what I'm gonna do is talk about some, two recent studies, sets of studies. One, which is I, maybe many of you have heard about. Briefly summarize what we know from the Oregon health insurance experiment.

And then, I'll talk about some studies that we've done in the state of Wisconsin. On a similar program the response and fore plan for childless adults.
>> So before I into that, we've known, it's very important in understanding, what the impacts of these expansions are, on decent healthcare, to use either experimental or pretty good quasi-experimental design.

And so, we actually have, there's a lot of studies that have been done. Probably thousands of studies that have been done, comparing, either comparing uninsured populations to prior insured populations and seeing how they use health care. And not surprisingly they find that uninsured populations use, have a lot you know, worst access to care than insured populations which almost certainly is true but the degree how large that gap actually is, is a big question mark.

Because you know, people who really want to have services will have slightly you know, will be more likely to go out and get private insurance or are enrolled in public insurance. Similarly, results a lot of studies have covered Medicaid covered individuals who, even private covered individuals, even sometimes uninsured individuals, and found that Medicaid population had worst outcomes in terms of health and things like this.

And this sort of cross sectional care seems to be quite misleading. I find, I find it very unlikely that Medicaid actually hurts people but you can find studies that suggest that they do by just comparing these two populations without doing suitable adjustment. So these types of designs can be helpful if you're not in, improving our understand of what the actual impact of these types of coverage expansions might be.

>> So, whether you use random assignments or such that the Oregon health insurance experiment did or use automatic enrollment such as our study took advantage of or some kind of natural experiment that we saw in the study by Craig said earlier when Tennessee kicked a 170,000 people off of its roles.

You know, not something to do with study, but we took advantage of that [LAUGHTER] to, to we'll look at some, some outcomes. These types of experimental or quasi experimental designs can be very helpful. So otherwise, ideally like with these situations where people something like a minimized experiment rather this just comparing populations some of which chose insurance and some of which didn't.

So, let me talk a little bit very briefly about the Oregon study. . You guys here probably actually know where Oregon is, I'm from Wisconsin [LAUGHTER] but the Oregon experiment, what it did was the the Oregon's Medicaid expansion program before adults, which was the OHB standard opened up a waiting list for people who want to get on the program.

And then, when when funding was available they randomly selected people from that waiting list, they actually been given the opportunity to enroll in the program. And so essentially, they had about roughly 90,000 people on their waiting list and they randomly selected 30,000 people to be given the opportunity to enroll of which 10,000 people actually enrolled in the program.

And so, what their, their study is really about is comparing people to lottery winners, people who were given the opportunity to enroll, and the lottery losers, the people who weren't given the opportunity to enroll, all of them wanted to enroll, at least at one point. And then assume, quite reasonably that all the differences between those two groups is driven by the, the fact that a thousand of this group were actually able to enroll into the program.

So what did they find? They looked at the effect of this enrollment on medical care utilization. They also look at managing financial well-being much like Sarah looked at and they also looked at some measures of self important health and in subsequent studies they looked at some, some clinical measures and some mentions of, of of mental he, mental health.

So what did they find, they found. First of all, very large increase in the probability of inpatient hospitalization, 30% increase in this probability, we also found, a, an even larger increase in the probability of, of, of an individual having an outpatient visit, these two. With increased inpatient hospitalizations, increased outpatient visits, they're strongly suggested that the lack of access to health insurance program, impeded the ability of individuals to access health care.

And, in both cases, once it, the individuals were able to enroll into a Medicaid-like program their their utilization went up. You know, they also found increase in probability of taking and habit of prescription drugs and an increase in the probability of the emergency department visit but this increase was very small and not statistically zero.

Adding all these changes up they found increases in spending. A 25% increase in total medical spending, medical spending for this group apparent treatment and So overall this study found an increase in utilization and an increase in cost. So maybe, the hope for finding that increased expansion Medicaid might then cost herd in some way and save money weren't realized, at least in this study.

What did we find in Wisconsin? This was the view from my office up until the last year the So basically, with Wisconsin, prior this, prior to the Affordable Care Act, Wisconsin, as part of its goal, sought to insure 98% of its citizens and it did this, it didn't achieve that goal but that was the goal and it did this in a few steps.

First, it expanded its standard what, Medicaid shift program, which is called BadgerCare in Wisconsin and, to cover, potentially all kids in the state. And they also did a substantial expansion in coverage eligibility, to adults parents and and caretakers and also did a lot of simplification and improvements in the program.

