



Revisiting Churn: An Early Understanding of State-Level Health Coverage Transitions Under the ACA

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Introduction

Individuals move on and off health insurance coverage for many reasons—from experiencing income or employment changes, to obtaining coverage through a family member’s plan, or losing/gaining eligibility for Medicaid. These types of health coverage transitions—sometimes referred to as churn—have always existed to some degree. Prior to the Affordable Care Act (ACA), churn most commonly referred to individuals moving back and forth between Medicaid or the Children’s Health Insurance Program (CHIP) and uninsurance.¹ Now with the ACA’s introduction of qualified health plans (QHPs) and the expansion of Medicaid to adults with incomes up to 138% of the Federal Poverty Level (FPL), there are additional possibilities for churning to occur across a spectrum of coverage including uninsurance, Medicaid, QHPs, and employer-sponsored insurance (ESI). Additionally, because not all states have

chosen to implement the ACA’s Medicaid expansion², health coverage churning patterns will be different in each state. Given these new health insurance options, there is more focus on the potential for churn among these multiple coverage sources.

These inevitable coverage transitions due to income fluctuations and other factors that affect eligibility could result in minimal negative effects for individuals, as long as coverage is maintained. However, transitioning between different health coverage programs has the potential to be disruptive to enrollees and may create challenges for health plans, providers, and entities that process enrollment changes.³ In addition to individuals potentially losing coverage altogether, some possible adverse effects of churn include difficulties in accessing care due to provider network differences within coverage sources, and increased costs for states associated with uncompensated care and/or re-enrolling individuals in coverage.

Considering the potential implications of churn, tracking state-level shifts in coverage is essential for developing a better understanding of these transitions. Data about churn can help inform policies to ensure that unavoidable coverage transitions are as seamless as possible. To learn whether states are able to measure churn and the degree to which churn occurs, the National Academy for State Health Policy (NASHP) engaged a small group of state officials in the spring of 2016.⁴ NASHP found that only

a few states with State-based Marketplaces (SBMs) have the necessary data analysis capability to track individuals' movement across programs, and that those states are only in the initial stages of assessing patterns in coverage transitions. However, states with Federally-facilitated marketplaces (FFMs) that indicated interest in measuring churn currently lack the capacity to do so because of challenges with obtaining the necessary data, which is an added complexity compared to SBMs that are more likely to have access to the data.

Causes of Churn/Coverage Transitions

Churn between health coverage programs and/or uninsurance can be caused by a range of factors:

- **Income or household changes:** Individuals may experience changes in income resulting in shifts in their eligibility for health coverage programs. Also, household size affects eligibility for health coverage programs, and consequently changes in household composition can cause shifts in coverage.
- **Administrative disenrollment:** Churning can also be caused by disenrollment from coverage due to administrative reasons, such as incomplete reenrollment paperwork or coverage renewals not occurring for other reasons.
- **Obtaining employer-sponsored insurance (ESI) coverage or shifting to other private market coverage:** Some individuals may move from Medicaid or exchange coverage due to a change in access to affordable ESI or because of enrollment in other private market coverage.
- **QHP premium nonpayment:** Some individuals may lose QHP coverage due to failure to make timely premium payments.

Defining Churn

Health coverage churn can refer to individuals moving from coverage to uninsurance as well as the movement of these individuals back onto coverage. The term is also used to describe distinct transitions between specific coverage sources. This brief primarily focuses on churn defined as the transition of individuals moving between Medicaid and exchange coverage, such as the one-direction coverage transitions and coverage transition loops described in Table 1.⁵

Table 1

Possible Types of Churn/Coverage Transitions Between Coverage Categories	Examples
One-direction coverage transitions Individual begins in one coverage category and moves to another.	QHP → Medicaid Medicaid → QHP
Two-step coverage transitions Individual begins in one coverage category, shifts to second, and then moves to a third.	QHP → Uninsurance → Medicaid Uninsurance → Medicaid → QHP Medicaid → QHP → Employer coverage
Coverage transition loops Individual begins in one coverage category, shifts to another, and then moves back to first coverage category.	Medicaid → QHP → Medicaid QHP → Medicaid → QHP

