

By Benjamin D. Sommers, Rebecca Gourevitch, Bethany Maylone, Robert J. Blendon, and Arnold M. Epstein

DOI: 10.1377/hlthaff.2016.0455  
HEALTH AFFAIRS 35,  
NO. 10 (2016): 1816–1824  
©2016 Project HOPE—  
The People-to-People Health  
Foundation, Inc.

# Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many

## Benjamin D. Sommers

(bsommers@hsph.harvard.edu) is an assistant professor of health policy and economics in the Department of Health Policy and Management at the Harvard T. H. Chan School of Public Health, and an assistant professor of medicine at Harvard Medical School/Brigham and Women's Hospital, all in Boston, Massachusetts.

**Rebecca Gourevitch** is a research assistant at the Harvard T. H. Chan School of Public Health.

**Bethany Maylone** is a project manager in the Department of Health Policy and Management, Harvard T. H. Chan School of Public Health.

**Robert J. Blendon** is the Richard L. Menschel Professor of Health Policy and Political Analysis in the Department of Health Policy and Management, Harvard T. H. Chan School of Public Health.

**Arnold M. Epstein** is the John H. Foster Professor of Health Policy and Management at the Harvard T. H. Chan School of Public Health.

**ABSTRACT** Changes in insurance coverage over time, or “churning,” may have adverse consequences, but there has been little evidence on churning since implementation of the major coverage expansions in the Affordable Care Act (ACA) in 2014. We explored the frequency and implications of churning through surveying 3,011 low-income adults in Kentucky, which used a traditional expansion of Medicaid; Arkansas, which chose a “private option” expansion that enrolled beneficiaries in private Marketplace plans; and Texas, which opted not to expand. We also compared 2015 churning rates in these states to survey data from 2013, before the coverage expansions. Nearly 25 percent of respondents in 2015 changed coverage during the previous twelve months—a rate lower than some previous predictions. We did not find significantly different churning rates in the three states over time. Common causes of churning were job-related changes and loss of eligibility for Medicaid or Marketplace subsidies. Churning was associated with disruptions in physician care and medication adherence, increased emergency department use, and worsening self-reported quality of care and health status. Even churning without gaps in coverage had negative effects. Churning remains a challenge for many Americans, and policies are needed to reduce its frequency and mitigate its negative impacts.

**T**he major coverage expansions of the Affordable Care Act (ACA) are now in their third year. Implementation of federal and state-based Marketplaces and Medicaid eligibility expansions have helped bring the nation's uninsurance rate to an all-time low, from 16.0 percent in 2010 to 9.1 percent in 2015.<sup>1</sup> However, expanding coverage is only one of many policy challenges to improving health care. Movement between and out of health plans—often called “churning”—may occur frequently, particularly among lower-income individuals.

The US multipayer health care system creates the possibility of several types of coverage tran-

sitions, many of which predate implementation of the ACA. These transitions include switching into or out of employer-sponsored insurance because of a job change; switching between sources of subsidized coverage because of changes in eligibility (for example, switching from Marketplace to Medicaid and vice versa); loss of coverage because of changes in eligibility (for example, switching from Medicaid to uninsured); switching between plans within the same coverage type, either voluntarily (if a better plan becomes available) or involuntarily (if an insurer exited a Marketplace); and switching because of administrative disruptions in coverage (for example, difficulty with Medicaid renewal).

People going through any one of these transitions may become uninsured for a time. Such a gap is likely to expose people to significant financial risk and impaired access to care.<sup>2,3</sup> But even a transition with no coverage gap may have negative effects because insurance benefits and provider networks often differ across coverage and plan types,<sup>4</sup> and simply changing providers has been linked to adverse outcomes.<sup>5</sup>

Previous research indicates that churning was common even before implementation of the ACA, with annual rates of coverage changes estimated at 12 percent for those with employer-sponsored insurance,<sup>6</sup> 43 percent for those in Medicaid,<sup>2</sup> and 58 percent for those with non-group private insurance.<sup>7</sup> Multiple analyses projected that churning under the ACA would be a major challenge in all states.<sup>8-10</sup> However, there has been limited evidence on actual churning since the law's major coverage expansions took effect in 2014.

Policy makers have considered various approaches to address the problem of churning. One approach, called the private option, is currently in use in Arkansas, where most new Medicaid beneficiaries are enrolled in subsidized Marketplace plans instead of Medicaid.<sup>11</sup> By providing primarily private insurance to both adults with incomes below the ACA's eligibility threshold for Medicaid of 138 percent of the federal poverty level and adults with incomes above the threshold, Arkansas's model may reduce the need for low-income adults to switch provider networks and treatment regimens in response to income fluctuations and other changes in life circumstances.<sup>12</sup> Several other states, including Iowa and New Hampshire, have adopted similar alternative approaches to Medicaid expansion.

In addition to there being little information in the literature on the impact of churning under the ACA, there has been limited evidence about the results of policy efforts to reduce that impact through approaches such as the one employed in Arkansas. In this article we report our findings from a survey of more than 3,000 low-income adults in Arkansas, Kentucky, and Texas in late 2015. Each state has responded in different ways to the ACA's option of expanding eligibility for Medicaid, with Arkansas using the private option; Kentucky expanding eligibility for traditional Medicaid, largely using Medicaid managed care; and Texas not expanding eligibility.

