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# Medicaid And Marketplace Eligibility Changes Will Occur Often In All States; Policy Options Can Ease Impact

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**ABSTRACT Under the Affordable Care Act (ACA), changes in income and family circumstances are likely to produce frequent transitions in eligibility for Medicaid and health insurance Marketplace coverage for low- and middle-income adults. We provide state-by-state estimates of potential eligibility changes ("churning") if all states expanded Medicaid under health reform, and we identify predictors of rates of churning within states. Combining longitudinal survey data with state-specific weighting and small-area estimation techniques, we found that eligibility changes occurred frequently in all fifty states. Higher-income states and states that had more generous Medicaid eligibility criteria for nonelderly adults before the ACA experienced more churning, although the differences were small. Even in states with the least churning, we estimated that more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months. Policy options for states to reduce the frequency and impact of coverage changes include adopting twelve-month continuous eligibility for adults in Medicaid, creating a Basic Health Program, using Medicaid funds to subsidize Marketplace coverage for low-income adults, and encouraging the same health insurers to offer plans in Medicaid and the Marketplaces.**

Beginning January 1, 2014, the Affordable Care Act (ACA) established two pathways to health insurance for nonelderly US citizens and legal residents. The first was an expansion of Medicaid coverage for people with annual incomes of up to 138 percent of the federal poverty level in states that elected to expand their programs. The second pathway was subsidizing private coverage purchased via health insurance Marketplaces for people with incomes of 138–400 percent of poverty who do not have an offer of affordable coverage through an employer. The pathways are designed to work in tandem, but a major challenge is how to promote continuity of coverage and health care for people when their incomes and life circumstances cause them to transition between Medicaid and subsidized private coverage.

In states that opt out of the ACA's Medicaid expansion, changes in income or family circumstance will lead many people to lose coverage entirely unless they qualify for coverage under one of the traditional categories of Medicaid eligibility: pregnancy, disability, or being the impoverished parent of a minor child. A less stark problem that presents a different set of challenges will occur in states that do expand Medicaid: the potential for moving between Medicaid and Marketplace coverage.

Both of these types of "churning"—loss of coverage and frequent transitions in the source of

coverage—can cause difficulties. The total loss of coverage raises the most serious problems in terms of access to care, but frequent transitions across coverage pathways also raise important issues for beneficiaries, health plans, providers, and policy makers. From one year to the next or during any given year, many individuals and families will experience changes in eligibility either for Medicaid or for Marketplace coverage. These eligibility changes could lead to both gaps in coverage and disruptions in the continuity of care, because people might have to find new providers or change their existing health treatments if their new insurance plan uses a different provider network or covers different services than their old plan did.

Previous research has estimated that approximately half of low-income adults might experience a change in income or family circumstances leading them to transition from Medicaid to Marketplace coverage (or vice versa) each year.[1] Policy makers continue to explore various options to reduce the frequency of churning or at least mitigate its adverse impact on the continuity of health care.

Because churning is the result of many factors, it may be a larger issue in some states than in others. To date, there is little evidence about which states are most likely to experience churning. In this context, state-level estimates of potential churning rates among people likely to participate in Medicaid and the Marketplaces would be extremely valuable.

A major limitation to analyzing state-specific churning is that the most commonly used source of data on changes in insurance coverage and income over time—the Census Bureau's Survey of Income and Program Participation (SIPP)—was not designed to provide samples of people that are representative of every state's population.[2] The survey's sample is relatively small and disproportionately includes lower-income people and people in particular localities.[3] We overcame these limitations by combining information on income and family changes from the SIPP with state-specific weights that we developed using a much larger survey, the American Community Survey (ACS).[4]

Our study objectives were to provide detailed estimates of the potential extent of churning between Medicaid and Marketplace coverage under health reform in each state and to identify state-level factors associated with higher rates of churning.

## Study Data And Methods

**DATA SOURCES** We used data from two sources. First, information on changes in eligibility over time came from the 2008 SIPP. Following previous research,[1,5] we identified all adults ages 19–62 (thus excluding adults who would age into Medicare during the survey's follow-up period) who were likely to enroll in Medicaid or subsidized Marketplace coverage. We defined this sample as those adults with family incomes estimated to be up to 400 percent of poverty (incomes that made them eligible for Medicaid or tax credits for Marketplace coverage) who did not have Medicare, employer-sponsored insurance, or military health insurance. These criteria yielded a sample of 11,898 people.

