MEASURING AND MONITORING CHURN AT THE STATE LEVEL

Moderator: Elizabeth Lukanen
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Elizabeth Lukanen: Welcome everyone and thank you for attending today's webinar, Measuring and Monitoring Churn at the State Level. My name is Elizabeth Lukanen and I'm the Deputy Director of the State Health Access Data Assistance Center, or SHADAC as we like to call it.

SHADAC is a multidisciplinary health policy research center based at the University of Minnesota. And our goal is to bridge the gap between research and policy by providing assistance to states in accessing sound data and rigorous analysis in the areas of health care coverage, access, quality and delivery system reform.

Funding for our work is provided by the Robert Wood Johnson Foundation, and we thank them for their continued support.

Before we begin, I want to cover a few technical details. Broadcast audio is available for today's webinar. But if you prefer, you can listen via telephone by dialing 844-231-3643 and using the conference I.D. 5540536.

The presenters will be using slides today. So if you're not able to access the ReadyTalk visual presentation, please either call the ReadyTalk helpline at 800-843-9166, or go to readytalk.com and click "chat with a representative" in the left hand side. And just so you know, the slides for this webinar will be posted on our website afterwards.

We will also have plenty of time today for questions, and you can submit your questions at anytime via the chat feature on the left hand side of your screen.

So the goal of today's webinar is to explore health insurance churn. And this includes individuals moving between coverage types, for example, between non group coverage in Medicaid, and also individuals who experience gaps in coverage.

We're joined by two wonderful speakers. Our first speaker is Colin Planalp, a research fellow here at SHADAC. And he's going to discuss how churn has changed since the implementation of the Affordable Care Act, and also going to some details on different approaches and data source that can be used to estimate churn.

He will be joined by Oliver Droppers, a policy analyst at the Oregon Office for Health Policy Research. And Oliver is really going to provide our state's eye view on this topic. He'll discuss Oregon's experience estimating churn and policy strategies that Oregon use to address churn in their state.

And now, I'm going to turn it over to Colin to kick us off.

Colin Planalp: Thanks, Elizabeth. Thanks everyone for joining us on this webinar. And I'm happy to be here talking to you about estimating churn at the state level.

So first, I want to acknowledge our funders on this work. This webinar is based on a paper that we did for the Office of the Assistant Secretary for Planning and Evaluation, and it was funded by ASPE. And I also want to acknowledge my coauthors on that paper, Julie Sonier and Brett Fried.

So I want to jump right in and start by talking a little bit about what churn is. So there is no single one definition of churn. Probably the narrowest definition of churn is right here, movement of individuals between insurance and uninsurance.

Today, we're talking about a broader definition of churn. Especially since the implementation of the ACA, churn has come to refer to shift across coverage types, as well as across coverage into uninsurance, so this one shows one example, Medicaid to subsidized private coverage.

So why are states interested in churn? States, historically, have been concerned with churn because of the phenomenon's effects on individuals and public programs. So for individuals, churn can have health consequences and financial consequences, as people churn between uninsurance, or even as they transition between different types of coverage.

And for public programs, churn also can have financial consequences, as programs reenroll people, and disenroll and reenroll them multiple times sometime within the same year. And it can also have higher health care spending cost after people come back to – say come back to Medicaid after a period of uninsurance.

So it's important to note that churn has long been an issue of concern for states since even before the ACA. Before the ACA, concern for states around churn mostly focused on cycling between Medicaid and uninsurance. And there are a couple of reasons why this would happen. One is for reasons of dropouts, so people may have problems reenrolling when it was time to reenroll, sometimes just because they're having trouble getting the correct paper work, or they may not even realize they need to reenroll.

And they also may have experiences with temporary loss of eligibility. Say, someone has a temporary increase in income because of a seasonal job where their income may just for a month or two exceed the limit for Medicaid eligibility.

But under the ACA, the dynamics of churn have changed a little bit. So under the ACA, it is expected to be less churn between Medicaid and uninsurance. And this is because people have enhanced access to coverage, and this is because of Medicaid expansion and subsidized coverage through health insurance marketplaces.

So while this should result in west churn between Medicaid and uninsurance, it also creates possibility for a new type of churn between Medicaid and subsidized marketplace based coverage.

So this slide provides kind of a visual example of how churn will differ between Medicaid and – Medicaid expansion and non-expansion states. If

you look at the second bar below, that shows an example of what churn could look like in a non-expansion state.

So you see Medicaid on the left and subsidy eligibility on the right. And in the middle is that coverage gap. And what that means is for people in non-expansion states, they have the potential to continue churning similar to pre ACA churn, between Medicaid and uninsurance, and now between subsidized private coverage and uninsurance. But if you look at that top bar, it shows the potential for people to churn directly between Medicaid and eligibility for private coverage subsidized through exchanges, which is what I was talking about a moment ago.