The second part that was only 2008 the second part of this in 2009 they created coverage expansion to childless adults with incomes below 200% of the federal poverty line. This was called the BadgerCare fore plan. And it's the second expansion that's what I'm going to talk about right now.

So how did the floor plan for childless adults effect healthcare? We have two different studies that we were able to examine in Wisconsin, one, was focused on a population in Milwaukee County and one just focused on a rural population in the Marshfield area of Wisconsin. And so these two populations are quite different from one another.

In Milwaukee, the study will focus on people below the poverty line who had previously been receiving some services through the county safety net programs that were in place in the county. And these individuals, the state does something which is not the focus of our study which I think is very innovative but they automatically enrolled these individuals into Medicaid program.

They weren't even the, they didn't wait around to have them sign up it doesn't, some of us talked a little bit about this in the previous session. A lot of these individuals might not sign up for the program. And so the state, because they were receiving services through the county safety net, they knew about them.

We went ahead and signed them up automatically. And the population is an injured population, high rates of chronic illness, use the, the health safety net. And so, they have very high rates of chronic illness, relative to a typical uninsured individual in Wisconsin. The rural Wisconsin population, we have very similar design, this was a low income population, population up to 200% of the federal poverty line.

Who had been receiving services from the Marshfield Clinic in some way or another. What, in this area, the Marshfield Clinic is the dominant provider. And they, they, I don't know if own is the right word, but they manage the community health centers, the clinics there. So if an uninsured person in this area is receiving care at all, it's with a very very high likelihood that they were receiving it from the Marshfield clinic or one of their affiliate providers, The Marshfield Clinic knew about the fore plan, and they knew these individuals were receiving care, uncompensated care from them through their clinics, and made a very very high effort to try to get these individuals for enroll.

They were not automatically enrolled, but there was a lot of outreach, a lot of effort by the clinic to get them enrolled in Medicaid. Because, they believed it was in the interest of the individuals to get enrolled in Medicaid, but also help the clinic interpret the rebirthing rate so the incentives were aligned to get everyone enrolled there.

This population was probably more represented, dependent on the uninsured population. At least representative of the rural part of the state, then then the, the population of the in Milwaukee. So we look at three different sets of outcomes. We're looking at our use of healthcare. We'll be looking at all patient visits, and various categories of alt patients visits.

Be looking at emergency department visits and also in trying to separate out ambulatory care, sensitive visits from non-ambulatory care sensitive visits, and also looking at hospitalizations and them some, some look at hospitalizations by, by cost as well. So we're not looking at prescription drugs here. We're not looking at, psychiatric visits or anything like that.

Just these, these types of things. So our data, for our Milwaukee study, come from the state of Wisconsin. We're using the Minister of Claims and Counters both from, they came from the country when they were running the safety. It's from, from the health safety net, which were then transmitted to the state and then, also, from the State Medicaid system, from the fore plan.

And this is Bascom Hall on the University of Wisconsin campus. This is the state capitol, these are about a mile and a half from one another down State Street. And so luckily the proximity of the State to the University has facilitated a lot of great collaborations between the university and the state, of which included these data shares.

So the data of the state Medicaid system data roll house at the university and so, when we have, some pretty long standing, and well established data use agreements, we have to do an analysis like this in a collaborative setting, with, with the state. so, of this population in Milwaukee that were automatically signed up for the program, which the state called the transitional four population.

That's not important. But this is, there were about, 13,000 individuals who were automatically enrolled into the Medicaid program, from Milwaukee. We were able to successfully match 9,600 of them across the administrative databases. The ones who are unmatched didn't look very different from the ones who were matched in you know, they just, trying to match them with social security number and quite frankly they weren't always maybe in the data properly for one reason or another.

So we're gonna be focusing on the ones who successfully matched. As I mentioned, this Milwaukee population was a very poor population had been receiving services. And they appeared to have very high rates of chronic illness. So, they weren't necessarily representative of what you would think a typical uninsured person would be.

But they're a very important population.' Cuz, not surprisingly, the chronically ill are high users of services. And maybe, that's where you're going to get the biggest return for coverage expansions is from this type of population. So, for example, 27% of our, of our population were, were, had depression, these are from the claims data that we're getting, it's our self reporting.

