

Eligibility Churning, Continuity of Coverage and Care: Policy Options Washington State Health Care Authority

Washington Health Care Authority
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WORKING DRAFT - revised May 21



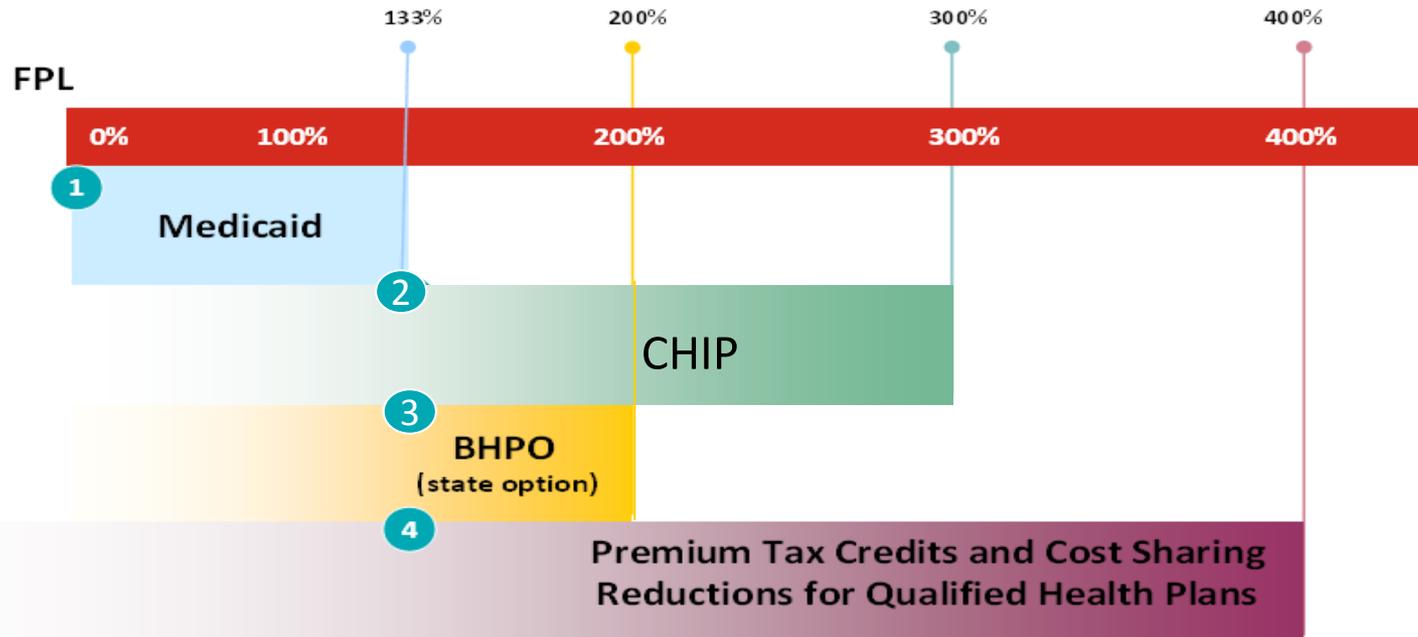
Agenda

- Review churn between Medicaid - Exchange
 - ❖ Churn modeling results
 - ❖ Preliminary options for minimizing churn implications
 - ❖ Incorporate input from health plans
 - ❖ Introduction to whole family coverage
 - ❖ Special case: pregnant women

Policy Goals

- **Optimize access and use of needed services**
- **Maximize continuity of coverage** as eligibility circumstances change
- **Maximize continuity of care** as eligibility circumstances change
- **Cost-effective use of federal, state and private dollars**
- **Identify and optimize administrative simplification** opportunities
- **Comply with or, seek waiver from,** specific ACA coverage and eligibility requirements

2014 Context: Insurance Affordability Programs



NOTE:

- CHIP \$\$\$ cover children 133-200% FPL and 200-300% FPL (with limited cost-sharing)
- Pregnant women covered up to 185% FPL

Why is churn a problem?

Medicaid Coverage	Exchange Coverage
Medicaid standard/benchmark benefits	Essential health benefits
No premiums	Subsidized premiums (Advance Premium Tax Credits)
No cost sharing	Subsidized cost sharing (Cost Sharing Reductions)
Medicaid provider network	Commercial provider network
Care management / health homes	Different care management (?)

Why is churn a problem?

