Churning Under the ACA and State Policy Options for Mitigation

Timely Analysis of Immediate Health Policy Issues

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Summary

Many state and federal officials implementing the Patient Protection and Affordable Care Act (ACA) are concerned about "churning," the involuntary movement of consumers from one health plan or system of coverage to another. Churning makes programs more complicated and costly to administer and interrupts continuity of coverage and care.

Earlier estimates of churning examined the effects of income fluctuations. This paper is the first that also takes into account affordable offers of employer-sponsored insurance (ESI), which disqualify consumers from all insurance affordability programs except Medicaid and the Children's Health Insurance Program (CHIP). This is an important analytic advance, since, at income levels where ESI offers affect subsidy eligibility—namely, between 138 and 400 percent of the federal poverty level (FPL)—ESI is now offered to 32 percent of the uninsured and 54 percent of people with individual coverage, according to national survey data.

Churning already occurs in Medicaid and CHIP, but the ACA's Medicaid expansion and subsidized coverage in health benefit exchanges will expand its scope. To estimate the extent and nature of that expansion, we analyze longitudinal data from the Survey of Income and Program Participation, coupled with statistical matches to national survey data showing the characteristics of people offered ESI. We conclude that, unless measures are taken to reduce churning under the ACA, 29.4 million people under age 65 will be forced to change coverage systems from one year to the next. This includes:

- 6.9 million people who move from Medicaid to subsidized coverage in the exchange or vice versa;
- 19.5 million people who move between Medicaid and ineligibility for all insurance subsidy programs (typically because of income over 138 percent of FPL and affordable ESI offers); and
- 3.0 million people who move between subsidized coverage in the exchange and ineligibility for all programs.

To place churning's magnitude in perspective, the 29.4 million people who will change coverage systems from year to year equal 31 percent of the estimated 95.9 million who will receive either Medicaid or exchange subsidies during any given year.

States can take several steps to reduce consumers' forced movement between health plans when household circumstances change. If the Basic Health Program (BHP) shifted the transition point between Medicaid plans and subsidized coverage in the exchange from 138 percent of FPL to 200 percent of FPL, churning between the two systems would decline by 16 percent, because higher income consumers receive more ESI offers that disqualify them from assistance. States can also reduce churning by encouraging or requiring the same plans to serve Medicaid and the exchange and to participate in individual and small group markets both inside and outside the exchange. Since 46 percent of people eligible for Medicaid or CHIP under the ACA will have an ESI offer in their families, encouraging them to obtain Medicaid in the form of premium assistance and "wrap-around" benefits could let more people stay in the same health plan when their incomes rise or fall across the Medicaid eligibility threshold.

However, these options have significant trade-offs and limitations. While states can combine multiple approaches to reduce health plan transitions, significant churning is inevitable under the ACA. This makes it important for states not just to lessen churning's scope but also to limit its harmful effects by guiding consumers through unavoidable changes in coverage. Such guidance can be offered by well-trained state staff and well-designed web sites, exchange call centers, and exchange Navigators. States seeking to ameliorate churning's harm will also need to implement policies that (a) maintain continuity of care when consumers are forced to change plans; and (b) offer affordable coverage at both ends of each transition while reducing the volume of paperwork people must complete to retain coverage during eligibility transitions, thereby preventing coverage gaps and losses.

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Introduction

The Patient Protection and Affordable Care Act expands eligibility for Medicaid[1] and subsidizes private insurance for low-income families through newly established health benefit exchanges. Eligibility for all insurance affordability programs is based on family income and size, and eligibility for subsidized coverage in the exchange also depends on whether the family has an affordable offer of ESI.[2] Changes in income, employment, and family composition can thus alter a family's eligibility. The resulting forced movement between health plans is known as churning. Churning makes programs more complicated and costly to administer. It can also interrupt continuity of care, create gaps in coverage when consumers need to move between programs or health plans, and interfere with accurate and comprehensive quality measurement. In addition, churning can lessen health plans' incentive to invest in long-term wellness if insurers know that today's enrollee may soon be served by a competitor.

Churning has long been a problem in Medicaid and the Children's Health Insurance Program,[3] but its scope is likely to increase greatly under the ACA, because more people will receive subsidized coverage, and because a new subsidy program will be created to operate in the exchange. In April 2011, Sommers and Rosenbaum found that, during each 12-month period under the ACA, among adults who have incomes at or below 200 percent of the federal poverty level and who do not receive ESI, 50 percent will experience income changes that move them between eligibility for Medicaid and eligibility for subsidies in the exchange.[4] In response to this research, states across the country have been focusing on the issue of churning and grappling for solutions.[5]

To aid this effort, we examine what churning would likely occur under a standard implementation of the law and under several state policy options that could reduce churning and mitigate its adverse effects. An important distinction between our analysis and prior research into churning[6] is that we consider ESI offers, not just ESI receipt, in determining whether consumers qualify for subsidies in the exchange and the BHP. This represents a significant analytic advance. Earlier research assumed that people who, under the status quo, are uninsured or receive individual coverage are not offered ESI; researchers thus treated all such people with incomes at or below 400 percent of FPL as eligible for assistance under the ACA. In fact, in the income range where ESI offers can preclude eligibility for insurance affordability programs—namely, between 138 and 400 percent of FPL—54 percent of participants in the current individual market[7] and 32 percent of the currently uninsured are offered ESI either directly or through an immediate family member (Table 1). Current uninsurance and individual coverage are not good proxies for the absence of ESI offers, making it imperative for churning analyses to assess such offers more directly—a task we undertake, as the next section explains.

Table 1. Among The Currently Uninsured and Current Recipients of Individual Coverage, The Percentage Who Are Offered ESI Directly or Through an Immediate Family Member, By Income: 2011

	Uninsured (50.3 million)	Recipients of Individual Coverage (14.5 Million)
0-138% FPL	11%	26%
139-400% FPL	32%	54%
401%+ FPL	43%	50%
Total:	**23%**	**45%**

Source: Health Insurance Policy Simulation Model (HIPSM) 2012.

