IOWA WELLNESS PLAN - ENROLLMENT AND CHURN

Calendar Years 2013 - 2018

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SUMMARY

The movement of Iowa Wellness Plan (IWP) members in and out of the Medicaid program and between MCOs is similar to that for a comparable study group, namely FMAP members. A few findings are worth noting.

- Membership in IWP has stabilized with small but steady growth in the last year to over 170,000 in January 2019.
- The demographic characteristics of IWP members has not changed significantly over the first 5 years of the program. Members are most likely to be female, white, living in a metropolitan area and between 22 and 30 years of age.
- In December 2016, over 85,000 AmeriHealth members were switched to United HealthCare (UHC) as AmeriHealth exited the Iowa Medicaid program.
- Members who returned after a gap in enrollment, as opposed to those never coming back into Medicaid, were significantly more likely to be female ($p<0.000$), white ($p<0.000$), and younger ($p<0.000$) than those who did not return.

INTRODUCTION

Iowa Health and Wellness Plan

The Iowa Wellness Plan (IWP) is an expansion of publicly funded health care allowed as part of the Affordable Care Act (ACA). IWP began as the Iowa Health and Wellness Plan (IHAWP) on January 1, 2014 under an 1115(a) Medicaid demonstration waiver with two separate components: 1) Wellness Plan (WP) and 2) Marketplace Choice (MPC). WP was a public program for adults with incomes from 0-100% of the Federal Poverty Level (FPL) who were not eligible for Medicaid through a categorical program such as Family Medical Assistance Plan (FMAP) or Medicaid for Employed People with Disabilities (MEPD) and was operated by the Iowa Medicaid Enterprise. In MPC, members selected a Qualified Health Plan (QHP) from eligible private plans in the Health Insurance Marketplace. Medicaid paid the health plan premiums for members in MPC. Until November 2014, members could choose between CoOportunity Health (CoOp) or Coventry Health Care (Coventry). CoOp withdrew from the IHAWP at the end of November, and beginning December 1, 2014, CoOp members were transitioned into WP. New MPC members enrolled as of December 1 were placed in WP.

On December 31, 2015 the MPC component of IHAWP became dormant in anticipation of the state-wide implementation of Managed Care Organization enrollment for all Medicaid members (with exceptions such as PACE members). MPC members and WP members became IWP members on January 1, 2016 with traditional fee-for-service coverage provided by IME. On April 1, 2016 all members were enrolled in one of three Managed Care Organizations (MCOs) Amerigroup Iowa (AmeriGroup), AmeriHealth Caritas Iowa (AmeriHealth) or UnitedHealthcare Plan of the River Valley (UHC). Effective November 30, 2017 AmeriHealth ended participation as an MCO. Members were moved to UHC.

Study purpose

This study presents information about how IWP members have experienced coverage. Previous reports have focused on the initial enrollment of new members into the IHAWP-some who were automatically enrolled (auto-enrolled) into IHAWP from the IowaCare program (a limited benefit, limited provider program for uninsured adults up to 200% FPL in Iowa) and some who were either uninsured or had another type of health insurance prior to joining the IHAWP. Additional information was provided concerning the continued eligibility of enrollees during the first year of the IHAWP-what is often referred to as “churn”. Important questions that were evaluated include: 1) what proportion of enrollees remained eligible for the first year and 2) how did the proportion of members who remained eligible for the year differ from a) IHAWP members who were auto-enrolled from IowaCare in 2014, b) IHAWP members who were gaining new coverage in 2014, c) IowaCare members in 2013 and d) Medicaid members in both 2013 and 2014. These results are located on the Public Policy Center (PPC) website at http://ppc.uiowa.edu/publications/iowa-health-and-wellness-plan-evaluation-interim-report.

The current report extends these analyses through CY 2018 capturing the transition of members through the elimination of QHPs and the implementation of MCOs. Within the context of ongoing member enrollment, the research questions primarily on how many transitions were experienced during shifts in coverage options rather than whether they were covered or retained coverage following the onset of IHAWP.

