Making Health Coverage Meaningful: Mitigating the Effects of Churn

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I. Background

Churn is the word commonly used to describe the movement of people between public and private health insurance and between insured and uninsured status due to fluctuations in income and household size. Churn deserves considerable attention because of the potential adverse personal, administrative and financial impacts of frequent movement in and out of coverage. These impacts extend to individuals, families, health providers, insurance carriers and government health insurance programs.

While the Affordable Care Act (ACA) has made it possible for most people to enroll in health insurance, the potential for gaps in coverage remains significant. Estimates are that as many as fifty percent of adults below 200 percent of the Federal Poverty Level (FPL) will move between Medicaid and eligibility for subsidized private insurance through an Exchange at least once over the course of a year. Certain populations are more vulnerable to churn. For example, Colorado's relatively high percentage of seasonal and self-employed workers are more likely to experience fluctuations in income over the course of a year, which may lead to changes in eligibility for insurance programs.[i]

Many individuals who lose Medicaid will qualify for Advanced Premium Tax Credits (APTCs), through Colorado's insurance marketplace, Connect for Health Colorado (C4HCO). APTCs are available to people with incomes under 400 percent of FPL and are designed to make private health insurance more affordable by offsetting the cost of premiums. However, while APTCs make it possible for people losing Medicaid to afford health insurance, transitions between Medicaid and tax credit eligibility present significant challenges. These challenges include finding and applying for new sources of coverage, navigating potential disruptions in care, managing changes in cost sharing obligations and overcoming administrative barriers to the application process. Additionally, gaps in coverage resulting from churn can lead to poorer health outcomes and increase costs for individuals and the health care system. Studies have found that "even brief interruptions in Medicaid coverage can lead to significant increases in hospitalizations for chronic diseases like diabetes, asthma and mental disorders."[ii]. While Colorado has taken significant steps to minimize the effects of churn, there is much more to do.

This brief examines steps that Colorado has taken thus far and makes recommendations for further action.

II. Churn: Progress and Opportunity

Continuous Eligibility in Colorado: In 2009, Congress passed CHIPRA, the Children's Health Insurance Program Reauthorization Act, which gave states the opportunity to adopt continuous eligibility for children enrolled in Medicaid and CHP+. Rather than assessing eligibility on a monthly basis, continuous eligibility keeps children enrolled in Medicaid and CHP+ for a twelve-month period despite changes in household size or family income. The most significant step Colorado has taken to mitigate churn has been to adopt continuous eligibility for children on March 1, 2014. The Colorado Department of Health Care Policy and Financing (HCPF) expects more than 535,000 children will benefit from this change.

Colorado also has taken steps to explore whether the state might adopt continuous eligibility for adults. HCPF began putting together a cost estimate in 2013, but no data has been released thus far. In order to implement continuous eligibility for adults, Colorado would have to apply to the federal government for an 1115 Medicaid Demonstration Waiver.[iii] The state would not be eligible under the terms of such a waiver for additional federal funding to offset any increased costs resulting from continuous eligibility; therefore an estimate of potential Medicaid savings from avoiding the increased health care costs and the administrative burden of churn is critical. Overall, the data suggest that the monthly cost of continuous eligibility would be substantially less than the monthly cost of discontinuous Medicaid coverage because people tend to need higher cost care when they cycle back on to Medicaid following a gap in coverage.[iv] Continuous eligibility for adults also should have a positive effect on the cost of private insurance because it would reduce the need for services due to pent up demand accumulated during gaps in coverage, as well as avoid cost shifting resulting from hospitalizations for the temporarily uninsured.

Congressional Action on Continuous Eligibility Legislation introduced in Congress would make continuous eligibility mandatory for states. HR 1698 *Stabilize Medicaid and CHIP Coverage Act* and S 1980 *Medicaid and CHIP Continuous Quality Act of 2014* would require states to implement continuous eligibility for all Medicaid enrollees. HR 1698 enjoys bipartisan support, including support from members of Colorado's congressional delegation. Neither bill is expected to move forward anytime in the near future.

