Fall 2021

A Report Prepared for the Virginia Department of Medical Assistance Services

Experiences with the First Year of Medicaid Enrollment

New Medicaid Expansion Members Describe Health and Health Care Experiences during the First Year of Enrollment

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EXECUTIVE SUMMARY

Effective January 1, 2019, Virginia expanded Medicaid coverage to adults with family incomes up to 138% of the federal poverty line, as allowed under the Patient Protection and Affordable Care Act. As of July 2021, over 560,000 low-income adults had enrolled in expanded eligibility for Virginia Medicaid. Understanding the experiences of new members *in the year prior* to enrollment and in *their first year of enrollment* is critical to understanding the impact of Medicaid expansion on the health and well-being of members over time.

The Department of Medical Assistance Services contracted with the Virginia Commonwealth University School of Medicine (VCU SOM) to conduct an evaluation of Medicaid expansion, which included two surveys of new Medicaid members enrolled under expansion. The first survey (described in detail below) asked new members about previous health insurance coverage, health behaviors, financial constraints, access to care, health conditions, how health impacts their ability to work, and health insurance literacy in the 12 months *prior* to enrollment. The second survey assessed these same experiences in the first year members enrolled in Medicaid. The second survey also included questions about healthcare delivery and health status during COVID-19. This report examines the changes in new members' experiences with health and health care after being enrolled in Medicaid for one year.

Virginia is the first state to conduct a survey of individuals before and after enrollment in Medicaid expansion. This survey was designed to measure the impact of Medicaid coverage for newly enrolled members. VCU SOM conducted the survey on behalf of the Commonwealth.

Highlights from the report include:

- Financial stress decreased significantly after members enrolling through Medicaid expansion, including for non-medical expenses, such as food, rent, or other monthly bills.
- After enrolling in Medicaid, a higher proportion of respondents had a usual source of care (81.5% vs 72.9% at baseline) and were more likely to use a doctor's office than an emergency room for their usual source of care (73.2% vs 4.1%).
- Across every type of unmet health included in the survey, members reported substantially fewer unmet needs after enrolling in Medicaid.
- After enrollment in Medicaid, members were more likely to report seeing a primary care doctor (72.1% vs. 51.6% before Medicaid enrollment), and less likely to have visited the emergency department (32.3% vs 48.0% before Medicaid enrollment). Importantly, among those who visited the emergency department, after enrollment in Medicaid, members had fewer visits to the emergency department.
- Non-Hispanic Blacks reported a larger decrease in worries about the cost of normal healthcare after enrolling in Medicaid compared to non-Hispanic Whites, suggesting that Medicaid expansion was particularly meaningful for this group.
- Rural members had a greater decrease in problems paying medical bills and unmet need for prescriptions in the year after enrolling in Medicaid compared to non-rural members.
- During the COVID-19 pandemic, 35.4% of members reported getting care in person and 10.7% got care by telephone or video only. During the COVID-19 pandemic, 24.5% of members reported not getting care they needed.

SURVEY METHODOLOGY

Researchers from the Virginia Commonwealth University School of Medicine (VCU SOM) conducted a new member survey in order to understand the experiences of newly enrolled Medicaid members eligible under the expanded coverage program in the 12 months prior to enrollment. During each month between December 2018 and April 2019, a random sample of members newly enrolled through the Medicaid expansion benefit was drawn from monthly enrollment files. Samples of new members were drawn on a monthly basis to maximize recall of health care experiences prior to Medicaid enrollment and before they obtained substantial experience with their Medicaid coverage. Both the enrollment files and the sample were limited to new Medicaid members who did not have full Medicaid coverage in the past year and were not in a Qualified Health Plan. The enrollment files were obtained from the Department of Social Services via the Department of Medical Assistance Services. In total, 7,500 paper surveys were mailed to new Medicaid members between December 2018 and May 2019 in seven waves. Each survey included a $2 incentive.

Paper reminder surveys were mailed to non-responders. A first reminder paper survey was sent out about one month after initial survey mailing (n=6,411). A second reminder paper survey was sent out about one month after the first reminder survey (n=6,045). Additionally, a total of 2,073 initial text reminders were sent allowing individuals to complete the survey online via RedCAP. The texts were sent out three times over the course of a week about one month after the initial survey mailing. In total, 1,556 surveys were completed and returned, representing a 20.7% response rate.