FINDINGS

Enrollment trends

After initially rapid growth due to auto-enrollment of IowaCare members, enrollment in IWP climbed more slowly and steadily through December 2015, leveling off around 158,000 members and remaining at roughly that level through December 2017. Enrollments rose 91% from 61,895 initially to nearly 118,512 in WP and 143% from 15,483 to 37,609 in MPC. Beginning January 2016, MPC became dormant and all enrollees in IHAWP became members of Iowa Wellness Plan (IWP). Ultimately, by December 2018 there were over 170,000 members enrolled in IWP (Figure 1).

There are two times at which IWP enrollment dips during the first 5 years of the program. The first dip occurs in July 2016 and is most likely due to MCOs communicating with IME regarding member eligibility verification for the first time. Members whose incomes are unable to be verified may be disenrolled and then reenrolled once information is provided. By September 2016, the number of members returns to pre-July levels, providing some evidence that members were able to regain eligibility. The second dip occurs in October 2017 the month prior to AmeriHealth ending participation in IWP. Enrollment was suspended as IME developed a mechanism to reassign and notify members. Members were primarily shifted to UHC. As with the previous reduction in enrollment, the number of members rose within two months to pre-shift levels.

Figure 1. Monthly enrollment in IWP by plan-all enrollees, CY 2014-CY 2018

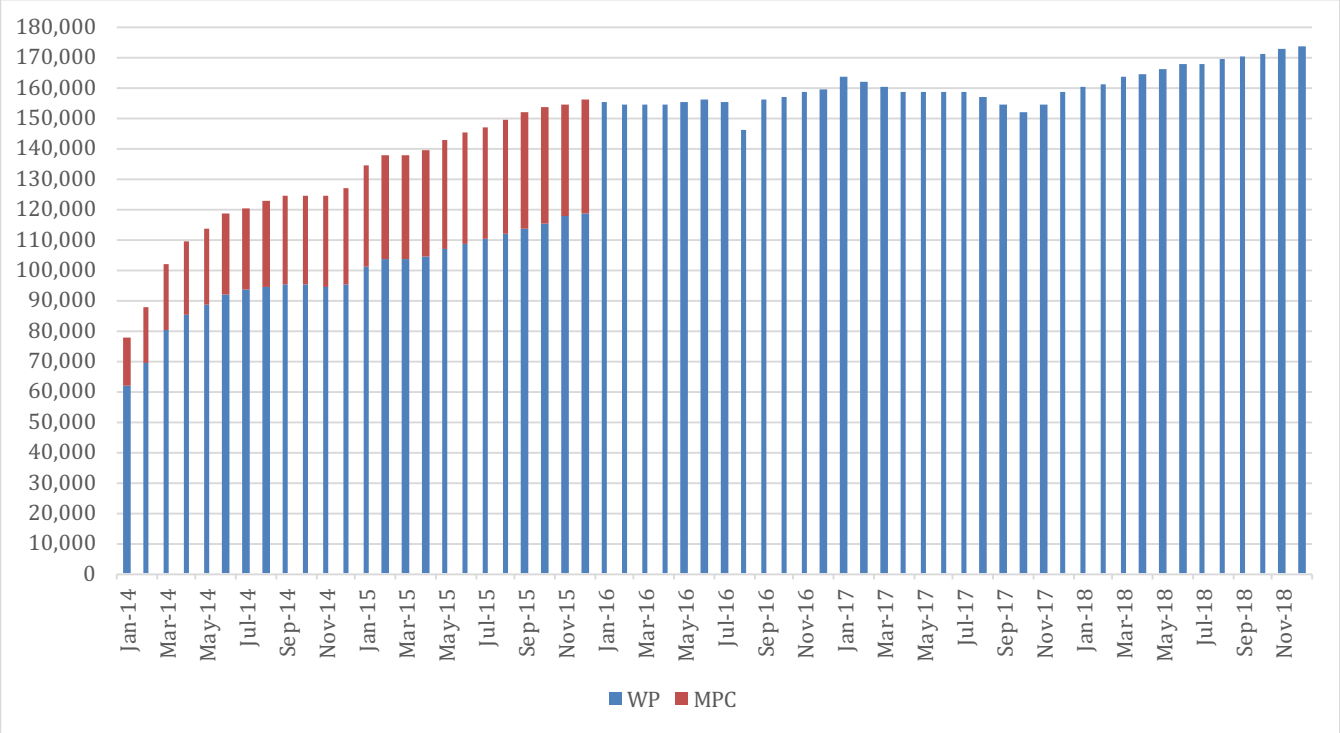


Table 1 provides comparisons of the IWP members over time. The characteristics of IWP members remained relatively stable over the five years following implementation. IWP members were equally likely to be male or female and most likely to be white, between 22 and 30 years of age, and living in a metropolitan area.