HCPF proposals regarding churn: In its Budget Briefing on January 7th 2013, HCPF reported that it was preparing to minimize the impacts of churn by guiding consumers through unavoidable changes in coverage by conducting outreach and providing well-trained eligibility site staff, consumer-friendly websites, upgrades and enhancements to its application and eligibility determination processes, and a state-of-the-art call center.[v]

During the summer of 2013, HCPF and Connect for Health Colorado (C4HCO) convened several stakeholder meetings to discuss churn mitigation strategies. As part of that conversation, HCPF said it would like to reduce churn through: (1) eligibility policies, (2) working with providers and plans to ensure continuity of care through carriers, essential community providers, and other providers, and (3) Medicaid benefit design options. That stakeholder conversation continued through the summer of 2013 and has not yet resumed.

III. Recommendations for Further Action

A. Continuous Medicaid Eligibility: Colorado has implemented continuous eligibility for children in Medicaid and CHP+, but not for Medicaid adults.

***Recommendations*:** Colorado should complete the analysis of the fiscal impact of implementing continuous eligibility for Medicaid adults so that policy makers and others may engage in an informed discussion about this option to mitigate the impact of churn. In addition, Colorado policy makers should support congressional efforts to implement continuous eligibility in Medicaid/CHIP

B. Annualize the Medicaid Income Calculation: Seasonal, self-employed, agricultural workers and others can experience significant changes in income from month to month. States have the option to use projected annual income in calculating Medicaid eligibility[vi]. Projected annual income would bring Medicaid eligibility determination more in line with income determination for APTCs and make it less likely that people would move in and out of Medicaid eligibility. This change also would reduce the substantial confusion that exists among many Medicaid applicants about how to report their income accurately, as well as avoid the administrative burden on applicants and state agencies resulting from frequent changes in eligibility determinations based on monthly income calculations.

Recommendation: Colorado should adopt annual projected income in determining Medicaid eligibility.

C. Emphasize training and information about changes in coverage: People terminated from Medicaid must move quickly to enroll in coverage through C4HCO in order to avoid a gap in coverage. The law requires that the effective coverage date for people who enroll in new coverage prior to losing Medicaid eligibility is the first day of the month following the month in which they lose coverage, regardless of when in the month they apply.[vii] Colorado has adopted the practice, approved by the federal Centers for Medicare and Medicaid Services, of terminating people from coverage the last day of the month in which they lose Medicaid eligibility. Therefore, if people losing Medicaid enroll in a plan through C4HCO by the last day of the month in which they lose Medicaid, they should have seamless coverage. For example, if John gets a notice on May 16 that he will lose Medicaid coverage as of May 31 and enrolls in private coverage through C4HCO by May 31, he will have coverage effective June 1. The key issue is whether people know and understand that they can take steps to avoid a gap in coverage and that they are highly likely to be eligible for tax credits through C4HCO if they lose Medicaid and do not have an offer of qualifying coverage from an employer.

Recommendations: (1) Examine whether Colorado is doing all it can to maximize the opportunity for seamless coverage including making efforts to inform clients of the importance of enrolling in coverage by the last day of the month in which they lose coverage. (2) Educate community-based organizations and other assistance organizations about the availability of seamless coverage. As an example, the Medicaid Notice of Action terminating benefits includes an information section about C4HCO. It does not, however, include information about the availability of seamless coverage if the individual terminated from Medicaid enrolls in a private

plan through C4HCO before the end of the month in which they are losing coverage. In addition, C4HCO receives electronic information about people being terminated from Medicaid. C4HCO ought to add information about the availability of seamless coverage to their outreach materials as they make contact with those individuals and families.

D. Promote continuity of care: ACA and Transitions of Care:

Essential Community Providers (ECP)s: Among the biggest challenges facing people losing coverage is continuity of care. Because many providers in Colorado, particularly specialists, do not accept Medicaid, transitions in coverage can mean having to change providers. This can be a source of significant disruption, particularly for people in the middle of treatment for a chronic or serious disease or illness. The ACA requires insurance carriers offering plans in C4HCO to contract with ECPs where available. The majority of ECPs in Colorado are primary care providers, many of them Federally Qualified Health Centers and Rural Health Centers. These clinics provide care for a large number of Medicaid clients and are generally willing to see them whether they are in Medicaid or privately insured.

