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IssueBRIEF

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Reporting on Pathways to Health Insurance Coverage: California's Experience

California publicly reports data about each step of the application and enrollment process for the state Medicaid program, Medi-Cal, and health plans made available through Covered California.

The Affordable Care Act opened new and expanded pathways to public health insurance coverage. Since 2014, many states have broadened their eligibility criteria for Medicaid, and have introduced new access points for Medicaid enrollment. During this time, publicly subsidized health insurance coverage also became available through state health insurance exchanges and through the federal health insurance marketplace.

Recognizing there is a great deal to learn about who applies for and obtains these types of public coverage, the federal government and some states have established new data reporting efforts on how people use both new and existing pathways to health insurance coverage. In 2014 and 2015, Mathematica Policy Research supported the launch of such a reporting effort in California, with funding from the California Health Care Foundation. In this brief, we describe California's experience in reporting on applications, eligibility determinations, enrollments and coverage renewals for public insurance, highlight some of the practical implications of California's first few reports, and offer lessons for other states that are launching comparable reporting efforts.

California Health Care Foundation

The California Health Care Foundation is leading the way to better care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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INTRODUCTION

In 2013, California enacted legislation to provide transparency about how people enroll in and move between public health insurance options in the state. These public health insurance options include the state Medicaid program, Medi-Cal, and qualified health plans (QHPs) made available through Covered California, the state's health insurance exchange. The required quarterly reporting plan, outlined in California Assembly Bill x1-1 (J. Perez), Chapter 3, aligns with and augments federal reporting requirements for state Medicaid programs and health insurance exchanges. California's reports include information for both Medi-Cal and QHPs and enable a closer look at the demographics of the applicants and their movement through the application, eligibility and enrollment processes. This information is intended to be useful to policymakers, advocates, researchers, and the people who implement the programs.

A few other states have also published reports on the population that is eligible for and enrolled in health care as a result of the Affordable Care Act. For example, the state of Washington regularly publishes a report on the characteristics of new enrollees, including the enrollees in QHPs available through the Washington Health Benefit Exchange and the group of adults who were newly eligible for Medicaid in 2014.[1] California's

reporting effort may be unique, however, in that it is designed to include all Medicaid applicants (not just those who are newly eligible under the expanded criteria), highlight data from each step of the application process, and reveal movement between public coverage options. As a result, this effort requires close cooperation and joint reporting by two separate entities: Medi-Cal, which is operated by the Department of Health Care Services (DHCS), and Covered California. California's experiences at the forefront of this type of reporting can inform future reporting efforts at the state and national levels.

WHAT IS CALIFORNIA REPORTING ABOUT THE PATHWAYS TO INSURANCE COVERAGE?

California has made substantial progress in fulfilling the legislature's reporting requirements, beginning with an effort to create meaningful technical definitions that could address the broad topics required by the law. Between February and September of 2015, California published three consecutive reports, each updating and building on the last.[2] As of the

Table 1. Status of reporting required by California's state assembly

Assembly Bill x1-1 requirement	Reporting status
Applications and eligibility decisions	
Applications received through each venue	Reported in full
Applicants included on those applications	Reported in full
Demographics of applicants (gender, age, race, ethnicity, primary language)	Reported in full
Eligibility determinations that resulted in approval for coverage	Reported in full
Program(s) for which the approved individuals were determined eligible	Reported in full
Applications denied for any coverage and reason(s) for denial	Not yet reported
Days for eligibility determinations to be completed	Not yet reported
Plan selections	
Health plans selected by applicants enrolled in an insurance affordability program (IAP)*	Partially reported
Medi-Cal enrollees who do not select a health plan but are defaulted into a plan	Partially reported
Redeterminations (Renewals)	
Redeterminations processed	Reported in full
Redeterminations that resulted in continued eligibility for the same IAP	Reported in full
Redeterminations that resulted in a change in eligibility to a different IAP	Not yet reported
Redeterminations that resulted in a loss of eligibility for any IAP and reason(s) for loss of eligibility	Not yet reported
Days for redeterminations to be completed	Not yet reported
Disenrollments	
Beneficiary disenrollments and reason(s) for disenrollments	Not yet reported
Number of disenrollments caused by individual disenrolling from one IAP and enrolling into another	Not yet reported
Consumer assistance	
Number of applications for IAPs that were filed with the help of an assister or navigator	Reported in full
Grievances and appeals	
Number of grievances and appeals filed by applicants and enrollees regarding eligibility for IAPs, the basis for the grievance, and the outcomes of the appeals	Reported in full

*IAPs are publically subsidized health insurance programs with income-based eligibility criteria. In California, IAPs include Medi-Cal and QHP coverage obtained with advance premium tax credits and/or cost-sharing reductions.

