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# ISSUES AND POLICIES AROUND "CHURNING" IN HEALTH INSURANCE PLANS

## DEVELOPMENT OF THE VERMONT EXCHANGE DESIGN
## TASK 3.1.7: FORMAL ASSESSMENT OF "CHURNING"

**August 11, 2011**

# TASK 3.1.7: FORMAL ASSESSMENT OF "CHURNING"

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# I. EXECUTIVE SUMMARY

"Churn", or recipient turnover in government sponsored health insurance programs, is a significant issue, both nationally and in Vermont. While the goal of health reform in Vermont is and has been to achieve universal coverage, churn has worked against this. The objective of this study is to identify policies that can reduce churn in the federally mandated insurance exchange being designed by Vermont.

The problem of churning in Vermont's Green Mountain Care programs was first documented in a health reform study UNE/CHPPR conducted with funding from the Robert Wood Johnson Foundation. The data showed that the number of beneficiaries on Catamount Health at any one time was approximately 10,000 people. However, if the number of individuals who churned in and out of the program were counted over the two years of available data, the number almost equaled the estimated total Catamount-eligible population.

This study follows up on that study by examining the problem of churn currently in greater detail both nationally and in Vermont, as well as identifying polices that can impact churn rates and surveying stakeholders and experts on which of these policies might work in Vermont given the current regulatory system.

For this study we conducted a comprehensive literature review—published and unpublished papers, reports, etc. The majority of the literature on churn policy focuses primarily on churn in Medicaid programs and less on private or state sponsored insurance. Many of these studies point to income fluctuations and inability to pay for insurance as driving the issue of churning, although other issues can play a significant role as well.[1] As a result of this literature review, we reviewed policies in other states and spoke to officials that have addressed the problem in order to inform policy recommendations for Vermont.

The amount of churn in public insurance programs such as Medicaid or CHIP appears to vary by state. No doubt this has something to do with the economy of a state as well as the way state programs are organized. Seasonal economies, for example, are a factor in churn to the extent that they contribute to fluctuations in income levels of individuals near the income eligibility levels of these programs. One cannot completely eliminate churn but it is clear that several states are attempting to reduce churn rates by adopting specific health policies around enrollment, information exchange, ease of insurance acquisition, etc.[2]

The Problem: Churn continues to be a significant problem for Green Mountain Care programs, which includes Catamount Health, Vermont Health Access Plan (VHAP), Dr. Dynasaur,

[1] The scope of work did not provide the opportunity to include interviews with individuals who churned in and out of Catamount during the past year. This was in the original scope of work but dropped due to time and resource constraints for the study. The length of time to obtain for HIPAA compliance was prohibitive.

[2] It is noted that we found few studies to estimate the impact these policies are having on churn. This is in part because many policies, e.g. online recertification, are relatively new, as well as because there are not many comprehensive studies of policy effects on churn rates.

Medicaid, and a number of pharmacy assistance and premium assistance programs. Looking specifically at disenrollment from Catamount Health, it is particularly acute within the first 12 months of enrollment. Enrollment data, covering November 2007-December 2010, showed 67% (16,425) of Catamount enrollees left the program, of which 13,738 (84%) disenrolled in the first 12 months. An additional 14% (2,376) disenrolled within 2 years with less than 2% within 3 years. About half of the individuals transitioning out of Catamount leave Vermont's public health insurance system. About a third (34%) of individuals leaving Catamount transferred to VHAP. Disenrollment from Catamount and other public programs is detrimental to the sustainability of programs and to individual enrollees' ability to rely on continuous insurance coverage. If the state wishes to achieve near universal insurance coverage, the issue of churn needs to be carefully addressed by focusing on policies that not only work to reduce churn rates, but also alleviate some of the negative implications associated with churning.

Policy Recommendations: While several policy approaches to controlling churn rates were explicated from the literature review and the stakeholder interviews, two areas in particular were highlighted as important for Vermont to focus on as it moves towards implementing its health exchange:

- *Improving the process for recertifying enrollees:* Vermont will need to update its current system for renewing enrollees, as its current recertification process was characterized by stakeholders as being cumbersome and confusing for many enrollees, as well as too reliant on paper-based forms. Upgrading the system by adopting improved renewal processes will be an important policy for Vermont to consider and will lower churn rates for those who drop off their coverage due to issues with the renewal process. Examples of such processes include:
    - Ex parte renewal, where enrollees are automatically recertified using third-party data;
    - Off-cycle renewal, where recipients renew insurance coverage by updating required information when applicants apply for other income-based benefits at other agencies, or at hospitals, clinics, other public locations, prior to actual renewal date;
    - Recertifying enrollees over the telephone or online;
    - Passive renewal, where enrollees are sent pre-filled renewal forms, and a response is required only if information has changed.
    - Proactive follow-up: Caseworkers or outreach workers notify families directly, through email or phone, prior to renewal date to let them know that they will need to update their information to retain coverage.

- *Standardizing the benefit packages between plans offered on the Exchange and Medicaid*: With the introduction of publicly-subsidized plans sold on the Exchanges – whose subsidies are sensitive to income - churning between public programs will undoubtedly increase, especially as Medicaid eligibility is also expanded. Eligibles whose income or personal circumstance changes will experience a shift in eligibility from Medicaid to an insurance exchange, or vice-versa. Unless efforts are made to standardize,

as much as possible, the benefit package between Medicaid and the Exchange plans, enrollees will find relied-upon benefits changing as well. As an example, this would mean private coverage on the Exchange including Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit; otherwise, children would lose significant coverage when they switch from Medicaid to private plans because of a change in eligibility. Likewise, patients enrolled in care management programs or wellness programs will also need to have these benefits covered by both Medicaid and private insurers in order to avoid disruptions. It should be noted that while these policies will not affect churn rates *per se*, they do work to mitigate one of the negative implications of churning: namely, that enrollees will not experience significant discontinuity in the provision of benefits that they rely on, simply because their income changes and they have to switch between Medicaid and a plan sold on the Exchange.

These are policies that Vermont is considering in collaboration with private insurers; stakeholders have noted that discussions are already ongoing to see if and how Medicaid and Catamount benefit packages might be aligned, as there are significant numbers of transitions occurring between programs (see quantitative analysis, below). However, as reported by stakeholders, federal guidelines concerning Essential Benefit Packages will need to be promulgated before any substantive decisions are made.

Other State Experiences: Churn has long plagued state Medicaid / CHIP programs and policy addressing churn rates has had decidedly mixed results. To date, there is no "silver bullet" that can completely eliminate churning, or the costs and negative implications associated with churning. However, experiences among certain states suggest that a commitment to maximizing enrollment by investing in improved enrollment and reenrollment processes can lead to positive changes. Among those states that have stood out as having implemented successful strategies aimed at streamlining reenrollment in public programs include Louisiana and Wisconsin, which have in turn minimized churn rates and maximized enrollment for their respective programs.

Louisiana's recertification process for children eligible for Medicaid and/or LaCHIP (Louisiana's Children's Health Insurance Program) is considered best practice for client-centered renewals among state public insurance programs. Most cases can be now be processed with little encumbrance to families, without forfeiting the integrity of the recertification process. Only 5% of Medicaid and 10 percent of LaCHIP cases require enrollees to submit a signed renewal form in order to renew their eligibility. The rest are recertified through using ex parte renewal, administrative renewal, telephone renewal, or web-based renewal. [3]

In Wisconsin, BadgerCare Plus, a consolidated program offering coverage to children, parents, and pregnant women, has been able to provide near-universal coverage for children and greater coverage for parents and childless adults. The state worked to facilitate and simplify enrollment

[3] Volk, Gwyn and Jacobs, Anne. "Implementing State Health Reform: Lessons for Policymakers." Robert Wood Johnson State Coverage Initiatives. Princeton, N.J.: RWJ, 2010.

and renewal in BadgerCare Plus by partnering with community-based organizations and health care providers to identify and enroll eligible children and families. They also have all eligibles apply to a single program, BadgerCare Plus, regardless of demographic factors; enrollment staff then place individuals into separate funding categories depending on the characteristics of enrollees. Initial assessments of BadgerCare Plus from Wisconsin administrators suggest that the State's efforts in improving the enrollment processes have resulted in a reduction in the state's churn rates and an improved continuity of coverage for enrollees. [4]

Both states offer replicable models that Vermont may want to emulate as it looks toward implementing its Exchange and improving its own renewal processes.

Next Steps: In order to determine the efficacy of these recommended policies, Vermont will want to quantify specifically how much these policies may reduce churn rates, what sort of investment Vermont may have to make in order to see reductions in churn rates, and finally, what sort of return on investment Vermont might see should it choose to pursue any of the suggested policy recommendations.

[4] Hynes, Emma and Thomas R. Oliver, "Wisconsin's BadgerCare Plus Health Coverage Program: A Qualitative Evaluation". University of Wisconsin. October 2010

## II. INTRODUCTION

The two pieces of legislation - the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 - that comprise the recent federal health care reform efforts (hereafter referred to collectively as PPACA) will have a profound effect on Vermont and its public and private health insurance markets. Under the PPACA, health insurance coverage will be extended to millions of Americans – and thousands of Vermonters - through the expansion of Vermont's Medicaid Program, and through the establishment of a state health insurance exchange that provides a market for private insurance plans to compete for small businesses and consumers, many of whom are expected to qualify for premium subsidies. While these reforms will increase the number of Americans with health insurance coverage, along with this will be an increase in the number of people who enroll and subsequently dis-enroll from their public or private insurance plans due to changes in familial income or personal circumstance, a process known as "churning".