Note: HIPSM combines data from the Current Population Survey—Annual Social and Economic Supplement (CPS-ASEC), the February 2004 Current Population Survey, and the Medical Expenditure Panel Survey—Insurance/Employer Component to estimate ESI offers by income and insurance status, among other factors.[8]

Methods

This analysis uses the Survey of Income and Program Participation (SIPP), which provides longitudinal data on nationally representative respondents. Since there is attrition of respondents over time, we reweight the data for consistency. We use eight waves (months 1 to 32) of the 2004 SIPP and nine waves of the 2001 SIPP. We only use the first eight waves of the 2004 panel because of the dramatic drop in sample size in wave nine. We restrict our attention to individuals who are in the sample in every month of the data. We estimate a simple logit in month four to account for attrition during that sample period (the 2004 SIPP has 110,659 individuals in wave 1 month 4 and only 91,630 in wave 8 month 4), and predict probabilities. The ratio of sample weights in wave one month four to these predicted probabilities form the sample weights in all 32 (36) months of the 2004 (2001) SIPP. The wave one month four weights are then inflated to projected population totals for 2012 by age category and divided by two so that the conjoined 2001 and 2004 SIPP panels represent the 2012 population.

In the 2004 SIPP, months one to 12 represent calendar year 2012, and months nine to 20 represent calendar year 2013, so four months are reused in constructing past income measures, which will slightly understate variability of income over time. Months 21 to 32 represent 2014. Transitions in eligibility are computed from one tax year to the next. To simplify the presentation, we did not include month-by-month changes in eligibility.

Eligibility for Medicaid was determined by the ACA threshold of family modified adjusted gross income (MAGI) up to 138 percent of FPL. Eligibility for CHIP was determined using each state's current income threshold. We did not have a detailed SIPP-based Medicaid eligibility model like the one used by the Urban

Institute's Health Insurance Policy Simulation Model (HIPSM), so certain types of adult Medicaid eligibility for those with MAGI above 138 percent of poverty could not be simulated. Such types of eligibility cover few people in many states. Also, maintenance-of-eligibility requirements for most of these categories expire in 2014. States may choose to discontinue eligibility for adults above the ACA MAGI threshold, which is precisely what is modeled here. Another limitation is that we do not have a detailed model for imputing immigrant documentation status for the SIPP, so we did not impute ineligibility based on immigration status.

As noted above, a major difference between this and earlier estimates of churning is that we take into account affordable ESI offers, which are an important criterion for subsidy eligibility in the exchange and BHP. This aspect of modeling is not straightforward because it requires the imputation of ESI offers and premiums, which are not available in SIPP. To do this, we use statistical matching of SIPP respondents to information about ESI offers available from the February 2004 Current Population Survey and recent data from the Medical Expenditure Panel Survey—Insurance/Employer Component, using the same methods previously applied in developing HIPSM estimates.[9]

Exchange premiums are imputed within cells of youngest age, oldest age, and dependents within family using the same methodology previously applied in developing HIPSM estimates, and subsidies are computed for those classified as eligible according to the formula defined in the ACA. Since our focus is a single-year estimate, we assume that the exchanges are fully implemented in 2014. This contrasts with the multi-year estimates of the Congressional Budget Office, which phase the exchanges in gradually over several years. Probability of ESI offer and premium if offered are imputed within categories of health insurance unit type (family type), MAGI as a percentage of FPL, age, industry, full-time and part-time employment status, and firm size.

In this paper, we present transitions in eligibility from one year to the next. There would also be transitions in eligibility from month to month. These are important, particularly for the reconciliation of premium subsidies in the exchange. However, our focus is to analyze the general magnitude of the problem and to assess the general effectiveness of various options for reducing churning.

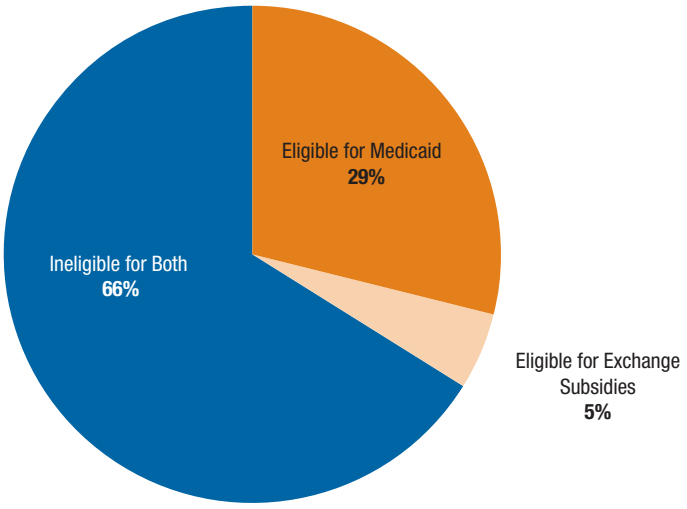
One other limitation is important to note. We show changes in *eligibility* for insurance affordability programs, rather than changes in *enrollment*. For some people, a change in eligibility will mean a transition between coverage and uninsurance—for example, if the consumer finds the available coverage unaffordable before or after the eligibility change.

Churning Under a Standard Implementation of the ACA

Under a *standard implementation* of the ACA, the subsidized insurance products are Medicaid, with eligibility expanded to 138 percent of FPL, and subsidized coverage in the health benefits exchange for those at or below 400 percent of FPL who are not eligible for public coverage, who do not have an affordable offer of employer coverage, and who are legally resident. At any given point in time, about 29 percent of the nonelderly would be eligible for Medicaid and 5 percent would qualify for exchange subsidies (Figure 1). The exact percentages will vary as incomes and levels of employment change from year to year. The percentage eligible for subsidized coverage is somewhat lower than will likely be the case in 2014 due to the better state of the economy in 2004 and 2001, the years of our underlying SIPP data.

