



Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic

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KEY POINTS

- Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.
- Studies indicate that beneficiaries moving in and out of Medicaid coverage (sometimes called “churning”) results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.
- One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs (\$371/month in 2021 after adjusting for inflation) than those with six months of coverage (\$583/month) or only three months of coverage (\$799/month).
- The postpartum period is a particularly high-risk time for churning as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months compared to 35 percent of women with private insurance. This is of particular concern for pregnant women of color, who experience large disparities in maternal mortality before and after childbirth and account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population.
- The Families First Coronavirus Recovery Act has helped reduce Medicaid churning, temporarily, through its continuous enrollment requirements for enhanced funding for the duration of the COVID-19 Public Health Emergency.
- State decisions, such as adopting the Affordable Care Act’s Medicaid expansion to adults and the extended continuous eligibility option for postpartum coverage starting in April 2022 under the American Rescue Plan, can play an important role in reducing rates of churning.

INTRODUCTION

Coverage disruptions and coverage loss in Medicaid, often referred to as “churning,” frequently occur among Medicaid beneficiaries. Difficulties navigating state renewal and redetermination procedures – even among individuals who are still eligible – as well as income fluctuations and changing family circumstances can lead to the loss of coverage. Churning occurs when people lose Medicaid and then re-enroll within a short period of time. Gaps in health coverage occur because many people experiencing churning do not transition successfully to Marketplace or employer-based coverage for the months in which they were not enrolled in Medicaid.¹ The Families First Coronavirus Response Act (FFCRA) maintenance of eligibility (MOE) and continuous enrollment requirements have temporarily halted most Medicaid churning. Under the continuous enrollment provision in FFCRA, states that accept the law’s temporary increase in federal Medicaid funding are prohibited from

terminating most beneficiary enrollment for the duration of the public health emergency with limited exceptions.¹ This Issue Brief reviews evidence on churning among the Medicaid population and different policy options for states and the federal government to reduce churning, including continuous eligibility, Medicaid expansion to adults, express lane eligibility, presumptive eligibility, multimarket plans, and limiting premiums and cost-sharing.

PREVALENCE AND CAUSES OF MEDICAID CHURN

Prevalence of Medicaid Churn

The typical Medicaid beneficiary is covered for less than 10 months out of the year. Length of coverage is slightly higher for beneficiaries with disabilities (10.8 months) and seniors (10.3 months), and lower for non-elderly, non-disabled adults (about 8.6 months).^{2,3} One study found nearly 25 percent of Medicaid beneficiaries changed coverage within one year and most of these beneficiaries (55 percent) also experienced a gap in coverage.⁴ Churning rates are somewhat lower in children, in part due to higher income eligibility levels and policies designed to improve continuity of coverage in this population; however, not all states have taken advantage of federal policy options that could reduce churning among children further.^{5,6} The postpartum period is a particularly high-risk time for churning, as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months, compared to 35 percent of women with private insurance. Pregnant women are also more likely to experience a coverage gap after delivery if they do not speak English at home or have a family income between 100–185 percent of the federal poverty level (FPL).⁷

State Eligibility and Renewal Policies

Policies that affect individuals' ability to maintain Medicaid coverage vary by state. As of January 2020, 23 states have adopted the Medicaid state option to provide a full 12 months of continuous eligibility for children.⁸ In the 36 states that have implemented the Medicaid adult group expansion, the median income eligibility limit for all non-elderly adults is 138 percent of the FPL. In non-expansion states, the median income eligibility limit for parents is 41 percent of FPL, and other adults without disabilities are generally ineligible for Medicaid regardless of their income level with the exception of a few state demonstrations (e.g., Georgia, South Carolina and Wisconsin). More restrictive eligibility criteria mean that modest and temporary increases in monthly income can lead to loss of Medicaid eligibility, even among very low-income beneficiaries.

States are required to review eligibility only once every 12 months for beneficiaries whose eligibility is based on Modified Adjusted Gross Income (MAGI) methodologies and at least once every 12 months for non-MAGI beneficiaries. States must first attempt to renew eligibility for all beneficiaries based on available information prior to contacting the individuals. The state must provide MAGI enrollees, for whom the state cannot renew eligibility based on available information, at least 30 days to return their renewal form and any required information. Between yearly renewals, enrollees must timely report changes that may affect eligibility (e.g., income changes) and states can conduct periodic data checks to identify potential changes. In 2020, 30 states reported periodic data checks however, as of March 2021, five states have discontinued periodic data checks during the public health emergency. If the state has information indicating an enrollee has experienced a change, it must request additional information from the individual. Some states provide as few as 10 days for enrollees to respond, raising concerns about the limited time allowed to gather appropriate documentation, which means eligible individuals may lose coverage if they do not respond to state information requests within the required timeframe.

