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Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges

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ABSTRACT **The Affordable Care Act will extend health insurance coverage by both expanding Medicaid eligibility and offering premium subsidies for the purchase of private health insurance through state health insurance exchanges. But by definition, eligibility for these programs is sensitive to income and can change over time with fluctuating income and changes in family composition. The law specifies no minimum enrollment period, and subsidy levels will also change as income rises and falls. Using national survey data, we estimate that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. To minimize the effect on continuity and quality of care, states and the federal government should adopt strategies to reduce the frequency of coverage transitions and to mitigate the disruptions caused by those transitions. Options include establishing a minimum guaranteed eligibility period and "dually certifying" some plans to serve both Medicaid and exchange enrollees.**

The signature achievement of the Affordable Care Act of 2010 is its near-universal guarantee of access to affordable health insurance. The law accomplishes this through two principal pathways. First, Medicaid eligibility will be expanded to all nonelderly citizens and eligible legal residents whose family income does not exceed 133 percent of the federal poverty level.[1] Second, Medicaid-ineligible people with incomes up to 400 percent of poverty can receive premium subsidies through tax credits for health plans offered through state health insurance exchanges.[2]

At any point in time, an income-sensitive approach to subsidizing the cost of health insurance neatly divides these populations into two. But over months and years, income fluctuates, and families change in composition and size, all of which will affect income-related eligibility. Because the Affordable Care Act specifies no minimum enrollment period, eligibility and subsidy levels will change as incomes rise and fall. The legislation, therefore, largely tracks existing federal law regarding Medicaid, under which states are required to conduct eligibility redeterminations only once a year, but individuals are required to report interim changes in income, and eligibility can cease in any month.[3]

This potential for movement between Medicaid and exchange coverage can be thought of as an update to the classic problem of "churning" (frequent changes back and forth, in and out of Medicaid), a problem with which Medicaid has long grappled.[4,5] For instance, research shows that 43 percent of newly enrolled adults in Medicaid experience a disruption in coverage within twelve months.[6] Of course, the Affordable Care Act rectifies the total loss of coverage associated with losing Medicaid eligibility by provid-

ing a second source of subsidized coverage. But the duality of the subsidy system presents important implementation challenges.

Income fluctuation raises issues for all subsidy-eligible individuals or families up to 400 percent of the federal poverty level, which includes those whose incomes place them squarely within the exchange system. For those purchasing coverage with subsidies through exchanges, income changes may trigger the obligation to repay some or all subsidies received; the amounts subject to repayment were significantly increased recently by Congress.[7] But income fluctuations pose a particular challenge for individuals and families who cross the Medicaid-exchange divide, because this change may trigger a shift between plans and provider networks. In short, for this group, income fluctuation carries both financial and health care consequences.

Research shows that insurance coverage disruptions have adverse effects on access and administrative costs[8–10] and, furthermore, that problems can arise simply from changes in health plans even without gaps in coverage.[11] For this reason, it is important both to estimate accurately the extent of these disruptions and to devise potential policy solutions to mitigate them.

For this study we used nationally representative data to explore the frequency of income fluctuations over time among low-income adults that would lead to switches between Medicaid and exchange eligibility under health reform.

Study Data And Methods

DATA Our data source was the Survey of Income and Program Participation, a nationally representative longitudinal survey conducted by the US Census Bureau. The survey is administered every four months and includes detailed questions on monthly income and insurance status for each of the prior four months. The data also include the relevant federal poverty threshold for each family in each month. The 2004 survey panel contained twelve waves, covering 2004–08, and this was the primary sample for analysis. A more recent panel, which began in 2008, contained only three waves at the time of our study; this panel was used for secondary analysis to supplement the 2004 panel.

The sample was made up of adults ages 19–60 whose family income at the outset of the survey was 200 percent of poverty or less. Our sample included only adults, who constitute the population directly affected by the new Medicaid eligibility rules. Most people with incomes of 200–400 percent of poverty receive insurance through their employers and are unlikely to participate in Medicaid or exchange plans in large numbers; therefore, they were not included in the sample. We excluded adults older than sixty, because they aged into Medicare by the end of the study period.

