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CHAPTER



Promoting Continuity of Medicaid Coverage among Adults under Age 65

Recommendations

Promoting Continuity of Medicaid Coverage among Adults under Age 65

This chapter underscores the Commission's support for two recommendations made in its March 2013 report to the Congress:

- ▶ The Congress should extend a statutory option for 12-month continuous eligibility for adults in Medicaid, parallel to the current state option for children in Medicaid.

- ▶ The Congress should eliminate the sunset date for extended Transitional Medical Assistance (TMA), while allowing states to opt out of TMA if they expand to the new adult group added under the Patient Protection and Affordable Care Act.

Key Points

- ▶ Low-income parents and childless adults experience substantial income volatility during the year, which can cause churning on and off of Medicaid coverage. Among adults under age 65 with income below 138 percent of the federal poverty level (FPL), 23 percent would have income above 138 percent FPL by four months. Of those, a third (34 percent) would be back below 138 percent FPL by their regular annual redetermination.
- ▶ After losing Medicaid eligibility, many parents and childless adults will not be eligible for, or take up, exchange or other coverage.
- ▶ Twelve-month continuous eligibility, which allows states to disregard the requirement in federal Medicaid regulations that enrollees report changes in income prior to their regularly scheduled redetermination, has been shown to reduce churning among children. However, this state plan option is no longer available for adults in Medicaid as a result of changes from the Patient Protection and Affordable Care Act (ACA, P.L. 111–148, as amended). To promote continuity of coverage, the Commission reaffirms its March 2013 recommendation that the Congress extend a statutory option for 12-month continuous eligibility for adults in Medicaid, parallel to the current state option for children in Medicaid.
- ▶ For decades, TMA has promoted employment and continuity of coverage. Subject to congressional authorization and funding, TMA provides 6 to 12 additional months of Medicaid eligibility to low-income parents and their children whose earnings would otherwise make them ineligible. To prevent unnecessary gaps in coverage, the Commission reaffirms its March 2013 recommendation that the Congress eliminate the sunset date for extended TMA, while allowing states to opt out of TMA if they expand to the new adult group.
- ▶ Other state strategies, such as bridge plans and premium assistance for exchange coverage, may be effective at mitigating some of the effects of churning. The Commission will continue to monitor the effectiveness of these new efforts and the extent to which churning and uninsurance still occur.


CHAPTER

Promoting Continuity of Medicaid Coverage among Adults under Age 65

For years, program administrators and policymakers have explored options to reduce churning, where individuals transition from one program to another or to uninsured status, often in a relatively short period of time. This chapter focuses on some of the churning that is expected to occur beginning in 2014 as the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) is fully implemented. Parents and childless adults, many of whom are newly eligible for Medicaid, will churn between Medicaid and exchange coverage as their incomes and other eligibility criteria change.¹ Even in expansion states, some parents and childless adults will not be eligible for, or take up, exchange or other coverage after losing Medicaid eligibility. Churning is of concern to policymakers because it causes disruptions in the continuity of care and causes individuals to forgo primary and preventive care that can prevent more costly health care utilization. Our focus in this chapter is on changes in coverage among parents and childless adults that occur between annual redeterminations because of changes in family income.^{2,3}

The chapter begins by briefly reviewing analyses on the impact of churning presented in MACPAC's March 2013 report to the Congress and the Commission's prior recommendations. We then present new analyses projecting significant income changes among parents and childless adults at or below 138 percent of the federal poverty level (FPL), which may cause these adults to move back and forth between various sources of coverage, or to uninsurance.⁴ The final section describes policy interventions to promote continuity of coverage, including the Commission's continued support of prior recommendations on two specific strategies: 12-month continuous eligibility and Transitional Medical Assistance (TMA).

Impact of Coverage Changes

In its March 2013 report, MACPAC provided examples and evidence, both from the research literature and from MACPAC analyses, regarding the effects of churning and strategies to mitigate it (MACPAC 2013a). Reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, and reduces the likelihood of inpatient hospital admissions and emergency room visits (Ku et al. 2009). Churning between insurance programs is disruptive for enrollees as well as for the plans, providers, and government entities that must process those changes. Twelve-month continuous eligibility, which allows states to disregard the requirement in federal regulations that enrollees report changes in income during the year that could affect their eligibility, has been shown to reduce churning among children. To enable states to maintain options for promoting continuity of coverage that were permitted prior to the ACA's implementation, the Commission recommended in March 2013 that the Congress statutorily authorize a state's option to provide 12-month continuous eligibility to adults enrolled in Medicaid, as exists for children in Medicaid.⁵

Since that recommendation was made, additional research has shown that non-disabled adults under age 65 have the lowest levels of continuous coverage of any Medicaid eligibility group (Ku and Steinmetz 2013).⁶ According to the authors, widespread use of 12-month continuous eligibility for children may explain why children have lower churning rates than non-disabled adults under age 65.