The Round 2 survey was conducted between July 2020 and January 2021. The purpose of the second survey was to ascertain the health, health care experiences, and financial well-being of members who had been enrolled in Medicaid expansion continuously for at least the past 12 months. To assess changes in measures of health care access and financial stress after enrollment in Medicaid, the survey questionnaire used the same set of questions asked in the Round 1 survey.

The sample for the Round 2 survey consisted of two populations. We resurveyed individuals who had completed the Round 1 survey and were still enrolled in Medicaid for at least 12 months, consisting of 1,269 members (82% of the Round 1 sample). To increase the size of the Round 2 sample, we also drew a comparable supplemental sample of members who enrolled through Medicaid expansion prior to June 2019 and had remained enrolled for at least 12 months. The enrollment files were again obtained from the Department of Social Services via the Department of Medical Assistance Services. We mailed out a total of 7,500 paper surveys between July 2020 and January 2021 in 10 waves. Each included a $2 incentive.

A paper reminder survey was mailed to non-responders about a month or two after the initial survey mailing. In total, 1,622 respondents completed and returned the survey, representing a 21.6% response rate.

All outcomes were weighted for survey non-response bias to represent 275,055 individuals; 136,759 in the baseline survey and 138,476 in the follow-up survey. The baseline survey weights were created to allow a representative sample of new Medicaid members who did not have Medicaid insurance or a Qualified Health Plan in the year prior to enrollment. The follow-up survey was weighted to represent continuously enrolled individuals in Medicaid.

All binary outcomes were also adjusted for gender, age, marital status, race, and rurality using linear regression. Categorical outcomes were adjusted for gender, age, marital status, race, and rurality using multinomial logit models. Our sample included 2,819 complete cases with gender, age, marital status, race, ethnicity, and rurality data present; 1,246 in the baseline survey and 1,573 in the follow-up survey. The sample sizes for each outcome vary slightly as individuals were not required to answer every survey question to be included in the sample.

Section 1 – Changes in Problems Paying Medical Bills, and Usual Source of Care in the Year after Enrollment in Medicaid Coverage

Problems Paying Medical Bills in the Past Year

After 12 months of enrollment in Medicaid expansion, the financial well-being of members improved, and members reported fewer concerns paying bills.

- In the first year of having Medicaid, new members enrolled through Medicaid expansion reported fewer problems paying medical bills compared to new members in the year prior to Medicaid enrollment (18.7% vs. 66.9%) as well as having fewer medical bills that require being paid off over time (14.8% vs 33.5%).
- In the first year of having Medicaid, significantly fewer new Medicaid expansion members were worried or very worried about paying for housing, normal monthly bills, food, minimum on credit cards, pay day or student loans as well as, or medical costs compared to the year before enrolling in Medicaid.

Financial Well-Being		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Any problems paying medical bills*	66.9%	18.7%
Any medical bills being paid off over time*	33.5%	14.8%
Worried or very worried about paying for:		
Rent, mortgage or other housing costs*	68.8%	62.1%
Normal monthly bills*	80.2%	72.2%
Food*	65.8%	55.5%
Minimum payments on credit cards, pay day, or student loans*	53.5%	44.6%
Medical costs if seriously ill or have an accident*	77.5%	51.8%
Medical costs of normal health care*	83.9%	48.5%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Sample sizes vary from 2,739-2775, depending on participant responses. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Usual Source of Care in the Past Year

New members were more likely to report having a usual source of care after enrolling in Medicaid coverage (72.9% pre-enrollment vs 81.5% post-enrollment).

- In the first year of enrollment, new members with a usual source of care had a higher rate of reporting a doctor's office as their usual source of care (73.2% vs. 44.1%) and a lower rate of reporting community health centers, free clinics, and the emergency department as their usual source of care (6.6% vs. 10.0%; 3.3% vs. 14.8%; 4.1% vs. 18.6%, respectively) compared to new members in the year prior to being enrolled in Medicaid.

Usual Source of Care in the Past Year		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Any place usually go for care*	72.9%	81.5%
Doctor's office or clinic*	44.1%	73.2%
Community health center*	10.0%	6.6%
Free clinic*	14.8%	3.3%
Urgent care	7.1%	8.4%
Emergency department*	18.6%	4.1%
Other	5.0%	3.8%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Overall sample size was 2,780 and 2,043 for those who reported having a usual sorce of cae depending on participant responses. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Section 2 – Unmet Health Care Needs and Health Care

Unmet Health Care Needs in the Past Year

Members reported significantly fewer unmet needs for health care after 12 months of enrollment compared to the year prior to enrollment (23.7% vs 61.6%).