Our objective was to address the following questions: What was the frequency of churning, and what were the risk factors for experiencing it? What were the most common causes of churning? And what were the consequences of churning for access to care, continuity and quality of care, and health? We hypothesized that churning

would have negative impacts on several dimensions of health care but that the private option model in Arkansas would reduce churning rates considerably, compared to a traditional Medicaid expansion.

## Study Data And Methods

**SURVEY DESIGN** We conducted a telephone survey using random digit dialing of both landline and cell phones in Arkansas, Kentucky, and Texas in November and December 2015. The sample was restricted to US citizens ages 19–64 whose family incomes were below 138 percent of the federal poverty level. Interviews could be conducted in either English or Spanish. For all estimates, survey weights were constructed using data from the American Community Survey and the National Health Interview Survey to yield estimates that were representative of low-income adults in each of the three states. Additional details regarding the survey methodology have been published previously.<sup>13,14</sup>

The survey assessed respondents' current insurance status and how many times they had changed coverage during the previous twelve months, defined as "losing, gaining, or switching one's health insurance plan." In the article, for brevity, we refer to these episodes as "churning," although we did not use that language in the survey itself. Respondents who reported any episodes of churning during the previous year were asked a series of questions about the impacts of churning on continuity of provider relationships, prescription medication use, quality of care, and health status. All respondents provided information about demographic characteristics, access to and affordability of care, and use of health care services. When it was feasible, survey questions were adapted from previous surveys.<sup>15-17</sup> The survey was pilot-tested before being fielded (for the questions, see the online Appendix).<sup>18</sup>

The survey response rate was 21 percent, for a total sample of 3,011 respondents distributed evenly across the three states. This survey built on two previous surveys that we conducted in these states in 2013 and 2014 to examine other aspects of health care for low-income adults.<sup>13,14</sup> The previous surveys asked about overall churning frequency, although they did not focus on this issue. Thus, for the measure of churning frequency, we compared the 2015 data to responses from a separate cohort of 2,823 respondents who answered the same question in our 2013 survey,<sup>13</sup> conducted before the ACA's major coverage expansions took effect.

**ANALYSIS** We compared the frequency of churning in each of the three states by examining

the proportion of respondents who, during the previous year, had experienced no coverage changes, one change, or at least two changes. We also estimated the proportions of respondents who changed coverage during the period before the ACA's coverage expansions (2013) and in the period after them (2015), comparing changes after Kentucky's Medicaid expansion, Arkansas's private option, and Texas's lack of expansion. This analysis employed a difference-in-differences regression model that compared the three states before and after the ACA's expansions and that controlled for the state; year; and respondents' race/ethnicity, age, sex, marital status, education, rural versus urban residence, and family size.

Then, using our 2015 survey data, we assessed the causes and implications of churning. We examined current coverage type, the total months of coverage for each individual in the previous year, and the percentage of respondents who had experienced a coverage gap. Respondents were asked to choose the main reason for their coverage change from the following options: going from being uninsured to getting new coverage, changing jobs or job-related coverage, dislike of the old plan, loss of eligibility, inability to afford the old plan, the old plan was no longer available, and inability to complete the renewal process.

Next, we used multivariate logistic regression to identify risk factors for churning. We used the following variables: sex, marital status, rural versus urban residence, whether or not the survey was conducted by cell phone, self-reported health status, having one or more chronic medical condition, age, race/ethnicity, education, income, state, and insurance status.

Our remaining analyses focused on assessing the potential negative consequences of churning. These analyses excluded respondents who had newly gained coverage (that is, those who had previously been uninsured) and focused instead on two distinct groups of people who might have experienced potentially harmful churning: those who had churned with a gap in coverage (a period without any insurance), and those who had churned without a gap in coverage (that is, they had switched from one type of insurance to another without becoming uninsured). We asked respondents in these two groups whether, because of insurance changes, they had to change primary care or specialist providers; whether they had to change or stop taking any prescription medications; and whether their coverage change had a positive, a negative, or no impact on the quality of care they received and their overall health.

Lastly, we investigated whether churning was associated with access to and affordability of

care. These questions were asked of every respondent. For this analysis, we conducted a multivariate logistic regression for each outcome to assess whether churning (with or without a gap in coverage) was associated with a change in that outcome. We estimated our results as adjusted odds ratios and converted them into predicted probabilities, to better convey the absolute change in outcomes after adjustment for covariates. All analyses were conducted using Stata, version 13.1.

**LIMITATIONS** Our study had several limitations. First, the survey's response rate was 21 percent in 2015 and 26 percent in 2013. While these rates are lower than those typically found in US government surveys, weighting to demographic benchmarks has been shown to reduce non-response bias,<sup>19</sup> and previous surveys using random digit dialing with similar response rates have produced estimates related to the ACA that have generally been consistent with results from government surveys.<sup>20-23</sup>

Second, the extent to which the adverse outcomes reported by respondents in our survey can be causally linked to churning is unclear. In part to address this concern, we presented the following two distinct approaches to measuring potential adverse results of churning: We asked respondents what effects they attributed to churning, and then we used multivariate regression to assess whether certain results were more common among those with coverage changes than among other respondents, after adjustment for other factors. However, respondents might not have accurately attributed adverse events to churning, and unmeasured confounders could explain some of the relationships we observed in our regression models.

