

Report on Health Reform Implementation
**Addressing Medicaid/Marketplace
Churn through Multimarket Plans:
Assessing the Current State of Play**

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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 Both before and after the Affordable Care Act (ACA), the US health insurance system is characterized by fragmentation. Pre-ACA, this fragmentation included major coverage gaps, causing significant periods of coverage interruption, especially for lower-income people. The ACA does not end the problem of churning

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among sources of public financing, but it does hold the potential for enabling people to move among sources of coverage rather than go without insurance. Several strategies for reducing coverage churn exist, but none is foolproof and all are in their early stages. Thus the ability of issuers to participate across multiple public financing arrangements and to offer stable provider networks becomes crucial to achieving continuity of care. Interviews with nine companies involved in developing or operating multimarket strategies confirm the feasibility of this approach while revealing major challenges, especially the challenge of finding providers willing to treat members regardless of the source of coverage. Strategies for increasing multimarket plans and networks represent one of the great areas of future policy and operational focus.

Keywords churn, Medicaid, multimarket plans

Introduction

As the Affordable Care Act (ACA) moved into its full implementation phase, the initial open enrollment was all about the numbers. After recovery from the near-death experience of Healthcare.gov, the question that eclipsed all others became how many people would gain coverage. The launch ended triumphantly; of an estimated 27.7 million people eligible for some form of assistance (Buettgens, Kenney, and Recht 2014), 8 million enrolled in marketplace plans (ASPE 2014) and 6 million enrolled in Medicaid (CMS 2014).

But the ACA is about far more than isolated enrollment snapshots. The nation is now in the initial stages of testing a deeper, underlying issue: Is the ACA's coverage stable and continuous? Numerous analyses have identified income fluctuation as a key characteristic of the subsidy-eligible population. One frequently cited study found that in a single year, about 50 percent of adults with incomes below twice the federal poverty level are likely to experience at least one income change sufficient to cause a shift between Medicaid and the marketplace, while 25 percent can be expected to experience two or more changes (Sommers and Rosenbaum 2011: 232). The problem affects all states, even those that have opted out of the Medicaid expansion, although entrenched poverty that inhibits mobility, along with highly restrictive Medicaid eligibility standards, lessens the likelihood in opt-out states (Sommers et al. 2014: 703).

Continuity of coverage is associated with more accessible and higher-quality health care, both of which are fundamental aims of the ACA. Thus simply counting the number of people who are insured at any given moment must give way to the more meaningful question of how many are able to maintain coverage over time.

In this regard, the ACA's continuity problems simply are the latest chapter in the story, since the overall structure of US health care financing militates against coverage continuity in general. The nation is characterized by multiple pathways to insurance coverage; until the point of Medicare enrollment is reached, coverage stability remains an elusive goal for millions. The problem with multiple coverage pathways of course is not necessarily their multiplicity (although fractured financing poses problems for other reasons); rather, it is that movement among the pathways is not smooth and the paths are riddled with pockmarks. One important analysis of the effects of this fracturing and gap-ridden system found that over one three-year period, 38 percent of all nonelderly Americans were uninsured at any point in time (Short, Graefe, and Schoen 2003: 4).

The ACA's great advance is not that it replaces a fragmented insurance market but that it offers the possibility, at least theoretically, for most Americans to traverse multiple coverage pathways without periods during which they lack any coverage at all. By closing the holes in Medicaid and building an affordable and accessible individual private insurance market, the ACA offers the potential to ensure that frequent transitions do not include periods in which coverage is totally lost because of health status, life events, or shifts in income. Thus, as the nation slowly settles into a new normal in which being insured is not just a legal requirement but a social expectation, the challenge of coverage continuity can be expected to move to the forefront. This challenge means devising solutions for those most at risk of disruption.

Improving the level of integration between Medicaid and health insurance marketplace enrollment systems would help. Indeed, an integrated enrollment process—not just a unified application but a single, integrated determination and redetermination system—lies at the heart of the Medicaid amendments as well as the design of the health insurance exchange. States' deep concerns over the workability of this model, coupled with fears that they would lose control over Medicaid enrollment, led to its early demise however, with implementing regulations that give states the choice over whether or not to integrate. State autonomy to maintain Medicaid as an isolated pathway has complicated matters; along with the rocky rollout of the federal marketplace and many state marketplaces, the failure to integrate has helped produce a backlog of millions of Medicaid applications (Pear 2013). With time these serious problems likely will abate of course, but, for now, integrated enrollment remains a pipe dream.