Churning has significant repercussions on both the public and the insurance administration. Churning creates disruptions in health insurance coverage and with that comes potential adverse health effects on those who, because of costs, might put off needed health care. Churning also incurs considerable costs for public and private insurers and threatens the sustainability and efficacy of programs such as Medicaid that rely on public sources of funding.

This report examines churning at several levels. We offer policy options on churning that Vermont might consider as the state designs its health insurance exchange and plans for implementation of a single payer system. Then we examine extent of the problem in Vermont followed by a discussion of reasons and costs of churning along with federal provisions that effect churning. Finally we report on how other states are addressing churning in their state sponsored insurance programs. Included in the policy section are findings from interviews with a number of Vermont stakeholders and several national experts on churning. The report presents an update on the churning analyses we recently concluded as part of our *Achieving Universal Coverage Through Comprehensive Health Reform: the Vermont Experience*, a two-year research study funded by the Robert Wood Johnson Foundation (RWJF). This was a comprehensive study of Vermont's recent (2007) state initiated health reforms.

## I. FINDINGS & RECOMMENDATIONS

The following table consists of policies that - based on our research and discussions with stakeholders - are potentially effective at mitigating the effects of churning either directly or indirectly. Please note that the following list is in no particular order. We interviewed a variety of stakeholders about these policies, including representatives from Vermont's Legislature, provider organizations, and non-profits involved in advocacy and/or implementation as well as national experts (please see Appendix I for full list of interviewees). We did this in order to gain a better understanding of how churning policy might be integrated into Vermont's regulatory framework.

Betsy Forrest, Health Care Reform Project Director from the Department of Vermont Health Access, assisted us in generating a list of key stakeholders from Vermont who were would be knowledgeable about implementing policies that addressed churning. Stakeholders were first contacted by email to explain the study, and, if needed, a follow-up phone call was made to arrange a time to meet.

### CHURNING POLICY RECOMMENDATIONS

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| **Presumptive eligibility** | Presumptive eligibility has primarily been used for health insurance programs for children. It allows a "qualified" entity (e.g., federally qualified health clinic, physician, Head Start, WIC, child support enforcement agency) to grant a child temporary public coverage based on the family's declaration of income so that a child (or adult) can obtain medical care while the application is processed for a formal determination of eligibility. Presumptive eligibility can be time bound and last up to one month or more. It can also "kick in" when a recipient has not renewed according to the timeframe for renewal. A state might wish to | Very positive responses. Some worried about adopting this policy at clinics or FQHCs, as it might be putting too much of a burden on providers. However others felt it allowed providers the opportunity to treat the patient at the time eligibility was "presumed" eligible and be reimbursed if proven not eligible. Respondents agreed it was appropriate for children and adults. | **Recommendation**: Vermont should consider adopting this policy for all beneficiaries of publicly subsidized insurance recipients. It is also recommended that the type of organizations that could offer presumptive eligibility be inclusive and length of coverage be up to one month. If the covered recipient is not approved for a subsidy then we recommend Vermont be prepared to reimburse services provided during the presumptive period at |

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | grant presumptive eligibility for those who for one reason or another have changed address and could not be reached to renew their status. Where it is used states usually need to guarantee the provider payment for the services rendered if the recipient ends up not qualifying for program coverage. | | the program rate. |
| **Premium payment policies** | Currently in Vermont, Catamount Health requires some level of premium payment. Some feel this hinders some potential recipients from enrolling and/or continuing with the program. The policy of requiring everyone to pay something might be addressed by co-payment increases for some--especially those who cannot pay a monthly fee. Co-pays would be required for non-preventive health services such using an ER for primary care. | Mixed responses. Many were wary of increasing co-pays and decreasing premium payments. One interviewee suggested instituting introducing a grace period for premium payments, rather than reducing them all together. Generally there is a lack of understanding of the scientific research findings on co-pays. For example, there are solid studies suggesting that co-pays rarely deter needed care. | **Recommendation**: Using selective co-pays is not a viable policy at this time to reduce churning and increase continuous enrollment. It may be too difficult to lower premium payments without threatening the sustainability of programs. At the same time using co-pays as a tool to deter unnecessary medical care should be explored by the state (and private insurers) as it may offers ways to bring down avoidable ER and inpatient hospital admissions. |
| **Enrolling newly eligible recipients continuously for 12-months regardless of income changes** | Permit continuous eligibility for 12 months, the maximum time permitted under federal law, regardless of income changes. This can occur when a recipient becomes newly eligible and/or upon renewal. This can be expected to reduce churning and provide more continuous care. | Almost all respondents reacted positively to enacting this policy. Many cited the reduced administrative burden for enrollment staff, while also improving the length of coverage for consumers. Many cited the fact that this would benefit the state, providers and recipients. Some supported this policy but expressed concern when a recipient's income went | **Recommendation**: Vermont should look to extend coverage for 12-months regardless of income changes. One might consider linking this to recipient enrollment in a primary care office as an incentive to using a PCP rather than an ED for primary care. |

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | | down, thereby making them eligible for a reduced premium. However others felt allowing this was acceptable. | |
| **Improvements in the renewal process** | *Ex parte renewal:* Ex parte renewal processes give eligibility staff access to external information systems, such as Food Stamps, state tax information, other government databases, or commercial systems to verify family income for an eligibility review. If the process can confirm income, enrollees can be renewed without further involvement from enrollment staff. It is currently used for CHIP in several states.<br><br>*Off-cycle renewal:* Allow recipients to renew insurance coverage by updating required information when applicants apply for other income-based benefits at other agencies, or at hospitals, clinics, other public locations, prior to actual renewal date<br><br>*Telephone /online renewal:* This permits eligibility staff to call individuals in order to review factors that are subject to change in order to process their renewal. Online renewal is another paperless approach that many states have begun to experiment with, by updating case information on an online portal and/or attaching paper based scans of required documentation.<br><br>*Passive renewal*: Consumers are sent pre-filled renewal forms, where response is required only if information has changed. | All interviewees wanted to see improvements in the reenrollment process. Many cited the form letters that are sent out to beneficiaries about to lose their coverage as a particularly onerous source of confusion for many. Several endorsed changes like these for Vermont. | **Recommendation**: Vermont will need to determine how best to streamline the enrollment and reenrollment processes, as the status quo affects churning rates, per our interviews. Pre-populating renewal forms sent to consumers is a start, as is moving more of the recertification process online; however, it will also be necessary to find ways of further lowering the burden on individuals looking to renew coverage. Adopting the renewal policies that are paperless (telephone / online renewal) beyond what is currently available, and/or that are less reactive and rely on 3rd party data (Ex parte, off-cycle, passive, proactive follow-up) would be policies that Vermont will need to consider. |

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | *Proactive follow-up*: Caseworkers or outreach workers notify families directly, through email or phone, prior to renewal date to let them know that they will need to update their information to retain coverage. [5] | | |
| **Exchange Navigator policies** | The PPACA recognizes the need for providing support services to potential recipients for shifts in coverage. This will be a critical component of the Exchanges. Whoever assumes this role will need to be proactive in order to affect churning rates. Exchange Navigators can be volunteers, publicly paid individuals and/or private sector individuals such as insurance agents who assist potential recipients in enrollment and renewal processes. | Opinions from respondents as to whom the Exchange Navigators should be varied. Many liked the idea of independent non-profits assuming the role of Exchange Navigators, especially those that are community-based and with local connections. While some were wary of utilizing private insurers as Exchange Navigators, others endorsed this idea. | **Recommendation**: In order to ensure that individuals have a local source to guide them through the renewal process, it is recommended that the state look to utilizing independent non-profits that are already engaged in assisting individuals who want to enroll/renew. |
| **Making private plans retroactive for people transitioning** | Require private plans to be retroactive to the date of first eligibility for people transitioning from Medicaid. This is designed to ensure continuous coverage for those whose incomes have increased and move to private plans with subsidies. | Respondents generally approved this policy. However some were concerned with the risk it placed on private insurers to cover services prior to date of enrollment application. A 30-day window was suggested as the time a recipient would have to change his/her coverage. | **Recommendation**: Explore the feasibility of adopting this policy with private insurers; it would significantly reduce the risks associated with transitioning from public to private coverage. A 30-day window for recipient re-enrollment in another plan is highly recommended as part of this policy. |

[5] Jennifer Edwards, et al. Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States. Robert Wood Johnson Foundation (Feb 2010).