- Discontinuity of provider relationships and care – associated quality and cost problems including undermining of medical/health homes
- Distress, inconvenience, confusion – access compromised for enrollees/patients/families
- Administrative expense for health plans
- Incentives for health plans/providers to invest in longer-term health improvements negated
- Affordability issues for tax-credit eligibles when current incomes increase temporarily

Who is likely to experience churn?

Income at Initial Determination v. Actual Annual Income for Enrollment Year

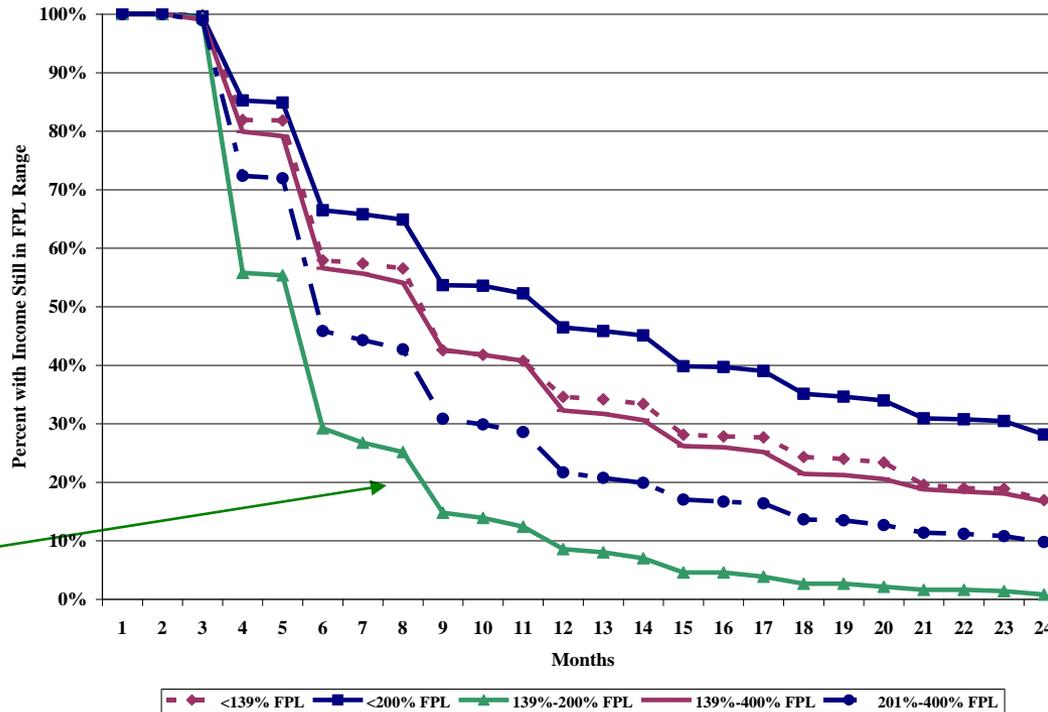
Row Percent	[- Final FPL Range -]				
Initial FPL Range	<139% FPL	139%-400% FPL	>400% FPL	TOTAL	
<139% FPL	68.9%	23.7%	7.4%	100.0%	
139%-400% FPL	21.7%	65.5%	12.8%	100.0%	
>400% FPL	13.5%	46.1%	40.3%	100.0%	
TOTAL	47.0%	39.9%	13.1%	100.0%	
Initial FPL Range	<139% FPL	139%-200% FPL	201%-400% FPL	>400% FPL	TOTAL
<200% FPL	63.0%	13.3%	16.3%	7.3%	100.0%
139%-200% FPL	33.0%	24.2%	35.8%	unreliable	100.0%
201%-400% FPL	15.8%	14.2%	54.2%	15.7%	100.0%
>400% FPL	13.5%	8.1%	38.0%	40.3%	100.0%

Notes: Based on Washington State adults age 19-64 without employer-sponsored insurance (ESI) at initial determination. FPL = federal poverty level. Source: SIPP analysis by John A. Graves, Ph.D.

Who is likely to experience churn?

- Over several years, very few stay in the 139-200% FPL income range – a very unstable group

Retention in Initial (Current) Income Level (WA Adults 19-64)



139%-200% FPL



Who is likely to experience churn?

- If an adult's income crosses the Medicaid/Exchange income boundary one year, it is likely to cross back in the following year.