¹ Exceptions include when a beneficiary's state residence changes or voluntary disenrollment from the program.

In some cases, state compliance with eligibility redetermination policies can result in significant coverage declines. In 2018, enrollment in Medicaid and the Children’s Health Insurance Program (CHIP) decreased by over 1.5 million enrollees, and there is evidence that state enrollment policies were a driving factor. For example, the three states with the largest percentage drops in enrollment - Tennessee, Arkansas, and Missouri - required the use of phone or mail for eligibility renewals, which can be fraught with problems. Beneficiaries may change addresses or miss mailings, and phone applications typically involve long wait times and problematic voice interfaces.⁹ In Missouri, enrollment dropped by 70,000 in one year, including 55,000 children, mostly due to families not returning a mailed renewal form created by the state’s new automated eligibility system. In Tennessee, after the state started conducting manual eligibility redeterminations in 2016 using a complex renewal packet, there was a nearly 10 percent decrease in Medicaid enrollment (over 148,000 individuals) between 2017 and 2018. Tennessee was under an approved mitigation plan at this time and had not conducted renewals for several years. While some disenrolled individuals were likely not eligible and needed to be terminated, eligible people were also disenrolled during this process.¹⁰

There is generally less Medicaid churning among children compared to other Medicaid populations, as noted earlier. In states with more restrictive redetermination policies, however, churning can be high among children as well. For example, about 90 percent of the coverage loss in Texas between December 2017 and 2018 was among children (over 144,000 enrollees), similar to Missouri’s experience in 2018. Texas conducts multiple checks of state income data throughout the year and sends routine mailings to parents and caregivers to verify income. These requests require a response within 10 days or children are at risk of coverage loss. This restrictive time period for verifying income has resulted in Medicaid coverage loss for children; for instance, the Texas Children’s Health Coverage Coalition reported that missing the 10-day window for a response accounts for over 90 percent of the losses in coverage.¹¹

Income Fluctuations

Research shows that people with lower incomes are more likely to experience frequent income fluctuations compared to higher income populations. One study of low and moderate-income households found that they experienced an average of 2.5 months each year in which income fell by more than 25 percent, and 2.6 months in which income increased by 25 percent.¹² This is far greater than income fluctuations seen among higher earners. For example, a 2014-2015 survey of 5,661 individuals about family finances found 53 percent of low-income households (less than \$25,000 per year) experienced significant income changes (i.e., changes greater than 25 percent) compared to 27 percent of upper income households (\$85,000 or more per year).¹³

Moreover, people of color and those with less education experience greater income volatility.¹⁴ In the 2014-2015 survey, 38 percent of Black households and 45 percent of Hispanic households experienced income volatility, compared to 32 percent of white households. In that same year, 40 percent of households with a high school diploma or less experienced income volatility compared to 28 percent of households with a bachelor’s degree. These income changes in turn can make individuals temporarily ineligible for Medicaid for short periods of time before their income changes again and they reestablish eligibility, requiring them to re-enroll in coverage. Income fluctuations have become even more common during the COVID-19 pandemic.¹⁵

IMPACTS OF MEDICAID CHURNING

Continuity of Care and Health Outcomes

People who experience churning or coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits. One study found that unstable Medicaid coverage increased emergency department use, office visits, and hospitalizations between 10 percent and 36 percent and decreased use of prescription medications by 19 percent, compared to individuals with consistent Medicaid coverage.¹⁶ Children with interruptions in coverage also are more likely to have delayed care, unmet medical needs, and unfilled prescriptions.¹⁷ Lack of coverage affects access to

care, and even short periods of uninsurance affect access. One study found individuals lacking coverage for 1-5 months had worse access to care compared with those covered for all 12 months.¹⁸

While disruptions in coverage often lead to periods of uninsurance, transitioning between health plans can also result in impeded access to care due to differing provider networks, benefits, and drug formularies. One study examining low-income adults whose insurance status changed but did not have a gap in coverage found that 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.¹⁹ An analysis of one health insurance carrier in 2019 found one-third of Medicaid expansion enrollees changed coverage type (i.e., fee-for-service, Medicaid managed care or individual market plans) or disenrolled within one year, and one-third of those who left re-enrolled with the same payer within one year.²⁰ Moreover, a 2015 survey of low-income adults in Arkansas, Kentucky, and Texas found one in four respondents changed health coverage at least once. Over half of respondents who changed insurance plans experienced a gap in coverage, and 47 percent reported a decline in their overall health.²¹