Table 1. Demographic characteristics of IWP members eligible for at least 1 month during the year - CY 2014 – CY 2018

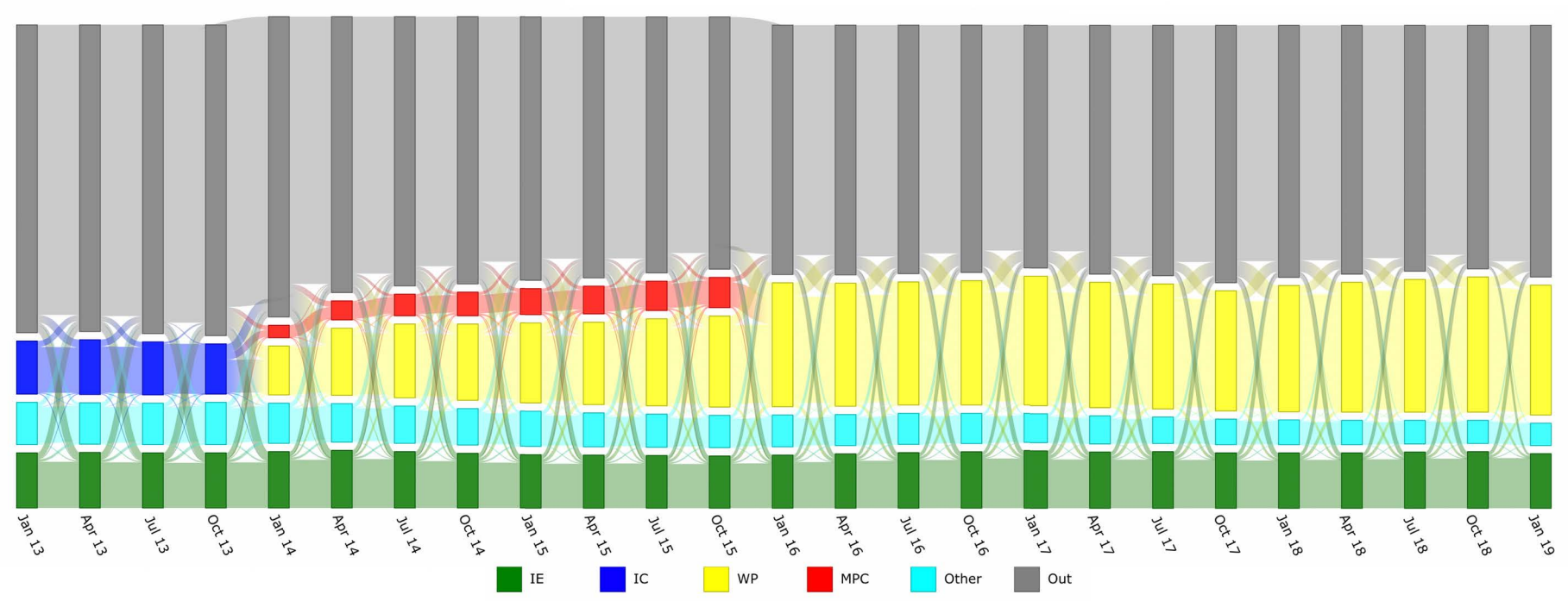
	CY 2018 N (%)	CY 2017 N (%)	CY 2016 N (%)	CY 2015 N (%)	CY 2014 N (%)
Gender					
Female	120,070 (53%)	117,991 (53%)	105,606 (51%)	102,598 (52%)	78,421 (51%)
Male	104,528 (47%)	102,372 (47%)	99,413 (49%)	95,086 (48%)	74,966 (49%)
Race					
White	140,236 (62%)	140,324 (64%)	134,327 (66%)	129,637 (66%)	99,487 (65%)
Black	19,338 (9%)	18,844 (9%)	17,337 (9%)	15,932 (8%)	11,908 (8%)
American Indian	3,656 (2%)	3,473 (2%)	3,145 (2%)	2,609 (1%)	2,017 (1%)
Asian	5,352 (2%)	5,226 (2%)	4,687 (2%)	4,323 (2%)	3,066 (2%)
Hispanic	10,874 (5%)	10,156 (5%)	9,182 (5%)	8,122 (4%)	5,548 (4%)
Pacific Islander	1,129 (<1%)	1,102 (<1%)	1,075 (<1%)	1,243 (1%)	819 (1%)
Multiple—Hispanic	3,145 (1%)	2,904 (1%)	2,643 (1%)	2,330 (1%)	1,502 (1%)
Multiple—Other	2,448 (1%)	2,188 (1%)	2,064 (1%)	1,810 (1%)	1,179 (1%)
Undeclared	38,420 (17%)	36,146 (16%)	30,559 (15%)	31,678 (16%)	27,861 (18%)
Age					
18-21 years	26,432 (12%)	18,205 (8%)	20,666 (10%)	19,325 (10%)	11,599 (8%)
22-30 years	59,500 (27%)	62,203 (28%)	56,234 (27%)	53,039 (27%)	38,997 (25%)
31-40 years	52,413 (23%)	53,260 (24%)	47,067 (23%)	44,720 (23%)	33,722 (22%)
41-50 years	37,780 (17%)	38,780 (18%)	36,281 (18%)	35,588 (18%)	30,503 (20%)
51 and over	48,471 (22%)	47,915 (22%)	44,769 (22%)	45,012 (23%)	38,566 (25%)
County rural/urban status					
Metropolitan	134,897 (60%)	132,548 (60%)	121,398 (60%)	119,368 (60%)	93,551 (61%)
Non-metropolitan, urban	78,921 (35%)	77,167 (35%)	69,809 (34%)	68,988 (35%)	52,977 (35%)
Non-metropolitan, rural	10,780 (5%)	10,648 (5%)	9,705 (5%)	9,328 (5%)	6,859 (4%)
Total	**224,598**	**220,363**	**205,019**	**197,684**	**153,387**