For each month in the survey, we estimated family income as a percentage of poverty,[6] using the concept of the health insurance unit (see the online Appendix for details).[7] We tracked the number of adults experiencing a change in income that would result in a shift in eligibility (based on crossing the Medicaid expansion income threshold of 138 percent of poverty) during the subsequent twelve months.

Annual income is used to calculate the proper tax credit for people who have coverage in the Marketplace and has been studied previously in the context of reconciliation payments.[5] However, eligibility for Medicaid is based on monthly income, and eligibility for Marketplace subsidies is contingent on not being eligible for Medicaid. Therefore, monthly income was the relevant measure for this analysis.

We were also more interested in coverage changes than in the receipt or extent of tax credits. Therefore, we did not analyze how often people had income changes that crossed alternative thresholds, such as 250 percent of poverty (the ACA threshold for receiving cost-sharing subsidies) or 400 percent of poverty.

Our second data source was a three-year sample of 9,204,447 people in the 2009–11 ACS. These data were used to construct state-specific weights for the SIPP sample, following the method developed by Allen Schirm and Alan Zaslavsky.[8] Specifically, state weights were developed using a Poisson regression model that calibrated SIPP state population totals to match a set of forty-three control totals from the ACS. If, for example, based on the ACS there were 35,000 people working in the manufacturing industry in North Dakota, then our SIPP estimate also yielded an estimate of 35,000. State-level control totals included demographic characteristics, income, family composition, insurance coverage type, and employment measures (both status in the labor force and industry).

Using the approach employed by John Graves and Katherine Swartz,[9] we restricted the construction of state weights so that only people in contiguous states and states with similar eli-

gibility policies for public programs could contribute information to an estimate for a given state (see the online Appendix for details).[7] The information for each person in the expanded state sample was then weighted by the appropriate state-specific weight to yield representative estimates for each state.

**ANALYSIS** Using the methods outlined above, we estimated rates of churning for each state. Our two primary outcomes were the percentages of adults with continuous eligibility for the same insurance program over a six-month period and over a twelve-month period. We limited our sample to people for whom we had complete income data for the first twelve months in the survey.

After producing state-specific estimates of rates of continuous eligibility over time, we analyzed whether churning rates varied by states' poverty rates or the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults.

For the state poverty rate analysis, the sample was divided into three groups based on the rate in each state (as derived from the Census Bureau's 2009 Current Population Survey), using natural breaks in the distribution to produce similar-size groups (people whose incomes were less than 11.0 percent, 11.0–14.5 percent, and greater than 14.5 of poverty). We also tested the impact of categorizing states by per capita income or median household income.

For the analysis of the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults, the sample was divided into three groups based on the share of a standardized national population that would be eligible for Medicaid under each state's laws (see the online Appendix for details).[7] This approach was similar to methods used in previous research.[10]

We used *t* tests to identify differences in churning rates across these classifications for all fifty states and the District of Columbia. We also ran bivariate linear regression models in which each state's percentage of adults with twelve months of uninterrupted eligibility was the outcome and the state poverty rate, per capita income, and Medicaid eligibility measure were separately used as continuous predictor variables.

Our goal in these analyses was not to present an exhaustive model of predictors of coverage stability. Instead, we sought to identify simple state-level measures that offer a straightforward way to conceptualize what kinds of states experience more or less churning. For this purpose, we selected measures that vary widely across states and might plausibly affect income mobility, program eligibility, or both over time.

**LIMITATIONS** Our study has several important limitations. First, we used self-reported income data, which might correspond imperfectly with income as it will actually be assessed by state Medicaid programs and the Marketplaces. The impact of this imprecision on state-level churning rates is unclear.

Second, our sample underrepresented people who dropped out of the SIPP sample. Such people are likely to have less stable circumstances than those who remain in the survey, so our approach could underestimate the extent of churning.

Third, our sample contained all adults who were potentially eligible for Medicaid or subsidized Marketplace coverage. Many eligible people have not enrolled in public coverage programs in the past,[11] but our sample design implicitly assumed full participation rates. However, it is unclear whether people who do not enroll are more or less likely to experience income changes than those who do sign up for coverage.

