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Early Findings From the ACA's Medicaid Expansion Show Substantial Increases in Costs Over Time

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Editor's note: This article highlights findings from an analysis conducted by Avalere Health using data from three managed care organizations. The full report[1] was released by Avalere Health in January 2018. Funding for this study was provided by the Anthem Public Policy Institute. Excerpted passages are copyright © 2018 Avalere Health. Reprinted/adapted by permission.

States and Medicaid managed care plans have gained valuable experience with the Medicaid expansion population since many states expanded eligibility under the Affordable Care Act (ACA) in 2014. While over 11 million individuals have gained coverage since the expansion,[2] relatively little has been shared publicly about the enrollment and utilization experience of expansion enrollees (i.e., low-income, childless adults).

Because the expansion population was new to Medicaid and likely to have been uninsured prior to gaining Medicaid eligibility, states and Medicaid managed care organizations (MCOs) initially had relatively little information on which to base utilization and risk assumptions. The Centers for Medicare & Medicaid Services (CMS) forecasted that newly eligible expansion adults who enrolled in the initial years of Medicaid expansion would have high levels of health care utilization due to pent-up demand, with per capita costs about equal to those of traditionally eligible adults in 2014. However, CMS also anticipated that the newly eligible expansion enrollees would use fewer services over time, expecting their costs to be about 80 percent of the per-enrollee costs of traditionally eligible adults in 2015.[3]

MCOs have not seen these results as forecasted by CMS; instead, claims experience for newly eligible expansion enrollees has continued to increase over time. This analysis of three MCOs' experience was conducted by Avalere Health to understand how enrollment, utilization and cost patterns for newly eligible enrollees have changed over time and whether spending patterns differed for earlier versus later expansion enrollees.

METHODOLOGY

This analysis was based on claims data from January 2014 through December 2016 from three Medicaid MCOs offering coverage in states that expanded Medicaid on Jan. 1, 2014. In total, the data represented nine unique state-plan combinations. All Medicaid expansion enrollees, defined as individuals who gained eligibility due to the state's decision to expand coverage under the ACA, in these state-plan combinations were included and assigned to a group based on the initial date of enrollment. Membership in each plan was categorized into six-month period enrollment groups based on the initial enrollment date (e.g., an individual who enrolled between January and June 2014 was included in the "first half 2014" enrollment group).

The claims data included both medical and pharmacy claims but excluded prescription drug claims for hepatitis C treatments. Services paid for on a sub-capitated basis were also excluded from the analysis. Except where noted in the category of service analysis, claims data were normalized by both age and gender to negate the effect of age or gender influences on the change in claims over time (i.e., duration or incurred period). The age/gender normalization factors were derived from a state's most recently available state pricing or expected claims costs for the expansion population. The claims were also adjusted for any material program changes (e.g., benefit changes, fee schedule changes) through 2016.

