*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm or contact* *herc@va.gov**.*

Moderator: I’d like to welcome everyone to today’s session for the HERC Health Economics Cyber Seminar. Today’s presentation is, “The Effect of Medicaid Expansion on Demand for VA Care.” We have a distinguished panel of presenters today. Austin Frakt is a Health Economist from the Health Care Financing & Economics Center at the VA Boston. He is also an Associate Professor at Austin University in the School of Medicine. He will be joined later by Amresh Hanchate, who is a Health Economist also at the VA Boston. He’s an Assistant Professor in General Internal Medicine at Boston University. He’ll also be joined by Steve Pizer, who is Director of Health Care Financing & Economics at the VA Boston. He is an Associate Professor of Health Economics in the Department of Pharmacy Practice and Economics at Northeastern University. So I’d like to welcome our presenters today and turn things over to Austin.

Austin Frakt: Okay. Thank you. Everyone can hear me, right? I hope so.

Moderator: Yes.

Austin Frakt: Good. The Affordable Care Act (ACA), as interpreted by the Supreme Court, offers states an option of expanding Medicaid. Some have done that expansion and some have not. Our study addresses what the effect of that expansion is on demand for VA care. As already mentioned, this is work done jointly with Steve Pizer and Amresh Hanchate. I want to acknowledge that we received funding from VA HSR&D, and also from the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. Our objective on this study was to estimate a historical relationship between Medicaid Expansion and demand for VA Care. So this is looking back in time and seeing how prior Medicaid expansions in different states effected VA demand. And then we were going to use that estimate to simulate the effect of the Affordable Care Act Medicaid Expansion on VA enrollment and utilization. And we’ll do that nationally. I’ll give you some national estimates, but then we’ll do that at the state level to accommodate the fact that some states have and some states have not entered into the Medicaid Expansion. Let’s do some background.

The Affordable Care Act aims to increase access to affordable health insurance in a number of ways, or expanding coverage in a number of ways. This could have a big impact on veterans because one in ten nonelderly veterans were uninsured in 2010. Only 2.8 million of 12.5 million nonelderly veterans have VA coverage, or come to the VA for care. These are statistics that come from some prior work by Haley & Kenney. They did a prior cyber seminar on this last November, so I encourage you to look at that for some really great coverage for veterans and how the ACA could affect it. What does the ACA do to expand coverage? Principally it does two things, one is a Medicaid expansion that was designed to be available to people with incomes below 138% of the Federal Poverty Level, but that’s only where states have chosen to do the expansion. So four in ten uninsured veterans would qualify under this income threshold, but half of those don’t live in states that have done the expansion. There’s another way the ACA aims to expand coverage and that’s through individual market plans through exchanges where subsidies are available for people with incomes between 100% and 400% of the Federal Poverty Level, and there’s cost sharing assistance for people with income below 250% of Federal Poverty Level. And between these two expansion approaches, Medicaid Expansion and the Exchanges, 90% of nonelderly VA users would qualify. That is they’d qualify for either the Medicaid Expansion or subsidies through Exchange Coverage.

We’re going to focus on Medicaid Expansion and ask, “What is the effect on VA demand from that expansion?” There are two ways that coverage expansion in general can affect VA demand. One is the Extensive Margin. People can substitute VA coverage with non-VA coverage. So either not enrolling in the VA at all, or completely leaving the VA and using care that’s financed through some other means like Medicaid. That’s called the Extensive Margin. Then there’s the Intensive Margin, which is substituting some non-VA care of VA care. So these are people who are enrolled in the VA. They use some VA care, but then they get other coverage through Medicaid or through a private coverage. They substitute away from the VA using that other coverage. The dual enrollment concept or issue that many of us are familiar with is fairly common. In 2011 34% of VA enrollees had private coverage, 4% had Medicaid coverage, and 17% had Medicare coverage. This is just the nonelderly VA enrollees. So dual use is something we’ve already seen in the VA, and the Affordable Care Act could increase that.