So I also want to talk a little bit about a couple of examples for state policy options for addressing churns. There are basically two approaches to addressing churn. The first is by attempting to smooth the impact of those churn transitions. So when people transition between Medicaid coverage and subsidized private coverage. And Arkansas is an example, and we'll talk about this a little bit more in a minute. But Arkansas is an example of a state that's implemented a policy that could smooth the effects of churn.

The other option is to try to reduce the prevalence of churn. And New York with its continuous eligibility policy for Medicaid is another example. And that's an example of a state that's trying to reduce the prevalence of churn.

So this slide shows a – this slide will go through those two examples of Arkansas and New York. Here, you can see Arkansas has expanded its Medicaid program via premium assistance. And what that does is it allows beneficiaries from Medicaid to obtain private marketplace plans with Medicaid funding. And this is expected to smooth transitions of churn.

And the way that should work is by allowing Medicaid expansion populations and subsidy eligible populations to have access to basically the same insurance plans, the main difference being the source of funding for those plans.

New York's approach is different, and that it's attempting to keep people within Medicaid for 12 months. So in 2014, New York became the first state

to receive approval to implement 12-month continuous Medicaid eligibility for adults. And under this option, beneficiaries remain eligible for Medicaid for 12 months from their date of enrollment.

And so what this does is it allows those people to remain enrolled in Medicaid regardless of temporary shifts in income that may put them above the Medicaid eligibility level. And what this would do is, because of that reduce those circumstances where people go in and out of Medicaid multiple times within 12 months.

And a number of states may already be familiar with this option, because many states have implemented this in their CHIP programs before.

So now that we've talked a little bit about the policy options for addressing churn, I want to walk through a framework, a framework for developing an estimate of churn.

So the first thing you would want to do for developing an estimate of churn is to identify the purpose of your estimate. So there's no single best approach to developing a churn estimate. That depends on the questions that you're trying to answer.

So for example, are you interested in a specific policy option under consideration, like those policies in Arkansas or New York? Are you interested in specific analytic questions, such as how prevalent is churn, how much churn is going on, or who is more likely to churn, what are the – what are some examples of people who are more likely to churn?

Second, you're going to want to define the type of churn that you're concerned with for your estimates. So this is important, because as we discussed earlier, churn can be defined very narrowly or very broadly, in which you want to do is make sure that you're tailoring your definitions, specifically toward the types of churn by coverage, and the types of churn by directionality.

So this slide describes a little bit about the different types of churn by coverage. You can have churn between Medicaid and uninsurance. And this is basically the same issue as pre ACA churn. And as we discussed earlier,

this is mainly going to be an issue in states that what not to expand Medicaid at this time.

Another option for estimating churn is looking at uninsurance to exchange churn. And again, this is more likely to be an issue in states that don't expand Medicaid.

And another type of churn that states are interested in monitoring is churn between Medicaid and exchange coverage. And this is more likely to be an issue in states that expand their Medicaid programs, because then the eligibility for Medicaid goes right up to that for eligibility for subsidies.

And you also want to look at the directionality of churn. So are you interested in each and every one way shift in coverage categories or between coverage in uninsurance? Are you interested in two-step shifts, for example, whether people are shifting from Medicaid to uninsurance, and then from uninsurance to subsidized coverage. Or are you just interested in those full two way loops that people make from Medicaid, for example, into subsidized coverage, and then back into Medicaid within 12 months?

After defining churn, you want to identify what you want to use for your basic model for estimation. So there are two basic types of models for estimating churn. The first is an income eligibility model.

And what that does is it allows you to estimate the potential for churn by looking for changes in income eligibility overtime. And what this requires is longitudinal data on income and family composition overtime, so you can calculate changes in someone's eligibility based on percent of federal poverty guidelines.

The second option is an estimate based on actual program in enrollment. And this may have benefits for certain estimates of churn, because it takes into consideration non-eligibility factors. So for example, whether people choose to take up coverage in Medicaid or subsidized coverage, and whether people are dropping out of those programs.

And fourth, you want to identify a data source for developing your estimate. So a few different options or you can use survey data, you can use administrator data, or there maybe some options in certain examples for states to link data sources.

So this slide shows that few of these survey data sources that states could use. The Behavioral Risk Factor Surveillance System may allow for a rough estimates of churn between Medicaid and uninsurance in 38 states that have adopted a new set of optional questions in this survey. And one benefit of these data sources, the BRFSS provides state level data.

Another potential option is the Current Population Survey. The Current Population Survey was recently redesigned and it will include monthly questions on coverage status. But whether this is an option depends on how the Census Bureau releases those monthly coverage questions. But one benefit to this survey data source, depending on how those data are released, is it also provides state level data.

Another option for survey data is the Survey for Income and Program Participation. This data source has been used by a number of people in producing income eligibility estimates of churn. And this is because it provides monthly income level data, as well as family composition data. So it allows you to look for those changes in eligibility based on federal poverty guidelines.