Our sample contained two groups: those whose income would initially qualify them for Medicaid under health reform, and those whose incomes would initially qualify them for exchange subsidies. The first group contained people with family incomes at or below 138 percent of poverty. The actual Medicaid cutoff is 133 percent of poverty plus an additional income disregard of 5 percent. In this article we refer to this threshold by the more commonly used 133 percent. The second group contained adults with incomes of 138–200 percent of poverty.

The sample size was 19,248 adults for the 2004 analysis and 19,784 for the 2008 analysis. At a population level, using survey weights from the 2008 data to produce full national estimates, we calculate that our sample represented 38 million adults below 138 percent of poverty and 18 million adults between 138 percent and 200 percent of poverty. All analyses were conducted using Stata, version 11.0, to account for the complex survey design.

PRIMARY OUTCOMES For adults initially below the nominal 133 percent cutoff, the primary outcomes were the percentages of people whose incomes made them consistently eligible for Medicaid throughout the study period; people whose incomes had risen above 133 percent of poverty (adults who would lose Medicaid eligibility and gain exchange eligibility); and people whose incomes had temporarily risen above 133 percent but subsequently dropped back below the cutoff (churning).

For adults initially above the 133 percent cutoff, the outcomes were the percentages of people whose incomes remained above 133 percent throughout the study period (consistently eligible for exchange subsidies); people whose incomes had fallen below 133 percent (adults who would lose exchange eligibility and gain Medicaid eligibility); and people whose incomes had temporarily dropped below 133 percent but subsequently risen back above the cutoff (churning).

All outcomes were calculated at six, twelve, twenty-four, thirty-six, and forty-eight months. Individuals lost to follow-up were included in analyses up until they left the survey.

ANALYSIS To identify risk factors for changes in eligibility, we performed Cox proportional hazards regression, using duration of continuous eligibility for a single program as the outcome variable. This analysis, therefore, identified risk factors for switching eligibility in

either direction, at any point during the study period. Variables were age, sex, race, ethnicity, education, marital status, parent with a child younger than age nineteen in the home, urban versus rural residence, health insurance status, and initial level of income (≤100 percent of poverty; >100–≤133 percent; >133–≤150 percent; and >150–≤200 percent). All variables were defined based on the respondent's first month in the survey.

LIMITATIONS Our study had several limitations. Income in the survey was self-reported and might not correspond exactly to how states will determine Medicaid and exchange eligibility—in particular, how they will treat structurally complex or multigenerational families. Thus, income-related eligibility was imperfectly measured in our study, although it is unclear if this imprecision biases our results toward more or less income mobility.[12] We found very frequent income mobility even among people initially far below or above the income cutoff, which suggests that month-to-month measurement error is not the primary explanation for our findings.

Loss to follow-up in the survey creates sample attrition, especially over longer periods of time. How one handles these missing—and in some cases, partially missing—observations affects the estimates provided. We chose to use the most conservative approach by simply excluding observations after a person left the survey. If anything, our results may underestimate the true extent of income fluctuations, because it is likely that households that dropped out of the survey over time (perhaps after a move, a serious illness, or a change in family status) were more likely to have unstable circumstances and fluctuating incomes than households that completed the survey for four consecutive years.

Although these issues created some imprecision in our estimates, even moderate reductions in the results we present below would leave sizable disruptions in Medicaid and exchange eligibility that need to be addressed in implementing health reform.

Study Results

Exhibit 1 presents the proportions of adults whose family incomes were initially less than 133 percent of poverty and who experienced income fluctuations above that threshold over time. Nearly 40 percent of adults experienced a disruption in Medicaid eligibility within the first six months. After a year, 38 percent were no longer eligible, and an additional 16 percent had lost eligibility but then regained it (churning). By three years, 47 percent of adults had incomes above the 133 percent cutoff, and an additional 30 percent of adults were below the cutoff but had experienced at least one episode of churning. By the end of the study period at four years, only 19 percent of adults would have been continuously eligible for Medicaid. Notably, this graph underestimates the extent of churning, because some adults above the 133 percent cutoff had switched back and forth multiple times.

