

Addressing Churn: Coverage Dynamics in Oregon's Insurance Affordability Programs

Recommendations from the
Oregon Medicaid Advisory Committee

August 5, 2014

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Presentation Overview

- What is churn and why is it an issue?
- Estimates of churn between Insurance Affordability Programs (IAPs) under the ACA
- Committee process, principles and recommendations

What is churn?

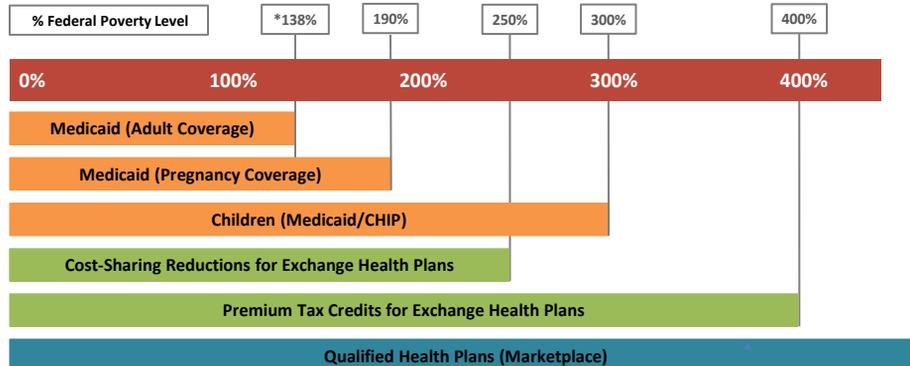
Churn is the involuntary movement of individuals from one health plan or system of coverage to another.*

- Occurs when there is a change in program eligibility due fluctuations in family circumstances, income and/or employment status
- Also occurs due administrative issues, such as difficulties meeting documentation requirements for continued eligibility/renewing coverage
- Results in changes in out-of-pocket costs, benefits, provider network, and plan; potential gaps in coverage
- Churning under the Affordable Care Act (ACA) landscape; new factors and policy considerations

*Urban Institute, "Churning Under the ACA and State Policy Options for Mitigation," (June 2012); Ku, L., & Ross, D. (December, 2002). Staying covered: The importance of retaining health insurance for low-income families. The Commonwealth Fund New York, NY.

ACA Insurance Affordability Programs in Oregon

As of June 2014, 971,000 Oregonians were on the Oregon Health Plan.



*The ACA's "133% FPL" is effectively 138% FPL due to a 5% across-the-board income disregard. (Illustration adapted from the Washington State Health Care Authority.)

Why is churn an issue?

- Coverage gaps can lead to increased use of the ED and hospital for ambulatory sensitive conditions, poorer management of chronic disease, and lower rates of preventive care.
- Differences in benefit coverage and provider networks can lead to fragmented, lower quality health care and increased costs.
- Decreased affordability, i.e. higher out-of-pocket costs as individuals churn out of Medicaid into commercial coverage.
- Undermines incentives for health plans/providers to invest in long-term health improvements.
- Difficult to measure and compare quality across health plans over time.
- Increased administrative expenses for state Medicaid programs and health plans.

Estimates of Churn Under the ACA

Millions of individuals and families will churn between coverage options on an annual basis, experts estimate:

Nationally:^{1, 2}

- 40-50% of adults with family incomes below 200% of the FPL will experience a change in eligibility from Medicaid to Exchange coverage, or the reverse *within a year*
- ~24% of adults will experience at least *two* eligibility changes *within a year*

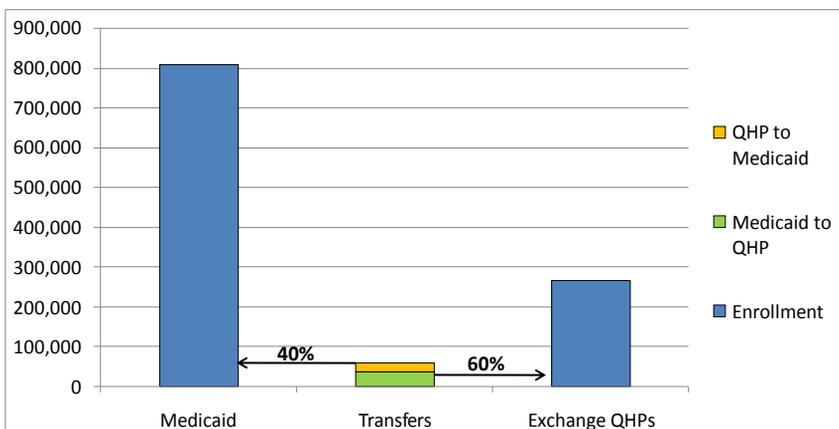
Oregon:³

- 27% of income eligible Medicaid parents and childless adults will experience a change in eligibility within *one year*

(1) Sommers, B., Rosenbaum, S. (2011). Issues in Health Reform; How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges. *Health Affairs*, 30(2), 228-236. (2) Sommers, B., Graves, J., et al., "Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact," *Health Affairs* (April 2014); SHADAC, "Medicaid Eligibility Churn as a Result of Income Shifts and Characteristics of Those Like to Churn: Oregon," (July 2013).