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | | | |
| **Incentivize enrollment staff** | This policy consists of building incentives into job performance for enrollment staff, illustrated by the practice of evaluating and incentivizing performance based on ability to enroll and retain eligible recipients, allowing work at home for top performers, and paying overtime to caseworkers who want to conduct outreach activities on evenings and weekends.[6] | Respondents were less enthused about this idea, as some did not think it was needed and did not see the benefit. A few thought it could be useful as an innovative way of reaching consumers e.g. on weekends when they were not working. However the general feeling was that this was not a good idea or needed more research. | **Recommendation**: This is not recommended at this time. |
| **Align essential benefit package offered in Exchanges** | For newly eligible Medicaid adults, benefits are set based on "benchmark" coverage rather than the full scope of benefits offered to traditional Medicaid beneficiaries. Per the ACA, the benchmark must consist of the same essential benefit package offered to adults who receive coverage through state health insurance exchanges. Conforming Medicaid benchmark coverage to the Exchanges' essential benefit package should alleviate these differences in coverage, although some disparities in cost sharing among plans and programs are likely to stay.[7]<br><br>For children, this would mean requiring private coverage to include Medicaid's Early and Periodic Screening, Diagnosis, and Treatment | Many thought this would be important to implement, although potentially challenging, especially given the direction Vermont is heading with recent legislation and Vermont's generous Medicaid benefit package. If it meant that current benefits would be reduced several were opposed to this. There was some confusion as to how this might work in Vermont. | **Recommendation**: This will be an important policy to implement. Vermont is already looking to see how it might be possible to align Medicaid and Exchange benefits; however, without knowing what federal regulations with regards to Medicaid's Essential Benefit Package, it has been difficult to put forward a definitive plan for aligning benefits. As a result, to the extent that it is feasible with private partners operating on the Exchange is not clear and will need further clarification before this is viable. |

[6] IBID

[7] Sommers, Benjamin, Sara Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs*, 30, no.2 (2011):228-236

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | (EPSDT) benefit; otherwise, children would lose significant coverage when they switch to private plans. | | Once regulation becomes clear, it will be especially important for Vermont to ensure those enrolled in chronic care management programs, wellness programs, healthy lifestyles incentives, etc. are able to maintain their enrollment in such programs through continued insurance coverage. Aligning insurance benefits such that enrollment in these care and wellness programs is uninterrupted, even if the source of coverage changes, will go a long way towards mitigating the effects of churning. |
| **Align coverage terms, provider networks, administrative systems, etc** | In order to ensure continuity of coverage and quality of care for those consumers who shift between Medicaid and private insurance, taking steps to align private and Medicaid/CHIP products on the Exchange may be an important step to prevent the negative effects of coverage changes. As much as possible, these plans would share common coverage terms, provider networks, administrative systems, consumer and patient protections, and quality and performance measures. To the degree that insurance plans with the same provider networks participate in the Exchange and Medicaid markets, the effects of repeated coverage changes may be significantly mitigated. [8] | Respondents thought this would be a good policy to adopt, although not as important for Vermont, given its size, small consumer base, and the small number of providers operating in the state. Others saw this as an important step towards Vermont's intention of achieving a single-payer system. | **Recommendation**: To the extent possible, Vermont will want to standardize provider networks over time as it starts toward a single-payer system. Standardizing coverage terms, provider networks, administrative systems, etc. will also reduce administrative burdens on insurers when consumers churn on and off their plans. |

[8] IBID

## TASK 3.1.7: FORMAL ASSESSMENT OF "CHURNING"

| Policy Options to Address Churning | Description / Explanation | Response from VT and other Stakeholders | Recommendations |
|---|---|---|---|
| | | | |
| **Monitor insurers for under-service** | Private insurers may not be amenable to providing comprehensive coverage if they know consumers' income changes will lead to an unstable consumer-base. Ensuring that insurers maintain continuous, high-quality insurance coverage may be important as consumers churn in and out of plans. | Most respondents thought this was important but were unsure if it was indeed a problem in Vermont with so few insurers operating in the state. | **Recommendation**: Vermont will want to look to see how they can improve processes for monitoring. Perhaps the use of periodic consumer surveys will be sufficient. |

# II. FINDINGS—CHURNING IN VERMONT

This section discusses the findings of the quantitative analysis conducted to further examine churning activities within CHAP– Catamount Health with premium assistance. Included in this chapter is a brief enrollment history, and findings related to the length of enrollment and transitions made by CHAP enrollees November 2007 - December 2010.

## DATA SOURCES

Data for the analysis of churning in Vermont was obtained from the Monthly Green Mountain Care Reports produced by the Department of Vermont Health (DVHA). Approximately 3 weeks after the close of each month DVHA issues a report including monthly enrollment information for CHAP and other state sponsored insurance programs such as Catamount Health without Premium (CH), Employer Sponsored Insurance Assistance (ESIA), and Vermont Health Access Plan – Employee Sponsored Insurance (VHAP-ESI).[9] While the information in the monthly reports is suitable for monitoring the success of Catamount Health Programs and other state sponsored health insurance programs, there are some challenges in using the data for quantitative analysis. For example, the monthly enrollment numbers presented in the monthly report do not indicate the number of returning enrollees who discontinued coverage for a period of time.

To gain more insight into the enrollment and disenrollment patterns, enrollment data was also obtained from DVHA covering the period between the initiation of the program, November 2007 and December 2010. Using the above data sources an in-depth churning analysis was conducted, including enrollment history, length of enrollment, and transitions made by CHAP enrollees.

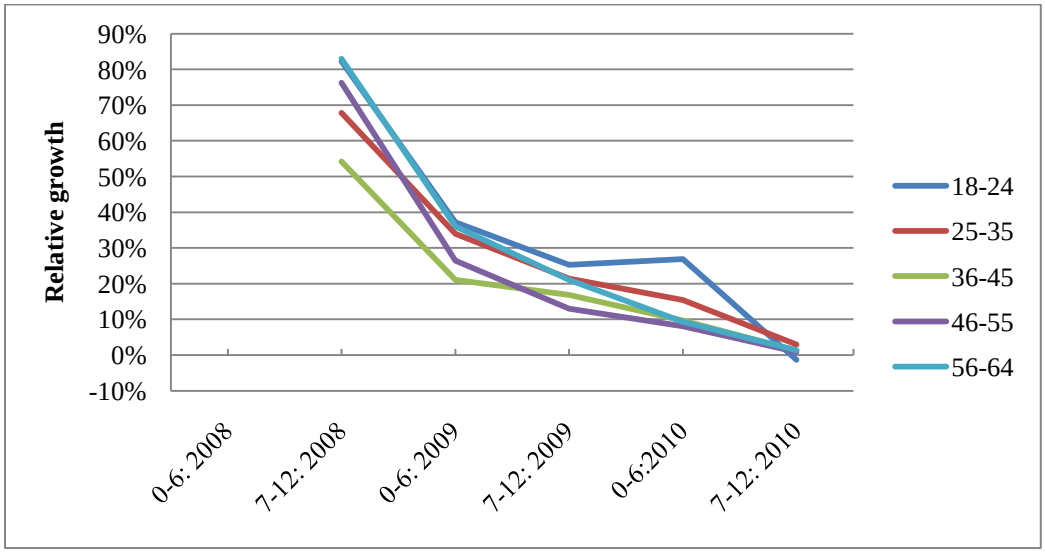
## CHAP ENROLLMENT HISTORY

Initial enrollment into the CHAP program grew rapidly during the first year of the program, 2008. Figure 1 shows the relative growth figures for the various age-groups identified within CHAP, findings include:

- The highest relative growth numbers were realized in the second quarter of 2008, and ranged from 54% to 84%. The highest relative growth was realized by the 56-64 (84%) and 18-24 (83%) age group.
- The 18-24 age-group showed the strongest growth figures from 2008 through the first half of 2010 (27%).
- The 36-45 age group showed the weakest growth per 6-month period.
- For the second half of 2010 relative growth figures were close to 0% or negative, for all age-groups

[9] For context, enrollment information is also provided for VHAP, Dr. Dynasaur, and other Medicaid.

**Figure 1: Relative Growth in CHAP Enrollment From 6-Months (1/2008-12/2010)**




The above figure shows that enrollment growth has slowed down over the years, which may be caused by a decline in new enrollees or increase in drop-offs. The data showed that the number of people enrolling in CHAP each month has risen slowly since the first month of the program, however the number of people discontinuing the program also increased, resulting in low net enrollment figures.

## LENGTH OF ENROLLMENT

The length of enrollment is analyzed to detect if patterns exist in movement into and off Catamount. The analysis shows 24,433 individuals were covered under Catamount during November 2007- December 2010. Once enrolled, 33% (8,006) of the Catamount enrollees did not leave the program, while for the majority the coverage was brief and episodic.

Once enrolled, 67% (16,425) left Catamount. The following patterns were found among disenrollees:

- 85% enrolled and disenrolled once from Catamount.
- 13% re-enrolled and disenrolled for a second time from Catamount.
- 2% disenrolled three or more times from Catamount.

A third of the group that enrolled and disenrolled discontinued their coverage within 3 months after the initial enrollment, while 84% discontinued their coverage within the year.

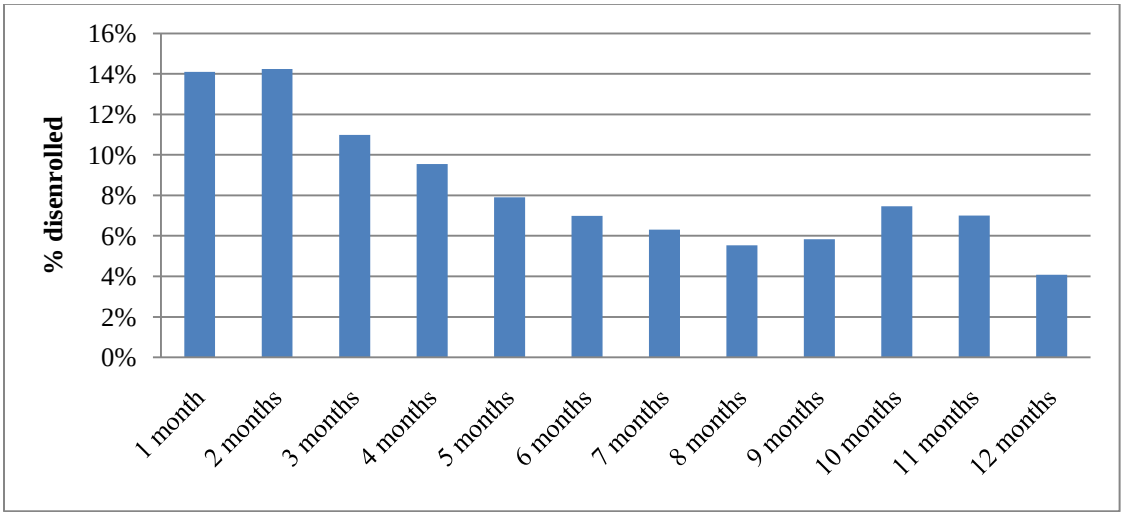
From the actual enrollment data it appears that enrollment, disenrollment, and re-enrollment activities mostly occur during the 12 months period following the initial enrollment. Therefore the first 12 months of CHAP enrollment is examined in more detail.