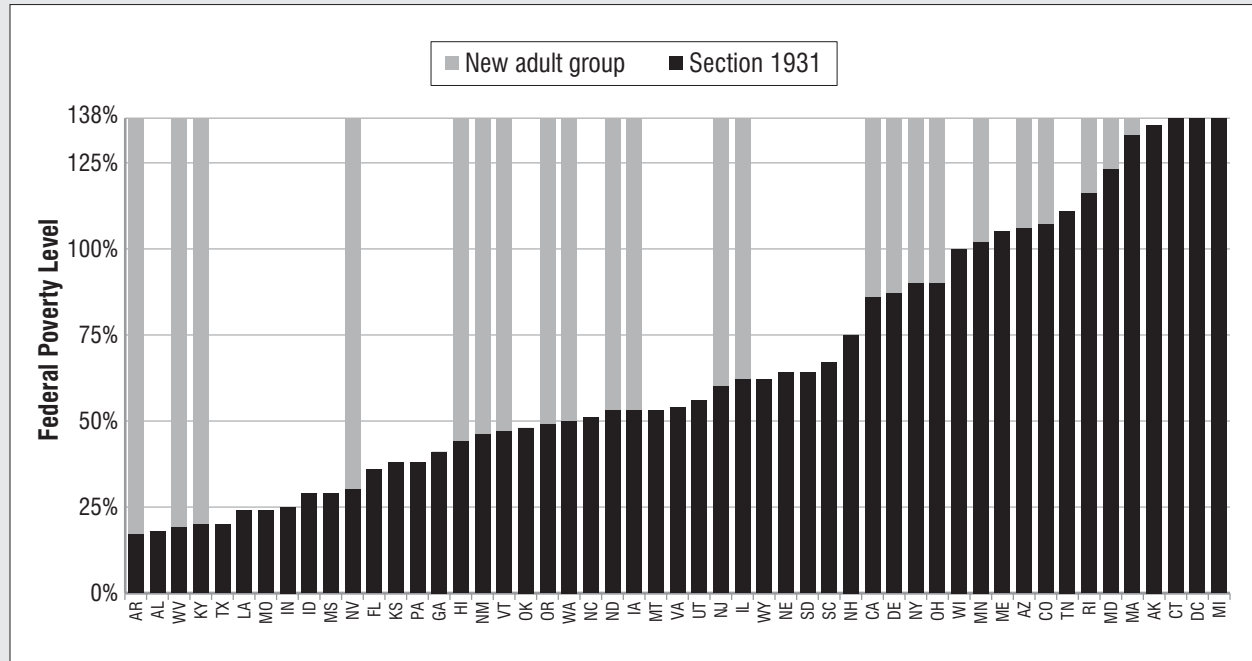
Churning between sources of insurance, or to no insurance, occurs in every state, but churning dynamics in 2014 and beyond will differ depending on whether or not states expand Medicaid to the new adult group. Approximately half the states are not implementing this expansion in 2014, which means the vast majority of poor childless

adults in these states will continue to be ineligible for Medicaid.⁷ In all states, however, the lowest-income parents will continue to be eligible for Medicaid based on the state-specific levels that continue to be in effect under Section 1931 of the Social Security Act (the Act). Current Section 1931 eligibility levels vary by state from 17 percent FPL in Arkansas (less than \$3,312 in annual income for a family of three) to levels above 100 percent FPL in a number of states (Figure 2-1).

Section 1931 was created in the welfare reform legislation of 1996. Prior to welfare reform, individuals eligible for the cash welfare program Aid to Families with Dependent Children (AFDC) were automatically eligible for Medicaid. When AFDC was eliminated by welfare reform, that eligibility pathway to Medicaid for low-income families was replaced by Section 1931 so that parents and children who would have been eligible for the state's AFDC program could still qualify for Medicaid. During fiscal year 2010, approximately 10.3 million children and 5.7 million adults were enrolled in Medicaid under Section 1931 (MACPAC analysis of the Medicaid Statistical Information System (MSIS) State Summary Datamart).

Another statutory provision that can mitigate churning is TMA. TMA has been available since 1974 to provide additional months of Medicaid coverage to certain low-income parents and their children whose increase in income would otherwise make them ineligible for Medicaid. Although TMA began by providing 4 months of extended Medicaid coverage, TMA currently requires states to provide at least 6 and up to 12 months of coverage (§1925 of the Act). Unlike most Medicaid provisions, Section 1925 TMA relies on regular extensions of its authority and funding by the Congress. TMA is only available to low-income parents and their children eligible for Medicaid under Section 1931. While the welfare reform legislation of 1996 delinked Medicaid eligibility from welfare assistance,

FIGURE 2-1. Income Eligibility Levels for Parents under the Section 1931 and New Adult Eligibility Groups by State



Notes: FPL is federal poverty level. Eligibility levels reflect a disregard equal to 5 percent FPL. This disregard only applies at the highest Medicaid eligibility level. Thus, in states that expanded to the new adult group, the disregard effectively increases eligibility from 133 percent FPL to 138 percent FPL but is not applied to these states' Section 1931 levels. For states not expanding to the new adult group, the disregard is applied to Section 1931 eligibility. In some states, Section 1931 eligibility levels as a percent of FPL vary by family size; this figure shows eligibility for a family of three, although levels may be slightly higher for smaller families. When Section 1931 eligibility levels vary within a state by region or other factors, the highest level is shown. For Section 1931 levels in Hawaii and New Jersey, Aid to Families with Dependent Children (AFDC) levels as of 1996 were used.

Sources: MACPAC analysis of: Centers for Medicare & Medicaid Services (CMS), *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (for MAGI groups, based on state decisions as of February 26, 2014)*; and CMS, *Medicaid moving forward 2014, State-specific documents, MAGI conversion plan and SIPP-based MAGI conversion results*, <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html>.

the Congress retained TMA for families eligible under Section 1931, to ensure that the poorest families could transition from welfare assistance to work without losing health insurance coverage.

To mitigate churning from Medicaid to uninsurance that may result from the coverage gap between Medicaid and subsidized exchange coverage in non-expansion states (which begins at 100 percent FPL for citizens), the Commission recommended in its March 2013 report that the Congress end the sunset date for 6- to 12-month TMA. For states implementing the expansion in which there is no coverage gap between Medicaid and subsidized exchange coverage, the Commission recommended that states be able to opt out of TMA.

