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State Health Access Reform Evaluation
Robert Wood Johnson Foundation
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State Health Access Data Assistance Center

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STATE OF REFORM

Lab Report #1: Evaluating state efforts to improve access to health care

Analysts working on federal health reform often turn to the states for lessons about what does and doesn't work in reform efforts. Many states have pioneered promising reform ideas in recent years – exploring concepts like individual mandates, pay-or-play requirements for employers, expanded programs for uninsured children, and streamlined efforts to enroll eligible residents in public insurance programs. The Robert Wood Johnson Foundation (RWJF) funded the State Health Access Reform Evaluation (SHARE) initiative in response to momentum in states for health reform, acknowledging that state experiences could inform national efforts. SHARE supports the evaluation of state health reform initiatives and the development of evidence-based resources to inform future state and national reform efforts. The following is the first in a series of "lab reports" from SHARE that highlight preliminary findings from select SHARE-sponsored studies.

In this Lab Report: Expansion of Public Programs

This lab report looks at preliminary findings from SHARE grantees related to the often-debated topic of public program expansion. The brief includes findings on:

1. *The benefits of simplifying eligibility*

   Project: A study from the University of Wisconsin School of Medicine & Public Health, Population Health Institute about Wisconsin's BadgerCare Plus Reform package
   Early Finding: Simplified enrollment procedures resulted in a large increase in eligible Wisconsin residents signing up for BadgerCare Plus.

2. *The effect of affordability on enrollment*

   Project: An evaluation conducted by the University of Southern Maine, looking at reform efforts in Maine, Massachusetts and Vermont
   Early Finding: Data from three states with cost-sharing provisions for public insurance suggest a strong correlation between low premium costs and enrollment in public programs.

3. *Crowd-out*

   Projects: **(1)** A study on Vermont's health reform, conducted by the University of New England Center for Health Policy, Planning and Research, College of Osteopathic Medicine; and **(2)** An evaluation by the Urban Institute, looking at the impacts of state health reform initiatives in Illinois, Massachusetts, and New York
   Early Findings: **(1)** Expanded eligibility for public programs in Vermont did not result in a decrease in enrollment in employer-sponsored insurance among low-income residents. **(2)** Take-up of employer sponsored insurance in NY and MA increased for lower income parents and childless adults, suggesting no evidence of crowd-out.

4. *Public/Private partnerships*

   Project: A study of small group employer participation in New Mexico's State Coverage Insurance (SCI) program, carried out by the NM Human Services Department and The Hilltop Institute at University of Maryland, Baltimore County
   Early Finding: The administrative burden (paperwork and process) resulting from a reliance on federal dollars under CHIP or Medicaid can deter businesses from enrolling in SCI.

ABOUT THE SHARE INITIATVE

SHARE is a national program of the Robert Wood Johnson Foundation (RWJF) and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has three key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, RWJF has provided SHARE with $7 million to oversee the evaluation of a wide variety of state insurance coverage initiatives. States being studied include: California, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

"We know that there is much to be learned from states that have already successfully reformed pieces of their local health care systems," said David C. Colby, Ph.D., vice president of Research and Evaluation at the Robert Wood Johnson Foundation. "We're happy to support a systematic evaluation of these initiatives. We need to know what worked and why so that future programs can benefit from their experience."

Descriptions of the studies can be found at the SHARE website: www.statereformevaluation.org. "We are working with the most sophisticated health services researchers in the nation," said Lynn A. Blewett, PhD, Director of the SHARE program. "States are eager to learn from others who have already benefited from hard-fought reform efforts. While there are a lot of ideas on what states might want to do, there needs to be far more research on what actual reforms have already produced. Even at this early stage of their work, the research teams we are supporting have begun to yield insights that will be useful for others."

States are sometimes called "laboratories for reform" as they can explore reform strategies on a smaller scale, function as experiments, and, ideally, inform future state and national efforts. This issue brief is the first in a series of "lab reports" from SHARE that are meant to synthesize findings on reform strategies underway at the state level. These strategies are playing a large role in the current debate over national health care reform, and findings about them are relevant to researchers and policy makers alike as the debate moves forward.