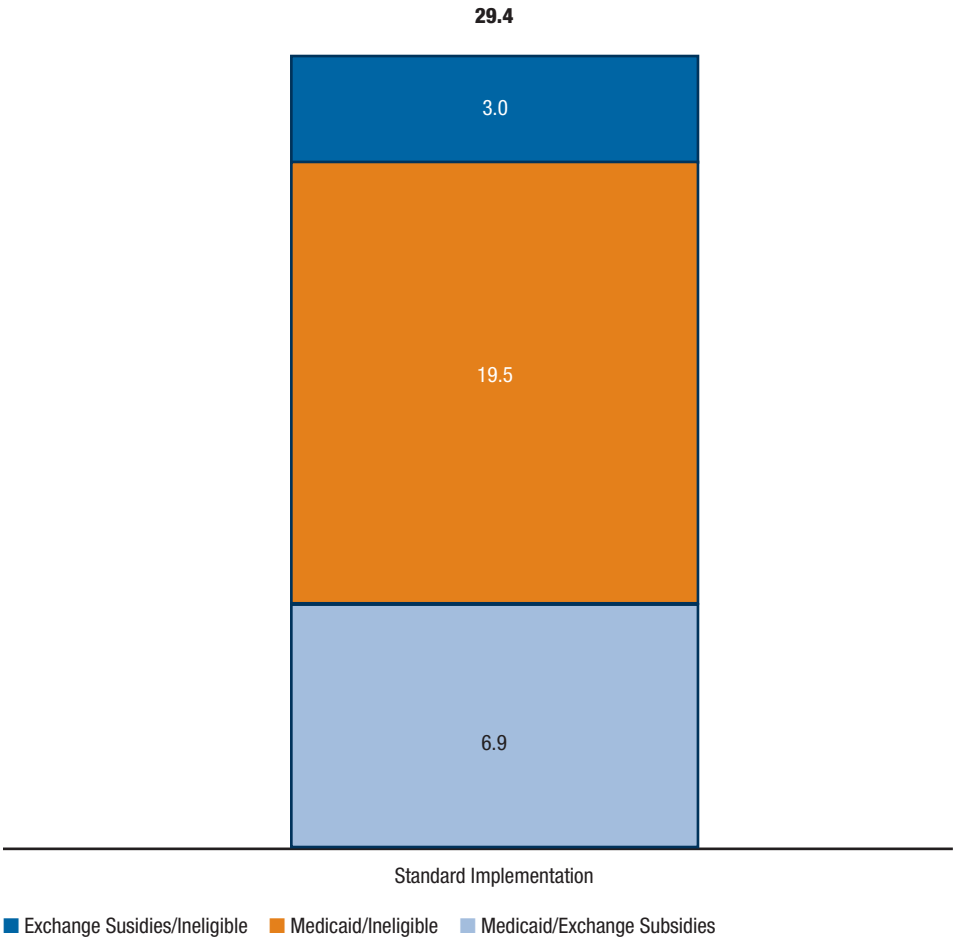
Under a standard implementation, churning reflects people's movement across three categories: eligible for Medicaid, eligible for exchange subsidies, and not eligible for any insurance affordability program. Figure 2 and Table 2 show the number who we estimate will change between Medicaid and subsidized coverage in the exchange (6.9 million moving in either direction), between Medicaid and ineligibility for all assistance (19.5 million), and between exchange subsidies and ineligibility (3.0 million). Churning between Medicaid and ineligibility is the largest category because most people with incomes above 138 percent of FPL are offered ESI that

Figure 1: Point-In-Time Eligibility Under a Standard Implementation of the ACA: U.S. Residents Under Age 65 (All Income Levels)



Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation.

Figure 2: Churning Under a Standard Implementation of the ACA, Coverage Transitions in Both Directions (Millions of People Under Age 65)



Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation.

Note: "Exchange Subsidies/Ineligible" shows the number of people who move, from one year to the next, between eligibility for subsidies in the exchange and ineligibility for all insurance affordability programs. "Medicaid/Ineligible" shows the number who move between Medicaid and ineligibility for all insurance affordability programs. "Medicaid/Exchange Subsidies" shows the number who move between Medicaid and subsidies in the exchange.

Table 2. Churning Under a Standard Implementation of the ACA, Coverage Transitions by Direction (Millions of People Under Age 65)

Type of Transition	Direction of Transition	Number Affected
Exchange Subsidies/Ineligible	From Exchange to Ineligible	1.4
	From Ineligible to Exchange	1.6
	Both Directions	**3.0**
Medicaid/Ineligible	From Medicaid to Ineligible	10.6
	From Ineligible to Medicaid	8.9
	Both Directions	**19.5**
Medicaid/Exchange Subsidies	From Medicaid to Exchange	3.5
	From Exchange to Medicaid	3.4
	Both Directions	**6.9**
	Total:	**29.4**

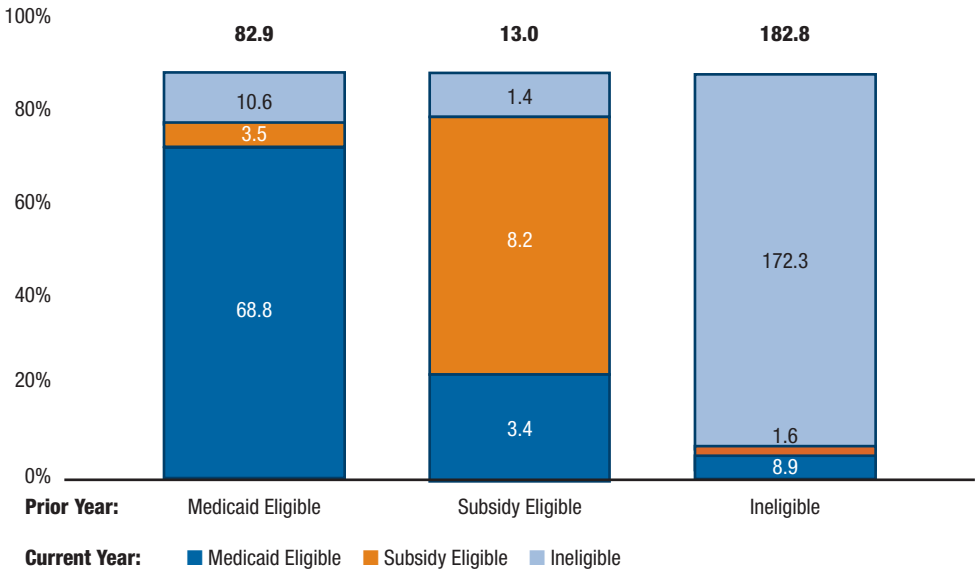
Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation.

makes them ineligible for subsidies in the exchange. Altogether, 29.4 million people under age 65 change their eligibility status from one year to the next.