Recommendation: Colorado should facilitate the participation of ECPs in health plans offered through C4HCO in order to assure continuity of care, particularly in primary care settings.

Federal Requirements for transitions in care: Federal Regulations require that a health plan providing Essential Health Benefits (EHB) must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.[viii] The preamble to the interim final rule on this topic included expansive language about the desirability and appropriateness of transition strategies that encompassed access to prescription drugs as well as medical care, saying: "We also strongly encourage issuers to take other approaches to ease the transition to QHPs for consumers who may be switching from other coverage. Two areas of focus for a smooth transition are access to providers and prescription drug coverage… We also encourage issuers to adopt policies in January [2014] to prevent disruptions in treatment of episodes of care (for example, considering a provider as in the plan's network for an acute episode of care at the start of the plan year). Some states like Arkansas have adopted policies like this."[ix]

As an example of a meaningful strategy for transiting medical care, Delaware has included a provision in its QHP Standards for Plan Year 2015 requiring QHP's to have a "transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs."[x] Delaware requires the Continuity of Care Transition Plan to include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In addition, the transition plan must address treatment of a medical condition or diagnosis that is in progress or for which a preauthorization for treatment has been issued.

***Recommendation*:** Colorado ought to investigate requiring robust transition standards as part of the QHP certification process. We ought to ensure that primary care ECP's continue to play a core role in ensuring smooth transitions in care. In addition, Colorado Medicaid's Accountable Care Collaborative (ACC) program depends on care coordination provided by Regional Care Collaborative Organizations (RCCOs). RCCOs should assist in facilitating seamless transitions for people who move back and forth between Medicaid and private coverage.

E. Provider Look-up: It would be very helpful for people selecting a commercial health plan to be able to find out not only whether their provider participates in the plan, but also whether that provider participates in Medicaid and/or CHP+. This information will help families with members on multiple forms of coverage make informed decisions that will improve continuity of care.

Recommendation: C4HCO should include information about Medicaid/CHP+ participation in the provider look up function and provide an explanation of why that information might be helpful for families that expect fluctuations in income or household size.

F. Managed Care: Health Plan Information: Some families and individuals might benefit from continuity of enrollment in a single plan as they transition from Medicaid/CHP+ to the private marketplace and back. Although only about 5 percent of Medicaid participants are in managed care, the majority of CHP+ enrollees are enrolled in managed care. Those plans that serve CHP+ also offer coverage through C4HCO.

Recommendation: Information about managed care plan participation should be available to families on a specific section on the C4HCO website that might be entitled: *Of interest to families who have participated in Medicaid or CHP+.*

G. Excellent customer service: Medicaid clients need to be able to reach county workers, state staff and contractors for assistance in understanding their options upon enrollment or termination. People calling the HCPF customer service center often experience very long wait times or are unable to get through to customer service at all.

Recommendation: Medicaid customer service and county offices should be adequately staffed so that applicants and clients can reach someone who can assist them within a reasonable amount of time. Reasonableness standards should be established, supported and monitored.

H. Formerly Incarcerated Populations: Churn has a different meaning for people who are incarcerated or who move in and out of incarcerated status. People who are incarcerated cannot receive services through the Medicaid program, and may not apply for tax credit eligibility unless they are "pending disposition". Between 9,000 and 10,000 people move out of the Colorado Department of Corrections each year and many more Coloradans are sentenced to county jail terms. Approximately three-quarters of those in custody are estimated to be Medicaid eligible and most others are likely tax credit eligible. There is a great deal of discussion underway in Colorado about how to help these individuals so that they understand the opportunity to enroll in coverage. One example of a strategy to encourage people to participate in coverage was SB08-006, which required the suspension, rather than the termination, of Medicaid benefits upon incarceration. Passed in 2008, the bill has not yet been implemented. Other examples of enrollment and coverage strategies include placing a kiosk in the county justice center to assist with enrollment. Jefferson County has done this. Denver County is embarking on a project where trained staff, both on site in the jail and in the jail visitor waiting room, will be available to help those who are incarcerated, their families, and other visitors to enroll in coverage. Seamless enrollment upon release means that the criminal justice population, which has a high prevalence of mental health and substance abuse treatment needs and higher rates of certain chronic diseases, will be more likely to get the care and treatment they need.

