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# Mitigating the Effects of Churning Under the Affordable Care Act: Lessons from Medicaid

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**Abstract** Through a combination of three needs-based public programs—Medicaid, the Children's Health Insurance Program, and tax credits for purchasing private plans in the new marketplaces—the Affordable Care Act can potentially ensure continuous coverage for many low- and moderate-income Americans. At the same time, half of individuals with incomes at less than twice the poverty level will experience a form of "churning" in their coverage; as changes occur in their life or work circumstances, they will need to switch among these three coverage sources. For many, churning will entail not only changes in covered benefits and cost-sharing, but also in care, owing to differences in provider networks. Strategies for mitigating churning's effects are complex and require time to implement. For the short term, however, the experiences of 17 states with policies aimed at smoothing transitions between health plans offer lessons for ensuring care continuity.



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## OVERVIEW

Implementation of the Affordable Care Act (ACA) thus far has focused on state Medicaid expansions for low-income adults and private health plan enrollment via the insurance marketplaces. But as implementation proceeds, achieving the law's promise will require efforts to ensure that coverage is lasting and stable over long periods. For this reason, attention is likely to turn to the prevention of churning; that is, the tendency for people to cycle on and off of coverage as a result of changing work, family, and other life circumstances.

For millions of Americans, the ACA will mean an end to the worst form of churning—the loss of insurance coverage entirely. The law's health insurance marketplaces are designed to work alongside Medicaid by offering subsidized coverage to those whose incomes are slightly above Medicaid's eligibility levels. Similarly, the law enables states to restructure Medicaid to

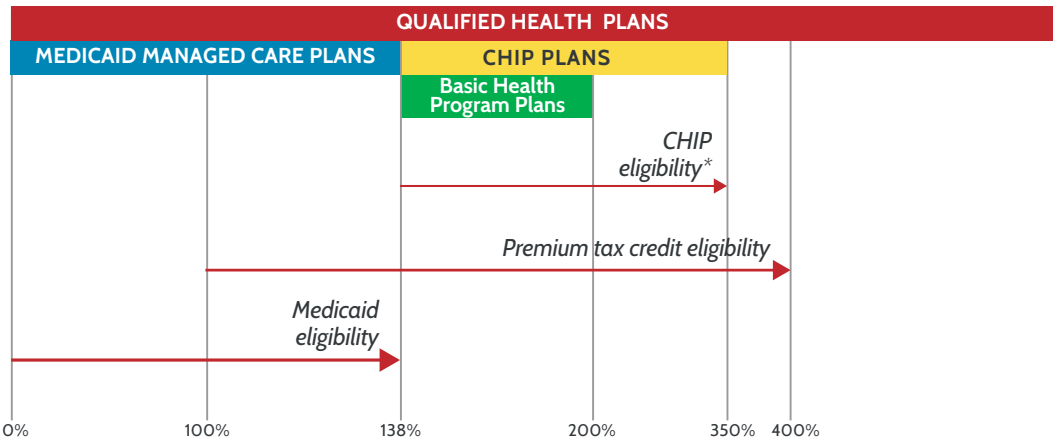
preserve coverage for those experiencing an income drop sufficient to fall below the eligibility threshold for marketplace premium subsidies.

But the ACA introduces a new risk of churning for individuals and families whose income fluctuations mean they will move between Medicaid and subsidized private coverage through the marketplaces. The number of people likely to be in this situation is considerable: in a given year, half of those with incomes below twice the federal poverty level (FPL) can be expected to experience at least one income change sufficient to trigger movement from Medicaid to the marketplaces or vice versa.[1] This problem is likely to occur in all states—not only those expanding Medicaid—as enrollees' work, family, and life changes lead to movement across the three major public-subsidy programs (Medicaid, the Children's Health Insurance Program, and the insurance marketplaces).[2] For this reason, greater alignment of the various pathways to affordable coverage will be an important step in the ACA's evolution.

The challenge of the ACA's churning effect is complicated by the fact that each of these public-subsidy programs has its own rules and standards for participating health plans, as well as its own network of participating plans: managed care plans in Medicaid, qualified health plans in the marketplaces, and child health plans in the Children's Health Insurance Program (CHIP) (Exhibit 1). (In states that choose to establish a Basic Health Program covering individuals and families with incomes between Medicaid eligibility and twice the FPL, there will also be standard health plans with their own rules and standards.) Covered benefits and cost-sharing also differ from plan to plan.

Most important, provider networks from market to market and plan to plan may differ enormously. This means that when patients change health plans they will often have to change providers—impinging on continuity of care, especially primary care, which affects care quality and health outcomes.[3] The effect of churning on care continuity may be exacerbated by the fact that Medicaid tends to have relatively limited provider participation while marketplace plans tend to have narrow networks.[4] A Medicaid-to-marketplace transition may separate a family from the community health center where members receive care or the children's hospital clinic treating a child with special needs.[5]

**Exhibit 1. Product Markets Under the Affordable Care Act**




* CHIP eligibility varies by state.
Note: The 2012 Supreme Court ruling in *NFIB* v. *Sebelius* made Medicaid expansion under the ACA optional for states.