We want to get at the question of, “How Medicaid Affects VA Use?” I’m going to go through some of the data we used quickly and then I’ll get into some detail about how we used it specifically. We’re interested in Medicaid, so we need to know about Medicaid eligibility rules over time. We get that from the Urban Institute, they have a model that simulates Medicaid and other social service programs and income replacement programs through their TRIM model. And they have a nice collection of the different state Medicaid rules. So we just downloaded all of those. That tells us the rules, but it doesn’t tell us directly how it affects different people. So then we used the Medical Expenditure Panel Survey, or MEPS, as a population to which to apply these rules in different states and see who would and would not be eligible for Medicaid. I’m going to go over that in a little more detail in a couple of slides. This is just an overview. So that’s one data source that tells us about Medicaid, and that’s our key independent variable. Then we have several dependent variables about VA enrollment in patient and in outpatient use. These come from Milliman. Milliman is the organization that designs and runs the VA projection model on utilization and enrollment. So they have this data nicely organized. They are annual data and they are sector-level. A sector is a collection of counties. I don’t exactly know why the VA does things at the sector-level, or how sectors are determined. But in any case they have the data at a sector-level and for our analysis we’ll be adopting that. I’ll have a little more to say about sectors in another slide.

We’re going to use the VetPop to give us a base of the size of the veteran population in each state, or actually in each sector. Then we recognize that other things effect VA enrollment besides Medicaid Expansion, things like employment and wealth. We can capture some of that using the housing value and the employment-to-population ratio. So where people’s houses are more valuable or where people are better employed, they’re less likely to use Medicaid and probably less likely to use the VA. I’m sure you can imagine many other factors that would affect VA utilization and enrollment, but I want to point out that we’re going to use year and sector fixed effects to capture any factors that are constant over time within sector or secular trends. So a number of things are kind of swept up in that. Data from all these sources overlapped in the years 2002-2008. So that’s our study window. This is definetely quite historical, but it’s the best we can do with existing data. The key issue on the cutoff in 2008 is the availability of the TRIM rules for Medicaid. They haven’t updated what’s available on the web so we don’t have any more recent detailed information on Medicaid Expansion. We estimated year-sector level models, though many of our independent variables are state level. Obviously our sector fixed effects are not at a state level, they’re at the sector-level. We have 566 sectors over 7 years, or about 4,000 year-sector observations. We’re focused on the nonelderly population who is less than 65. We used cumulative enrollments since April 1st of 1999. In each year of our data we’re counting how many people have enrolled since that time. We focus on the under 65 population because this is where the ACA impact will be concentrated, because that’s the focus of the ACA expansion.

I want to go over the Medicaid Eligibility Variable Details, because it’s our key independent variable. If you’re familiar with some of the work of Currie and Gruber or Cutler and Gruber from the mid-nineties, this will be somewhat familiar to you. We did something similar to what they did, although they used the CPS and we’re using MEPS. But what we did is we took a MEPS dataset, so this is a national representative dataset and we focus on one year. We take the 1998 MEPS and we ask ourselves the question, “What if everyone in that data lived in each state separately?” So everyone lives in New Jersey. Everyone lives in New Mexico. Everyone lives in California. And we take that and we take the rules from TRIM, the Medicaid rules, and we compute the proportion of people in that MEPS dataset who would be eligible for each state’s Medicaid program. What’s important here is that the only thing that’s varying is the rules that govern each state’s Medicaid program. We have a fixed population with the 1998 MEPS. There is nothing here that can’t be affected by anything that’s changing over time, one year. And it can’t be affected by any demographic differences across states, because we’re not taking state-level population. We’re taking one national population. You could do this with any fixed population. It’s just convenient to take a national population. As I said, prior work did a similar thing but with the CPS. MEPS has some other advantages that CPS doesn’t offer, some greater detail on health care spending for example.

We’re focused on the nonelderly population, but we had to restrict a little further than that for this part of the variable construction. We focused on kind of a working-age population, ages 25-62, so that the lower cutoff at 25 is because that is typically when most people are done with their education. That’s where their income starts to reflect the kind of income they’ll have. This is a standard starting point for a nonelderly age range when you’re not focused on kids. And then 62 is just because MEPS has this idiosyncricity where it’s a little bit unusual in that you can’t distinguish between social security income that comes from early retirement which can start at age 62, versus just for disability. We need to know the difference because disability income can trigger Medicaid eligibility, but early retirement doesn’t. We’re confounded there if we look past age 62, so we stop at age 62. So we’re taking MEPS in 1998 on this age range of people and asking the question, “What proportion of them would be eligible for Medicaid in each state separately?” And that proportion becomes Medicaid eligibility variable. It’s a number between zero and one. It’s proportion of this standardized population eligible for Medicaid in each state. I’m going to go through a few of our key variables with some maps, and I’m going to illustrate what these variables were doing over our study window, how they were changing. This is just to give you some context. I hope you can see some of these numbers, but I don’t expect you’ll be able to absorb all of this. That’s okay, you can study the slides later.