Churn

Figure 2 visualizes Medicaid program churn from the 1st quarter 2013 through the 4th quarter 2018. This figure includes any member enrolled for at least 1 month in any Medicaid program from CY 2013 through CY 2018 as contained in the enrollment file for March 2019. Within the figure, lines moving away from the program from left to right indicate a movement out of the program, while lines moving toward the program from left to right indicate movement into the program. The thickness of the line is related to the number of members making a move. A thicker line indicates more members are moving. For example, the line portraying movement from IC to WP is thicker than the line portraying movement from IC to MPC from Q4 to Q5 because more members moved to WP than MPC.

Within the figure, IE member numbers remain stable, as does the number of members in other Medicaid programs including Supplemental Security Income (SSI). Within the last 3 years, the bulk of members have moved from MPC in IWP as expected when MPC became a dormant program. Since January 2016, the movement in and out of programs seems to be relatively stable with no large groups of members moving into or out of any program. However, there is still significant movement between within IWP as seen in the results presented below.

Figure 2. Churn in Medicaid programs, 1st Quarter 2013 through 4th Quarter 2018



IC=IowaCare Other=Other Medicaid programs, including SSI IE=Income Eligible WP=Wellness Plan MPC=Marketplace Choice

Previous reports have provided information on churn following the implementation of IWP. Program churn can be defined as the movement of enrollees into and out of Medicaid programs with or without a gap in coverage. Those results are found at http://ppc.uiowa.edu/health/study/evaluation-iowas-medicaid-expansion-iowa-health-and-wellness-plan.

Gaps in coverage can be an indicator of positive life changes that result in other insurance or an indicator of negative consequences due to difficulty with continuing coverage requirements. Within the eligibility data, it is not possible to determine why members may have a gap period during which they are not covered. However, we can determine the number of individuals who experience a gap in coverage during the period December 2016 through January 2019 and ascertain the gap length.