Another option for mitigating market churn might be twelve-month continuous Medicaid eligibility, modeled on the idea of annual enrollment periods in the individual and group markets. A continuous eligibility option

already exists for children, and the Centers for Medicare and Medicaid Services (CMS 2013a) has made continuous eligibility for adults a state Medicaid option using its Section 1115 demonstration authority to enable states to overcome normal month-to-month income reporting requirements. Thus far, only New York State appears to have pursued this demonstration option; legislation to require twelve-month continuous enrollment in Medicaid has been introduced in the House and Senate during the 113th Congress (H.R. 1698; S. 1980), but prospects for passage obviously are slim.

Another option would be to adopt a Basic Health Program. Added as a coverage option under the ACA and modeled on a program launched in Washington State in the 1990s, the Basic Health Program permits states effectively to replace marketplace coverage for people with incomes between 133 percent and 200 percent of poverty with an alternative, publicly funded insurance pathway administered in tandem with Medicaid. Research suggests that by pushing the point of churn to twice the federal poverty level, this approach might produce a modest impact on the problem (Hwang, Rosenbaum, and Sommers 2012: 1318). But lengthy delays in the Department of Health and Human Services' (HHS) implementation of the program probably have doomed its chances, unless such a model is pursued by states in 2017 as part of broader innovation models permitted under the ACA.

A very different option, being pursued most prominently by Arkansas under Section 1115 demonstration authority, is to simply eliminate a separate Medicaid health plan market and enroll most or all Medicaid poverty-linked Medicaid beneficiaries in marketplace plans. This approach obviates the need to switch health plans whenever the source of insurance subsidy changes (Rosenbaum and Sommers 2013: 8). Although Arkansas holds promise, limits exist. First, CMS (2013b) has indicated that it will approve only a few such models in advance of the 2017 innovation option, until an evaluation is made. Second, Arkansas probably was politically feasible at least in part because the state had no large-scale Medicaid managed care industry. Without qualified health plans, the state literally would have had to resort to traditional fee-for-service coverage or enrollment of some two hundred thousand newly eligible adults into small primary care case management systems.

Even if premium assistance is expanded and states aggressively pursue annual eligibility periods and integrated enrollment systems, nothing can make churn go away. Evidence from Massachusetts, where near-total coverage has been achieved, suggests that this number is misleading, masking thousands who remain ineligible for any coverage, as well as

thousands who at any given time are experiencing breaks in coverage. Indeed, the state's community health centers, bellwethers of the underlying problem, report an average of 25 percent uninsured.

Inevitably, it is important to go beyond attempts to mitigate the effects of churn from a coverage perspective and think about how to alleviate its impact on the systemic side of the ledger. In this regard, a central strategy might be for issuers to offer both Medicaid managed care plans and marketplace plans, operated in an integrated fashion, most notably, using a shared provider network. Plans branded and positioned as continuity plans appear to be a highly plausible strategy for offering continuous care to their members regardless of the "back office" business of aligning subsidy sources with public sponsors at any given time. At least conceptually, this type of multimarket plan solution would have the power to shield people from the financial dimensions of health care, so that plans and payers can focus on the key issues of continuity and quality.

Could this approach work? In fact, the model seems to be taking off. According to the Association of Community Health Plans, as of December 2013, four in ten issuers of marketplace plans also offered Medicaid managed care plans (ACAP 2013). With a grant from the Commonwealth Fund, the George Washington University Department of Health Policy set out to study this phenomenon in order to glean early insights from plan sponsors about their multimarket experiences.¹

In reviewing the literature and consulting with industry representatives, our research team concluded that we needed to capture the early experiences of three distinct types of issuers: large Medicaid managed care companies moving into the commercial market, community-based Medicaid managed care plans seeking to enter the commercial market, and commercial insurers that have acquired a Medicaid subsidiary. In the end we selected a total of nine companies, several of which have nationwide markets and others of which are more localized to particular communities. We sought to ensure at least one company in each of the three basic categories and were able to do so. In interviewing even the companies with a national reach, we sought to focus on particular state markets, since experiences from state to state might be different and we wanted to ground the discussion as much as possible in the experiences in specific markets. All of the companies we interviewed were highly experienced in one or both markets (i.e., Medicaid and private insurance products). Interviews were conducted during the winter of 2014.

1. The George Washington University research team consisted of myself and Nancy Lopez, Mark Dorley, Carla Hurt, Jacqueline Miller, and Sara Rothenberg.

Findings

The interviews yielded a number of notable findings. First, all respondents reported that the problem of Medicaid/marketplace churn was a central factor in their focus on developing a business model that can traverse markets. Certainly, the opportunity to pursue covered lives in a new market was a major consideration, but even more pronounced was their concern over losing customers in whom they had made a major investment to capture, simply because the source of subsidy changed. Previously, of course, companies could do little about churn, since its most obvious consequence was the total loss of financial sponsorship. Now, however, the problem was one that could be addressed by devising an approach to business operations that effectively followed their customers to a new form of subsidy. Far from feeling that they could benefit financially from short enrollment periods and constant movement in and out of plan membership, companies saw continuity of coverage and care as a real plus from a business perspective.