One downside to the SIPP is it doesn't provide state level estimates, so depending on what you're wanting to do, you may have to wait that to the state specific characteristics for the state you're wanting to look at.

And finally, one more national survey that may have some possibility is the Medical Expenditure Panel Survey, the Household Component. And that provides monthly enrollment data, however, like the SIPP, it doesn't provide state level data.

For administrative data, one major benefit here is they will provide state level data for all of these, the Medicaid, the marketplace, and the – if you're able to

link those. The main limitation of administrative data though, is in determining some of the dynamics of how people are churning.

For example, with Medicaid data, you could go in and you could potentially see that someone's been enrolled for six months, and then they disenrolled for six months. But you don't necessarily know where that person went after they had left Medicaid, whether they were actually uninsured, maybe that person received employer sponsored insurance. You don't know exactly what was going on when that person churned.

And another option here is you could link possibly Medicaid and marketplace data. And that provides the benefit of – you could potentially see whether people are – whether and how often people are churning between Medicaid and marketplace plans. However, you again run to that issue of, if someone disappears for a period of months between being on Medicaid coverage and marketplace coverage, you don't know whether that person was uninsured, or whether that person had ESI or some other kind of private coverage.

And back to those state examples, I want to run through really briefly that four-step framework for Arkansas and New York, so Arkansas, their premium assistance, and New York, their 12-month continuous eligibility.

So with Arkansas, we first want to identify the purpose of our estimate. In here, let's say, we want to project the number of people who could potentially be affected by this smoother type of churn, as people shift between Medicaid coverage and subsidized private coverage through the exchange.

Second, we want to define the type and scope of churn that we're interested in for the purpose of this estimate. In here, again, we're interested in one way shifts between Medicaid and subsidy eligibility.

Next, we want to identify the type of model that will allow us to perform this estimate. In here, we want to use an income eligibility estimate, so we can look at the potential for churn, and the number of people who are going to shift between those eligibility levels across that threshold of 138 percent of federal poverty guideline between Medicaid and marketplace-based subsidized coverage.

And finally, you're going to want to select the data source. So here, what you could do is use the survey for – this survey on income and program participation to conduct that income eligibility estimate. And you may want to wait that to your Arkansas characteristics to see exactly kind of what you would see going on in this situation in Arkansas.

And on to New York, here, we're looking at their policy for continuous 12-month eligibility. And what we want to do here is estimate potentially the administrative cost savings by preventing people looping between Medicaid, and out of Medicaid, and back into Medicaid, due to temporary income fluctuations or program dropout.

It's also important to note here that while you may see administrative cost savings, you're also going to see increased cost in a case like this, because people are going to have additional care, as they're on Medicaid for a longer period of time.

So here, like I said, we're interested in two-way looping. So instances that people starting in Medicaid, leaving Medicaid, and then coming back to Medicaid within 12 months.

We want to identify the model that we would want to use for estimating churn. And in this example, we would want to use an enrollment estimate. And what that allows us to do is take into consideration those non-eligibility reasons that people might be either taking up or dropping out of Medicaid.

And here's the case where you could use Medicaid administrative data to conduct that estimate, because it doesn't necessarily, for this purpose, matter where that person is going when they're outside of Medicaid if your main concern is what the administrative cost savings would be for implementing 12-month continuous eligibility.

I hope you find this helpful. If you have additional questions, I'm happy to talk more at the Q&A portion of this webinar. And I also encourage you to visit the SHADAC website and take a look at that paper that I talked about earlier. That paper provides a literature summary on churn. It provides some

more examples of state policy options for addressing churn. It goes into more depth on that framework for estimating churn. And we also go into a lot more detail on the pros and cons of some of those potential data sources for estimating churn.

Here's my contact information. And next, I want to turn it over to Oliver Droppers from the state of Oregon.

Oliver Droppers: Great. Thank you, Colin. So Oregon, we're pleased that we were asked to be a participant on today's exciting topic and on the webinar, and to really be able to share some of our work that we've done in terms of estimating churn related to the ACA here in Oregon.

In 2013 and 2014, Oregon collaborated on several studies and effort to really start to better understand what churn might look like in our state as a result of the ACA for reasons that Colin previously walked us through.

In 2013, in partnership with SHADAC, we were able to complete a churn analysis in anticipation of our 2014 Medicaid expansion.

And in the fall of 2103, the Oregon Health Authority, which is the agency responsible for overseeing Oregon's Medicaid program, the Oregon Health Plan tasked our state's Medicaid advisory committee with conducting a more in-depth study and comprehensive assessment of churn, which I'll share today.

Before moving ahead, I would like to acknowledge the support and expertise provided by SHADAC, Manatt Health Solutions, and Wakely Consulting Group, which was made available through the State Health Reform Assistance Network. And I'd also like to thank my colleague, (Janet Taylor), for her contributions to the overall body of work.