Adapted from model included in State Health Access Data Assistance Center (SHADAC) brief, "ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level"

Possible Consequences of Churn

Care Access Challenges

Individuals who churn between different sources of health coverage or become uninsured are unlikely to have a regular source of care.⁶ This can result in individuals not receiving preventive care or necessary treatment for existing health conditions, as well as individuals using emergency departments for non-urgent care needs.⁷ Further, changes in health coverage have been shown to have negative effects on an individuals' access to care, and treatment delays can occur even when there is no gap in coverage.⁸ This could be particularly problematic for individuals with chronic and complex health conditions.

For individuals cycling between Medicaid and QHP coverage, churning may result in a number of issues that can pose challenges to accessing care. Each health coverage source has its own set of participating health plans that are likely to have different standards.⁹ These can include differences in coverage of benefits and prescription drugs, cost sharing requirements, and provider networks. Individuals may need to change providers, which can disrupt care continuity and in turn negatively affect health outcomes.¹⁰ Also, for individuals moving from Medicaid to QHP coverage, greater cost sharing requirements such as copayments and deductibles in QHP plans could create financial barriers for individuals and limit their ability to access care.

Potential increased costs for states

If churning results in individuals losing coverage altogether, it can also have financial implications for states, both in terms of potential increases in health care costs and administrative expenditures. When individuals delay seeking routine care due to gaps in coverage, this can result in increased costs associated with unmet health needs that become exacerbated without treatment. Individuals without coverage may also seek care in emergency rooms for minor ailments, which also adds to increased health care system costs at the state and local level.¹¹

There are also increased administrative costs for states associated with re-enrolling individuals who become disenrolled.¹² Further, research has demonstrated that for individuals covered through Medicaid, on average their monthly Medicaid expenditures decline the longer that they are enrolled in the program.¹³

Lack of coverage caused by income-related churn

For some individuals, eligibility changes or affordability issues may result in a total loss of health coverage, even within the context of the ACA's new coverage options. For example, because the ACA provides advanced premium tax credits (APTC) for exchange coverage for individuals with incomes between 100-400% FPL, adults residing in states that have not expanded Medicaid up to 138% FPL may be eligible for subsidized exchange coverage if they have income above the poverty level. Yet if their income falls below 100% FPL, they will likely not be able to afford any source of coverage and will become uninsured. Other adults may not be eligible for any subsidies on the exchange due to having an offer of employer-sponsored coverage that is considered affordable under the ACA,¹⁴ but they may not be able to actually afford the employer coverage. Additionally, uninsured individuals or those covered by Medicaid who experience an increase in income, making them eligible for subsidized exchange coverage, may still find this coverage unaffordable and become or remain uninsured.

Prior Churn Predictions Under the ACA

While it was anticipated that expanded coverage options and more streamlined enrollment and renewal procedures through the ACA would reduce uninsurance, churn was still expected to occur across different coverage types. Estimates prior to ACA implementation predicted that there would be a high prevalence of churn between Medicaid and QHP coverage, especially for individuals with incomes below 200% FPL.

For example, one analysis conducted in 2011 using samples from national survey data found that within six months, 35 percent of adults with household incomes below 200% FPL would have experienced an eligibility change, and that 50 percent of adults would have done so within a year.¹⁵ Another analysis in 2012 estimated that approximately 6.9 million individuals would move from Medicaid to QHPs and vice versa, and three million were predicted to move from subsidized exchange coverage to ineligibility for any program.¹⁶ A 2014 study found that churn between Medicaid and QHP coverage would be greater in states with lower poverty rates and higher per capita incomes. This is because states with higher incomes would have a larger proportion of individuals at the 100-250% FPL income range, which is where eligibility shifts would occur.¹⁷ Some analysts have highlighted that these estimates may overestimate churn because they may include individuals who could be ineligible for coverage due to their immigration status or they may assume that individuals will always report temporary income changes and disenroll.¹⁸

