THE URBAN INSTITUTE

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

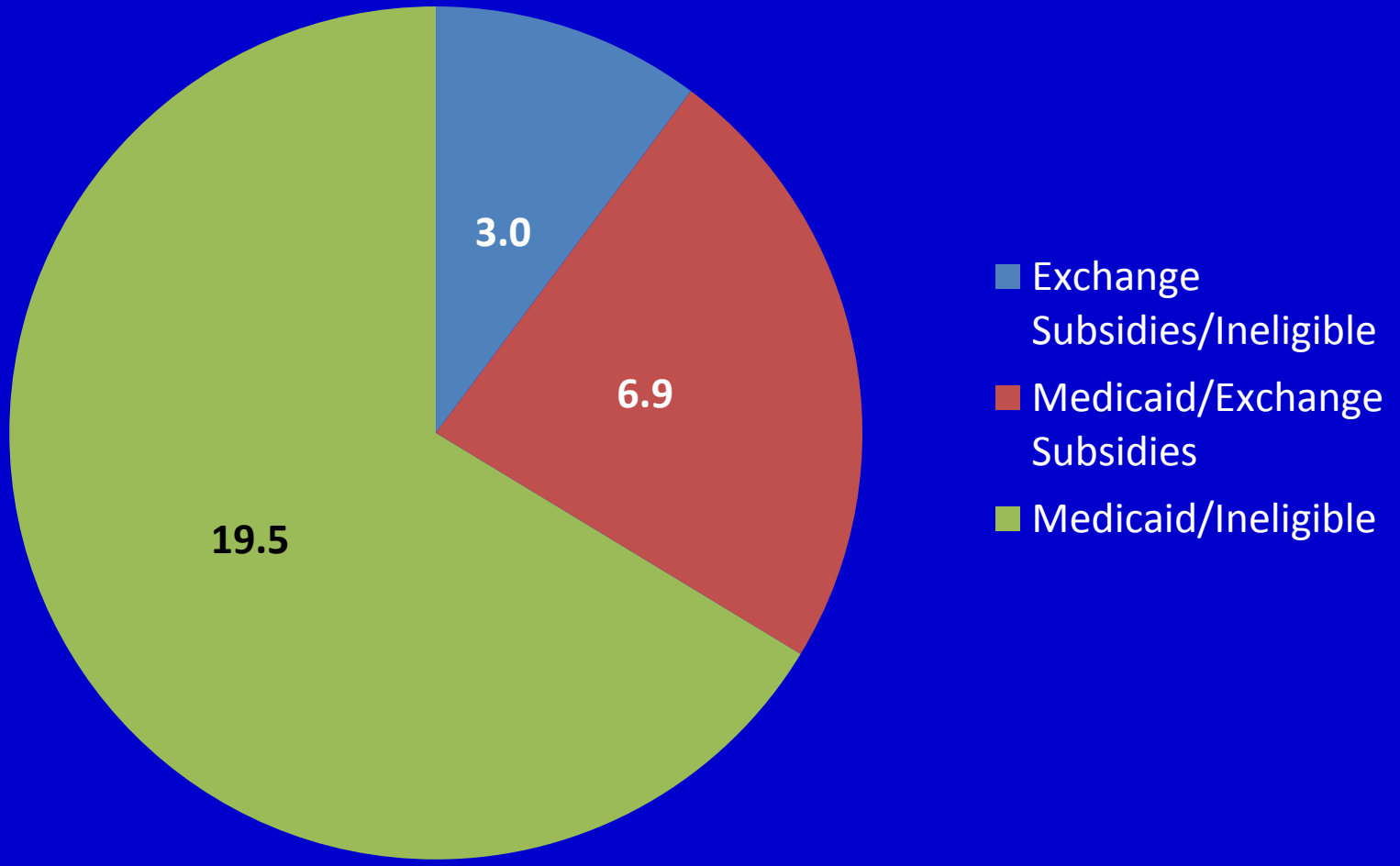
- 29.4 million people will change eligibility status from year to year
  - Equals 31 percent of all enrollees in insurance affordability programs

	People retaining eligibility, year to year	People gaining or losing eligibility
Medicaid/ CHIP	68.8 million	26.4 million
HIX subsidies	8.2 million	9.9 million

Source: Buettgens, Nichols and Dorn. *Churning Under the ACA and State Policy Options for Mitigation*. 2012.

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

Total churning: 29.4 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

Type of churning	Strategies
Between Medicaid and subsidies in the exchange	Use the Basic Health Program to offer Medicaid health plans up to 200 percent FPL – cuts churn by 16 percent
	Encourage or require the same health plans to serve Medicaid and the exchange
Between Medicaid and ineligibility for all assistance	Implement premium assistance for some Medicaid beneficiaries
Between subsidies in the exchange and ineligibility for all assistance	Encourage or require the same plans to serve multiple markets, inside and outside the exchange, for individuals and small firms

Reducing churning's harm

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

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
    - Biforcated 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