Finally, our results from three southern states may not be generalizable to other states or regions. However, these states were chosen for their different responses to implementation of the ACA and therefore are useful case studies for how these responses might or might not influence churning and associated outcomes.

## Study Results

### CHURNING RATES AND REASONS FOR COVERAGE

**CHANGES** In 2015 nearly one-quarter of respondents in each state reported one or more changes in health insurance status during the previous twelve months (Exhibit 1). Churning rates were fairly similar across the states both in 2013 (before implementation of the ACA's major coverage expansions) and in 2015 (after implementation). A difference-in-differences logistic regression model showed no significant changes from the 2013 baseline to 2015 based on the

state's expansion policy, with Arkansas's private option associated with an odds ratio for churning of 0.99 compared to Texas ( $p = 0.98$ ), and Kentucky's Medicaid expansion associated with an odds ratio of 1.13 compared to Texas ( $p = 0.61$ ) (data not shown). A linear model showed similar results.

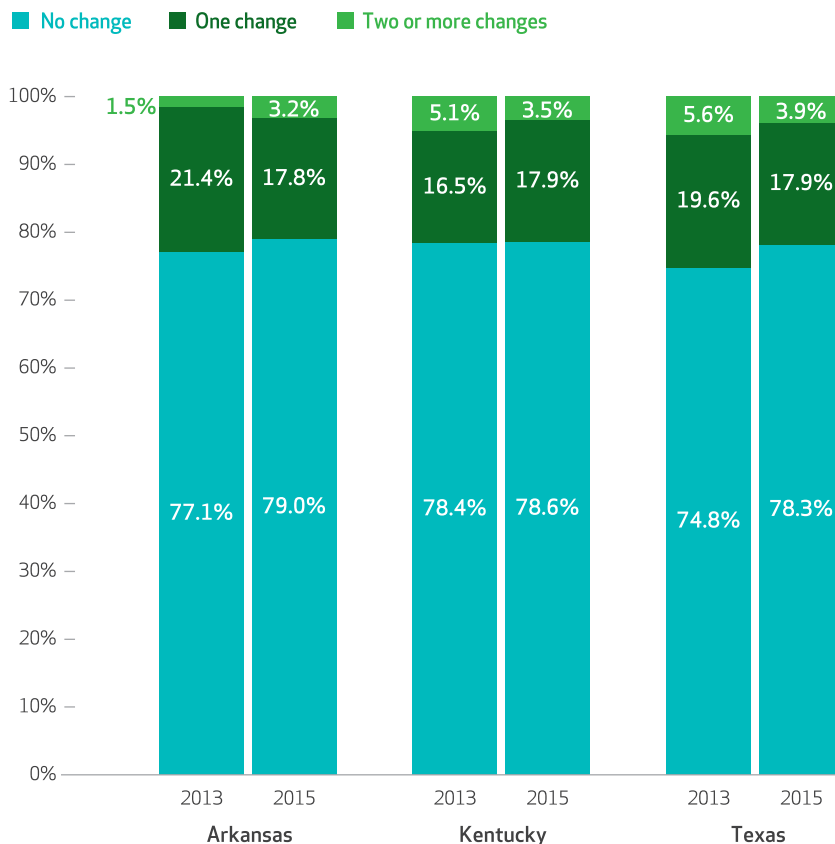
More than half of the respondents who had coverage changes experienced a gap in coverage, and more than a quarter were uninsured for longer than four months (Exhibit 2). Fewer Kentuckians who churned experienced a gap in coverage (47.8 percent), compared to Arkansans (58.4 percent) or Texans (60.7 percent), although this difference was not significant.

Overall, nearly 20 percent of those who churned did so because they gained insurance coverage. The proportion of respondents in Arkansas and Kentucky who gained coverage was approximately double the proportion of respondents who did so in Texas. The remaining respondents churned for other reasons, the most common of which was a change in a job or job-related coverage (33.8 percent). Other reasons included losing eligibility for Medicaid or subsidized Marketplace coverage and inability to afford previous coverage.

Reasons for churning differed significantly across the study states. Respondents in Texas were the most likely to say that they had dropped coverage because they couldn't afford it, while those in Arkansas were the most likely to say that their plan was no longer available. Respondents in Kentucky were the most likely to report trouble with the renewal process in Medicaid or Marketplace coverage as the main reason for churn-

**EXHIBIT 1**

**Frequency of health insurance coverage changes among low-income adults in Arkansas, Kentucky, and Texas**



**SOURCE** Authors' analysis of data from a telephone survey in 2013 and 2015 of adults ages 19-64 with family incomes below 138 percent of the federal poverty level. **NOTES** In 2013, 2,823 adults responded to this survey question; in 2015, 3,011 adults responded. "Changes" refer to changes in health insurance coverage during the previous twelve months.