So I think, it's worth sharing Oregon's rationale for wanting to develop a model estimates of churn. I think, first and foremost, in our state, as in probably many states, we recognized early on that the ACA, while offering new coverage opportunities for individuals and families, also would create new transition points.

Coverage transitions for Oregonians, or churn, obviously we know is not new, but clearly its extent of scope have changed, and are more complex due to the different coverage dynamics provided by the ACA.

From a policy standpoint, federal state policy makers, as well as state Medicaid officials, here in Oregon and elsewhere, realize that some degree of churn, although inevitable, it at least can be mitigated through several options, which I'll describe in a little bit.

So today, I want to share several different, but what I would view as complementary churn estimates that we were able to develop, and then highlight a range of policy options that Oregon considers in 2013 and 2014 in response to the estimates about the types and magnitude of churn that were projected for 2016.

And then I'll conclude by offering several recommendations for states based on our work, including several lessons that I think we've learned from exploring churn measurement strategies in an effort to better understand coverage transitions here in Oregon.

So not surprising to most of you on today's webinar, and clearly supported by a large body of existing research, is that our collective understanding that churn is this significant and unavoidable policy issue. Although states can't eliminate churn entirely, we can take action to reduce its frequency and minimize its adverse impact.

But today, instead of covering a large body of research that most of us are already familiar with, and as outlined on the slide, let me start by sharing why Oregon was interested and continues to be in churn.

I think most fundamental is that, as part of our comprehensive health reform initiatives here in Oregon, we're continuously working towards creating seamless continuity of care across all Insurance Affordability Programs or IAPs.

Oregon Medicaid, and Children's Health Insurance Programs, and subsidized private coverage and exchange, this is really a core principle of our health

reform initiative. We're also in the midst of reforming our state's Medicaid delivery system through coordinated care organizations, often referred to as Medicaid accountable care organizations, although with some important nuances here on our state, churn, however, can undermine any number of those objective that a state, including Oregon, are working towards, and that it disrupts health and health care for many residents.

So taking a step back, in 2012 and 2013, Oregon and a number of other states had been closely tracking the national studies that were beginning to report churn estimates. Some with rather alarming figures, such us a third of adults with incomes below 200 percent could experience a change in eligibility within six months. Or a quarter of all adults could experience at least two eligibility changes within a year. So those are pretty alarming and we knew it would create some significant dynamics within our new IAP, ACA environment.

So based on this new coverage or options, Oregon had a keen interest in really trying to estimate the magnitude and scope of churn and its effects, including the types of churn, and the directionality of churning between Medicaid and private coverage. But in particular, Medicaid exchange related churn as Colin described earlier.

So it might be helpful to provide a little bit of context before I walk through our churn estimates. Let me first start by sharing the success of the ACA implementations here in Oregon, which is that our states Medicaid expansion in 2014 at the end. Within 12 months, we had 350,000 individuals that became newly eligible in our state for Medicaid, and enrolled in the Oregon Health Plan, which translates to approximately one million Oregonians being now enrolled in Medicaid, which is one out of four.

So that's a considerable increase in the overall amount of coverage that we were able to provide residents in Oregon through Medicaid.

We also have Medicaid for pregnancy related coverage up to 190 percent of the FPL and CHIP, which provides no cost shouldering in our state to families

up to 300 of the FPL. And we also have the qualified health plan with federal subsidies for individuals up to 400 percent.

As I stated a little bit ago, I think really the key policy issue for Oregon that we were starting to really think about was prior to the ACA, how best to manage churn in a way though that would preserve continuity of care and coverage and ensure consumer affordability across the IAPs that are illustrated on the slide.

The expiration of Oregon's like the churn population, fortunately, we were able to work with SHADAC and the Providence Center for Outcomes Research and Evaluation and start looking at this issue.

So Oregon worked with SHADAC, and we were able to access their projection model, which is based on multiple data sources and draws from three federal surveys, the 2010 American Community Survey, the ACS, the 2009 Medical Expenditure Survey Household Component, and the 2010 Medical Expenditure Panel Survey Insurance Component.

So really, we're able to – using the SHADAC model draw up on multiple survey data inputs, and then using data from the ACA and the MEPS, we're able to take some state level estimates not available through the national data, and match it to Oregon ACS data using statistical matching techniques.

So SHADAC, using the Census Bureau of Survey of Income and Program Participation, or SIPP, applied to the Oregon Health Plan administrative data to taking the national survey data. And our Medicaid administrative data from 2102 and 2013, we were able to model enrollment dynamics between Medicaid Oregon health insurance marketplace and other coverage options.

The bar graph on this slide represents SHADAC's 2013 estimate for Medicaid retention rates of OHP parents and childless adults based on Medicaid expansion, and the potential impact by streamlining redetermination of OHP.

