Transitions Between Medicaid, CHIP, and Exchange Coverage

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires states to coordinate eligibility and enrollment processes between Medicaid, separate State Children's Health Insurance Programs (CHIP), and subsidized coverage on health insurance exchanges (collectively referred to as insurance affordability programs). The goal of these policies is to reduce gaps in coverage when a beneficiary experiences changes in income or other circumstances.

This brief summarizes MACPAC's analysis of insurance affordability program enrollment data and beneficiary transitions among those programs in 2018. Overall, we found that only about 3 percent of all adult and child beneficiaries who were disenrolled from Medicaid and CHIP enrolled in exchange coverage within a year after disenrolling, which was lower than previous estimates. In addition, we found that most individuals who moved from Medicaid to the exchange had a gap in coverage; these gaps were longer for racial and ethnic minorities.

The brief concludes with a discussion of policy approaches that have been proposed to help to reduce gaps in coverage. These issues have received renewed attention as states make plans for conducting Medicaid redeterminations on a regular cadence at the end of the public health emergency (PHE), since many beneficiaries who are expected to lose Medicaid coverage may be eligible for exchange coverage.

Background

Medicaid, CHIP, and health insurance exchanges provide different levels of coverage for health care expenses for individuals at different income levels:

- Medicaid provides coverage to low income adults and children and generally does not charge premiums.[1] Medicaid also provides coverage to seniors and individuals with disabilities through other eligibility categories that often have different eligibility rules.
- CHIP covers children who are not eligible for Medicaid due to higher family incomes and often requires families to pay a premium for coverage. As of July 2021, 34 states had separate CHIPs for children, and 16 states and the District of Columbia used CHIP funds to provide coverage for children with higher family incomes through an expansion of the Medicaid program (MACPAC 2021a).[2]
- Subsidized coverage on health insurance exchanges is available for individuals under age 65 who are not eligible for Medicaid or CHIP and who do not have an offer of employer-sponsored insurance (ESI) that is considered affordable (9.61 percent of family income in 2022). Individuals with family incomes between 100 and 400 percent of the federal poverty level (FPL) are eligible for premium tax credits,

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which reduce premiums on a sliding scale, and individuals with incomes between 100 and 250 percent FPL are eligible for reduced cost sharing for certain health plans. Individuals can enroll in exchange coverage during the annual open enrollment period and during qualifying life events, such as the loss of Medicaid or CHIP coverage.

Each state establishes specific eligibility policies (within federal rules) and manages the eligibility determination and redetermination process for Medicaid and CHIP. States also have the option to operate their own health insurance exchange or to use the federal marketplace to administer their exchange. Currently, 39 states use the federal marketplace for making eligibility determinations. These include states with a federally-facilitated marketplace (FFM), where the federal government runs the entire exchange, as well as states with state-based marketplace-federal platform (SBM-FP) or state-federal partnership (SFP) marketplace structures, which are jointly administered by states and the federal government.

The ACA included several provisions intended to ease transitions between these insurance affordability programs, including (1) a common income standard, (2) a single, streamlined application process, and (3) standardized procedures for transferring eligibility data between programs.

First, the ACA requires Medicaid, CHIP, and exchange coverage to use a common income standard, referred to as modified adjusted gross income (MAGI). MAGI standards apply to most Medicaid eligibility groups, but states can continue to use non-MAGI income rules for Medicaid beneficiaries age 65 and older and those eligible on the basis of a disability. Despite this common standard, there can still be some differences in income calculations between insurance affordability programs, since Medicaid and CHIP programs calculate income at the point in time that an individual applies for coverage, whereas health insurance exchanges calculate eligibility for subsidies based on an individual's annual income.

Second, states are required to have a single, streamlined application for Medicaid, CHIP, and subsidized coverage on the health insurance exchanges. States can use the Centers for Medicare & Medicaid Services (CMS)-developed model application or an approved alternative to determine eligibility for individuals applying on the basis of MAGI. All insurance affordability programs require enrollees to answer common questions about income and family size, but eligibility for subsidized exchange coverage also requires enrollees to answer additional questions about ESI coverage, if offered. In addition, individuals applying for Medicaid often need to submit additional information about disability status or other criteria to be considered for eligibility through non-MAGI pathways.[3]

Third, the ACA requires Medicaid, CHIP, and health insurance exchanges to follow standard procedures for transferring applicant data between programs. In general, insurance affordability programs are not allowed to ask individuals to resubmit information that they have already submitted to another program, and states must meet certain standards for timely review. When an individual is determined potentially eligible for Medicaid by the federal exchange, states have the option to accept the exchange eligibility determination and enroll the individual (referred to as a determination state) or re-review the eligibility information provided by the exchange before making a final decision (referred to as an assessment state). Of the 39 states using the federal exchange platform in 2018, 9 were determination states and 30 were assessment states (Brooks et al. 2018). Conversely, when a Medicaid agency determines that an individual is

potentially eligible for subsidized coverage on health insurance exchanges, the federal exchange must re-review the data transferred from the state and cannot automatically accept the determination.