**EXHIBIT 2**

**Gaps in coverage and reasons for coverage changes among low-income adults in Arkansas, Kentucky, and Texas in 2015**

Adults who changed coverage	All 3 states	Arkansas	Kentucky	Texas	p value
Gap in coverage (n = 551)					
No gap	44.4%	41.6%	52.2%	39.3%	0.15
Any gap	55.6	58.4	47.8	60.7	0.15
Gap of 1-4 months	26.8	25.7	24.4	30.1	0.65
Gap of 5-8 months	16.4	20.4	16.4	12.7	0.36
Gap of 9-11 months	12.5	12.3	7.0	18.0	0.09
Main reason for coverage change (n = 376) <sup>a</sup>					
Went from uninsured to new coverage	19.6	25.8	22.6	11.6	0.09
Change in job or job-related coverage	33.8	31.7	31.9	37.3	0.75
No longer eligible for Medicaid or Marketplace	14.9	11.5	15.8	16.9	0.66
Could no longer afford old plan	14.1	6.2	10.4	24.1	0.007
Old plan no longer available	8.8	19.1	4.6	4.0	<0.001
Couldn't complete renewal process	6.5	3.7	13.6	2.2	0.002
Didn't like old plan	2.4	2.0	1.1	3.8	0.27

**SOURCE** Authors' analysis of data from a telephone survey in 2015 of 3,011 adults ages 19-64 with family incomes below 138 percent of the federal poverty level. **NOTE** Significance refers to differences for each outcome across the three states. <sup>a</sup>The categories exclude nonresponse and "other." Because of a survey administration error, some respondents were not asked to provide a reason for changing coverage. These respondents were not included in the denominator for this result, and the estimates for the remaining respondents were reweighted to account for the demographic characteristics of the excluded respondents.



ing. In our remaining analyses, we excluded respondents who went from uninsured to insured (gained new coverage), because this is a desired result of coverage expansion.

Appendix Exhibit 1 shows which demographic factors were associated with churning in 2015, excluding respondents who went from uninsured to insured.<sup>18</sup> Churning was significantly more common among women and younger adults than among men and older adults; it was less common among Latinos than among whites. Churning was roughly twice as common among respondents with Marketplace coverage or non-group private coverage compared to those with Medicaid, and churning rates were lower in Arkansas and Kentucky than in Texas. Churning did not differ significantly between Arkansas and Kentucky.

**IMPLICATIONS OF COVERAGE CHANGES** Nearly 20 percent of churners had to change at least one doctor as a result of changing coverage in the previous year, and 9 percent had to change both primary care and specialist providers (Exhibit 3). Changing doctors was nearly twice as common among churners with a coverage gap than among those without a gap. Churning also had an impact on medication use: 16.2 percent of churners had to switch or change their prescription medications as a result of a coverage change, while 33.9 either skipped doses or stopped taking medications. Skipping medications was twice as common among those with coverage gaps than among those without gaps.

Approximately half of churners with a cover-

age gap reported that their coverage change had had a negative effect on the overall quality of their medical care and on their health. Even among those who switched coverage without a gap, more than 20 percent reported negative effects on quality of care and health.

Appendix Exhibit 2 shows these outcomes by state.<sup>18</sup> The proportion of churners who had to change doctors because of coverage changes was significantly higher in Texas (32.3 percent) than in Arkansas (14.1 percent) or Kentucky (11.4 percent). However, changes in health care quality or health associated with churning did not differ significantly across the three states.

After we controlled for factors such as demographic characteristics, health status, current insurance, and state of residence, churners with a coverage gap were significantly more likely than nonchurners to have changed doctors because of insurance reasons, skipped taking prescription medications or delayed getting needed care because of cost, had trouble paying medical bills, and reported medical care that was fair or poor quality (Exhibit 4).

Respondents who churned without any gap in coverage still experienced challenges. Compared to those who did not churn, people in this group were more likely to have changed doctors and to have more trouble getting appointments with primary care and specialist providers, and were more likely to go to the emergency department because they could not obtain an outpatient appointment. They were also more likely to report receiving fair- or poor-quality medical care.

### EXHIBIT 3

#### Health care disruptions related to changes in coverage among low-income adults in Arkansas, Kentucky, and Texas, 2015

Outcome	Adults who changed coverage			p value
	All (n = 475)	Coverage gap (n = 231)	No coverage gap (n = 244)	
Had to change any doctor <sup>a</sup>	19.8%	25.2%	13.3%	0.02
Had to change primary care doctor	6.1	7.0	5.0	0.49
Had to change a specialist	2.1	1.9	2.3	0.79
Had to change primary care doctor and a specialist	9.1	11.5	6.2	0.15
Had to change prescription medications when changing insurance	16.2	17.0	15.3	0.73
Skipped doses or stopped taking prescription medications when changing insurance	33.9	44.9	22.4	0.001
Overall quality of medical care declined	41.3	51.7	28.8	<0.001
Overall health declined	35.6	47.3	21.5	<0.001

**SOURCE** Authors' analysis of data from a telephone survey in 2015 of adults ages 19–64 with family incomes below 138 percent of the federal poverty level. **NOTES** Of all respondents, 571 reported a coverage change in 2015, but we excluded from this analysis the 78 who went from being uninsured to being insured and an additional 18 who reported a coverage change but did not indicate whether or not they had a gap in coverage. All estimates exclude respondents who did not respond to that survey item. Significance refers to the difference between those with and those without a coverage gap. <sup>a</sup>Percentages of those who had to change particular types of doctors do not sum to the total because some respondents who reported changing any doctor chose not to answer the follow-up question.

