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Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective

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ABSTRACT Medicaid churning—the constant exit and reentry of beneficiaries as their eligibility changes—has long been a problem for both Medicaid administrators and recipients. Churning will continue under the Affordable Care Act because, despite new federal rules, Medicaid eligibility will continue to be based on current monthly income. We developed a longitudinal simulation model to evaluate four policy options for modifying or extending Medicaid eligibility to reduce churning. The simulations suggest that two options—extending eligibility either to the end of a calendar year or for twelve months after enrollment—would be the most effective methods for reducing churning. The other options—a three-month extension or eligibility based on projected annual income—would reduce churning to a lesser extent. States should consider implementation of the option that best balances costs while improving access to coverage and, thereby, the health of Medicaid enrollees.

Medicaid "churning"—the constant exit and reentry of beneficiaries as their eligibility changes—has long frustrated Medicaid administrators concerned with providing continuity of medical care while reducing unnecessary administrative costs.[1–5] Recent research estimating the number of people whose Medicaid eligibility might change from year to year because of changes in income or family size underscores how churning will continue under the Affordable Care Act (ACA).[6–8] Estimates based on 2004–08 data indicate that more than 30 percent of Medicaid-eligible people lose their eligibility within six months of enrollment, and about half lose it within twelve months.[7,8] These estimates should still remain valid, as the ACA maintains the requirement that current monthly income serve as the basis for Medicaid eligibility.[9] The estimates also align with ACA provisions by assuming that eligibility ends when a person's monthly income increases above 138 percent of the federal poverty level.[7,8]

In part to address Medicaid churning caused by fluctuating income or enrollees' not providing recertification documents, the ACA provided substantial federal funding to states to modernize the computer systems that determine Medicaid eligibility. This modernization should increase efficiencies in eligibility determination, particularly by enabling verification of income with electronic data from other federal and state agencies. Moreover, eligibility will be renewed administratively (without requiring enrollees to provide documentation) if enrollees' Medicaid records match electronically with other agencies' verification data that indicate continuing eligibility.

However, even with greater use of electronic data linkages, failed matches and data inconsistencies will sometimes trigger the disenrollment of eligible people. Moreover, because monthly income changes frequently in lower-income

households, electronically verifying income every quarter will lead to churning unless states choose to develop mitigating procedures.

We developed a longitudinal simulation model to evaluate four options for reducing Medicaid churning under the ACA by modifying or extending Medicaid eligibility. Two are by far the most effective at reducing churning, but they have different impacts on average monthly caseloads and the number of people covered throughout the year. Comparing the options illustrates the trade-offs policy makers face when considering both Medicaid program costs and costs to Medicaid enrollees who might churn.

Background

Medicaid churning often occurs year after year for certain beneficiaries. The typical causes are seasonal employment and overtime pay, which increase earnings to the point at which a person loses eligibility for some months, only to become eligible again and reenroll when the extra income ends. Churning is distinct from transitions to other insurance coverage associated with longer-lasting changes in income, employment, or marital status. Churning and more permanent transitions have different cost implications for individuals and society.

Churning creates substantial administrative costs for traditional Medicaid and Medicaid-managed care plans. From 2005 to 2010, estimated administrative costs per enrollment or disenrollment ranged between $180 and $280.[3,10,11] Based on these data, in 2015 the administrative cost of one person's churning one time (disenrolling and reenrolling) could be from $400 to $600 (accounting for inflation since 2005). To put this estimate in perspective, in fiscal year 2011 (the most recent year for which data are available), average Medicaid expenditures were $4,141 for a nondisabled adult younger than age sixty-five.[12] Churning-related administrative costs, multiplied by the number of people who churn in a year, generate a substantial share of Medicaid expenses.