Specific State Findings

Previous research examining states' ability to develop estimates of health coverage churn has demonstrated that only a handful of states measured and assessed churn patterns prior to ACA implementation,¹⁹ possibly in part because churn has always been a part of the health coverage landscape. As anticipated, because of ACA implementation being in the relatively early stages, most of the states indicated that they were not currently measuring health coverage churn. States frequently noted that while there is interest in measuring churn, there is a lack of data, technical capacity, and/or staff resources to do so.

Some states indicated that they are in the final stages of integrating their eligibility systems and anticipate that once complete this will allow for better analysis of changes and patterns in health coverage. Two states with FFMs and recently implemented Medicaid expansions, Louisiana and Montana, indicated that their efforts to measure churn are either not yet underway or are in the very early stages, but that they expect they will explore the issue of churn further at some point.

States noted systems or policy issues possibly causing churn as well as factors making it challenging to measure. One state with a partnership marketplace mentioned that there were challenges with real-time data transfers from the marketplace to the state, which resulted in multiple application processes. Churn may have occurred in the state when a bulk eligibility redetermination was conducted for all enrollees, which resulted in staff overload and communication issues with enrollees. Another state reported that federal regulations require that applicants with monthly income above Medicaid limits and annual income below 100% FPL be determined eligible for Medicaid based on their annual tax household income. The state indicated that this could lead to churn if a Medicaid enrollee has an onset of income during the certification period that results in ineligibility for Medicaid and subsequently a transfer to the marketplace. The marketplace then determines the individual is under 100% FPL and ineligible for subsidies and sends the case back to the state.

Although not all of the SBM states reported being able to measure churn, of the states that could, all operated their own marketplaces. In contrast, none of the fully federally-facilitated or partnership marketplaces reported having the capability to measure churn between Medicaid and QHPs.²⁰ While states that are aiming to measure churn are in varying stages of being able to specifically quantify the extent of coverage changes, states indicated that the most common direction of movement was from QHP to Medicaid coverage. States currently attempting to measure health coverage churn are described in further detail in the following section.

States with SBMs and Implementing Traditional ACA Medicaid Expansion

California

State officials in California indicated that they are currently informally tracking churn. They noted there are some challenges in measuring individuals' movement between coverage programs due to necessary system programming changes, and additional work is needed to develop more defined metrics to assess churn. The state reported that approximately 80,000 to 100,000 cases shifted from exchange coverage to Medicaid in January 2015 due to the exchange renewal period.²¹ However on average the number of individuals moving between coverage sources is smaller, as the state indicated about 5,000 to 10,000 cases transition on a monthly basis throughout the year due to reported changes in circumstances. Additionally, California reported that individuals most commonly move from QHP to Medicaid coverage, and that these occurrences happen multiple times over the course of a year.

State officials noted that further analysis is needed to assess churn patterns, causal factors, and the specific population groups that are churning. The state reported that based on anecdotal information, some individuals moving from Medicaid to exchange coverage may misunderstand certain coverage start and end dates or the timing for selecting a QHP and paying the first month's premium.

Kentucky

Kentucky state officials reported that the state is measuring churn and has not experienced any major challenges associated with doing so. Although Kentucky is in the process of transitioning to a FFM, this information reflects current practice in which the state has an integrated eligibility and enrollment system for Medicaid and exchange coverage. This system can help the state analyze coverage patterns as well as avoid duplicate coverage. In 2014, slightly more than 13,000 individuals transitioned between Medicaid and exchange coverage. The state indicated that the most common direction of churn is from QHP coverage to Medicaid (approximately 7,400 individuals) as compared to movement from Medicaid to QHP coverage (approximately 6,000 individuals). Also, generally churn occurs just once a year for individuals, although some enrollees move across coverage programs more frequently. For individuals that move from Medicaid to QHP coverage, the state has anecdotal information that some may struggle with maintaining this coverage due to affordability issues.