Figure 3 provides more comprehensive information about our results. The figure includes three columns, one for each initial eligibility category. Each column is divided into three sections, indicating the eligibility category based on the following year's household circumstances, including taxable income. Even though the eligibility categories contain very different numbers of people, the columns are displayed at the same height so the reader can see the proportion of eligible people who stay in the same category and the proportion who change from year to year.

About 83 percent of Medicaid eligibles during one year (68.8 million) would retain eligibility during the next year (first column of Figure 3), based on annual income. Two groups would lose initial Medicaid eligibility: 3.5 million of those initially eligible for Medicaid would become eligible for exchange subsidies, and 10.6 million would lose eligibility for both programs, in most cases because their income rises above 138 percent of FPL and they are offered ESI.[10] Two groups would gain Medicaid eligibility: 3.4 million who qualify for subsidies during one year would become eligible for Medicaid in the second year (second column). Another 8.9 million not eligible for either program would become Medicaid eligible during the second year (third column). Hence, churning between Medicaid and exchange subsidies involves nearly 7 million people, counting transitions in either direction. Churning between Medicaid and ineligibility for all insurance affordability programs, typically due to affordable ESI offers coupled with income above 138 percent of FPL, would affect nearly 20 million people a year. This category includes two-thirds of all churning, disrupting continuity for almost three times the number of people who transition between Medicaid and subsidies in the exchange.

Figure 3: Churning Under a Standard Implementation of the ACA, Total Coverage Effects (Millions of People Under Age 65)



Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation.

How to read this chart: Among the 82.9 million people who qualified for Medicaid and CHIP during the prior year, 68.8 million qualify for Medicaid and CHIP this year; 3.5 million are subsidy-eligible this year; and 10.6 million are ineligible for all insurance affordability programs this year. Among the 13.0 million people who qualified for subsidies in the exchange last year, 3.4 million qualify for Medicaid and CHIP this year; etc.

Note: Totals may not add because of rounding.

Churning between Medicaid and ineligibility for all insurance affordability programs, typically due to affordable ESI offers coupled with income above 138 percent of FPL, would affect nearly 20 million people a year. This category includes two-thirds of all churning, disrupting continuity for almost three times the number of people who transition between Medicaid and subsidies in the exchange.

Of those who start out being eligible for subsidies in the exchange (second column of Figure 3), nearly two-thirds (8.2 million) retain eligibility from one year to the next. However, the amount of premium subsidies for which they are eligible could change during the year, potentially making them liable to repayment at tax time. Their cost-sharing subsidies would also change with income, but those subsidies are not subject to repayment.

Two groups lose eligibility for subsidies: 3.4 million gain Medicaid eligibility and 1.4 million lose eligibility for both subsidies in the Exchange and Medicaid, because they receive an affordable employer offer or their income rises above 400 percent of poverty. Two groups gain eligibility: 3.5 million who started off eligible for Medicaid and 1.6 million who were not eligible for either Medicaid or subsidies in the exchange. Accordingly, more people gain or lose subsidy eligibility in the exchange (9.9 million) than retain such eligibility from year to year (8.2 million). Insurers in the individual market exchange can thus expect a large amount of policy turnover unless the state intervenes. We consider several possible interventions below.

Most nonelderly people are ineligible for both Medicaid and subsidies in the exchange (172 million). This large group includes 91 million people with incomes above 400 percent of FPL; 73 million between 138 and 400 percent of FPL who have affordable employer offers; and 8 million people below 400 percent of FPL whose immigration status disqualifies them from insurance affordability programs. Two groups gain eligibility for affordability programs from one year to the next: 8.9 million become eligible for Medicaid, and 1.6 million qualify for exchange subsidies. Two groups join this category by losing eligibility: 10.6 million were previously eligible for Medicaid, and 1.4 million were previously eligible for subsidies in the exchange.

More people gain or lose subsidy eligibility in the exchange (9.9 million) than retain such eligibility from year to year (8.2 million).

To place churning's total magnitude in perspective, the 29.4 million people who will change coverage systems from year to year equal 31 percent of the estimated 95.9 million who will receive either Medicaid or exchange subsidies during any given year (compare Figure 2 to the first two columns of Figure 3).

Potential State Strategies to Reduce Churn

In this section, we analyze several possible approaches to reducing the number of people who are forced to transition between health plans because of changed household circumstances. Several approaches—namely, the Basic Health Program and Medicaid premium assistance—can be implemented by all states. Other strategies require states to exercise authority over the plans that participate in the exchange and so can only be adopted by states that either run exchanges or perform plan management functions in a State Partnership Exchange.[11]

Basic Health Program

Under the BHP,[12] the state contracts with plans to provide coverage to those below 200 percent of FPL who would otherwise have qualified for exchange

subsidies—mostly adults between 138 and 200 percent of FPL who are not offered affordable ESI.[13] Such consumers would enroll in a BHP plan rather than a plan in the exchange. A state could implement this option so that BHP plans and Medicaid plans would be jointly administered, differing only in cost-sharing. This would effectively eliminate churning between Medicaid plans and exchange plans for those below 200 percent of FPL. It would, however, create a new churning threshold at 200 percent of FPL between BHP and the exchange, but the magnitude of churning would be lower. That is because ESI offers that preclude subsidy eligibility are more prevalent at higher income levels.[14] Accordingly, if Medicaid and BHP allowed the same plans to serve all residents up to 200 percent FPL, the number who transition between Medicaid plans and the exchange would fall from 6.9 million to 5.8 million—a 16 percent reduction (Table 3). At any given time, the number of subsidy recipients who receive coverage in the exchange would drop by 33 percent, from 13 million to 8.7 million.