*Churning During First 12 Months of Enrollment*

Churn is particularly acute in the first 12 months of enrollment. The enrollment data, covering November 2007-December 2010, showed that of the total 24,333 enrollees, 67% (16,425) left the program. Most enrollees, 13,738 (84%), disenrolled within 12 months of their initial enrollment. An additional 14% (2,376) disenrolled within 2 years with less than 2% within 3 years.

Almost 49% (6,714) of enrollees that discontinued their coverage within 12 months was covered for 4 months or less, and 64% (7,447) for 6 months or less. Figure 2 below, shows the portion (%) CHAP disenrollees and the time that elapsed between their initial enrollment and disenrollment.

**Figure 2: Time Elapsed Between Initial Enrollment and Disenrollment**

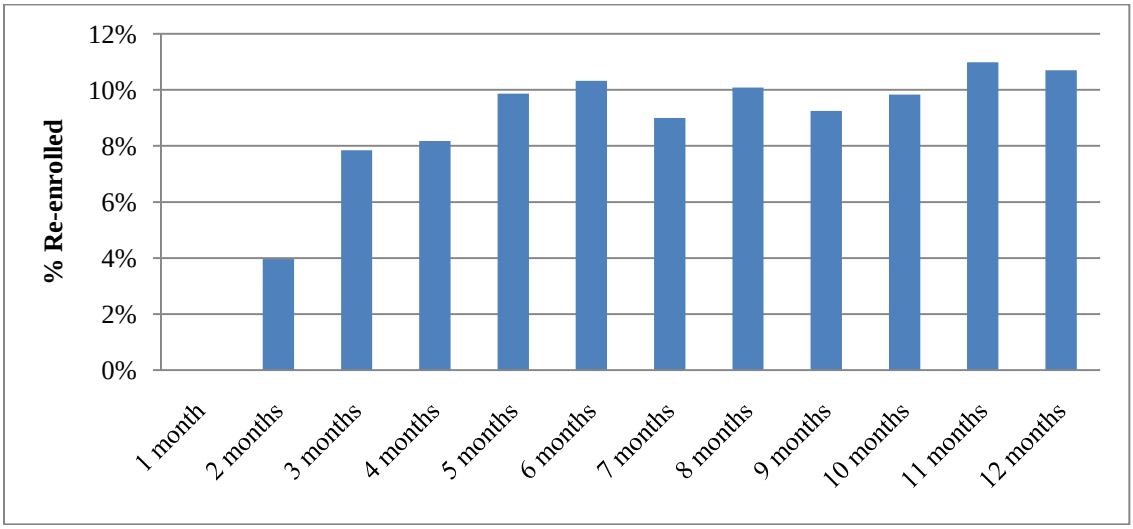



When further examining the enrollment patterns of those leaving the program within 12 months, the data showed that:

- 2,444 (18%) CHAP enrollees leaving the program, re-enrolled within 12 months of the initial enrollment month.
- 835 (6.1%) re-enrolled and disenrolled for a second time within 12 months of the initial enrollment.

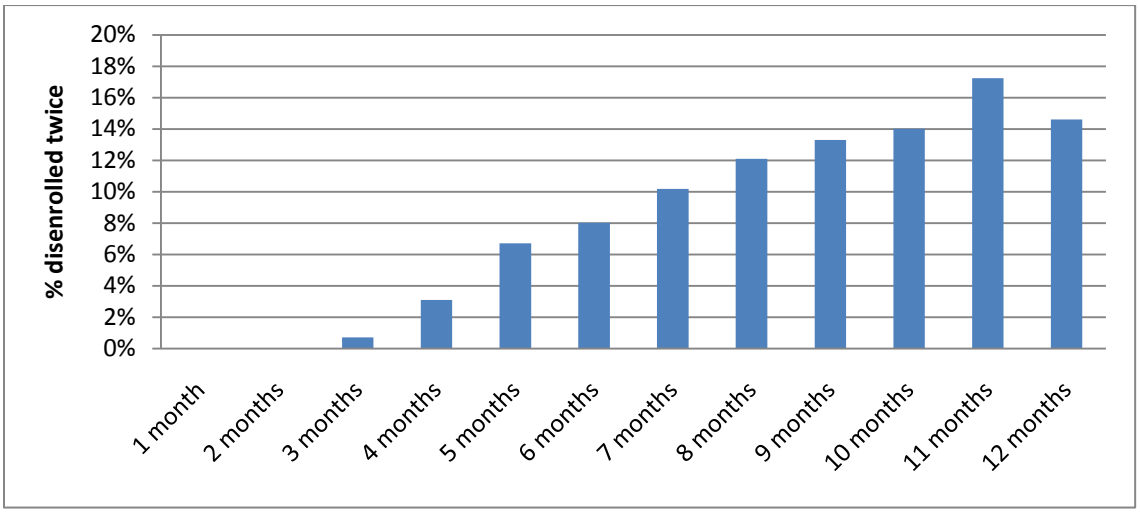
Re-enrollment numbers appear to be evenly distributed between 5-12 months after initial enrollment, see Figure 3.

**Figure 3: Time Elapsed Between Initial Enrollment and Reenrollment**




About a third (34%) of re-enrollees disenrolled for a second time within 12 months of their initial enrollment, Figure 4 shows the portions of CHAP disenrollees and the number of months that elapsed between their initial enrollment and second disenrollment. As can be expected, most of the second disenrollment activities take place toward the end of the 12 month period.

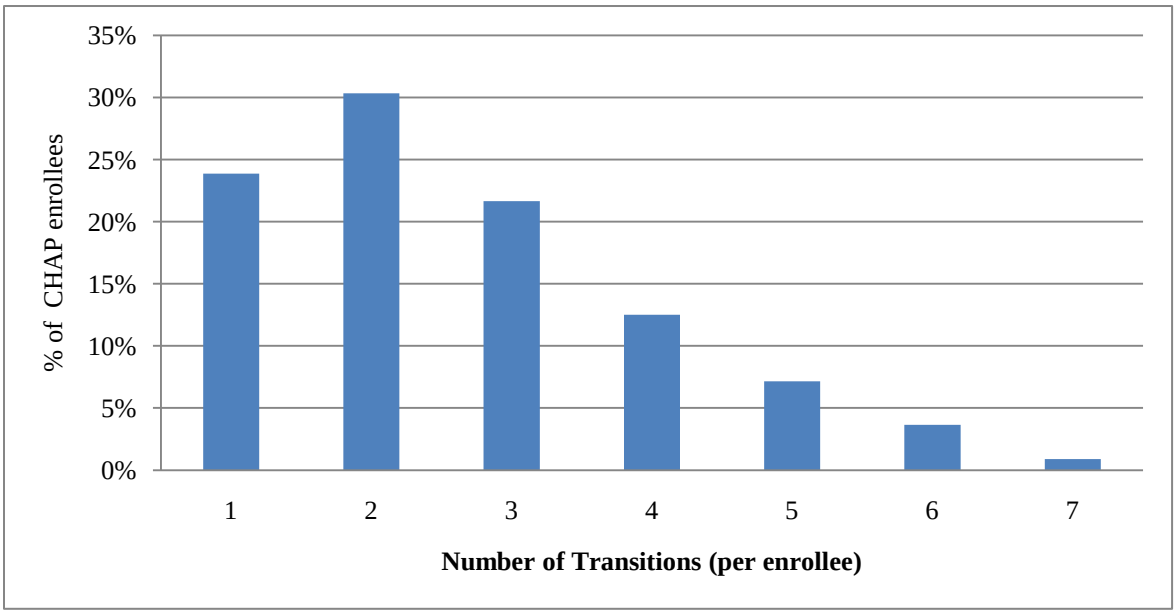
**Figure 4: Time Elapsed Between Initial Enrollment and 2nd Disenrollment**



## TRANSITIONS INTO AND OFF CATAMOUNT

Individuals enrolled in Catamount (24,431) made a total of 15,478 transitions between the various state sponsored health insurance programs. Approximately 24% (3,692) made one transition, 30% (4,694) two transitions, and 22% (3,351) three transitions, see Figure 5.