E.g., based on comparing annual income over 3 years:

- Adults whose income drops below 139% FPL from Y1 to Y2 are 3 times more likely to rise above 139% FPL in Y3 than are adults whose income was below 139% for both Y1 and Y2 (46.5% v. 15.4%)
[Similar at 200% FPL: 39.6% v. 13.9%]
- Similarly, adults whose income rose above 139% FPL from Y1 to Y2 are 3+ times more likely to fall below 139% FPL in Y3 than are adults whose income was above 139% FPL for both Y1 and Y2 (24.0% v. 6.7%)
[Similar at 200% FPL: 24.3% v. 8.8%]

Options for Addressing Churn

- Retain current health plan and providers
 - ❖ Medicaid to Exchange continuity
 - ❖ Exchange to Medicaid continuity
- 12 month continuous eligibility/ guaranteed Medicaid enrollment

Background Assumptions

- Medicaid Benchmark will have comparable services and consumer cost-sharing to Medicaid Standard
- Medicaid Benchmark will closely align with “essential health benefits” required by QHPs
- QHPs will “fill-in” cost-sharing to meet Medicaid specifications
- Not all Medicaid carriers will offer QHPs; not all Exchange carriers will offer Medicaid coverage
- Provider networks likely to be different for health plans that offer Medicaid / QHPs

Medicaid to Exchange Continuity

Medicaid to Exchange Continuity: Option

- Medicaid plans not otherwise participating in the Exchange could participate on a limited basis, i.e., (only) to cover existing enrollees who lose Medicaid eligibility and gain eligibility for federal tax credits in an Exchange QHP.

Rationale: Such Medicaid health plans have limited capacity which could not accommodate guaranteed issue to all higher-income populations (but can accommodate continued coverage of current enrollees).

Medicaid to Exchange Continuity: Considerations

- Medicaid plan costs less than tax-credit “benchmark” commercial plan
- (Former) Medicaid enrollees typically have depleted resources and are likely to return to Medicaid
- May permit continued coverage to be free up to 200% FPL (assuming tax credit based on commercial QHP)
- Similar request to Tennessee Bridge Option
- Limits on scope and/or exposure may be needed to avoid equity, state cost, and systemic risk selection problems.

Medicaid to Exchange Continuity: Considerations

Why might limits be needed?

- Many Exchange enrollees will have short-duration income reductions below 139% FPL per month.
- Such individuals would be incented to apply for Medicaid to obtain ongoing free coverage in the Exchange not available to many with lower annual incomes.
- Incentives could be particularly strong for low-risk adults and create systemic adverse selection problems for QHPs.
- This could also increase Medicaid enrollment and costs.

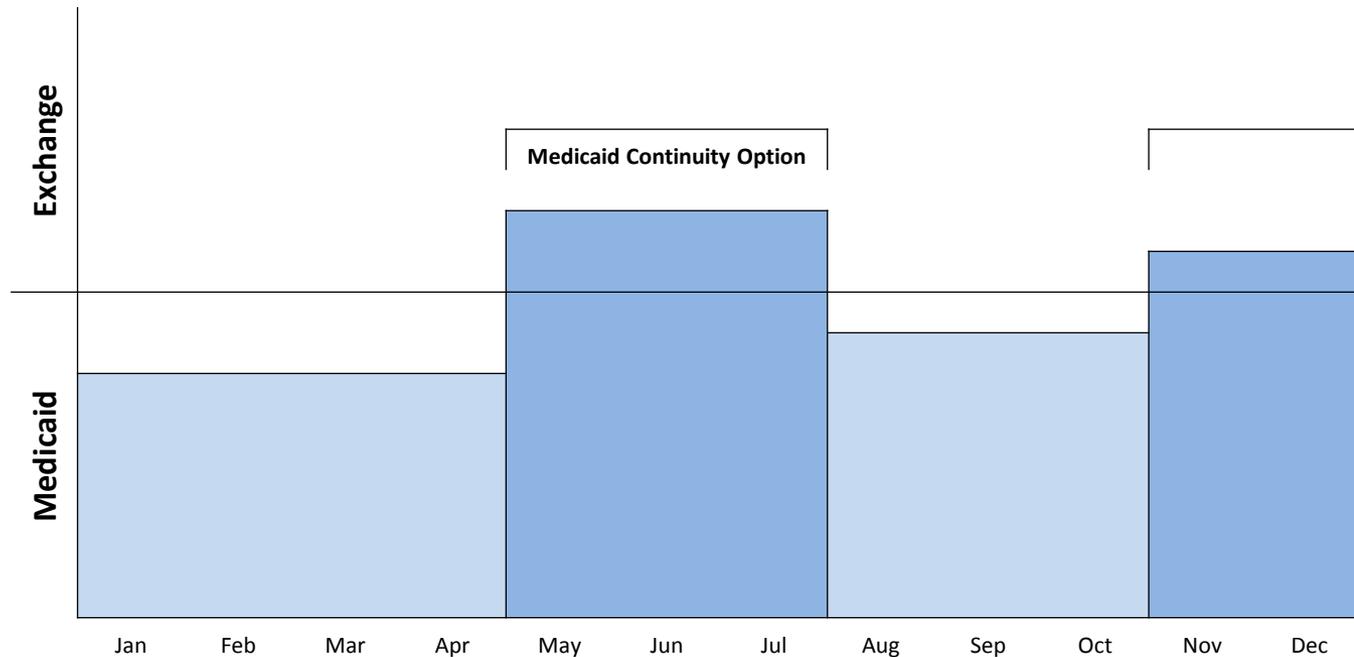
Medicaid to Exchange Continuity: Variations