BHP would also protect the lowest-income families from two other adverse effects of changed circumstances. The first involves possible tax penalties. In the exchange, people receiving tax credits are subject to a possible "claw-back" of support at the year's end if their income rises by enough to reduce their credit or if they lose eligibility (perhaps because of a job change that results in an affordable ESI offer). The estimated income used to calculate the subsidy during the year must be reconciled with the income reported on the recipient's subsequent tax return. Inadequate credits provided during the year are supplemented by additional credits when the return is filed. But any excess credit is recouped by the Internal Revenue Service, subject to repayment caps for those whose income remains below 400 percent of FPL. Even the capped amounts, however, could be difficult for a low-income family to pay, and the risk of incurring tax debts could deter many low-income uninsured from using tax credits to enroll in coverage.[15]

Second, BHP could involve fewer transitions between Medicaid and uninsurance when family income changes. That is because BHP permits much more affordable coverage than will be available in the exchange, even with subsidies. As found in earlier research, the average subsidy-eligible adult with income in the BHP range (between 138 and 200 percent of FPL) will need to pay $101.50 a month in premiums to enroll in subsidized coverage in the exchange. By reducing those premium costs, BHP could increase the proportion of subsidy-eligible consumers who accept coverage.[16]

On the other hand, BHP implementation would cut by one-third the number of subsidy-eligible people in the exchange, as noted above, and increase the proportion of such people whose eligibility changes. Only 51 percent of subsidy eligibles would remain in that category from one year to the next, down from 63 percent in the absence of BHP. It would thus be important to combine BHP with other strategies to reduce churning, including approaches to exchange plan portability like those described below.[17]

Integrating Medicaid and Exchange Plans

To reduce the number of people who must change insurers when they transition between Medicaid and the exchange, state policymakers could encourage or require health plans to participate in both systems. The potential effectiveness of this strategy will depend on the extent to which a state's Medicaid program has shifted from fee-for-service into managed care (all but four states have more than 50 percent of Medicaid beneficiaries enrolled in managed care)[18] and the level of overlap between plans and their provider networks that participate in the two coverage systems.

Such Medicaid/exchange integration is complicated. Licensure and other legal requirements can be quite different in the two markets; it may require significant cost and effort for an insurer to move from one to both systems, even though a state interested in integration can simplify the transition. Also, providers are likely to strongly resist plans in the exchange reimbursing at Medicaid rates, or even rates slightly above Medicaid levels, but significantly lower than what current private plans pay. Medicaid plans entering the exchange would probably need to pay significantly higher provider rates and offer a broader provider network for their exchange enrollees than their Medicaid enrollees. This could mean that, even if a consumer stays in the same plan while moving between Medicaid and the exchange, he or she must change providers.

On the other hand, Medicaid/exchange integration could create problems if plan networks are the same or similar

Table 3. Transitions Between Medicaid Plans and Subsidized Coverage in the Exchange, Without and With BHP Implementation (Millions of People Under Age 65)

Type of Transition	Direction of Transition	Number Transitioning Without BHP Implementation	Number Transitioning With BHP Implementation
Medicaid/Exchange Subsidies	From Medicaid Plans to the Exchange	3.5	2.7
	From the Exchange to Medicaid Plans	3.4	3.1
	Both Directions	**6.9**	**5.8**

Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation.

Note: The right-hand column shows what would happen if the same plans participated in Medicaid and BHP. It thus classifies BHP coverage as involving "Medicaid plans" rather than "the exchange."

in the two systems. If two or more Medicaid plans entering the exchange paid provider rates significantly below private levels, one such plan would likely establish the "reference premium" used to compute subsidy amounts in the exchange. In that case, BHP payments would be substantially lower than may be needed to cover BHP costs, depending on how the state structured its BHP program. It may thus be difficult or impossible to combine these two options if the result would be reference premiums at or near Medicaid levels. In addition, the exchange could be unable to offer tax credit recipients affordable access to mainstream insurance that pays providers anything like current commercial rates. That is because a tax credit beneficiary choosing a plan more costly than the reference premium must pay the extra premium amount, in addition to the consumer's income-based payment. However, these potentially worrisome scenarios will not result if providers refuse to accept anything close to Medicaid payment rates for coverage offered in the exchange.

One possible model is offered by Minnesota, where health maintenance organizations, which play an unusually prominent role in the state's insurance markets, cannot obtain a license to sell private coverage unless they offer to participate fully in Medicaid. That state is likely to feature a substantial overlap between Medicaid and exchange plans. Not all states will take similar steps compelling plans to join Medicaid as a condition of private insurance licensure or access to the exchange. Short of imposing such requirements, however, states could take effective action to facilitate or encourage the operation of plans in both Medicaid and the exchange.[19]

Using Medicaid Premium Assistance to Lessen Churning Between Medicaid and Ineligibility for All Assistance

As explained earlier, two-thirds of all churning will involve transitions between Medicaid and ineligibility for insurance affordability programs, usually due to affordable ESI offers and income over 138 percent of FPL. To deal with this common scenario, states could make Medicaid coverage under 138 percent of FPL available as ESI premium assistance. If premium assistance is available, a worker who is offered ESI, and who loses or gains Medicaid eligibility because of income fluctuation, could receive ESI both before and after the income change. Under this approach, the Medicaid-eligible consumer enrolls in the employer plan, and Medicaid pays for premiums, cost sharing, and supplemental benefits that lower consumer costs and raise covered services to Medicaid levels. Only a few states currently make significant use of this "wrap-around" mechanism to deliver Medicaid coverage, but the ACA increases the ability of states to implement voluntary premium assistance if they find it cost-effective.

The cost-effectiveness of premium assistance depends on multiple factors. On the one hand, the state is no longer responsible for services covered by the employer, which lowers Medicaid costs. On the other hand, states must pay premium assistance and additional cost-sharing at commercial rather than Medicaid rates, and the administrative expense and complexity of administering wrap-around packages can be substantial. The ACA gives states new tools to lower those administrative costs,[20] and states can limit premium assistance to Medicaid beneficiaries for whom administrative costs relative to state benefit savings would be lowest,[21] but the net fiscal effects will vary, depending on the state and its approach to Medicaid premium assistance.

