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Program Results Report
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# Evaluating Health Reform at the State Level

## Assessing the impact of premium requirements and participant cost-sharing on access to care in Maine and Massachusetts

## SUMMARY

Researchers at the University of Southern Maine evaluated state health reforms in Maine and Massachusetts from 2008 to 2011.[1] Each state had launched a new health insurance plan to provide coverage to low-income residents who would otherwise be uninsured before federal health reform was enacted in 2010. The researchers also intended to evaluate Vermont's program but dropped the state from the analysis because they could not obtain all the data they needed.

The researchers compared a group of adult enrollees in the new health insurance plan in each state with a group of insured state employees in each state. Elizabeth Kilbreth, PhD, associate research professor at the Muskie School of Public Service at the University of Southern Maine, directed the project.

The project was conducted under *State Health Access Reform Evaluation* (SHARE), a national program of the Robert Wood Johnson Foundation (RWJF) launched in 2006. (See Program Results Report for more information on the goals and strategies of the program and links to other Program Results Reports on its projects.)

### Key Findings

Researchers reported these key findings to RWJF:

- The design of a publicly subsidized health insurance plan has a major impact on who enrolls. The Massachusetts plan requires individuals who qualify to enroll, and the lowest-income participants do not pay premiums. In Maine, in contrast, coverage is voluntary, and participants of all income levels pay premiums on a sliding scale.
  - Enrollees in the Massachusetts plan were younger and healthier, on average, than enrollees in the Maine plan.

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[1] A separate SHARE project also examined the Massachusetts experience as part of an analysis of health reform that also included Illinois and New York (Grant ID# 64315). For more information, see Project Results Report.

— Adverse selection occurred in Maine: a higher proportion of enrollees were older, or had chronic health conditions, than in both Massachusetts groups and the comparison group of Maine state employees.

- Low-income residents enrolled in the new state plans used fewer health care services than comparable state employees. However, the researchers may revise this finding as they continue to analyze the data.

### Funding

RWJF supported this project from April 2008 to July 2011 with two grants totaling $631,838.[2]

## CONTEXT

Maine, Massachusetts, and Vermont all took significant steps in 2005 and 2006 to expand health insurance to individuals who would otherwise be uninsured by creating new plans:

- Maine's DirigoChoice Plan, which began in 2005, subsidizes both premiums and deductibles on a sliding scale for adults in households with income below 300 percent of the federal poverty level.
- Massachusetts passed a comprehensive health care reform bill in 2006 designed to move the state toward universal insurance coverage.[3] One component of that reform, Commonwealth Care, provides coverage without premiums or deductibles to individuals with income below 150 percent of the federal poverty level who are not eligible for Medicaid. Adults with income of 150 percent to 300 percent of poverty are eligible for subsidies and make copayments on a sliding scale.
- After passing health reform legislation in 2006, Vermont launched the Catamount Health Plan, which provides subsidies on a sliding scale to adults with household income at or below 300 percent of the federal poverty line. The state also provides assistance to low-income employees so they can purchase employer-sponsored insurance coverage.

### RWJF's Interest in This Area

A long running RWJF program that has focused on the states' activities in expanding insurance coverage to the uninsured is *State Coverage Initiatives* (1991 to 2013). A $52.5 million program, it provides funding and technical assistance to help 28 states develop health care financing and delivery mechanisms to expand coverage to the uninsured. Since the enactment of the federal Affordable Care Act (ACA) in 2010, the program is

[2] Grant ID#s 64216 and 68845.

[3] For more information on Massachusetts health care reform, see Program Results Report (ID# 64315).

also helping states implement health reform. Most participating states have adopted at least one of these interventions:

— Reform of the small group health insurance market, including regulations limiting the ability of insurers to exclude certain groups or individuals, or to charge them different rates

— Health insurance purchasing alliances, which allow small groups to pool resources to negotiate lower rates and cut administrative costs

— Expanded public insurance options, such as broader eligibility for Medicaid

Another RWJF program in this area is *State Health Access Reform Evaluation (*SHARE*)*, a $10.5 million national program that tracks the affordability, sustainability, and administrative efficiency of state coverage reforms. It began in November 2006 and runs until mid-January 2014. From 2006 through mid-2010, the focus was on state policy. Starting in September 2010, the program shifted to concentrate on health reform issues as they relate to state implementation of the ACA.

The SHARE national program office is at the State Health Access Data Assistance Center at the University of Minnesota's School of Public Health. (See Program Results Report for more information on the goals and strategies of the program and links to other Program Results Reports on its projects.) The project described in this report was funded under *SHARE*.

## THE PROJECT

### Research Questions

The researchers proposed exploring four questions regarding the low- and moderate-income enrollees in new public health insurance plans in Maine, Massachusetts, and Vermont:

- How does the size of the premiums participants must pay affect enrollment, including the risk of adverse selection—that is, the risk that individuals most likely to need health care will seek insurance coverage in greater numbers than healthier individuals?
- How do out-of-pocket payments for enrollees affect their use of health services?
- Do out-of-pocket payments affect the amount of care individuals with chronic illnesses obtain?
- How does the coverage plans' success—or lack thereof—as measured by answers to those three questions affect the stability of the plans, and political support for them?