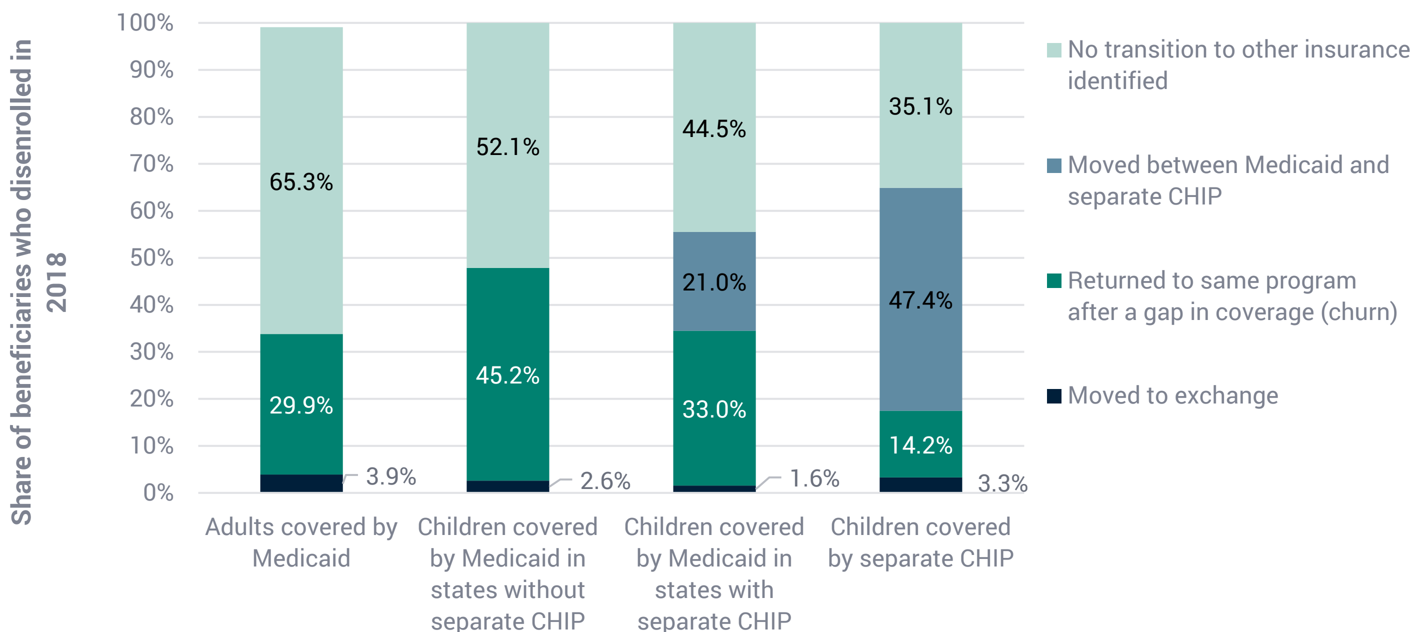
To further ease the transfer of eligibility information between programs, some states have developed integrated eligibility systems that can determine eligibility for multiple programs, particularly Medicaid and CHIP. Prior to the enactment of the ACA, half of states with separate CHIP had separate eligibility systems, but as of January 2018, 34 of 36 states with separate CHIPs had an integrated system (Brooks et al. 2018).

Findings

To examine transitions between insurance affordability programs, we examined 2017–2019 enrollment data for Medicaid, CHIP, and the federal marketplace.[4] We used beneficiary social security numbers, which were available in all the data sources we examined, to link Medicaid, CHIP, and federal exchange data and track individual beneficiaries as they gained and lost eligibility or transitioned among programs.[5]

Overall, we found that most beneficiaries who disenrolled from Medicaid or CHIP in 2018 returned to the same program within 12 months (a phenomenon referred to as churn) or did not enroll in another insurance affordability program (Figure 1).

FIGURE 1. Coverage Transitions for Children and Adults Who Were Disenrolled from Medicaid or CHIP in 2018



Notes: Medicaid children include those enrolled in Medicaid expansion CHIP. Analysis excludes partial benefit enrollees, beneficiaries dually eligible for Medicare and Medicaid, and those eligible in a medically needy eligibility category. Analysis also excludes states with a state-based exchange and those with incomplete or unreliable T-MSIS data.
Source: Mathematica, 2022, analysis of T-MSIS and federal exchange data.