Maryland

State officials in Maryland are in the initial stages of assessing some trends in churning by looking at a small group of Medicaid enrollees who are approaching their renewal dates. The state indicated that there have been some challenges tracking enrollment data and the impact of churn because until recently they were in the process of transitioning from a legacy eligibility system to conducting eligibility determinations for all programs through the SBM. State officials anticipate that they may be able to

conduct further analysis of churning patterns across the entire population of Medicaid and exchange enrollees now that all enrollee records are in the same system.

Washington

In Washington, the exchange and the state's Medicaid agency worked together to assess data to determine trends in churning. The findings were summarized in a [report](#) that was published in January 2016 and focuses on data collected between April 2014 and March 2015. The state found that during this time period, over 30,000 individuals churned between Washington Apple Health, the state's Medicaid program, and QHP coverage.²² Relative to the entire enrolled population this is a small proportion, as churn only affected 8.5 percent of the QHP population and 0.7 percent of the Medicaid population.

The state also examined details regarding some of the characteristics of the churn population. The state found that over two-thirds of the individuals who churned had income below 200% FPL, and that the greatest percentage of churn occurred among those with incomes between 151-200% FPL. Additionally, they found that churn occurred most commonly among households with mixed sources of coverage (households with both Medicaid and QHP enrollees), with between 62 and 63 percent of those churning having households with mixed coverage.²³

The state's analysis also looked at both the direction and frequency of churn. The state found that the vast majority of individuals who churned—93.9 percent—had only one churn event over the course of the year. Regarding the direction of churn, the state found that individuals were more likely to churn from QHP to Medicaid (61.6 percent) than from Medicaid to QHP.

As noted in the state's report, this analysis is viewed as an initial attempt to assess churn patterns and the characteristics of the churn population. Additional analyses to better understand the underlying issues causing churn and its impacts could include examining provider network differences between coverage sources, qualitative analyses of consumers' experiences, and administrative and claims cost analyses.

Additional States

Arkansas

Arkansas operates a state-based exchange using the federal platform²⁴ and is implementing the ACA's Medicaid expansion through a Section 1115 waiver, using a premium assistance model to enroll Medicaid-eligible individuals in QHPs in the marketplace. As part of the required evaluation of the waiver, the state is beginning to track churning trends, which will be included in their summary evaluation report to be published in 2017.

The state indicated that while they are not yet able to assess churn between specific QHPs, they have assessed the stability of wage data among individuals enrolled in their Medicaid waiver. They found that within the group of individuals reporting having no income, there were income shifts that occurred. Specifically, approximately half of these individuals with no income did have wages in the quarter either prior to or after eligibility determination, suggesting that these income changes could be causing churning.

Arkansas noted that while they are able to measure churn to some degree, they are not able to collect

data from carriers currently, which would allow the state to more accurately assess churn. However the state highlighted that recently passed legislation to require carriers to submit claims and enrollment data to the state's all-payer claims database may have the potential to better equip the state to measure churn.

Montana

Montana uses the FFM and has recently implemented the ACA's Medicaid expansion through a Section 1115 waiver (eligibility became effective in January 2016). While the state indicated it is too early to identify churn patterns, state officials mentioned that there have been some challenges related to individuals transitioning from one source of coverage to another. Specifically, individuals with incomes between 100-138% FPL who were previously enrolled in exchange coverage are now considered to be eligible for Medicaid with the state's implementation of expansion. However, state officials noted that the FFM did not inform consumers that they should take action to cancel their QHP coverage. Many of these individuals were subsequently enrolled in both Medicaid and exchange coverage due to technical challenges associated with the FFM eligibility determination system. The state's Department of Insurance (DOI) drafted a letter to the individuals that became dually enrolled to inform them of the issue. The DOI worked with the QHP issuers to identify these individuals and is currently in the process of resolving these instances of duplicate coverage.

