“Churning” Within Health Insurance Plans: Issues and Policy Solutions

Authors
Ronald Deprez, PhD, MPH (lead)
Carry Buterbaugh, PhD
Hank Stabler, MPH

Center for Community and Public Health
University of New England
716 Stevens Avenue
Portland, Maine 04103
T (207) 221-4563, F (207) 523-1914
rdeprez@une.edu
cbuterbaugh@une.edu
hstabler@une.edu

(Word count: 1499 not including references)

Introduction

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (2010), are expected to increase the number of Americans with health insurance coverage— for both public and private insurance plans. Without revisions to current policies for eligibility and renewal, many enrollees experiencing changes in income or personal circumstances (e.g., change of address, change in employment), will be subject to dis-enrollment and re-enrollment in the same or another program, a process known as “churning.”

Churning is costly for federal and state budgets and creates conditions for redundant costs for public and private insurers, threatening sustainability and efficacy of programs dependent upon public funding, such as Medicaid. Churning results in disruptions in coverage that broaden and deepens risks for negative health outcomes for the uninsured that, unable to pay for care, delay seeking needed treatment

This commentary examines churn to identify policies that can effectively reduce churn levels in state and federal insurance programs offered under insurance exchanges.

Discussion

Churning In State Programs

Churning is a problem in state Medicaid and State CHIP (SCHIP) programs. In Rhode Island, for example, the Medicaid agency found that 25% of all enrollees had a gap in Medicaid coverage over a 12-month period. About 60% of those that dropped off returned within a year (1). Washington State Medicaid found that over a 3-month period in 2004, 36% of children whose coverage was terminated were subsequently re-enrolled (ibid). Oregon found that 15% of the Medicaid population was dis-enrolled and subsequently re-enrolled in their 2003 Medicaid expansion that was designed to increase enrollment of non-elderly adults (2).

A 2006 nationwide study indicated that 1/3rd of all uninsured children had either been on Medicaid or SCHIP the previous year but had lost their coverage. Had no drop-off occurred, the number of uninsured American children in a given year would have fallen by a third (3).

Vermont found widespread churning within the Vermont Green Mountain Care. Implementation of Catamount Health in Vermont - a state subsidized insurance program – resulted in approximately 10,000 beneficiaries at any one time. However, after adjusting for individuals in and out of the program over the 2-year period, the total was closer to the number estimated for the entire eligible program population –approximately 18,000 (4).

Adults appear to be at much higher risk than children for dis-enrolling and becoming uninsured even through public insurance (5). Low-income adults are particularly susceptible to changes in coverage, and gaps in coverage are common. Race and ethnicity also appear to be correlated with unstable coverage (ibid).

What Drives Churn

Drivers for churning are multi-determined, reflecting the complexity inherent in the organization of public and private health insurance plans that invariably cause gaps in coverage and frequent transitions between sources of coverage. People can change their source of coverage with change in job status, i.e. becoming unemployed, working more or fewer hours, or transitioning to a new job. However, many conditions related to instability in coverage can be modified through revised policies.

74

75 A significant amount of churning is due to the inability to maintain enrollees for extended time
76 periods. This is especially true in the renewal process when enrollees;

77 - are unaware of the need to renew their coverage;
78 - encounter barriers to re-enrolling due to complicated and/or onerous renewal procedures; or
79 - do not have the time or resources (e.g. cannot take time off work, lack transportation) to
80 collect required documentation for renewal (6).

81 Churning may occur when people are unable to pay monthly insurance premiums*, even when
82 publicly subsidized. Many eligible recipients lack stable income, making contributions impossible at
83 times. Those who dis-enroll due to the cost of premiums, may drop for other factors as well, for
84 example, the cumbersome process used to pay premiums every month (1).

85

86 *Churn impacts population health*

87 There is evidence to indicate that loss of insurance whether through lost eligibility or drop out, is
88 detrimental to one's health, even in the case of temporary disruption. When controlling for
89 confounding factors, non-elderly adult Medicaid enrollees who lose coverage have been found to be
90 more likely to use the emergency room (8), less likely to use ambulatory care (9), more likely to
91 have higher costs associated with their care (10), more likely to have worse health outcomes (11);
92 and have eligible children who are also likely to be uninsured and at risk for the aforementioned
93 health and cost concerns (ibid).