More information about the effects of gaps in coverage on health and state policies that may help to reduce rates of churn is available in MACPAC's issue briefs *Effects of Churn on Potentially Preventable Hospital Use* and *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP* (MACPAC 2022, 2021b).

Rate of transition to exchange coverage

About 3 percent of beneficiaries who were disenrolled from Medicaid or CHIP in 2018 enrolled in exchange coverage within 12 months. The rate of transition to exchange coverage was higher for adults enrolled in Medicaid (3.9 percent) and children enrolled in separate CHIP (3.3 percent) than for children enrolled in Medicaid in states with separate CHIP (1.6 percent).

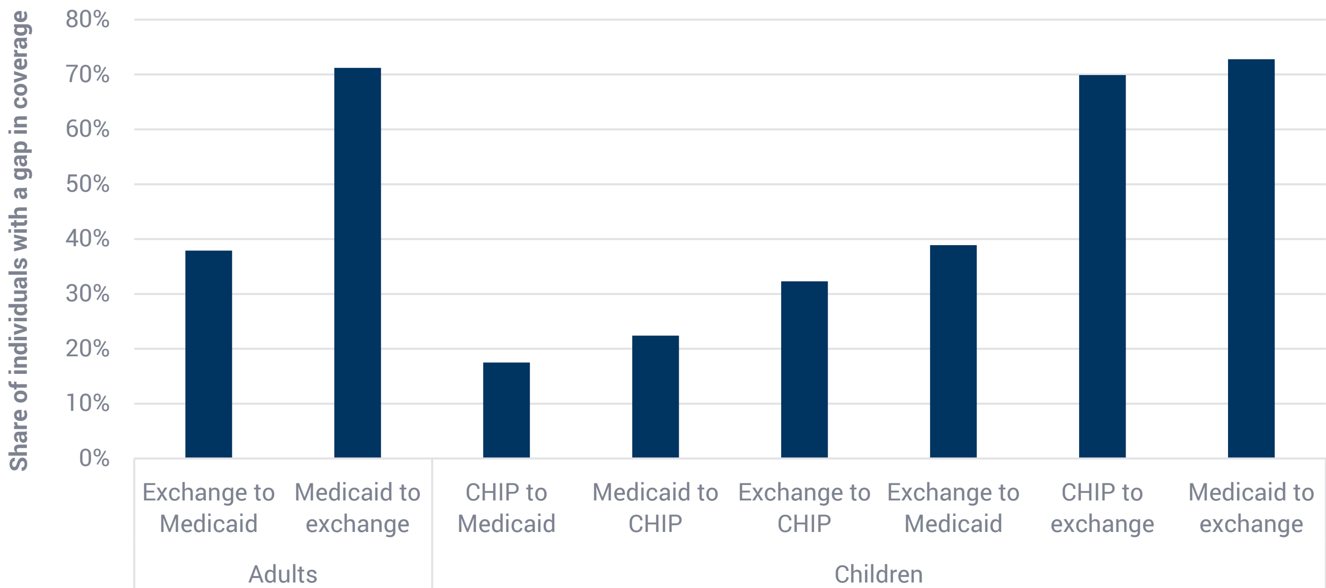
The rate of transitions to exchange coverage that we observed is lower than prior estimates. For example, prior to the implementation of the ACA coverage expansion, the Urban Institute estimated that about one-quarter of Medicaid enrollees who lost coverage would be eligible for exchange coverage (Buettgens et al. 2012).

One reason for this discrepancy may be that beneficiaries who are eligible for exchange coverage may not enroll because of premiums, administrative barriers to enrollment, or other issues. For example, one study in Colorado found that enrollment among those close to the 138 percent FPL threshold was 81.3 percent lower in the exchange compared to Medicaid, suggesting that many of these potentially eligible adults did not enroll in exchange coverage (Bhanja et al. 2021).[6]

Gaps in coverage during transitions

We also found that beneficiaries moving from Medicaid or CHIP to exchange coverage were much more likely to experience gaps in coverage than beneficiaries moving between other insurance affordability programs (Figure 2). For example, less than one quarter of children moving between Medicaid and CHIP experienced a gap in coverage, but more than 70 percent of adults and children moving from Medicaid to exchange coverage had gaps.

FIGURE 2. Share of Adults and Children with a Gap in Coverage when Moving Between Coverage Types, 2018



Notes: CHIP is State Children's Health Insurance Program. Analysis includes states with federally-facilitated marketplace (FFM) and state-based marketplace-federal platforms (SBM-FP) and excludes 11 states and the District of Columbia, which have state-based marketplaces. An additional five states (Florida, Kentucky, Oklahoma, Oregon, and Pennsylvania) were excluded because of incomplete or unreliable T-MSIS data.
Source: Mathematica, 2022, analysis of T-MSIS and federal exchange data.