Approaches to Measuring Churn at the State Level

The State Health Access Data Assistance Center (SHADAC) has identified a framework for states to use for measuring and projecting churn, available in the publication, [ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level](#). The 2014 publication provides information about considerations for states in defining churn and developing a model for estimating churn in terms of scope, characteristics of individuals who churn, causes of churn, and possible effects of churn.

Policy Options to Address Churn

States can implement policies to potentially reduce the occurrence of health coverage churn and/or ease transitions between coverage sources, although strategies may take time to implement and involve a number of factors.²⁵ The following section explores state options along with some federal measures designed to address health coverage churn.

Multimarket health plans

Health plans that participate in public coverage programs such as Medicaid and CHIP as well as in health insurance exchanges have the potential to minimize some of the possible negative effects of Medicaid/QHP coverage transitions. Individuals who are enrolled in these multimarket plans and transition back and forth between Medicaid and QHP eligibility due to income fluctuations would be able to potentially remain in the same health plan. Research from the Association for Community Affiliated Plans (ACAP) examining health plans participating in both the Medicaid and QHP markets found that in 2015, nearly 40 percent of QHP issuers also offered a Medicaid managed care plan in the same state, referred to by ACAP as "overlap issuers."²⁶

While coverage limits and cost sharing might differ, this option has the potential to offer a shared provider network so that individuals who experience eligibility shifts would not need to switch providers.²⁷

However, this would only be the case if there were substantial provider network overlap in both Medicaid and QHPs among the multimarket health plans.²⁸ Also, while an issuer may offer both Medicaid and exchange coverage within a state, they may not offer both types of coverage in all regions of the state, which could result in some individuals needing to switch plans when their eligibility changes.²⁹

Researchers examined the early experiences of some of the issuers that offer multimarket plans through interviews conducted in 2014 and found that they cited the importance of maintaining customers as one of the key factors for choosing to participate in both markets. Also, issuers did not see regulatory differences between Medicaid and the marketplace as a barrier to multimarket involvement. One potential challenge identified for multimarket plans was that some providers might not be willing to treat individuals without concern for the source of coverage due to differences in reimbursement rates.³⁰

12-month continuous eligibility policies in Medicaid

Another option that states could use to address churn in Medicaid would be to implement policies that allow for 12-month continuous eligibility in the program. The ACA requires that states review eligibility for Modified Adjusted Gross Income (MAGI)-based Medicaid only once every 12 months³¹ (unless the state receives information that may affect an individual's eligibility). While this requirement is not the same as 12-month continuous eligibility it may help reduce churn due to administrative disenrollment³², particularly in states that previously reviewed Medicaid eligibility every six months.³³ Twelve-month continuous eligibility policies for adults have the potential to even further reduce churn in Medicaid, because the policy grants a full year of coverage to individuals regardless of small changes in income that may affect eligibility.

Continuous eligibility policies have proven successful in terms of coverage continuity for children in Medicaid and CHIP, where these policies have been permitted since 1997.³⁴ In March 2013 the Medicaid and CHIP Payment and Access Commission recommended that Congress allow for a statutory option for 12-month continuous eligibility for adults in Medicaid.³⁵ The Centers for Medicare and Medicaid Services in May 2013 issued guidance to states about facilitating Medicaid and CHIP enrollment and renewal, and one of the recommended options was for states to adopt 12-month continuous eligibility for adults through an 1115 waiver.³⁶ As of January 2016, only two states—Montana and New York—have implemented continuous eligibility for adults through Medicaid's waiver authority.³⁷ States considering implementing 12-month continuous eligibility policies would need to develop estimates of how their Medicaid program enrollment and costs would be impacted and assess the overall financial implications of these policies.³⁸