Income Changes among Parents and Childless Adults below 138 Percent FPL

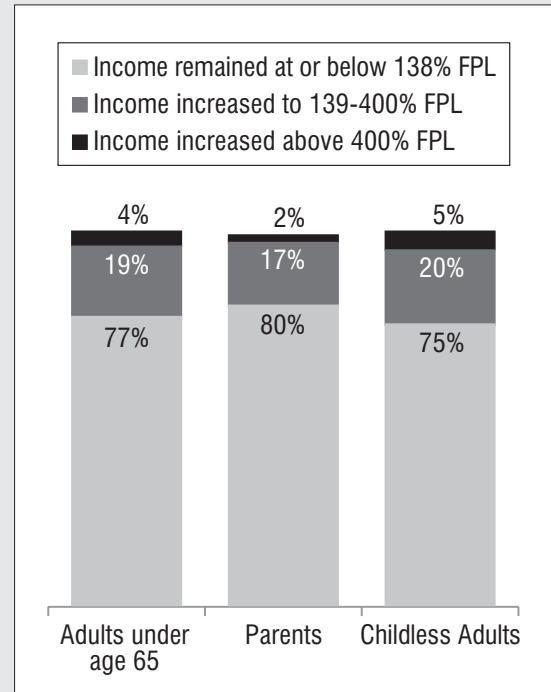
For parents and childless adults enrolled in Medicaid in expansion states, transitions out of Medicaid will occur primarily because of income changes from below to above 138 percent FPL (\$16,105 in annual income for an individual). New analyses suggest that there is significant intra-year income changes among adults under age 65 moving from below to above 138 percent FPL and back again. Because of frequent income changes, these individuals may be required to move back and forth between Medicaid and other sources of coverage (or uninsurance).

In expansion states, when parents and childless adults lose eligibility for Medicaid because of a reported income change, many may become uninsured. Not all those eligible for subsidized exchange coverage will enroll because some out-of-pocket cost sharing and premium payments will generally still be required. In addition, many parents and childless adults losing Medicaid eligibility will be ineligible for subsidized exchange coverage because they are offered employer-sponsored insurance that is considered affordable under the law, but may not be practically affordable. Under the ACA, employer-sponsored insurance is considered affordable if employees' out-of-pocket premiums for self-only coverage comprise less than 9.5 percent of family income. This affordability test—sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered—could contribute to many former Medicaid enrollees moving to uninsurance if families find that employer-sponsored insurance and unsubsidized exchange coverage are not affordable. In fact, of those enrolled in Medicaid, more would become uninsured at least part of the year than would enroll in exchange coverage at least part of the year (Buettgens 2013).

Many parents and childless adults who are below 138 percent FPL at a point in time experience increases in income that could make them ineligible for Medicaid—as shown at 4 months (Figure 2-2), 8 months (Figure 2-3), and 12 months (Figure 2-4). If all individuals reported income changes during the year as required, 23 percent of these adults would move out of regular Medicaid by 4 months, and 28 percent by 8 months (Figure 2-5).⁸ Nearly one-third (32 percent) of adults initially below 138 percent FPL would be above 138 percent FPL by the time of their annual redetermination and would thus be ineligible for Medicaid, unless TMA were available (Figure 2-5).

The vast majority of adults projected to have income changes from below to above 138 percent FPL would still be below 400 percent FPL

FIGURE 2-2. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 4 Months



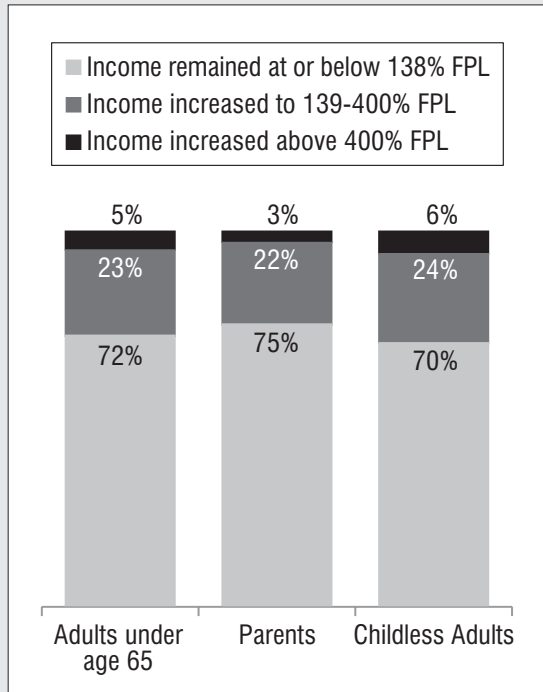
Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

(Figures 2-2, 2-3, and 2-4) and thus potentially eligible for subsidized exchange coverage unless they had access to employer-sponsored coverage that was considered affordable.

Income changes are more common among the lowest-income adults, which could lead to significant uninsurance if TMA did not exist for parents, particularly in non-expansion states. In states not implementing the Medicaid expansion, Medicaid eligibility for parents will only be available under Section 1931, typically at 50 percent FPL or below. At these states' relatively low-income eligibility levels, changes in income from below to

FIGURE 2-3. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 8 Months



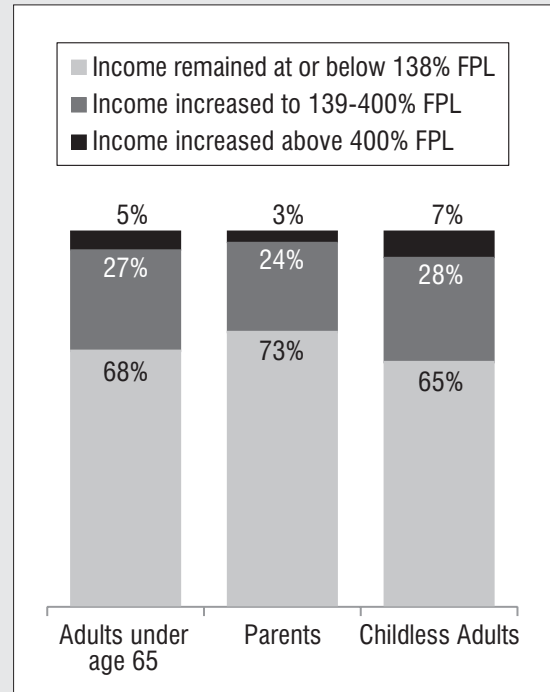
Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

above these thresholds are double that of parents at 138 percent FPL (Figure 2-6).