**EXHIBIT 4**

**Association between coverage changes and access to care for low-income adults in Arkansas, Kentucky, and Texas, 2015**

Outcome	Adults who changed coverage				Adults who did not change coverage <sup>a</sup> (n = 2,477)
	With a coverage gap (n = 231)		Without a coverage gap (n = 244)		
	Odds ratio	Predicted probability	Odds ratio	Predicted probability	
Have a personal doctor	1.07	63.6%	1.15	64.7%	62.4%
Had to change any doctor	4.63***	23.5	1.87**	11.9	7.0
Trouble getting a primary care appointment	1.59*	18.5	1.81**	20.4	12.9
Trouble getting a specialist appointment	1.43	17.7	2.03***	22.7	13.6
Went to ED because no outpatient appointment was available	1.04	11.9	1.84**	18.5	11.5
Did not take medications because of cost	2.52***	44.3	1.11	28.1	26.3
Did not get needed care because of cost	3.54***	53.9	1.20	31.4	28.0
Medical care was fair or poor quality	1.76**	25.6	1.75**	25.6	17.3
Trouble paying medical bills	2.95***	50.6	1.11	30.1	28.2
Out-of-pocket spending >\$1,000	2.22***	25.8	1.32	18.1	14.8
Out-of-pocket spending >\$200	2.01***	51.3	1.37	43.3	36.8

**SOURCE** Authors' analysis of data from a telephone survey in 2015 of adults ages 19–64 with family incomes below 138 percent of the federal poverty level. **NOTES** Models adjusted for sex, age, race/ethnicity, education, family income, marital status, rural versus urban residence, self-reported health status, presence of chronic conditions, insurance status, months without insurance, state, and whether or not the interview was conducted by cellular telephone. Respondents who went from uninsured to insured (that is, who gained coverage) were included in the group who did not change coverage. The results for each row excludes people who did not respond to that item; we also excluded forty-one respondents who did not answer the question about coverage changes and eighteen who reported a coverage change but did not answer whether or not they had a coverage gap. Predicted probabilities were calculated from logistic regression estimates using Stata's "margins" command with default settings, which holds all other covariates at their actual values. ED is emergency department. <sup>a</sup>Because this is the reference group, all odds ratios were 1.00. \*p < 0.10 \*\*p < 0.05 \*\*\*p < 0.01

**Discussion**

The ACA has reduced the uninsurance rate to a historic low. However, our study of insurance dynamics since the law's major coverage expansions provides important new evidence that the negative impact of churning remains a significant challenge for many Americans. In our 2015 survey of more than 3,000 low-income adults in three states, we found that nearly one in four respondents had changed coverage in the previous twelve months. Although these numbers are lower than projected before implementation of the ACA's major coverage expansions,<sup>8,9</sup> they are still substantial, and they were not reduced by use of the private option model in Arkansas.

Approximately 20 percent of the respondents who changed coverage were uninsured people who gained coverage. For the remainder, churning caused problems—forcing respondents to change doctors; change prescription medications, skip doses, or stop taking the medications altogether; and experience what they perceived to be negative changes in quality of care and health.

**CONSISTENCY ACROSS STUDIES** These results are consistent with evidence before implementation of the ACA's major coverage expansions that insurance changes and switching clinicians can erode perceived health care quality.<sup>3,24</sup> But to our

knowledge, our study is the first to examine the adverse impacts of churning since the coverage expansions took effect.

Moreover, our analysis adds nuance to the results of previous research by distinguishing between churners who had gaps in coverage and those who did not. While those with gaps experienced the worst outcomes, even among churners who did not have a gap in coverage, 13 percent had to change at least one provider, 22 percent skipped doses or stopped taking prescription medications, and 29 percent reported an overall harmful effect on the quality of their health care. Our findings suggest that in addition to reducing gaps in coverage, policy makers must also improve transitions in coverage to address the potential harms caused by churning.

**LESS CHURNING THAN PREDICTED** While churning itself is clearly problematic for health care continuity, overall rates of churning in our sample were much lower than predicted by many analyses before the ACA's coverage expansions took effect. For example, one study projected that within twelve months of initial enrollment, as many as half of all Marketplace and Medicaid beneficiaries could experience a coverage change.<sup>9</sup> Instead, we found that fewer than 25 percent of people churned in 2015. Moreover, the majority of coverage changes were of a dif-

ferent nature than the Medicaid-to-Marketplace churning that was the focus of much of the research before 2014 (for example, many of our respondents reported changes in employer-sponsored coverage or plan switching between Marketplace offerings).

In part, these differences reflect differences in study samples: Previous projections referred to Marketplace and Medicaid beneficiaries,<sup>8,9</sup> whereas our sample contained low-income respondents across all coverage types. While Marketplace beneficiaries in our sample did experience high rates of churning, we found that churning rates in Medicaid were actually lower than those in other kinds of coverage, including employer-sponsored insurance. This pattern is consistent with administrative data from seven states, which showed modest churning (2–13 percent) between Medicaid and Marketplace coverage in 2014.<sup>25</sup>

In addition, projections before implementation of the ACA's coverage expansions<sup>8,9</sup> typically assumed that monthly fluctuations in income would be reported promptly and acted upon by states, as required by law. But in practice, people might not report such changes in a timely manner, or states may be slow to respond. The Centers for Medicare and Medicaid Services (CMS) gave states the option of delaying the annual eligibility redetermination process in Medicaid for 2014, and more than two-thirds of states did so.<sup>26</sup> Both slow reporting of income changes and delays in redetermination may have blunted the potential for frequent income-based churning, which was not the main cause for coverage switching in our sample. More commonly, churning in our study was the result of job-related changes in insurance.