Fourth, some people in this income range may have declined an offer of affordable employer-sponsored insurance (that is, insurance costing less than 9.5 percent of the employee's income), which would have precluded their receiving Marketplace tax credits.[12] SIPP does not supply information on employees' potential premium obligations, which prevented us from accurately identifying such people in the data set.

Consistent with the ACA, our approach assumed that people could lose eligibility for Medicaid or subsidized Marketplace coverage in any given month based on changed economic or family circumstances. Whether interruptions will be as frequent as the law contemplates is unclear, since families might fail to report changed circumstances each time they occur. Moreover, the Centers for Medicare and Medicaid Services (CMS) has used Section 1115 waivers under the Social Security Act to enable states to apply to adults a policy of twelve-month continuous eligibility for Medicaid—an option that already exists for children.[13] State Medicaid agencies and the Marketplaces also may vary in how quickly they respond to reported changes in eligibility.

For the purpose of estimating rates of churning, we assumed that all states would expand Medicaid eligibility to 138 percent of poverty. As of January 2014, however, only twenty-five states and the District of Columbia had elected to do so.[14] Furthermore, the landscape of the Medicaid expansion is changing rapidly, and it is possible that some states will scale back higher-income (above 138 percent of poverty) eligibility for Medicaid once Marketplace subsidies become available. Therefore, we felt that a simplifying assumption using the same income

cutoff for all states would produce the most plausible comparisons across states.

The state-based weighting approach also has limitations. Our reweighting method was designed to strike a balance between the biased and imprecise direct state estimates yielded by small samples and the also potentially biased but more reliable indirect state estimates produced by appropriately weighted larger samples. As noted above, we also limited out-of-state "borrowing" to respondents in contiguous states and states with similar public program eligibility policies. This might result in less statistically reliable estimates for states with few neighbors.

## Study Results

Exhibit 1 shows eligibility continuity curves for selected states representing the upper and lower bounds, the median, and selected percentiles of adults experiencing continuous eligibility for Medicaid or Marketplace coverage. Appendix Exhibit 2 lists the specific values for each state and 95% confidence intervals for the estimates.[7] The curves are clustered in a fairly narrow band. Across all states (not including the District of Columbia), an estimated 63–72 percent of adults did not experience any changes in eligibility through the first six months, and in all but two states, 40–55 percent of adults did not experience any changes during the full twelve-month period.

Two states' estimates were outliers, with little churning at six months but marked churning at twelve months; thus, we did not include those states in Exhibit 1. Hawaii and Maine experienced more churning at twelve months than any other state—with only 40 percent and 42 percent of adults, respectively, having stable eligibility. However, those states' estimates at six months were fairly high, at 70 percent and 67 percent, respectively. As discussed above, our weighting approach may be less reliable in states with few or no neighboring states, such as these two outliers.

Appendix Exhibit 3 shows the values by state for people whose incomes were initially below 138 percent of poverty versus those with incomes between 139–400 percent of poverty.[7] Although the precise pattern varied across states, the median rate of continuous eligibility at twelve months was slightly higher for those with initial incomes in the range of 139–400 percent of poverty than for those whose incomes were initially below 138 percent of poverty (53 percent and 47 percent, respectively).

We found that eligibility continuity was lowest (that is, churning rates were highest) at twelve months in states with the lowest poverty rates (Exhibit 2). Each percentage-point decrease in a state's poverty rate was associated with a 0.29 percent increase in churning at twelve months (Exhibit 3). However, it is important to note that this relationship is not exactly linear: Churning rates were quite similar across states with low and medium levels of poverty, in contrast to high-poverty states.

We found a similar pattern—higher-income states having more churning—when we used alternative groupings of states by their poverty rates and when we used per capita income or median household income instead of poverty rates (Appendix Exhibit 4).[7] Continuity of eligibility was also lower in states that had more generous Medicaid programs before the ACA (Exhibit 2).