For example, Texas is not currently planning to implement the expansion to the new adult group, and, in 2014, the state will cover parents up to 15 percent FPL, or \$2,969 in annual income for a family of three (CMS 2013a). Because of the ACA requirement that all state Medicaid and CHIP programs count income for most enrollees according to modified adjusted gross income (MAGI), states will be required to disregard income equal to 5 percent FPL when determining eligibility. Thus, the effective level for parents' eligibility in

FIGURE 2-4. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 12 Months

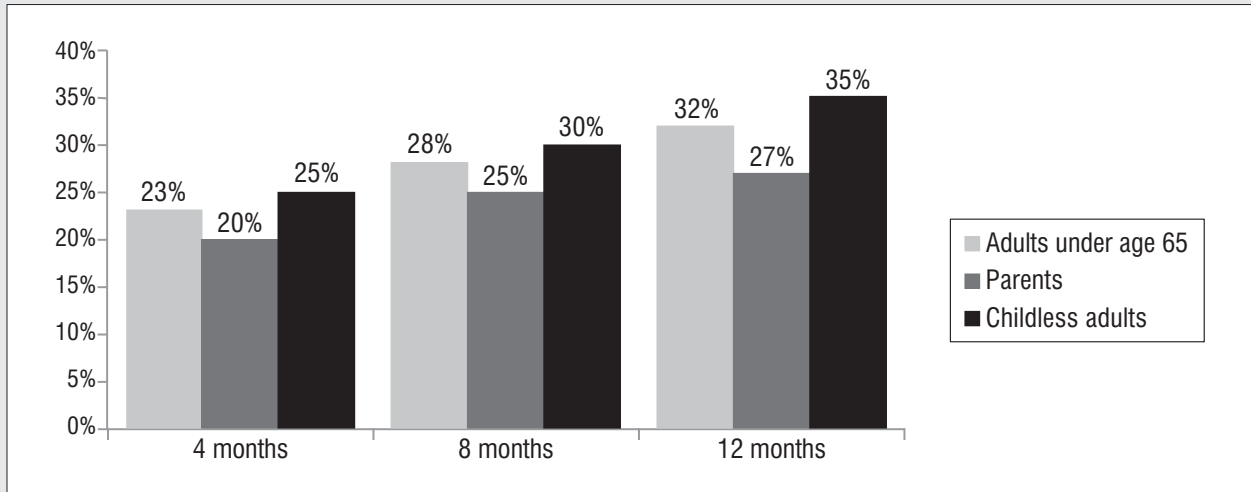


Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

Texas will be 20 percent FPL, or \$3,958 in annual income for a family of three. Among parents nationwide below 20 percent FPL, 49 percent would have income above that level after just four months (Figure 2-6) compared to 20 percent of parents who would have income increased from below to above the threshold of 138 percent FPL after four months (Figure 2-5).⁹ Considering the additional income volatility among the lowest-income parents enrolled in Medicaid under Section 1931, TMA will play an important role in non-expansion states to reduce the extent to which parents churn off of Medicaid to uninsurance.

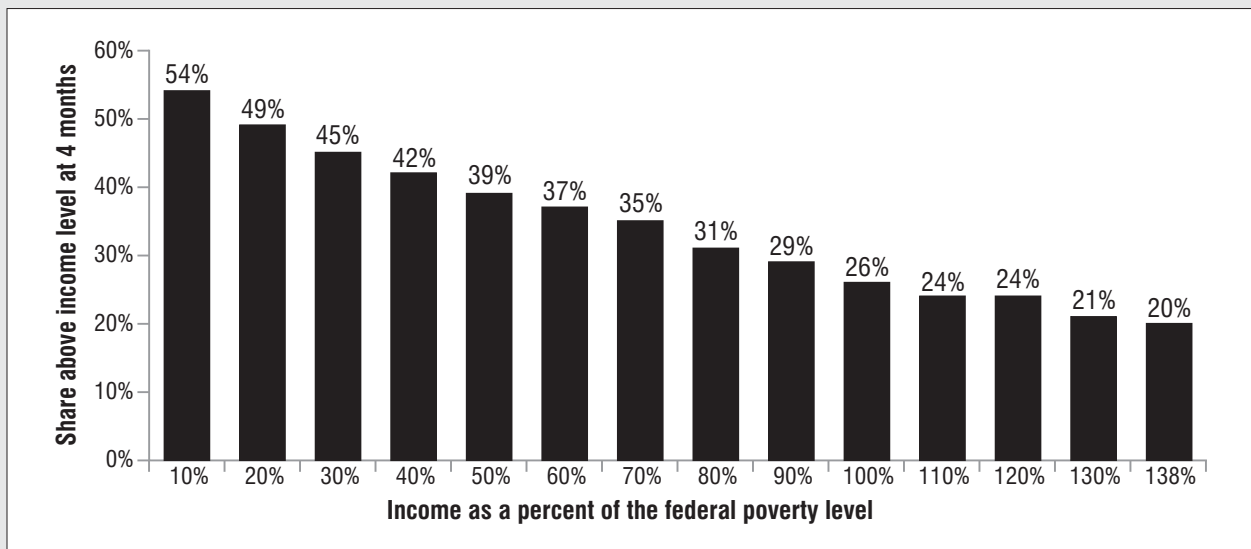
FIGURE 2-5. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases above 138 Percent FPL Observed at 4, 8, and 12 Months



Note: This figure shows the income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau’s Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

FIGURE 2-6. Percent of Parents under Age 65 Who Experience an Increase in Income Level Observed at 4 Months



Notes: This figure shows the income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Sources: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau’s Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

Strategies to Improve Continuity of Coverage among Parents and Childless Adults

Changes in income and family situations can cause a change in individuals' health coverage affecting benefits to which they are entitled, cost sharing, participating providers, and the plan in which they are enrolled. But experiences will vary among individuals. Some may move to TMA, employer-sponsored insurance, or uninsurance. In non-expansion states, the gap between Medicaid eligibility and exchange coverage for parents may result in greater churning to uninsurance once their TMA is exhausted.