**Figure 5: Number of Transitions by CHAP Enrollees Between State Sponsored Insurance Programs, 2007-20**

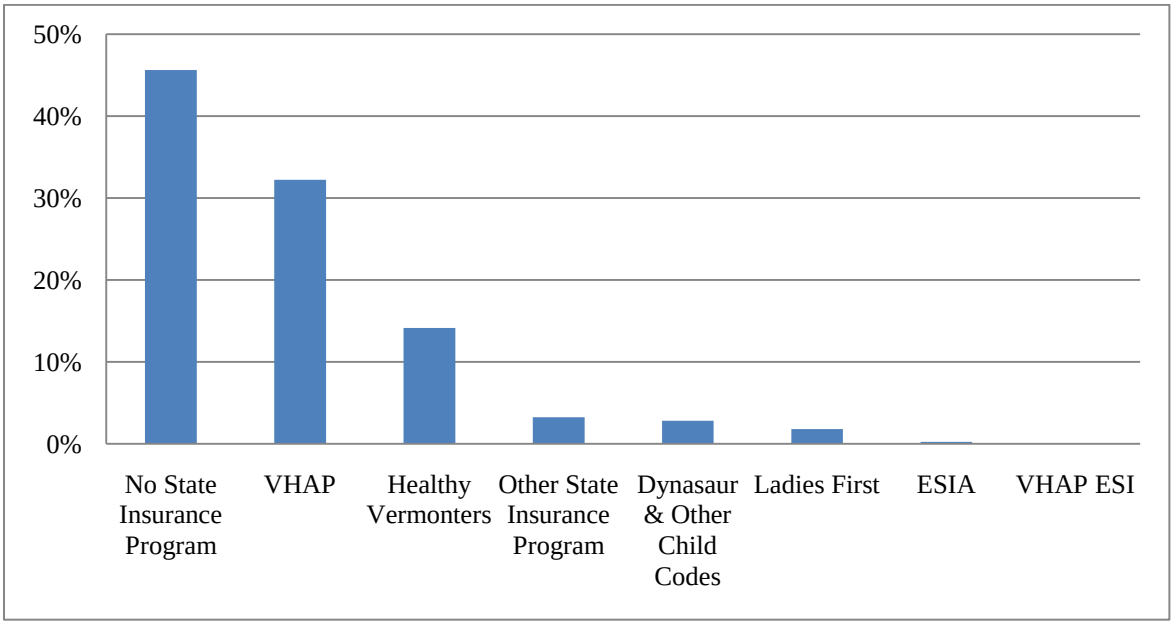



In 2007, the most popular transition was from Healthy Vermonters into CHAP. The data showed that in 2008, of all transitions that took place between public health insurance programs in Vermont, 7% transferred from Healthy Vermonters[10] into Catamount, 11% from VHAP,[11] and 18% from outside the existing state sponsored health insurance programs. The data further indicated that individuals leaving Catamount transitioned outside the existing public health insurance system (10%) or into VHAP (4.2%). The data showed these same transition patterns for 2009 and 2010, just slightly different percentages.

Prior to enrolling into Catamount, 46% (13,259) was not covered under a state sponsored health insurance program, 32% (9,367) transitioned from VHAP, and 14% (9,367) from Healthy Vermonters, see Figure 6.

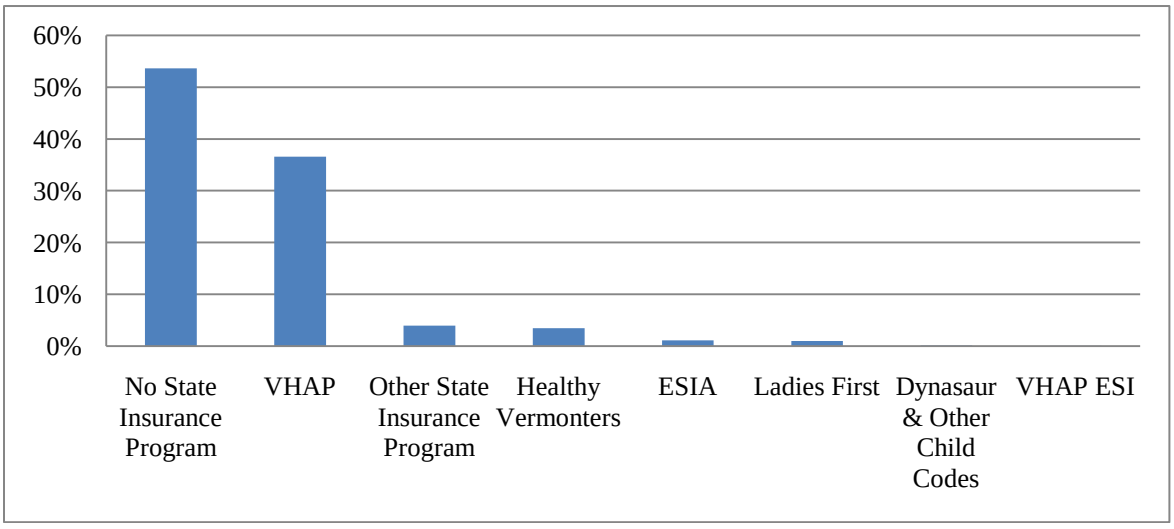
[10] Healthy Vermonters: This program provides a pharmacy discount to eligible Vermonters, helping beneficiaries purchase prescription medicines necessary to maintain their health and prevent unnecessary health problems.
[11] VHAP: Program that provides coverage to childless adults up to 150% of poverty who are not otherwise eligible for Medicaid.

**Figure 6: Insurance Coverage Prior to Enrolling in CHAP 2007-2010**




The majority, 54% (10,184), of enrollees leaving Catamount did not enroll in another state sponsored health insurance program, however 37% (6,952) transitioned into VHAP, 4.0% to other state programs, and 3.5% (659) into Healthy Vermonters, see Figure 7.

**Figure 7: Insurance Program Subsequent to CHAP 2007-2010**



## SUMMARY OF CHURNING ANALYSIS

The analysis of the Monthly Green Mountain Care Reports and DVHA enrollment data covering November 2007-Decmeber 2010 shows considerable movement on and off Catamount. While a substantial number of people have enrolled in Catamount and maintained their coverage, for the majority coverage is brief and sporadic.

Key findings of quantitative churning analysis:

- The number of people enrolling into CHAP has risen slowly since the first month of the program; however, the number leaving the program has increased every month also, slowing down the net enrollment. The last 6 months of the period analyzed, July-December 2010, shows 4 months of negative net enrollment.

- From a total of 24,431 CHAP enrollees two thirds (16,425) discontinued their coverage. About 84% (13,738) discontinued enrollment within 1 year of their initial enrollment, 15% (2,376) within 2 years, and less than 1% within 3 years.

- About half of the individuals transitioning out of CHAP leave Vermont's public health insurance system. Unfortunately the data provided did not allow further examination to determine what portion of this group obtained coverage from another (non-public) source or became uninsured. About a third (34%) of individuals leaving CHAP transferred to VHAP. The distribution for those leaving Catamount is similar to that of those who enroll into Catamount.

## III. OVERVIEW OF CHURNING

### CHURNING IN OTHER STATE PROGRAMS

There is significant research illustrating that churning is a longstanding, common phenomena, especially among state Medicaid and SCHIP programs. For example:

- In Rhode Island, the state Medicaid agency found that 25% of all enrollees had a gap in Medicaid coverage over a 12-month period. About 60% of those that had dropped off then returned within a year.[12]
- Washington's Medicaid agency found that over a 3-month period in 2004, 36% of children whose coverage was terminated were subsequently reenrolled.[13]
- A retrospective study in Oregon found that 15% of the Medicaid population were disenrolled and subsequently reenrolled from their 2003 expansion of Medicaid designed to enroll non-elderly adults enrolled.[14]
- Nationally, a recent study found that in 2006, one-third of all uninsured children had either been on Medicaid or SCHIP the previous year, but had lost their coverage and were disenrolled. Had no drop-off occurred, the number of uninsured American children in a given year would have fallen by a third.[15]
- Another 2008 national study found that every year, 2 million adults lose Medicaid coverage and become uninsured. Moreover, an estimated 50% of non-elderly adults experience a gap in coverage within 2 years of initial enrollment. Among those who disenroll, half are still uninsured 6 months later; the remaining half re-enroll in some form of insurance program - 17% rejoin Medicaid.
- Vermont experienced widespread churning among and between its Green Mountain Care programs based on our 2010 RWJF funded study. [16]

These findings suggest that adults are at much higher risk than children for disenrolling and becoming uninsured even though public insurance retention for adults does not receive the same level of attention from researchers and policymakers.[17]

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[12] Summer, Laura and Cindy Mann. Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies. The Commonwealth Fund. June 2006

[13] IBID

[14] Carlson MJ, DeVoe J, Wright BJ. Short-term impacts of coverage loss in a Medicaid population: early results from a prospective cohort study of the Oregon Health Plan. Ann Fam Med. 2006;4(5):391–8.

[15] Sommers, Benjamin. Why Millions Of Children Eligible For Medicaid And SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up. *Health Affairs*, 26, no.5 (2007):w560-w567

[16] Deprez, Ronald, et al. Achieving Universal Coverage Through Comprehensive Health Reform: The Vermont Experience. Prepared for the Robert Wood Johnson Foundation. August 2010

[17] Sommers, Benjamin. Loss of Health Insurance Among Non-elderly Adults in Medicaid. *J Gen Intern Med* 24,1 (2008):1–7

## REASONS FOR CHURNING

Reasons for churning are extensive and reflect the complexity inherent in a public /private health insurance system that invariably causes gaps in coverage and frequent transitions between sources of coverage. Most frequently, people will change their source of coverage with a change in job status, whether that means becoming unemployed, working more or less hours, or transitioning to a new job. Of much greater concern to public policymakers is the churning that occurs among different publicly provided or publicly subsidized insurance programs, particularly as many of the issues that cause instability in coverage can be addressed and mitigated through pro-active policy approaches.

Churning is more likely to occur among certain demographic groups. Low-income individuals are particularly susceptible to changes in sources of coverage and gaps in coverage are common. Race and ethnicity are also strongly correlated with unstable coverage, particularly among Hispanics.[18]

For the purposes of this report it is important to differentiate between the *types* of churning that will occur with more frequency under PPACA in Vermont:

- Enrollees dropping on and off the same insurance program,
- Enrollees moving between different programs due to changes in eligibility or status.[19] [This already occurs with regular frequency between various Green Mountain Care programs and will continue to occur with the introduction of subsidized private plans offered on the Exchange.]