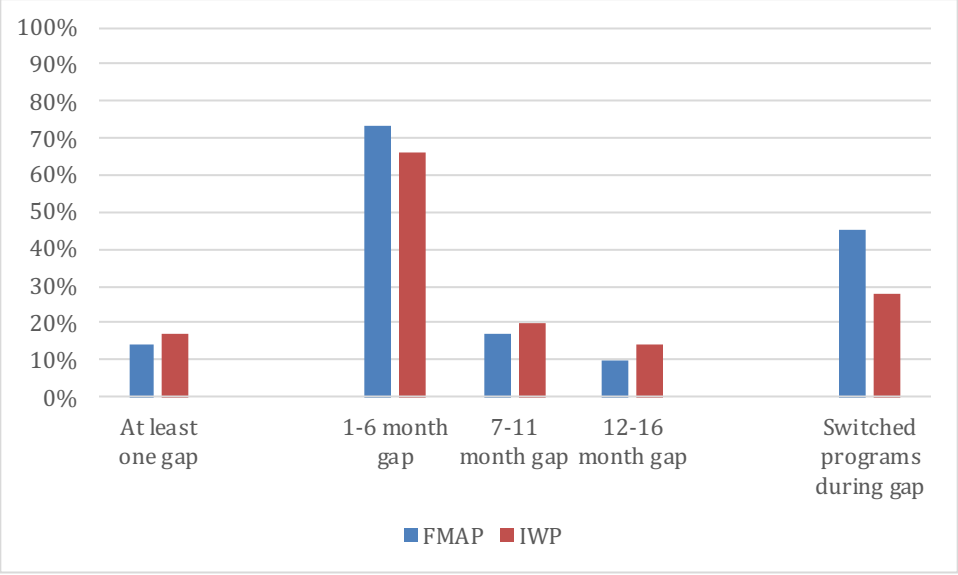
The proportion of members with at least one gap was significantly higher for IWP members, than for FMAP members (Table 2). The length of gap is also significantly different between IWP and FMAP members. IWP members are more likely to experience gaps greater than 6 months, the majority of members in both programs experience a 1-month gap in coverage. FMAP members are more likely to switch to a different Medicaid program at the end of the gap than IWP members. This may be a result of FMAP members having an increase in income allowing them to move up into the IWP group, while IWP members with an increase in income may have to leave the Medicaid program completely.

Table 2. Gap experience of FMAP and IWP members, December 2016 – January 2019

	FMAP	IWP
At least one gap	19,964 (14%)	36,659 (17%)*
1-6 month gap	15,184 (73%)	25,260 (66%)*
7-11 month gap	3,586 (17%)	7,777 (20%)
12-16 month gap	2,026 (10%)	5,177 (14%)
Switched programs during gap	8,906 (45%)	10,414 (28%)

p<=.001

Figure 3. Comparison of IWP and FMAP members with at least one gap, December 2016 and January 2019



Members in IWP and FMAP also lost coverage during the period December 2016 – January 2019. 69,503 member lost coverage in IWP (32%), while 33,332 FMAP members (23%) lost coverage during this time. Table 3 provides information on those who left IWP and either **did not return** to IWP or any other Medicaid program or **returned** to IWP or another program (had a gap in coverage). Those who returned were significantly more likely to be female (p<0.000), white (p<0.000), and younger (p<0.000) than those who did not return.

Table 3. Demographic characteristics of IWP members who left by return status - CY 2018

	Returned	Did not return
Gender		
Female	17,643	19,041*
	48%	52%
Male	14,354	18,465
	44%	56%
Race		
White	20,821	22,260*
	48%	52%
Black	3,851	3,272
	54%	46%
American Indian	648	573
	53%	47%
Asian	789	919
	46%	54%
Hispanic	1,727	2,568
	40%	60%
Pacific Islander	101	216
	32%	68%
Multiple-Hispanic	628	477
	57%	43%
Multiple-Other	493	357
	58%	42%
Undeclared	2,939	6,864
Age		
18-21 years	4,321	3,705*
	54%	46%
22-30 years	9,743	10,608
	48%	52%
31-40 years	8304	8931
	48%	52%
41-50 years	5068	6106
	45%	55%
51 and over	4,561	8,156
	36%	64%
County urbanicity		
Metropolitan	19,688	22,718
	46%	54%
Non-metro, urban	1,354	1,757
	44%	57%
Non-metro, rural	10,955	13,031
	46%	54%