Exhibit 2 presents income fluctuations of adults whose family incomes were initially above 133 percent of poverty. Within six months, nearly 30 percent of adults would have experienced a disruption in exchange eligibility. After a year, 24 percent were no longer eligible, and an additional 19 percent had lost eligibility but then regained it. By three years, 24 percent of adults were no longer eligible, and an additional 40 percent had lost eligibility but regained it after churning. By four years, only 31 percent of adults would have been continuously eligible for exchange subsidies.

Exhibit 3 combines the samples from Exhibits 1 and 2 and presents more detailed figures on how frequently people with incomes below 200 percent of poverty would have experienced multiple changes affecting Medicaid and exchange eligibility. Churning was quite common. By the end of three years, 29 percent of adults would have experienced four or more changes in eligibility since the start of the study; this number rises to 38 percent by the end of four years.

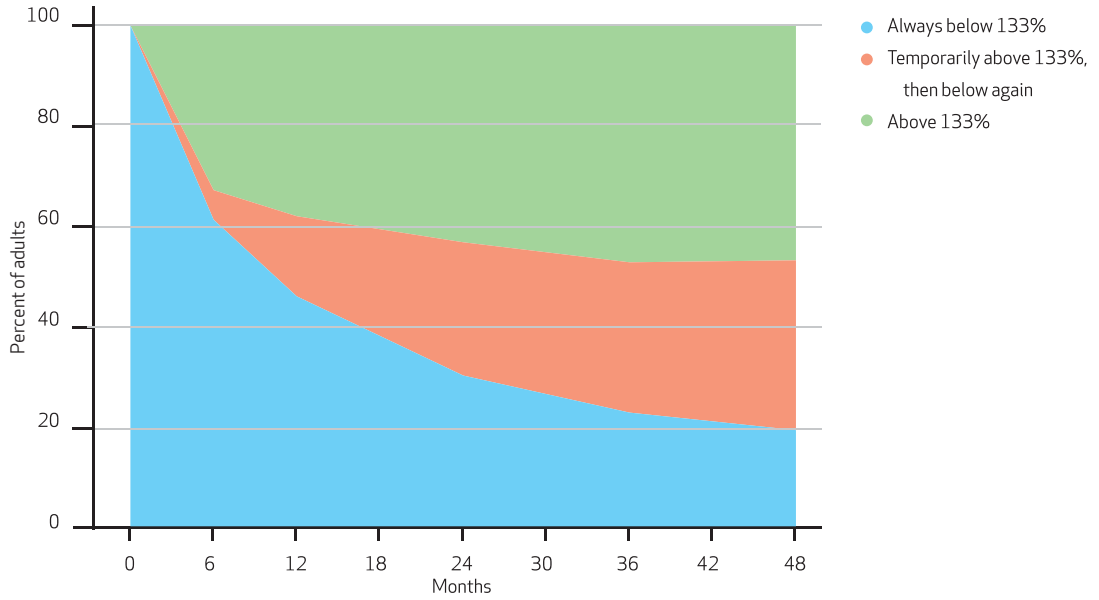
Exhibit 4 presents the Cox proportional-hazards regression results, identifying predictors of income fluctuations across the 133 percent threshold. Hazard ratios greater than 1.0 indicate a higher likelihood of income fluctuations, and ratios less than 1.0 indicate a lower likelihood. Income changes were significantly more likely among younger, male, and married individuals, and less likely among blacks, less-educated individuals, and adults with children in the home. Income fluctuations were significantly less likely among adults with Medicaid or Medicare coverage, compared to the uninsured and those with private insurance.

The strongest predictor was initial income. Eligibility changes were most common in adults at the point of the Medicaid-exchange market divide—that is, people with incomes of >100–≤133 percent and >133–≤150 percent of poverty. Changes were moderately common among adults with incomes below the poverty level and least common for adults with incomes above 150 percent of the poverty level.