Administrative and Beneficiary Costs

Churning increases administrative costs and is associated with more avoidable and less predictable expenditures on medical care by beneficiaries cycling in and out of Medicaid. A 2015 analysis estimated the administrative cost of one person's churning, including disenrolling and reenrolling, to cost between \$400 and \$600.²² Providers and Medicaid managed care organizations are also burdened by churning as it limits the ability to provide effective care and achieve managed care quality requirements, and increases administrative costs, such as the costs of processing new applications.²³

While churning lowers Medicaid medical expenditures by creating smaller monthly patient caseloads, it can lead to higher monthly per member costs. Some studies suggest people who churn in and out of coverage have higher Medicaid monthly health care costs due to pent-up demand for health care services after a period of ineligibility.²⁴ One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs (\$371/month enrolled in 2021 after adjusting for inflation) than those with six months of coverage (\$583/month enrolled) or only three months of coverage (\$799/month enrolled).²⁵ Cost impacts may be especially pronounced for beneficiaries with chronic conditions. For example, Medicaid beneficiaries with diabetes with a lapse in coverage had per member per month costs that were \$239 greater during the three months after reenrollment than in the three months prior to the coverage lapse.²⁶ Thus, by reducing churn, states spend more on Medicaid overall, but do so in a more efficient manner that improves care for beneficiaries: continuous coverage leads to more predictability in monthly caseload expenditures, lower average monthly spending, lower enrollee spending on administrative costs, and better overall continuity of care for beneficiaries.

FAMILIES FIRST CORONAVIRUS RESPONSE ACT

Maintenance of Eligibility and Continuous Enrollment

FFCRA provides a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for certain Medicaid spending to support states and promote coverage stability during the pandemic. To receive the enhanced FMAP, states must meet certain maintenance of eligibility (MOE) requirements, including ensuring continuous enrollment for current enrollees through the end of the public health emergency.²⁷ Following enrollment declines from 2017 through 2019, preliminary data show that total Medicaid and CHIP enrollment grew to 77.3 million in September 2020, an increase of almost 6.7 million (9.4 percent) from actual enrollment in February.²⁸ Medicaid enrollment is increasing at a much greater rate than applications. Thus, enrollment increases are likely being driven by existing enrollees remaining eligible due to the FFCRA MOE requirements.²⁹

Upon conclusion of the public health emergency, normal state Medicaid operations will resume, including eligibility redetermination. This will represent a substantial and unprecedented undertaking for Medicaid programs, with the potential for significant coverage losses and disruptions. The end of the public health emergency may be a natural time to consider making Medicaid coverage more stable and less administratively burdensome using some of the policies described in this Issue Brief, including the American Rescue Plan's (ARP) new option for continuous eligibility for women after childbirth.

POLICY OPTIONS TO ADDRESS CHURNING

ACA Medicaid Expansion to Adults

Research has found that part of the ACA's reduction in the uninsured rate can be attributed to increased retention of Medicaid enrollees, and states that have adopted the Medicaid adult group expansion have lower rates of churning in and out of Medicaid than non-expansion states.³⁰ Among Medicaid beneficiaries aged 19–64, disruption in coverage decreased by 4.3 percentage points in states that expanded Medicaid compared to states that have not expanded, amounting to approximately half a million beneficiaries maintaining their coverage each year. Among pregnant women, nearly half of women in Medicaid non-expansion states experienced an insurance disruption from preconception to postpartum between 2015-2017, compared to one-third of women in Medicaid expansion states.^{31,32} Further, there was a greater decrease in disruptions of coverage among people of color compared to white individuals in expansion states compared to non-expansion states. Researchers have highlighted three likely ways Medicaid expansion has reduced churning:

1. The higher income threshold of 138 percent of FPL accommodated larger monthly fluctuations in income without loss of eligibility;
2. The standardized upper eligibility threshold simplified requirements across states; and
3. Expansion states generally increased their outreach efforts and enrollment assistance for Medicaid.³³

Moreover, expanding Medicaid to more parents also benefits their children. Family coverage has been shown to play an important role in whether eligible children renew their coverage in Medicaid or CHIP,³⁴ and research demonstrates that states that have expanded Medicaid coverage for low-income parents have experienced significantly greater gains in enrollment among eligible children as well.³⁵

The ARP encourages non-expansion states to take up Medicaid expansion by providing an additional temporary fiscal incentive. Under the ARP, states receive the ACA 90% FMAP for the adult group expansion population costs. In addition, states that do not have expansion in place when the ARP was enacted are eligible for a 5 percentage-point increase in the state's traditional FMAP rate for two years (2021-2022) if they implement the expansion for the adult group. The traditional FMAP applies to most services for non-expansion groups, including children, non-expansion adults, seniors, and people with disabilities.³⁶ In addition to receiving the ARP's temporary FMAP increase, states will also receive the 90 percent ACA FMAP for the expansion population costs.