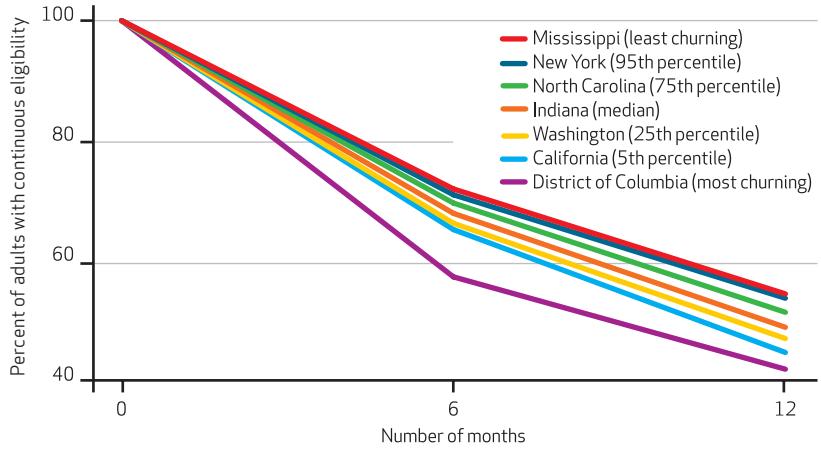
## Discussion

Beginning in January 2014, the pathways to affordable insurance expanded significantly in all states as a result of the ACA's insurance Marketplaces, especially in states that have expanded their Medicaid programs. The ACA was designed to ensure coverage continuity for US citizens and qualifying residents, with a pathway available to everyone—regardless of income or life circumstances.

In states that fully implement the ACA with expanded Medicaid programs, this vision will

**EXHIBIT 1**

**Estimated Percentages Of Adults In Selected States Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage**




**SOURCE** Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text). **NOTES** The sample contained adults ages 19–62 with family incomes of less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey ($N = 11,898$). A change in eligibility was based on a change in the family's monthly income as a percentage of poverty that moved the income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit.

**EXHIBIT 2**

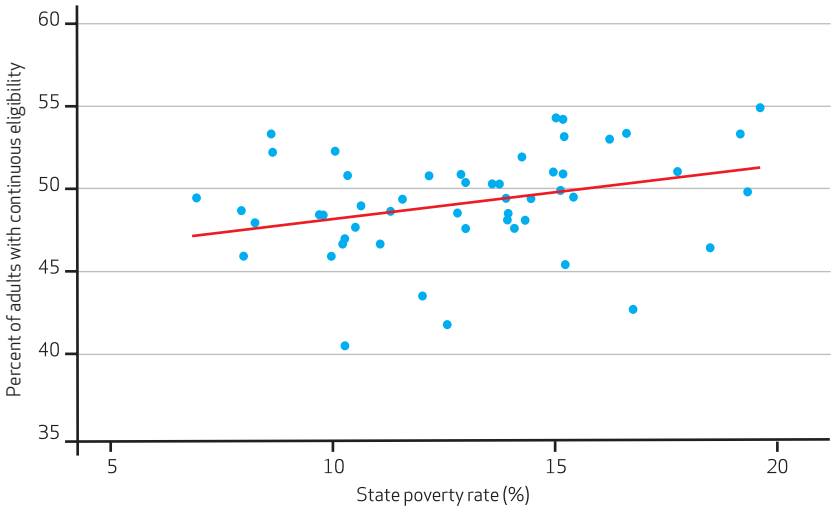
**Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage, By State Characteristic**

| State characteristic | Percentage of adults with continuous eligibility at: 0 months | 6 months | 12 months | *p* value[a] |
|---|---|---|---|---|
| **POVERTY RATE** | | | | |
| Low ($n = 16$) | 100.0 | 67.9 | 48.4 | 0.03 |
| Medium ($n = 19$) | 100.0 | 67.6 | 48.5 | 0.03 |
| High ($n = 16$) | 100.0 | 68.9 | 50.8 | Ref |
| **MEDICAID ELIGIBILITY CRITERIA BEFORE THE AFFORDABLE CARE ACT** | | | | |
| Most generous ($n = 17$) | 100.0 | 68.0 | 48.1 | 0.005 |
| Moderately generous ($n = 17$) | 100.0 | 67.2 | 48.4 | 0.01 |
| Least generous ($n = 17$) | 100.0 | 69.1 | 51.1 | Ref |

**SOURCE** Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text), using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state characteristics, of data from the 2009 Current Population Survey and of eligibility data from the Kaiser Family Foundation. **NOTES** The sample contained fifty-one state-level estimates (for the fifty states and the District of Columbia), based on an analysis of adults ages 19–62 with family incomes less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey ($N = 11,898$). A change in eligibility was based on a change in the family's monthly income as a percentage of poverty that moved the family's income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit. [a]*p* values for difference at twelve months were based on a *t* test comparing the twelve-month estimate across the groups as indicated.