Numerous studies have investigated why churning occurs; the following are commonly found to be the most prevalent reasons for churning:

*Low Retention Rates*

Studies that have examined retention rates among public insurance programs have shown that a significant amount of churning is due to programs being unable to maintain their enrollees for an extended period of time, especially when enrollees are required to renew their coverage. Reasons cited for this include:

- Enrollees have been unaware of the need to renew their coverage.
- Enrollees have encountered barriers to reenrolling due to complicated and/or onerous renewal procedures, such as confusing forms, verification requirements that are time-consuming or unavailable to the enrollee, forms that are not translated in their native language, and/or limited guidance instructions
- Enrollees do not have the time or resources (e.g. cannot take time off from work, lack transportation) to collect required documentation for renewal[20]

[18] IBID

[19] Sommers, Benjamin, Sara Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs*, 30, no.2 (2011):228-236

[20] I. Hill and A. W. Lutzy, Is There a Hole in the Bucket? Understanding SCHIP Retention

To the extent they can, states have tried to streamline and simplify the renewal process; however, the policies that have been found to be the most efficacious at retaining eligible enrollees are those that reduce the frequency of renewals as well as limiting the involvement of enrollees when required data is already available.[21] For example, a three-year, five state study (Pennsylvania, California, Ohio, Michigan, and Oregon) that examined children who had been enrolled and subsequently disenrolled in Medicaid found varying rates of churning, ranging from 16% in Pennsylvania, to 41% in Oregon. As the authors note, one of the distinguishing characteristics of Oregon at the time was that Medicaid enrollees were required to re-enroll every 6 months, while the other five states required enrollees to re-enroll every 12 months.[22]

*Inconsistent Transitions Between Programs*

For many enrollees, issues with maintaining their eligibility for coverage arise once they experience any change in status, even if the change is temporary, and the transition in and out of programs is difficult to navigate. Currently, for example, children often find themselves without coverage once they age out of eligibility, or their families' income changes; even if they are eligible for Medicaid, there is often is an extended period where children are not covered.[23]

Because the PPACA does not indicate a minimum enrollment period for subsidies on the Exchange, eligibility and the corresponding subsidy will change with any increase or decrease in income. Under Medicaid law, states are required to determine continued eligibility yearly, but enrollees must report any change in income, and eligibility can cease in any month.[24] The result will be significant movement between Medicaid and Exchange coverage (as well as changes in subsidies received by individuals enrolled in qualified health plans) as income changes are reported.

*Premiums Are Too Expensive*

An oft-cited reason for many enrollees to drop off their insurance is the inability to pay a monthly premium for insurance, even if those premiums are publically subsidized; many eligible recipients do not have a stable monthly income to pay a set amount each month. How much churning is driven by this factor alone is difficult to discern from enrollment data alone. Those who disenroll due to the cost of premiums likely drop for other factors as well such as changes in their income, income stability, and the procedures used to pay premiums every month.[25]

A 2008 study examined the enrollment changes among uninsured low-income individuals who meet the required income and other eligibility standards to enroll and/or reenroll in managed care

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(Washington, D.C.: The Urban Institute, May 2003)

[21] Summer, Laura and Cindy Mann. Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies. The Commonwealth Fund. June 2006

[22] Fairbrother, Gerry Lynn, Heidi Park Emerson, Lee Partridge. "How Stable Is Medicaid Coverage For Children?" *Health Affairs*, 26, no.2 (2007):520-528

[23] Summer, Laura and Cindy Mann. Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies. The Commonwealth Fund. June 2006

[24] Sommers, Benjamin, Sara Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs*, 30, no.2 (2011):228-236

[25] Summer, Laura and Cindy Mann. Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies. The Commonwealth Fund. June 2006

plans sold in Commonwealth Care – Massachusetts' health exchange. Specifically, the study examined how an eligible recipient factored premiums and co-pay/deductible levels into their decision-making process when it came time to enroll and reenroll in a variety of managed care plans. Results showed that both new enrollees and those who were already enrolled were both highly sensitive to price, with a $10 increase in premiums leading to 8-16% expected relative reduction in the probability of enrolling/reenrolling in a given plan. [26]

Looking even closer, the authors found that:

- Those who chose a plan requiring lower out of pocket costs, but higher premiums in 2007 (the first year of the study) were less price sensitive to changes in premium levels in 2008, when compared with those who chose a lower cost plan in 2007.
- Prior enrollees in the first year of the study who were less healthy were somewhat less price sensitive than their healthier counterparts, but the differences between the two groups were not significant. However, for new enrollees in 2008, there were large differences in price sensitivity by health status: the healthier were much more likely to choose a plan based on price. This result suggests that adverse selection is more likely to occur when enrollees are first enrolling in a plan.

As the authors suggest, these study results suggest that health exchanges may offer a strong incentive for insurance plans to lower costs in order to attract new enrollees, as new enrollees are more likely to be price sensitive.[27]

*Barriers to Enrollment and Reenrollment in Green Mountain Care Programs*
In the course of researching Vermont's 2007 health reform efforts as part of our RWJF-funded study, we asked informants whether enrollment for programs like Catamount Health or the Employer Sponsor Insurance Assistance (ESIA) program met their expectations, why enrollment in these programs was lower than those initial projections, and what they thought might be driving the churning finding. Their responses reflect many of the barriers to enrollment and reenrollment mentioned above. [28]

Many interviewed felt that enrollment in the Green Mountain Care programs was adequate, even though it was lower than initial projections. However, some informants felt that enrollment was inadequate, either because it was lower than projected or because they had heard from the Vermonters they represent that there were barriers to enrollment.

The affordability of the plan, particularly for those individuals who do not qualify for premium assistance, was a barrier cited by informants. At the time of the interviews, enrollment in Catamount Health costs over $400 a month for individuals, and, thus, it may not be affordable

[26] Chan, David and Gruber, Jonathan. "How Sensitive are Low Income Families to Health Plan Prices?" *American Economic Review*, May 2010. 100(2): 292–96
[27] IBID
[28] Deprez, Ronald, et al. Achieving Universal Coverage Through Comprehensive Health Reform: The Vermont Experience. Prepared for the Robert Wood Johnson Foundation. August 2010

for those with family incomes just above 300% FPL, who do not qualify for premium assistance but have limited disposable income. Enrollment among those who do not qualify for premium assistance was limited, perhaps, in part, as a result of the cost of the plan. Additionally, some of the key informants felt that even Vermonters who qualify for premium assistance find their monthly premium share too expensive. In particular, those who are young, healthy and free of disease may perceive the plan to be unaffordable. The fact that the majority of those who signed up for Catamount receive some level of premium assistance indicates that it may not be affordable without this subsidy and, in some cases, may not be *perceived* as affordable even with subsidies.

Enrollee premiums were increased in 2010 for those above 200% of the FPL as a result of rate filing increases from both MVP Health Insurance and Blue Cross Blue Shield (rates for those below 200% were protected by the American Recovery and Reinvestment Act (ARRA) of 2009 and PPACA Maintenance of Effort provisions).

It should also be noted that cost was a barrier to coverage cited many times over by consumers in the stakeholder focus groups conducted under Task 9 of this Health Exchange Planning initiative.[29]

Another barrier to enrollment was the 12-month waiting period for coverage. Although several events pre-empt this waiting period (e.g., being laid off or becoming ineligible for parental coverage due to age), many individuals have to be uninsured for 12 months before qualifying for Catamount Health. For those who are self-employed – and, thus, cannot be laid off – or those who only have catastrophic insurance plans because they have not been able to afford comprehensive coverage (the underinsured),[30] this waiting period is particularly problematic. Many are not willing to bear the risk of going without coverage for a year, even if their current coverage is much more expensive than Catamount Health or if it is inadequate.

The issue of the underinsured was of particular concern in Vermont, and the Legislature attempted to address this issue in 2008. Act 203 of 2008 allowed those with deductibles of $10,000 or greater (single coverage) to sign up for Catamount without waiting for 12 months. Act 61 passed in 2009 further reduced the high deductible exemption to $7500 and changed the rules for eligibility of self employed and small business owners in cases of businesses closing or bankruptcy. Although Acts 203 and 61 improved opportunities for the underinsured, several of those interviewed felt that the new provision was inadequate to address the concerns of the underinsured for several reasons including:

- There is likely a significant cohort of Vermonters who have insurance deductibles between $1000 and $7500. These individuals could be considered underinsured because

[29] Mildner, Curtis, and Jennifer MacBride. "Task 9: Underinsured Vermont Residents Focus Group Report" Planning for Vermont's Health Benefits Exchange (May 2011)

[30] Although researchers, including the Commonwealth Fund and others, have recently been working to create a quantifiable, common definition of underinsurance, in this report we are using the term in a more general sense. It is a topic that arose frequently in our key informant interviews and was generally described as an inability to afford out of pocket health care costs among the insured.

they cannot access primary care and preventive services without substantial out of pocket cost. However, they originally did not qualify for the waiting period exemption.

- Those with a $7500 or greater deductible in their existing coverage, while now exempt from the 12-month waiting period, are not eligible for Catamount premium assistance until one year from the date they sign up for a Catamount health plan. Purchasing Catamount at full premium price for one year may not be an option for many of these Vermonters.