Churning also contributes to increased Medicaid expenditures for medical care. People who experience lapses in coverage often reenroll in Medicaid when, for example, they obtain high-cost care in hospitals that could have been avoided with better ongoing care.[13–15]

Churning-related administrative costs and the costs of avoidable medical care fall on taxpayers. Other costs fall on the individuals who experience churning. In order to reenroll, they have to provide documentation to reestablish eligibility and may have to change health care providers, a process that disrupts medical care and contributes to poor health. Research has shown that people with short episodes of coverage have poorer quality of health care than people enrolled for longer episodes.[11,16,17] Costs to taxpayers and to Medicaid-eligible individuals would be much lower if Medicaid churning were reduced.

Churning And The ACA

In issuing two final federal rules in 2012 regarding income calculations for Medicaid eligibility under the ACA, the Department of Health and Human Services recognized that monthly income changes can cause churning.[9] The first of these [42 CFR 435.603(h)(2)] allows states to use projected annual income for the remainder of the calendar year when evaluating a person's eligibility for Medicaid. The projection is in contrast to a prior rule requiring people to enroll if their current monthly income qualifies them for Medicaid and then to disenroll if their projected annual income for the entire calendar year (including previous months) exceeds the Medicaid limit. The new federal rule enables someone in these circumstances to remain in a Marketplace plan with a premium subsidy. The other 2012 federal rule, 42 CFR 435.603(h)(3), also allows states to include or exclude a prorated portion of a predictable income change when determining current eligibility. This rule aims to reduce churning among people expecting income changes as a result of seasonal employment or overtime pay.

Proposed Options For Reducing Churning

Many strategies have been proposed to reduce Medicaid churning and provide continuity of coverage for beneficiaries.[1,6,8,18] We focused on four policy options intended to minimize churning: annualize income when determining Medicaid eligibility [similar to federal rule 42 CFR 435.603(h)(2)]; if a quarterly income verification check indicates that an enrollee is no longer eligible, extend Medicaid coverage by three months; if a quarterly income verification check indicates that an enrollee is no longer eligible, extend coverage to the end of the calendar year; and grant initial coverage for twelve continuous months. The options are designed to simplify the recertification of Medicaid eligibility and avoid disruptions in coverage attributable to income fluctuations, administrative errors, and enrollees' not fulfilling recertification requirements.

We discuss the options in more detail after describing the model used to simulate the effects of each option.

Study Data And Methods

SIMULATION MODEL AND DATA Our longitudinal simulation model used monthly income data from the Survey of Income and Program Participation (SIPP) to create periods of Medicaid eligibility under current ACA rules. SIPP is nationally representative, and our simulations used all of the data on monthly changes in income and family structure in the survey. The simulations estimated the effects of the four policy options under the circumstances originally envisioned by the ACA. We assumed that all states opted to expand Medicaid eligibility for adults to 138 percent of the federal poverty level.

Our simulation year was calendar year 2006, the last calendar year in the 2004–07 SIPP panel with twelve months of data for all sampled individuals. We used this SIPP panel instead of the 2008–12 panel because 2006 was a year of relative economic prosperity and we did not want to confound our simulation results with the Great Recession's impact on Medicaid enrollment.

Our simulations included adults ages 19–64 at the end of 2006. Our SIPP sample consisted of adults with data for the entire panel (forty-eight months). We used the longitudinal weights provided by SIPP to make national estimates from this sample. To correct for any attrition bias associated with health insurance status, we revised the longitudinal weights to match estimates of the distribution of health insurance status in the last month of SIPP using the cross-sectional SIPP weight for that month.[6]

Estimates of policy outcomes were simulated with two different assumptions about monthly participation rates (85 percent and 50 percent) after a year of eligibility. Two different administrative disruption rates (35 percent and 15 percent) were assumed to simulate disenrollment at the point of annual redetermination of continuing eligibility caused by data inconsistencies or enrollees' not providing requested documents. The online Appendix provides further details on the longitudinal simulation model and the rationale for our choices of participation and administrative disruption rates.[19]

OUTCOMES SIMULATED The simulation model allowed us to estimate the number of people covered by Medicaid at some point during the chosen calendar year and the number covered for the entire calendar year, as well as the number of transitions into and out of Medicaid and the number of people with at least one churning episode (that is, who exited and reenrolled) during the calendar year.