Transfers between markets are small portion of enrollment (2016)*



Estimates were developed in March 2013 prior to Fast-Track enrollment into OHP.

Source: SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data from November 2012-March 2013.



Committee Process

- Reviewed historical churn in OHP and estimates of churn based on Oregon Health Study longitudinal data
- Conducted an environmental scan of state options to address churn
- Representatives from Washington Health Care Authority shared their experience and approach
- Worked with Manatt Health Solutions to identify and assess churn mitigation strategies
- Wakely Consulting performed financial modeling to examine feasibility and implications of alternative coverage options



Committee Recommendations to Address Churn



MAC's Principles for Addressing Churn

Maximize quality, affordable, benefit coverage and continuity of care for individuals and families

Consider the health and support needs of diverse subpopulations, parents, women, children, persons with disabilities, and residents in rural and frontier areas, among others served by OHP

Balance consumer needs with the need for financial viability and operational self-sufficiency in the state's Medicaid program, the health insurance Marketplace, and the health care delivery system

Promote coverage options that ensure access and continuity to comprehensive health services and result in the lowest net level of churn



Reduce or Avoid Churn

Goals:

- Reduce the number of times an individual moves from one coverage vehicle to another
- Minimize insurance gaps as individuals transition

Strategies:

- Align income budget period rules
- Implement adult 12 month continuous eligibility for Medicaid
- Simplify and streamline eligibility, enrollment and redetermination processes
- Adopt transparent eligibility, enrollment and redetermination performance indicators



Aligning Medicaid and Tax Credits' Income Budget Periods

Background: Medicaid/CHIP eligibility is based on monthly income; tax credits/cost sharing reductions' eligibility is based on projected annual income.

Coverage gap: When an individual is found ineligible for Medicaid based on monthly income and ineligible for tax credits/cost sharing reductions based on projected annual income, regulations require Medicaid eligibility to be based on projected annual income. As a result, the individual will be eligible for Medicaid.

Regulatory Budget Period Options for Medicaid:

- For new applicants, the state may take into account **reasonably predictable changes** in income
- For Medicaid MAGI beneficiaries renewing their coverage, the state may use a **projected annual budget** period as well as take into account "reasonably predictable changes" in income



12 Month Continuous Medicaid Eligibility

Overview: Regardless of change in income, individuals remain eligible for 12 months. Already in place for children.

Authority: State must seek 1115 Waiver approval for adult 12 month continuous eligibility.

Match Rate: CMS assessed that 97.4 percent of the cost should be financed at the enhanced matching rate available for newly-eligible adults and the remaining 2.6 percent at a state's regular Medicaid matching rate.

Financing: The federal government will finance **99 percent** of the cost of providing 12 month continuous coverage to adults newly eligible for Medicaid in Oregon.



Simplify and Streamline OHP Eligibility, Enrollment and Redetermination Processes

● **Overview:** Reduce enrollment barriers for consumers and administrative burdens in processing applications and renewals for staff by making improvements and simplifications at every step of the enrollment process.

● **Goals:**

- Use of plain language, accessible application and renewal forms
- Use of member notices that clearly explain basis of eligibility determination and needed steps by the consumer to ensure enrollment or renewal
- Eliminate eligibility criteria and verification procedures not required under federal law
- Use existing data sources to automatically enroll individuals in Medicaid; complying with federal administrative renewal procedures that minimize consumer action and further ensure retention
- Maximize state and community partnerships to assist with outreach, enrollment and renewal processes



Adopt Transparent OHP Eligibility, Enrollment and Redetermination Performance Indicators

● **Overview:** CMS requires states to report on a specific set of Medicaid and CHIP Performance Indicators.

● **Goals:**

- Ensure consistent, timely and reliable set of data for program monitoring and public reporting.
- Provide information about impact and outcomes of Medicaid and CHIP eligibility and enrollment processes.

● **Using data from disenrollment and denial reason codes:** This data can be used to identify reasons for procedural denials and to modify processes, materials, or policy to improve retention in one program or improve rates of seamless transfer to others.



Recommendations to Reduce and Avoid Churn in 2015:

- Simplify and streamline OHP eligibility, enrollment and redetermination processes.
- Align OHP income eligibility and QHP tax credits' income budget periods.
- Conduct a cost-benefit analysis of adopting 12-month continuous eligibility for OHP income-eligible adults.
- Adopt transparent eligibility and enrollment performance indicator(s) to monitor churn in OHP.



Churn Mitigation

Goals:

- Maintain access to the same plans and providers as family circumstances change
- Reduce the affordability cliff as a result of a transition from Medicaid to a QHP
- Enroll families in the same plan

Strategies:

- **Benefits and Provider Network Alignment:** enables continuity of benefits and providers during transition period
- **Tax Credits/Cost Sharing and Benefits Wrap:** reduces affordability cliff; smooths changes in benefits
- **Medicaid Bridge Plan:** facilitates continuity of plans and providers; reduces affordability cliff; enables families with mixed coverage to enroll in the same plan; smooths change in benefits
- **Basic Health Plan:** reduces affordability cliff; may facilitate continuity of plans and providers

Benefits and Provider Network Alignment Strategy

● **Overview:** Leverage QHP contracting process to mitigate disruptions in coverage and care during transition period.