Increasing consumer assistance and simplifying renewal processes

States can invest resources to provide consumers with additional enrollment and other types of assistance to help individuals manage coverage transitions and fully understand their health coverage options. States can also implement policies and procedures designed to streamline health coverage renewals to minimize churning caused by administrative disenrollment. The ACA requires states to attempt coverage renewals through administrative/ex-parte renewal procedures, which involve using third party data sources to conduct eligibility redeterminations. When states cannot confirm eligibility automatically, states send individuals pre-populated renewal forms with information they have available, which is intended to streamline the renewal process.³⁹

Premium assistance

Some predictive analyses prior to ACA implementation estimated that many individuals might churn

from Medicaid to being ineligible for insurance affordability programs due to having income above 138% FPL and an offer of affordable ESI. One possibility for addressing this type of churning would be to provide ESI premium assistance for Medicaid-eligible individuals. If these individuals then experienced income fluctuations resulting in changes in Medicaid eligibility, they would be able to remain on the same coverage through their offer of ESI.⁴⁰

The premium assistance strategy can also be applied to marketplace coverage, where states use Medicaid funding to purchase QHP coverage for Medicaid-eligible individuals. This model is currently in operation in Arkansas and New Hampshire for most individuals who are newly eligible for Medicaid under the ACA. With Medicaid enrollees integrated into the marketplace, this model can allow individuals to remain on the same plan as their income shifts. However some policy analysts have identified challenges associated with this model.⁴¹ One issue is that it requires Medicaid to take on a new role of overseeing private insurance coverage to ensure that benefits and cost sharing are appropriate. Also, it could be difficult to find an adequate number of plans to participate, as recently occurred in Iowa, with the termination of its Marketplace Choice Plan due to a lack of plan issuers.⁴² Additionally, it is possible that because individuals who experience an increase in income above 138% FPL would have increased premiums and cost sharing they may opt to disenroll from coverage.⁴³

Basic Health Program

The Basic Health Program (BHP) is an option available to states through the ACA to cover individuals with incomes between 138-200% FPL. Some policy analysts have estimated that the creation of a BHP would reduce expected churning between Medicaid and exchange coverage by approximately four percentage points.⁴⁴ Other analysts note that the BHP could increase the total amount of churn by establishing an additional coverage transition point at 200% FPL between BHP and the exchanges.⁴⁵ One notable advantage is that states could choose to align BHP benefits and plans with Medicaid and offer lower cost sharing as compared to exchange coverage. This could facilitate less disruptive transitions and access to more affordable care for individuals in the 138-200% income range.

The BHP requires significant state investments of resources to establish and integrate a BHP into existing coverage options. As of mid-2016, only two states, Minnesota and New York, have implemented a BHP. Consequently, the BHP is unlikely to be a widely used option by states.

Transition policies

Existing policies in state Medicaid programs designed to ease transitions for individuals moving between different Medicaid managed care plans may help inform options for addressing Medicaid and QHP churning. For example, an analysis published in 2014 found that 16 states and the District of Columbia have policies for Medicaid plan transitions, which range from general directives to more specific policies, such as the transfer of medical records and implementation of continuity of care standards. These can include requirements to maintain existing provider relationships for a period of time, as well as certain transition procedures for particular populations or conditions.⁴⁶ Transition policies could also include contract provisions that require plans to accept prior authorizations from other plans for a defined time period in order to minimize care disruptions for individuals receiving a course of treatment.⁴⁷

Federal policies to reduce churn

The federal government is currently implementing some efforts that have the potential to minimize health coverage churn, particularly around churn caused by nonpayment of QHP premiums. A March

2016 [blog](#) from Kevin Counihan, the director of the Center for Consumer and Information and Insurance Oversight (CCIIO), indicated that CCIIO will be implementing measures to simplify marketplace premium payment procedures for consumers.⁴⁸ Specifically, to help prompt consumers to pay their first premium payment, CCIIO has put in place improved marketplace outreach efforts, which include earlier and more frequent reminders along with clarifications on payment deadlines. CCIIO is also working to improve coordination with insurers to restore coverage for individuals whose coverage was terminated due to challenges in the payment process.

