Report on Health Reform Implementation

From Coverage to Care: Addressing the Issue of Churn

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Editor's note: The two essays in this issue's Report on Health Reform Implementation section emerged from a workshop, generously funded by the Robert Wood Johnson Foundation, that was held in Chicago in January 2014. The purpose of the workshop was threefold: first, to increase communication and learning between state-level policy practitioners and health policy researchers; second, to address key Affordable Care Act implementation issues that states are currently grappling with; and, third, in response to these issues, to identify useful policy instruments and strategies for dissemination across the states. With these as the goals, we asked several policy practitioners in different states to submit questions on current implementation challenges that might benefit from the insights of a policy researcher. We then identified researchers with significant expertise in applicable areas to respond to a small selection of these important questions. Charles Milligan's question on how to address churn to ensure continuity of care and Sara Rosenbaum's response are examples of the work that came out of this productive process. They represent the second of three sets of 2014 conference essays to be published in this section. We welcome any feedback on the process or the issues.
—Colleen M. Grogan

Abstract In any given year, a significant number of individuals will move between Medicaid and qualified health plans (QHP). Known as "churn," this movement could disrupt continuity of health care services, even when no gap in insurance coverage exists. The number of people who churn in any given year is significant, and they often are significant utilizers of health care services. They could experience disruption in care

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in several ways: (1) changing carrier; (2) changing provider because of network differences; (3) a disruption in ongoing services, even when the benefit is covered in both programs (e.g., surgery that has been authorized but not yet performed; ongoing prescription medications for chronic illness; or some but not all therapy or counseling sessions have been completed); and (4) the loss of coverage for a service that is not a covered benefit in the new program. Many strategies are available to states to reduce the disruption caused by churn. The specific option, intervention, and set of policies in a given state will depend on its context. Policy makers would benefit from an examination and discussion of these issues.

Keywords churn, Medicaid, Maryland, qualified health plan (QHP)

Introduction

In any given year, a significant number of individuals will move between Medicaid and qualified health plans (QHP). This transition will not represent a loss of insurance coverage, but it could disrupt continuity of health care services. Policy interventions are available in new laws and regulations to prevent or ameliorate the risk of disrupted care. Maryland has taken one approach to this issue, but the broader topic would benefit from insights and strategies that could be adapted to other states.

Churn

One of the overlooked virtues of the Affordable Care Act (ACA) was the standardization of eligibility criteria under the framework of "modified adjusted gross income" (MAGI). The MAGI rules standardized two key definitions: the composition of a household and the income that is "counted" within that household. These standard definitions make it possible to calculate any household's percent of the federal poverty level (FPL). Because of the uniform approach to this calculation, a point-in-time calculation of a household's percent FPL will be the same in all states, which enables a household to move across state lines while retaining the same percent FPL. In addition, any change in a household's percent FPL will be treated identically by Medicaid and subsidized QHPs, which enables a household to seamlessly lose Medicaid eligibility and gain subsidized QHP eligibility (and vice versa), with no gap or overlap between the two. And for many households during the course of a year, the percent FPL does change, and the members of the household will move between Medicaid and QHPs. This phenomenon, known as "churn," could disrupt the provision of health care services, even if insurance coverage is seamless.

Prevalence of Churn

In Maryland, we examined the prevalence of churn. Using data on the 880,416 individuals who had Medicaid at some point during state fiscal year 2011 (July 1, 2010–June 30, 2011), and focusing on the MAGI-like eligibility categories, we found:

- 592,373 individuals (67.3 percent) had Medicaid continuously throughout the year;
- 174,996 individuals (19.9 percent) gained Medicaid coverage during the year (i.e., were on Medicaid on June 30, 2011, but not July 1, 2010);
- 103,573 individuals (11.8 percent) lost Medicaid coverage during the year (i.e., were on Medicaid on July 1, 2010, but not June 30, 2011); and
- 9,474 (1.1 percent) gained *and* lost coverage during the year (were on Medicaid neither on July 1, 2010, nor on June 30, 2011, but had coverage during the year).

We hypothesized that most people who gained Medicaid during the year would have been churned from a QHP, had subsidized QHPs existed in fiscal year 2011. Moreover, we hypothesized that most people who lost Medicaid during the year would have churned into a QHP.

While the specific pattern of churn would vary by year, based on factors like the economy, the fact that fully one-third of all Medicaid participants would have churned into or out of QHPs in a given year led Maryland to enact a state law (discussed below) in 2013 to address continuity of care.