Looking at the Medicaid Eligibility Trends, this is taking the Medicaid variable I just described and looking how it changes from 2002 to 2008, and I’m doing this in a ratio. So anything over one is growth, and anything under one is shrinking. On average over this time period the Medicaid eligibility variable nationally grew by 23%. We’re putting that more in the terms that are shown here at the state level of 1.23. Texas is 1.26, so that’s 26% growth over the time period. In most states Medicaid eligibility is growing over our time period. This gives us a sense of the variation in that growth geographically. In some states it’s shrinking. Utah for example is .38. Medicaid eligibility went way down in that state over this period. What about our key dependent variables? This is VA Enrollment Trends over our study window. On average it went up 56%, but there’s quite a bit of variation nationally. So for example in Texas it says 1.77. That’s a 77% increase over the time period. I believe it is increasing everywhere. I don’t think there’s a single state here where it has decreased. I see New Jersey has 1.03, so that’s a very small increase of 3%. In general increases are pretty high, but they are varying somewhat. You would expect if enrollment is increasing so would be utilization, and that’s what we found where inpatient utilization increased 87% over the study period on average. For example again looking at Texas just because it’s easy to pick out, it says 1.67. So that’s a 67% increase. VA Outpatient Utilization Trends are the clinic stops. I don’t know if I mentioned that an inpatient day is our inpatient utilization and clinic stops is outpatient. Outpatient Utilization grew a startling amount over the six years here to a 146% growth on average. So you’re looking at numbers over two on this chart and you just subtract one to get the percent growth. Texas says 2.49, that’s a 149% growth.

These are all of the variables in our model and both independent and dependent variables apart from fixed effects. I don’t need to talk through all these numbers, but there’s one in particular I want to go through which is at the very top I have Proportion Medicaid Eligible Baseline. This is just the year sector average in our data of the proportion that are Medicaid eligible across a whole dataset and it’s 0.09. So on average 9% of people are eligible for Medicaid coming from the MEPS sample that we used. Then when we go to the Affordable Care Act Medicaid Eligibility it’s a big expansion of Medicaid. In fact what this shows since the mean goes from 0.09 to .18 when we go from the baseline to the ACA-simulated from the first row to the second, it’s a doubling of Medicaid eligibility, or a 100% increase. That’s really all I want you to remember from this slide is that when we go from the data we’re using to estimate our relationship between Medicaid and VA enrollment and utilization to the ACA-simulation, we’re going to a doubling of Medicaid eligibility. We’re going to do the estimation first and then the simulation.

In our estimation methodology we’re going to use a Poisson model because our dependent variables are all counts. They’re positive whole numbers, and the Poisson model has the form of the dependent variable Y = exp(xb + epsilon) where “x” is the independent variables and we’re estimating the data or the “b” there. We constrained “Y” to be positive, again because these are counts. As I said we use year-sector nonelderly veteran population as the exposure variable in the Poisson model. That’s technical detail, but what it does is that it accounts for the fact that some sectors had more veterans than others. We expect more enrollment and utilization where there are more veterans, so we need to control for that and that’s what this does. The last bullet says what you think because I already told you what all of the independent variables are and that we use fixed effects, so that’s just the model in a more of a mathematical form. I’m going to give you some broad results on elasticity. I want to make sure that everybody understands what elasticity is. It reflects sensitivity to change. It’s a percent change in “Y,” or the dependent variable, divided by the percent change in “x,” or the independent variable. This goes through three examples. They’re all a doubling of “x.” Remember our key independent variable is Medicaid Expansion, and doubling is exactly what it does from our research data to our simulation under the ACA. It’s a 100% growth. In the first example here it shows when “x” doubles, if “Y” also doubles, that’s an elasticity of one. So when you see an elasticity of one, it means that doubling an “x” caused a doubling in a “Y.” If “x” doubles and “Y” grows by half, that’s an elasticity of 0.5. If “x” doubles and “Y” drops by half, that’s an elasticity of 0.05.