September 2015 report, 9 of 18 legislative requirements had been reported in full, 2 were partially reported, and 7 have not yet been reported (Table 1). Reporting the outstanding requirements will require the establishment of new, complex data sharing processes or the integration of data systems. The challenges of doing so are discussed later in this brief.

In the spirit of enhancing transparency, California's reports also include data that are not required by the legislation. These additional data include applications to Medi-Cal that come through Medicaid's Express Lane Eligibility and Hospital Presumptive Eligibility programs; the demographic profile of individuals who are eligible for coverage; total enrollment in both QHPs and Medi-Cal; and the net change in enrollment during the reporting period for both programs and for different groups of Medi-Cal enrollees. The reports also describe a broader population than the legislation requires, including individuals who are automatically enrolled in Medi-Cal based on their receipt of Supplemental Security Income or their enrollment in CalWORKS, the state's Temporary Assistance for Needy Families program.

WHAT HAS THE STATE LEARNED FROM ITS REPORTING EFFORT SO FAR?

Even as DHCS and Covered California keep working to fulfill the remaining legislative requirements, the data that are already published offer important insights on the pathways to public health insurance coverage. For example, the reports demonstrate how well the initial pool of applicants reflected earlier estimates of the eligible uninsured population; highlight a new seasonality to health insurance applications, driven by Covered California's open enrollment period; illustrate how new eligibility criteria have led to changes in the codes under which beneficiaries qualifying for Medi-Cal are classified; and provide evidence on the stability of individuals' health insurance coverage over time.

Actual applicants for insurance coverage had similar characteristics to early estimates of the eligible uninsured population. During the first year of reporting, there were similarities between the demographics of applicants processed through CoveredCA.com, which serves as both an enrollment portal and a processing system to determine the program for which an applicant is eligible, and the projected demographic profile of California's eligible uninsured population, which was based on a 2013 survey of the uninsured before the coverage expansion.[3] Like the uninsured population described in that survey, the greatest number of actual applicants through CoveredCA.com were of Hispanic/Latino origin (45 percent and 57 percent, respectively). In addition, the share of eligible uninsured who were young adults (20 percent) was only slightly higher than the share of CoveredCA.com applicants in the same age range (15 percent). These data confirm that the results of early surveys were generally helpful in predicting who the new applicants would be. If state officials revisit the survey data, they could learn more about the eligible population that remains uninsured and refine outreach plans accordingly.

The open enrollment period drives enrollment growth for both QHPs and Medi-Cal. The end of Covered California's open enrollment period, which ran from mid-November in 2014 through mid-February in 2015, coincided with a substantial increase in the number of applications submitted through CoveredCA.com. Between the last quarter of 2014 and the first quarter of 2015, the number of applications submitted this way rose by 37 percent. Individuals who apply for coverage through CoveredCA.com can be determined eligible for QHPs or for Medi-Cal, depending on their income and other characteristics. As a result, even though Medi-Cal enrollment is open year-round, the heightened application activity during Covered California's open enrollment period seems to drive increased enrollment in both programs. While there have long been seasonal changes in Medi-Cal enrollment—for example, enrollment typically increases among school-age children in the fall because of back-to-school outreach efforts—the new, larger variations have implications for planning. The data suggest that County Human Services Agency Offices, which handle final processing of eligibility determinations for all Medi-Cal applicants, should be prepared to manage a dramatically fluctuating number of applications and that health plans and providers should expect an influx of patients in early spring.

> The data systems that support routine public reporting are a powerful tool for advancing transparency and the foundation for more data-driven policymaking and continuous improvement.

The most common eligibility codes for Medi-Cal beneficiaries are shifting.
Changes to Medi-Cal eligibility rules under the Affordable Care Act introduced a new category of eligibility based on modified adjusted gross income (MAGI). Under pre-expansion eligibility rules, there were a multitude of pathways to Medi-Cal eligibility, each with its own code in state data. Researchers and other analysts commonly used these diverse codes to track specific groups of beneficiaries over time. These pre-expansion pathways, known as non-MAGI eligibility, are based on household income in combination with other characteristics such as age or disability status. These non-MAGI pathways still exist. However, with the introduction of MAGI-based eligibility, a sizable portion of beneficiaries whose eligibility status would previously have been classified under non-MAGI codes are instead eligible under MAGI codes. Thus, while MAGI eligibility has substantially simplified and streamlined the enrollment process, one consequence is that it may be difficult or impossible for researchers to identify comparable groups of non-MAGI beneficiaries before and after the switch to MAGI-based eligibility. For example, before the switch to MAGI-based eligibility many Medicaid beneficiaries in treatment for breast or cervical cancer could be identified as being part of the Breast and Cervical Cancer Treatment Program eligibility group, but some are now eligible under a more general MAGI-based eligibility group. Researchers wishing to study similar individuals over time would need to develop new ways of identifying this population.