A final barrier mentioned during interviews to enrollment in Catamount Health, the ESI premium assistance program (ESIA), and VHAP ESI, is the enrollment process itself. There are several issues that complicate enrollment. They include the following:

- Although there is a common website for determining potential eligibility for programs, actual enrollment, until recently, required a multi-step process due to the need to dually sign up with the State for premium assistance via a contracted enrollment company, Maximus, and then to sign up for Catamount, ESIA, or VHAP ESI with a private insurance company. Recently, this was changed to create a one-step process for Catamount enrollment from the enrollee perspective, whereby the State works directly with the insurance companies and eliminates the second step.
- Additionally, those potentially eligible for ESIA must produce documentation about the coverage offered to them through their employer and must wait for the state to determine comparability and cost effectiveness of their employer's plan versus Catamount.
- The enrollment processes and methods were designed for low income, Medicaid populations and are now being used for private insurance products with a target audience above 200% FPL. Many enrollees were not used to being asked to produce income documentation for insurance purposes. Further, it was noted that Vermont's 2006 Health Care Affordability Acts (HCAA) legislation mandated some language that increased the clumsiness of forms for the new programs.

As noted above, there are also indications that many who enroll in the Green Mountain Care programs drop coverage periodically and re-enroll later. In order to explore this finding, key informants were asked to reflect on the possible causes. One cited factor is the renewal process itself. After 12 months on the program, a form is mailed to participants asking for updated income information and asking them to mail back the form. Advocates report that this process is cumbersome and confusing to many enrollees and that if the form is not returned in time, the policy may be cancelled requiring re-enrollment. This is another area that the State has identified to work on in the coming years. Many other States have struggled with these issues, and there are creative examples to emulate including using pre-populated forms or allowing people to renew by phone (see recommendations, above).

Another potential cause of churning cited was the cost of the program or affordability. Many expressed that it remains unclear whether those who drop off due to the cost of premiums truly can't afford this product or simply make choices to spend their money on other needs. Further,

some suggested that the high quality of the Catamount product, and its associated cost, may not be the right vehicle for those who want to spend less on health care because they are relatively young and healthy. Lastly, it was suggested that many of the people eligible for services have less stable employment and income, and therefore, their eligibility for Catamount vs. VHAP vs. Medicaid changes from month to month. This factor was cited particularly in the context of the 2008/2009 recession which increased employment instability. However, despite these enrollment and re-enrollment challenges, most agree that actual enrollment has been successful and has led to more Vermonters with health insurance coverage, despite the current economic environment.

It is important to note that Vermont has taken a number of steps specifically aimed at reducing churning. For example:

- Assets tests for Dr. Dynasaur, VHAP, and the premium assistance programs have been phased out
- Self-declaration of income is now in use for Dr. Dynasaur, VHAP, and the premium assistance programs
- Review frequency has been reduced from 6 to 12 months
- An online enrollment/re-enrollment option has been implemented
- Various premium payment methods, including credit card, automatic withdrawal, and cash have been implemented
- The Catamount Health enrollment process has been automated.
- The call center used to assist in the enrollment and renewal processes now has the capacity to respond to e-mail requests from new applicants and existing enrollees
- Face-to-face interviews have been eliminated.
- A combined application form has been instituted for VHAP, CHIP, and the premium assistance programs (applicants can use this form for Medicaid also, but a supplemental form to ask about assets has to be subsequently sent).

The federal mandates for online enrollment and eligibility determination in the 2010 PPACA increase the urgency for Vermont to update these systems, but it is unclear at this point whether there will be adequate federal or state funding to augment these changes. In any case, OVHA and the Legislature have done an impressive job of responding to identified shortcomings in the programs and making modifications to improve the eligibility and enrollment processes despite minimal funding specifically allocated for this purpose.

The lessons learned from this report and these interviews should be used to inform ongoing planning efforts for how the Exchange and the expansion of Medicaid will be seamlessly incorporated into Vermont's system of insurance, without introducing further impediments to the enrollment and reenrollment processes.

## COST TO ENROLLEES

There is substantial evidence that the loss of insurance, whether through lost eligibility or drop out, is detrimental to enrollees' health, even if the loss of insurance is temporary. Even

controlling for confounding factors, non-elderly adult Medicaid enrollees who lose their coverage have been found to be:

- More likely to use the emergency room[31]
- Less likely to use ambulatory care[32]
- More likely to have higher costs associated with their care[33]
- More likely to have worse health outcomes[34]
- Have eligible children that are also likely to be uninsured and at risk for many of the aforementioned health and cost concerns[35]

In Oregon, Medicaid beneficiaries who experienced a gap in coverage were less likely to have a primary care visit, more likely to report an unmet health care needs, and more likely to report being in medical debt than those who were continuously insured, controlling for demographic characteristics, income, and health status.[36]

Churning also affects the quality of care given to enrollees. Disease management programs, for example, are less effective for beneficiaries than they would be otherwise due to difficulties in maintaining their coverage. Enrollees also experience higher costs once they are able to reenroll in a program.

## ADMINISTRATIVE COSTS OF CHURNING

Churning in public programs has significant and troubling consequences for states and administrators, health plans, and providers as well. There are unnecessary and burdensome staff and system costs associated with:

- Enrolling, disenrolling, and reenrolling beneficiaries because of duplicative paperwork, system updates, extra mailings
- Delivering "new member" services each time an enrollee reenrolls after dropping off their coverage
- Researching and reconciling any billing problems
- Verifying enrollment status, counseling consumers about their status,
- Staff time allocated to track and assist individuals participating in disease management programs who have lost their coverage
- Cost-shifting and depleted resources when payments are not available to reimburse safety-net providers

[31] Lowe R, McConnell K, Vogt M, Smith J. The impact of Medicaid cutbacks on emergency department use: the Oregon experience. Annals of Emergency Medicine. 2008

[32] Carlson MJ, DeVoe J, Wright BJ. Short-term impacts of coverage loss in a Medicaid population: early results from a prospective cohort study of the Oregon Health Plan. Ann Fam Med. 2006;4(5):391–8.

[33] Rimsza ME, Butler RJ, Johnson WG. Impact of Medicaid disenrollment on health care use and cost. Pediatrics. 2007;119(5):e1026–32.

[34] Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons, and consequences. Ann Intern Med.1991;114(4):325–31.

[35] IBID

[36] Carlson, Matthew, Jennifer DeVoe, Bill J. Wright. Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan. *Ann Family Med*. Sept/Oct 2006: 4(5)

- The difficulty in measuring quality of care[37]

## FEDERAL PROVISIONS THAT WILL LIKELY EFFECT CHURNING

There are a number of federal provisions in the PPACA that should reduce churning. The most significant is the individual mandate requiring individuals to obtain insurance. Requiring individuals to obtain a qualified health insurance plan or face a tax penalty that will increase over time is expected to increase uptake significantly in public and private insurance enrollment; nationally, the Congressional Budget Office estimates a reduction in the number of uninsured by 32 million individuals.[38] Experience in Massachusetts suggests that the mandate employed in Massachusetts was very successful at maximizing enrollment into any sort of health insurance plan. Most recently, 98% of the population reported having some form of health insurance on their state tax fillings; rates of uninsurance have declined 60-70% since Massachusetts enacted health reform.[39] How the individual mandate influences the number of drop-offs and transitions among enrollees, however, remains to be seen.

State rules for Medicaid eligibility will become much more standardized through under the ACA: 1) use of the Modified Adjusted Gross Income (MAGI) standard for Medicaid eligibility; 2) eliminating any sort of asset test; and 3) simplification of enrollment procedures into Medicaid. These eligibility provisions will, for example, affect eligibility determination. Medicaid and CHIP will usually allow applicants to deduct certain expenses that help them claim eligibility for subsidized insurance. While the MAGI standard will be much simpler to use, it may result in pushing adults out of Green Mountain Care plans (children are prohibited from losing insurance coverage due to the application of the MAGI standard) and into other subsidized insurance plans sold on the state Exchange. These plans may be less generous in terms of benefits than those provided by Medicaid.[40] In terms of asset testing, Vermont has mostly phased out the use of asset testing in determining eligibility for expansion plans already, although it is still in use for Medicaid.

A third provision of PPACA requires the simplification of enrollment procedures into Medicaid and includes:

- A less complicated application process for not only Medicaid, but other forms of federally-subsidized insurance, including those sold on the state Exchanges.
- The creation of a web-based portal that will allow Vermonters to apply to, enroll in, or renew enrollment in Medicaid.

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[37] Summer, Laura and Cindy Mann. Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies. The Commonwealth Fund. June 2006

[38] Douglas W. Elmendorf (Director, Congressional Budget Office). Committee on Energy and Commerce, Subcommittee on Health. "Testimony on CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 before the Subcommittee on Health, Committee on Energy and Commerce U.S. House of Representatives" (Date: 3/30/2011). Available: http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

[39] Gruber, Jonathan. "The Impacts of the Affordable Care Act: How Reasonable Are the Projections?" NBER Working Paper No. 17168 (June 2011).

[40] Bernstein, William, Patricia Boozing, Paul Campbell, et al (California HealthCare Foundation). "Implementing National Health Reform in California: Changes to Public and Private Insurance". June 2010

- Conduct efforts to increase enrollment among communities of vulnerable populations, including children, homeless youth, pregnant women, racial and ethnic minorities, rural households, etc.[41]

It is expected that US DHHS will develop a single application form that can be used for all three need-based health insurance programs, Medicaid, CHIP, and subsidies in the Exchanges. States will be encouraged to use these forms, although they are by no means required.[42] As previously noted, procedures that make enrollment and reenrollment simpler will likely lower churn.

The overarching application process will require significant interaction between Medicaid, the Exchanges, and external sources of data in determining eligibility. This will require data-matching systems that will allow all health agencies to exchange information from the application form and determine appropriate eligibility for Medicaid, the Exchanges, or some other form of subsidized insurance.[43]

A final provision of PPACA that could lower churn is the Exchange Navigator initiative, a policy that will be up to states to implement. PPACA requires Exchanges to establish a program for awarding grants to eligible organizations that are knowledgeable of state programs and can: conduct outreach programs to let people know of qualified health plans on the Exchange; distribute information on enrolling in plans, availability of tax credits, and cost-sharing reductions; facilitate enrollment in qualified health plans; refer enrollees to the applicable agency for any grievance or complaint; and provide culturally and linguistically appropriate information. These Exchange Navigators will be critical as a resource for providing support to enrollees who have to transition from Medicaid to and/or from the Exchange.