- Members reporting foregoing care due to worry about costs of healthcare services decreased substantially from 72.8% in the year prior to enrollment to 31.0% in the year after enrollment.
- More members, however, reported unmet health care needs due to a doctor not accepting insurance (24.3% vs. 5.2%), a health plan not paying for treatment (20.2% vs. 5.2%), or not getting an appointment soon enough (24.6% vs. 5.5%).
- In the year after obtaining Medicaid coverage, significantly fewer members reported being unable to get any type of care including: primary care (21.4% vs 58.5%), prescriptions due to cost (14.9% vs 56.3%), specialty care (16.4% vs. 43.6%), mental health care (10.9% vs. 24.4%), substance use treatment (3.0% vs. 8.1%), dental care (41.9% vs. 67.0%), and eyeglasses (27.7% vs. 47.7%).
- Note: while dental care need remained high after enrollment, this survey was conducted prior to the Virginia General Assembly allocation of funds to expand full dental benefits to all Medicaid adults which occurred July 1, 2021.

Unmet Health Care Needs in the Past Year		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Needed medical care but did not get it?*	61.6%	23.7%
Because worried about cost*	72.8%	31.0%
Because did not have health insurance*	67.8%	11.5%
Because doctor would not accept insurance*	5.2%	24.3%
Because health plan would not pay for treatment*	6.8%	20.2%
Because could not get appointment soon enough *	5.5%	24.6%
Because doctors or hospitals too far away	3.3%	5.2%
Because other	6.7%	22.3%
Types of health care needed but not received		
Primary care*	58.5%	21.4%
Prescriptions due to cost*	56.3%	14.9%
Specialty care*	43.6%	16.4%
Mental health care*	24.4%	10.9%
Substance use treatment*	8.1%	3.0%
Dental care*	67.0%	41.9%
Eyeglassses*	47.7%	27.7%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Overall sample sizes vary from 2,738-2773 depending on participant responses, and 1,113 for members reporting any unmet needs. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Health Care Utilization in the Past Year

Enrollment in Medicaid coverage is associated with an incrase in seeing a primary care provider and receiving routine preventive care.

- Compared to the year prior to enrollment, members enrolled in Medicaid for one year were more likely to report a primary care visit (72.1% vs. 51.6%) and less likely to report an emergency department visit (32.3% vs. 48.0%) or hospital admission (12.5% vs. 16.8%).
- After being enrolled in Medicaid for a year, members were more likely to report getting a flu vaccine, as well as getting their blood pressure, cholesterol, or blood sugar checked by a professional compared to members in the year before they were enrolled.

Health Care Utilization in the Past Year		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Visited primary care*	51.6%	72.1%
Number of primary care visits		
1-2	36.9%	41.6%
3-4	34.0%	32.7%
5 or more	29.0%	25.8%
Went to the emergency department*	48.0%	32.3%
Number of emergency department visits		
1*	31.6%	45.6%
2-3	44.5%	38.5%
4 or more	23.9%	15.8%
Stayed overnight in the hospital*	16.8%	12.5%
Number of nights[6]		
1*	17.8%	25.3%
2	19.1%	17.2%
3-4*	22.0%	33.5%
5 or more	41.1%	24.0%
Blood pressure checked by health professional*	68.0%	78.1%
Cholesterol checked by health professional*	41.8%	55.1%
Blood sugar checked by health professional*	42.1%	53.9%
Got a flu vaccine*[9]	30.0%	39.8%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Overall sample sizes vary from 2,745-2769 depending on participant responses, and 1,605 for members reporting any primary care visit, 977 for those with any ED visit, and 360 for those with any hospital stay.
*Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Section 3 – Health Status and Ability to Work

Health Status

While overall health sttaus did not change significantly after a year of receiving Medicaid coverage, new members did report increases in diagnoses of chronic conditions and reported treatment.

- There was no change in self-rated physical health among those in the year prior to Medicaid enrollment compared to those in the year after Medicaid enrollment.
- There were significantly fewer individuals who reported their self-rated mental health as excellent in the year after enrollment (15.2% vs. 18.3%) as well as significantly fewer individuals who reported their mental health as fair after enrollment (20.0% vs. 23.3%).
- Medicaid expansion members who had been enrolled for a year were more likely to have a physician tell them that they had hypertension (41.8% vs. 37.6%), diabetes (17.5% vs. 12.5%), or cancer (9.8% vs 4.6%), and less likely be told by a physician they have lung disease such as COPD (13.0% vs. 10.1%) compared the year before enrollment. Individuals were more likely to receive treatment for all conditions after a year of Medicaid enrollment compared to the year prior to Medicaid enrollment.