States pursuing this approach need to overcome the complexity that can make it difficult for enrollees to use their supplemental benefits and take advantage of Medicaid cost-sharing assistance. Furthermore, persuading employers to participate can be challenging, because they may need to pay premiums for more workers and they may find it burdensome to meet state requirements. On the other hand, some insurers and state policymakers have expressed concern that, under the ACA's Medicaid expansion, workers may switch from ESI to Medicaid, adversely affecting the ESI risk pool and interfering with some employers' ability to continue meeting insurers' minimum participation requirements. With premium assistance, workers remain in the employer's plan. Also, some states operate significant premium assistance programs. In Massachusetts, for example, more than 30,000 people currently receive such assistance. That is much higher than the number of workers covered through their employers in Commonwealth Choice, the Massachusetts exchange.

Premium assistance is unlikely to become a central feature of most states' Medicaid programs, but even a modest implementation of this approach could have a nontrivial effect on churning, given the overall magnitude of transitions between Medicaid and ineligibility for all insurance affordability programs. We find that 38 million out of the 82.9 million people who will qualify for Medicaid or CHIP under the ACA (46 percent) are offered ESI either directly or through a family member, including 13.4 million who either work full-time at small firms (up to 100 workers) or are dependents of such workers.[22]

Of course, many people who gain or lose Medicaid eligibility because of a job change will be forced to move between plans, whether or not they receive Medicaid in the form of premium assistance. However, other people move in and out of Medicaid without changing jobs; their earnings rise or fall because of fluctuating hours or wages. Premium assistance that lets these consumers receive Medicaid in the form of employer coverage along with a state-administered supplement could keep many of them in the same health plan if their incomes move across the Medicaid eligibility threshold. Particularly for consumers who value access to the provider networks available in commercial coverage, which are typically much broader than Medicaid networks, this could be an important advance.

Exchange Plan Portability

A state could structure its individual and small group (SHOP) exchanges so that many of the same plans are offered inside and outside the exchange in both the individual and small group markets. This approach would seek to help the 3.0 million people who move between subsidized coverage in the exchange and ineligibility for all subsidies. Helping them keep the same insurer despite changing incomes and employment arrangements would increase continuity of coverage and care.

Roughly half of this group, 1.5 million, remains outside large group coverage and so can most easily have continuity of coverage assured through state regulation of the small group market and organization of exchange plans. If a state ensures that plans inside and outside the exchange "play by the same rules," many of the plans inside the exchange could also be available outside the exchange in the small group and individual markets.[23] Even if a carrier offered different plans inside and outside the exchange, so long as the carrier used the same provider networks and the same procedures for accessing benefits in both places, significant aspects of continuity would be preserved.

This approach would help more people than those gaining or losing subsidy eligibility. For example, many people who change from one small firm job to another could stay in the same health plan.[24] A successful exchange, coupled with efforts to make the same plans available in multiple markets, could thus improve continuity of care and make private insurance coverage much more portable than it is today.

This strategy may present challenges to state policy-makers who pursue an "active purchaser" model for the exchange. By excluding a number of licensed plans from the exchange, such policy-makers seek to simplify consumer decisionmaking and potentially achieve further policy goals.[25] At the same time, other state policy-makers may oppose vigorous regulation that guarantees the same plans are offered inside and outside the exchange, in both group and individual markets. However, even in a state that does not enact such requirements, policies that encourage or incentivize the same plans to be offered in multiple venues could lessen the extent of compelled health plan transitions when subsidy eligibility changes and when consumers who are ineligible for subsidies move between jobs.

12-Month Continuous Eligibility

Providing 12-month continuous eligibility for Medicaid would reduce month-to-month losses of Medicaid eligibility. We did not model this option, in part because it would not prevent year-to-year changes in subsidy eligibility. Many states have been hesitant to apply continuous eligibility because it would increase enrollment and coverage costs. Under the ACA, higher enrollment would affect not just newly eligible adults but also existing eligibility categories, for which the federal government would continue to pay its current matching percentage. The amount of such additional costs would vary considerably between states based on their pre-reform eligibility standards and programs.

Continuous eligibility for adults will require a Medicaid waiver under Section 1115 of the Social Security Act.[26] However, without waivers, ACA Medicaid regulations give states the option to base Medicaid eligibility, for children and adults alike, on projected annual income. To the extent this option can "smooth out" midyear income changes and provide coverage year-round, it could achieve many of the continuity gains promised by 12-month continuous eligibility.

Implications

States can take multiple steps that, taken as a whole, would reduce the number of compelled transitions between health plans when eligibility for insurance affordability programs changes (Table 4). Such steps would reduce the clinical damage caused by breaks in coverage and care. They may not, however, yield appreciable administrative savings, since the underlying basis of subsidy eligibility would still change, notwithstanding continuous enrollment in a particular health plan.

Rather than move each state to one set of health plans for all residents and one need-based assistance program, the ACA preserved multiple health insurance markets and subsidy systems. As a result, churning will be a fact of life under the ACA, just as it is today. To lessen the damage done by churning, it will be important for states to provide consumers with intensive assistance to help them navigate through the health coverage transitions that millions of Americans will continue to experience, regardless of how vigorously their states combat churn. Building on carefully designed web sites that provide easily understood information about the full range of health coverage options, such assistance could be provided by well-trained state staff, exchange call centers,

Table 4. Multiple Strategies to Reduce the Magnitude of Churning Between Health Plans

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 of FPL.
	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.

exchange Navigators,[27] and Medicaid or CHIP contracts with community-based organizations.[28] In addition, states will need to implement policies that maintain continuity of care when consumers are forced to change health plans.[29] Finally, states can work aggressively to lessen the paperwork consumers must complete to retain coverage during eligibility transitions, thereby reducing the number who become uninsured for procedural reasons.[30] To further limit coverage losses, states could increase the affordability and value of the coverage that is offered at each end of eligibility transitions—for example, by using BHP to provide low-income consumers with much more affordable coverage than subsidies would allow in the exchange.[31] Table 5 lists some of the strategies states can employ to limit the harm caused by churning.