## OTHER STATE APPROACHES

States have long been leading innovators in approaches to covering their uninsured populations, and offer a number of insights into how churning might be lowered through enacting smart policies and procedures, particularly around eligibility and (re)enrollment systems.

*Eligibility and Enrollment Systems*

States such as Louisiana, Massachusetts, and Wisconsin have implemented automatic enrollment strategies to increase enrollment and abate high administrative costs, especially since federal reform requires the implementation of a coordinated system for determining eligibility for Medicaid and subsidized coverage in the health insurance exchanges.

Automatic enrollment works toward resolution of longstanding criticism of public benefit programs by tightening the application process, therefore promoting program integrity, and increasing enrollment of eligible individuals while lowering administrative costs by simplifying

[41] IBID

[42] Dorn, Stan (Urban Institute). "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals. Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2010. Available at: http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Final_updated_8.5.10.pdf. Accessed August 10, 2010.

[43] IBID

the application process. The enrollment of already eligible individuals also yields financial benefits for the state because if eligible people get sick it is likely that their providers will help them enroll into available health coverage at the State's expense. If they were already enrolled, early detection might have prevented some of these costs.[44]

*Medicaid/ SCHIP renewals in Louisiana*

In July 2001 Louisiana's Medicaid program changed its renewal procedures for children to ensure that children were not losing coverage because of errors or failure to complete paperwork. This initial effort has led to substantial improvements over the past decade in how eligible children are processed, to the point where Louisiana's recertification process is considered a national model for client-centered renewal. Most cases can be now be processed with little encumbrance to families, without forfeiting the integrity of the recertification process. Louisiana's Medicaid Payment Error Rate Measurement (PERM) rate is only 1.54%, which is 25% of the national average.

The following four renewal approaches account for 95% of Medicaid and 90% of LaCHIP renewals:

- Ex parte renewal, which involves verification of information using Food Stamp case information, state tax information or a private employment and income verification service (33% of Medicaid and 33% of LaCHIP)
- Administrative renewal, which entails sending a letter to families meeting certain criteria requesting that they report changes in income or household composition (44% of Medicaid and 4% of LaCHIP);
- Telephone renewal, which involves enrollment staff calling or receiving a call from enrollees, in which certain eligibility information that are subject to change are reviewed (15% of Medicaid and 37% of LaCHIP); and
- Web-based renewal, which represents 4% of LaCHIP cases.[45]

The Louisiana Department of Health and Hospitals has worked to develop criteria to establish which cases are suitable for ex parte renewal or administrative renewal. Decision standards are programmed directly into Louisiana's eligibility information systems, MEDS, and ex parte or administrative renewals are used when these standards are met.[46]

Certain cases are considered appropriate for administrative renewals if they meet specific eligibility criteria, including: if the applicant is a relative other than the parent (e.g., grandparent, aunt, uncle); the parent has Retirement, Survivors Disability Insurance (RSDI) income; a single

[44] Dorn, Stan (The Urban Institute). "Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals." Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2007. Available at: http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf. Accessed August 10, 2010.

[45] Jennifer Edwards, et al. Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States. Robert Wood Johnson Foundation (Feb 2010).

[46] IBID

parent has stable unearned income, such as child support or alimony; and/or there has been no change in eligibility in the last three years and net income is less than or equal to $500.[47]

If a child's recertification process does not meet the requirements for administrative renewal, and they have an open Food Stamps case in the Food Stamps (FS) eligibility system, the recertification process is qualified for ex parte renewal. Every month, all children's insurance files that are scheduled for renewal are matched against the FS eligibility system overseen by the Department of Social Services.[48]

If eligibility cannot be determined because the FS case is closed or the data is out of date, the renewal process requires involving contacting the enrollee's household. If changes are reported, the case returns to a standard recertification process. If not, eligibility of the child is extended and the electronic record is flagged to show completion of recertification process without requiring an eligibility worker. Only 5 % of Medicaid and 10 % of LaCHIP case reviews require the member to submit a signed renewal form in order to renew their eligibility.[49]

*Enrollment into Commonwealth Care in Massachusetts*

For many years Massachusetts provided hospital care and certain outpatient services to the uninsured with the Uncompensated Care Pool (UCP). Now the Commonwealth Care (CommCare program) covers these uninsured residents of Massachusetts. At the program's inception, State officials automatically enrolled all individuals who previously used the UCP, and now people from 100-150% FPL are also automatically enrolled.[50] On the CommCare website, Massachusetts residents can also check their eligibility for various State programs. Massachusetts' automatic enrollment system helped produce rapid and high take-up. The state currently receives 85 percent of enrollment applications through the website. [51]

*Wisconsin BadgerCare Plus*

Wisconsin's BadgerCare Plus program, implemented in 2007, merged the state's three Medicaid programs for children, parents, and pregnant women into one comprehensive health coverage program. By focusing on enrolling entire families, rather than individuals, BadgerCare Plus has been able to provide near-universal coverage for children and greater coverage for parents and childless adults. High demand for coverage and severe budget crises in Wisconsin has limited the success of BadgerCare Plus because potential enrollees have found themselves on waiting lists for the program. Despite this, Vermont can look to Wisconsin as an example of how to simplify eligibility and enrollment processes.

The state worked to facilitate and simplify enrollment and renewal in BadgerCare Plus by partnering with community-based organizations and health care providers to identify and enroll eligible children and families. Organizations can automatically enroll children if their family income is less than 250% FPL and pregnant women if their family income is below 300% FPL.

[47] IBID
[48] IBID
[49] IBID
[50] IBID
[51] Volk, Gwyn and Jacobs, Anne. "Implementing State Health Reform: Lessons for Policymakers." Robert Wood Johnson State Coverage Initiatives. Princeton, N.J.: RWJ, 2010.

The enrollment process is further simplified because of the creation of a centralized and paperless application system. This system is fully integrated with an online tool, ACCESS, which allows individuals and families to determine their eligibility for public programs, apply for benefits, and check their application status. State residents are able to apply for health coverage electronically and the system simultaneously verifies the applicant's income and lack of access to employer coverage.[52]

Also of importance to the streamlining of the enrollment process is the consolidation of public programs. Prior to the implementation of BadgerCare Plus, low-income individuals were placed in a selection of different programs depending on their income, age, whether they had dependent children, pregnancy status, employment status and several other characteristics. Now, all low-income individuals apply for a single program, BadgerCare Plus, regardless of demographic factors. Behind the scenes, enrollment staff place individuals into separate funding categories depending on the characteristics of enrollees.[53]

Initial assessments of BadgerCare Plus from Wisconsin administrators suggest that the State's efforts in improving the enrollment processes have resulted in a reduction in the state's churn rates and an improved continuity of coverage for enrollees.[54]

[52] "Wisconsin's BadgerCare Plus Program: Moving Forward on Health Reform Amid a Recession." Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA: THE HENRY J. KAISER FAMILY FOUNDATION. Available at http://www.kff.org/medicaid/upload/8078.pdf. Accessed August 10, 2010.

[53] Hynes, Emma and Thomas R. Oliver, "Wisconsin's BadgerCare Plus Health Coverage Program: A Qualitative Evaluation". University of Wisconsin. October 2010

[54] IBID

## IV. CONCLUSION

This report has presented a number of policy options on churning that Vermont might want to consider as it moves forward with its health insurance Exchange and continues to plan for the implementation of a single payer system. As this report has made clear, churning has been – and will continue to be – a problem that Vermont will need to address. Reasons for churning are complex, numerous, and difficult to confront, but the costs of churning for both enrollees and administrators are very real and well worth addressing through smart, targeted policy. We have reported on a number of ongoing state-level efforts to address churn rates, particularly through improved reenrollment policies; it will be very important to continue monitoring these efforts, in order to see what benefits – financial or otherwise - can be achieved.

Next steps that Vermont may want to look into include quantifying by how much these suggested policies may reduce churn rates, determining what sort of investment Vermont may have to make in order to see significant reductions in churn rates, and finally, extrapolating what sort of return on investment Vermont might see should it choose to pursue any of the suggested policy recommendations included in this report.

## APPENDIX 1 - LIST OF KEY INFORMANTS

| Interviewees | Organization |
|---|---|
| Senator Claire Ayer | Vermont State Senate |
| Denis Barton<br>Director of Public Policy | Bi-State Primary Care Association |
| Mike Davis<br>Acting Deputy Commissioner | Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) – Division of Health Care Administration |
| Betsy Forrest<br>Health Care Affordability Director | Dept of Vermont Health Access |
| Cassandra Gekas<br>Health Care Advocate | Vermont Public Interest Research Group (VPIRG) |
| Maureen Hensley-Quinn<br>Policy Specialist | Robert Wood Johnson Foundation (RWJF) MaxEnroll Program |
| Danielle Hibbard<br>Vermont Outreach Specialist | Bi-State Primary Care Association |
| Senator Jane Kitchel | Vermont State Senate |
| Lynn Raymond-Empey<br>Executive Director | Vermont Coalition of Clinics for the Uninsured (VCCU) |
| Trish Riley<br>Former Director | Maine Governor's Office of Health Policy and Finance |
| Peter Sterling<br>Executive Director | Vermont Campaign for Health Care Security |