Some churning is inevitable. For example, the eligibility of parents and childless adults enrolled in Medicaid must be redetermined annually, with changes in income or family status potentially leading to a change in source of coverage. Steps can be taken, however, to smooth transitions and mitigate the consequences of churning—thus ensuring continued coverage and preserving access to current providers, benefits, and cost-sharing protections. The remainder of this chapter describes various strategies to improve the stability of coverage, or, when churning cannot be avoided, to mitigate some of its negative effects. The strategies are discussed in terms of whether or not they are effective in preventing changes in the providers that enrollees can see, the plan in which they are enrolled, and the benefits and cost-sharing protections they can access. Few of the strategies can address all of these factors.

Managed care plan participation in both Medicaid and exchange markets. As individuals transition between Medicaid and exchange coverage, the change may be less disruptive if the same insurer participates in both the Medicaid and exchange markets. In this case, individuals could stay with the same insurer and potentially the same network

of providers. However, the provider networks may not be identical across markets. Moreover, the presence of such plans would not prevent other significant impacts of churning—for example, changes in benefits and cost sharing resulting from a move from Medicaid to exchange-based coverage.

The prevalence of Medicaid managed care could provide opportunities for large enrollment in plans that participate in both Medicaid and exchange markets. Currently, more than two-thirds of state Medicaid programs contract with full-risk Medicaid managed care plans, which account for half of all Medicaid enrollees (MACPAC 2013b). Most states that are implementing the expansion to the new adult group are enrolling the majority in managed care (Sommers et al. 2013). A recent study by the Association for Community Affiliated Plans found that 41 percent of insurers offering exchange coverage also offer a Medicaid managed care plan in the same state (ACAP 2013). More analysis will be needed to determine the extent to which provider networks vary even if an insurer offers products in both markets.

An insurer's decision to participate in both Medicaid and exchange markets is affected by many factors. Business and strategic considerations appear to be the most significant contributors to plan decisions about whether to participate in both markets. Participation in exchanges requires substantial investments in time and resources, and the potential return on the investment is still unknown. In addition, plans must also be able to negotiate sufficiently competitive provider contracts to support competitive pricing within the exchange (Holahan 2012). As a result, some insurers decided to opt out of the exchanges in 2014 and are waiting to see how the market unfolds before deciding whether to participate in future years. Other insurers chose to participate in the exchanges for a number of reasons, including a desire to gain membership in the first year of exchange operation,

capture family members of current enrollees, and retain enrollees who transition between Medicaid and the exchanges.

Whether differing requirements for exchange plans versus Medicaid managed care plans might pose a barrier to multimarket participation remains to be seen. However, federal requirements for exchange plans and Medicaid managed care plans are relatively similar, allowing for substantial state flexibility and control. While there are some differences between the federal rules governing each market, these differences do not appear to be a barrier for plans that wish to participate in both markets. Exchange rules vary considerably among states that operate their own exchanges. As with Medicaid, states operating their own exchanges have the ability to make many of their own management decisions, which may affect plan willingness and ability to participate in the exchange market. On the other hand, for some plans interested in operating in multiple states, this variation is a concern. MACPAC plans to monitor the presence of multimarket plans and their effect on reducing disruptions in enrollees' access to providers.

Bridge plans. Bridge plans are another mechanism that could mitigate some of the negative effects of churning—in particular, the need to switch plans and providers. Bridge plans are a type of multimarket plan that is permitted to cover only a fraction of individuals in the other market. For example, bridge plans may be exchange plans that are also permitted to enroll family members who are eligible for Medicaid or CHIP or vice versa (Johnson 2013, CMS 2012). This allows the family to be enrolled in the same plan, albeit with different cost sharing. Bridge plans must meet the requirements of both Medicaid and exchanges, and, in 2014, they can only be offered in states with a state-based exchange (CMS 2012). As a result, take-up of this approach has been quite limited. At this time, only two states appear to be implementing

bridge plans—California and Washington (Covered California 2013, Johnson 2013).

Premium assistance for exchange coverage.

Premium assistance is another vehicle to bring exchange plans to Medicaid enrollees. Premium assistance permits Medicaid-eligible individuals to enroll in exchange plans, with Medicaid paying for the premiums and cost-sharing reductions. Like multimarket plans and bridge plans, premium assistance has the potential to provide access to the same plans and provider networks as individuals churn between Medicaid and exchange coverage. Like multimarket plans and bridge plans, premium assistance cannot be used to preserve Medicaid's benefits and cost-sharing protections as an individual's income increases from Medicaid to exchange levels. However, as long as individuals remain eligible for Medicaid, those enrolled in exchange-based premium assistance generally cannot face cost sharing in excess of what they would face in regular Medicaid (CMS 2013b).

Premium assistance is distinct from multimarket plans and bridge plans in that the exchange plan is not required to meet federal requirements that otherwise apply to Medicaid managed care plans. An exchange plan does not need to be certified as a Medicaid managed care organization in order to enroll Medicaid beneficiaries when the state has elected to implement premium assistance. However, states may elect to add certain plan requirements.

While premium assistance prevents enrollees from having to switch plans when their income reaches or exceeds 138 percent FPL, it may simply move the point at which such a switch is required. For example, in 2014, Arkansas will maintain traditional fee-for-service Medicaid coverage for its Section 1931 parents, up to 17 percent FPL. Thus, if parents' income increases from below to above 17 percent FPL—that is, to the new premium assistance option—they would have to choose an exchange plan, with a different network although

still with virtually no cost sharing (CMS 2013c). To eliminate this effect of churning, Arkansas has expressed an interest in enrolling Section 1931 parents, as well as children, in its premium assistance program in the future (Arkansas 2013a).