94

95 *Churn impacts administrative costs of coverage*

96 Churning within public programs has cost consequences for administrators, health plans, and
97 providers, including unnecessary staff and system costs associated with:

98 - Enrolling, dis-enrolling, and re-enrolling beneficiaries, duplication of paperwork, system
99 updates, mailings and contact efforts;
100 - Delivering "new member" services for each re-enrollment;
101 - Researching/reconciling complicated and problematic billing when enrollees transition;
102 - Verifying enrollment status and counseling consumers regarding status;

* A 2008 study of the Massachusetts health exchange, Commonwealth Care, showed new enrollees and those already enrolled were highly sensitive to price: a $10 increase in premiums led to an 8-16% expected relative reduction in the probability of enrolling/re-enrolling in any given plan (7).

- Staff time to track and assist intermittently insured individuals participating in disease management programs; and,
- Cost-shifting and depleted resources when payments are not available to reimburse safety-net providers (1).

State Responses to Churn

Eligibility and Enrollment Systems-State Innovations

Automatic enrollment/re-enrollment policies can simplify the application process by limiting the enrollee involvement in renewal when required data is already available (1). Automatic enrollment increases enrollment of eligible individuals and reduces the frequency of renewals while lowering administrative costs (12). Polices that permit longer times before re-enrollment, for example 12 months instead of 6, can significantly impact churning (13).

Medicaid/ SCHIP enrollment and renewal policies in Louisiana and Wisconsin

In Louisiana, eligible children can now be reenrolled through:

Ex parte renewal accounts for 33% of Medicaid and LaCHIP renewals and obtains enrollee information from Food Stamp case information, state tax information or a private employment and income verification service;

Administrative renewal accounts for 44% of Medicaid and 4% of LaCHIP renewals and entails sending a letter to families meeting certain criteria requesting to report changes in income or household composition;

*Telephone renewa*l accounts for 15% of Medicaid and 37% of LaCHIP renewals and involves enrollment staff calling or receiving calls from enrollees, during which eligibility is reviewed; and,

Web-based renewal accounts for 4% of LaCHIP renewals (14).

These policies have resulted in increased participation, higher rates of insurance coverage for children, and administrative savings. In one-year administrative savings of 1 million dollars for enrollment costs and between $8.0 to $12.0 million for renewal costs were reported (15). Yet Louisiana's Medicaid Payment Error Rate Measurement (PERM) is only 1.54%, which is 25% of the national average (ibid).

Wisconsin's BadgerCare Plus, a Medicaid program for children, parents, and pregnant women, enrolls families rather than individuals. This has enabled it to provide near-universal coverage for

135 children and greater coverage for parents and childless adults. The enrollment process uses a
136 centralized and paperless application system and is fully integrated with an online tool, ACCESS,
137 which allows individuals and families to determine their eligibility for public programs, apply for
138 benefits, and check their application status. State residents are able to apply for health coverage
139 electronically, and the system simultaneously verifies the applicant's income and lack of access to
140 employer coverage (16). Initial assessments indicate BadgerCare Plus has reduced state churn rates
141 and improved continuity of coverage for enrollees (17).
142
143 **PPACA and Churn**
144 A number of federal provisions in the PPACA will impact churn—the most significant is the
145 individual mandate requiring individuals to obtain insurance. State rules for Medicaid eligibility will
146 become more standardized under the PPACA. These rules include: 1) use of the Modified Adjusted
147 Gross Income (MAGI) standard for Medicaid eligibility; 2) eliminating any sort of asset test; and 3)
148 simplification of enrollment procedures within Medicaid. (18). For example, a single application
149 form can be used for all three needs-based health insurance programs - Medicaid, CHIP, and
150 subsidies in the Exchanges is currently being developed (19). To be efficient, it will require data-
151 matching systems, allowing all health agencies to exchange information from application forms to
152 determine appropriate eligibility for Medicaid, the Exchanges, or other forms of subsidized
153 insurance (ibid). In addition, with PPACA funding of exchange navigators, states will be given a
154 resource for providing support to enrollees in need of transitioning from Medicaid to the Exchange.
155 and vice versa.
156
157 **Bottom Line**
158 Without revisions to current policies for eligibility and renewal, many enrollees under insurances
159 exchanges will be subject to dis-enrollment and re-enrollment in the same or another program.
160 Several policies outlined above have been shown to reduce churn, including enrolling recipients
161 using presumptive eligibility standards; allowing continuous (12 month) enrollment for newly
162 eligible regardless of income changes; streamlining the renewal process; using exchange navigators;
163 and taking advantage of policy changes permitted under PPACA. Churning is likely to be reduced
164 with these types of policies in effect uniformly across the states, which in turn should reduce system
165 costs.