We also estimated the average monthly caseload for each option, defined as total person-months of enrollment in the calendar year divided by twelve. Thus, differences in monthly

Costs to taxpayers and to Medicaid-eligible individuals would be much lower if Medicaid churning were reduced.

caseloads among the four options reflect differences in both the number of enrollees and the length of enrollment per enrollee. Average monthly caseload is a good indicator of predictable spending on Medicaid-covered medical services, assuming that such expenditures are roughly proportional to the number of people enrolled each month.

BASELINE SCENARIO A counterfactual comparison was needed to quantify the effects of the policy options, so we first simulated coverage in a "baseline" scenario. The scenario assumed that people neglect to report changes in their income or family size that would affect their monthly eligibility. Enrollees left Medicaid only when a quarterly check of administrative data or the annual redetermination of eligibility revealed that they were no longer eligible. The simulation model also assumed that administrative disruptions occurred during annual eligibility redeterminations; causes of such disruptions included clerical errors or enrollees' not providing documentation after discrepancies between electronic records generated a disenrollment notice. Disruptions caused a percentage of enrollees to be disenrolled, despite their continuing eligibility for Medicaid.

FOUR POLICY OPTIONS SIMULATED

▶ OPTION 1: ANNUALIZE INCOME: Annualizing income (that is, estimating one year's income of beneficiaries) when determining eligibility would reduce churning that predictably occurs each year. This option is similar in spirit to the previously discussed federal rules [42 CFR 435.603(h)(2) and 435.603(h)(3)], ACA provisions designed to address income fluctuation. In simulating this option, income is annualized by assuming that monthly income in each of the remaining months of the calendar year will continue at the current monthly level and then adding actual income from the previous months. If either current monthly income or the projection of average monthly calendar-year income is less

States that do not try to reduce churning are likely to experience increased churning going forward.

than the eligibility limit in any month, then the person is considered eligible for Medicaid in that month.

▶ OPTION 2: EXTEND COVERAGE BY THREE MONTHS: When a change in income or life circumstances causes loss of eligibility, Medicaid beneficiaries must be given ten days' advance notice that they are no longer eligible. Medicaid coverage generally stops at the end of the month in which the eleventh day occurs. An exception to this general rule is a program known as Transitional Medicaid Assistance (TMA), which provides between four and twelve months of additional Medicaid coverage to families who otherwise would lose eligibility because an adult family member has higher earned income from more work hours or because spousal or child support payments increased.[18,20] TMA sets a precedent for extending Medicaid eligibility by three months if an income verification check indicates that a Medicaid enrollee has lost eligibility. In our simulation of this option, someone loses coverage only if a second verification check confirms a continuing lack of eligibility.

▶ OPTION 3: EXTEND COVERAGE TO END OF CALENDAR YEAR: This option extends Mediaid coverage until the end of the calendar year for those who are newly enrolled or anyone for whom a quarterly check of administrative data confirmed continued eligibility earlier in the year. This option has the effect of causing annual redeterminations of Medicaid eligibility to coincide with the open enrollment period for the ACA health insurance Marketplace. These simultaneous events make it easier for those who might be losing Medicaid eligibility because of increased income to immediately enroll in a Marketplace health plan without experiencing a gap in coverage.

▶ OPTION 4: GRANT COVERAGE FOR TWELVE CONTINUOUS MONTHS: Twelve months of continuous eligibility is already a state option for children covered by either the Children's Health Insurance Program or Medicaid.[21] Adults can be given twelve months of continuous coverage if a state requests a section 1115 waiver to do so. So far, only New York has obtained such a waiver for parents.[22] Option 4 would eliminate the need for a state to request an 1115 waiver. Adults would be granted Medicaid for twelve months from the date of their initial or annual eligibility determination and would retain coverage for twelve months even if a change in income or life circumstances would otherwise make them ineligible.