Although states can implement premium assistance without a waiver, most states wanting to use premium assistance with exchange plans are seeking waivers in order to implement it in a way not otherwise permitted. For example, a waiver is required if states want to mandate enrollment in exchange-based premium assistance, as implemented by Arkansas and Iowa. However, the Centers for Medicare & Medicaid Services (CMS) is only willing to approve “a limited number of premium assistance demonstrations” (CMS 2013d). Approval of such waivers would have additional limitations—for example, that enrollees have a choice of at least two exchange plans and that the demonstration end by December 31, 2016 (CMS 2013d).

Other states are considering the premium assistance approach (Sommers et al. 2013). While it can reduce the extent of plan switching necessitated by churning, exchange-based premium assistance raises a number of other questions that the Commission will be exploring in the future, such as whether the state Medicaid agency has a role in overseeing exchange plans receiving premium payments from Medicaid and whether enrollees are able to access the benefits to which they are entitled.

Basic Health Program. The ACA permits states to create a Basic Health Program that covers individuals above 138 and up to 200 percent FPL. If offered in their state, eligible individuals would be required to enroll in the Basic Health Program in lieu of obtaining subsidized coverage in the exchanges. States would receive 95 percent of the money the federal government would have paid for subsidized exchange coverage. Depending on how it is implemented by states and how much coverage states can purchase with the federal funds,

a Basic Health Program could require little or no cost sharing from enrollees. If this occurs, a state may be able to implement a Basic Health Program to reduce the effects of churning from below to above 138 percent FPL by maintaining the same plans, benefits, and cost sharing as in Medicaid. These programs are intended not only to reduce churning, but also to reduce the likelihood that low-income families would be forced to repay premium tax credits they received should they experience an increase in income or a change in family composition (CMS 2013e). Because CMS delayed the implementation of the Basic Health Program until 2015, it will be some time before the effects of this ACA provision can be assessed (CMS 2013e). Seven states are known to be considering this option for 2015 (Sommers et al. 2013).

Twelve-month continuous eligibility.

By disregarding income changes, 12-month continuous eligibility has the potential to eliminate income-related churning altogether between annual redeterminations, thus avoiding mid-year changes in benefits, cost sharing, plans, and networks.

In its March 2013 report, the Commission addressed the issue of churning by recommending that the Congress statutorily authorize the option for states to implement 12-month continuous eligibility to adults enrolled in Medicaid (MACPAC 2013a).¹⁰

Under current rules, Medicaid enrollees are generally required to report changes that may affect eligibility between regularly scheduled redeterminations (42 CFR 435.916(c)). Based on these requirements, enrollment in Medicaid can change in any month. Medicaid applications clearly state the requirement to report income changes. For example, the model application available through the federally facilitated exchange asks applicants for their signature, acknowledging that “I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application” (CMS

2013f). The application then describes how individuals can report any changes. Many state Medicaid applications have similar language.

Twelve-month continuous eligibility allows states to enroll individuals in Medicaid or CHIP for 12 months, regardless of changes in family income that occur in the interim. For example, among parents and childless adults who begin the year at or below 138 percent FPL but then experience an income change by four months to above 138 percent FPL, 34 percent are back below 138 percent FPL at the time of the regular annual redetermination. Among those whose income is above 138 percent FPL at the 8-month mark, 26 percent are back below 138 percent FPL by the 12-month mark (Fried 2013). Twelve-month continuous eligibility would prevent these individuals from churning off and back on to Medicaid during the year.

Twelve-month continuous eligibility is an explicit statutory option for children in Medicaid used by 23 states but, as of 2014, is no longer available as a state plan option for adults in Medicaid (CMS 2013b, HHS 2012). Prior to the implementation of MAGI in 2014, states had the ability to implement 12-month continuous eligibility for adults without a waiver, by using their income-counting flexibility to disregard all changes in income between redeterminations. Because MAGI permits no state-specific income disregards, this approach for implementing 12-month continuous eligibility for adults is no longer available.

For adults in Medicaid, 12-month continuous eligibility is now available only through a Section 1115 waiver; however, waivers are accompanied by requirements that do not apply for regular state plan options (CMS 2013b). For states without an existing waiver, the process would be more difficult, requiring the state to go through the full array of transparency rules in addition to the full waiver application process. To facilitate

the application process, CMS provides an online template for Section 1115 waivers, which includes space for states to note their desire to implement 12-month continuous eligibility (CMS 2013g).

CMS' interpretation of how 12-month continuous eligibility for adults is financed under a waiver may have contributed to reduced state interest in the approach. No state has yet implemented 12-month continuous eligibility for adults through a waiver, although five states reported in 2013 that they were planning to do so (Sommers et al. 2013). For example, Arkansas's original Section 1115 application in 2013 sought to implement 12-month continuous eligibility for newly eligible adults (Arkansas 2013b), but the provision was dropped in the final waiver application (CMS 2013c). While the state is eligible for 100 percent federal funding for newly eligible adults in 2014, CMS informed the state that some adjustment to the enhanced matching rate for newly eligible adults would be required to account for an estimate of those adults who would have become ineligible due to reported changes in income.

To ensure that states continue to have the flexibility to implement 12-month continuous eligibility for adults, the Commission recommended in its March 2013 report that the Congress create a statutory option for 12-month continuous eligibility for adults in Medicaid. The Commission continues to support this recommendation as an approach that promotes stability of coverage and reduces administrative burden associated with intra-year redeterminations. This would give states the option to align their redetermination policies for families, so that if children are eligible for 12-month continuous eligibility, their parents can be as well. Congressional action should also clarify that states implementing 12-month continuous eligibility for adults in Medicaid would continue to receive the appropriate matching rate for those populations, as with

enhanced federal matching for children enrolled using 12-month continuous eligibility in CHIP.