The findings included in this brief are not comprehensive of what is being studied by the grantees and are preliminary in nature. Full findings from each grantee will be published at the completion of each project.

Grantee organizations selected to conduct the evaluations include the following:

- Mathematica Policy Research
- Johns Hopkins University
- Bloomberg School of Public Health
- University of California, Los Angeles
- Wake Forest University
- University of Southern Maine
- Brown University
- University of New England
- University of Wisconsin
- Urban Institute
- New Mexico Human Services Department
- Rutgers University
- University of Southern California Department of Family Medicine

THE BENEFITS OF SIMPLIFYING ELIGIBILITY

Is simpler better?

Evaluating Wisconsin's BadgerCare Plus: Effects on Enrollment, Efficiency, and Churning

Grantee Institution:

University of Wisconsin School of Medicine & Public Health, Population Health Institute, Madison, WI

Principal Investigator:

Thomas Oliver, PhD, Associate Professor and Director for Health Policy

Co-Principal Investigator:

Tom Deleire, PhD, Associate Professor, UW School of Medicine & Public Health

This study is evaluating simplification initiatives that are part of BadgerCare Plus and how they affect enrollment, efficiency, churning, and program sustainability. The study uses the Wisconsin Family Health Survey, ACCESS usage reports, the County Income Maintenance workload model and interviews with enrolled members, providers, advocacy groups, employers, and program administrators.

Introduced in late 2007, BadgerCare Plus provides health insurance to Wisconsin residents through one comprehensive program that consolidates family Medicaid, CHIP, and Healthy Start under one umbrella. The program's goals are to simplify the state's existing health programs, ease enrollment and expand coverage for children.

Early estimates from Population Health Institute find that thanks to the program:

- Total enrollment increased 34 percent—to 590,000 in September 2008 from 440,000 in December 2007.
- The increase included more than 57,000 adults and more than 92,000 children.
- Children in families earning less than $27,465 for a family of three (150 percent of the federal poverty level, or FPL) accounted for almost two-thirds of the additional children enrolled in the program.

Study investigators have noted that enrollment in the program has been substantially higher than expected.

Based on qualitative research and interviews with key stakeholders (legislators, Wisconsin Department of Health Services, patient and consumer advocates, business representatives, and health care providers), researchers have determined that expanding eligibility and simplifying eligibility requirements have played a large role in the success of the program.

Prior to the BadgerCare Plus expansion, the eligibility requirements for state programs were a confusing web of eligible groups and income requirements, but the new system has a set of simple eligibility standards: children are covered with no limit, pregnant woman are covered to 300 percent of FPL, and parents and caretaker relatives are covered to 200 percent of FPL. There is now only one standard discount and disregard rate: gross income, less all student earnings and child support payments.

In addition, BadgerCare Plus simplified the eligibility confirmation and enrollment process, making it easier for eligible families to sign up for the program. Changes included streamlining the method for verifying employer sponsored health insurance status, and using a consumer-friendly online application process.

THE EFFECT OF AFFORDABILITY ON ENROLLMENT

If you make it affordable, will they come?

Evaluation of Three States' Reforms to Cover All Children

Grantee Institution:
University of Southern Maine, Portland, ME

Principal Investigator:
Elizabeth Kilbreth, PhD, Associate Research Professor

Co-Principal Investigator:
Katherine Swartz, PhD, Professor, Dept. of Health Policy and Management, Harvard School of Public Health

This study uses program enrollment and utilization to assess the effects of premium requirements and cost-sharing among participants on access to care. The investigators are using a cross-sectional study using multivariate modeling and qualitative policy analytic techniques to create person-level data files that link claims information with income and demographic data.

Maine, Massachusetts, and Vermont have all enacted strategies to expand health insurance to people who would otherwise be uninsured. Dr. Kilbreth and her team are examining the impact of cost-sharing on access to care for low-income persons. Early in their research, the team focused on establishing subsidy levels that are considered affordable and looked at the correlation of these subsidy levels to the success of insurance reform.

Preliminary cross-sectional analysis and qualitative interviews indicate that there is a strong association between low premium levels and enrollment, regardless of whether or not an insurance mandate is in place. Penetration rates are highest among individuals in the lowest income tiers—where premiums are most heavily-subsidized—and lowest among groups where subsidies are minimal.