And then key here in this figure is that it indicates that by expanding Medicaid eligibility to adults from what was current income threshold up to 138 percent

of FPL, we were projected that this substantially reduce churn as indicated in the red bar.

SHADAC estimates further suggested that streamlining the renewal procedures to further reduce churn. Generally about half of the program terminations occurring at renewal are for process related reasons. And SHADAC estimated this rate could be reduced up to half.

So the combined effects of Medicaid expansion and streamline renewal in our state could result in continuous eligibility rates of 72 to 80 percent pairing by eligibility group shown in the green bar chart, which is considerable if you look historic enrollment and redetermination in the Oregon Health Plan here in our state.

But clearly, expanding Medicaid, we knew, although it resolved improvements with eligibility and program, we want to really though also understand how individuals would transfer between Medicaid and other coverage.

So we looked while significant shifts were projected between Medicaid and the marketplace in 2016, we were able to use SHADAC as much to also understand that the majority of individuals that moved out of both Medicaid and the marketplace would likely transition to employer sponsored coverage as indicated in the table on the top part of the slide.

SHADAC also estimated that in terms of two way looping for 2016, approximately 60 percent of the movement between Medicaid and the marketplace, shown on the bottom of the slide, which is approximately 36,000 individuals would likely move form Medicaid to QHPs, so that's turning upward.

Conversely, 40 percent, or approximately 24,000 individuals were projected to churn downwards for QHP coverage into Medicaid. So the estimated number of individuals moving between Medicaid and QHPs, or transferring outward, would still be relatively small proportion of total enrollment in these programs.

So these estimates really started to help Oregon answer the question of how prevalent, and what direction, as well as type of churn we could be looking towards in 2016, based on a various coverage types in our state.

In addition to estimating the number of individual likely to churn, SHADAC study also revealed that the following characteristics about Oregon's individuals that were expected to churn between Medicaid and QHPs in particular in Oregon, it appears there's a number of demographic data, approximately 38 percent, would be between the ages 45 to 60, so the baby boomer generation, approximately half would be married.

More than 70 percent, either not working or are at part-time employment, around 33 percent likely to have work limiting or work preventing physical or mental condition. And an estimate of 40 percent without income is between 100 to 138 percent of the FPL.

So really, I think what this was able to do was understanding the characteristics of the individuals that would be expected to churn, would help us have better understanding in terms of those key demographic factors that would likely predict what group of individuals would churn.

As Colin described, there are a variety of data sources clearly perceived to use to estimate churn. In Oregon, setting aside the SHADAC example I just provided, we also were able to work with the Providence Center for Outcomes Research and Education, we commonly refer to it as CORE, which is an Oregon based health research center.

Through the Oregon Health Study, CORE had collected longitudinal survey data from 17,000 low income individuals who had signed up for the OHP or the Medicaid lottery, and they were therefore – we thought a reasonable representation of Oregon's likely Medicaid expansion population.

For those not familiar with the Oregon Health Study, it's a randomized study or lottery that began in 2008 to examine the impact of providing public insurance coverage through the Oregon Health Plan to low income population in Oregon.

So findings from this alternative churn of assessment, we were able to understand in start thinking about what was the magnitude of changes and household income, how that vary. And it indicated that there was a significant level of income volatility among the population, with incomes between one to two hundred percent of the federal poverty level. Also approximately 17 percent of household would likely churn across the 138 FPL thresholds annually.

I think of particular interest for Oregon was that a greater income variation was estimated via experience by those with chronic conditions, and those living in urban households in our state.

So I think, in other words, key on this slide is poor households were less likely to move upward, and that churn estimates dropped considerably when starting with households with higher starting income.

So for example, a family has started at 176 percent of the FPL higher, they were estimated to be less likely to move downward across that 138 threshold in the Medicaid.

So while the SHADAC improvements core analysis were derived from different data sources, I think when you put those together, Oregon was able to provide a fairly clear picture of volatility of Oregon's estimated churn population, and really helped Oregon identify the key drivers of churns specific to our state.

So as I mentioned, in the fall of 2013, our state's Medicaid advisory committee began working with Manatt Health Solutions and Wakely Consulting to identify policy options using the churn estimates produced by SHADAC.

Our state Medicaid Advisory Committee spent several months carefully examining a range of strategies to address churn. With the help of Manatt, we developed a detailed overview of each option, and then it sets the impacts, including potential advantages and disadvantages among key stake holder groups in Oregon that included consumers, health plans, and providers, or state to marketplace in the state of Oregon.

Two types of churn strategies were evaluated. The first set aims to reduce or avoid individuals from churning, such as the New York example, that Colin offered. Although we didn't model the four strategy that are listed on this slide, we did access how each strategy may help reduce or avoid the number of times an individual move on and off of Medicaid.

In the interest of time, I'm not going to review these strategies, but they are described in detail in the Oregon Churn Report that's available online.