Recommendations: (1) Implement the Colorado law, passed in 2008 (SB08-006), requiring the suspension of Medicaid eligibility during periods when Medicaid enrollees are confined. (2) Support outreach to the criminal justice population as much as possible by training coverage guides and eligibility workers about the special circumstances and needs of people in the criminal justice system.

IV. Data Needs

Good policy depends in substantial part on good data. Therefore we recommend that Colorado track and report regularly on the following:

- The percentage of people losing Medicaid that enroll in insurance through C4HCO, and of those, the percentage receiving tax credits.
- The number of people who transition between Medicaid/APTC/Medicaid during the course of a year.
- The percentage of Medicaid enrollees who re-enroll in Medicaid upon annual redetermination of eligibility.
- For those applicants who are not re-enrolled in Medicaid, the reasons for denial.
- Disaggregated data, including data on race, ethnicity, geographic location and age, in order that community-based organizations, advocates and others can track the movement of specific populations between Medicaid and APTC.
- The number of people released annually from prison that are enrolled in Medicaid or APTC.
- The number of people losing Medicaid who become enrolled in C4HCO the first day of the month following loss of coverage.

V. Additional Options

While not discussed in this brief, other states have explored additional avenues to mitigate the effects of churn. The Basic Health Program (BHP), Medicaid premium assistance, and bridge plans are several options that other states have considered or implemented. It is unlikely, however, that these options would be appropriate for Colorado. Colorado, for instance, has low participation in Medicaid managed care; therefore, solutions that smooth transitions between private market and Medicaid managed care are not generally applicable to Colorado.

VI. Conclusion

Colorado has had extraordinary success in enrolling the uninsured in coverage. Mitigating churn will make those coverage gains more meaningful, help to improve health outcomes, improve family economic security and reduce overall health care costs. Colorado should continue to explore strategies to mitigate churn and adopt the recommendations outlined in this brief.

This issue brief was prepared by the Colorado Center on Law and Policy and Colorado Consumer Health Initiative. If you have questions, please contact CCLP at (303) 573-5669 x 302 or CCHI at (303) 839-1261.

Colorado Center on Law and Policy is a nonprofit, nonpartisan research and advocacy organization seeking justice and economic security for all Coloradans.

Colorado Consumer Health Initiative is a nonprofit advocacy organization seeking equitable access to high quality, affordable health care for all Coloradans.

Endnotes

[i] *Overview of Coloradans' Health Care Coverage, Access and Utilization*, Colorado Trust, November 2011. http://www.coloradotrust.org/attachments/0001/6590/IssueBrief_Overview_FINAL_11_9_11.pdf

[ii] See Ku et al, *The Continuity of Medicaid Coverage: An Update; April 19, 2013 http://www.communityplans.net/portals/0/coverageyoucancounton/Continuity_of_Medicaid_Coverage_Update_4-2013.pdf*

[iii] CMS Dear State Medicaid Director Letter of May 17, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf

[iv] See Ku et al, *The Continuity of Medicaid Coverage: An Update.*

[v] HCPF Joint Budget Committee Hearing, January 7th, 2013, p 37. https://www.colorado.gov/pacific/sites/default/files/Hearing%20Responses.pdf

[vi] 42 CFR §435.603

[vii] 45 CFR 155.420(b)(2)(ii);

[viii] 45 C.F.R. §156.122(c)

[ix] *See* 78FR at 76215, 12/17/13

[x] *Delaware State-Specific Qualified Health Plan (QHP) Standards for Plan Year 2015*. Delaware Department of Insurance, May 2014. http://www.delawareinsurance.gov/health-reform/DE-QHP-Standards-PY2015-May2014-v1.pdf