Twelve-month continuous eligibility can also prevent the potential loss of Medicaid from serving as a disincentive to work. As individuals' incomes increase, they could lose Medicaid eligibility but qualify for exchange coverage that, even when subsidized, requires premiums and cost sharing that can be difficult for families to afford. These financial implications can serve as a disincentive for families to increase their earnings, if those additional earnings are reduced by out-of-pocket premiums and cost sharing. For low-income families, there could also be concerns with churning in and out of exchange coverage and their potential liability to repay premium tax credits.¹¹ Ensuring that Medicaid policy does not provide a disincentive to work has been a goal of the Congress in enacting many Medicaid provisions, including TMA (GAO 2002, U.S. House of Representatives 1972). Giving states the option that existed prior to the ACA to implement 12-month continuous eligibility for adults in Medicaid would be consistent with this goal.

According to the Congressional Budget Office (CBO) and the ranges of cost estimates it provides to MACPAC, statutorily permitting states to implement 12-month continuous eligibility for adults in Medicaid would increase federal spending in 2015 by \$50 million to \$250 million. Over the five-year period of 2015 to 2019, this recommendation would increase federal spending by less than \$1 billion, the smallest non-zero category used by CBO.

There are many reasons for the relatively small projected federal costs, including potentially low state take-up of the option, since no state has ever implemented 12-month continuous eligibility for adults. Even to the extent that it is implemented, the net federal costs could be limited by the fact that continued Medicaid

enrollment resulting from 12-month continuous eligibility would often be replacing other federal spending—such as, for subsidized exchange coverage—thus providing offset savings from any increased federal Medicaid spending.

On the other hand, the Commission acknowledges that states choosing to implement 12-month continuous eligibility could see increased Medicaid spending resulting from enrollees remaining covered for a greater number of months during the year, on average. For example, compared to other states, states that implemented 12-month continuous eligibility between 2008 and 2010 for children in Medicaid experienced 2 percent larger increases in children's average months of enrollment, which could be expected to result in a 2 percent increase in spending on children in Medicaid (Ku et al. 2013). However, some of those costs could be offset by administrative savings of reduced intra-year redeterminations and lower per capita spending from greater stability of coverage.

State projections of the cost of 12-month continuous eligibility have varied widely. The greatest estimated costs were projections by states that had not yet implemented 12-month continuous eligibility (e.g., Colorado Legislative Council 2009).¹² One state that had implemented 12-month continuous eligibility for children noted there was little increased spending as a result and perhaps even some net savings (Barkov and Hale 2013).

Transitional Medical Assistance. As described earlier, Section 1925 TMA provides an additional 6 to 12 months of Medicaid to the lowest-income parents and children who would otherwise lose Medicaid under Section 1931, generally because of an increase in earnings. Like 12-month continuous eligibility, TMA delays churning and, during that time, avoids the concomitant changes in covered benefits, cost sharing, plans, and networks. In 2011, 43 states reported TMA enrollment of over 3.7 million individuals (GAO 2013).

The context for TMA has changed because of the coverage options available under the ACA. Many parents in states implementing the Medicaid expansion will be eligible for the new adult group or subsidized exchange coverage, so TMA may not be as essential in preventing uninsurance as it was in the past. In states that do not expand coverage to the new adult group, however, there is a gap in coverage between states' Section 1931 levels and eligibility for subsidized exchange coverage, which begins at 100 percent FPL for citizens. TMA will be particularly crucial in preventing uninsurance in states that do not expand Medicaid coverage for adults.

As of the publication of this report, Section 1925 TMA funding ends after March 31, 2014. For the past several years, funding for TMA has continued through short-term extensions. Most recently, the Bipartisan Budget Act of 2013 (P.L. 113-67) extended TMA funding by another three months, from December 31, 2013, to March 31, 2014.

If the authorization and funding for TMA is not extended, TMA will not disappear altogether but will revert to its original four-month duration. Four-month TMA has different eligibility policies that have not been in effect since 1990. States would also lose some of the flexibility they currently have under Section 1925 TMA. For example, states may currently require TMA beneficiaries to enroll in employer-sponsored insurance if offered to them. States using this option must pay the enrollees' share of premiums and cost sharing. At least 23 states use this premium assistance option under TMA to purchase employer-sponsored insurance—an option that would disappear if Section 1925 TMA is not renewed (GAO 2012). This option currently provides the opportunity for low-income individuals to transition to employer-sponsored insurance rather than abruptly facing the premiums and cost-sharing requirements that might discourage them from working or working more hours. Thus, reverting to four-month TMA would require states to implement resource-intensive

changes, which may be less than ideal as states are making other significant changes to their eligibility systems, and would increase costs—both for states and the federal government.

The Commission's recommendation in its March 2013 report would have ended the sunset date for Section 1925 TMA. The Commission continues to support this recommendation so that states do not face the perennial possibility of reverting to four-month TMA and of needing to modify their eligibility systems to reinstitute TMA policies from 1990. In addition, TMA in its current form also prevents uninsurance, particularly in states not expanding Medicaid to the new adult group. Since non-expansion states will have a gap in eligibility for parents between Medicaid and subsidized exchange coverage, TMA will be critical in those states to reduce churning from Medicaid to uninsurance. The Commission also recognizes that providing incentives to promote increased earnings and employment opportunities for the lowest income Americans is an important goal. TMA has helped many to move on to employment without compromising ongoing health care during the transition.

For providers and health plans, the continuation of 6- to 12-month TMA would reduce the administrative burden associated with individuals moving on and off of Medicaid. Longer tenure by enrollees with the same plan or provider helps ensure that efforts to improve care management and quality are not compromised because of churning. While some churning is inevitable, the Commission's recommendation to eliminate the sunset date for TMA seeks to reduce churning that is disruptive to care delivery.

CBO projects that ending the sunset date for Section 1925 TMA would save the federal government between \$1 billion and \$5 billion over a five-year period from 2015 to 2019. CBO's current-law assumption is that when 6- to 12-month TMA expires, it will revert to its four-month duration, after which time individuals move to other sources

of coverage or to uninsurance. Under CBO's current-law assumption, the other sources of coverage—for example, subsidized exchange coverage or Medicaid coverage for newly eligible adults currently at the 100 percent federal matching rate—may result in higher federal spending than under regular Medicaid. From the federal perspective, the savings projected by CBO from ending the sunset date on 6- to 12-month TMA result from replacing those more costly sources of coverage with additional months of TMA at the regular Medicaid matching rate. However, if TMA reverts to four months—shortening TMA and allowing individuals to move to subsidized exchange coverage, newly eligible Medicaid, or to uninsurance—states would incur less of an expense than continuing with 6 to 12 months of TMA at the regular Medicaid matching rate.