Health Status		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Self-Rated Physical Health		
Excellent	6.5%	6.9%
Very good	17.7%	21.0%
Good	37.9%	38.0%
Fair	28.2%	26.3%
Poor	9.7%	7.8%
Self-Rated Mental Health		
Excellent*	18.3%	15.2%
Very good	20.4%	23.7%
Good	29.7%	32.5%
Fair*	23.3%	20.0%
Poor	8.3%	8.5%
Diagnosed Health Conditions		
High blood pressure/hypertension*	37.6%	41.8%
If yes, received treatment?*	51.8%	70.8%
Heart condition/heart disease	11.5%	10.4%
If yes, received treatment?*	44.2%	58.5%
Diabetes*	12.5%	17.5%
If yes, received treatment?*	53.7%	66.4%
Cancer*	4.6%	6.8%
Depression, anxiety, or other mental health problems	41.4%	43.1%
If yes, received treatment?*	39.4%	61.3%

Stroke	4.8%	4.6%
Asthma	15.2%	17.0%
If yes, received treatment?*	36.6%	61.3%
Chronic bronchitis, COPD, emphysema*	13.0%	10.1%
If yes, received treatment?*	36.5%	53.1%
Problems with alcohol or drugs	11.6%	9.8%
If yes, received treatment?*	27.9%	49.5%
Hepatitis C	6.5%	5.0%
HIV/AIDS	2.7%	3.9%
Number of diagnosed conditions*		
0 conditions	29.2%	28.0%
1 condition	30.0%	27.8%
2-3 conditions	31.0%	33.9%
4 or more conditions	10.2%	10.3%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Overall sample sizes vary from 2,732-2774 depending on participant responses, and 1,274 for members reporting high blood pressure, 353 for those reporting heart conditions, 502 for those reporting diabetes, 1,126 for those reporting depression, 456 for those reporting asthma, 382 for those with bronchitis/COPD, emphysema, and 251 for those reporting a problem with alcohol or drugs. There were not enough respondents with a diagnoses of cancer, stroke, Hepatitis C, or HIV/AIDS to report the percent receiving treatment. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Ability to work

After enrolling in Medicaid coverage, new members were less likely to report that health conditions restricted them from carrying out daily activities, and less likely to cut back hours or not take a job due to illness.

- Significantly fewer individuals had 6-10 (8.9% vs. 10.9%) or more than 10 days (21.5% vs. 24.8%) of poor health after enrollment in Medicaid compared to the year prior to enrollment.
- Fewer individuals who had been enrolled in Medicaid for a year could not take or keep a job (34.6% vs. 39.7%) or had to cut back hours at their job (28.7% vs. 37.5%) because of mental or physical health conditions compared to those in the year prior to Medicaid enrollment.

Ability to work		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Number of days poor health kept from doing usual activities		
0	45.2%	49.7%
1-5	19.1%	19.9%
6-10*	10.9%	8.9%
More than 10 days*	24.8%	21.5%
Could not take or keep a job because of physical or mental health problems*	39.7%	34.6%
Cut back number of hours worked because of physical or mental health problems*	37.5%	28.7%
Currently have health conditions that prevent part- or full-time work	36.1%	34.6%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Sample sizes vary from 2,598-2762 depending on participant responses. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05

Section 4 – Health Behaviors

- In the year after enrollment, tobacco use among newly enrolled Medicaid members was higher than the national average of adults (37.0% vs. 30.8%) but any binge drinking was lower (22.5% vs. 25.8%).
- Note: questions regarding health behavior such as binge drinking and tobacco product use were only included in the follow-up survey so comparisons between the years prior and after enrollment cannot be assessed.