- Allow continued enrollment only while income remains < 200% FPL
 - ❖ People with greatest need for lower costs.
 - ❖ Cost-sharing reductions in Exchange makes benefits similar to Medicaid, easier for Medicaid plans to administer.
 - ❖ Medicaid plan providers more likely to accept participation for this low-income group.
- Limit to only individuals originally enrolled in Medicaid for a specified minimum duration
 - ❖ For example - 3 months or more:
 - Continuity of plan and providers not otherwise an issue
 - People with very short-term income reductions not as needy

Medicaid to Exchange Continuity: Variations

- Limit maximum period of continued enrollment
 - ❖ For example - up to 12 months; for the remainder of the plan year; until the end of the plan year that ends 9 or more months later
 - ❖ Equity consideration –people in similar situations don't get free coverage because they haven't been on Medicaid
- Target (or exclude) specific categories of enrollees?

Medicaid to Exchange Continuity: Adult Example



Jan - Income qualifies for Medicaid

May - Hours increase, income increases, qualifies for Exchange Qualified Health Plan (QHP)

Aug - Hours decrease, income decreases, qualifies for Medicaid

Nov - Hours increase, income increases, qualifies for Exchange

Exchange to Medicaid Continuity

Exchange to Medicaid Continuity: Option

- Require or allow Exchange QHPs to participate in Medicaid (using the same provider network) on a limited basis to provide continuing coverage to commercial QHP enrollees whose circumstances make them eligible for Medicaid

Exchange to Medicaid Continuity: Considerations

- Medicaid capitation rates would be less than Exchange QHP premiums
- Reduced churning could lead to some cost avoidance for health plans through:
 - ❖ Administrative savings
 - ❖ Reductions in redundant testing, inconsistent or incompatible care regimens / prescriptions etc
 - ❖ Reductions in service use per month due to improved early intervention and care management (e.g., for patients who would otherwise leave the plan and associated care management then return in worsened condition and/or with pent-up care needs)

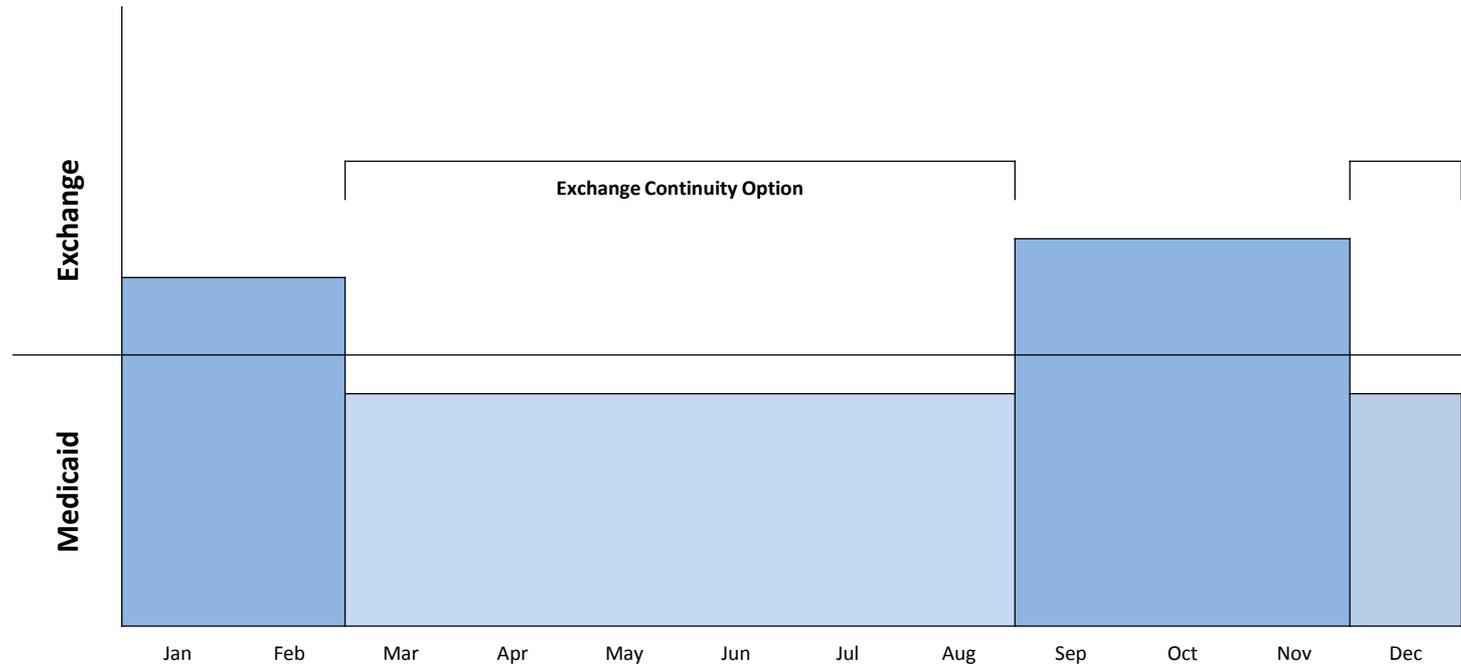
Health plan feedback suggests cost avoidance impact small, but experience indicates per-month costs are lower after initial enrollment period.