Second, companies that were moving from Medicaid into the marketplace (as discussed below, this direction appeared to be most pronounced for reasons that became apparent as the interviews proceeded) had lower-income marketplace customers as their primary focus. These companies did not envision their great competitive edge to be in the middle- and upper-income customer base (which in any event turned out to be a small segment of the individual marketplace, dominated by lower-income, subsidized customers). Instead, these companies focused on their traditional customers—poorer individuals and families—who either had a real chance at continued coverage or were acquiring it for the first time. From a business perspective, a critical issue is that so many companies viewed the new marketplace as an extension of the Medicaid market, since this business orientation may propel many future decisions around how to structure and operate the new market, from regulation of health plan products and practices to decisions regarding when and how to update the ACA's essential health benefit coverage standards, which guide the individual and small group markets generally.

This understanding of the new marketplace in terms of customer demographics appears to be quite accurate, given who actually enrolled. Depending on how health reform ultimately affects the employer-sponsored health insurance market and even underlying employment patterns, as well as the ultimate popularity of marketplace shopping, this initial demographic profile might change. For now, however, these early business assumptions regarding who would be in the marketplace have been borne

out by the fact that the overwhelming majority of people who enrolled in marketplace plans received tax subsidies; in the federal market alone, which accounts for enrollment in thirty-six states, 87 percent of enrollees are receiving subsidies (Burke, Misra, and Scheingold 2014).

Third, because the companies were targeting a heavily low-income population, pricing their products became a major challenge. Premiums had to be kept low, but so did deductibles and other forms of patient cost sharing. Even with both premium assistance and cost-sharing reductions available to people with incomes below 250 percent of poverty, pricing posed problems, since both the premium and cost-sharing reduction assistance is pretty slim. Cost-sharing assistance begins at the poverty level, but by 150 percent of poverty, reductions begin to decline precipitously, from 94 percent actuarial-value-level help to 87 percent. By 200 percent of poverty, help falls to a 73 percent actuarial value level. When companies tried to hold down cost sharing, premiums inevitably rose, making them noncompetitive. Lower-income people chose well, clustering in the silver market, where cost-sharing reductions are available, but, inevitably, premium pricing was key. Companies reported focusing cost-sharing reductions on outpatient primary care and commonly used drugs, leaving those with more serious health problems significantly more exposed to high costs, a problem borne out by separate research (Brantley, Bray, and Pearson 2014).

Provider networks emerged as the most prominent challenge, a fact that helps explain why the future of multimarket plans may lie in decisions by Medicaid companies to move into the marketplace, rather than vice versa. For plans with roots in Medicaid, moving into the marketplace largely raised issues of capacity, not provider willingness. But even these companies encountered difficulties when they attempted to grow additional primary and specialty capacity. Physicians and hospitals expected commercial rates, not the discounted rates that would enable companies to keep premiums and cost sharing low. Commercial issuers with affiliated Medicaid business lines saw little prospect of convincing their commercial networks to participate in plans whose membership would toggle between Medicaid and the marketplace. Most respondents reported variable success in negotiating provider discounts and devising alternative payment approaches that could support a model that necessarily rests on limited premium and cost-sharing assistance for a low-income population. The inability to mount sufficient networks at deeply discounted rates, coupled with surging Medicaid enrollment, caused several Medicaid-based companies to delay a cross-market move.

A final and important finding was that companies did not view differences in the Medicaid and marketplace regulatory regimes as a deterrent to

multimarket participation. Companies did not consider different coverage, cost sharing, and plan performance measurement as insurmountable barriers to being able to conduct business in multiple markets.

Discussion

Our interviews confirmed what the ACAP figures suggest: multimarket plans are a viable approach. Whether such an approach enables members to overcome breaks in care arising from constant subsidy switches remains to be seen. Careful evaluation of plan performance and customer response over time will be needed.

But to the extent that this approach appears to be a plausible means of mitigating the deleterious effects of fractured financing, encouraging its growth will depend on several factors: adopting continuous eligibility that helps reduce the need to switch subsidy sources; using aggressive branding strategies, coupled with consumer assistance and counseling, to enable lower-income consumers to understand the continuity advantage and make a continuity choice when selecting a plan; upward adjustment in Medicaid managed care rates for plans that link to marketplace counterparts in order to more equalize provider payments; and CMS guidance on approaches that encourage multimarket plan growth through adoption of payment, certification, regulatory, and outreach strategies that maximize the potential for this solution to spread.

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