Attributes of the Population That Churns

We also looked at the diagnoses and service utilization of the population that churns. We found the following:

- Of the population that lost Medicaid eligibility: 41 percent were receiving prescriptions at the time they lost Medicaid, 10.1 percent were receiving mental health services, and 3.6 percent were receiving services related to substance use disorders.
- Of the population that gained Medicaid eligibility: 6.8 percent were women who became Medicaid eligible because of pregnancy, 46.3 percent were receiving prescriptions by the end of the year, 21.4 percent became Medicaid eligible while they were hospitalized, 9.6 percent were receiving mental health services by the end of the year,

and 4.0 percent were receiving services related to substance use disorders by the end of the year.

In short, the population that churned comprised utilizers of services, and, in particular, the group that gained Medicaid eligibility was correlated with medical needs.

Disruption in Care

Disruption in care as a result of churn can take four different forms:

- *Change in carrier*. This would occur when a person moves between a QHP that participates in the marketplace and an unrelated managed care organization (MCO) that participates in Medicaid.
- *Change in provider*. This would occur when a person must change provider because his or her former provider is not in-network in the new program or carrier. This form of disruption, we should note, could occur even if the QHP and MCO are part of the same corporate family, because the networks might not align even when the corporate parent company is the same.
- *Disruption to ongoing covered services*. This would occur when a person is in the midst of receiving care when he or she churns, even when the given service is a covered benefit in both Medicaid and the QHP. Examples include surgery that has been authorized but not yet performed, ongoing prescription medications for chronic illness, some but not all therapy or counseling sessions have been completed, and churn during an inpatient stay. We should note that services could be disrupted even when the treating provider is in-network in both programs, if the authorization rules and standards vary.
- *Disruption due to benefit design differences*. This would occur when a person is receiving services that are no longer covered in the new program. Examples include a child receiving robust Medicaid services under the "early and periodic screening, diagnosis, and treatment" (EPSDT) requirements in Medicaid who then moves to a more typical commercial well-child benefit in a QHP; an adult receiving robust behavioral health services in Medicaid who then moves to a more commercial behavioral health benefit in a QHP; an adult who is receiving more robust services in a QHP (e.g., private duty nursing, chiropractic services, or acupuncture services) who then moves to Medicaid in a state where these are not covered optional services. This form of disruption arises because the person becomes uninsured with respect to the formerly covered services.

Strategies to Reduce Disruption

A number of strategies can be used to reduce disruption. One involves a decision by the state to align the programs as closely as possible—the same carrier, network, and covered benefits. Encouraging carriers to participate as a QHP and MCO and encouraging providers to participate broadly are examples of this strategy. The Basic Health Plan in the ACA is another example.

States can also attempt to align programs in the procurement strategies they use to list QHPs on their marketplace or offer Medicaid MCO contracts.

Maryland's Approach

In Maryland in 2011 and 2012, we initially attempted to align the QHPs and MCOs as a strategy to reduce the disruption of churn. This effort was largely unsuccessful: the dominant commercial carrier in the individual and small group market is Maryland's Blue Cross Blue Shield plan (known as CareFirst). CareFirst does not participate as a Medicaid MCO, and it does not intend to participate in Medicaid for the foreseeable future. Similarly, the largest Medicaid MCOs do not participate in the commercial market or as QHPs, and they do not intend to do so for the foreseeable future.

As a result, Maryland shifted its strategy. With broad support from stakeholders, in 2013 the Maryland General Assembly passed a continuity of care law, which Governor Martin O'Malley signed into law.

The highlights include the following:

- *Continuity with provider*. For the first ninety days or until the course of treatment ends (whichever occurs first), the "receiving" carrier (QHP or MCO) must allow the person to stay with his or her provider from the "relinquishing" carrier, even if the provider is out-of-network, for certain delineated care. The provider must agree to accept the receiving carrier's standard fee schedule.
- *Continuity with services*. For the first ninety days or until the course of treatment ends (whichever occurs first), the receiving carrier must honor all authorizations from the relinquishing carrier for services that are covered services in the receiving carrier's benefit design.

An actuary hired by Maryland estimated that these protections would add only about seven cents to the monthly premium for QHPs, and only five

cents to the monthly premium for MCOs, because the law neither expanded the benefit package for QHPs and MCOs nor changed what the QHPs and MCOs must pay providers for covered services.

These protections are intended to ensure that care and services are not disrupted.

Scholarship, Research, and Insights

Maryland's approach is just one possible approach. The right solution for a given state depends on its context and environment. As a result, policy makers across the country would benefit from thoughtful analysis and insights.

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