Exchange to Medicaid Continuity: Variations

Limit cost impact on Exchange QHPs that provide continuity for enrollees moving to Medicaid through:

- Limit duration of coverage continuation – to capture most individuals whose income is temporarily reduced and will return to QHP.
- Limit to individuals who meet minimum (pre-Medicaid) QHP enrollment duration, e.g., 3 months or more
 - ❖ Longer QHP enrollment could be tied to longer limits on duration of coverage
- Limit disproportionate burdens on any QHP
 - ❖ (Pro-rata limits on Medicaid enrollment obligation based on Exchange enrollment)
- Limit qualifying income level
 - ❖ For example – constrain to expansion populations above 75% FPL
- Compensate QHPs for losses – probably unrealistic
 - ❖ For example – risk adjust across Exchange QHPs; total individual market; or combined individual/small group markets

Exchange to Medicaid Continuity: Adult Example



Jan - Income qualifies for Exchange Qualified Health Plan (QHP)

Mar - Hours decrease, income decreases, qualifies for Medicaid

Sep - Hours increase, income decreases, qualifies for Exchange at new income level

Dec - Hours decrease, income decreases, qualifies for Medicaid

12 month continuous eligibility/ guaranteed Medicaid enrollment

12 month continuous eligibility/ guaranteed Medicaid enrollment: Option

- Guarantee enrollment for 12 months for adults (19-64) determined eligible for Medicaid, regardless of subsequent changes in income or family composition during the period
- No parallel provision available in federal rules to support continuous Exchange eligibility
- Could increase member-months covered by Medicaid by 70%-80%.

Whole Family Coverage

Whole Family Coverage: Problem

- Under presumptive ACA structure, parents (<300% FPL in WA) enrolled in Exchange QHPs could only gain affordable coverage for their children by enrolling them *separately* in Medicaid/CHIP health plans
- Barriers to appropriately accessing care increase for families when parents receive care through one system but have to access care for their children through another

Whole Family Coverage: Goal and Considerations

- Goal:
 - ❖ Make family plans available through the Exchange to simplify children's coverage and access to care for often-overburdened, modest-income parents
- Considerations:
 - ❖ State budget neutrality
 - ❖ Affordability for family
 - ❖ Administrative simplicity for family and state program(s)
 - ❖ Compliance with market rules

Whole Family Coverage: Policy Rationale

- Common coverage for the *whole* family:
 - ❖ Simplifies coverage solutions for families that otherwise face a bifurcated and potentially confusing coverage experience
 - ❖ Realizes and sustains the “one-stop” shop consumer experience
 - ❖ Retains continuity of coverage and provider networks through same insurance vehicle when family income changes, mitigating the impact of churn
 - ❖ Enhances spectrum of choices for tax credit-eligible families (*parents retain choice to enroll their children in an Apple Health for Kids product*)
 - ❖ Essential health benefits offered by Exchange QHPs provide comprehensive coverage comparable in substance and scope to Apple Health for Kids benefits
 - ❖ Equalizes shopping experience for families of low, modest, or high income by providing same plan options regardless of income