We estimate elasticities for enrollment and inpatient and outpatient utilization. The results are here. Enrollment in outpatient utilization is statistically significant. Inpatient utilization is significant at the 0.05 level, but not as significant as the other ones. One way to interpret these is that when Medicaid eligibility doubles, or has a 100% increase, the elasticities reported here implies that VA enrollment would decrease by 11%. VA inpatient utilization would decrease by 6.5% and VA outpatient utilization would decrease by 14%. That’s from the historical data 2002 to 2008 using the model I discussed. And now we want to simulate Medicaid Expansion. The latest year of data we have is 2008, so we’re going to assume that ACA’s Medicaid Expansion occurred in 2008, not in 2014 as it actually did. We’re going to try to do it as realistically as we can under that assumption using 2008 data. We’re going to account for what we know about expansion/non-expansion states. In our simulation we’ll just expand Medicaid where states have done so and we won’t where they haven’t. And then we’re going to predict enrollment and utilization under both the expansion and the baseline. So without expansion and with expansion, then compute the percent change in VA enrollment and inpatient/outpatient utilization to show the effect of expansion relative to baseline.

This is a slide showing Where the States Stand on Medicaid Expansion, or it’s where they did stand on Medicaid Expansion in February, which is when we did this work. Things have changed a little since then. Pennsylvania and New Hampshire have agreed to do an expansion. I don’t they’ve actually implemented it, so this probably still accurately reflects what’s happened in 2014, but it doesn’t reflect what may be happening in 2015 or other years. It would be quite simple to change our model to bring in other states. It’s just trivial actually. When I show subsequent maps, which I’ll do shortly, all these states here that are grey, they’re not doing the expansion in 2014 or they haven’t, you won’t see any changes in those states because again we’re computing the ration of baseline to the expansion condition. And if there’s no expansion there’s no change, so all the grey areas will just be a ratio of one. Before I get to maps that show all of the simulated changes at a state level, this slide gives you a summary of what you’re going to see. Consistent with what you saw with the elasticities, everything’s going to go down. Enrollment would fall between 85% and 98% of the baseline, depending on the state. Inpatient days would fall between 91% and 99% of baseline, depending on the state. And outpatient clinic stops would fall between 81% and 97% of baseline, depending on the state. These all exclude Vermont. There’s no change in Vermont. Vermont already did a Medicaid Expansion and so nothing changes there. These obviously exclude all of the states that aren’t doing the expansion. Vermont’s unusual because it is doing the expansion, but it had already done it as of 2008. So that’s why I noted it here.

This Change Under ACA: Medicaid Eligibility slide is showing how our key, our independent variable, changes from baseline to the simulated-ACA condition. This is a ratio, so where you see larger numbers, that’s an expansion of Medicaid under the ACA. For example, California has a 1.76, so that’s a 76% increase in eligibility for Medicaid in a standardized population. Like I said you’ll see lots of “1’s.” All of these except for Vermont are places that have opted not to expand Medicaid. So with that, this is what is simulated to happen with VA enrollment under the expansion. I should say that the color scheme is not consistent across these slides, so the “1’s” on this slide are colored differently than the “1’s” here and I’m sorry about that. You can refer to the key on the side that gives you a crosswalk between color and number. So enrollment goes down in all of the states that do Medicaid expansion. For example in California you see a 0.92, so enrollment would go to 92% of what it was at baseline. Inpatient utilization would fall where expansion occurs. Again just looking at California, it would fall to 95% of baseline. Outpatient utilization would also fall, and in California it would fall to 89% of baseline. You can study these maps to your hearts content, but I’m not going to go through each state by state.

Moderator: There are a couple of questions if you’d like to take questions right now.

Austin Frakt: We could take questions, but I am actually a few slides from the end. So I’m happy to take questions now, or just wrap it up and then take questions.

Moderator: Why don’t you go ahead and finish.