**EXHIBIT 3**

**Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage At Twelve Months, By State Poverty Rate**




**SOURCE** Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state poverty rates, of data from the 2009 Current Population Survey. **NOTES** The red line shows the following regression equation: twelve-month continuous coverage = 45.4% + 0.29% × state poverty rate ($p = 0.04$). See Exhibit 2 Notes for additional information.

be realized. There, the challenges become how to ensure that eligibility translates into actual enrollment, and how to make transitions in coverage as smooth as possible. In states that do not expand Medicaid, these transitions will be starker and more painful.

Previous research[1,12] has demonstrated that millions of Americans will face circumstances that cause them to transition among coverage pathways during a year. Our study estimated how such churning might vary across states. Our results have three primary implications.

First and most important, transitioning among pathways to coverage has the potential to be a major issue in every state. Medicaid—and state health policy more generally—is typically characterized by differences across states in numerous domains.[11,15–17] However, we found that if all states were to expand Medicaid, most would experience relatively similar rates of changes in eligibility for Medicaid and premium subsidies over six or twelve months.

We estimated that approximately half (plus or minus 5 percentage points) of adults likely to be eligible for Medicaid or subsidized Marketplace coverage will experience an eligibility change within twelve months. Our estimated churning rates are slightly higher than those in one previous analysis of four large states.[5] However, our approach used more robust state-level weighting than the previous study and measured income based on the health insurance unit, instead of the family.

Second, although churning rates were likely to be high everywhere, we found some small differences in the rates across states. States with lower poverty rates and higher per capita incomes were likely to experience higher rates of churning between eligibility for Medicaid and eligibility for premium subsidies.

To see why this might be the case, consider two states, one with a poverty rate of 10 percent (and a relatively high median household income) and the other with a poverty rate of 15 percent (and a relatively low median household income). The richer state has a larger share of its population with incomes of 100–250 percent of poverty, while the poorer state has a larger share of its population with incomes of below 50 percent of poverty. The richer state has more people close enough to the eligibility cutoff that they are likely to transition between Medicaid and Marketplace coverage as their incomes rise. Fewer people in the poorer state will be able to raise their incomes above 138 percent of poverty.

Third, states with more-generous eligibility criteria for their Medicaid programs before the ACA also had higher churning rates. In part, this is a result of the fact that these states tended to

**Most adults who lose Marketplace subsidies in nonexpanding states will become uninsured.**

have lower poverty rates. But, in addition, states whose pre-ACA Medicaid enrollment included people at higher income levels were likely to have a larger population in Medicaid with incomes at or near the threshold of 138 percent of poverty. That increases the likelihood that many of them would transition between Medicaid and the Marketplace during a year. In contrast, in states without generous Medicaid eligibility, some of the people in this income group likely have employer-sponsored insurance instead of Medicaid, which makes them less likely to have Medicaid or Marketplace coverage in 2014.

It is important to recognize that the eligibility changes we have analyzed are the result of an effort to expand pathways to affordable coverage for all Americans. Churning has often been used to describe the negative outcome of moving into and out of insurance coverage and becoming uninsured. In contrast, we are discussing changes that are a by-product of a system that allows for transitions among insurance pathways. These transitions increase the risks of disrupting care continuity and of having short gaps in coverage. But they represent a different (and less problematic) form of churning than that between having Medicaid or Marketplace coverage and being uninsured.

However, when low-income adults in states that opt not to expand their Medicaid programs experience a loss of income that drops them below 100 percent of poverty, most will not be eligible for subsidized coverage in the Marketplace or for Medicaid. Most nonexpansion states restrict Medicaid eligibility for adults to pregnant women, certain low-income adults with disabilities, and parents of minor children with incomes of no more than 35 percent of poverty on average.[18] In other words, most adults who lose Marketplace subsidies in nonexpanding states will become uninsured, as has traditionally happened to adults who lose Medicaid eligibility.[19]

## Policy Implications

Our findings indicate that every state is likely to experience significant rates of eligibility changes over time. A number of policies have recently been proposed to mitigate the effects of churning between Medicaid and Marketplace coverage, and state policy makers should consider them in the light of our findings.[12]

One option is for states to adopt twelve-month continuous eligibility periods in Medicaid as a means of overcoming the churning effects of periodic income fluctuations. As noted above, CMS has offered states a fast-track option to adopt this approach, using Section 1115 waivers.[13] In addition, legislation that would enable states to choose such an option without a waiver is now pending in Congress.