LIMITATIONS Our estimates had several limitations that should be kept in mind. First, the SIPP monthly income data were self-reported and might not match exactly with incomes assessed by state Medicaid programs. Second, as noted, our sample was limited to individuals who remained in SIPP for the full panel. We revised the longitudinal weights supplied by SIPP to better correct for any attrition bias associated with health insurance status. Nonetheless, we may still have been underestimating numbers if individuals who left the SIPP sample were particularly likely to churn. Third, by using all respondents in the SIPP sample who met our selection criteria, the simulations implicitly assumed that all states expanded Medicaid eligibility to 138 percent of poverty. This was done to lend greater statistical power with a larger sample and because there are strong financial incentives for states to expand Medicaid. Finally, we focused only on the loss of Medicaid eligibility instead of other ways to exit the program. Thus, we simulated only the effects of policy options that might reduce churning. We did not consider other strategies to improve continuity of coverage, such as the participation of managed care plans in both Medicaid and the insurance Marketplaces.[18]

Study Results

Exhibit 1 shows the simulation results for the baseline scenario and the four policy options, assuming that 85 percent of Medicaid-eligible adults enroll (participate) each month and that the administrative disruption rate is 15 percent. Exhibits 2–4 illustrate, respectively, how each of the four policy options changed our three outcomes of interest: the number of adults reenrolling in Medicaid (churning), the number covered by Medicaid all year, and the average monthly Medicaid caseload. The changes are shown as the percentage change relative to the baseline scenario population.

Exhibits 2–4 also show how these three outcomes were affected by both varying the Medicaid participation rate while holding the administrative disruption rate at 15 percent and varying the disruption rate while holding the participation rate at 85 percent.

EXHIBIT 1

Simulated Medicaid Coverage Scenarios For Baseline And Four Policy Options, Assuming 85 Percent Participation Rate And 15 Percent Administrative Disruption, 2006

Scenario	Number of people (millions)			
	Covered any time in 2006	Average monthly caseload in 2006	Covered all months in 2006	Churning: leaving and reentering in 2006[a]
BASELINE SCENARIO				
People covered	57.1	41.2	25.6	7.6
POLICY OPTIONS				
Option 1: annualized income				
People covered	58.4	42.9	27.3	8.1
Change from baseline	1.4	1.7	1.7	0.4
Option 2: three-month extension				
People covered	57.4	42.4	26.6	7.6
Change from baseline	0.3	1.2	1.1	0.0
Option 3: end-of-calendar-year extension				
People covered	57.1	46.8	38.5	1.8
Change from baseline	0.0	5.6	12.9	−5.9
Option 4: twelve-month continuous eligibility				
People covered	60.6	48.0	30.6	5.4
Change from baseline	3.5	6.8	5.0	−2.3

SOURCE Authors' simulation model using the 2004–07 panel of the Survey of Income and Program Participation. **NOTES** The weighted estimate of the US population of adults younger than age sixty-five is 181.877 million. [a]Includes people covered in December 2005 who disenrolled in January 2006 and reentered later in the year.

Our discussion of the simulated effects of the policy options assumed a participation rate of 85 percent and a disruption rate of 15 percent. Recall that the simulations are for calendar year 2006 and are applied to national data, as if all states expanded Medicaid eligibility under the ACA.

ANNUALIZE INCOME Compared to the baseline scenario, annualizing income increased the number of people reenrolling (churning) in Medicaid by 5 percent (400,000 people; see Exhibits 1 and 2). Option 1 also was estimated to increase the number of people covered by Medicaid for the entire year by 7 percent (1.7 million more people) as well as the average monthly caseload by 4 percent (coincidentally, also 1.7 million people).