Austin Frakt: Okay. I want to go over some key limitations of this work. Historical Medicaid expansion data is only available through 2008. So we’re using several year old data, six year old data to do our simulation pretending that it happened in 2008. So other things may have changed since then that would affect our results, but we don’t have more recent data to look at it. Compared to the ACA Medicaid expansion, the historical Medicaid expansions were modest. I don’t know if you recall, but I actually had this in a slide that historically over the time window we’re looking at, Medicaid expansions increased Medicaid eligibility by 23% over the time period. Whereas as you might recall the ACA expansion increases Medicaid eligibility by 100%. So we’re doing a very large out-of-sample extrapolation here. Again that’s all we can do. We only have the historical data we have and the policy is what the policy is, but this is a key limitation and a caveat. We were unable to simulate the effect of ACA’s coverage mandate, the individual mandate, and other features of the law including the existence of exchanges. These things could matter. I will get to that on the next slide. The end result is that accounting for Medicaid expansion alone, had it occurred in 2008, VA enrollment, inpatient and outpatient utilization would have fallen in expansion states. That’s not a surprise but we quantified that and we find no effect on non-expansion states. But we’re not considering a few other things that could change these results.

VA enrollment is creditable coverage, satisfying the individual mandate. That might give people an incentive to enroll in the VA in order to satisfy the mandate, and that would offset some of the decreases that we might see under Medicaid expansion alone. All of the outreach around coverage expansion could increase knowledge of the VA, because it satisfies the individual mandate and that could increase demands for it. We’re also not considering availability of coverage through exchanges, and you might think that could further decrease demand for VA coverage because it’s a substitute for it. I should say coverage and utilization, or utilization. Our study years of 2002-2008 coincide with the period of rapid VA enrollment growth, so our results could be driven by a reduction of that growth where and when Medicaid eligibility was relatively more expansive. So this would be the extensive margin. If as enrollment was generally growing in the VA, more and more people were coming to the VA, if states would expand Medicaid, fewer people came to the VA at all, that would be an extensive margin change. It’s possible, but we don’t know, that there’s little effect on existing VA enrollees, the intensive margin. If this were the case, then we might expect a more modest effect of Medicaid expansion today than we’ve seen historically, because enrollment growth has abated somewhat. So this is a little bit of a complicated argument, but it rests on the key difference between the nature of VA enrollment and the expansion during our study period and what it is today with the fact that the effect on VA demand of a Medicaid expansion connects through either the extensive or intensive margin or both, and we don’t have the data to tease those apart. So it’s possible that we’d get a different result if we had more recent data. That’s my last slide and I’m happy to take questions.

Moderator: There are a couple of questions in the queue. One asked, “Why did you use MEPS from 1998, as opposed to a more recent year?”

Austin Frakt: As I said it actually doesn’t matter what you use. You don’t even need a national population. You do want a population that covers all of the different relevant ways people can get into Medicaid. I think the reason we used 1998 is just a vestige of some other work that we did where we did have data going back to the late nineties. In the 1998 work it was just before our study window and we just borrowed the variable that we had created for that study on this one. But we could redo it all with the year 2000, 2001 MEPS and it really shouldn’t change anything.

Moderator: Okay. The next question is sort of long so I’ll just read the second part of it, “Would you anticipate that enrollment would drop by 11% of those still enrolled? The utilization drops proportionately, so after your enrollment drops among those who are still enrolled would utilization drop among those veterans or is the drop in utilization occuring due to the drop in enrollment?”

Austin Frakt: I think this is the difference between the intensive and the extensive margin. What we’re estimating is across both those margins when we look at utilization, and we really don’t know what’s driving that. That gets into one of these caveats at the end on the last slide. If people who remain in the VA don’t change their utilization pattern to a different extent than people who aren’t entering the VA at all, then we’d get a different result if we just sort of focus on one or the other.

Moderator: Okay. The next question asks, “You had said that enrollment goes down. Does that mean that veterans just enroll or not enroll?”

Austin Frakt: No. I think it’s the later more accurately. We have fixed effects here, so we’re looking at really changes from baseline or change from the average. It means that where Medicaid expansion is larger you get less of an increase in VA enrollment than you would otherwise. So you have to keep the counter factual in mind; it’s sort of relative to what it would have been otherwise. It doesn’t mean that necessarily when Medicaid expands that suddenly people run away from the VA. It just means relative to what the enrollment would have been otherwise and lower.

Moderator: Another question asks, “Your findings suggest that for those eligible for Medicaid or for coverage through the VA, they are more likely to select Medicaid. Can you give some reasons of why that might be?”