These are what the physician reported, from claims, 50% had hypertension, half the sampling had hypertension 27% had diabetes, overall 83% of our sampling had one chronic illness or another so would be fine for this group. So, we were able to compare very simply, the utilization of health services for this uninsured group, in the year prior to their enrollment into the BadgerCare fore plan when they were uninsured.

With the utilization, the year, first year following their insurance enrollment, we found, that's not surprisingly, that their use of outpatient services went up quite a bit, by about 30%, almost the same as they found in Oregon. This, this increase come from, it came predominantly from increase in specialty visits.

Primary care business went up but too much which makes sense. Given that the place where these individuals would have been receiving care while uninsured is primarily community health centers, which has a real primary care focus. What about the emergency department? We also found, surprising to our partners at the state, but maybe not that surprising to researchers that emergency department visits went up as well.

They'd been hoping I think, to find emergency department visits fall, they found the opposite. A substantial 46% increase in emergency department visits. Individuals who are uninsured you know, even though they're poor unlikely to pay, still can be charged.
>> And you know. and maybe deterred from these emergency department so we found that this financial, you know, in fact that this went away used to with.

>> Moreover we found that most of this increase took place for non, for for ambulatory care sent to the visits. These are business the emergency department that could have taken place in a primary care setting, is the idea. We found no increase in input in visits due to injuries, or visits maybe that loosely speaking might be termed, true emergencies.

Which is reassuring that this, this response is due to a change in insurance status and not due to something else that was going on. Well, but at the same time we found a very, very dramatic decline in the rates of patient hospitalization, it's a 59% decline and which is, you know.

Just to remind you, the exact opposite of what they found in the Oregon health insurance experiment where they found a big increase in all hospitalizations. And so and at the same time we found reductions in hospitalizations in, almost all, all but one measures of, of, of peak QI's, prevent quality indices.

These are hospitalizations that hopefully would not occur for population that was well covered with primary care. So, hopefully if an individual has access to prescription drugs, has access to primary care, is seeing a doctor on a regular basis, and they have hypertension. Hypertension can be managed, hopefully he'd never end up in the hospital due to hypertension.

And so, this is again consistent with the idea that the disease declines into hospitalization that are occurring with this chronically ill population are occurring, perhaps, because of the increase in access. As to primary care, that, that, that occurred due to the, Medicaid expansion of this group. What about costs?

We don't, as, as Doctor Katz mentioned earlier, its hard to measure cost in safety care net settings. So what to do we do? We infer, we use Medicaid. Wisconsin state Medicaid fee for service reimbursement rates are our measure of cost, and that use a, use that to figure out what a good approximate change in the cost of a, a, putting these populations occur.

And we found that overall costs fell ten percent of its population. That, and, and basically you know, outpatient services went out, the ED visits went out. The client populations are large enough, and populations themselves are

expensive enough as to on net less is spent on this population of when insured and when not insured.

Which is a remarkable result and one which I wish we could easily rep, replicate in other places and probably can't be. This is a sort of a special population a very chronically ill group. So in summary, we found that, an increase in outpatient care, an increase in, in, emergency department visits, that was driven by ambulatory care sensitiveness can, can a large prime hospitalization and, and that a small decline in cost as a result.

But a decline. Remember in Oregon they found 25% increasing costs one and suspensions. 10% they, they 10% decline for deviation on that. Okay. What about in rural Wisconsin? So we strive here to have a very similar research design to what we found in Milwaukee. Our data actually come from the Marshfield plant in this case.

And so we are not, relying entirely on their data system, and their encounters and outcomes. And as I mentioned, the MarshfieldClinic, is a very diverse set of hospitals, providers, provider groups, in rural Wisconsin, and on. So we had about 65 thousand low income. On previously uninsured adults who have been receiving some kind of uncompensated care on who then enrolled in the Fast Care four plan, and so we have a very similar set up.

We're going to be comparing their, utilization two years prior to when they were enrolled in the fast care four plan. Utilization in the two years following that period. And we found again very similarly, about a 35% increase in outpatient visits and a a 36% increase in emergency department visits.

So these two increases were very similar to what we found in Milwaukee and increase in outpatient visits is very similar that was found in Oregon, but we found also, we did not see any decline in hospitalizations, in fact we found a very large increase in hospitalizations. So my initial reaction was this is, might be due to the fact our Milwaukee sample has very, had very very high rates of chronic illness.