THREE-MONTH EXTENSION Compared to the baseline scenario, extending enrollment for three months after a failed verification check had virtually no effect on the number of adults reenrolling during the year. The number of adults covered all year increased by 4 percent (1.1 million people), and the average monthly caseload rose by 3 percent (1.2 million people).

END-OF-CALENDAR-YEAR EXTENSION By design, administrative disruption during the calendar year was almost eliminated with this option. Relative to the baseline scenario, churning dropped by 78 percent (a decline of 5.9 million people). The number covered by Medicaid for the entire calendar year increased by 50 percent (an additional 12.9 million people), and the average monthly caseload increased by 14 percent (5.6 million people).

TWELVE MONTHS OF CONTINUOUS ELIGIBILITY Compared to the baseline scenario, this option reduced the number of people churning when reenrolling in Medicaid by 30 percent (2.3 mil-

EXHIBIT 2

Estimated Effects Of Four Policy Options On Percentage Change In Adults Experiencing Medicaid Churning, Run Through Three Simulations
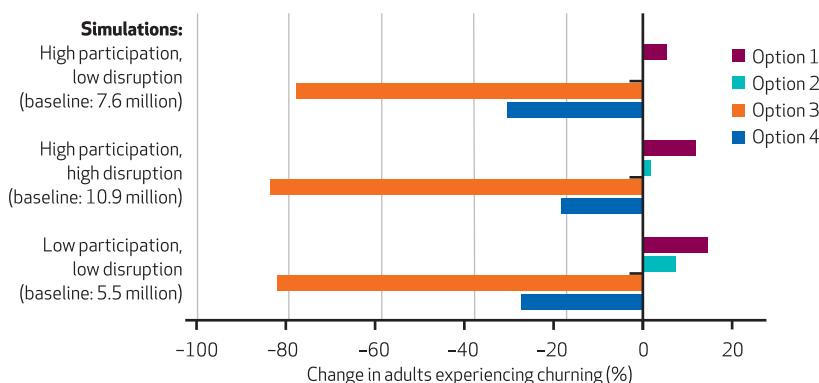
SOURCE Authors' simulation model using the 2004–07 panel of the Survey of Income and Program Participation. **NOTES** Options 1–4 are listed in Exhibit 1 and described in the text. High participation and low participation assume Medicaid participation rates of 85 percent and 50 percent, respectively. High disruption and low disruption assume administrative disruption rates of 35 percent and 15 percent, respectively.

lion). Twenty percent more people (5.0 million) were covered all year, and the average monthly caseload increased by 17 percent (6.8 million more people). Among the four options, twelve months of continuous eligibility maximized the number of people covered at some point in a calendar year (60.6 million).

SENSITIVITY OF RESULTS TO ASSUMPTIONS

Exhibits 2–4 illustrate how sensitive the estimated outcomes were to alternative assumptions about the impact of administrative disruption and Medicaid participation rates. Option 3 (the end-of-calendar-year extension) was particularly effective at reducing churning and increasing all-year coverage in the face of a high disruption rate. This option moved the redetermination of eligibility to the end of the calendar year as soon as a person's eligibility was verified once, so an otherwise high disruption rate contributed little to churning. Option 4 (twelve months of continuous eligibility), on the other hand, was sensitive to the disruption rate because coverage was conditioned on successful redetermination of eligibility during the calendar year. In contrast, the increase in average monthly caseload associated with each of the policy options was not particularly sensitive to the participation rate.

Discussion

Before conducting these simulations, we were unsure of the relative effects of these four options on the outcomes of interest. In particular, we did not foresee that annualizing income would have only modest effects on the number of people churning during a year and the number covered by Medicaid all year. Annualizing income has limited impact on churning largely because more people are eligible to reenroll in Medicaid when two possible income standards are available (current monthly income or annualized income).

Medicaid churning within a calendar year declines the most (78 percent) with option 3 because it extends coverage through December for enrollees whose initial eligibility was verified sometime during the year. This explains why most adults who otherwise would have experienced churning during the year did not and why option 3 yields the greatest increase in the number of people covered throughout the year.