Austin Frakt: I’m not so sure that’s the right interpretation given what I just said. Enrollment is just lower than it would be otherwise. I don’t think you can back out from any of this precisely what the probability of a given veteran is to enroll in Medicaid versus the VA. So I don’t think we’re saying that Medicaid is more attractive than the VA. But having said that, there are reasons for an individual of why they might prefer Medicaid or the VA or the other way around. They’re very different. Under Medicaid you can perhaps more easily access community providers in some places.

Moderator: Right. It also offers some reasons like family coverage.

Austin Frakt: Sure.

Moderator: Medicaid might cover an entire family as opposed to the VA just covering an individual.

Austin Frakt: Yes, that’s another good reason. And then we all know there are reasons to come to the VA.

Moderator: Is your line open?

Austin Frakt: I’m talking but you can’t hear me?

Moderator: I can hear both of you with no problem.

Austin Frakt: Okay, so I don’t know what to do. I can hear both of you also. I’ve answered the question so I don’t have anything to say anyway.

Moderator 2: Jean, are you able to hear me? Okay I’m guessing it may be something with Jean’s audio here. I am not sure where she was in questions right now. Were you following along with questions and know where we were in there? You can undock it if you click on the word “questions” and slide it over to the left it will undock that whole portion. I’ll just start from the bottom here. The question is, “What’s your justification for using Poisson? Did you compare the results with that from a negative binominal model?”

Austin Frakt: I might defer to Amresh on this for justifying the Poisson. I don’t recall if we compared it to a negative binominal. I do recall that we did some OLS regressions because they’re easier to see through and understand. We actually did a number of models on different subsets of the VA enrollment. We looked at the elderly separately under the idea that they shouldn’t be affected by Medicaid expansion. We looked at Priority 5 specifically. I’m not going to remember exactly all of the results from all of that. Let me ask Amresh is he can talk about the Poisson Model choice.

Steve Pizer: This is actually Steve. There’s a test that you can do to see whether the data is called overdispersed, which means the variance of the data is more than what a Poisson Model would assume. And in this case the Poisson Model fit very well, so there was no reason to go to a negative binominal.

Austin Frakt: I’m glad Steve is here because I actually don’t remember that. But I’m sure that he’s right that we did that.

Moderator 2: Great. Thank you. The next question we have here is, “Was there any analysis conducted regarding primarily rural areas versus urban, meaning does expansion reduce VA enrollment at higher rates in rural areas?”

Austin Frakt: Again, I don’t’ recall doing that specifically. It would be possible since we have sectorial-level data. We have a sector fixed effect. I guess we could code them for rural or urban status. I’m thinking out loud, but that would be a linear combination of the sector fixed effects I think. So I’d have to think through how to do that.

Amresh Hanchate: So just to add Austin, the data that we got was not at the individual level, but aggregated at the sector level. So to the extent that sector is largely rural or largely non-rural, we can probably get a good estimate. We don’t know how much of it is mixed.

Austin Frakt: A Medicaid variable is a state level, so I think that the change here would come through on the fixed effects on the rural or urban indicators. In any case we didn’t do it and thinking out loud is probably a bad idea, but we can think about it.

Moderator 2: The person sent in a follow-up here, “It seems to reason that in a rural area where there’s limited VA access, that patients would prefer non-VA care.”

Austin Frakt: I think that’s a reasonable hypothesis. We’ve done a lot of work and other people have on VA and Medicaid and it’s certainly true as the distance to the VA Medical Center increases reliance on VA alternatives goes up.

Moderator: Hi this is Jean. I just wanted you to let you know that I’m back. I just got kicked off for some reason. Thank you Heidi for taking over for asking the questions. I did have one question myself, “Historically a lot of people who have been eligible for Medicaid don’t enroll in Medicaid due to paperwork or the stigma of being enrolled in Medicaid. So I wonder to what extent you have looked at this issue. Can you incorporate this into your model?

Austin Frakt: So our key Medicaid variable is Medicaid eligibility, not Medicaid enrollment. So I don’t think that we can get at that issue through the historical model. However, it is a caveat for interpreting the results. There’s a caveat and there’s a caveat on the caveat, but let me try to get into it. The individual mandate is satisfied by Medicaid and the VA. So you just take the VA out of the picture for a moment, Medicaid becomes more attractive both because people are more eligible for it in general, it’s more accessible in that way, but because it satisfies the mandate. That didn’t exist in the historical data. So Medicaid becomes sort of more of an attractor under the ACA than it had been, and so that you might argue that would tend to pull people further away from the VA than in the historical data. But the whole reasoning I just gave was because of the individual mandate, and that also pulls people toward the VA potentially as I already said. So I’m not sure how this all washes out and I don’t think we can get at it with our existing data and technique.