And for families moving from the marketplaces to Medicaid, the transition may mean losing access to a family practice or specialists.

## LESSENING THE IMPACT OF CHURNING

The following strategies may mitigate the effects of churning in the three public-subsidy programs.

### Multimarket Health Plans

Some companies are beginning to sell health plans across the three major pathways to affordable, publicly subsidized health insurance: the health insurance marketplaces, Medicaid, and CHIP. By participating in all three markets (and potentially the Basic Health Program market as well), these companies can smooth transitions across health plans by applying a consistent approach to covered benefits, although coverage limits, deductibles, and copayments will vary, depending on the source of the subsidy. Perhaps most important, these Multimarket health plans can provide a common provider network to help preserve provider/patient relationships. While this approach holds promise, it is too early to know whether it can be broadly applied, especially given the complex financing and service delivery issues it entails.

### Premium Assistance

Another approach to mitigating the effects of churning is for states to use Medicaid dollars to subsidize the purchase of private insurance coverage in the marketplaces. This strategy is being tested in Arkansas, which received federal approval to offer premium assistance to adults newly eligible for Medicaid (about a quarter million people) and, ultimately, to extend the model to most adults and children enrolled in Medicaid (with the exception of medically frail beneficiaries). By providing private coverage through the marketplaces rather than through Medicaid managed care, this approach will connect people to a stable group of plans and provider networks, regardless of members' minor income fluctuations.

This approach does present challenges, including the need to attract a sufficient number of plans and provider networks with the capacity and willingness to serve a large population of low-income patients. It also will require Medicaid to oversee a private insurance market unaccustomed to operating in accordance with the program's special coverage, cost-sharing, and access protections.

### Continuous Enrollment

To stabilize the source of subsidy for a full membership year, another potential state approach is to introduce annual 12-month enrollment periods. Annual enrollment is an option for children under Medicaid and CHIP, and the Obama administration has issued guidelines permitting states to establish annual Medicaid enrollment periods for adults through the use of Section 1115 demonstration authority.[6] (The demonstrations need to be budget-neutral, meaning that states would not receive additional federal payments to cover periods when people remain enrolled in Medicaid because of the special continuous coverage protection.)[7] While 12-month continuous enrollment would provide some protection against loss of the Medicaid subsidy itself, it does not guarantee beneficiaries would have access to the same group of health plans or providers.

### Basic Health Program

Another way to mitigate the effects of churning is for states to adopt a Basic Health Program, authorized by Congress under the Affordable Care Act as a companion to Medicaid and covering people with incomes between 133 percent and 200 percent of the federal poverty level.[8] Research suggests that such programs could have a stabilizing effect on coverage while also reducing the size of premiums and cost-sharing for low-income populations.[9] Final regulations published in March 2014 permit states to phase in Basic Health Programs in 2015, but it is uncertain how many states will do so next year. Doing so requires states to build a new program, design standard health plan requirements and secure standard health plan participation, and redesign the marketplaces because individuals whose incomes fall within Basic Health Program eligibility standards would have to move off of marketplace coverage and reenroll in the Basic Health Program.[10]

## LESSONS FROM MEDICAID

Some state Medicaid programs have experience in developing policies to smooth transitions among Medicaid managed care plans, in which churning is relatively common. These policies—which may offer insights for mitigating the effects of ACA-related churning—address the duties of transferring plans, the duties of receiving plans, special considerations for patients in the midst of a course of treatment, inter-plan coordination, and medical records transfer.

As Exhibit 2 shows, 16 states and the District of Columbia have plan transition policies. With the exception of Nevada's, all policies focus on the Medicaid market. Nevada requires that entities that sell Medicaid managed care plans also offer qualified health plans in the marketplace using the same provider network and similar drug formularies.[11] Oregon is notable in that its insurance laws specifically exempt issuers from plan-to-plan transition obligations.

There is variation among state policies, ranging from general directives (found in all states) to relatively detailed standards governing certain aspects of the transitions between Medicaid managed care plans. Four states identify medical records transfer as part of their transition policy, and four states establish continuity-of-care standards for patients in the course of treatment. Nine states direct their transition policies at one or more specific population or condition.

## DISCUSSION

Mitigating the effects of churning across Medicaid, CHIP, and publicly subsidized private coverage is a long-term challenge for health reform. Several promising strategies for doing so exist, and states are likely to test one or more of them to achieve greater stability of coverage and continuity of care. Still, lessons from past experiences indicate that strategies to reduce the impact of churning are complex and will take time to have an effect. In the meantime, the potential for frequent movement across the three public-subsidy programs makes transition planning especially important for patients, health plans, and providers.