In the near term, option 3 might create a greater workload for state employees in November and December by aligning eligibility redetermination for current Medicaid enrollees with the ACA open enrollment period. In time, however, new state information technology systems that permit automated enrollment and eligibility redetermination should streamline this process.

EXHIBIT 3

Estimated Effects Of Four Policy Options On Percentage Change In Adults Covered All Year By Medicaid, Run Through Three Simulations
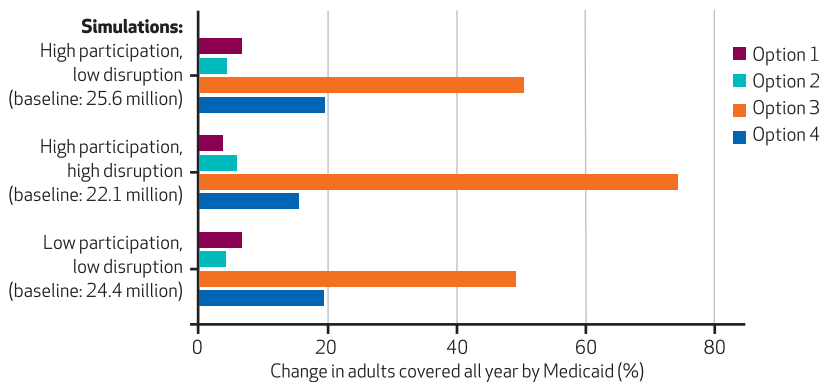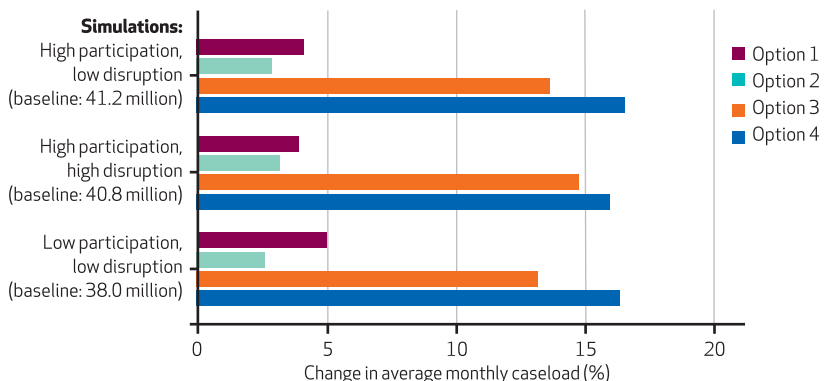

SOURCE Authors' simulation model using the 2004–07 panel of the Survey of Income and Program Participation. **NOTES** Options 1–4 are listed in Exhibit 1 and described in the text. High participation and low participation assume Medicaid participation rates of 85 percent and 50 percent, respectively. High disruption and low disruption assume administrative disruption rates of 35 percent and 15 percent, respectively.

Moreover, by enabling enrollees to remain Medicaid-eligible through the open enrollment period, option 3 is consistent with the rationale for final rule 42 CFR 435.603(h)(2). It enables people to remain in a Marketplace health plan instead of possibly churning if their eligibility changes.

Option 4 guarantees coverage for twelve months after initial and subsequent eligibility redeterminations, eliminating churning for a year. However, option 4 is less effective than option 3 (the end-of-calendar-year extension) at

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EXHIBIT 4

Estimated Effects Of Four Policy Options On Percentage Change In Average Monthly Medicaid Caseload, Run Through Three Simulations

SOURCE Authors' simulation model using the 2004–07 panel of the Survey of Income and Program Participation. **NOTES** Options 1–4 are listed in Exhibit 1 and described in the text. High participation and low participation assume Medicaid participation rates of 85 percent and 50 percent, respectively. High disruption and low disruption assume administrative disruption rates of 35 percent and 15 percent, respectively.

reducing churning within the calendar year. This is because under option 4 some enrollees experience monthly redeterminations of eligibility, at which point some are found to be ineligible. Many of these people will become eligible again and reenroll with another twelve months of coverage, so option 4 yields a larger increase in the average monthly Medicaid caseload than option 3. Covering more people each month suggests that option 4 is more costly than option 3 in terms of Medicaid expenditures for medical care.

