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Building On the ACA To Reduce Health Insurance Disruptions

By Nicole Rapfogel April 2, 2021

The COVID-19 pandemic has created the perfect storm for health insurance churn—which represents individuals and families experiencing changes between types of health care coverage, including becoming uninsured. Rampant job loss and an economic recession has caused millions of Americans to lose their job-based health insurance, with some workers switching to marketplace or Medicaid coverage and others becoming uninsured.[1] Churn often has detrimental effects on individuals' and families' health and finances.

The Affordable Care Act (ACA) made significant strides in making coverage more accessible. Still, every year, millions of people change or lose their insurance, often at times when the enrollment system is ill-prepared to support them.[2] In 2018, 10 percent of nonelderly adults reported being insured at the time they were surveyed but facing a coverage gap at some point during the year, on top of the 12 percent who were uninsured at the time of the survey.[3] Eleven years after the ACA became law, policymakers must take additional steps to reduce churn and make health coverage more stable, affordable, and effective. These steps, which are detailed below, include the following policy recommendations:

- Increase investments in enrollment assistance and outreach.
- Offer Medicaid continuous enrollment to adults.
- Extend Medicaid eligibility for people who have recently given birth.
- Auto-enroll or streamline eligible people into coverage.
- Smooth transitions between Medicaid and marketplace coverage.

The causes of health insurance churn

Many changes can result in health insurance churn. Some may be voluntary, such as accepting a new job, and others may be involuntary—for example, changes in public coverage eligibility or administrative errors. In some cases, churn can result in monthslong or yearslong gaps in coverage, while other people transition to a

new form of coverage immediately. Churn can be related to income changes; losing or gaining employer-sponsored coverage; changes in life circumstances, such as moving to a new state, getting married, or having a child; premium nonpayment; and administrative errors. Churn related to disruptions and gaps in coverage often results in poorer health outcomes and delayed care-seeking.[4]

Because nearly half of all Americans obtain health coverage through an employer and tens of millions of others are enrolled in public coverage or receive premium subsidies, for which eligibility is income-based, the coronavirus crisis has made concerns about churn particularly salient. Volatility in employment and income makes health insurance churn more likely.[5]

During the pandemic, millions of people have newly enrolled in Medicaid and marketplace coverage.[6] Compared with February 2020, 6.7 million more people enrolled in Medicaid and the Children's Health Insurance Program (CHIP) in September.[7]

The ACA offered subsidies to individuals and families with incomes up to 400 percent of the federal poverty level (FPL) who are seeking individual market coverage. The ACA also created a state option to expand Medicaid coverage to people with incomes up to 138 percent of the FPL. These expanded coverage options greatly decreased uninsurance rates, and low-income individuals and families experienced fewer gaps and disruptions in coverage.[8] Pre-ACA estimates show that 43 percent of adults who had Medicaid coverage were disenrolled from the program within 12 months. Compared with pre-ACA rates, a 2015 study of three states—Kentucky with traditional Medicaid expansion, Arkansas with a private Medicaid expansion option, and Texas with no expansion but other ACA reforms—found that overall churn rates were nearly 60 percent lower for low-income adult residents after the passage of the ACA.[9]

Just as relative reductions in uninsurance due to the ACA were greatest among Black, Hispanic, and American Indian and Alaska Native people, the reduction in Medicaid churn varied across communities.[10] One study found an overall 4.3 percentage point decrease in disruption of Medicaid coverage in Medicaid expansion states compared with states that did not expand Medicaid.[11] Of this, nonwhite Medicaid beneficiaries experienced greater reductions in churn, with decreases in coverage disruption and coverage loss of 5.9 percentage points and 4.7 percentage points, respectively.[12] Comparatively, there was no significant change in these metrics among white Medicaid beneficiaries. Nevertheless, today's Medicaid churn rates, while lower than those of the past, still pose problems in terms of health care access and administrative cost. A 2015 study estimated that the administrative cost of churn was $400 to $600 per every churn—a disenrollment and re-enrollment.[13]

Why churn is concerning

As noted above, churn can have detrimental effects on individuals' and families' health and finances. People who churn in and out of coverage or remain uninsured often have low incomes, further compounding the negative health effectives of lack of care.[14] Churning is associated with increased emergency department use and fewer office-based health care visits.[15] Limited access to regular care can prevent long-term management of chronic conditions, which in turn may lead to emergency department visits when chronic conditions become medical crises.[16] In one survey, 1 in 3 respondents who experienced churn reported a decline in health.[17] People experiencing churn may also face emotional impacts due to the stress and uncertainty of access to health care, as well as financial impacts.[18]