Nonetheless, even at an annual rate of almost 25 percent, churning affected a substantial portion of our sample and was strongly associated with adverse consequences. Moreover, in addition to the adverse effects on consumers identified in our survey, churning has other potential impacts—including higher administrative costs for states and plans, difficulty in measuring plan quality for members who leave midyear, and reduced incentives for plans to make long-term investments in beneficiaries' health.<sup>10</sup>

**POLICY CHALLENGES** Our findings raise important policy challenges. One potential solution was Arkansas's private option, which some policy makers and analysts had hoped would reduce the frequency and negative effects of churning.<sup>12</sup> In theory, the private option allows coverage to remain constant in spite of changes in income: Enrollees could keep their health plans and doctors, while only premiums would change. However, we found no evidence that churning rates

among low-income people were lower under the private option than under Kentucky's traditional Medicaid expansion.

Given predictions that the private option would reduce churning dramatically,<sup>12</sup> how can we explain our findings? In part, they reflect the multifaceted nature of coverage changes in these states. Transitions from Marketplace to Medicaid and vice versa were only a portion of the frequent coverage changes we observed. The gain or loss of employer coverage, switches between private plans, and difficulties in renewing enrollment in Medicaid or Marketplace coverage all played varying roles in the different states.

Additionally, some evidence points to Arkansas's renewal process as a contributor. In mid-2015 the state imposed a ten-day response window in which private-option beneficiaries had to provide proper documentation of eligibility; failure to respond resulted in a termination of benefits. As a result of this policy, nearly 50,000 people were dropped from coverage.<sup>27</sup> Furthermore, only one of the three original issuers in 2014 remained in the Arkansas Marketplace in 2015 (there were three new entrants in 2015), which is consistent with our finding that Arkansas respondents were more likely than those in either of the other two states to report churning because their old plan was no longer available.<sup>28</sup>

Turnover in Marketplace offerings has been a challenge in other states as well. In Texas only four of the twelve issuers from 2014 returned in 2015—when there were ten new entrants.<sup>28</sup> And in October 2015, Kentucky Health Cooperative (the state's Marketplace co-op) announced that it would cease operations by the end of the year, though other issuers did remain active in the state's Marketplace.<sup>29</sup> Moreover, Kentucky's decision to dismantle its state Marketplace and shift to the federal Marketplace in 2017 raises the prospect of further disruptions in coverage in the state. More broadly, whether Marketplace offerings will become more stable over time in these states and elsewhere is an open question.

However, even with stable offerings, plan switching within Marketplaces may be frequent. To capitalize on competition between plans, frequent plan switching may be an essential component of a well-functioning market. In fact, President Barack Obama's administration has encouraged Marketplace beneficiaries to shop for different plans during open enrollment periods and consider changing coverage each year.<sup>30</sup>

In this context, what policy options remain available to decrease the incidence of churning or its adverse consequences? Twelve-month continuous eligibility for Medicaid, which has been part of the generally successful national effort to improve retention rates for children,<sup>31</sup> has only

# 20%

## Gained coverage

Nearly 20 percent of those who churned did so because they gained insurance coverage in 2015. Nearly 34 percent churned for a job-related reason.

recently become an option for adults. CMS has informed states that they can apply through an accelerated process for a section 1115 waiver that allows them to use twelve-month continuous eligibility for adult beneficiaries, but to date only New York has adopted this approach.<sup>26</sup>

The use of another option for states under the ACA—creating a Basic Health Program to cover people whose incomes are less than 200 percent of poverty in a single state program—may also reduce churning. This approach moves the transition point between being eligible for Medicaid and being eligible for subsidized Marketplace insurance from 138 percent of poverty to 200 percent. However, there is no evidence to date on this policy's effects on churning other than pre-ACA projections,<sup>32</sup> which suggests the need for additional research to evaluate this approach.

Another set of policy options focuses less on reducing coverage changes and more on reducing the changes' negative impacts. In this regard, we found some evidence that either form of coverage expansion—expanding traditional Medicaid or using the private option—is preferable to not expanding eligibility in terms of the likelihood of changing providers. Adults in Texas were two to three times more likely to have to switch providers after churning than were their counterparts in Arkansas and Kentucky, and it is likely that some of this difference is a direct effect of Texas's decision not to expand Medicaid. Simply put, coverage expansion is an important tool for reducing the harms of churning by reducing the risk that churners will have a coverage gap.

Another promising policy option to mitigate the impact of churning is the use of multimarket plans, which can enable individuals to keep the

same provider network and benefit design as they move between Medicaid and Marketplace coverage. One 2016 estimate is that 40 percent of all insurers that offer Marketplace plans also offer a Medicaid managed care plan in the same state, and thirty-six states had at least one such “overlap” insurer.<sup>33</sup> Policies to encourage the development of overlap insurers in the remaining states could improve the continuity of care.