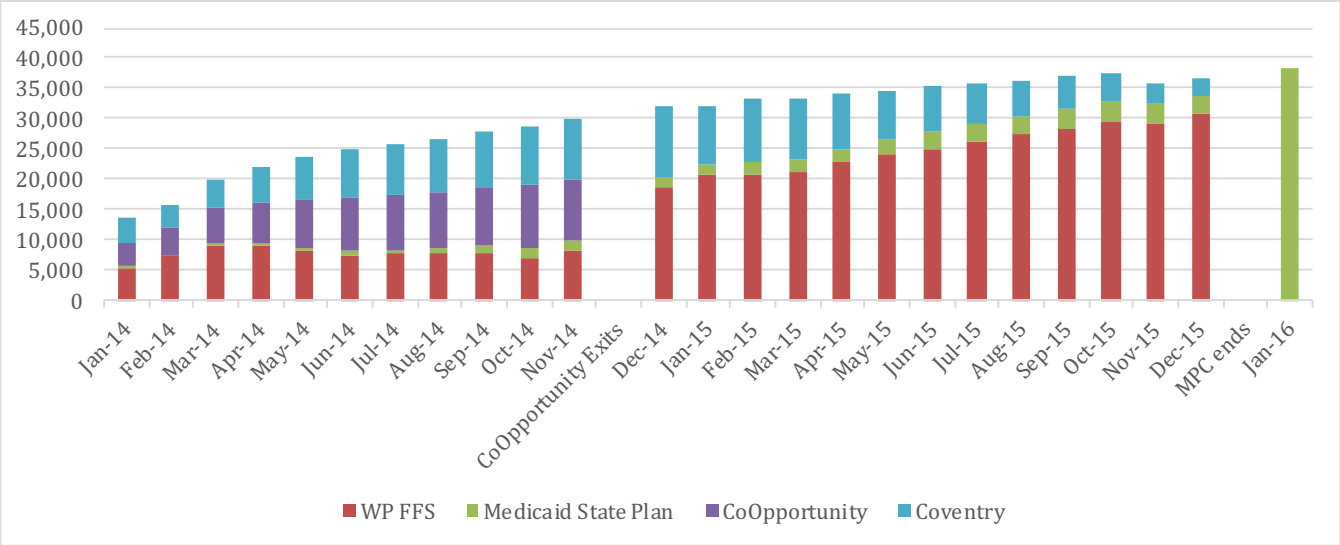
Transitions

This report contains information on transitions that occur within IWP for the period January 2014 through December 2018. During this time, IWP members who qualified for MPC (income 101-138% FPL), transitioned from QHPs to traditional fee-for-service Medicaid to MCOs. At each transition point members had to determine whether their health care providers were in the new option and, if not, how to access health care. Members who qualified for WP or who qualified for MPC but were determined to be 'medically exempt' were not assigned to a QHP but remained in a traditional Medicaid managed care option; either Meridian HMO or the MediPASS primary care gatekeeper program. Additionally, members in MPC may not have been assigned a QHP during the first few months of enrollment.

