



Enrollment Churning In Medicaid

Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill

Patricia Boozang, MPH, Laura Braslow, MPA, and Anthony Fiori, MPA

Over the past ten years, New Yorkers have seen dramatic growth in the public health insurance options for low-income individuals and families, including the development of Family Health Plus (FHPlus) and the expansion of the Child Health Plus (CHPlus) program.^[1] Even with these program developments, a large number of people remain uninsured. As many as 2.6 million New Yorkers – 13.5 percent of the population – lack health insurance.^[2] Almost 1.3 million uninsured New Yorkers are in fact eligible for coverage through one of the state’s public health insurance programs.^[3]

Increasingly, New York’s public insurance programs have moved toward serving their respective populations through a managed care delivery system in which beneficiaries are required to enroll in a managed care plan and select a primary care physician. In 1999, New York State implemented mandatory managed care enrollment for Medicaid beneficiaries. Today, New York has established the mandatory Medicaid managed care program in 23 counties, including all of New York City. In all, 68 percent of the State’s eligible Medicaid beneficiaries are now enrolled in a managed care plan.^[4] New York’s CHPlus and FHPlus programs are administered entirely through managed care, with no fee-for-service option.

New York’s rationale for embracing a managed care model for its public programs was to control costs and “improve the health status of low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and
- Expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.”^[5]

Achieving these goals through the managed care delivery model relies heavily on maintaining continuity of care, such that patients and providers have stable and ongoing partnerships in order to improve overall patient care, health and well-being.

In the managed care delivery system, as in every health care delivery system in our country, continuity of care is inextricably linked with continuity of health insurance coverage.^[6]

The annual recertification process in New York’s public insurance programs is the single most significant threat to eligible enrollees’ ability to continue their coverage. According to the New York City Human Resources Administration (HRA), 70 percent of enrollees in 2005 submitted recertification materials, but over one-third of these beneficiaries submitted incomplete packages, primarily due to their failure to submit correct documentation of income. The remaining 30 percent of Medicaid and FHPlus beneficiaries slated to recertify coverage during the year failed to submit any materials at all. As documented in prior studies, many of these enrollees remain eligible for public insurance programs and re-enroll subsequent to losing their coverage. This cycle of enrollment, loss of eligibility, and re-enrollment in health insurance programs – known as “churning” – imposes a significant burden on enrollees, providers, health plans, and the broader public health insurance system.

Previous research indicates that half of publicly insured managed care patients are disenrolled from the Medicaid and FHPlus programs at recertification, thus losing their health insurance coverage and health plan membership.^[7] Three previous studies regarding enrollment churning demonstrate that many of those disenrolled at recertification eventually find their way back onto a public program, but only

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after several months of being uninsured and only at significant and unnecessary administrative cost.^[8]

Churning in public insurance programs undermines efficiency and quality of care and is particularly detrimental in a managed care delivery model. Churning interferes with plans' efforts to improve beneficiaries' care-seeking behaviors, disrupts patient-provider relationships, and results in lapses in access to preventive care and treatment for chronic conditions for low-income people. Additionally, health plans that serve New York's public health insurance programs spend millions of dollars to reach out to, enroll, and start treatment programs for patients whose enrollment tenure is too short for clinical interventions to be meaningful or for financial investments to be recouped. Churning also drains hospital and community health center resources as they struggle to continue caring for patients who lose their insurance.

Using administrative data on involuntary disenrollment of more than 33,000 Medicaid managed care and FHPlus enrollees, this study documents the current state of churning in those programs and examines its impact on individuals with chronic medical conditions. Despite many years of qualitative and quantitative evidence of the prevalence and negative impact of churning,

this study finds that there has been little improvement in disenrollment rates from New York's public health insurance programs. Specific findings include:

- Involuntary disenrollment at recertification in New York's public health insurance programs remains high at 46 percent.
- Public insurance beneficiaries with one or more chronic health conditions, including asthma, hypertension and diabetes, are less likely to lose insurance coverage at recertification. Those beneficiaries with chronic diseases are 16.5 percent less likely to be involuntarily disenrolled than those without chronic diseases.
- Despite this fact, nearly one-third (32 percent) of beneficiaries with known chronic conditions lose their health insurance coverage at recertification.
- Chinese speakers are much more likely to be involuntarily disenrolled than English speakers and Spanish speakers.

These findings suggest that New York State has not made material progress in reducing churning and confirms that churning is a problem even for the sickest beneficiaries in the Medicaid managed care and FHPlus programs.

[1] See Appendix A of full report for program descriptions.

[2] Bureau of the Census, August 2006.

[3] United Hospital Fund 2005. Based on data from the 2004 Current Population Survey, Annual Social and Economic Supplement.

[4] NYS Department of Health statistics, June 2006.

[5] 1115 Waiver Extension Request, November 23, 2005.

[6] John Z. Ayanian, Joel S. Weissman, et al. "Unmet Health Needs of Uninsured Adults in the United States," *Journal of the American Medical Association*. 2000; 284:2061-9

[7] Deborah Bachrach and Anthony Tassi, "Coverage Gaps: The Problem of Enrollee Churning in Medicaid Managed Care and Child Health Plus," NYS Coalition of Prepaid Health Services Plans, June 2000. Data provided by health plans.

[8] Michael Birnbaum and Danielle Holahan, "Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences," United Hospital Fund, 2003; A. W. Dick, R. A. Allison, S. G. Haber, C. Brach, and E. Shenkman, "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review*, Spring 2002, 23(3); Bachrach and Tassi, 2000.