In fact, preliminary findings from Maine and Massachusetts show that rates of enrollment in the first years of the programs were considerably higher among people with incomes below 200 percent of poverty than among those with incomes between 200 and 300 percent of poverty. Both in the state with an insurance mandate (Massachusetts) and the states with voluntary program participation, there is a strong association between enrollee premium levels and enrollment.

Based on stakeholder interviews, the research team has also found that in all three states, the initial program cost and enrollment estimates differed from actual enrollment experience—with Massachusetts exceeding projections and Vermont and Maine enrolling fewer residents than estimated.

Based on these preliminary findings, the researchers have determined that program design has a measurable impact on early program enrollment experience, even in the context of an insurance mandate. They believe the findings raise issues about affordability and enrollment that policy makers should consider as they evaluate various proposals for how to structure subsidies in the event that a national individual mandate is enacted.

CROWD-OUT

Does public program expansion cause people to drop private coverage?

Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience

Grantee Institution:

University of New England Center for Health Policy, Planning and Research, College of Osteopathic Medicine, Portland, ME

Principal Investigator:

Ronald D. Deprez, PhD, MPH, Executive Director

Co-Principal Investigator:

Sherry Glied, PhD, Professor & Chair, Department of Health Policy and Management, Columbia University, Mailman School of Public Health

For this study, the investigators are evaluating the Vermont health reform initiative that is intended to provide universal access to comprehensive, affordable health insurance coverage and, ultimately, access to quality health care. Primary and secondary data sets (primarily the 2005 Vermont Household Health Insurance Survey and CPS) will be analyzed to assess the impact of the reform on public, private, and self-insured coverage options, enrollment, premiums and other out-of-pocket costs, utilization indicators, program implementation administrative costs, and related measures.

In May 2006, the Vermont governor signed the Health Care Affordability Acts (HCAA) into law. Several key dimensions distinguish the HCAA from other state health insurance reform initiatives. The HCAA is designed to expand insurance coverage within the context of comprehensive health system reform. It establishes a voluntary approach for individual enrollment and an assessment on employers if they do not offer health insurance to employees, or if their employees choose not to enroll in employer sponsored insurance (ESI) and are otherwise uninsured. The HCAA also uses a unique combination of income-generating and system-changing policies in an attempt to achieve sustainability. Implementation of the HCAA began in early 2007.

Between 2005 and 2008, the percentage of all residents with some type of insurance coverage in Vermont increased by 2.2 percent, bringing the percentage of residents covered by insurance up to 92.4 percent. During this time period, insurance coverage in Vermont increased more rapidly than in other New England states, with most of the increase in Vermont's coverage coming through increases in public coverage. Enrollment in the new public Catamount Health program increased sharply and steadily during the initial months. By April 2009, nearly 8,800 people were enrolled in Catamount Health. Most Catamount enrollees receive premium assistance. Only 13.9 percent of enrollees have family incomes above 300 percent of FPL and therefore do not receive premium assistance.

To estimate the extent of crowd-out, the researchers examined the 2008 Vermont Household Insurance Survey (VHHIS)[i] for look at changes in uninsurance rates over time and compare them to regional trends, and also to examine changes in private insurance coverage in the region. Researchers discovered that private insurance coverage rose more in Vermont than in New England overall, suggesting that crowd-out has not been a significant issue.

The researchers also looked at paths people took toward enrollment in public or private insurance. Researchers looked at take-up in public or private insurance among three groups: those originally eligible for public insurance; those newly eligible; and those never eligible. For those in the newly eligible category, the increase in insurance came from increases in both public coverage (0.7%) and private coverage (2.9%), suggesting that new eligibility for public coverage did not crowd out private coverage.

CROWD-OUT (CONTINUED)

An Evaluation of the Impacts of State Health Reform Initiatives in IL, MA, and NY

Grantee Institution:

Urban Institute, Washington, DC

Principal Investigator:

Sharon K. Long, PhD, Principal Research Associate, Health Policy Center

Co-Principal Investigator:

Alshadye Yemane, MPP, Research Associate, Health Policy Center

This study examines the effects of reform efforts in Illinois, Massachusetts and New York. In particular, it assesses impacts on coverage, access to and use of care, and out-of-pocket (OOP) health costs using National Health Interview Survey (NHIS) data. The impact analysis takes advantage of the "natural experiment" that occurred in the three states to compare outcomes (insurance status, access and use, and OOP costs) for the target populations in each state before and after policy changes.