So the challenge, I think, for churning plus ACA, is complicated by the fact that each public – publicly, subsidy program in Oregon, as in most other states, starting with Medicaidship and QHPs in the marketplace, have their own rules and standards for our participating health plans, as well as their own network of plans with some level on – overlap here in Oregon.

We have 16 coordinated care organizations serving them Medicaid release and over a dozen qualified health plans offered in the marketplace. Several of our CCOs do offer QHPs in the marketplace, which ride some overlap.

So if you look at the goal's outline on the slide above, I think the challenge for policy makers is to identify how best to mitigate the impact churning referred here as term mitigation strategy.

So beyond administrative improvements in Medicaid program to reduce or prevent churn, Oregon wanted to examine opportunities for market alignment between Medicaid and the marketplace, base on three term mitigation options, the basic health plan, the bridge plan, and wrap.

These alternative programs cover specific populations in effort to facilitate care, promote coverage continuity, and reduce financial burden on individuals moving from Medicaid to subsidized coverage in the marketplace.

So working with Wakely Consulting, to financially assess these alternative coverage options, the basic health plan, the bridge, and wrap, Wakely built a detailed model with demographic claim cost and premium data by households.

The premier data sources for their model were the SHADAC estimates that I described earlier, American Survey Demographic Data, as well as Oregon marketplace rate filings, in our exchange by age and region, and then finally, Medicaid administrative data.

So using the SHADAC model and Oregon specific data, Wakely was able to estimate the size and demographic characteristics of the eligible, and likely to enroll population in 2016 in Medicaid and our marketplace.

Funding available for implementation of these three alternative coverage programs, both private state, as well as federal, the financial impact to consumers, the state in Oregon's exchange, varied benefit coverage and subsidization of consumer premiums and cost sharing, so we could start to assess the affordability issue and the impact of consumers of these areas, program options, and look at the revenues and expenses for the state in Oregon's exchange entity.

So here's our churn mitigation model that we put together in 2013. And so key estimates were, I'd say, bit surprising, and I'll walk through those now. But the first zero of the table illustrate the different scenarios that we model in terms of covered benefits, either full Medicaid or less generous coverage that's offered in our QHPs in Oregon, different provider reimbursement rates, either 100 percent commercial or an average between commercial Medicaid, and member cost sharing.

So for member cost sharing, we model three different levels of consumer benefits. Starting with consumer paying zero out of pocket cost, to 50 percent of the allowable federal cost sharing in the marketplace, to the third scenario of being 100 percent of cost sharing that's allowed on the exchange.

So in terms of outfits in the model, if you look at the bottom three rows, for BHP, we estimated 72,000 Oregonians would be eligible for the program. And then for Bridge and wrap, there would be an estimate of 109,000 individuals approximately, which included 69,000 individuals previously eligible for Medicaid that then would be no longer eligible, and we can either offer them a bridge, or put them into a QHP-wrap.

And then the second option that we modeled was looking at CHIP parents, and then giving those individuals, between 138 and 200 of the FPL, the option to move into a bridge or a QHP-wrap scenario.

We also looked at consumer savings in terms of how that would be impacted by these coverage options. So the basic health plan was estimated to provide annual out-of-pocket savings of 460 to 15,000 per capita.

If you look at the bridge plan, it has the potential to provide even higher capita out-of-pocket savings, which was estimated to be 600 to 1725 per person.

And then the third model option, the wrap-around program, could potentially provide annual out-of-pocket cost savings of $11 to $24 per million dollars of the expenditures. How are these program would be entirely state funded? In Wakely's analysis, merely represents an estimate of state expenses required to provide different levels of concepts in the benefit wrap.

I think an important caveat to share, on today's webinar, is that Wakely's analysis was for a point in time, it was only 2016 only. Also, their analysis was highly dependent on our 2014 premiums developed by the Oregon insurance carriers for our QHPs.

The subsequent analysis of BHP in 2014 that used 2015 exchange premiums did show remarkably different results, and that the 2014 rates for the second lowest cost over plan was cheaper than our 2014 rates, which were used for this model.

So I think the takeaway here is by developing the model and using multiple data sources, Oregon was able to evaluate several churn mitigation options that are designed ultimately to smooth coverage transitions for low income residents by assessing each program's potential impact on consumer affordability coverage, as well as the financial impact to the state in Oregon's exchange.

So for my last slide, the churn estimates that we were able to develop in 2013, and in the model created by Wakely, really did help our understanding in our

state about what are some practical, as well as comprehensive strategies for policy makers to start addressing churn in the future.

These policy options, I think, will help Oregon support continuity of care, and coverage affordability, and administrative simplification for those served by IAPs.

And I'd like to conclude by offering several observations that stemmed from Oregon's work around churn. And I think it's necessarily a big "Ahah" moment, but we do recognize as a state that some level of churn, although again, as I shared, is inevitable.