The 2008 survey repeating the same analyses yielded similar results at six and twelve months—the period covered by these data. These analyses are available in Appendices A and B.[13] The multivariate analysis using 2008 data produced the

EXHIBIT 1

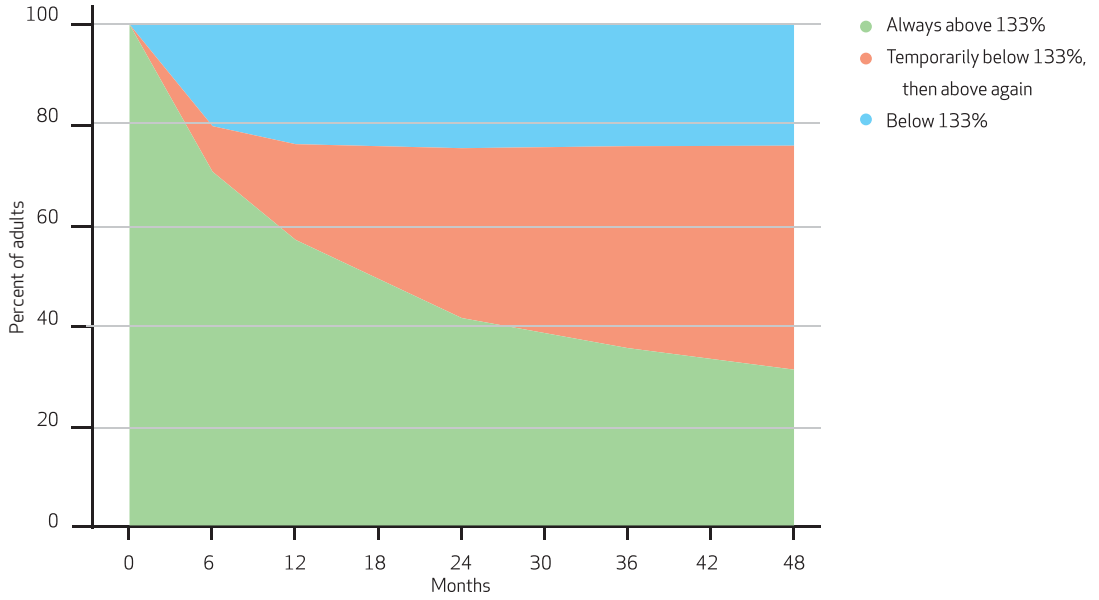
Income Changes Over Time Among Adults Ages 19–60 With Incomes Initially Under 133 Percent Of The Federal Poverty Level



SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. **NOTES** $N = 12,753$. The 133 percent federal poverty level threshold includes an additional 5 percent income disregard, according to the provisions of Medicaid eligibility in the 2010 health reform legislation. In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.

EXHIBIT 2

Income Changes Over Time Among Adults Ages 19–60 With Incomes Initially Between 133 Percent And 200 Percent Of The Federal Poverty Level



SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. **NOTES** $N = 6,495$. The 133 percent federal poverty level threshold includes an additional 5 percent income disregard, according to the provisions of Medicaid eligibility in the 2010 health reform legislation. In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.

EXHIBIT 3

Frequency Of Income Fluctuation Across Medicaid-Exchange Eligibility Threshold, Among Adults Ages 19–60 Initially Under 200 Percent Of The Federal Poverty Level

	Number of changes					
Month	0 changes (%)	1 change (%)	2 changes (%)	3 changes (%)	4 or more changes (%)	Sample size
0	100.0	0.0	0.0	0.0	0.0	19,248
6	64.5	26.9	6.7	1.6	0.3	17,227
12	49.8	26.6	14.8	5.9	2.9	15,274
24	34.1	19.9	18.7	11.9	7.8	11,937
36	27.2	16.4	15.6	11.5	29.3	4,855
48	23.6	13.8	14.5	9.7	38.4	4,101

SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. **NOTES** "Changes" refers to monthly income moving across the Medicaid-exchange eligibility threshold of 133 percent of the federal poverty level (plus an additional 5 percent income disregard, yielding an effective threshold of 138 percent of the poverty level). In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.

same results as the analysis using 2004 data, with one difference: Private insurance became a significant predictor of income change, relative to uninsurance.

Discussion

SUMMARY OF FINDINGS Income mobility is quite common across what will become the key Medicaid-exchange market divide at 133 percent of the federal poverty level. Our results show that 35 percent of the adults in our sample would have experienced a change in eligibility within six months, and 50 percent would have experienced a change within one year. Perhaps of even greater concern, 24 percent would have experienced at least two eligibility changes within a year, and 39 percent would have experienced such churning within two years. Beginning in 2014, these income changes may lead to the movement of millions of adults and their families between Medicaid and state exchanges, often within months of their initial enrollment in the programs.