Conclusion

Household circumstances change. As a result, churning—movement between health plans and health coverage systems—is inevitable, since the ACA preserves multiple insurance affordability programs and insurance markets. While state policy-makers cannot end such transitions, they can reduce their prevalence through a multipart strategy that addresses each component of churn. They can also limit the resulting damage by providing consumer assistance to help people navigate through health coverage transitions, by implementing policies that maintain continuity of care when consumers are forced to change health plans, and by taking steps to prevent eligibility transitions from creating coverage gaps and losses.

Table 5. Strategies to Limit the Harm That Results from Churning

Type of Harm	Strategies
Coverage Gaps and Losses	Provide intensive consumer assistance.
	Reduce the amount of paperwork consumers must complete to retain coverage during transitions.
	Maximize the affordability and value of coverage available at each end of the transition.
Disrupted Continuity of Care	Provide intensive consumer assistance.
	Implement policies that preserve continuity of care when people are forced to change health plans.

Note: This table does not list strategies for limiting the administrative costs of churn; for preventing low-income households from incurring tax debts due to changed household circumstances; or for increasing health plans' incentive to invest in consumers' long-term wellness.

Churning will be a fact of life under the ACA, just as it is today. To lessen the damage done by churning, it will be important for states to provide consumers with intensive assistance to help them navigate through the involuntary coverage transitions that millions of Americans will continue to experience, regardless of how vigorously their states combat churn. In addition, states will need to implement policies that maintain continuity of care when consumers are forced to change health plans and that lessen the paperwork consumers must complete to retain coverage during eligibility transitions, thereby reducing the number who become uninsured for procedural reasons. To further limit coverage losses, states could increase the affordability and value of the coverage that is offered at each end of eligibility transitions.

Notes

1 In this paper, references to "Medicaid" usually include the Children's Health Insurance Program (CHIP).

2 Regulations interpreting the ACA classify ESI as affordable if worker-only coverage costs 9.5 percent of household income or less. In theory, someone with an affordable offer of coverage could nevertheless qualify for subsidies in the exchange if the employer plan had an actuarial value below 60 percent, measured against the set of covered benefits chosen by the employer. In practice, however, little or no employer coverage is likely to fall below this threshold of minimum value.

3 See, e.g., Anna S. Sommers, Lisa Dubay, Linda J. Blumberg, Fredric E. Blavin, and John L. Czajka, "Dynamics In Medicaid And SCHIP Eligibility Among Children In SCHIP's Early Years: Implications For Reauthorization," *Health Affairs* 26(5) (2007): w598–w607; Milda R. Saunders and G. Caleb Alexander, "Turning and Churning: Loss of Health Insurance Among Adults in Medicaid," *Journal of General Internal Medicine* 24(1) (January 2009): 133–34; Kathryn Klein, Sherry Glied, and Danielle Ferry, *Entrances and Exits: Health Insurance Churning*, 1998–2000 (New York, NY: The Commonwealth Fund, September 2005) http://www.thecommonwealthfund.com/~/media/Files/Publications/Issue%20Brief/2005/Sep/Entrances%20and%20Exits%20%20Health%20Insurance%20Churning%20%201998%202000/klein_855_entrancesexits_ib%20pdf.pdf.

4 Benjamin D. Sommers and Sara Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges" *Health Affairs* (30)2 (February 2011): 228–36.

5 See, e.g., State of Vermont, State Planning and Establishment Grant for the Affordable Care Act's Exchanges Project, Quarter Reporting Period: Quarter 1 (09/30/2010–12/31/2010), January 31, 2011, http://dvha.vermont.gov/administration/hbe-grant-quarterly-report-oct-dec-2010.pdf; Jennifer Farnham and Dorothy Gaboda, *Helping New Jersey Families Coordinate Transitions and Maintain Coverage When Changing Health Plans* (New Brunswick, NJ: Rutgers Center for Health Policy, March 2012) http://www.cshp.rutgers.edu/Downloads/9240.pdf; Ashley Hague, *National Health Care Reform Update: Subsidized Health Insurance* (Boston, MA: Massachusetts State Connector, April 12, 2012) https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2012/2012-04-12/6-NHCRSubsidizedHealthInsurance.pdf.

6 In addition to the Sommers and Rosenbaum article, see John A. Graves, Rick Curtis, and Jonathan Gruber, "Balancing Coverage Affordability and Continuity under a Basic Health Program Option" *New England Journal of Medicine* 365 (December 15, 2011): e44.

7 At first, it may seem surprising that so large a proportion of individual coverage recipients decline ESI offers. To place that finding in context, roughly 178 million people were offered ESI in 2011 either directly or through an immediate family member. Of these, 6.5 percent report being uninsured and 3.7 percent report having individual coverage. As one would expect, the latter percentage is quite small. But because the individual market is so much smaller than the group market, ESI decliners constitute a surprisingly large share of individual market participants.

8 For more information, see Matthew Buettgens, *Health Insurance Policy Model (HIPSM) Methodology Documentation* (Washington, DC: The Urban Institute, 2012) http://www.urban.org/health_policy/url.cfm?ID=412471.

9 For more information, see Buettgens, *Health Insurance Policy Model (HIPSM) Methodology Documentation*.

10 A few people lose Medicaid eligibility when their income rises above 400 percent of FPL because of a new job, marriage, or other factors.

11 For information about state options for structuring exchanges, see Center for Consumer Information and Insurance Oversight, *Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges* (Washington, DC, 2012) http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf.

12 For a more detailed discussion of BHP, including many more advantages and disadvantages than we explore here, see Stan Dorn, Matthew Buettgens, and Caitlin Carroll, *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States* (Washington, DC: The Urban Institute, 2011) http://www.urban.org/health_policy/url.cfm?ID=412412.

13 Lawfully present immigrants with incomes below 138 percent of FPL also qualify for BHP if their immigration status disqualifies them from Medicaid. In addition, citizen children with incomes at or below 200 percent of FPL qualify for BHP if they are ineligible for Medicaid and CHIP.