In the Medicaid program, people experiencing discontinuity in coverage are less likely to have a regular source of care and twice as likely to forgo care for financial reasons than those with continuous Medicaid coverage.[19] They are also more likely to be hospitalized for chronic conditions and depression and less likely to be screened for breast cancer.[20]

Churn is worrisome even when it only applies to part of a family. While there has long been agreement about the importance of children's coverage, it has become increasingly clear that children also benefit from having insured parents.[21] According to a 2017 study, children whose low-income parents were enrolled in Medicaid were 29 percentage points more likely to receive a well-child visit than children whose parents were not enrolled in Medicaid—pointing to spillover effects of Medicaid expansion and consistent coverage and the dangers of churn with coverage gaps.[22]

Even those who churn directly from one source of health coverage to another may face access and affordability problems. Switching plans typically requires a beneficiary to navigate a new web of benefits and networks. Churn can also increase out-of-pocket costs for those with high-deductible plans. No matter when in a calendar year an individual or a family switches coverage, their deductible resets. Imagine a family that is covered by an employer-sponsored plan and has already met their $3,655 family deductible, the national average for job-based coverage in 2019.[23] In June, the primary insurance holder loses their job and the family purchases a plan through the ACA marketplaces, where average deductibles ranged from $1,136 to $4,619 across states in 2020.[24] Due to churning, this family may have to pay more than $8,000—more than double its original deductible—in one calendar year before being able to access the financial protection of its insurance plans.

Alternatively, the family could avoid changing plans by enrolling in COBRA continuation coverage, in which they keep their employer-based coverage for 18 months to 36 months after job loss.[25] While their deductible would not reset, their

premiums would likely rise, as they can be held responsible for the entire cost to the plan for coverage of similar individuals and required to cover the costs typically borne by both the employee and employer.[26]

Notably, the American Rescue Plan Act, recently signed into law by President Joe Biden, offers financial assistance with both these job-loss scenarios. Under the American Rescue Plan, a 100 percent subsidy for COBRA coverage from April 1, 2021, to September 30, 2021, is available for qualified beneficiaries who have involuntarily lost their jobs or experienced a reduction in hours.[27] The law also enhances financial assistance for marketplace coverage, including making people who receive unemployment benefits at any point during 2021 eligible for $0 silver-tier coverage and helping people with deductibles and other cost-sharing. Although temporary, this financial assistance is a lifeline for individuals and families experiencing job loss during the coronavirus pandemic.

Policies to reduce churn

Policymakers should build on the momentum from the American Rescue Plan's coverage improvements and invest in outreach to the uninsured, remove roadblocks to continuous Medicaid coverage, and smooth transitions between types of coverage.

Make greater investments in enrollment assistance and outreach to help people find and renew coverage

While the ACA increased coverage options, knowledge about eligibility for marketplace coverage remains a problem. The Commonwealth Fund found that nearly 1 in 2 uninsured adults may have been eligible for marketplace subsidies or Medicaid expansion, using data from 2018.[28] But according to the Kaiser Family Foundation, only 15 percent of uninsured people knew when open enrollment began one month before the 2018 open enrollment period.[29] Many uninsured adults point to perceived unaffordability: Two-thirds of uninsured adults hadn't looked at coverage options on ACA marketplaces, yet 36 percent of the same group didn't think they could afford coverage.[30]

The ACA's navigator program has been key for guiding potential enrollees in the ACA marketplaces. Navigators are grant-funded organizations that assist potential enrollees, educate consumers, and provide technical enrollment assistance.[31] Unlike private insurance brokers, they have no financial incentive to direct enrollees to a particular plan and instead can offer impartial guidance.

Marketing initiatives and outreach programs fight churn by helping uninsured consumers select plans, educating the public about coverage options, and assisting returning beneficiaries with renewing their existing coverage.[32] Unfortunately, the Trump administration's sabotage of the ACA included defunding outreach and

enrollment assistance, cutting navigator funding by 84 percent from 2016 to 2018 and cutting advertising funds by 90 percent in 2017.[33] In early March 2021, the Centers for Medicare and Medicaid Services (CMS) announced it was adding $2.3 million to the navigator budget for 2021.[34] For the upcoming open enrollment period for 2022 coverage, the Biden administration should restore navigator funding to pre-Trump administration levels or higher, an increase of at least $53 million.[35] Much of this outreach funding could come from more than $1.2 billion in unused federal marketplace user fees that the government has already collected.[36]