Health Behaviors[a]		
	Members with 12 months of enrollment	National Sample of Adults
Frequency of tobacco product use		
Every day	26.2%	--
Some days	10.8%	--
Not at all	63.1%	--
Any tobacco use	37.0%	30.8%
Frequency of binge drinking in the past 30 days		
0 days	77.8%	
1-3 days	12.6%	
4+ days	9.9%	
Any binge drinking	22.5%	25.8%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. Health behaviors were not assessed in the baseline survey. Sample sizes vary from 1,281 to 1,556 depending on participant responses. National estimates from: Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742; SAMHSA, Center for Behavioral Health Statistics and Quality. 2019 National Survey on Drug Use and Health. Table 2.20B – Binge Alcohol Use in Past Month among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2018 and 2019.

Section 5- New Member Experience During the COVID-19 Pandemic

The follow-up survey was conducted during the COVID-19 pandemic, and therefore, additional questions were included to assess member experiences with the healthcare system and COVID-19 more broadly.

- In our sample, 28.4% of individuals had been tested for COVID and of those tested, 8.5% had a positive test. Out of the total sample, 4.9% believe they had been infected with COVID.
- Receiving care in person was the most common form of care during COVID-19 (35.4% of respondents), and 15.9% of members obtained care by multiple modalities during COVID-19.
- Almost a quarter of new members experienced an unmet need for care during COVID-19. The most common reasons for not seeking care during COVID-19 was because the doctor's office was closed and not seeing patients (41.0%) followed by concern about catching the virus from the doctor's office (34.4%).
- The quality of dental care was the most negatively impacted due to COVID as compared to other health care services.
- **Medicaid expansion may have acted as an additional safety net for members during the COVID-19 pandemic, as more members report difficulties with personal finances during the pandemic.**

COVID-19 Experiences	
	Members with 12 months of enrollment
Have been tested for COVID	28.4%
Test result for those tested for COVID	
Positive	8.5%
Negative	88.8%
Inconclusive/don't know	2.4%
Believe they have been infected with COVID (regardless of receiving a test)	
Yes	4.9%
No	78.4%
Unsure	16.6%
Health Care Access during COVID-19	
Mode of Care during COVID	
Obtained care in person only	35.4%
Obtained care by telephone	5.6%
Obtained care by video	5.1%
Obtained care by multiple modalities	15.9%
Did not obtain care	37.7%
Experienced unmet need for care since COVID began in March, 2020	24.5%
Type of care members did not get	
Routine checkup or exam	45.4%
Urgent medical condition	18.4%

Treatment for a medical condition	33.2%
Prescription medication	15.6%
Dental care	47.2%
Mental health counseling or treatment	19.2%
Substance use counseling or treatment	1.4%
Reason they didn't get care	
Concerned about spreading the virus at the doctor's office	5.2%
Concerned about catching the virus at the doctor's office	34.4%
No phone or internet access	3.7%
Doctor's office didn't see patients by phone or video	8.9%
Doctor's office was closed and not seeing patients	41.0%
Other	27.3%

Notes: All estimates are adjusted for gender, age, marital status, race/ethnicity, rurality, and weighted to adjust for non-response bias. COVID-19 questions were not assessed in the baseline survey as it was conducted prior to the pandemic. Overall sample sizes vary from 1,500 to 1,574 depending on participant responses, with 447 reporting receiving a COVID-19 test, and 377 reporting they needed care but did not receive it.

Section 6 –Other New Member Characteristics

- Demographics were generally similar between the two samples, with some differences in education and work status.
- More than half of the sample of new members is non-Hispanic White, with 32.9% non-Hispanic Black, 2% Hispanic, and 12% reporting as other race/ethnicity.
- Nearly 3 in 4 members sampled resided in non-rural areas of the Commonwealth.

Demographics		
	Members in the year prior to enrollment	Members with 12 months of enrollment
Race & Ethnicity[a]		
Non-Hispanic White (ref)	53.6%	53.2%
Non-Hispanic Black	30.9%	32.9%
Non-Hispanic Other	14.0%	12.0%
Hispanic	1.5%	2.0%
Gender[a1]		
Male	47.5%	47.4%
Female	52.5%	52.6%
Rurality[a2]		
Non-Rural	75.4%	74.0%
Rural	24.6%	26.0%
Highest level of education[b3]		
9th grade or less	4.9%	5.2%
Some high school	13.2%	10.8%
High school graduate (ref)	32.8%	35.0%
Some college*	26.6%	22.7%
Associate's degree	7.9%	10.9%
Bachelor's degree or higher	13.4%	14.4%
Current employment status[b4]		
Employed or self-employed (ref)	44.3%	44.8%
Not employed but looking for work*	32.9%	25.8%
Retired and not employed*	12.4%	16.9%
Student	4.4%	3.2%
Homemaker*	6.1%	9.2%
Marital status[b5]		
Single (never married) (ref)	50.5%	48.5%
Married	20.9%	20.9%
Separated	7.9%	6.9%
Widowed*	3.0%	4.2%
Divorced	18.6%	19.5%
Medicaid MCO Plan[b6]		
Aetna Better Health (ref)	23.6%	22.7%
Anthem HealthKeepers Plus	20.9%	23.8%