Continuous Coverage

Continuous eligibility policies allow Medicaid beneficiaries to maintain continuous coverage even if they experience a change in circumstances (e.g., income) during the continuous eligibility period. One 2015 analysis found Medicaid churning within a calendar year would decrease by 30 percent with 12 months of continuous eligibility. This translates to 20 percent (5 million) more beneficiaries covered all year, increasing the average monthly caseload by 17 percent (6.8 million).³⁷

States have been able to allow children to stay enrolled in Medicaid and/or CHIP for up to 12 months regardless of changes in their families' circumstances under the "continuous eligibility" option since 1997. As of January 2020, 23 states provide 12-month continuous eligibility for children in Medicaid and 25 states do so for children enrolled in CHIP.³⁸ Children living in these states are much less likely to be uninsured (7.8 percent

vs. 11.7 percent) and to have had a gap in coverage in the previous 12 months (11 percent vs. 15.9 percent) compared to children in states without continuous eligibility.³⁹

While not the same as continuous eligibility (which guarantees ongoing coverage even with a change in circumstance), extending the time period for eligibility renewals and redeterminations can also impact continuity in coverage. In the first two years after California extended its Medicaid redetermination period for children from 3 months to 12 months, the percentage of children who had continuous coverage increased from 49 percent to 62 percent, and there was a reduction in hospitalizations related to ambulatory care-sensitive conditions, reducing hospital spending by \$17 million.⁴⁰

Two states, Montana and New York, have approved 1115 demonstration projects that provide continuous eligibility for adult group beneficiaries. The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that Congress create a state plan continuous eligibility option for adults in Medicaid so states could adopt it without a waiver, concluding that the option would reduce “churning and the negative health effects that may result.”⁴¹ In evaluating the New York and Montana demonstrations that extended continuous eligibility to adults, the Centers for Medicare & Medicaid Services (CMS) estimated that increased enrollment due to the policy would raise costs for the Medicaid expansion population by 2 to 3 percent, which is similar to cost increases seen in states when extending continuous coverage to children.⁴²

The ARP established a new state plan option for states to extend postpartum coverage in Medicaid and CHIP to women for 12 months and provide continuous eligibility through the extended postpartum period. Starting in April 2022, women covered under this option will receive comprehensive Medicaid benefits, not just pregnancy-related benefits, and will have continuous eligibility for the extended postpartum coverage period regardless of change in circumstances for the 12-month period. This option will be available to states for five years, granting states the opportunity to extend postpartum coverage without a section 1115 demonstration.⁴³ Medicaid covers about 42 percent of all births in the U.S., so extending Medicaid coverage in the postpartum period may increase rates of health insurance coverage during this period. This new option also may help address the U.S.’s high rates of maternal mortality and severe morbidity, which include deaths up to one year postpartum, particularly among Black and American Indian and Alaska Native (AI/AN) mothers. Overall, Black and AI/AN women are 2 to 3 times more likely to die of pregnancy-related causes than white women. These disparities exist across all age groups but increase with maternal age. For example, in the under 20 age group, Black women have a pregnancy-related mortality rate 1.5 times higher than white women, but in the 30-34 age group, Black women have a mortality rate 4 times higher.⁴⁴ While maternal mortality rates generally decrease with education attainment, racial and ethnic disparities in the rates widen. College-educated Black women have maternal mortality rates over 5 times higher than college-educated white women and over 1.6 times higher than white women without a high school diploma. Similarly, maternal morbidity rates are almost twice as high among Black and AI/AN women than among white women.⁴⁵ Black and AI/AN individuals also account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population, raising the importance of Medicaid coverage policies in addressing racial and ethnic disparities in maternal health outcomes.⁴⁶