Under the Affordable Care Act, income shifts can result in coverage and care disruptions while potentially increasing administrative costs. Furthermore, 43 percent of the adults in our sample had children under age nineteen who, along with their parents, might experience similar disruptions. The magnitude of these effects is quite large: Our 2008 sample corresponds nationally to fifty-six million adults with thirty-five million children.

Our findings are consistent with prior research demonstrating significant income mobility in the United States, even among lower-income families.[14,15] Our analysis of more-recent 2008 survey data showed trends similar to the 2004 data, which suggests that this degree of income mobility is not dramatically different now from what it was five years ago, and it probably persists in times of both economic recession and growth.

EFFECTS OF INCOME FLUCTUATIONS Our multivariate analyses show that income fluctuations were common even among adults initially with incomes below the poverty level. This is particularly troubling because many of these people will often have incomes low enough to exempt them from the federal insurance mandate,[16] which means that fatigue with frequent coverage changes may lead them to simply stop signing up for insurance over time. This is a problem on two fronts. First, it is uninsured low-income adults who have the most to gain from health reform. Second, this group includes millions of healthy adults whose participation in the exchanges is crucial to robust risk pools. We found that income changes were more common among adults who were younger, more educated, and white—characteristics that correlate with a lower burden of illness. Indeed, these results are consistent with previous findings on changes in Medicaid coverage among adults.[6]

The extent to which the income fluctuations discussed here will lead to actual eligibility and coverage changes under the Affordable Care Act is unclear. Coverage and subsidy shifts will depend on the speed with which individuals report income changes and how quickly this information is processed by states. Although the system created by the Affordable Care Act assumes the potential for monthly changes in coverage, actual shifting may be less frequent. Nonetheless, given current experience with Medicaid coverage gaps, it seems highly likely that many families will face income-related insurance coverage disruptions under health reform.[4–6] To assess how large a problem churning actually poses,

EXHIBIT 4

Predictors Of Income Fluctuation Across Medicaid-Exchange Eligibility Threshold, Among Adults Ages 19–60 Initially Under 200 Percent Of The Federal Poverty Level

Variable	Hazard ratio	95% CI	*p* value
AGE (YEARS)			
19–29	1.30	1.21, 1.39	< 0.001
30–39	1.15	1.08, 1.23	< 0.001
40–49	1.13	1.06, 1.20	< 0.001
50–60	1.00	Reference	—[a]
SEX			
Male	1.11	1.07, 1.16	< 0.001
Female	1.00	Reference	—[a]
MARITAL STATUS			
Married	1.23	1.16, 1.30	< 0.001
Divorced	1.04	0.97, 1.10	0.27
Widowed	1.11	0.96, 1.28	0.14
Single	1.00	Reference	—[a]
PARENTAL STATUS			
Parent with children in the home	0.92	0.88, 0.96	0.001
Parent with no children in the home	1.00	Reference	—[a]
EDUCATION			
Less than high school diploma	0.73	0.69, 0.78	< 0.001
High school diploma or equivalent	0.87	0.83, 0.92	< 0.001
College graduate	1.00	Reference	—[a]
RACE			
Black	0.87	0.82, 0.92	< 0.001
Asian	0.94	0.85, 1.03	0.20
Other race	1.06	0.97, 1.16	0.22
White	1.00	Reference	—[a]
ETHNICITY/URBAN STATUS			
Latino ethnicity	0.97	0.91, 1.02	0.23
Urban residence	1.03	0.99, 1.08	0.14
INITIAL HEALTH INSURANCE			
Medicaid	0.79	0.74, 0.83	< 0.001
Medicare	0.60	0.54, 0.68	< 0.001
Private insurance	0.98	0.93, 1.02	0.31
Uninsured	1.00	Reference	—[a]
INITIAL INCOME (AS PERCENT OF POVERTY)			
≤100%	1.51	1.43, 1.59	< 0.001
>100%–≤133%	2.24	2.11, 2.37	< 0.001
>133%–≤150%	2.02	1.85, 2.21	< 0.001
>150%–≤200%	1.00	Reference	—[a]

SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. **NOTES** $N = 19,248$. The 133 percent federal poverty level threshold includes an additional 5 percent income disregard. Hazard ratios are from Cox proportional-hazards regression, using continuous months without crossing the 133 percent federal poverty level threshold as the outcome. CI is confidence interval. [a]*p* values cannot be calculated for variables that are the reference group in a regression.

it would be helpful if states were required to collect and report data on churning in Medicaid and the exchanges once the law takes effect, as is currently done for the Children's Health Insurance Program (CHIP).