The potential adverse impact, such as disruptions in care, gaps and loss in coverage, can be mitigated. However, it optimally require additional financial resources, and then scenarios that we model likely to state funds.

We were able to often recognize the benefits of estimated churn using multiple national data sources, but the use of additional state data is necessary and critical in order to develop more precise estimates that reflect your state healthcare environment delivery system, ACA coverage dynamics.

Hopefully, I think Oregon can offer other states an example to draw upon in terms of being able to model a range of comprehensive strategies to address churn. Clearly, it's not a one size fits all approach for any state.

That said, I do think it's fair to say that churn mitigation option should ensure consumer access, and promote seamless continuity across existing I.P. programs. But we also need to recognize the reality that sates must balance financial liability and operational self sufficiency of existing programs.

Lastly, the churn strategies that I walked through, I think can be implemented simultaneously. And there are some alternative complementary churn options to reduce, as well as to mitigate that a thing can be implemented overtime potentially together.

Thank you. I'll hand this back to Colin.

Elizabeth Lukanen: Thanks, Oliver. This is actually Elizabeth taking over for question and answer session. Thank you so much to both of our speakers. This has been really informative.

And we have a number of questions that are coming for each of you. It looks like we have about 10 minutes left for question and answer. So if you haven't had a chance to ask a question, please feel free to submit one to the chat function on the left hand side of your screen.

And with that, I will jump in to the questions that we've gotten. I think the first one is probably best addressed to Colin.

And the question is, should your approach to estimating churn differ depending on whether you're projecting churn or monitoring churn?

Colin Planalp: So in using different approaches for projecting or monitoring, I probably recommend you, you could still go through that same four step framework for developing an estimate.

The main difference between projecting and monitoring is what kind of model and what kind of data source you use.

For example, if what you wanted to do is monitor churn for what churn you're actually seeing, probably what you're going to want to do is using an enrollment based estimate model, rather than an income eligibility. Through that way, you've taken to account such as take up, whether people are taking up coverage and dropout, how people are dropping out.

In that case, you probably also would want to use, if possible, administrative data. Say, your Medicaid administrative data, which is likely to be more timely than available, like national survey data.

Elizabeth Lukanen: Great, thanks, Colin.

There was a lot of interest in data on the characteristics of churners, so Colin, maybe if you can then tell us which of the data sources you mentioned are probably best for getting at that information?

And then I'd like to ask Oliver how they used that information.

Colin Planalp: Sure. So in determining the characteristics of churners, survey data is a good place to go. And there, which you would probably want to use is the survey for income and program participation. And that would allow you to conduct one of those income eligibility, estimates of churn.

The challenge there is that the SIPP isn't state representative, so what you would want to do in a case like that is wait the national SIPP data to state characteristics. And you could get those state characteristics from a state representative survey, such as the American Community Survey, the ACS.

Elizabeth Lukanen: And I would just put a plug in that SHADAC is happy to provide technical assistance on that type of endeavor. It's something that we've done in the past, specifically for Oregon.

And Oliver, I know, SHADAC did provide you with some characteristics of churners, and I'm not sure maybe Wakely did as well. But how did you use that information when you were thinking about policy development?

Oliver Droppers: That's a good question. I think here in Oregon, the way that we've been able to use that is to really – if we are to enact any of the strategies that I laid out during the webinar, we could have a more targeted approach, either using through our marketplace, as individuals transition through coverage.

Or as well as people in certain communities here in Oregon that I think we have, you know, the demographic data, knowing that they're less likely to enroll or churn. So we can do more targeted outreach efforts to ensure that they have the opportunity to enroll into the Oregon Health Plan, or if not eligible for Medicaid, then enroll into market-based coverage.

Elizabeth Lukanen: OK. That's really helpful. I have a couple more questions for you Oliver. What kind of churn work were you doing prior to the ACA?

I think the questioner's trying to get at, you know, at the very end of your talk, you talked about the importance of the state level information that goes into this type of analysis. And I think that the questioner is curious of, you know,

was Oregon doing a lot of churn work before the ACA? And what pieces of data were you able to bring to the table in this analyses that were helpful?

Oliver Droppers: I don't think Oregon was, you know, several years prior to this, really focused on churn necessarily. I think the Oregon Health Plan has a long history in our state, and that we've been able to do some innovative tinkering with the plan, and know that certain design elements either can increase or decrease continuity coverage in Medicaid.

I think with that historical context, we were really interested in really exploring the garment of churn scenarios and policy options here in our state. I think it was fairly comprehensive to the point of really looking at almost everything that was potentially feasible from a policy standpoint here in our state.

So I think that's kind of the background in why Oregon really wanted to look at churn. And that we felt it's important to use that information to think about – obviously we're only, you know, we're about 15 months into full Medicaid expansion and marketplace coverage.