Magellan Complete Care	8.8%	9.5%
Optima Health	18.4%	18.1%
United Healthcare	11.6%	10.5%
Virginia Premier	16.7%	15.3%

Notes: Sample sizes vary from 2,704-2877 depending on participant responses. Data on race/ethnicity, gender, and rurality were obtained from enrollment files. *Difference in the follow-up and the baseline survey was significant at a p-value<0.05.

Section 7 – Health Equity of Coverage Impacts

Across Racial/Ethnic Groups

- Generally, non-Hispanic Black Medicaid members and non-Hispanic White members experienced similar changes after being enrolled in Medicaid for a year in problems paying medical bills, usual source of care, utilization of services, and health and ability to work outcomes.
- However, non-Hispanic Black members reported significantly larger reductions in worry over normal medical costs after enrollment (85.1% vs. 41.7%) compared to non-Hispanic White members (85.6% vs. 51.8%).
- Non-Hispanic Black members reported a greater increase in using a doctor's office (25.6% vs. 75.4%) compared to non-Hispanic White members (51.3% vs. 73.3%).
- Non-Hispanic Black members also reported a greater decrease in using decrease in using the emergency department (29.9% vs. 7.3%) or a free clinic (21.0% vs. 3.3%) as their source of usual care after being enrolled in Medicaid compared to non-Hispanic White members (15.1%vs. 2.6% for emergency department use; 12.2% vs. 3.4% for free clinic use).
- Although, non-Hispanic White members had a greater decrease in unmet need due to cost (78.0% vs. 25.9%) compared to non-Hispanic Black members (66.6% vs. 38.9%) after enrollment.

Across Rural and Non-Rural Members

- Rural Medicaid members reported a significantly larger decrease in problems paying medical bills in the year after enrollment (74.0% vs. 17.4%) compared to non-rural members (64.4% vs. 19.3%).
- Both rural and non-rural members had similar decreases in financial concerns for medical and nonmedical needs.
- Likewise, both rural and non-rural members experienced similar increases in using the doctor's office or clinic as their usual care as well as decreases in using free clinics and emergency departments as their usual source of care.
- However, rural members reported a significantly greater decrease in unmet need for prescriptions due to cost after enrolling in Medicaid (62.7% vs. 14.3%) compared to non-rural members (54.2% vs. 15.1%), but these two groups had similar decreases in other unmet healthcare needs.
- Rural Medicaid members had a significantly larger increase in cholesterol checks (39.0% vs. 63.5%) and blood sugar checks (40.4% vs. 59.5%) after enrolling in Medicaid compared to non-rural members (42.5% vs. 52.3% for cholesterol checks; 42.4% vs. 52.1% for blood sugar checks).
- Although, non-rural members experienced a significant decrease in not being able to take a job or having to cut back hours due to illness after enrolling in Medicaid while rural members did not experience any significant changes in these employment outcomes.

Section 8 – Member-Reported Most Important Impact of Medicaid Coverage for New Members in their First Year of Enrollment

- Members were generally satisfied with care and many commented on the "life-saving" nature of Medicaid.
- Common complaints included lack of vision coverage and dental coverage as well as other barriers to care such as providers not taking Medicaid or not being located near the member.