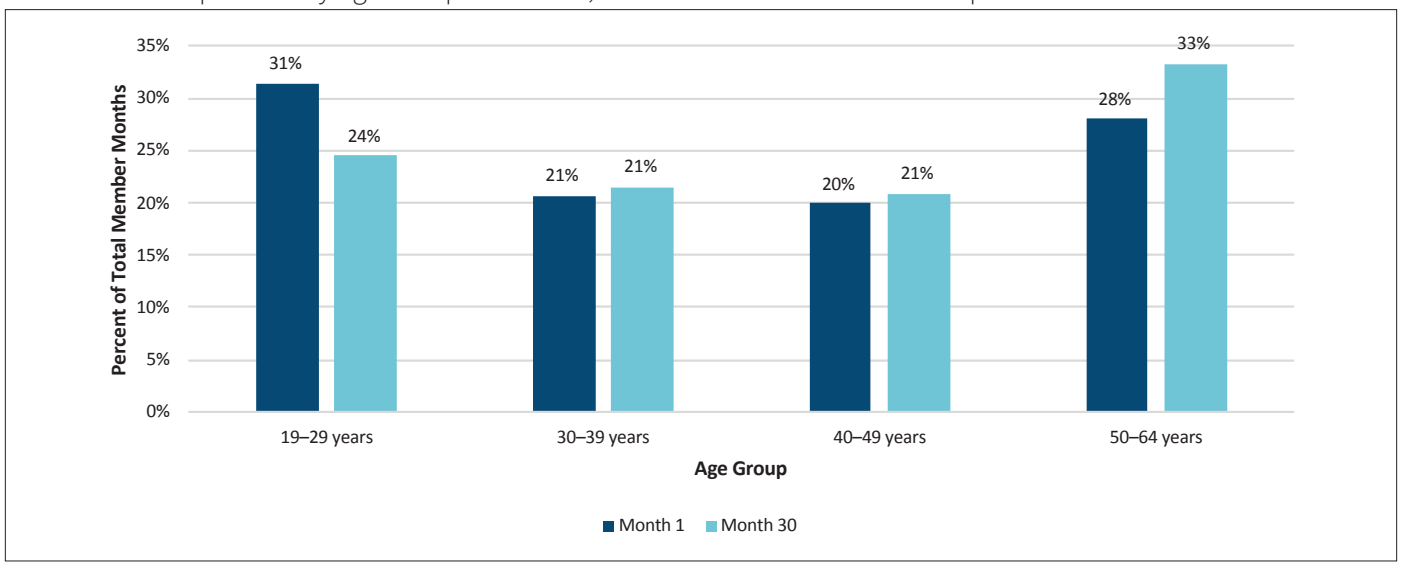
RESULTS

Avalere analyzed enrollment/membership and claims/utilization data to identify trends across the Medicaid expansion population.

Enrollment and Membership Analysis

Avalere's analysis provides helpful insights regarding disenrollment and retention rates among the expansion population. Across plans and states, the expansion population experienced high disenrollment rates, indicating that, as in other Medicaid eligibility groups, there is substantial churn in this population. For example, the study found that among expansion population enrollees who enrolled in coverage in 2014 and early 2015, only about half of those initially enrolled were still covered after 18 months, irrespective of enrollees' coverage start date. This finding is consistent with prior analyses of Medicaid disenrollment,

Figure 1
Enrollment Composition by Age Group Over Time, First Half 2014 Enrollment Group



which have noted disenrollment rates of up to 50 percent after 12 months of coverage in other eligibility groups.[4]

While newly eligible expansion enrollees generally were likely to drop coverage over time, disenrollment was more common among the younger enrollees in each group. These patterns were consistent across enrollment groups and were similar for males and females. As illustrated in Figure 1, among the group enrolling in the first half of 2014,

> enrollees ages 19–29 accounted for 31 percent of member months in the first six months of coverage, while enrollees ages 50–64 made up approximately 28 percent of member months. After two and a half years of enrollment, however, enrollees ages 19–29 made up just 24 percent of member months, while enrollees ages 50–64 made up about 33 percent.

> Older enrollees may likely stay enrolled longer than their younger counterparts for a variety of economic and demographic reasons. For example, younger enrollees may be more likely to experience fluctuations in income due to job changes. Importantly, older enrollees also tend to have higher claims costs due to a higher prevalence of chronic conditions and comorbidities than younger enrollees. Therefore, higher retention rates among older enrollees would suggest that claims costs could increase over time.