And I think now, we want to start looking at using administrative data here for Medicaid to understand where are folks dropping off, are those estimates accurate or not.

And so the second part of the question is what did use in terms of state data. We had the luxury of having survey data for multiple years, the Oregon Health Study.

And then working with Wakely, we were able to use our Medicaid enrollment data, as well as having our administrative data to look at actual cost related to Medicaid versus providing alternative coverage options on the commercial side.

So I think that was helpful to have the actual administrative data to understand what those costs would look like among the various coverage options.

Elizabeth Lukanen: Thank you. That's really helpful. Colin, this is for you, but I think, Oliver, if you have something to add on this, please feel free to jump in as well.

Colin, in your talk, you mentioned that Medicaid and marketplace link data is a potential source – potential good source of data for churn analysis. And the questioner's just curious how feasible is this option in practice? You know what, can you think of any states that have done this successfully?

Colin Planalp: So there are some interesting possibilities for a state that is able to link Medicaid and marketplace data. There are some challenges in doing that, but those aren't necessarily challenges that completely rule that out.

One issue is that stat would probably need to have a state based exchange to have access to the data that they would want to use in one of those instances of linking exchange in Medicate data.

Another issue is kind of a technical issue that state would have to develop some way of linking individuals across those data sources. So depending on how those administrative data sources are set out. There may be some individual identifiers that could be linked across those.

Another possibility, are there maybe some matching techniques where you could match those people pretty accurately based on their characteristics?

Another challenge that states would need to consider is simply the coordination of doing the linking, so there are likely to be issues of data privacy. In linking those data there may be – depending on how that state Medicaid agency and the state based marketplace are set up.

They may have to put together some kind of data use agreement. And it may be easier in a state where the marketplace and the Medicaid agency are more closely related whether in the same agency together.

Elizabeth Lukanen: Thanks Colin, that's really helpful. Oliver, I don't know if you have anything to add on that topic.

Oliver Droppers: No, I mean, I would only just reiterate with Colin. I think there are definitely interesting possibilities, but a number of technical complexities that states need to be thinking through with that particular issue.

Elizabeth Lukanen: Absolutely, so work to do in the future.

This is a question I'm not sure, you know, which of you is best suited to answer. But there have been some questions about, you know, income churn versus churn that's related to, you know, people dropping coverage due to administrative issues.

Do either of you have a sense for how much churn related to income changes drives the issue of churn versus things like program drop off? So is it income that is contributing to the majority, or administrative issues?

Colin Planalp: I can go ahead and take that. This is Colin. So I know that income is a big driver of churn, however the exact size of income versus there's more process reasons for dropout, or whether people take it up, or likely to depend on the state.

I know some of that is being more standardized by the ACA. For example, there are some efforts to make it simpler to reenroll. Another thing going on is the ACA's that they standard 12-month reenrollment period for Medicaid.

So previously, some states had six-month reenrollment periods, where every six months, a person had to submit paperwork to confirm that they are still eligible for Medicaid.

So with the ACA, those dropout issues, those process issues are probably likely to decrease, and income is probably going to be I would think a larger share of what's driving churn.

Elizabeth Lukanen: And Oliver, do you know in Oregon, is churn driven primarily by income, administrative issues?

Oliver Droppers: I would say that it's both. I think Colin's right. I think income will probably be the larger driving force if you will. But I do think the administrative issue has not entirely subsided with the ACAs.

I think that's something states should be keenly monitoring in the next 12 to 18 months, and see how that affects overall rate of churn in their Medicaid programs.

Elizabeth Lukanen: Thank you. Final question, the questioner's interested in whether either of you are aware of churn analysis that has actually been done on the sub state level, so for instance, urban-rural differentials, maybe even by provider type or network type.

Colin Planalp: This is Colin. I am not aware of any, but it may be possible again, similar to using the SIPP to do a state level analysis. If you could try to tailor by waiting the SIPP to a smaller geographical area, or some of those rural versus urban characteristic is one possibility.

Elizabeth Lukanen: And Oliver, has Oregon done anything in a sub state level?

Oliver Droppers: No, we have not specific the churn. I mean, we have estimates around change in insurance coverage at that level, but we haven't looked at churn per se.

Elizabeth Lukanen: OK. Well, I want to thank both of you, both Colin and Oliver today, for your wonderful presentations, and thank everyone on the line for sending in questions.

Just a reminder, that on our website, we will have links to additional churn related resources. And if anyone on the call has resource that they would like us to post, so that, you know, the group can see it, please feel free to send it to us.

Also, a recording of the event will be posted on our website within a few days, and that will include a direct link to both our recording and the slides, which will be sent in a follow up e-mail.

To stay up to date with all of our work at SHADAC, we encourage you to sign up for our mailing list, and also follow us on Twitter and Facebook. So thank you again for joining us, and have a wonderful day.

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