However, this option addresses only churning between Medicaid and a Marketplace. Continuity of care across other coverage transitions requires broader action, such as New York's law that requires up to sixty days of coverage for treatment after a change in insurance plans and up to ninety days after a change in provider networks for patients who are pregnant or have serious conditions.<sup>34</sup> Extending this sort of approach nationally could provide an important safeguard for patients.

## Conclusion

Churning rates in the three states we studied do not appear to be as high as initially feared before implementation of the ACA's major coverage expansions, but nearly one-quarter of the low-income population changes coverage annually. Patients report that these changes in coverage reduce access to care and harm the continuity and quality of care. As the law's coverage expansions take hold, policy makers and researchers will need to ensure that the ACA's impressive insurance gains are not compromised for many Americans by gaps in coverage and disruptions in care over time. ■

This project was supported by a grant from the Commonwealth Fund. Benjamin Sommers's work on this project was also supported in part by the Agency for Healthcare Research and Quality (AHRQ; Grant No. K02HS021291). Arnold

Epstein serves in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (HHS), but the views presented here are those of the authors and do not represent the views

of HHS, AHRQ, or the Commonwealth Fund. The authors appreciate helpful feedback from Sara Collins and Sara Rosenbaum.

## NOTES

- 1 Cohen RA, Martinez ME, Zammit EP. Health insurance coverage: early release of estimates from the National Health Interview Survey, 2015 [Internet]. Hyattsville (MD): National Center for Health Statistics; 2016 May [cited 2016 Aug 3]. Available from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf>
- 2 Banerjee R, Ziegenfuss JY, Shah ND. Impact of discontinuity in health insurance on resource utilization. *BMC Health Serv Res.* 2010;10:195.
- 3 Olson LM, Tang SF, Newacheck PW. Children in the United States with

- discontinuous health insurance coverage. *N Engl J Med.* 2005; 353(4):382–91.
- 4 Rosenbaum S, Lopez N, Dorley M, Teitelbaum J, Burke T, Miller J. Mitigating the effects of churning under the Affordable Care Act: lessons from Medicaid [Internet]. New York (NY): Commonwealth Fund; 2014 Jun [cited 2016 Aug 3]. Available from: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1754\\_rosenbaum\\_mitigating\\_effects\\_churning\\_aca\\_rb\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1754_rosenbaum_mitigating_effects_churning_aca_rb_v2.pdf)
- 5 Wasson JH, Sauvigne AE,

- Mogielnicki RP, Frey WG, Sox CH, Gaudette C, et al. Continuity of outpatient medical care in elderly men. A randomized trial. *JAMA.* 1984; 252(17):2413–7.
- 6 Cutler DM, Gelber AM. Changes in the incidence and duration of periods without insurance. *N Engl J Med.* 2009;360(17):1740–8.
- 7 Sommers BD. Insurance cancellations in context: stability of coverage in the nongroup market prior to health reform. *Health Aff (Millwood).* 2014;33(5):887–94.
- 8 Sommers BD, Graves JA, Swartz K, Rosenbaum S. Medicaid and mar-