Whole Family Coverage: Legal Rationale for Title XXI

- Final Medicaid Eligibility Final Rule:

Preamble Excerpt: “We also note that there are several ways that States can promote the ability of families to enroll in the same plan. States may contract with the same plans that participate as QHPs in the Exchange to deliver covered services in their CHIP programs. States also may offer CHIP eligible individuals the choice of receiving premium assistance through a QHP offered in the Exchange consistent with the standards and requirements of section 2105(c)(3) of the Act. Guidance about the use of premium assistance and coordination of coverage with QHPs in Exchanges is forthcoming.”

- Social Security Act 2105(c)(3):

Waiver for purchase of family coverage.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

(A) purchase of such coverage is cost-effective relative to—^[97]

(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

(ii)^[98] the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families;^[99] and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

Whole Family Coverage: Legal Rationale for Title XIX

- In Washington state, 138-200% of FPL income range covered by early Medicaid expansion, not CHIP
- Language in 2105(c)(3) clearly allows family coverage solutions in states with CHIP programs that start at 133%. Federal technical assistance needed to interpret this framework for Title XIX children in WA
- Current statutory authority for premium assistance in Medicaid populations may also provide means for achieving this same goal

Whole Family Coverage: Option 1

- Parents enrolling in the Exchange who have Apple Health-eligible children (138% - 300% FPL*) would have OPTION to enroll their children and themselves in family coverage, if they choose a QHP offering this option
 - ❖ Parents' premium obligation for their children's coverage would be no greater than for Apple Health for Kids (i.e., \$20/child at 200-250% FPL or \$30/child at 250-300% FPL)
- Parents opting for a Medicaid plan for their child would have opportunity to enroll in the whole family product during next open enrollment period
- Children could continue their QHP coverage until next open enrollment period should their parent(s) leave the Exchange (e.g., due to an affordable offer of employer coverage)
- This option would also be available to existing Exchange families if their incomes fell below 300% FPL

* 300% of FPL is the income cap for CHIP coverage in Washington State

Whole Family Coverage: Option 1 (cont)

- Silver level QHPs would have OPTION to participate in this family coverage program
 - ❖ State could *limit* participation to plans offering Silver level premium for children no greater than state per capita rates for Apple Health for Kids, (see slide #7)
 - ❖ Alternatively, if allowed, any silver plan could participate with parents allowed to pay premium differential and have access to full range of plans for themselves and their children
- QHP would reduce Silver plan cost-sharing for children to same actuarial value (AV) level as their parents' plan (i.e., 94% AV up to 150% FPL, 87% AV to 200% FPL, 73% AV to 250% FPL)
 - ❖ Depending on difference between QHP premium and Medicaid payment amounts, cost-sharing reduction might be partially/entirely at plan's expense
 - ❖ Plan could cover these costs via broad revenue source (e.g., interest on reserves, charitable contributions from others, or some other source)
 - ❖ This should *not* be financed via increased Silver plan premiums and should *not* otherwise complicate or compromise application of risk spreading and individual market rules regarding premium levels