Theme	Example Quote from Survey Respondent	Number	Percent
Improve Access to Primary Care and Preventive Services	"My doctor was able to treat my high blood pressure and offer alternatives to my chronic pain care."	110	12%
Improved Health	"Medical coverage saved my life. I didn't know I had diabetes or high blood pressure until I was able to go to the doctor. I probably would not be eating right and taking care of myself. Thank you!"	58	6%
Increase Use of Dental Care and Vision Care	"Being able to get my bad teeth pulled. Now I no longer have toothaches."	37	4%
Reduce Stress	"I've had less anxiety about bills, so I've been more able/likely to follow up on health considerations. Hopefully I can keep my conditions under control and possibly prevent others from happening."	169	19%
Afford Medications	"Being able to get the medications I needed for my conditions."	179	20%
Access to Specialty Care	"Being able to have surgery to fix a major issue and being able to get help when I hurt my knee because of help for both I can still work" "Knowing I had Medicare during my cancer ordeal. Long and trying experiences. At times not sure I was going to start healing"	109	12%
Access to Behavioral Health Care	"Medicaid has actually saved my life. I was a drug addict and Medicaid helps me receive help for this with counseling and medication."	57	6%
Generally Improved Access to Healthcare	"Allowed me to seek medical attention"	102	11%
General Improvement in Affordability of Care	"Covering medical bills and prescription meds lessening some of the stress of trying to figure out how they were gonna get paid"	170	19%
Because of Medicaid, Able to Do other Activities	"Being able to go to the doctors for my blood pressure and not worry about being able to get any and all medication without worrying about the cost. Saved my life and enabled me to be a	26	3%

(Employment, Caring for Dependents, etc.)	good caregiver to my 71 year old developmentally disabled mother who is a stroke survivor." "Medicaid is a huge help. Without it I couldn't afford to go to the doctor or be on asthma and depression anxiety meds. I wouldn't be able to hold a job if I wasn't on my meds"		
Knowing Members Can Get Care When Needed	"Just basically knowing that I'm covered for the unpredictable"	18	2%
Care Related to COVID -19	"Just having the Medicaid coverage during the coronavirus pandemic was a very important impact on my life and health"	10	1%
Generally Satisfied with care	"Medicaid did real good for me I thank God the impact that Medicaid have help me wonderful"	25	3%
Did Not Use Care	"In past year I have no problem about health I'm so happy that don't have any health condition sign"	13	1%
Experienced Problems with Care	"Not able to find doctors in my area that accept my health plan or pay for my medications "	76	8%
Other		77	7%

Percentage Points do not add up to 100% as some quotes applied to multiple themes.

CONCLUSIONS

As of July 2021, over 560,000 low-income adults have enrolled in expanded eligibility for Virginia Medicaid. Understanding the experiences of new members *in the year prior* to enrollment and in *their first year of enrollment* is critical to understanding the impact of Medicaid expansion on the health and well-being of Virginians over time. Using member surveys to make comparisons between members' experiences before they enrolled in Medicaid and after enrollment in Medicaid is unique to Virginia's evaluation of Medicaid expansion and adds immensely to our understanding of Medicaid coverage overall.

Key findings suggests that Medicaid coverage improves financial well-being for non-medical concerns and medical concerns. Additionally, more members have a usual source of care after enrollment in Medicaid (72.9 vs 81.5% after enrollment). Importantly, more members are using doctor's offices as their source of usual care after enrollment than in the year prior to enrollment (73.2% vs 44.1% before enrollment). Members also have less unmet need for medical care overall after enrollment than in the year prior (61.6% vs. 23.7% before enrollment) as well as less unmet need for all specific types of care. Individuals received treatment more often after enrollment for all conditions we inquired about. The impact of Medicaid was not just limited to healthcare utilization. Fewer members had to cut their work hours due to health problems after enrollment than before enrollment (28.7% vs 37.5%).

Because this survey was fielded during the COVID-19 pandemic, we were able to assess the impact of the pandemic on Medicaid members. About 25% of members did not get care since the pandemic began and the most common type of delayed care was dental care (47.2% of members) and routine checkups (45.4% of members). The impact of COVID-19 was greatest for financial well-being as 44.9% of respondents stated they their financial well-being declined, while only 17.0% said they physical health worsened during the pandemic.

We also examined the equity of coverage effects across racial/ethnic and geographic groups. We found that non-Hispanic White members and non-Hispanic Black members generally reported similar improvements after Medicaid enrollment, except that non-Hispanic Black members reported a greater decrease in concern about paying for medical costs of normal healthcare and experienced a greater increase in using the doctor's office or clinic as their source of usual care compared to non-Hispanic White members. Rural and non-rural members had similar improvements after Medicaid enrollment, except that rural members had a greater decrease in concern about paying for medical bills compared to non-rural members, and rural members had a greater increase in having their blood sugar and cholesterol checked by health professional after enrollment compared to non-rural members.

Looking ahead, Virginia Commonwealth University and the Virginia Department of Medical Assistance Services will continue their collaboration evaluating how expanded Medicaid coverage has changed the healthcare delivery system, health care utilization, and members' lives.