IHAWP transitions - January 2014 through December 2015

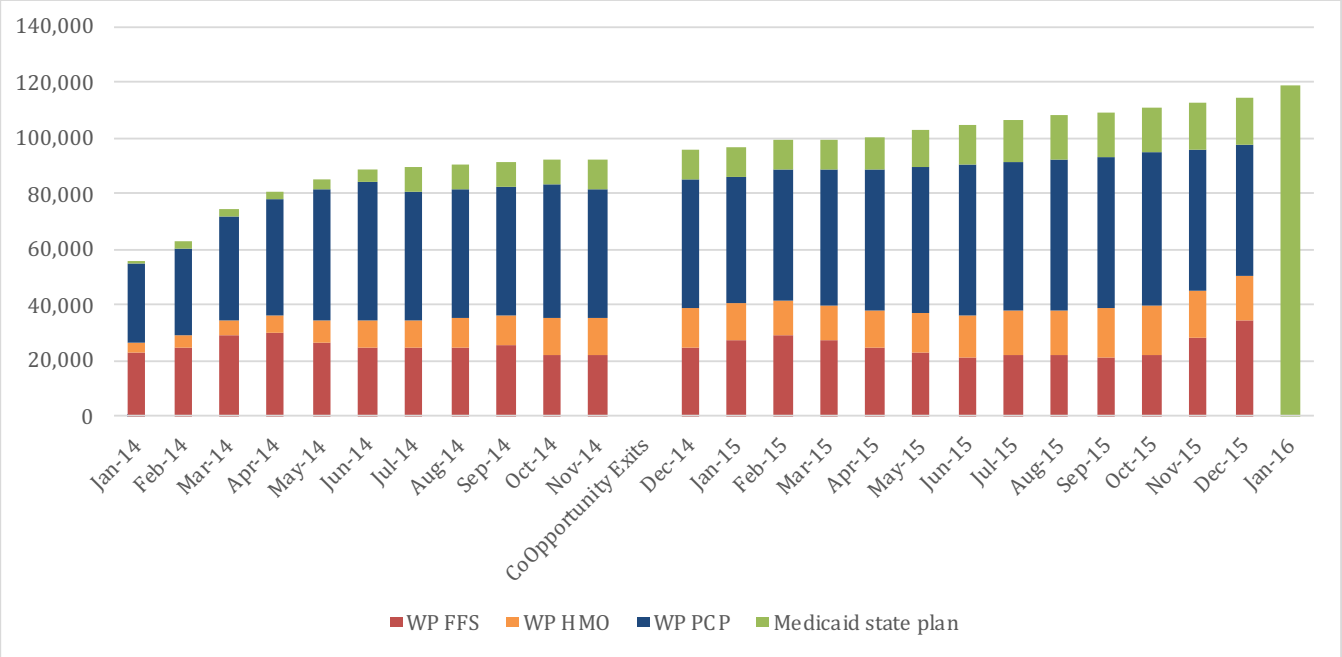
Figure 4 shows the distribution of members in MPC from January 2014 through December 2015. By December 2014, the point at which CoOpportunity exits, most MPC members who had been enrolled in CoOpportunity had been transitioned to WP fee-for-service coverage, as Coventry was unwilling to add these members to their membership. A smaller proportion of former CoOpportunity members were enrolled in traditional Medicaid fee-for-service. None of these members were enrolled in either Meridian HMO or MediPASS.

Figure 4. Marketplace Choice enrollment, CY 2014 – CY 2015



WP members were primarily enrolled in MediPASS (WP PCP), (Figure 5) with a growing number enrolled in Medicaid fee-for-service from July 2014 through December 2015. This represents members who were deemed 'Medically Exempt' and allowed to enroll in Medicaid fee-for-service to take advantage of waiver services not available under Wellness Plan.