## Sources of Data

To answer these questions, the researchers collected data from administrative records and insurance claims for two groups of adults aged 18 to 64 in each state. The groups included enrollees in each state's subsidized health insurance plan, and a control group of insured state employees in each state.

The researchers tapped data from the U.S. Census Bureau's Current Population Survey. They also interviewed state officials and other stakeholders—18 in Massachusetts, 16 in Vermont, and 14 in Maine—on program design and operations, affordability, administrative efficiency, and sustainability.

After gathering those data, researchers dropped plans to include Vermont in their analyses, for two reasons. First, some of the claims data on state employees in Vermont lacked the coding needed to allow comparisons on the use and cost of health care. Second, the researchers could not accurately link information on the household income of enrollees in Catamount Health Plan, provided by the Vermont Agency for Human Resources, to data on insurance claims.

## Subcontractors

Katherine Swartz, PhD, of the Harvard School of Public Health served as co-principal investigator, under subcontract to the University of Southern Maine.[4]

The university also subcontracted with Onpoint Health Care to prepare the data for analysis. The researchers encountered significant delays in securing usable data from Onpoint, which had more experience with reporting aggregate data than with linking claims data to the characteristics of individuals.

# FINDINGS

The researchers reported these findings to RWJF, noting that they may revise the findings as they continue to analyze the information:

- **The design of a publicly subsidized health insurance plan has a major impact on who enrolls.** Massachusetts requires uninsured individuals who qualify for the plan to enroll and does not charge the lowest-income participants any premiums. In Maine, insurance coverage is voluntary, and participants of all income levels pay premiums.
  - Enrollees in the Massachusetts plan were younger and healthier, on average, than enrollees in the Maine plan.

[4] Katherine Swartz directs the RWJF Scholars in Health Policy Research Program at Harvard. Read her profile.

— Adverse selection occurred in Maine: a higher proportion of enrollees in DirigoChoice were older, or had chronic health conditions, than enrollees in Commonwealth Care and the plans for state employees in Massachusetts and Maine.

— The Maine plan had lower overall enrollment than the Massachusetts plan, but less enrollment turnover.

- **Participants in both Commonwealth Care and DirigoChoice used fewer health care services than comparable state employees.** After controlling for age, sex, and health status, the researchers found that Massachusetts enrollees received about 31 percent less health care—and Maine enrollees received about 13 percent less care—than state employees.

- **The lowest-income enrollees in the Massachusetts plan—those with income below 150 percent of the federal poverty level—used the fewest health services, while enrollees in the Maine plan showed no differences in the use of care based on income.**

  Given that the lowest-income enrollees in the Massachusetts plan have very low out-of-pocket health care costs, this suggests that nonfinancial barriers affect their use of care.

  In Maine, where the costs of health care rise with income, all participants may face similar barriers to care. Or enrollees' use of health services may be relatively unaffected by cost, regardless of income, because of adverse selection.

- **In Massachusetts, people with chronic conditions appeared to use fewer health care services and spend less on pharmaceuticals.** "We are working to try to figure out whether our findings have some kind of data flaw, or whether this reflects true use patterns," said Kilbreth.

  For example, enrollees in subsidized plans may simply use more generic drugs than state employees, or plans and pharmacies may negotiate drug discounts. In those cases, lower overall drug costs among enrollees could reflect these factors rather than less access to drugs.

### Limitations

Some of the data related to the use of health care services are "startling," Kilbreth said, and noted that the researchers are continuing to analyze the puzzling data for possible distortions.

## LESSONS LEARNED

1. **Commercial insurance claims offer opportunities for research on health services and risks.** Because those claims are not primarily designed for research, coding may

not be uniform across insurers, or data may be missing. For example, records on the use of health services may be incomplete if insurers prepay providers or bundle payments.

Nonetheless, insurance claims offer a potential "treasure house" for research on the health system, including access to care and its quality, according to Kilbreth. "We need a workgroup from the research community collaborating with payers and providers to reach consensus on how information is reported, so these data become more reliable and useful for research."

Meanwhile, researchers should allow extra time to check and clean data to ensure that it is as uniform and complete as possible, she said. Planning for a backup data source, should the original have too many flaws, also would be prudent.

2. **Expect delays in receiving approval from Institutional Review Boards for the use of health claims data, and in ensuring compliance with the federal Health Insurance Portability and Accountability Act (HIPAA).** Although the researchers had contacts within six state agencies and requested "completely depersonalized" data, the information did include partial zip codes and dates of service, triggering HIPAA rules. Gaining access to the data therefore took far longer than anticipated.

   "There are unbelievable hurdles and red tape impeding access to data for research purposes. While I am very sympathetic to protecting people's medical information for privacy, the rules are cumbersome, and some are unnecessary," said Kilbreth.

## AFTERWARD

The researchers are preparing two articles for publication. The first is on health care use among low-income participants in the new state plans. The second is on how the structure of the plans influences patterns of enrollment and disenrollment.

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