A second, more incremental option offered in CMS's 2012 regulations allows states to assess people's ongoing eligibility for Medicaid using projected annual income instead of current monthly income. This option could reduce rates of eligibility changes, particularly for workers whose earnings vary seasonally.[20]

A third option for states is to use Medicaid funds to purchase coverage in qualified health plans in the Marketplace for people with incomes below 138 percent of poverty. This is similar to what Arkansas proposed in its waiver application, which was approved by CMS.[21] Previous estimates have suggested that such premium support could reduce churning by as much as two-thirds in those states whose pre-ACA eligibility standards were very restrictive.[22] In effect, people covered through premium support arrangements could maintain their enrollment in the same health plan regardless of the source of subsidy. However, people whose income rose above 138 percent of poverty would face monthly premiums and additional cost sharing that could lead some to drop coverage entirely. Thus, even a premium support model is unlikely to eliminate churning entirely.

A fourth approach is the Basic Health Program, an option under the ACA that enables states to combine their Medicaid expansions with Marketplace subsidies into a single program for individuals and families with incomes of up to 200 percent of poverty. This option has been estimated to reduce churning by 4–5 percentage points per year and to push the churning point to a higher income level, where employer-sponsored coverage is more likely to be an option.[5] However, the impact of the Basic Health Program on churning depends on the population affected and assumptions made about who will sign up for coverage.[5,12,23] In any case, the option will not be available until at least 2015: CMS has not yet issued regulations on

how the Basic Health Program will work.

A fifth option relates to how and when income changes are verified. Previous research has found that some Medicaid churning is the result of administrative errors or misunderstandings of the application process by beneficiaries when they attempt to reenroll.[24,25] This suggests that using state administrative data to verify eligibility might produce errors. Safeguards such as automatically continuing eligibility for an extra three months or until the next period of open enrollment for the Marketplace could help minimize inappropriate changes in coverage and reduce unnecessary reenrollments.[26] Similarly, integrating Marketplace and Medicaid eligibility determination could help eliminate the possibility of gaps in coverage associated with changes in eligibility. Unfortunately, many states using the federal Marketplace do not plan to allow it to determine people's eligibility for Medicaid, which will increase the risk of bureaucratic delays.

Finally, a state option that combines enrollment and marketing strategies is to encourage certified Medicaid managed care plans to enter state Marketplaces. In recent months it has become clear that a number of companies with historic roots in Medicaid managed care have decided to pursue such certification because they realize that their members will experience income fluctuations and thus might have disruptions in coverage and care. The use of multimarket plans could promote continuity of coverage. However, states will need to ensure that Medicaid managed care plans have adequate financial reserves before allowing them to sell coverage in the Marketplace.

The "bridge plan" option created by CMS in 2012 is essentially a partial version of the multimarket plan strategy.[27] It allows plans to operate in both markets under limited circumstances, such as covering only people who have experienced a change in eligibility in the previous year.

## Conclusion

Our findings add to a growing body of literature that documents the potential for changes in eligibility for health insurance coverage among low-income families under the ACA. In particular, our study demonstrates that if all fifty states and the District of Columbia were to expand Medicaid under the ACA, a substantial number of people in every state would experience income changes over the course of a year that would change their eligibility for Medicaid or the subsidized health plans sold in the Marketplaces.

**Eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues.**

We found that higher-income states might be particularly prone to churning between Medicaid and plans sold in the Marketplaces, but the differences between higher- and lower-income states were small. The implication is that eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues. Of course, the disruptions in care resulting from churning are even more serious in states that are not expanding Medicaid in 2014: Those states will have large gaps in eligibility for many low-income adults whose incomes will be too high for Medicaid but too low for tax credits.

Large government programs such as Social Security, Medicare, Medicaid, and the Children's Health Insurance Program typically do not start operating with all of their policies already perfectly tuned. The transition issues raised here will require attention in the coming years, and our key conclusion is that every state will need to address them.

Fortunately, during the past two years an increasing number of feasible policy options have emerged that could mitigate the effects of such changes in eligibility. State officials should consider using these options to reduce inefficient transitions that are a by-product of multiple pathways to insurance and fluctuating incomes. Reducing such churning will greatly increase the likelihood of stable coverage and improved quality of care under the Affordable Care Act. ■

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