● **Same Providers**

- Require or incent CCOs and QHPs to maintain same provider network in Medicaid and the Marketplace.

● **Same Benefits**

- Require CCOs /QHPs receiving enrollees to be responsible for care previously provided by a relinquishing payor for a limited period of time.
- Examples in state managed care contracts include:
 - pregnancy coverage;
 - certain dental care, such as orthodontia;
 - hospitalizations or transplants;
 - chemotherapy, radiation therapy, and dialysis;
 - individuals with prior authorizations for procedures; and
 - behavioral health and chemical dependency services.



State Subsidizes Premiums and Cost Sharing and Wraps Benefits

● **Overview:** State provides subsidies to reduce the cost of premiums and cost-sharing using state-only dollars.
State wraps additional Medicaid benefits not offered by a QHP using state-only dollars (e.g., non-emergency transportation, vision, dental).

● **Individual Eligibility:** Must meet QHP eligibility requirements; consider income eligibility up to 200% of the FPL.

● **Financing:** No federal funding available; must use state only dollars.

● **State Activity:** Massachusetts subsidizes premiums and cost-sharing for individuals with incomes up to 300% of the FPL. (Received a waiver and uses federal Medicaid dollars for subsidies).



Bridge Plan Overview

- **Overview:** A CCO certified as a QHP; limits enrollment to consumers, and their family members, transitioning from Medicaid to the Marketplace
- **Individual Eligibility:** limited enrollment to individuals previously enrolled in Medicaid, and their family members, with incomes below 200% of the FPL and also limit enrollment to 12 months or less.
- **Bridge Plan Certification:** Bridge Plans to meet QHP certification requirements.
- **State Activity:** Originally developed by Tennessee but not implemented. California awaiting approval from CMS to offer Bridge Plans to a projected 670,000 individuals with incomes below 200% FPL churning off of Medicaid.
- **Affordability:** The second lowest cost silver plan (SLCSP) will be different for Bridge Plan eligible individuals than non-Bridge Plan eligible individuals. The Bridge Plan eligible individual will be able to use his/her tax subsidy to purchase a Bridge Plan which is expected to be a lower cost alternative because it is built off of the Plan's existing Medicaid provider network.



Basic Health Plan (BHP) Program Requirements

- **Overview:** States use federal tax credits and costs sharing reductions to subsidize coverage for individuals with incomes below 200% FPL otherwise eligible to purchase Marketplace coverage. States can use the BHP to reduce premiums and cost sharing for eligible consumers. Depending on design, the BHP may also help consumers maintain continuity across plans and providers as incomes fluctuates.
- **Eligible Individuals:** Individuals with incomes between 138% - 200% FPL (and under 138% FPL for lawful immigrants subject to Medicaid 5 year bar), under age 65, and who meet all other eligibility requirements for QHPs.
- **Comparable, or Better, Costs and Benefits:** Enrollees must receive at least the same benefits and pay no more in premiums and cost sharing than they would in the Marketplace.
- **Financing Formula:** The federal government pays the state 95% of value of the premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the applicable 2nd lowest cost silver Marketplace plan.
- **Administration:** States must set up a trust fund to receive federal funding for subsidies; administrative costs are not federally funded.



Alternative Coverage Options: Key Considerations

Basic Health Plan (BHP)

- Eligible enrollees ineligible for QHP subsidies
- New transition point and affordability cliff created at 200% FPL
- Federal funding may not cover cost of plans; State has financial exposure
- State fiscal responsibility for start-up and ongoing administrative costs
- Fewer covered lives in the Marketplace may affect risk pool, increase QHP premiums
- Providers may receive lower reimbursement rates than in a QHP

Medicaid Bridge Plan

- Equity issue for individuals never enrolled in Medicaid; not eligible to enroll (139-200% FPL)
- Administrative complexity; eligibility and enrollment systems will have cost implications
- To reduce consumer costs, providers paid at a lower rate than what they would be paid in a QHP



Recommendations to Mitigate Disruptions from Churn in 2016

- Implement contractual mechanisms to support and streamline care transitions between relinquishing and receiving Medicaid CCOs and QHPs.
- Develop a plan to ensure insurance and delivery system alignment between Medicaid CCOs and Oregon's commercial market.
- If funding is available, offer wraparound of targeted consumer out-of-pocket costs and /or benefits.
- BHP and Medicaid Bridge not viable options for 2014 or 2015 due to implementation costs and administrative complexity.



Conclusion

- Committee extensively reviewed a set of comprehensive and practical strategies for policymakers and state officials to address churn
- Recommendations align with the Oregon's existing policies, and may enhance the Medicaid and Marketplace delivery system
- Several strategies could be implemented simultaneously and are complementary
- If adopted, recommendations will help Oregon achieve multiple, overlapping goals



Questions & Comments

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