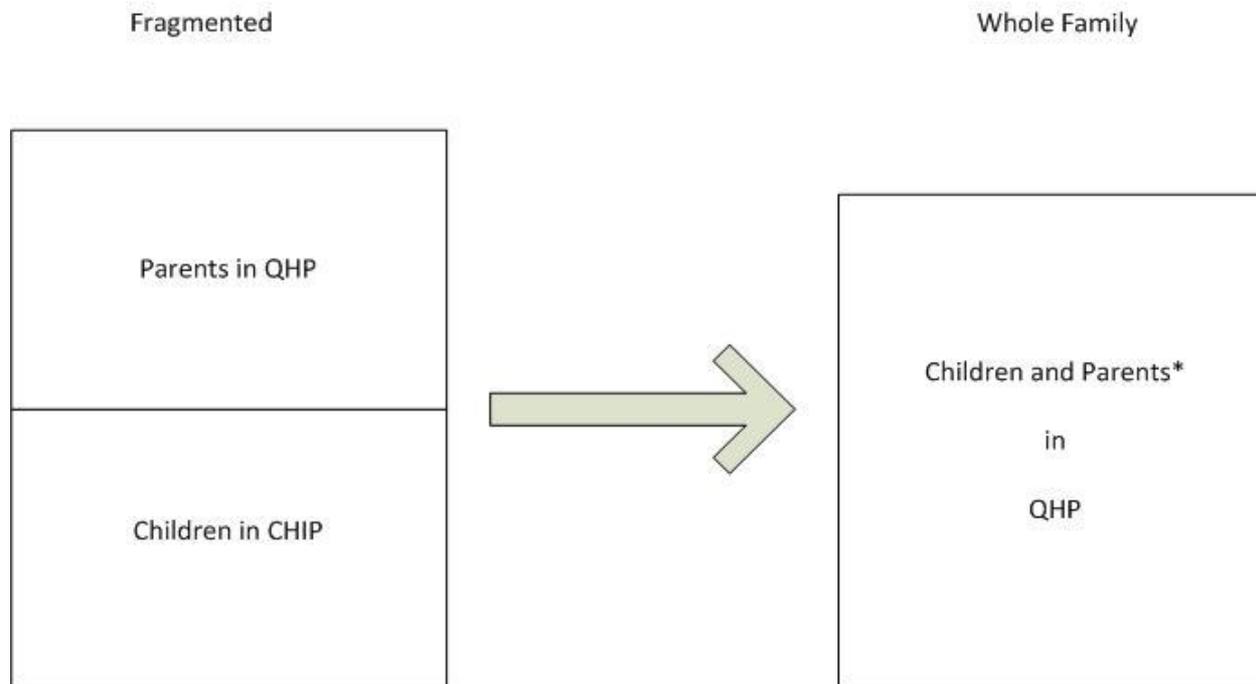
Whole Family Coverage: Option 1 (cont)

- Title XIX or XXI dollars - with accompanying state match – would finance premiums for QHP coverage at applicable Medicaid per capita rate
 - Medicaid/CHIP would provide “premium assistance” payment toward QHP applicable premium for children up to lesser of:
 - ❖ Medicaid's normal per-capita payment levels, or
 - ❖ QHP’s premium plus cost-sharing reduction costs
- * *For children whose parents leave the Exchange to obtain employer coverage, the state might consider extending premium assistance where such children could maintain family coverage with their parents through the employer plan (if deemed cost effective for the state)*

Whole Family Coverage: Option 2

- In lieu of Medicaid/CHIP coverage, children of Exchange-covered parents would become tax-credit eligible members of the family
 - ❖ These families would qualify for tax credits and cost sharing reductions on the basis of their family income
 - ❖ Their premium contribution (*for the 2nd lowest cost silver plan*) would be the same as it would be for coverage of the parents without the children
 - ❖ These families could choose any other Silver level QHP, and pay or save the associated premium difference (like other tax-credit and cost-sharing-reduction recipients)
 - ❖ State would make “*maintenance of state effort*” payments to federal government for these children equal to state cost for covering them directly through Medicaid
- This potential variation may require Section 1115 waiver

Whole Family Coverage: Example



*Per Capita Premium Medical Assistance and APTC/Cost Sharing Fill-in

Special Case: Pregnant Women

Pregnant Women: Problem

- Pregnant women could have significant continuity and fragmented family coverage problems under Washington's MOE 185% FPL eligibility level.
- QHP enrollees who become pregnant and apply for additional assistance would have to switch to Medicaid plan coverage if their current income is below 185% FPL
 - ❖ This will be problematic for women who have established care relationships with providers who do not participate in Medicaid plans, and for women enrolled as a couple with their spouse in the same QHP.
 - Most categorically eligible pregnant women do not enroll in Washington's Medicaid program until their second trimester.

Pregnant Women: Problem

- Those whose incomes are above 139% FPL will have to switch back to QHP coverage 2 months after delivery (because they are no longer eligible for Medicaid).
 - ❖ Most such women would change coverage sources twice over a 5 to 8 month period
 - ❖ The resulting discontinuities in care, and compromised plan incentives for positive health outcomes would be particularly unfortunate for these women and their children.

Pregnant Women: Problem

- Nevertheless, such women will have compelling reasons to apply for additional assistance and thus be switched to Medicaid when they become pregnant.
 - ❖ Most will have incomes between 200% and 250% FPL before they apply as pregnant, and therefore receive only a 73% Actuarial Value QHP, and pay between 6.3% and 8% of family income toward premium.
 - ❖ When they are pregnant and apply for additional assistance, their increased family size will reduce their income as a percent of the federal poverty level and thus qualify them for free comprehensive Medicaid coverage.
 - ❖ If, as in other states, they were not eligible for Medicaid, they could remain in their QHP and (in the year of expected birth) receive 94% or 87% AV and reduce their premium to between 2% and 5% of income.