At a state level, there was considerable variation in the share of beneficiaries with a gap in coverage when moving from Medicaid to exchange coverage. For example, more than 90 percent of adults in New Hampshire and Tennessee experienced gaps in coverage when moving between Medicaid and exchange coverage, compared to 62 percent of adults in Louisiana and Oregon. In our analyses, we were not able to include fully state-based exchanges, which often have integrated eligibility systems that may help to reduce gaps in coverage when moving between insurance affordability programs.

On average, the gap between Medicaid and exchange coverage was about three months for individuals who successfully moved between programs. However, this gap in coverage was longer for Black, Hispanic, and American Indian Alaskan Native beneficiaries. For example, white, non-Hispanic adults moving between Medicaid and exchange coverage had an average gap of 73 days, while Black, non-Hispanic adults making the same coverage transition had an average gap of 105 days.

Policy Issues

Under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) states have been eligible to receive a 6.2 percentage point increase in the federal medical assistance percentage (FMAP) during the COVID PHE if they maintain Medicaid enrollment for all beneficiaries. This continuous coverage provision is currently scheduled to end the month when the PHE ends, and when it does, states will need to begin processing Medicaid redeterminations again and transferring applicant data to other insurance affordability programs if appropriate.

Although many individuals who lose Medicaid coverage are expected to be potentially eligible for exchange coverage, the analyses in this memo suggest that many eligible individuals may not enroll. Some factors that may contribute to low enrollment in exchange coverage include administrative barriers with transferring applications between public coverage programs, and policy differences between Medicaid and exchange coverage, such as premiums.

Administratively, states are required to transfer applications from Medicaid to the exchange if individuals are potentially eligible, but in practice, these account transfers do not always work as intended. In particular, beneficiaries often must provide additional information to complete an application for exchange subsidies since some of the unique information needed to assess eligibility for exchange subsidies (e.g., access to affordable ESI) is not collected as part of the Medicaid or CHIP renewal process.

To address some of these administrative challenges, CMS has been providing states with additional guidance on steps that they can take to smooth transitions between insurance affordability programs. These strategies include improving notices, transferring beneficiary contact information, and working with community-based organizations to assist applicants in gathering additional information that is needed to complete an application for exchange coverage (CMS 2022).

The higher premiums for exchange coverage compared to Medicaid or CHIP may also be a barrier to enrollment for eligible individuals. The analyses in this memo used data from 2017–2019. However, in 2020, the American Rescue Plan Act of 2021 (P.L. 117-2) temporarily expanded the amount of subsidies for exchange coverage and expanded the number of people eligible for subsidies to include those with family incomes below 600 percent of the FPL. On average, these subsidies reduced the cost of exchange coverage by $70 a month for individuals enrolled in the exchange, including $0 premiums for many individuals with incomes below 150 percent FPL (Rae et al. 2021). Under current law, these expanded premium subsidies expire in 2023.

Endnotes

[1] Medicaid programs can impose premiums on some individuals with family incomes above 150 percent of the federal poverty level. More information about Medicaid rules for premiums and cost sharing is available in MACPAC's issue brief *Federal Requirements and State Options: Premiums and Cost Sharing*.

[2] Virtually all states with separate CHIP also use CHIP funding to expand Medicaid coverage for some children. These states that operate both a separate CHIP and a Medicaid expansion CHIP are typically referred to as combination programs. Six states that cover CHIP children through a Medicaid expansion CHIP also cover unborn children (i.e., pregnant individuals) through a separate CHIP.

[3] States can choose to use a separate application for the people whose eligibility is not determined using MAGI methods or a combination of the single, streamlined application and supplemental forms necessary to collect the information to determine eligibility for non-MAGI pathways. The single, streamlined application includes some high-level screening questions to identify disability or the need for long-term services and supports, but it does not capture all the information needed to conduct a non-MAGI eligibility determination (CMS 2017). For example, because enrollees who qualify for Medicaid through a non-MAGI may be subject to an asset test and need a disability determination, additional information may be required on the application in order to make an eligibility determination.

[4] The 11 states and District of Columbia that operate fully state-based exchanges were not included in our analysis because their enrollment data are not managed by CMS.

[5] Due to data quality issues with Medicaid and CHIP enrollment data available in the Transformed Medicaid Statistical Information System (T-MSIS), we ultimately included 35 states in our analysis.

[6] Colorado operates a state-based exchange and thus the transitions between public coverage programs in this state may be different from the transitions we observed in our analysis of states that use the federal platform.

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