A research team at the Urban Institute has been looking at public program expansion across three States:

1. New York's 2000 expansion of public coverage for lower-income adults and its new premium support program for working adults;
2. Illinois' 2002 expansion of public coverage for lower-income parents, with a premium assistance program option;
3. Massachusetts' 2006 expansion with a goal of near universal coverage for all adults, by expanding public coverage, subsidizing private coverage, creating purchasing pool, requiring employers to offer insurance, and enacting an individual mandate to have insurance.

Using a difference-in-differences model,[ii] the team analyzed data from the Current Population Survey to estimate the impact of the public subsidies and coverage expansion in each state.

In both New York and Massachusetts, ESI take-up and public coverage increased for parents and childless adults, suggesting no evidence of crowd-out in either of those states. This is likely due to the fact that in both of these reform models, careful attention was paid to bolstering both public programs as well as ESI—and in the case of Massachusetts a hybrid of public and private coverage as well.

In Illinois, there was also an increase in ESI and public coverage for eligible parents earning up to 185 percent of FPL, but because of low take-up rates of the public subsidies, more research is needed to draw strong conclusions on crowd-out.

FUNDING A “THREE-SHARE” PUBLIC/PRIVATE PARTNERSHIP

Could federal requirements hold partnerships back?

Evaluating Small Group Employer Participation in New Mexico’s SCI Program

Grantee Institution:

New Mexico Human Services Department, Santa Fe, NM

Principal Investigator:

Anna S. Sommers, PhD, Senior Research Analyst, The Hilltop Institute, University of Maryland, Baltimore County

Co-Principal Investigator:

Mari Spaulding-Bynon, JD, Insure New Mexico Bureau Chief, New Mexico Human Services Department

This study examines the New Mexico State Coverage Insurance (SCI) program that targets working-age adults through a public/private partnership program. The principal objective of the study is to identify factors that have influenced employer participation in New Mexico’s SCI program. Data include state administrative data on enrollment into SCI, a survey of participating employers and non-participating employers who inquired about SCI, and employed individuals who enrolled with no employer sponsorship.

New Mexico’s State Coverage Insurance (SCI) program began in July of 2005, making adults with a family income at/or below 200 percent of FPL eligible for health insurance coverage through a Medicaid waiver program—which utilizes federal and state funding, plus contributions by employers and employees on a sliding scale based on income. The program uses a “three-share” partnership: 71 percent CHIP funds, 18 percent state funds and 11 percent from employers and individuals. The program allows employers with 50 or fewer employees that have not offered insurance benefits in the previous 12 months to buy insurance through a state-sponsored and administered program.

Based on interviews with both participating employers and employers who have inquired about the program, researchers have uncovered valuable feedback that has implications for other states looking to create three-share partnerships, as well as for national reformers. First, there is a significant tradeoff between accessing federal money through Medicaid/CHIP funds and requiring employers to meet the processing and paperwork requirements that accompany these funds. Using the federal funds requires adherence to what employers perceive to be a burdensome application process, and they note that whether or not their workers will be eligible for the program (and the cost to the business) is not immediately transparent. In fact, more than half of participating businesses (51%) and inquiring businesses (54%) reported that clearly understanding how eligibility works is a major concern that affected their business when deciding whether or not to participate in SCI.

Based on their initial findings, the research team recommends de-linking business recruitment from the federal Medicaid/CHIP funding requirements, which would simplify the administrative processes and make it easier to recruit employers to participate.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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NOTES

[i] 2008 Vermont Household Health Insurance Survey: Initial Findings, Submitted to the Vermont General Assembly, January 15, 2009 Available at: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/legislative_reports/VHHIS_Initial_Findings2008_01_15_09.pdf

[ii] Difference-in-difference model - $Y = ß_0 + ß_1$ StudyState $+ ß_2$ Post $+ ß_3$ StudyState * Post $+ \varepsilon$