States that have made extra investments in enrollment assistance and outreach have seen their efforts pay off. For example, California attributes its marketplace's high enrollment rates and robust risk pool to its outreach spending—more than four times the navigator funding, and more than 26 times the advertising funding, per uninsured resident offered by the federal government for its federally facilitated marketplaces.[37] Many states have taken creative approaches to outreach: In 2018, Rhode Island advertised on pizza boxes, while Massachusetts hosted visibility events in nightclubs to target young, Latino, single men with high uninsurance rates.[38] Massachusetts also has a targeted ConnectorCare program, with "coverage crews" of volunteers in five cities that have high rates of uninsurance.[39] During the 2019 open enrollment period, 4 of the 5 state marketplaces that spent the most per uninsured resident on enrollment assistance and outreach reported higher increases in enrollment plan selections than the federally facilitated marketplaces.[40] Massachusetts, which launched a social media campaign to educate consumers about the state's individual mandate in addition to other reforms, reported the highest increase in enrollment plan selection of all state-based and federal marketplaces—13 percent.[41]

Implement Medicaid continuous enrollment for adults

Medicaid enrollees must report changes in income, which could end eligibility. Low-wage workers who may be eligible for Medicaid are more likely to work in sectors with hours that fluctuate week to week or involve irregular scheduling, and they have faced disproportionate job loss during the coronavirus-induced financial crisis.[42] The administrative barriers of reporting changes or reapplying can result in increased churn; one study of a large carrier in two states found a spike in disenrollment near eligibility redetermination dates.[43] Churning in and out of Medicaid as incomes fluctuate slightly is inefficient for both the beneficiaries and the Medicaid program.[44]

One solution to reduce Medicaid churn is continuous enrollment, which allows enrollees to remain eligible for Medicaid for a 12-month period regardless of changes to family income. The Medicaid program currently gives states the option to provide continuous eligibility for children covered by Medicaid and/or CHIP.[45] While the plan option is only for children, states can extend this provision to adults using Medicaid Section 1115 waivers, as Montana and New York have

done.[46] The nonpartisan Medicaid and CHIP Payment and Access Commission (MACPAC) has long recommended extending 12-month continuous eligibility to adults.[47] Estimates of continuous eligibility point to a modest increase in costs due to increased enrollment and a 30 percent decrease in churn.[48] CMS should take steps to identify pathways for states to move forward with continuous eligibility.

An alternative to 12-month continuous eligibility would be continuous eligibility through the end of a calendar year. One argument in favor of the year-end strategy is that aligning Medicaid disenrollment with the open enrollment period for marketplace plans would provide beneficiaries with better access to enrollment support, such as navigators. Year-end Medicaid renewals, meanwhile, would allow states to minimize administrative disruption and burdensome reporting requirements, as well as allow enrollees to avoid midyear deductible resets.[49] Calendar year continuous eligibility may produce even greater churn reduction than other continuous eligibility proposals, according to one study.[50]

Expand Medicaid coverage for postpartum people

Federal law generally requires states to extend Medicaid eligibility for pregnant people for 60 days postpartum.[51] At the 60-day mark, however, many people are still facing pregnancy-related health concerns, including mental health issues and conditions that contribute to a significant number of pregnancy-related deaths, with disproportionate impacts for Black and American Indian and Alaska Native women.[52] In fact, about one-third of all pregnancy-related deaths occur in the postpartum period.[53] Access to insurance coverage after 60 days postpartum is made even more critical by the fact that a majority of postpartum heath spending occurs after new parents have passed this 60-day mark.[54] Postpartum people can enroll in Medicaid or marketplace coverage, depending on their incomes, but many struggle to secure longer-term coverage during this critical period.

The American Rescue Plan includes a new state option, via a state plan amendment, to extend Medicaid coverage to new parents up to one-year postpartum.[55] While this provision will expire on April 1, 2026, this year's MACPAC report recommends codifying a more robust approach: Congress should set a federal requirement for states to provide 12-month postpartum Medicaid and/or CHIP coverage with a 100 percent federal match.[56] Before this happens, states should continue to submit Medicaid Section 1115 waivers to CMS, or adopt the new state plan amendment option, to establish a long-term commitment to extending postpartum Medicaid and/or CHIP.[57] Several states have submitted waivers that are currently pending approval. The Urban Institute estimates that under this policy, 28 percent of mothers uninsured during the first year postpartum "would become newly eligible for Medicaid/CHIP."[58]

Auto-enroll or streamline eligible uninsured people into coverage

Many policy experts have proposed various ways to simplify enrollment or automatically enroll eligible people into Medicaid or marketplace coverage. There are a wide range of ways to facilitate auto-enrollment that would have varying impacts. While all options may not be feasible in the short term, state and federal policymakers should move to enact the most streamlined approach possible in their political or economic contexts.

