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Introduction

As states like Georgia begin to make choices about Health Insurance Exchange development and implementation, it will be important to consider if and how to integrate coverage under Medicaid, PeachCare for Kids™ (PeachCare), and private insurance offered through the exchanges. These considerations will have potential impacts on individuals' retention of health insurance and movement between coverage types. The issue of individuals transitioning in and out of public and private insurance coverage, or "churning," is important due to its implications for consumers, their providers, health plans, and the state.

Churning occurs as individuals cycle off and on public and private insurance, often resulting in coverage gaps that persist or repeat over time. Fragmented and unstable coverage can lead to discontinuity and breakdown in care delivery, increased administrative costs for public and private payers, and unpredictable risk pools within health plans.[1]

Coverage disruptions due to income changes are not a new problem. State Medicaid and Children's Health Insurance Programs (CHIP) deal with this issue routinely, although on a smaller scale. In an effort to provide context to Health Insurance Exchange development, this brief describes research on public coverage churning in Georgia and places the findings in the context of national studies.

The Scope of Health Insurance Churning

The number of uninsured in the U.S. in 2009 was estimated at nearly 17 percent (50 million).[2] This represents only a fraction of the total number of individuals who lose and gain coverage over the course of a year. Based on studies of the Survey of Income and Program Participation (SIPP), about 32 percent of the non-elderly (<65 years of age) population were estimated to have been uninsured for at least one month during the four year period from 1996-1999.[3] A further examination of the data reveals a high level of churning in this population. Forty-three percent of those experiencing such a gap in coverage were involved in three or more coverage changes during this period. More than 75 percent were repeatedly uninsured. Other national studies, such as the Medical Expenditure Panel Survey (MEPS) covering the years 1998 to 2000, show a similar pattern and scale of health insurance churning.[4]

Data from the 2008 Georgia Population Survey reveals a similar churning story in our state. Among all non-elderly Georgians, 16 percent were uninsured at the time of the survey, but 21 percent had experienced at least one gap in coverage during the preceding 12 months. Among children, coverage levels are generally higher, with only eight percent uninsured at the time of the survey; however, the data also revealed that 14 percent of all children had experienced at least one gap in coverage during the preceding 12 months.[5]

Between 2007 and 2008, it was estimated that 38 percent of Low-Income and Right from the Start Medicaid children experienced fewer than 12 months of continuous coverage in Georgia. Because publicly insured children are eligible for coverage on a monthly basis, the total number of missing eligibility months for this same group of children can be estimated. From that estimate, it appears that many Medicaid children disenrolled and regained coverage in a relatively short period of time.

Populations at Risk

The populations most affected by churning and insurance instability include low-income individuals and families, minorities, and young adults ages 19-24.[6] Many within these groups work in unstable or part-time employment and have limited opportunities for obtaining health insurance coverage. Others at risk are those with low educational attainment and those with private non-group insurance.[7] A study of families with children enrolled in PeachCare for Kids™ (PeachCare) showed that nearly 57 percent of all PeachCare parents worked in small, low-wage firms earning less than $2,500 per month ($30,000 per year) and that no more than half of PeachCare parents were eligible for employer-sponsored insurance.[8] These families have incomes from 100 to 235 percent Federal Poverty Level (FPL), which is comparable to families who will be eligible for subsidies through the exchange under the Affordable Care Act. Consistent with the findings of other states, these numbers show a population that is significantly more at risk than the general population for churning and coverage instability.

The 2008 Georgia Population Survey can be used to study subpopulations at risk for churning in Georgia. For example, the regional data on children in Georgia shows that churning is more of a problem in the rural northern part of the state when compared to metro areas and the rural southern part of the state. Among all adults, the poor and near poor (<200 percent FPL) have very high levels of churn, with close to half experiencing at least one gap in coverage in the preceding year. However, as income increases, the presence of children may alter preferences for insurance and job choices. About one quarter of the childless adults 200-400 percent FPL had a period without health insurance, but only 14 percent of the adults with children living in the same FPL range experienced a period without health insurance. Data on insured children in Georgia revealed that 11 percent of children living below the FPL were uninsured while that figure dropped to four percent for children living above 250 percent of FPL. Almost a quarter of children below 100 percent FPL have experienced some periods where they were uninsured.