Enrollment in insurance coverage is more stable over time than expected.
Within this changing environment, there are also signs of stability. Among Medi-Cal beneficiaries whose eligibility was evaluated at annual renewal (also called redetermination) during the last quarter of 2014 or the first quarter of 2015, roughly 80 percent (82 percent and 77 percent, respectively) remained eligible for Medi-Cal coverage. Similarly, the vast majority of individuals enrolled in QHPs renewed their coverage (92 percent) during their first annual renewal, and approximately 94 percent of those who were renewing stayed with the same insurance carrier (35 percent through active choice, after exploring health plan options, and 65 percent by default). This stability rate is higher than predictions, which anticipated that 74 percent of Medi-Cal enrollees and 57 percent of subsidized QHP enrollees would keep the same health insurance coverage at renewal.[4] More years of data are needed to assess whether this stability will continue or whether it is a function of the types of people who enrolled at the beginning of the coverage expansion. If insurance coverage does remain relatively stable over time, however, it will strengthen the incentive for issuers and payers to invest in preventive health services and could lower administrative costs.

WHAT ARE THE REMAINING BARRIERS TO MORE COMPLETE DATA REPORTING?

As officials from DHCS and Covered California work to fulfill the remaining reporting requirements and enhance the data they have already reported, two types of barriers remain—those that affect data collection and those that affect the integration of data systems.

Barriers in data collection affect how data are captured as they are originally created. These barriers can be remedied with standardized guidance and procedures that enhance data quality. For example, California's legislature has asked for the reasons why people disenroll from (that is, lose or terminate their coverage in) public health insurance options. Covered California and DHCS each have their own disenrollment codes, and in order to produce comparable data, these two sets of codes must be reconciled. Complicating this exercise, of the more than 50 disenrollment codes maintained by DHCS, only 13 are required to be used consistently by all County Human Services Agency Offices that are partners in administering the Medi-Cal program. Over time, counties have developed different practices for using many, or just a few, of the possible codes. Developing an accurate picture of the reasons why people disenroll will require standardizing the guidance that counties use to assign disenrollment codes to Medi-Cal cases and ensuring that those codes can be aligned with codes used by Covered California. This standardized approach would enhance officials' ability to pinpoint where and why individuals are losing or terminating coverage.

Barriers to integrating data systems affect the way data are organized, stored, and accessed. For example, California's legislature has asked to know the outcome of renewal processes, including whether a beneficiary moves to another public coverage option or loses eligibility entirely upon renewal. To report renewal outcomes, Covered California must know whether QHP cases that appear to be Medi-Cal eligible at renewal actually go on to result in Medi-Cal coverage after referral to DHCS. Conversely, DHCS must know whether individuals in cases that are referred to Covered California actually go on to select a QHP and make their first premium payment to activate the coverage. This type of tracking is not yet possible because it requires the development and use of a unique beneficiary identifier that can be maintained as the beneficiary renews or changes coverage over time. California is in the process of developing a data warehouse that can accommodate cross-coverage reporting in future years, but at present neither DHCS nor Covered California can track the resolution of referrals.

HOW CAN THESE DATA BE USED TO IMPROVE THE PATHWAYS FOR ENROLLMENT INTO CALIFORNIA'S HEALTH INSURANCE OPTIONS?

Developing the data systems and standardized procedures that will support routine public reporting is an important investment. Once data on applications, eligibility determinations, enrollments, and coverage renewals can be regularly generated, DHCS and Covered California will not only have a powerful tool for advancing transparency, but also a foundation for more data-driven policymaking and continuous improvement in the business processes that underlie pathways to insurance coverage in California.

For example, the officials who implement these insurance programs will be able to look for any associations between the mode of submission (for example, mail, online portal, and with or without assistance) and the proportion of applications that are complete and accurate. If such an association is identified, officials can investigate the reasons for it. For example, although the state uses a single streamlined application, does the interactive nature of the online version influence a person's ability to accurately complete certain sections of the application? Do applicants for temporary Medi-Cal coverage via hospital presumptive eligibility go on to complete full applications at the same rate in all counties and across participating hospitals? If not, would educating providers result in greater consistency?