States should consider offering streamlined Medicaid enrollment to people receiving or requesting unemployment insurance (UI) benefits and other means-tested programs.[59] Several public benefit programs rely on the eligibility determinations of other programs.[60] For example, Medicaid agencies use Supplemental Nutrition Assistance Program (SNAP) income information to determine eligibility for renewal. The American Rescue Plan, for the first time, extends marketplace subsidy eligibility based on receipt of unemployment benefits. People who attest to receiving unemployment compensation at any point during 2021 will be eligible to purchase marketplace coverage with maximal subsidies.[61] The pandemic presents a key opportunity to think through more permanent connections between coverage and the social safety net.

Another option for boosting coverage is allowing people to indicate their uninsured status on their tax returns, which would trigger auto-enrollment or additional outreach. Tax-based auto-enrollment on a federal level would produce the greatest impact, but policymakers would have to make substantial changes, including allowing prior-year income to be used for Medicaid eligibility and eliminating the employer coverage firewall.[62] However, the ACA laid the groundwork for linking federal tax returns to nudges for coverage. Under authority granted by the ACA, the IRS can send notices to taxpayers describing coverage options, connecting them to the marketplace, and even letting them know they are likely eligible for subsidized coverage based on their income the previous year. While the IRS has only once used this authority for outreach, Treasury Department researchers estimate that the 3.9 million letters that the department sent in 2016 to notify uninsured people about the ACA coverage mandate and enrollment options saved 700 lives.[63] More funding could enable the IRS to engage in more robust outreach or share the necessary information with states to conduct that outreach.[64]

Maryland is the first state to implement a policy that offers streamlined enrollment and outreach to uninsured tax filers.[65] The Maryland Easy Enrollment Health Insurance Program passed the state legislature by a landslide with bipartisan support and was signed into law by Gov. Larry Hogan (R) in 2019.[66] The program allows uninsured tax filers to check a box authorizing the state to predetermine eligibility and contact the tax filer about coverage options. Those that qualify for Medicaid or CHIP are offered the opportunity to select a managed care organization (MCO) and are enrolled in a Medicaid plan if they are unable to enroll themselves within a specified time frame. Those who do not qualify for Medicaid

or CHIP have a 35-day special enrollment period to sign up for individual market coverage. Of the 41,000 Maryland residents that checked the box in spring 2020, about 9 percent enrolled in coverage by July 2020.[67]

Other states that operate their own state-based marketplace should monitor Maryland's progress this spring and consider implementing similar programs. Millions of people nationwide are unenrolled yet eligible for Medicaid or marketplace coverage with no premium.[68] With the marketplace subsidy enhancements of the American Rescue Plan, about 1.8 million uninsured people are eligible for $0 silver-tier plans.[69]

Smooth transitions between Medicaid and marketplace coverage

When a person switches health insurance, provider networks, benefits, medication coverage, and cost-sharing can all change, potentially leading to disruptions in patient-provider relationships and affecting medication adherence.[70] Aligning benefits and plan designs between Medicaid and marketplace coverage would not reduce churn rates but could lessen the effect of churn on beneficiaries, especially lower-income enrollees who churn in and out of Medicaid due to fluctuations in income.[71]

One option is to encourage participation of multimarket plans, in which insurers offer plans with the same provider networks both through the marketplaces and Medicaid MCOs.[72] This would improve continuity of care for beneficiaries churning between Medicaid and marketplace coverage. Many issuers already participate in both markets: In 2016, nearly 45 percent of marketplace plans also operated Medicaid MCOs in the same state.[73] However, issuers that offer both Medicaid and marketplace plans in a given state may not offer both types in all regions.[74] While states can enact policies to encourage issuers to participate in both markets, it may be a challenge for issuers to build the same provider networks in both markets because providers may be unwilling to agree to lower payments for their work with Medicaid beneficiaries.[75]

Conclusion

Health insurance churn is not only administratively burdensome, but it is also disruptive to patient care continuity and can lead to poorer health outcomes. Therefore, it is essential to include the topic of coverage transitions and gaps in the conversation about reducing uninsurance and promoting access to care. It is imperative that policymakers improve and expand upon the ACA to reduce gaps and discontinuity in coverage. Doing so would improve health outcomes, promote continuity of care, and limit administrative costs and burdens.

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