14 Among the uninsured, the percentage with ESI offers either directly or through a family member rises from 11.4 percent below 139 percent of FPL to 28.4 percent at 139–200 percent of FPL, 32.7 percent at 201–300 percent of FPL, 40.3 percent at 301–400 percent of FPL, and 42.6 percent above 400 percent of FPL. Among people with individual coverage, ESI offers reach 25.7 percent below 139 percent of FPL, 50.5 percent at 139–200 percent of FPL, 55.7 percent at 201–300 percent of FPL, 56.5 percent at 301–400 percent of FPL, and 50.3 percent above 400 percent of FPL. Source: HIPSM 2012 (see note to table 1).

15 Although the Department of Health and Human Services (HHS) has not yet provided guidance about BHP, federal BHP amounts are likely to take into account what would have happened to BHP members if they had been subject to tax reconciliation after receiving advance credits in the exchange. Reconciliation would be between the state and the U.S. Treasury Department, with both debits and credits to the state aggregated across the state's entire BHP population. Since income and employment changes move in both directions, they would tend to even out over time unless there is a strong trend of rising or falling incomes for low-income families. As noted earlier, reconciliation debits are subject to caps for those whose income remains low, but reconciliation payments are not. With BHP, reconciliation debits to the state would thus be capped, but credits to the state would not, yielding yet gains to states in many cases. Even if, as seems likely during the next few years, incomes are generally rising as the overall economy improves, risks to states could be limited if HHS decides that reconciliation effects may be factored into a state's initial federal BHP payment for the year, based on economic projections, rather than recaptured from or granted to the state after the end of the year. See January Angeles, *State Considerations on Adopting Health Reform's "Basic Health" Option: Federal Guidance Needed for States to Fully Assess Option* (Washington, DC: The Center on Budget and Policy Priorities, 2012).

16 Dorn, Buettgens, and Carroll, *Using the Basic Health Program*.

17 For example, if the same plans served the exchange and the small group market outside the exchange, 59 percent of subsidy eligibles in the exchange would remain in the same plan from one year to the next, despite BHP implementation.

18 Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2011, analyzed by the Kaiser Family Foundation, http://statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4.

19 See, e.g., Deborah Bachrach, Patricia Boozang, and Melinda Dutton, *Medicaid's Role in the Health Benefits Exchange: A Road Map for States* (New York, NY: Manatt Health Solutions, 2011).

20 For example, Medicaid premium assistance could be built into the structure of a state's SHOP exchange. Also, a state's Essential Health Benefits (EHB) and Medicaid benchmark packages could be coordinated to simplify benefit wrap-around packages for Medicaid beneficiaries whose employers offer coverage that is limited to EHBs.

21 Examples of such groups are consumers offered ESI with benefits that are limited to EHBs; consumers eligible for Medicaid benchmark benefits rather than standard Medicaid; and consumers with incomes above specified percentages of FPL, for whom ESI offers are more common.

22 We used HIPSM to estimate the proportion of Medicaid- and CHIP-eligible people who will be offered ESI under the ACA. The proportion of Medicaid and CHIP *enrollees* offered ESI will be lower since, all else equal, enrollment in Medicaid and CHIP is less likely for eligible people who are offered ESI.

23 Self-insured plans can obstruct this kind of portability. Such plans are playing an increasingly important role in the small group market and may become more common under the ACA. However, if a carrier uses the same provider network and procedures for accessing care in both its insurance products and self-insured plans, many of the benefits of continuity will apply when a consumer moves between the carrier's self-insured and fully insured products.

24 This was an important consideration in the design of Utah's small business exchange.

[25] See, e.g., Rosemarie Day and Pamela Nadash, "New State Insurance Exchanges Should Follow The Example Of Massachusetts By Simplifying Choices Among Health Plans" *Health Affairs* 31(5) (2012): 982–9; Sabrina Corlette and JoAnn Volk, *Active Purchasing for Health Insurance Exchanges: An Analysis of Options* (Washington, DC:Georgetown University Health Policy Institute, 2012) http://chis.georgetown.edu/pdfs/Active%20Purchaser%206%203%2011.pdf.

[26] New York has already obtained such a waiver.

[27] Navigators receive exchange funding to help consumers enroll in coverage. They can be community-based organizations, insurance brokers, etc. For more information, see Community Catalyst, *Navigators: Guiding People Through the Exchange* (Boston, MA: Community Catalyst, 2011) http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf.

[28] For general information about consumer assistance under the ACA, see, e.g., Elaine Saly, *Navigator Programs and Consumer Assistance Program Grants Under the Affordable Care Act* (Washington, DC: Families USA, 2011) http://familiesusa2.org/assets/ppt/Navigators-and-CHAPs.pptx; Trilby de Jung, Carrie Tracy, and Elisabeth R. Benjamin, *Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York* (New York, NY: New York State Health Foundation, 2011) http://nyshealthfoundation.org/uploads/resources/navigators-consumer-assistance-programs-september-2011.pdf.

[29] See Carolyn Ingram, Shannon M. McMahon, and Veronica Guerra, *Creating Seamless Coverage Transitions Between Medicaid and the Exchanges* (Princeton, NJ: Center for Health Care Strategies, 2012) http://www.statenetwork.org/resource/creating-seamless-coverage-transitions-between-medicaid-and-the-exchanges/. For a good analysis of a broad range of state policies to address churn, including continuous eligibility, measures to prevent the involuntary movement of consumers between health plans, and strategies to lessen the resulting disruption in continuity of care, see Patricia Boozang and Alice Lam, *Achieving Continuity of Insurance Coverage for Lower-Income New Yorkers in 2014* (New York, NY: Coalition of New York State Public Health Plans, 2012) http://nyshealthfoundation.org/uploads/resources/Coverage-Continuity-for-Lower-Income-New-Yorkers.pdf.

[30] For example, redundant documentation requests and inadvertent losses in coverage are less likely if a single, integrated system determines eligibility for all of a state's insurance affordability programs than if each program simply ships case files elsewhere when a beneficiary becomes ineligible.

[31] See Dorn, Buettgens, Carroll, *Using the Basic Health Program*.

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