POLICY IMPLICATIONS Although income fluctuations present important challenges, the Affordable Care Act represents the largest expansion of health coverage for lower-income people since the enactment of Medicare and Medicaid. Coverage disruptions due to income changes are not a new problem: State Medicaid and CHIP programs already deal with this issue routinely, although on a smaller scale. But currently, when people lose eligibility for Medicaid, they often become uninsured; in contrast, the Affordable Care Act offers an opportunity to ensure that families do not experience lapses in coverage and care when their incomes change. Thus, the challenge becomes how to mitigate the potential harm of transitions between Medicaid and the exchanges. We identify several policy

options.

▶ **REDUCE LIKELIHOOD OF FREQUENT ELIGIBILITY CHANGES:** One straightforward option is to establish a minimum guaranteed eligibility period—a strategy used by some state Medicaid and CHIP programs. A guaranteed eligibility period was considered in the health reform legislation but set aside for cost reasons. This may prove to be shortsighted if churning leads to higher administrative costs of frequently enrolling and disenrolling people or to downstream medical costs resulting from disruptions in continuity of care. States can promote guaranteed eligibility periods by using annual redetermination procedures instead of more frequent eligibility verification, to reduce the likelihood of mid-enrollment shifts.

▶ **PROVIDE SUPPORT SERVICES FOR THE SHIFT:** The Affordable Care Act requires that the new health insurance exchanges serve as enrollment "portals" that will allow people to sign up for either Medicaid or the exchange. It also specifies procedures for ensuring that enrollees have a means of reporting real-time income changes that could affect eligibility.[17] But these steps do not address the discontinuity in care created by eligibility shifts, so additional approaches will need to be taken.

There are two major concerns about how to support enrollees as their coverage shifts between Medicaid and plans in the exchanges. The first concern is the real-time reporting of income and adjustment of subsidies for insurance coverage based on income. Even when small income changes occur, subsidies for premiums and cost sharing will need to be adjusted efficiently, which poses administrative challenges.

When implementing both the Medicaid and exchange reforms, states should clarify that the source and size of the subsidy is sensitive to income. Furthermore, by making real-time reporting easily accessible, it may be possible to address Medicaid-exchange shifts more quickly while also helping people select plans that participate in both Medicaid and the exchanges. Of particular importance will be the role of "exchange navigators," as called for under the Affordable Care Act. These are individuals or organizations knowledgeable about both programs and markets whose services will be available to assist consumers.

The second major concern is the issue of timing of coverage. Medicaid coverage can be retroactive up to ninety days before the date on which eligibility is actually determined.[18] On the other hand, if typical industry standards are used, plans participating in the exchange would begin coverage the first of the month after an individual becomes eligible. To ensure that movement from Medicaid to an exchange plan does not lead to a break in coverage, states may need to require enrollment in plans through the exchange to be retroactive to the date of first eligibility for people transitioning from Medicaid, or to extend Medicaid coverage until exchange coverage takes effect.

▶ **ALIGN COVERAGE AND BENEFITS:** Income mobility that prompts people to move between Medicaid and insurance exchanges ultimately may lead to variable levels of coverage in terms of benefits, premiums, and cost sharing. For newly eligible Medicaid adults, benefits are set based on "benchmark" coverage rather than the full scope of benefits offered to "traditional" Medicaid beneficiaries. The Affordable Care Act further clarifies that for these adults, the benchmark must consist of the same essential benefit package offered to adults who receive coverage through state health insurance exchanges.[19] This conformance of Medicaid benchmark coverage to the exchanges' essential benefit package should mitigate these coverage differences, although some differences in cost sharing among plans and programs are likely to remain.