Implication For States: Trade-Offs

The estimated outcomes of the four policy options help illuminate the trade-offs states face with respect to the issue of churning. From a state budget perspective, high rates of churning are undesirable because they increase Medicaid administrative costs and less predictable expenditures on avoidable use of medical care by people who churn. But churning also creates smaller monthly patient caseloads, lowering budgeted Medicaid medical expenditures. By reducing churning, a state gains control of the less predictable Medicaid expenses in exchange for higher predictable monthly caseload expenditures.

How a state views this cost trade-off depends on several factors that vary by state: financial solvency, willingness to extend Medicaid eligibility to low-income residents, and the amount of churning in its current Medicaid program.[8] Considerations also might include net costs to individuals caused by interrupted medical protocols and lower quality of care as a result of churning.

If states were to adopt options 3 or 4, the average monthly caseload would increase by 5.6 million or 6.8 million adults, respectively (14–17 percent). This range is close to an estimated base-case increase in Medicaid enrollment suggesting that an additional 7,400 physicians would be needed to care for the newly eligible adults.[23] In the short run, the increased enrollment may strain existing providers, especially if some of the newly eligible adults have previously undiagnosed health conditions. In response, Medicaid managed care plans will likely increase their use of nurses and nurse practitioners. Over time, with less churning and more consistent, coordinated care, enrollees' needs for care and Medicaid medical expenditures should stabilize.

States that do not try to reduce churning are likely to experience increased churning going forward. As with already eligible adults, newly eligible adults in states expanding Medicaid are likely to enroll only when they have a medical problem that involves hospital care. Unless such

Creativity in federal reimbursement of specific costs could encourage states to adopt options to reduce churning.

enrollees are receiving continued care, they will let their enrollment lapse and reenroll when they have another health problem. Such churning will increase the costs of avoidable hospital care and the uncertainty in a state's Medicaid budget.

Creativity in federal reimbursement of specific costs could encourage states to adopt options to reduce churning. For example, Medicaid administrative costs are generally shared equally by state and federal governments, but some administrative costs are matched at a higher federal rate than 50 percent. The federal administrative matching rate could be raised to 75 percent (or more) for states that met a threshold reduction in churning along with an increase in enrollment of adults. Similarly, the federal matching rate could be raised substantially for states that adopt more efficient information technology systems to facilitate appropriate program eligibility during open enrollment or maintain consumer assistance programs that help people understand their eligibility for Medicaid. Other federal funds might be made available for state efforts to locate "hot spots" where there are relatively high numbers of Medicaid enrollees with very high medical expenses—and tie such funds to a state's reduction in churning among newly enrolled people.

Conclusion

Our simulations demonstrate that if states want to reduce Medicaid churning, extending coverage to the end of the calendar year (option 3) and providing coverage for twelve months (option 4) are the most effective among the four policy options we examined. Because option 3 provides fewer months of continuous coverage than option 4, it has a smaller impact on the average monthly caseload of enrollees during a calendar year. Lower average monthly caseloads suggest smaller Medicaid expenditures for medical services. On the other hand, higher average month-

ly caseloads indicate that more people are covered continuously by Medicaid. Continuity of coverage is good for the enrollees' health and reduces less predictable Medicaid spending for avoidable care that often occurs because of churning.

The federal government also has an interest in reducing churning. Creative changes in the federal matching rates could incentivize state efforts to reduce churning and improve the health of millions of Americans. ■

NOTES

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