CCIIO also plans to address instances where consumers lose QHP coverage because of a lack of information to confirm eligibility, such as when income or Social Security numbers cannot be verified with other federal data. For example, CCIIO has improved notifications during the application process to help resolve these data matching issues in real time and has implemented other measures designed to help avoid and address these types of problems.

Conclusion

States' measurement of health coverage churn within the context of the ACA is currently in the early stages and highly dependent on the capacity of states to track individuals across different coverage programs. Additional data about the prevalence and causes of churn and the characteristics of individuals that move between coverage sources are necessary to better understand churn patterns. Some analysts predict that churning may be a more significant issue in certain states compared to others because of the numerous factors that can cause churn.⁴⁹ Consequently collecting and analyzing more detailed state-by-state information about churning trends will be useful for policymakers seeking to gain a clearer picture of churn nationwide. More specific state-level data on the frequency of churn will also help to determine whether predictions prior to the ACA's implementation possibly overestimated the degree of churn that would occur, particularly given early findings from Washington state.

Obtaining data on health coverage churn may be challenging for states and may take time, especially for states that have FFMs that are currently unable to obtain specific and identifiable information about enrollees' coverage transitions. Another barrier is that some state officials have reported resource and/or technical capacity limitations in terms of being able to measure churn. However, some states have already taken steps to measure churn or are anticipating being able to do so in the near future, often because of having or moving towards an integrated eligibility system. The current policy discussion concerning churn would also benefit from qualitative information from individuals about whether or not they face challenges in accessing care as they transition across coverage types available now through the ACA.

Churn is inevitable in a health system with multiple income-based sources of coverage and is not always an indication of a problem, especially since the term can include transitions across programs that may have been achieved successfully. However, in states that have not implemented the ACA's Medicaid expansion, individuals may lose coverage altogether when their income changes. In examining churn in states that have expanded Medicaid, key issues will be identifying any challenges that may be associated with moving between Medicaid and QHP coverage. Policymakers should focus on promoting strategies to reduce gaps in coverage and advancing policies that minimize any potential adverse consequences of coverage transitions.