Given that there are 58 counties in California and that county offices play a key role in administering the Medi-Cal program, California has the opportunity to use its data systems to look within the state for best practices. Where there is variation between counties, DHCS and Covered California can examine whether there are policy or process differences that might be driving different outcomes. For example, do some counties have especially high rates of application assistance, and are applicants from these counties more likely to submit an application that is accurate and complete enough for an eligibility determination? If so, are there best practices that can be gathered from the local assister community and replicated in other counties? As another example, are application processing times especially efficient in some counties or for certain groups of eligible individuals, suggesting the opportunity to identify and replicate best practices in prompt eligibility determinations?

WHAT CAN OTHER STATES LEARN FROM CALIFORNIA'S EXPERIENCES WITH PUBLIC REPORTING?

California's experience with reporting on public insurance coverage suggests that significant levels of engagement and effort are needed to define the data elements that will be meaningful and to produce those data. Both DHCS and Covered California have dedicated staff to their quarterly reporting effort, including programming staff who can query complex databases and policy experts who help define measures that reflect noteworthy policy distinctions and examine data trends against the timing of known policy changes to look for evidence of effects. Routine meetings with the advocacy community have helped the reports evolve because they offer a forum for collecting feedback on stakeholder priorities that can be incorporated into the report as additional data become available.

The systematic understanding that California is gaining about the flow of enrollment, stability of coverage, and diversity of beneficiaries lays the groundwork for anticipating challenges in delivering adequate access to care.

In producing a report that will give insight into the full range of pathways to public insurance coverage, the challenge of communicating the results is as formidable as the work of specifying and producing the data. California has sought to balance the sometimes competing pressures to make information simple enough to be accessible to broad audiences, but detailed enough to engage well-informed stakeholders. With each new data element that the state chooses to add, plain language explaining the technical processes and data limitations must also be prepared. In addition, the central issues of interest may change over time, necessitating shifts in the focus of the report. For example, over time information that answers questions about the use of new enrollment pathways may become less relevant than questions about the stability of coverage.

Once the report is produced, officials must also be prepared to field questions about the data and explain the nuances that inevitably color any point-in-time snapshot of an eligibility and enrollment system. Coverage status is dynamic, reflecting consumer choices, changing circumstances, and even the various stages of administrative processing. As a result, even measures that are extracted from the same underlying data source and produced by a well-refined reporting system may differ depending on whether they are produced in the middle of the month or at the end of the month. Unless public data releases are well coordinated both within and between agencies, these inherent features of coverage-related data will look like conflicting information to some stakeholders. State officials must be prepared to field and address these types of inquiries.

Despite these challenges, public data reporting can be a powerful tool for advancing transparency and identifying areas for improvement. California is one of the first states to attempt this level of public reporting on applications, eligibility determinations, enrollment, and renewal for both Medicaid and QHP coverage. As the project continues to evolve, California's measures and reporting methods will continue to offer lessons for other states and may also be of interest to the Centers for Medicare & Medicaid Services as it maintains and updates its federal reporting requirements and public reports – particularly as data become available to report on movement between Medi-Cal and QHP coverage. Most importantly, state officials now have substantial information at hand to begin to look for opportunities to improve program administration. Identifying and replicating promising county-level eligibility and enrollment processes is an immediate opportunity, but the systematic understanding that California is gaining about the flow of enrollment, the stability of coverage, and the diversity of enrolled beneficiaries also lays the necessary groundwork for anticipating challenges in delivering adequate access to care for a greatly expanded Medicaid population.

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REFERENCES

[1] Washington Health Benefit Exchange. "Health Coverage Enrollment Report." March 2015. Accessed September 23, 2015. Available at: https://wahbexchange.org/files/9914/2740/7310/2015_Enrollment_Report_2_032615.pdf

[2] California Department of Health Care Services. "CA Eligibility and Enrollment Data Quarterly Report." February, July, and September 2015. Accessed September 25, 2015. Available at: http://www.dhcs.ca.gov/formsandpubs/Pages/Reports2theLegislature.aspx

[3] Kaiser Family Foundation. "California's Uninsured on the Eve of ACA Open Enrollment: The Kaiser Family Foundation Baseline Survey." September 2013. Accessed September 21, 2015. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8485-t.pdf

[4] Miranda Dietz, Dave Graham-Squire, and Ken Jacobs. "The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal." April 2014. Accessed September 21, 2015. Available at: http://laborcenter.berkeley.edu/the-ongoing-importance-of-enrollment-churn-in-covered-california-and-medi-cal/

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