Churning, eligibility determination, and exchanges under the ACA

Stan Dorn
Senior Fellow
Urban Institute
Washington, DC

19th Annual Princeton Conference
May 24, 2012
Part I

CHURNING—THE FORCED MOVEMENT OF CONSUMERS FROM HEALTH PLAN TO HEALTH PLAN WHEN CHANGING CIRCUMSTANCES MODIFY A CONSUMER’S ELIGIBILITY FOR HEALTH PROGRAMS
Total magnitude of churning

- 29.4 million people will change eligibility status from year to year
  - Equals 31 percent of all enrollees in insurance affordability programs

<table>
<thead>
<tr>
<th>People retaining eligibility, year to year</th>
<th>People gaining or losing eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/CHIP</td>
<td>68.8 million</td>
</tr>
<tr>
<td>HIX subsidies</td>
<td>8.2 million</td>
</tr>
</tbody>
</table>

Year-to-year churning under the ACA: millions of people changing eligibility status

Total churning: 29.4 million

- Medicaid/Exchange Subsidies/Ineligible: 6.9 million
- Medicaid/Ineligible: 19.5 million
- Exchange Subsidies/Ineligible: 3.0 million

Source: Buettgens, Nichols and Dorn 2012
Why does churning matter?

- Risk of becoming uninsured
- Disrupting continuity of care
- Decreased incentive for insurers to invest in their members’ long-term health
- Can require repayment of tax credits at year’s end
- Administrative costs
## Reducing churning’s magnitude

<table>
<thead>
<tr>
<th>Type of churning</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Medicaid and subsidies in the exchange</td>
<td>Use the Basic Health Program to offer Medicaid health plans up to 200 percent FPL – cuts churn by 16 percent</td>
</tr>
<tr>
<td></td>
<td>Encourage or require the same health plans to serve Medicaid and the exchange</td>
</tr>
<tr>
<td>Between Medicaid and ineligibility for all assistance</td>
<td>Implement premium assistance for some Medicaid beneficiaries</td>
</tr>
<tr>
<td>Between subsidies in the exchange and ineligibility</td>
<td>Encourage or require the same plans to serve multiple markets, inside and outside the exchange, for individuals and small firms</td>
</tr>
<tr>
<td>for all assistance</td>
<td></td>
</tr>
</tbody>
</table>
# Reducing churning’s harm

<table>
<thead>
<tr>
<th>Type of harm</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential loss of coverage</td>
<td>Reduce the amount of paperwork consumers must complete to retain coverage during eligibility transitions</td>
</tr>
<tr>
<td></td>
<td>Make coverage on both ends of the transition affordable and appealing</td>
</tr>
<tr>
<td></td>
<td>Provide intensive consumer assistance to help people navigate transitions</td>
</tr>
<tr>
<td>Interrupting clinical continuity of care</td>
<td>Implement policies that preserve continuity of care when people are forced to change health plans</td>
</tr>
<tr>
<td>Plan incentives to invest in members’ health</td>
<td>Provide access to the same carriers in multiple markets</td>
</tr>
<tr>
<td>Repaying tax credits at year’s end</td>
<td>Much longer discussion required</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>??</td>
</tr>
</tbody>
</table>
Part II

ELIGIBILITY
The ACA’s vision of eligibility determination

- No wrong door
  - Can apply at any program
  - Can apply through any modality
    - Web, phone, mail, in-person

- Multiple programs are served by—
  - One common application form
  - One common eligibility determination process

- Whenever possible, use data matches to verify eligibility rather than ask consumers to provide documents

- Simultaneously achieve multiple goals
  - Simple and streamlined enrollment increases participation by eligible consumers
  - Integrated, data-driven eligibility determination lowers administrative costs
  - Using data matches to verify eligibility reduces errors
Much of the vision is being realized

• No wrong door
  ❖ Can apply at any program
  ❖ Can apply through any modality (web, phone, mail, in-person)
• Multiple programs are served by one common application form
• Whenever possible, use data matches to verify eligibility rather than ask consumers to provide documents
• But what’s missing?
Who might not like a common eligibility process?

• Some states may not want a federally-facilitated exchange to qualify people for Medicaid and CHIP

• Some public employee unions may not want a non-profit corporation or quasi-public entity that runs an exchange to determine Medicaid eligibility
The likely result: an option for bifurcated eligibility determination

- Unitary options
  - Medicaid determines eligibility for all programs
  - If someone applies to the HIX, the HIX determines eligibility for all programs
- The option for bifurcated eligibility determination
  - If someone applies to the HIX, the HIX “assesses” Medicaid and CHIP eligibility. When an applicant appears eligible for Medicaid or CHIP, the HIX sends the application to the state for further processing.
- Risks of bifurcated eligibility determination
  - Eligible consumers do not receive coverage
  - Administrative costs rise
Solutions

• State solutions
  ❖ Behind the scenes, Medicaid determines eligibility for all programs
    ○ Already done in Massachusetts
  ❖ Under a Medicaid/CHIP/HIX interagency agreement, one system performs automated eligibility functions for all applications and all programs

• Federal solution: “guardrails” to prevent bifurcated eligibility determination from increasing consumer burdens and reducing coverage
  ❖ Final rules contain important safeguards
  ❖ More could be added, including:
    ○ HIXes apply Medicaid policies and procedures in assessing Medicaid eligibility
    ○ Bifurcated eligibility may not increase consumer burdens or delay application processing
    ○ CMS operational review precedes implementation of bifurcated system
    ○ Eligibility is determined in real time whenever it can be established by attestations and data matches
    ○ Interagency agreements and verification plans are publicly available
    ○ Within each state, a single, shared eligibility service performs automated functions for all applications and all programs