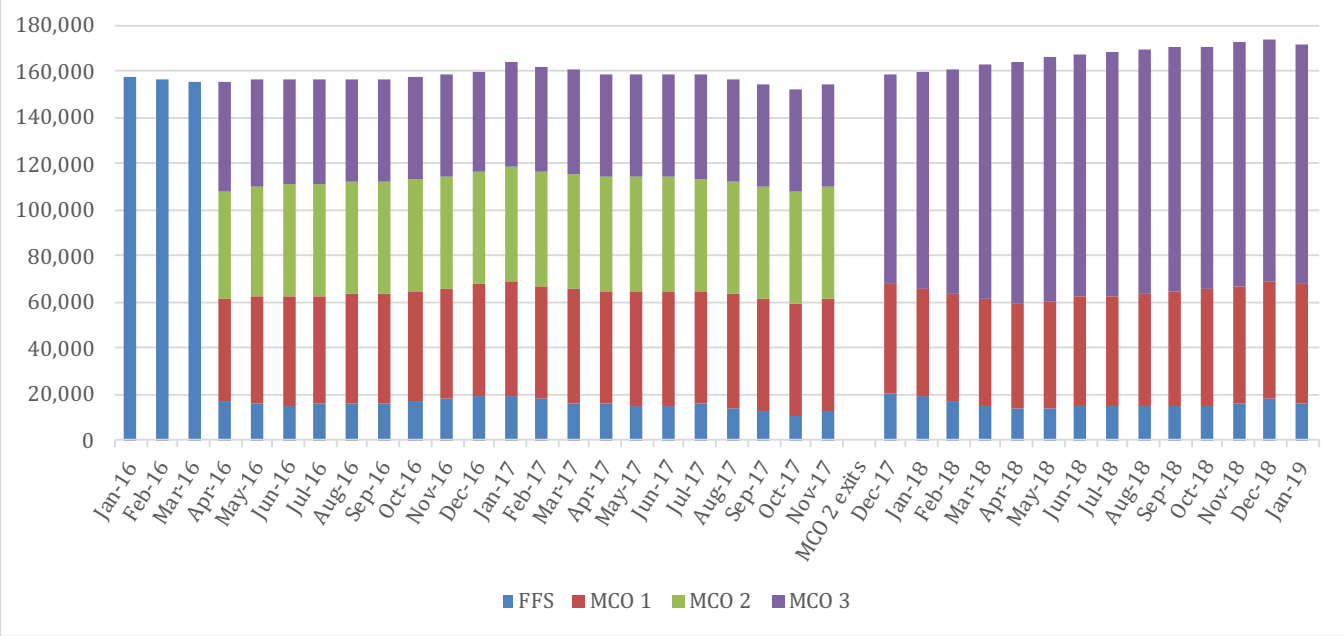
Figure 5. Wellness Plan enrollment, CY 2014 – CY 2015



IWP transitions - January 2016 through January 2019

Beginning in January 2016, the WP and MPC became IWP. Figure 6 shows the distribution of IWP enrollment by MCO. The numbers and distribution of members remains stable across the MCOs until November 2017 when AmeriHealth exits the Medicaid program. Members are almost exclusively enrolled in UHC because AmeriGroup was unwilling to tolerate an increase in membership.

Figure 6. Iowa Wellness Plan enrollment, January 2016 – January 2019



Transitions between MCOs are only allowed during the first 90 days of the first enrollment, the member's open enrollment period after the initial enrollment, and for 'Good Cause'. Table 4 and Figure 7 provide the transitions between MCOs for IWP members and FMAP members during the period April 2016 – November 2016. For both groups, the majority of transitions were from UHC to AmeriGroup or AmeriHealth (44% IWP; 41% FMAP), while the MCO with the fewest transitions to another MCO was AmeriGroup (27% IWP; 29% FMAP).

On November 30, 2016 AmeriHealth ceased operations as an MCO in Iowa Medicaid and over 85,000 members were moved to UHC beginning December 2016. Transitions for the period January 2017 - January 2019 are not shown, as members only moved between UHC and AmeriGroup with less than 1,000 members moving between the two in either IWP or FMAP.

Table 4. Numer and proportion of transitions between MCOs, April 2016 – November 2016

			MCO they went to			Total
	MCO they came from		AmeriGroup	AmeriHealth	UHC	
IWP						
	AmeriGroup	Count	-	479	305	784
		%	0%	61%	39%	27%
	AmeriHealth	Count	566	-	313	879
		%	64%	0%	36%	30%
	UHC	Count	612	675	-	1,287
		%	48%	52%	0%	44%
	Total	Count	1,178	1,154	618	2,950
		%	40%	39%	21%	100%
FMAP						
	AmeriGroup	Count	-	459	288	747
		%	0%	61%	39%	29%
	AmeriHealth	Count	494	-	276	770
		%	64%	0%	36%	30%
	UHC	Count	503	549	-	1,052
		%	48%	52%	0%	41%
	Total	Count	997	1,008	564	2,569
		%	39%	39%	22%	100%

Figure 7. Proportion of transitions between MCOs, December – November 2016