The second part of the Commission's TMA recommendation in March 2013 was to permit expansion states to opt out of TMA altogether. Because these states have no eligibility gap between Medicaid and subsidized exchange coverage, TMA may no longer be as necessary in these states to prevent uninsurance. Its continuation could create unnecessary confusion and administrative burden for enrollees, state Medicaid and CHIP programs, and exchanges.

For expansion states, opting out of TMA will also address an inequity between those parents and children who are eligible for TMA and those who are not. For example, while very low-income parents and children who are eligible for Medicaid under Section 1931 may qualify for TMA, parents enrolled through the new adult group will not have access to TMA.¹³

The two parts of the Commission's March 2013 TMA recommendation were originally projected by CBO to have little effect on federal spending. However, the same policies are now projected by CBO to increase federal spending by \$750 million to \$2 billion in 2015 and by \$5 billion to \$10 billion

in the five-year period between 2015 and 2019. The increased estimate results from changes in how CBO projects the federal cost of expansion states opting out of TMA. CBO projects that every expansion state would opt out of TMA, which would result in much higher federal spending as individuals who would otherwise receive TMA at the regular Medicaid matching rate would receive Medicaid as newly eligible adults or would enroll in subsidized exchange coverage, which results in higher federal spending.

The Commission also considered an alternative—allowing expansion states to only opt out of TMA if they replaced it with 12-month continuous eligibility. This alternative would achieve the same purpose—preventing people from forgoing additional income in order to maintain their Medicaid coverage. In addition, the 12-month eligibility period would be more consistent with the annual open enrollment that exists in employer-sponsored insurance and in exchange coverage (MACPAC 2012). Although this approach would be less costly to the federal government than simply allowing expansion states to opt out, the Commission considered but ultimately chose not to recommend that these states be required to adopt 12-month continuous eligibility.

Endnotes

¹ For the remainder of this chapter, childless adults generally refer to individuals age 19–64 who are not pregnant, not eligible for Medicaid on the basis of a disability, and do not have dependent children living in the home.

Individuals could also churn from Medicaid to uninsurance if they are below 400 percent FPL and do not enroll in available employer-sponsored insurance that is considered affordable (i.e., self-only coverage that comprises less than 9.5 percent of income). Having an offer of affordable employer-sponsored insurance disqualifies individuals from receiving premium tax credits for exchange coverage.

² Churning can occur for a variety of reasons. Research on churning has historically focused on transitions from Medicaid or CHIP to uninsurance, particularly at enrollees' regular eligibility redetermination. This is generally referred to as administrative churning, where enrollees' coverage terminates because families do not or cannot provide the necessary application or documentation. However, the ACA required states to streamline eligibility determinations and to use existing data wherever possible, in order to minimize the likelihood of administrative churning at redeterminations. A full assessment of the impact of the ACA on administrative churning will not be possible until actual data are available on redeterminations in 2014. This will be an area of interest for the Commission when those data are available.

³ Other chapters in this report analyze changes in coverage among children and pregnant women in CHIP. Individuals eligible for Medicaid on the basis of being aged or disabled have the highest levels of continuity of coverage (Ku and Steinmetz 2013).

⁴ Because of the ACA requirement to count income according to modified adjusted gross income, states will be required to disregard income equal to 5 percent FPL. For this reason, eligibility for the new adult group is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

⁵ This recommendation also applied to children enrolled in CHIP. Twelve-month continuous eligibility in CHIP is discussed in Chapter 5 of this report.

⁶ The eligibility groups in this analysis were aged, blind/disabled, children, and non-elderly adults.

⁷ Some states not implementing the expansion to the new adult group cover certain childless adults through Medicaid-funded premium assistance for employer-sponsored insurance or limited-benefit coverage under Section 1115 waivers.

⁸ The estimates are of the share of adults under age 65 starting at or below 138 percent FPL who are at a higher-income category at a specific month in the year (at 4 months, at 8 months, and at 12 months). These estimates assess income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

⁹ Because of TMA, these parents would continue Medicaid coverage for at least six more months.

¹⁰ While this chapter focuses on parents and childless adults, the Commission's recommendation was to enable states to use 12-month continuous eligibility for any population in Medicaid, including adults eligible on the basis of being aged or disabled.

¹¹ In the ACA as originally enacted, families who were below 400 percent FPL would not be required to repay more than \$400 when their actual 2014 tax return was reconciled with their advance premium tax credits (§36B(f)(2)(B) of the Internal Revenue Code as originally enacted in §1401(a) of the ACA). The potential repayment amounts are now much higher, which could increase individuals' reluctance to obtain subsidized exchange coverage. In 2014, families below 200 percent FPL may be required to repay up to \$600, families with income of at least 200 percent FPL but below 300 percent FPL may be required to repay up to \$1,500, and families with income of at least 300 percent FPL but below 400 percent FPL may be required to repay up to \$2,500.

¹² Commissioners noted that if it were uncommon for states to eliminate 12-month continuous eligibility once implemented, then this may indicate that its cost to the state is not substantial. Only one state—Washington—was found to have dropped 12-month continuous eligibility for children in Medicaid. In 2003, Washington eliminated 12-month continuous eligibility along with numerous other changes that, in combination, reduced children's enrollment by 30,000. One large contributor to the reduction may have been requiring redeterminations every 6 months rather than every 12 months. Less than two years later, the state restored 12-month redetermination periods and 12-month continuous eligibility (Center for Children and Families 2009).

¹³ TMA is also not available to children enrolled through CHIP and Medicaid's poverty-related pathways, rather than Section 1931.

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