In this regard, state Medicaid program's experiences with plan-to-plan transitions, particularly in Medicaid managed care, offer insights. In some cases, states establish general directives to plans to coordinate transfers; in others, state policies designate policies for issues such as transfer of medical records, maintenance of established patient–provider relationships for some time, and transition protocols for designated populations and conditions.

## Exhibit 2. States with Plan-to-Plan Transition Policies

| State | General directive covering one or more population | Specific populations and treatments covered | Medical records transfer | Inter-plan coordination and planning | Maintaining provider–patient relationships |
|---|---|---|---|---|---|
| **Arizona**<br>*Medicaid* | X | X[1] | X | X | |
| **Arkansas**<br>*Section 1115 premium assistance demonstration* | X | | | | |
| **California**<br>*Medicaid managed care* | X | | X | | X |
| **Connecticut**<br>*Marketplace directives* | X | | | | |
| **Delaware**<br>*Recommended certification standards for qualified health plans sold in marketplace* | X | X[2] | | | |
| **District of Columbia**<br>*Recommended certification standards for qualified health plans sold in marketplace* | X | X[3] | | | X[4] |
| **Hawaii**<br>*Medicaid* | X | | | | |
| **Illinois**<br>*Medicaid managed care* | X | X[5] | | | |
| **Iowa**<br>*Section 1115 premium assistance demonstration* | X | | | | |
| **Kentucky**<br>*Medicaid managed care* | X | | X | X | X[6] |
| **Maryland**<br>*Recommended certification standards for qualified health plans sold in marketplace* | X | X[7] | | | X[8] |
| **Michigan**<br>*Medicaid managed care* | X | X[9] | | | |
| **Minnesota**<br>*Certification standards for Medicaid managed care and qualified health plans sold in marketplace* | X | X[10] | | | |
| **Nevada**<br>*Medicaid managed care and certification standards for qualified health plans sold in marketplace* | X | | | | |
| **New Mexico**<br>*Medicaid managed care* | X | | X[11] | X | |
| **Ohio**<br>*Medicaid managed care* | X | X[12] | | | |
| **Oregon**<br>*Medicaid managed care*[13] | X | | | | |
| Pennsylvania<br>*Medicaid managed care* | X | X[14] | | | |
| Totals | 18 | 9 | 4 | 3 | 4 |

1 Policy applies to: those with significant medical conditions including high-risk pregnancies or those receiving chemotherapy or dialysis, people hospitalized at the time of treatment, people receiving out-of-area specialty care, people who have received prior authorization for treatment, people with drug prescriptions, and people using durable medical equipment or medical transportation.
2 Policy applies to: people receiving prescriptions (with continuing coverage at the correct tier), people with serious mental health conditions, and current treatment for medical conditions covered by a written prior authorization plan.
3 Policy applies to enrollees in active treatment.
4 Policy requires recognition of non-network providers for remaining course of treatment or 90 days, whichever is shorter.
5 Policy applies to inpatient care.
6 Policy requires specific coordination at the level of primary care providers.
7 Policy applies to: individuals with serious and chronic conditions, mental health or substance use disorders, pregnancy, dental care, and acute conditions.
8 Policy requires patients to be given the option of remaining with current providers at in-network payment rates or receiving assistance in making a transition to a new provider if out-of-network provider declines to continue participation.
9 Policy requires preauthorized care for children with special needs.
10 Policy applies to: acute conditions, life-threatening physical or mental health conditions, pregnancy after the first trimester, physical or mental disability (Americans with Disabilities Act definition), a disabling condition in an acute phase, and care for remainder of patient's life if death within 180 days certified by a physician. It also provides for continuity of care for members receiving culturally appropriate care from a former provider for up to 120 days in cases in which receiving plan has no geographically accessible in-network provider with similar expertise.
11 Policy requires transfer of medical records specified as "clinical information."
12 Policy applies to members who are hospitalized or receiving prescheduled services and provides for special and extended standards for members with disabilities.
13 Qualified health plans are explicitly exempt under state law (Ch. 743.854(b)) from inter-plan transition obligations.
14 Policy applies to individuals receiving previously authorized treatments.

Source: Authors' review of state Medicaid and qualified health plan policies from various state websites, October 2013.

In the U.S. health insurance system, which links the source of coverage to access to treatment, problems with care continuity are by no means unique to publicly subsidized programs. But because the ACA's public-subsidy programs are income-sensitive, churning on and off of coverage is likely to be especially prominent. In the coming years, it will be crucial for pubic-subsidy programs to align their efforts to promote health care quality, efficiency, and continuity.

## NOTES

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