For children, the shift to exchange coverage may result in a major loss of benefits, unless private coverage is required to meet the standard of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment benefit.[20]

▶ **ALIGN MARKETS AND PROVIDER NETWORKS:** In our view, the most crucial aspect of income fluctuation is its potential effect on the continuity and quality of care for individuals and families who shift between Medicaid and exchange coverage. To the extent that the same plans with the same provider networks participate in both the exchange and Medicaid markets, the practical impact of coverage changes might be markedly reduced.

For this to happen, it is important for the secretary of health and human services to take steps to align, as much as possible, the conditions of participation for both exchange-qualified health plans and Medicaid managed care organizations, to promote dual market participation. States also could consider the development, in collaboration with Medicaid plans and health insurers, of products that are certified to operate in both markets. To the greatest extent possible, these plans would share common coverage terms, provider networks (especially participation by essential community providers), administrative systems, consumer and patient protections, and quality and performance measures.

▶ **MONITOR ACCESSIBILITY AND QUALITY OF CARE:** Improving the quality and efficiency of

care is a central goal of health reform. High-quality care is by definition continuous over time. Quality-measurement systems will need to be particularly sensitive to plan and provider performance for patients whose coverage changes as they churn in and out of programs, because the incentive may be to provide few services and to delay care on the assumption that they will soon be gone.

Discontinuities may also lead to inadequate clinical follow-up of chronic diseases, especially since acute deteriorations in health status may often be accompanied by changes in income and eligibility due to job loss. Monitoring for the risk of underservice has been a challenge for Medicaid managed care plans for years as a result of unstable eligibility; Medicaid-exchange churning is an extension of this challenge.

CONCLUSION The Affordable Care Act offers the opportunity to expand health insurance coverage to millions of low-income families. Our analysis of national survey data indicates that income fluctuations are extremely common among lower-income individuals and families. Therefore, state and federal implementation should expressly include strategies aimed at minimizing the frequency of coverage transitions and promoting the quality and continuity of care. ■

The authors are grateful to Arnie Epstein and Nancy Turnbull for insightful comments, and to Michael Miller for helping generate the idea for this project.

NOTES

1 Affordable Care Act, Pub. L. 111-148 and 111-152; 2010. Sec. 2001, Medicaid coverage for lowest income populations. Revises United States Code, Title 42, Sec. 1396a(a)(10), State plans for medical assistance. Further revised by the Health Care and Education Reconciliation Act of 2010, Pub. L. 100-152.

2 Internal Revenue Code, Sec. 36B(b)(3)(A), added by Sec. 1401 of the Affordable Care Act. Legal US residents with family incomes below 100 percent of the federal poverty level who have not resided in the United States long enough to qualify for Medicaid instead will receive premium credits through their state exchanges.

3 Medicaid eligibility, like eligibility for cash welfare, historically has been tied to monthly income. At their option, states can limit eligibility redeterminations to once annually, but federal regulations require that individuals report interim changes in income, and when such information is received, states must promptly redetermine eligibility. 42 CFR, Sec. 435.916, Periodic redeterminations of Medicaid eligibility.

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5 Fairbrother GL, Emerson HP, Partridge L. How stable is Medicaid coverage for children? Health Aff (Millwood). 2007;26(2):520–28.

6 Sommers BD. Loss of health insurance among non-elderly adults in Medicaid. J Gen Intern Med. 2009;24(1):1–7.

7 The Medicare and Medicaid Extenders Act, Pub. L. No. 111-309; 2010. Sec. 208 finances the latest version of Congress's fix to the Medicare physician payment problem by increasing the size of the advance payment recoupment to which individuals are exposed. Specifically, this legislation amends Sec. 36B of the Internal Revenue Code, as added by the Affordable Care Act, to significantly increase repayment obligations by individuals who receive advance tax credits based on prior-year income and whose incomes then rise during the enrollment year. Under the Affordable Care Act, the maximum repayment penalty was $400; the more recent legislation increased this penalty to $500 for individuals and families with incomes below 200 percent of the federal poverty level and to as much as $2,500 in the case of individuals with family incomes of 350–400 percent of the poverty level.