Pregnant Women: Option

One Potential Solution: Medicaid purchase of continuing QHP coverage and cost-sharing reductions for pregnant women between 139% and 185% FPL.

- This would afford continuity of coverage and provider care for these women
- If purchased as Exchange coverage, regular QHP monthly premiums would pertain, thus reducing State Medicaid costs relative to current state Medicaid service payments.
- Note this would increase the number of deliveries covered by QHPs.

Pregnant Women: Option

- If desired, QHPs might be protected from disproportionate effects via a risk adjustment factor.
- However, QHPs' incidence of deliveries should be the same as nationally under ACA, and comparable to commercial coverage for other income and coverage groups.*

* *“This should be true with respect to continuing coverage for QHP enrollees.” Note, however, that “if QHP coverage included all Medicaid eligible pregnant women from 139-185% FPL” to the degree that such women shift from employer coverage they are still eligible for Medicaid for their deliveries, and there could be a disproportionate incidence of deliveries under this policy in Washington State. (In other states, such women with access to affordable employer coverage will not be eligible for subsidized QHP coverage.) Actuarial estimates should be possible using existing Washington State Medicaid data and projections of Exchange and individual market enrollment under ACA..*

Continuity Option in the Context of a BHP

Issue:

- While a BHP for those 139% to 200% FPL could afford plan and provider continuity for Medicaid enrollees with increased incomes, it is unlikely to provide such continuity for those with Exchange or former employer coverage whose incomes decline.

One possible solution:

- The Exchange-to-Medicaid continuity option discussed above could be adapted to a BHP context to meet this need. In short, QHPs could participate on a limited basis in the BHP for purposes of continuing coverage of their current enrollees.

Continuity Option in the Context of a BHP

- Exchange enrollees whose incomes decline to beneath 200% FPL could be given the option to either :
 - ❖ enroll in a BHP-participating Medicaid plan at the normal BHP premium contribution cost, or
 - ❖ continue enrollment in their QHP coverage with the same reduced contribution and AV plan as they would have received via the Exchange if there had been no BHP.
- This would apparently allow a participating QHP to be paid 95% of its Exchange premium for that person.
 - ❖ I.e., because the BHP would receive funds for coverage of enrollees that are equal to 95% of what tax-credit and cost-sharing-reduction costs would have been for those enrollees.

Continuity Option in the Context of a BHP

- This should be readily acceptable to QHPs in the context of a BHP . . .
 - ❖ The medical costs for ongoing enrollees are on average lower than for the initial enrollment months, and
 - ❖ A QHP would have already incurred the administrative expenses associated with initial enrollment.
- However, this would probably *not* be feasible because actual BHP revenues could be substantially less than 95% of what federal tax credits would have been for a person with a BHP determination of income.
 - ❖ Why? (Next 2 slides.)

Continuity Option in the Context of a BHP

- SIPP data analysis indicates that most people who would be determined to be BHP eligible at initial application do not even have actual annual income in the BHP range.
- Federal funds for a BHP are to be based on what recipients' actual tax credits would have been in lieu of a BHP. Those tax credits will be reconciled based on recipients' actual year-end incomes.
- The tax credits for individuals initially in the 139-200% FPL range, but whose annual incomes increase to above 200% FPL, will receive final tax credits based on that higher income.
- The annual reconciliation limits that might otherwise curtail that person's tax-credit reduction would often not be binding in the case of BHP funds adjustments, because such individuals would often be in a BHP for much less than a year.

Continuity Option in the Context of a BHP

- The tax credits for persons whose incomes decline to under 139% FPL will be adjusted upwards only for the months they were not on Medicaid. Those with a significant income decline are likely to apply for additional assistance and will be required to be enrolled in Medicaid.
- Thus, because ACA clearly requires that BHP funds will be 95% of what tax-credit spending would have been in the absence of a BHP and, if needed, federal payments are to be retrospectively adjusted to that level, final revenues may be substantially under those needed to support subsidies based on BHP income determinations. Since Washington state does not have an income tax system, it does not seem feasible for it to emulate such federal income reconciliations.

Next Steps

- Gather feedback – written and otherwise
- Make further revisions as necessary based on discussion and feedback
- Revise options in light of federal guidance (e.g., whole family coverage, Tennessee Bridge proposal to reduce churn)
- Identify operational implications
- Plan future discussions for decision-making

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