Table 1: Children's Health Insurance Coverage in Georgia, by Income (2008)

	All	Below 100% FPL	100-249% FPL	Above 250% FPL
Privately Insured Children	54%	13%	39%	83%
Publicly Covered Children	37%	76%	50%	9%
Never Uninsured	86%	77%	81%	93%
Ever Uninsured	14%	23%	19%	7%
Currently Uninsured Children	8%	11%	10%	4%
Chronically Uninsured *(> 6 months)*	3%	5%	3%	1%

Source: Tabulations from the Georgia Population Survey, 2008

Table 2: Children's Health Insurance Coverage in Georgia, by Region (2008)

	Region					
	All	North Rural	South Rural	Suburban Atlanta	Urban Atlanta	Other Metro
Total Children						
Privately Insured Children	54%	48%	40%	66%	60%	46%
Publicly Covered Children	37%	42%	49%	28%	32%	40%
Never Uninsured	86%	81%	85%	91%	86%	85%
Ever Uninsured	14%	19%	15%	9%	14%	15%
Currently Uninsured Children	8%	10%	8%	3%	8%	8%
Chronically Uninsured (> 6 months)	3%	3%	4%	2%	3%	2%

Source: Tabulations from the Georgia Population Survey, 2008

Income Instability

Income instability is influenced by the constant fluctuation of a dynamic U.S. job market and the resulting volatility in wages and unemployment rates. A number of inter-related factors in the economy impact income including firm performance, globalization, "pay for performance" arrangements, and the declining influence of unions.[9] Research conducted by Hacker shows that, after seeing declines in the 90's, income instability has been increasing steadily since 2000 to near record levels with households experiencing greater income declines than in previous periods.[10]

Particularly among low-income individuals, sudden shifts in income levels result in health insurance eligibility changes for both children and adults, causing them to move between different programs. This movement often results in coverage lapses. Klein, Gleid, and Ferry found through analysis of the Survey of Income and Program Participation (SIPP) data that low-income individuals (< 200 percent FPL) are at greatest risk of coverage instability, largely due to their transitioning in and out of poverty.[11] This population continues to fluctuate in and out of public coverage while private insurance remains largely unattainable due to cost and/or accessibility. Many state Medicaid income limits are set so low that only a slight variation in income will result in loss of eligibility and coverage.[12] In Georgia, the Low-Income Medicaid (LIM) income level is currently set at $500 per month ($6,000 per year) for a family of four.[13]

One measure of income instability in Georgia is the extent to which children enrolled in PeachCare experience a decline in income such that they qualify for Medicaid. For example, a study of periods of enrollment over two and a half years from 2003 to 2006 showed that among nearly 85,000 PeachCare children in the 150-235 percent FPL income range, approximately seven percent experienced a decline in income.[14] Among all PeachCare enrollees, an estimated 17 percent are in families that experience income instability which causes them to experience such coverage transitions.[15] A study from 2000-2002 found that a significant cohort of children (22.6 percent) transitioned to Medicaid from PeachCare after their sixth birthday, representing a decline in family income.

The Impact of Premiums

While income instability can result in churning because it alters eligibility for various public programs, premiums have an additional effect on continuity of insurance enrollment. PeachCare premium levels were altered in 2003 and again in 2004 to create a sliding scale that ranges from $10 to $35 for a single child and $15 to $70 for two or more children. Several studies of the impact of these premiums on continuity of coverage highlight this effect:

- The introduction of premiums for children at age six led to a 13 percentage point increase in disenrollment above the base.[16] Furthermore, the price sensitivity to premiums is higher for children with prior Medicaid enrollment versus children who have only been enrolled in PeachCare. Under a policy that required enrollees to pay their PeachCare premiums in the month prior to receiving coverage with no grace period, an average of two and a half percent of enrollees were terminated each month for failure to pay their monthly premium.

- On average, a $1 increase in the per-child premium resulted in an increased risk of disenrollment over the already high base line, ranging from 7.0 to 8.0 percent on a monthly basis.[17] Similar to other evidence on populations vulnerable to churning, the probability of exiting PeachCare at age six when faced with a premium was higher for African Americans and families with a mother as the primary provider. The probability of an exit was lower for those in families with higher incomes and for those enrollees suffering from a chronic condition (e.g., asthma, diabetes).