166 References

1. Summer L and Mann C. Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies. The Commonwealth Fund, 2006 June; 27.

2. Carlson MJ, DeVoe J, Wright BJ. Short-term impacts of coverage loss in a Medicaid population: early results from a prospective cohort study of the Oregon Health Plan. Ann Fam Med. 2006 Sept.; 4 (5): 391–8.

3. Sommers, B. Why Millions Of Children Eligible For Medicaid And SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up. Health Affairs. 2007 July; 26 (5): 560-567.

4. Deprez, Ronald, et al. Achieving Universal Coverage Through Comprehensive Health Reform: The Vermont Experience. Portland (ME): CHPPR, UNE; 2010 Aug. 98 p. Prepared for the Robert Wood Johnson Foundation.

5. Sommers, B. Loss of Health Insurance Among Non-elderly Adults in Medicaid. J Gen Intern Med. 2008 Jan.; 24 (1): 1–7.

6. Hill I. and Lutzy A. W. Is There a Hole in the Bucket? Understanding SCHIP Retention. The Urban Institute. 2003 May; Occasional Paper (67): 1-23.

7. Chan, D and Gruber, J. How Sensitive are Low Income Families to Health Plan Prices? American Economic Review. 2010 May; 100 (2): 292–96.

8. Lowe R, McConnell K, et al. The impact of Medicaid cutbacks on emergency department use: the Oregon experience. Annals of Emergency Medicine. 2008 Dec. 52 (6): 1-7.

9. Carlson MJ, DeVoe J, Wright BJ. Short-term impacts of coverage loss in a Medicaid population: early results from a prospective cohort study of the Oregon Health Plan. Annals of Family Medicine. 2006 Sept.; 4(5): 391–8.

10. Rimsza ME, Butler RJ, Johnson WG. Impact of Medicaid disenrollment on health care use and cost. Pediatrics. 2007; 119 (5): 1026–32.

11. Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons, and consequences. Ann Intern Med. 1991; 114 (4): 325–31.

12. Dorn, S. Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals. Academy Health State Coverage Initiatives. Robert Wood Johnson Foundation, 2007 August [Cited August 10, 2010]. Available from: http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf.

210 13. Fairbrother, G, Park Emerson H, Partridge L. How Stable Is Medicaid Coverage For
211 Children? Health Affairs. 2007; 26 (2): 520-528.
212
213 14. Edwards J, et al. Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of
214 Enrollment and Retention in Eight States. Robert Wood Johnson Foundation. 2010 Feb. [Cited
215 October 23, 2012]. Available from:
216 http://www.maxenroll.org/files/maxenroll/file/Synthesis%20-%20FINAL%20-
217 %20for%20posting%20(2).pdf.
218
219 15. Dorn, S, Hill I, Adams F. Louisiana Breaks Ground: The Nation's First use of Automatic
220 Enrollment Through Express Lane Eligibility. State Health Access Data Assistance Center. The
221 Urban Institute. 2012 Aug. [Cited October 23, 2012]. Available from:
222 http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf400618.
223
224 16. "Wisconsin's BadgerCare Plus Program: Moving Forward on Health Reform Amid a
225 Recession." Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA: THE
226 HENRY J. KAISER FAMILY FOUNDATION. Available at
227 http://www.kff.org/medicaid/upload/8078.pdf. Accessed August 10, 2010.
228
229 17. Hynes, Emma and Thomas R. Oliver, "Wisconsin's BadgerCare Plus Health Coverage
230 Program: A Qualitative Evaluation". University of Wisconsin. October 2010.
231
232 18. Bernstein, William, Patricia Boozing, Paul Campbell, et al (California HealthCare
233 Foundation). Implementing National Health Reform in California: Changes to Public and Private
234 Insurance. June 2010.
235
236 19. Dorn, S. State Implementation of National Health Reform: Harnessing Federal Resources to
237 Meet State Policy Goals. Academy Health State Coverage Initiatives. Robert Wood Johnson
238 Foundation, 2010 [Cited August]. Available from:
239 http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Final_updated_8.5.10.pdf.