And our Marshfield example won't, which have, also have high rates of chronic illness relative to the population was more typical of the Medicaid population. And but when we adjust our results by trying to focus more on the chronically ill individuals in Marshfield so they, maybe, look more comparable to our Milwaukee sample, we still found an increase in hospitalizations for this group.

So it wasn't, these differences weren't due to the difference in case mix between Milwaukee and Marshfield, although there are some unlimted ways to to adjust in any of those dimensions. So in summary in, in Marshfield we found increase across the board basically all types of utilization. Outpatient visits, emergency department visits, hospitalizations.

So what seems to be coming from this. I can summarize these, these, you know, this one site is Oregon and Wisconsin. Urban Wisconsin, rural Wisconsin. We've found, we seem to be finding some divergence in results. We find in all three of these studies a large, you know, roughly in the 30% to 35% range increase in outpatient.

Compare uninsured individuals to insured individuals. And perhaps it's the least surprising result that you might come up with that when people have health insurance they're able and do go to the doctor more. In terms of emergency department it's found increases in all three studies but only large increase.

In Wisconsin. They do not find large or, increases at all in Oregon. And again maybe I didn't find large increases very surprising. But they could whether they're large or not. Where hit. Whether you found this surprising or really depends on what you're holding. But the hospitalization results are all over the place.

We found big increases in organ and in rural Wisconsin but large confines in Milwaukee. And that's where a lot of the money is in hospitalization that maybe where, that maybe if we were to meas, not measuring health in our Wisconsin study but maybe. What might be closest to what proxies for health outcome would be the authorization perhaps with that group.

And finding outcomes. In terms of cost. We weren't able to measure it in rural Wisconsin where we found increases in Oregon, the clients So what could possibly explain all these differences? Well, at least in Wisconsin, it doesn't seem,

as I mentioned, it doesn't seem to be explained by differences in case mix of population.

We found increases in rural Wisconsin. Even if we focus on the crime there. So it seems, I don't have an answer for you. I'm sorry to say. But, it seems that. The incen, the nature of the existing health system that's on the ground and the environment that these health insurance expansions are taking place is going to matter a whole lot.

We see that, within Wisconsin it's getting very divergent results depending on where we're looking at. If urban. Health safety net system, where individuals are getting expansions to enroll a group. And maybe you know, l the population between and the engine population in Milwaukee are different than a large number of dimensions.

Dr. Kat Lunar said the, the half even have this in our study. The population that were automatically enrolled into the core plan in Milwaukee also have other issues that are going on. That are, you know, you know, leads to, led to their unusually high rates of hospitalization in the uninsured period.

Where the, maybe the uninsured enrolled in Wisconsin actually were. You know maybe be better served by the primary care system in some way. I don't know at this stage but if we were to try to summarize what we should expect to see from Medicaid expansions as develops I would say it's pretty confident that we're going to see increases in allocation.

I'd say I wouldn't be shocked to see big increases in emergency department visits, although there is some divergence across the studies in that. And what we're going to see in hospitals in terms of, hospitalizations maybe ultimately help. Probably, on average, whether it's gonna be, it probably will. Mobile, pardon me the gas, but it's gonna really matter about what part some populations are focusing on, and we might really find a lot of divergence that results across the areas, so, the one size fits all isn't gonna fit, and we're gonna have to do a lot more work in this area, to find.

Doubt what's gonna happen and you want those to happen in your community or your hospital and your area, you know. You probably will have to take a look yourself, or maybe you know, are you more like Milwaukee or are you more like Oregon or more like rural Wisconsin?

Babies are the best, the best guests at Information you could, you could take at this point?
>> so, some limitations here. You know, there's a lot of differences in the health system, the health care system. Of the underlying health care system of these three studies, which have not being taken account for, in, in this And and this is probably going to be true in any study.

That is gonna be very hard. And, and I wanted you to keep that mind. And I think the, I was hoping and expecting to see declines in rural Wisconsin like we saw in Wisconsin and we didn't. You know, that's sort of the, at the end of the day that's because the health care systems in these two areas are very, very different, and, and maybe that's not, not the most satisfying answer.

About that seems to be, maybe, what the true answer is. So, thank you very much, and I look forward to your questions.
>> I'm Ann Stevens, the Director for the Center of Poverty research, 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 non partisan academic research on domestic poverty to disseminate this research and to train the next generation of poverty scholars. Core funding comes from the U.S. Department of Health and Human Services. for more information about the center, visit us online at www.poverty.ucdavis besaw.edu.