Moderator: Thanks for that. There are clearly no more questions in the queue, so if you have any questions, please feel free to go to the question box and type in your question for any of the presenters. You looked at changes in inpatient stays and outpatients. I wonder if you had drilled down to the different types of inpatient stays and different types of outpatients.

Austin Frakt: I think that would be a really great additional thing to do. We didn’t do it on this study and it’s something that we’ve considered for future work, but we haven’t started doing that.

Steve Pizer: This is Steve again. I’m apologizing for having joined in a little bit late. Austin, did you talk at all about the implications for ACA?

Austin Frakt: Maybe you should say more, because I’m not sure that I did. I talked through the slides.

Steve Pizer: It’s just that access to VA care has been an issue of concern lately.

Austin Frakt: I see what you’re saying. No, I wasn’t going there, but you may.

Steve Pizer: Okay. If you click back to the VA enrollment map was that an actual historical?

Austin Frakt: Yeah.

Steve Pizer: Yeah, so they changed right here. If you look at that map you see that there are some states that have much bigger growth and VA enrollment over this period, 2002 to 2008. There’s sort of a big band across the South and some in the Sunbelt, so one might think that that would strain VA resources. I don’t know if that’s literally true, but you might think that. Then if you click forward to the Medicaid Expansion map, you can compare those two maps.

Austin Frakt: I cannot do that quickly.

Steve Pizer: As an exercise at home one can compare the two maps and think about what the impact of Medicaid Expansion in the states that have not expanded on the capacity constraints in the VA.

Austin Frakt: That was a little bit coded, but I know where you’re going.

Steve Pizer: I wanted to see if that stimulates any questions.

Moderator: Right, so the mandate could be bringing a lot of people to the VA.

Steve Pizer: That enrollment growth was historical. It was before the mandate. The mandate is another issue entirely. But the historical growth in VA enrollment hasn’t been even across the country. The capacity issues across the country aren’t’ completely even either. So Medicaid Expansion is relevant, because at least based on this research the effect of Medicaid Expansion on demand for VA services could be pretty large.

Moderator: Right and do you want to say anything about the potential for dual use of services, people that might be dually enrolled in Medicaid and in the VA?

Steve Pizer: Yeah, that’s another critical issue. VA is trying to do a better job of coordinating care through patient aligned care teams and a number of other programs and initiatives. They try to improve quality, and they try to reduce costs. And that might be harder to do as patients split their care in between the VA and providers. We know from research on Medicare/VA dual enrollees that that’s what they do. They split their care between the two sources of financing. And we also think we know from some research our group has done that people who split their care can have some worse outcomes that appear to be due to coordination problems, in particular, their ambulatory care sensitive hospitalizations are higher. And it seems to be because of the degree of fragmentation of their care. That kind of work has not been done on VA Medicaid dual users and VA Medicaid dual users has been a much smaller group. But it is now becoming a larger group, so I think the same questions are relevant and will be increasingly relevant as Medicaid expands and the effects of the mandate take hold as well. So there are a bunch of interesting research questions that are kind of on the table.

Moderator: Right, and there are some project that are starting to look at that question. Some people have also looked historically at the Health Care Reform in Massachusetts to what happened there.

Steve Pizer: Right.

Moderator: So we have a couple more minutes if there are any final questions for our presenters. I do want to thank all three of you for joining us today and presenting your new work. I think it’s very timely and I think it’s very important as the VA addresses questions related to access and the continued rollout of the Affordable Care Act and veterans can make choices about which coverage they’re going to choose and what providers they see. It doesn’t look like there are any further questions, so Heidi do you want to have any final words?

Moderator 2: I want to thank our presenters for taking the time to prepare and to join us for today’s call. For the audience, thank you everyone for joining us. As you leave the session today you will be prompted with a Feedback Form. We would appreciate it if you would take a few moments to fill that out. We really do read through all of the feedback that we receive. With that we’ll close out today’s session. Thank you everyone for joining us for today’s HRS&D Cyber Seminar. Thank you.