Loss of Coverage and its Consequences

The consequences of this churning and insurance instability impact state and local governments, health plans, health care providers, and consumers.[18] They include:

- Administrative costs enrolling, disenrolling, and reenrolling individuals;
- Costs associated with verifying enrollment eligibility, resolving billing issues, reconciling claims;
- Difficulty in measuring quality of care;
- Reduced effectiveness of disease management programs;
- Disruption of care for those changing providers and plans; and
- Consumer challenges arranging and accessing regular care.

In 2005, the Georgia Health Policy Center (GHPC) was engaged by the Georgia Department of Community Health (DCH) to evaluate the impact of a 2004 PeachCare policy (since rescinded) which required disenrollment and "lockout" of children for a period of three months due to late payment of premiums. The study found that of those parents whose children experienced the three month "lockout" period, nearly 90 percent reported no health insurance coverage for their children during that time.[19] Furthermore, out of this group, nearly half reported needing health services and approximately 20 percent needed care that they did not receive. At the end of the three month period, 16 percent of these children were eligible to reenroll in PeachCare but remained uninsured. These data highlights some of the access issues that result from lapses of coverage and the challenge of reenrolling those who drop out.

Ultimately, the downstream impact is on the health of individuals. Children who are uninsured are significantly more likely to lack a usual source of care, delay care, or have unmet health needs than those with coverage, putting them at higher risk for preventable hospitalizations and missed diagnoses. [20] [21] Olson et al found that continuous coverage among children, either public or private, is critical for ensuring access to care. Those with intermittent or no coverage were significantly more likely than those with continuous coverage to have more unmet health needs. [22]

Policy Implications for Exchange Design

A recent study using national survey data found that within six months of implementation of exchanges, more than 35 percent of all adults with family incomes below 200 percent FPL will experience a shift in eligibility from Medicaid to an insurance exchange.[23] Formal policy and the operational decisions surrounding the exchange in Georgia will have a direct effect on the level of churning in and out of coverage or between coverage types. Drawing upon the experiences of other states, it will be important for Georgia policymakers to consider the costs and benefits of the many exchange decisions. A few examples of policies which will have an impact on the level of churning include:

- Conditions of participation for both exchange qualified health plans and Medicaid managed care organizations;
- Alignment of benefit packages and provider returns between public programs and exchange plans;
- Alignment of eligibility rules including timing of determinations and income verification for exchange based subsidies and public programs;
- Alignment of open enrollment periods within the exchange and recertification periods for public insurance programs;
- Decisions surrounding lockout policies for failure to pay premiums;
- Implementation of penalties for failure to purchase coverage; and
- Premium assistance options for pregnant women within the individual exchange or CHIP and/or Medicaid-eligible children within the Small Business Health Option Programs (SHOP Exchange).

The decision on whether to offer a Basic Health Plan option under the individual exchange is also a policy choice which will impact churning. A Basic Health Program would provide insurance to those with incomes between 133 to 200 percent FPL. Individuals would receive their coverage through this program rather than through the exchange and would receive, at a minimum, the same essential health benefits. States would receive 95 percent of the federal subsidies that would have been provided in the exchange to eligible individuals in the form of tax credits and cost sharing reductions.

There is the potential for states to provide a stronger and more affordable benefits package under a Basic Health Program than what would be comparably available through the exchange. There are, however, some tradeoffs that need to be considered. [24] It is likely that a large number of uninsured individuals eligible for premium subsidies through the exchange will fall into this income group between 133 to 200 percent FPL. A Basic Health Program would separate these individuals from the rest of the risk pool, making them ineligible for premium subsidies and cost sharing through the exchange. This could have a negative effect on premiums in the individual market by separating a large group that otherwise would have participated in the exchange.

Conclusion

Most of the previous research describes churning in and out of public insurance. The implementation of exchanges under the Affordable Care Act creates an additional transition between public coverage and new subsidized exchange plans. The income instability experienced by low-income families in Georgia will magnify the churning problem and cause operational inefficiencies if these issues are not considered by those designing the state's exchange. The challenge to state policymakers becomes how to make operational and policy decisions that consider:

- The short-term administrative costs of frequently enrolling and disenrolling people in both pubic coverage and private exchange plans;
- The challenges of transitions that change the benefit package substantially;
- The implications of changing provider networks;
- The potential for lapses in coverage due to timing;
- The difficulty measuring and ensuring quality of care; and
- The longer term medical costs resulting from disruptions in continuity of care.

These decisions will need to be approached from a systems perspective that weighs the costs and benefits to all participating parties in order to effectively and efficiently implement a Health Insurance Exchange in Georgia.

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