Claims and Utilization Analysis

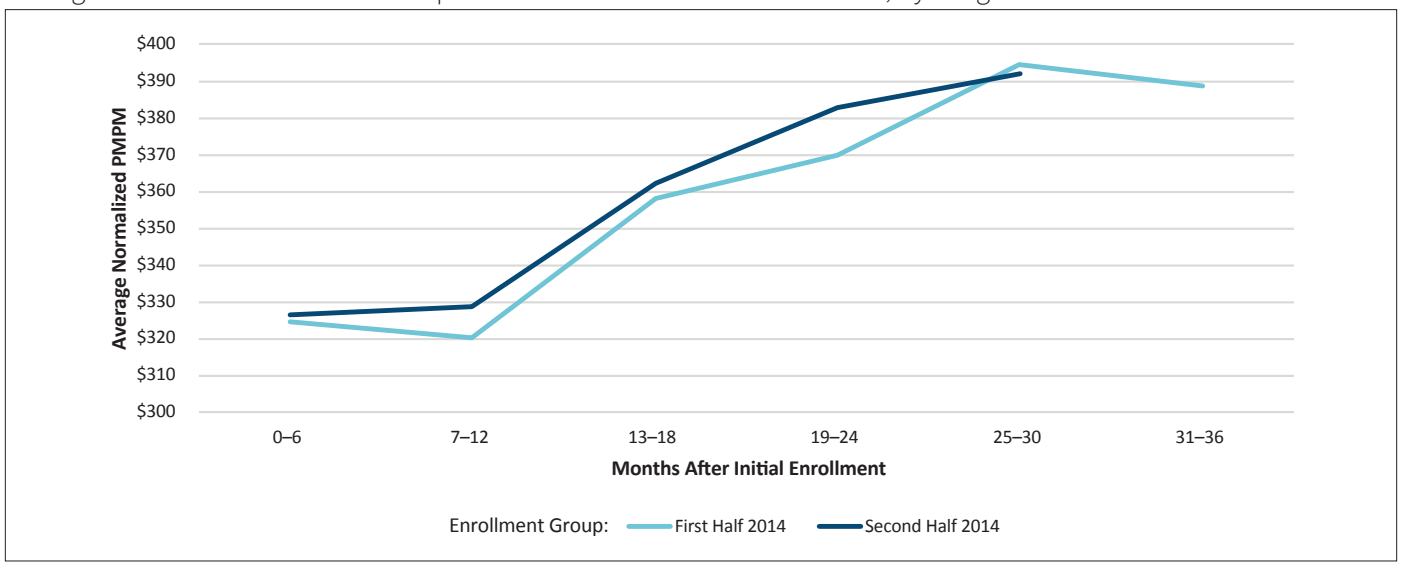
Most important, the study provides new data on the cost trends for the expansion population. In contrast to early forecasts released by CMS and other entities, this analysis shows that claims costs did increase over time for the expansion population—even after adjusting or normalizing for age and sex. While some enrollment groups experienced a dip in claims costs during the second six months of enrollment, suggesting some pent-up demand, the overall trend was toward higher claims costs over time. (See Figure 2.)

> For example, among those who enrolled during the first half of 2014, average claims costs were $324 per member per month (PMPM) during the first six months of coverage and rose to $389 PMPM during the final six months of the study period.

Notably, costs rose substantially after an initial decrease during months 7 to 12 following initial enrollment.[5] This suggests that, despite some pent-up demand for services, remaining enrollees used more services or required more costly services.

Relative spending by claims type also suggested that expansion enrollees have chronic health care needs. While inpatient claims declined fairly quickly as a share of total claims costs, the share of professional and outpatient claims was consistent over time and prescription drug spending increased significantly as a share of total claims costs.

Figure 2
Average PMPM Costs for Medicaid Expansion Beneficiaries Enrolled in 2014, by Length of Enrollment



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For the group who enrolled in the first half of 2014, Figure 3 (on page 28) shows that inpatient claims initially accounted for the largest share of claims costs—nearly one-third—suggesting that expansion enrollees had significant medical needs upon enrollment, or that many expansion enrollees enrolled as a result of an inpatient encounter (hospitals may presumptively determine Medicaid eligibility).[6]

However, as beneficiaries spend more time with comprehensive insurance coverage and establish relationships with physicians, their health care costs shift toward outpatient visits and prescription drugs—a core component of chronic disease treatment—and away from hospitalizations, which reflect acute health needs. The study showed that pharmacy costs (excluding hepatitis C) almost doubled over the two-and-a-half-year time period that the initial cohort was tracked. This is likely an indication that the previously uninsured population may have had untreated conditions and gaining access to health insurance helped provide needed care to these enrollees.

LIMITATIONS

Because plan data were blinded in this study, there are limitations in the conclusions that can be drawn from the results. MCO experience could differ across states and plans due to covered benefits, plan capitation rates, negotiated rates with providers, and if a state has a unified formulary. Finally, states have different processes for eligibility applications and redeterminations with some states allowing enrollees to stay enrolled until eligibility is re-determined, while others disenroll enrollees until they are re-determined eligible.

CONCLUSION

This study meaningfully expands on the information available about the Medicaid expansion population by examining enrollment, demographic and utilization trends across states and health plans. While some studies have examined early utilization and spending for the expansion population, this analysis provides additional clarity by following individual health plan enrollees over time. Major findings are:

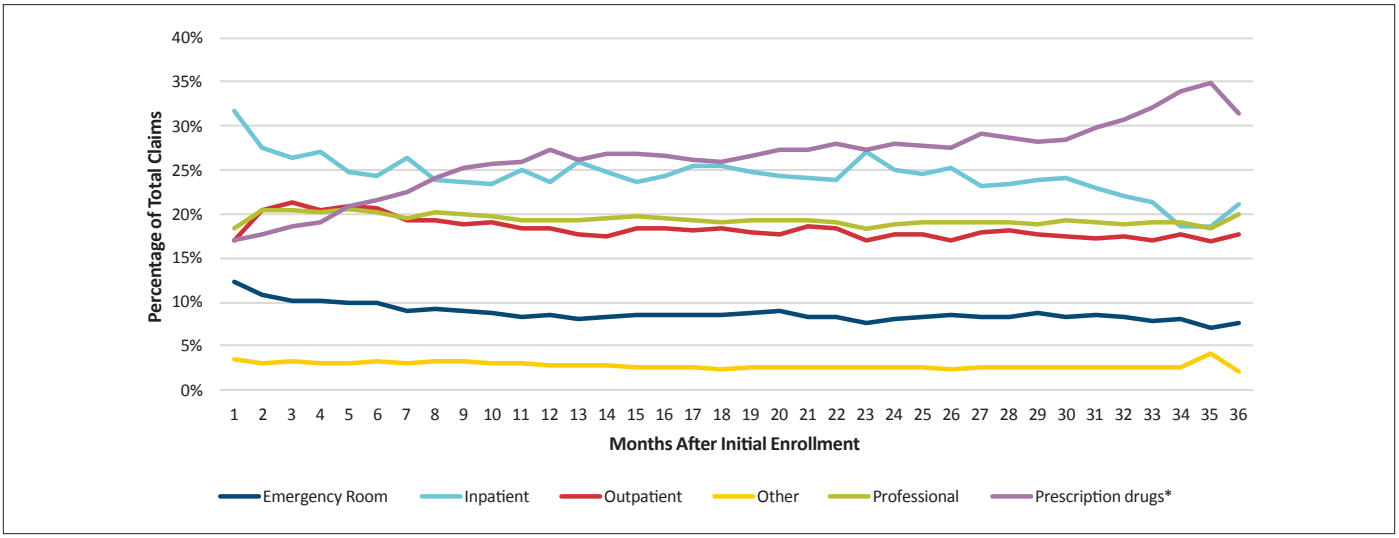
- Across plans and states, the expansion population experienced **high disenrollment rates**, indicating that, as in other Medicaid eligibility groups, there is substantial churn in this population.

- **Even after adjusting for age and gender, claims costs increased steadily over time**, suggesting that expansion enrollees have complex and/or chronic conditions. For some enrollment cohorts, average claims costs decreased modestly in the second half of the first year of enrollment, suggesting **some initial pent-up demand for services**, though claims costs increased steadily from that point forward.

- Across enrollment groups, **PMPM spending on prescription drugs increased with enrollment duration**.

- Among enrollees who remained enrolled the longest, **inpatient claims initially made up the largest share of claims costs, but were surpassed by prescription drug claims by month 8 of enrollment**, on average.

Figure 3
Percentage of Health Care Costs by Type Over Time, First Half 2014 Enrollment Group



*Excludes claims for hepatitis C treatments
Note: Claims not adjusted for age and gender.
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The results of this study provide valuable insights into the Medicaid expansion population and MCOs' experience across multiple states and enrollment cohorts, which can inform policy and program changes and assist state regulators in establishing payment rates and program standards. ■

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ENDNOTES

1 Avalere Health. *Profile of the Medicaid Expansion Population: Demographics, Enrollment, and Utilization*. January 2018, *http://go.avalere.com/acton/attachment/12909/f-0517/1/-/-/-/-/Avalere%20Medicaid%20Expansion%20Analysis.pdf* (accessed Aug. 2, 2018).

2 Centers for Medicare & Medicaid Services. Quarterly Medicaid Enrollment and Expenditure Report (July–September 2016). July 2017, *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/enrollment-mbes/index.html* (accessed Aug. 2, 2018).

3 Centers for Medicare & Medicaid Services. 2013 Actuarial Report on the Financial Outlook for Medicaid, *https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf* (accessed Aug. 2, 2018).

4 Swartz, Katherine, Pamela Farley Short, Deborah Roempke Graefe, and Namrata Uberoi. 2015. Evaluating State Options for Reducing Medicaid Churning. *Health Affairs* 34 no. 7: 1180–1187.

5 Avalere's analysis looked only at the magnitude of change in PMPM claims over time for the Medicaid expansion population and did not compare the results to prior membership.

6 This analysis is not adjusted for enrollee age and gender.