People lacking insurance not likely to migrate to obtain Medicaid coverage

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Amidst the patchwork nature of Medicaid expansion in the U.S. under the Affordable Care Act (ACA), some have worried that low-income adults in states without expanded coverage might move to states that have chosen to expand—thus placing a financial burden on those states. But a new Harvard School of Public Health (HSPH) study finds little evidence of such cross-state migration.

"Though many states have not opted in to the ACA Medicaid expansion, they may decide to do so in the future. Our study can inform these decisions by showing what happened when states implemented similar public insurance expansions in the past. We found no evidence that these states became so-called 'welfare magnets,' attracting low-income individuals from other states," said lead author Aaron Schwartz, a doctoral candidate in health policy at Harvard.

The study was published in the January 2014 issue of *Health Affairs*—and was one of several in the issue co-authored by Harvard School of Public Health researchers. Other studies in the same issue examined the challenges and successes of accountable care organizations and conflict-and-resolution programs.

Migration for benefits?

Although the ACA is expanding Medicaid in 2014 to millions of low-income adults, a June 2012 U.S. Supreme Court ruling gave states the

option of whether or not to participate in the expansion. Several states had already expanded public insurance to many of these adults in the past decade, and Schwartz and senior author Benjamin Sommers, assistant professor of health policy and economics at HSPH, looked at the experiences of those states—Arizona, Maine, Massachusetts, and New York—to see if migration could be expected to occur under the ACA.

The researchers found that there were no consistent increases in migration to these states. "These results suggest that migration will not be a common way for people to obtain Medicaid coverage under the ACA expansion and that interstate migration is not likely to be a significant source of costs for states choosing to expand their programs," the authors wrote.

Medicaid expansion: lessons learned

Sommers was lead author on another paper on Medicaid expansion and the ACA, which looked at several early adopters of the ACA's expanded Medicaid coverage—California, Connecticut, Minnesota, and Washington, D.C.—to see if there were useful insights for states and policymakers as Medicaid expansion ramps up in 2014.

The researchers found that Medicaid enrollment occurred gradually over time, with participation continuing to climb several years into the expansions; was highest among people with the worst health; and that, among some young people, Medicaid primarily replaced private coverage, while among older adults and those with worse health, most had been uninsured. Finally, there was increased participation in Medicaid among previously eligible low-income parents who had not signed up in the past—possibly a positive "spillover" effect caused by increased media coverage about the expansion.

"Right now, as we see news reports each week on whether the ACA is signing up enough people, our results indicate we need to take a more patient view. Enrollment was slow and steady in these states, with coverage continuing to grow significantly more than three years after the initial expansion. Grading the ACA after just two or three months is extremely premature," said Sommers.

A look at Accountable Care Organizations

A third study, led by Arnold Epstein, John H. Foster Professor of Health Policy and Management at HSPH and chair of the Department of Health Policy and Management at HSPH, provides the first formal report about the characteristics of Accountable Care Organizations (ACOs) established by the ACA, which are among a series of new programs to improve health care delivery. In these ACOs, a group of health care providers assumes collective responsibility for care for a particular Medicare population.

Examining 123 ACOs around the country, the researchers found that ACOS were somewhat more likely to be located in the South. Fewer than half of the ACOs included a participating hospital; and hospitals participating in ACOs were typically large, teaching, and not-for-profit. ACO patients were more likely than non-ACO patients to have higher incomes, and were less likely to be black, covered by Medicaid, or disabled. The cost of ACO patients' care was slightly lower than for non-ACO patients.

The authors said that the study provides an important baseline as researchers continue to evaluate the ACO program. Future research should establish whether differences in the patient population served by ACOs versus non-ACOs evolve and whether patterns of care and success differ between ACOs that do and don't have a hospital participant.

Two studies of Communication-and-Resolution Programs

Michelle Mello, professor of law and public health at HSPH, was lead author on two papers focused on communication-and-resolution programs (CRPs), in which health systems and their malpractice insurers encourage the disclosure of adverse events to patients and proactively seek resolutions by offering an apology, an explanation, and in some cases, compensation.

In one paper, Mello and co-authors examined six institutions that pioneered the CRP approach to learn what factors contributed to the success they have reportedly had in reducing liability costs and easing the distress that families and care providers experience when an unexpected care outcome occurs. The researchers identified strategies that helped these institutions overcome challenges in implementing the programs—such as getting physicians to disclose errors and helping patients have realistic expectations about compensation they might receive.

The second paper reported on five New York City hospitals' experiences implementing CRPs. The Obama Administration funded three-year demonstration projects in 2009 to test whether the CRP approach could work in new settings—such as financially stressed hospitals operating in a volatile liability environment without tort reforms. The researchers in the New York demonstration project found that while all of the hospitals were able to improve communication with patients about adverse events, they struggled to implement the proactive compensation component of the CRP as envisioned.

More information: "Moving For Medicaid? Recent Eligibility Expansions Did Not Induce Migration From Other States," Aaron L.

Schwartz and Benjamin D. Sommers, *Health Affairs*, January 2014

"New Evidence On The Affordable Care Act: Coverage Impacts Of Early Medicaid Expansions," Benjamin D. Sommers, Genevieve M. Kenney, Arnold M. Epstein, *Health Affairs*, January 2014

"The Care Span: Analysis Of Early Accountable Care Organizations Defines Patient, Structural, Cost, And Quality-Of-Care Characteristics," Arnold M. Epstein, Ashish K. Jha, E. John Orav, Daniel J. Liebman, Anne-Marie J. Audet, Mark A. Zezza, Stuart Guterman, *Health Affairs*, January 2014

"Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters," Michelle M. Mello, Richard C. Boothman, Timothy McDonald, Jeffrey Driver, Alan Lembitz, Darren Bouwmeester, Benjamin Dunlap, Thomas Gallagher, *Health Affairs*, January 2014

"Implementing Hospital-Based Communication-And-Resolution Programs: Lessons Learned In New York City," Michelle M. Mello, Susan K. Senecal, Yelena Kuznetsov, Janet S. Cohn, *Health Affairs*, January 2014

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