All state Medicaid programs must provide pregnancy-related coverage under the state plan regardless of changes in income, through the end of the month that a 60-day postpartum period ends, at which point women who qualify for Medicaid on the basis of pregnancy risk becoming uninsured or experiencing disruptions in coverage. Women in states that have not expanded Medicaid to the adult group are particularly vulnerable as states’ income eligibility levels for parents are often much lower than for pregnancy.⁴⁷ Some states have sought to extend Medicaid’s postpartum period through section 1115 demonstration projects. To date, CMS has approved targeted extensions of postpartum coverage in the Georgia Planning for Healthy Babies demonstration and the South Carolina Palmetto Pathways to Independence demonstration, as well as in a number of states that have used section 1115 authority to extend the duration of Medicaid eligibility for

pregnant women beyond the 60-day postpartum period to provide a benefit of family planning and related preventive women's health services. In addition, five states (Georgia, Indiana, Missouri, New Jersey, and Texas) have pending section 1115 requests for postpartum coverage extensions from six months up to 12 months, including the existing 60-day postpartum period.ⁱⁱ Four of these states are seeking to provide full Medicaid benefits beyond the standard 60-day postpartum period. One state seeks to provide targeted benefits to address major health conditions recognized as contributing to maternal morbidity and mortality. These states are also seeking to align the continuous eligibility period provided to pregnant women with the extended postpartum period to maintain enrollment regardless of changes in income. In addition, through a state funded program, California has extended coverage for up to 12 months for eligible individuals diagnosed with a maternal mental health condition, such as postpartum depression, through the state's Provisional Postpartum Care Extension.⁴⁸

Express Lane Eligibility and Presumptive Eligibility

Express Lane Eligibility (ELE) allows states to use eligibility findings from other public programs to verify Medicaid and CHIP eligibility for children, eliminating duplication of administrative efforts and easing the burden on families from having to provide the same information to multiple agencies.⁴⁹ ELE agencies may include: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC).⁵⁰ ELE may be adopted by states through a state plan amendment, which 13 states have done for children in Medicaid and/or CHIP. These states have reported reduced administrative burden and cost savings.⁵¹

Presumptive Eligibility (PE) is a Medicaid state option to allow specific "qualified entities," such as health care providers, hospitals, schools, government agencies and community-based organizations, to screen pregnant women, children, parents and other non-elderly adults for Medicaid eligibility and temporarily enroll them. These policies allow individuals determined presumptively eligible to secure covered health care services without delay while they complete the regular application process for ongoing coverage. As of January 2020, 30 states had implemented PE policies for pregnant women, 19 states had PE for children, 9 states had PE for parents, and 8 states provided PE for other non-elderly adults.⁵² PE can be used in conjunction with targeted efforts at the community level to find and enroll the hardest to-reach, uninsured children. It also simplifies the enrollment process through direct, one-on-one assistance.⁵³

ELE and PE policies support President Biden's whole-of-government equity agenda.⁵⁴ A central component of this agenda is identifying and addressing barriers that underserved communities and individuals may face related to enrollment in and access to benefits and services in federal programs.

Shared Plans between Medicaid and Marketplace

Having the same insurers in both Medicaid and the Marketplace can help keep beneficiaries in more consistent coverage, with similar provider networks and formularies, even if they have to transition from Medicaid to Marketplace or vice versa.⁵⁵ The ability for issuers to participate across multiple public financing arrangements and provide stable provider networks is essential to achieving continuity of care.⁵⁶ Medicaid managed care companies may be suited to playing a role in this area. In 2021, 47 percent of all parent insurers offered a Marketplace plan and Medicaid plan in the same state, and there were 36 states with at least one of these parent insurers.⁵⁷ However, these multimarket plans – while reducing the potential disruption from churning – only address churning between Medicaid and Marketplace coverage (but not employer coverage) and do not eliminate the underlying disruption in coverage, unlike some of the other policies discussed earlier.

ⁱⁱ Illinois received approval on April 12, 2021 for a demonstration project extending postpartum coverage for 12 months.

Limiting Premiums and Cost-Sharing

Using section 1115 authorities, states have implemented premiums and cost sharing in Medicaid with the stated goals of promoting personal responsibility, preparing beneficiaries to transition to commercial and private insurance, and supporting consumers in making value-conscious health decisions. However, research has shown premiums act as a barrier to accessing care and maintaining coverage, including increasing disenrollment and shortening length of enrollment in Medicaid and CHIP among adults and children.^{58 59}

CONCLUSION

Churning between sources of health coverage, including periods without health insurance, occurs frequently in the Medicaid and CHIP population and is associated with adverse effects on health care access. Continuous coverage or allowing beneficiaries to maintain Medicaid coverage for a set period of time irrespective of changes in their circumstances, helps prevent disruptions in health care for beneficiaries and provides states more predictable and efficient spending. While the FFCRA MOE and continuous enrollment requirements have temporarily halted most Medicaid churning, the pandemic's health and economic toll has increased the importance of the Medicaid program for beneficiaries and providers, and there is the potential for significant coverage disruptions and losses of health insurance coverage when the public health emergency ends. As states prepare to return to normal operations, policymakers should consider a range of policies that promote more stable coverage in the Medicaid population, including Medicaid expansion and continuous coverage options such as those created by the ARP.

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