Endnotes

1. Colin Planalp, Brett Fried, and Julie Sonier, “ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level,” State Health Access Data Assistance Center (SHADAC), September 2014. Available at: http://www.shadac.org/sites/default/files/Old_files/shadac/publications/ACADDataAnalytics_Paper%20%234%20Measuring%20and%20Monitoring%20Churn%20for%20web.pdf
2. As of August 2016, 31 states and D.C. have implemented the ACA’s Medicaid expansion.
3. Medicaid and CHIP Payment and Access Commission (MACPAC), Chapter 2, “Promoting Continuity of Medicaid Coverage Among Adults Under Age 65,” March 2014 Report to Congress. Available at: <https://www.macpac.gov/publication/ch-2-promoting-continuity-of-medicaid-coverage-among-adults-under-age-65/>
4. For purposes of this brief, NASHP focused on churn that occurs when individuals move between Medicaid and QHP coverage, and did not focus on individuals moving to uninsurance or examine movement to employer-sponsored or other types of private market coverage or transitions within the Children’s Health Insurance Program (CHIP). NASHP collected responses from state officials in Medicaid, exchange and insurance commissions/departments. The states comprised a mix of those with SBMs, FFMs, and partnership marketplaces. The information about Washington was collected from the state’s public report on measuring churn between Medicaid and QHP coverage, and then verified by the state. The published report is “Churn Between Washington Apple Health and Qualified Health Plans: A Data Analysis,” January 2016. Available at: http://www.wahbexchange.org/wp-content/uploads/2015/12/HBE_EN_160112_Medicaid_QHP_Churn_Analysis.pdf.
5. Further defined as this movement between coverage sources occurring within a time period of 12 months. This brief does not focus on individuals cycling between having coverage and uninsurance.
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7. For individuals that churn between having health coverage and uninsurance, the health consequences have the potential to be even greater, as without any source of coverage individuals may delay treatment or not seek care at all.
8. Shana Lavarreda, Melissa Gatchell, Ninez Ponce, E.Richard Brown, Y. Jenny Chia, “Switching Health Insurance and Its Effects on Access to Physician Services,” *Med Care* 46(10): 1055-63, 2008.
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11. Leighton Ku, Patricia MacTaggart, Fouad Pervez, and Sara Rosenbaum, “Improving Medicaid’s Continuity of Coverage and Quality of Care,” Association for Community Affiliated Plans, July 2009. Available at: <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>
12. Colin Planalp, Brett Fried, and Julie Sonier, “ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level,” State Health Access Data Assistance Center (SHADAC), September 2014. Available at: http://www.shadac.org/sites/default/files/Old_files/shadac/publications/ACADDataAnalytics_Paper%20%234%20Measuring%20and%20Monitoring%20Churn%20for%20web.pdf
13. This is likely due to these individuals receiving more preventive and primary care services, and also because individuals who were previously uninsured may have higher care utilization in the early stages of their enrollment in Medicaid. Leighton Ku, Patricia MacTaggart, Fouad Pervez, and Sara Rosenbaum, “Improving Medicaid’s Continuity of Coverage and Quality of Care,” Association for Community Affiliated Plans, July 2009. Available at: <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>
14. Employer-sponsored coverage is considered affordable under the ACA if the premiums for self-only coverage are no more than 9.66 percent of family income.
15. Benjamin Sommers and Sara Rosenbaum, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” *Health Affairs* 30(2): 228-236, February 2011. Available at: <http://content.healthaffairs.org/content/30/2/228.full>
16. Matthew Buettgens, Austin Nichols, and Stan Dorn, “Churning under the ACA and State Policy Options for Mitigation,” Urban Institute, June 2012. Available at: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF>
17. Benjamin Sommers et al., “Medicaid and Marketplace Eligibility Changes Will Occur Often in all States; Policy Options Can Ease Impact,” *Health Affairs* 33(4): 700-707, April 2014. Available at: <http://content.healthaffairs.org/content/33/4/700.full>
18. Colin Planalp, Brett Fried, and Julie Sonier, “ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level,” State Health Access Data Assistance Center (SHADAC), September 2014. Available at: http://www.shadac.org/sites/default/files/Old_files/shadac/publications/ACADDataAnalytics_Paper%20%234%20Measuring%20and%20Monitoring%20Churn%20for%20web.pdf
19. Colin Planalp, Brett Fried, and Julie Sonier, “ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level,” State Health Access Data Assistance Center (SHADAC), September 2014. Available at: http://www.shadac.org/sites/default/files/Old_files/shadac/publications/ACADDataAnalytics_Paper%20%234%20Measuring%20and%20Monitoring%20Churn%20for%20web.pdf
20. This is only based on the information gathered from the states that NASHP contacted.
21. Regarding renewal of marketplace coverage, enrollees’ eligibility for coverage and financial assistance is redetermined on an annual basis.

Federal regulations allow for the federal marketplace to automatically reenroll eligible individuals in their current coverage unless an individual takes action, and state-based marketplaces can opt to do this as well or develop alternative renewal processes. California allows for automatic renewal of consumers' marketplace coverage and consequently a large number of individuals moved between coverage sources during this annual renewal period.

22. Washington's report focused on movement between Medicaid and QHPs, and did not focus on uninsurance/gaps in coverage.
23. Specifically, 63.6 percent of individuals experiencing their first churn event are from households with mixed coverage, and 62.3 percent of individuals experiencing their second churn event are from households with mixed coverage.
24. Arkansas was previously a partnership marketplace, but is now a designated conditionally approved state-based exchange that will use the federal platform (SBE-FP) in plan year 2017. States with SBE-FPs are considered to be state-based marketplaces and operate core marketplace functions, but they rely on the federal marketplace platform for enrollment and eligibility functions. Arkansas also operates a state-based Small Business Health Options Program (SHOP) marketplace.
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