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

10 Ku L, Ross DC. Staying covered: the importance of retaining health insurance for low-income families. Washington (DC): Center on Budget and Policy Priorities; 2002.

11 Lavarreda SA, Gatchell M, Ponce N, Brown ER, Chia YJ. Switching health insurance and its effects on access to physician services. Med Care. 2008;46(10):1055–63.

12 Waves 2–4 of the 2004 survey contained an income imputation error for some households. This result does not appear to have biased our results since the 2008 data (unaffected by this error) produce the same findings. US Census Bureau. SIPP 2004 panel general income user note [Internet]. Washington (DC): The Bureau; 2008 Feb 19 [cited 2010 Dec 12]. Available from: http://www.census.gov/sipp/core_content/core_notes/2004General_Income.html

13 To access the Appendix, click on the Appendix link in the box to the right of the article online.

14 US Department of the Treasury. Income mobility in the US from 1996 to 2005. Washington (DC): The Department; 2007 (revised 2008).

15 Congressional Budget Office. Trends in earnings variability over the past 20 years. Washington (DC): CBO; 2007.

16 Internal Revenue Code, Sec. 5000A(e)(2), exempts from the mandate any individual with income below the code's filing threshold for a taxable year. In 2009, the threshold was $9,350 for an individual and $18,700 for a couple. Internal Revenue Service. 1040EZ instructions 2010 [Internet]. Washington (DC): IRS; 2010 [cited 2010 Dec 12]. Available from: http://www.irs.gov/pub/irs-pdf/i1040ez.pdf

17 Affordable Care Act, Sec. 1311, Affordable choices of health benefit plans, and Sec. 1401, Refundable tax credit providing premium assistance for coverage under a qualified health plan.

18 42 US Code, Sec. 1396a(a)(34). "A State plan for medical assistance must...provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished."

19 42 US Code, Sec. 1396u-7(b), defines "benchmark coverage" for the Medicaid eligible expansion group under the Affordable Care Act; coverage was amended in Sec. 2001(c) of the act.

20 Rosenbaum S, Wise PH. Crossing the Medicaid–private insurance divide: the case of EPSDT. Health Aff (Millwood). 2007;26(2):382–93.

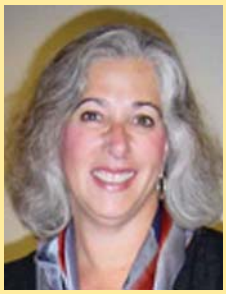
ABOUT THE AUTHORS: BENJAMIN D. SOMMERS & SARA ROSENBAUM

Benjamin D. Sommers is an assistant professor at the Harvard School of Public Health.

In this issue, Benjamin Sommers and Sara Rosenbaum shed light on one unintended consequence of the Affordable Care Act: the likelihood that many low-income individuals and families will move back and forth between Medicaid and subsidized insurance coverage obtained through state exchanges. Many of these individuals and families experience small changes in income that will alter their eligibility for these programs and the subsidies to buy coverage.

This process, called churning, could affect half of the lower-income people in these programs within a year, jeopardizing their continuity of care. The authors hope that by calling attention to the potential problems, they can "maximize the amount of creative thinking that can be brought to bear on the issue," Rosenbaum says, and help foster successful implementation of the expansion of Medicaid and the state exchanges.

Sommers is an assistant professor of health policy and economics at the Harvard School of Public Health. He received a doctorate in health policy and medical degree from Harvard, and he completed his residency in internal medicine and primary care at the Brigham and Women's Hospital. He has had a long-standing interest in the stability of coverage under Medicaid and the Children's Health Insurance Program, which led him to the topic of transitions and maintenance of coverage between Medicaid and the exchanges.



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Rosenbaum is the Hirsh Professor and chair of the Department of Health Policy at the School of Public Health and Health Services at the George Washington University. She earned her juris doctor degree from Boston University. Her research has focused on the problem of quality and continuity of care for low-income, minority, and medically underserved populations.

Long experience with Medicaid, she says, has taught her that poorer people experience great instability in their coverage; this awareness led her to examine the potential for such instability in two side-by-side programs, Medicaid and subsidized coverage through exchanges.