- ketplace eligibility changes will occur often in all states; policy options can ease impact. *Health Aff (Millwood)*. 2014;33(4):700–7.
- 9 Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Aff (Millwood)* 2011;30(2):228–36.
  - 10 Buettgens M, Nichols A, Dorn S. Churning under the ACA and state policy options for mitigation [Internet]. Washington (DC): Urban Institute; 2012 Jun [cited 2016 Aug 3]. Available from: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF>
  - 11 Guyer J, Shine N, Musumeci M, Rudowitz R. A look at the private option in Arkansas [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2015 Aug 26 [cited 2016 Aug 3]. Available from: <http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>
  - 12 Rosenbaum S, Sommers BD. Using Medicaid to buy private health insurance—the great new experiment? *N Engl J Med*. 2013;369(1):7–9.
  - 13 Epstein AM, Sommers BD, Kuznetsov Y, Blendon RJ. Low-income residents in three states view Medicaid as equal to or better than private coverage, support expansion. *Health Aff (Millwood)*. 2014;33(11):2041–7.
  - 14 Sommers BD, Blendon RJ, Orav EJ. Both the “private option” and traditional Medicaid expansions improved access to care for low-income adults. *Health Aff (Millwood)*. 2016;35(1):96–105.
  - 15 Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: 2012 summary data quality report [Internet]. Atlanta (GA): CDC; 2013 Jul 3 [cited 2016 Aug 3]. Available from: [https://www.cdc.gov/brfss/annual\\_data/2012/pdf/summarydataqualityreport2012\\_20130712.pdf](https://www.cdc.gov/brfss/annual_data/2012/pdf/summarydataqualityreport2012_20130712.pdf)
  - 16 Long SK, Kenney GM, Zuckerman S, Goin DE, Wissoker D, Blavin F, et al. The Health Reform Monitoring Survey: addressing data gaps to provide timely insights into the Affordable Care Act. *Health Aff (Millwood)*. 2014;33(1):161–7.
  - 17 National Center for Health Statistics. National Health Interview Survey [Internet]. Hyattsville (MD): NCHS; 2015 Oct [cited 2016 Aug 18]. (NCHS Fact Sheet). Available from: [https://www.cdc.gov/nchs/data/factsheets/factsheet\\_nhis.htm](https://www.cdc.gov/nchs/data/factsheets/factsheet_nhis.htm)
  - 18 To access the Appendix, click on the Appendix link in the box to the right of the article online.
  - 19 Pew Research Center for the People and the Press. Assessing the representativeness of public opinion surveys [Internet]. Washington (DC): The Center; 2012 May 15 [cited 2016 Aug 3]. Available for download from: <http://www.people-press.org/2012/05/15/assessing-the-representativeness-of-public-opinion-surveys/>
  - 20 Collins SR, Rasmussen PW, Doty MM, Beutel S. The rise in health care coverage and affordability since health reform took effect: findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014 [Internet]. New York (NY): Commonwealth Fund; 2015 Jan [cited 2016 Aug 3]. (Issue Brief). Available from: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800\\_collins\\_biennial\\_survey\\_brief.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf)
  - 21 Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. *JAMA*. 2015;314(4):366–74.
  - 22 Black LI, Cohen RA. Insurance status by state Medicaid expansion status: early release of estimates from the National Health Interview Survey, 2013–September 2014 [Internet]. Hyattsville (MD): National Center for Health Statistics; 2015 May [cited 2016 Aug 3]. Available from: [https://www.cdc.gov/nchs/data/nhis/health\\_insurance/MedExAUER.pdf](https://www.cdc.gov/nchs/data/nhis/health_insurance/MedExAUER.pdf)
  - 23 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance coverage and the Affordable Care Act [Internet]. Washington (DC): ASPE; 2015 May 5 [cited 2016 Aug 3]. Available from: [https://aspe.hhs.gov/sites/default/files/pdf/139211/ib\\_uninsured\\_change.pdf](https://aspe.hhs.gov/sites/default/files/pdf/139211/ib_uninsured_change.pdf)
  - 24 Orfield C, Hula L, Barna M, Hoag S. The Affordable Care Act and access to care for people changing coverage sources. *Am J Public Health*. 2015;105(Suppl 5):S651–7.
  - 25 Dickson V. Income-based “churn” in coverage less common than feared. *Modern Healthcare* [serial on the Internet]. 2015 Apr 22 [cited 2016 Aug 3]. Available from: <http://www.modernhealthcare.com/article/20150422/NEWS/150429959>
  - 26 Brooks T, Touschner J, Artiga S, Stephens J, Gates A. Modern era Medicaid: findings from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP as of January 2015 [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2015 Jan [cited 2016 Aug 3]. Available from: <http://kff.org/health-reform/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015/>
  - 27 Ramsey D. The 10-day cancellations and the rocky transition off of the private option. *Arkansas Blog* [blog on the Internet]. 2015 Aug 8 [cited 2016 Aug 3]. Available from: <http://www.arktimes.com/ArkansasBlog/archives/2015/08/08/10-day-cancellations-lead-to-rocky-transition-off-of-the-private-option>
  - 28 Data.HealthCare.gov. QHP landscape individual market medical [Internet]. Washington (DC): Department of Health and Human Services; [cited 2016 Aug 3]. Available from: <https://data.healthcare.gov/dataset/QHP-Landscape-Individual-Market-Medical/b8insz6k>
  - 29 Kentucky Health Cooperative not offering plans in 2016. *PR Newswire* [serial on the Internet]. 2015 Oct 9 [cited 2016 Aug 3]. Available from: <http://www.prnewswire.com/news-releases/kentucky-health-cooperative-not-offering-plans-in-2016-300157384.html>
  - 30 Mangan D. Government to Obama-care customers: shop more. *CNBC* [serial on the Internet]. 2015 Oct 28 [cited 2016 Aug 17]. Available from: <http://www.cnbc.com/2015/10/28/full-obamacare-rate-picture-has-yet-to-be-released.html>
  - 31 Kenney GM, Lynch V, Haley J, Huntress M, Resnick D, Coyer C. Gains for children: increased participation in Medicaid and CHIP in 2009 [Internet]. Washington (DC): Urban Institute; 2011 Aug [cited 2016 Aug 3]. Available from: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412379-Gains-for-Children-Increased-Participation-in-Medicaid-and-CHIP-in-.PDF>
  - 32 Hwang A, Rosenbaum S, Sommers BD. Creation of state basic health programs would lead to 4 percent fewer people churning between Medicaid and exchanges. *Health Aff (Millwood)*. 2012;31(6):1314–20.
  - 33 Association for Community Affiliated Plans. Overlap between Medicaid health plans and QHPs in the Marketplaces: an examination [Internet]. Washington (DC): The Association; [updated 2015 Jan; cited 2016 Aug 3]. Available from: <http://communityplans.net/Portals/0/2015%20ACAP%20QHP%20Analysis%20Brief.pdf>
  - 34 New York Department of Financial Services. Your rights as a health insurance consumer [Internet]. New York (NY): The Department; [updated 2015 Mar 12; cited 2016 Aug 3]. Available from: <http://www.dfs.ny.gov/consumer/heights.htm>