CHAPTER 2

Eligibility Issues in Medicaid and CHIP: Interactions with the ACA

Recommendations

Eligibility Issues in Medicaid and CHIP: Interactions with the ACA

2.1 In order to ensure that current eligibility options remain available to states in 2014, the Congress should, parallel to the existing Medicaid 12-month continuous eligibility option for children, create a similar statutory option for children enrolled in CHIP and adults enrolled in Medicaid.

2.2 The Congress should permanently fund current Transitional Medical Assistance (TMA) (required for six months, with state option for 12 months), 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

To meet the requirements of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), all states must make changes to their Medicaid and CHIP programs and will experience enrollment increases in 2014, regardless of whether or not they expand coverage to adults with incomes up to 138 percent of the federal poverty level (FPL). This chapter explores key issues states will face related to Medicaid and CHIP eligibility in the context of new ACA provisions.

- In 2014, millions of individuals may move between sources of coverage during the year, or off of coverage altogether, due to changes in income or family composition. This churning can create access barriers for enrollees and administrative and financial burdens for providers, plans, payers, and states.
- State flexibility to reduce churning by using 12-month continuous eligibility, which allows states to waive the requirement that enrollees report income changes during the year, is hampered by provisions of the ACA requiring a new income-counting methodology that is consistent across states. The Commission recommends that states continue to be able to implement 12-month continuous eligibility for adults in Medicaid and children in CHIP.
- While Transitional Medical Assistance (TMA) has helped prevent uninsurance by providing six or more months of Medicaid coverage to families whose earnings increase, states face perennial uncertainty about whether TMA will continue to be funded. To end this uncertainty, particularly for states not expanding coverage to 138 percent FPL for adults, the Commission recommends permanently funding TMA.
- In states expanding coverage for adults, TMA may no longer be necessary to prevent uninsurance and could create unnecessary confusion and administrative burden for enrollees and states. The Commission also recommends allowing states to opt out of TMA if they expand to the new adult group.

CHAPTER 2

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To increase the number of Americans with health insurance, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created a continuum of coverage with substantial federal funding by expanding Medicaid eligibility, providing new premium tax credits for the purchase of private health insurance, and instituting numerous other changes effective in 2014. Implementing these large-scale, complex changes will be an ongoing endeavor for the federal and state governments.

The ACA's expansion of Medicaid eligibility in 2014 to nearly all adults with income up to 138 percent of the federal poverty level (FPL), or less than $16,000 annually for an individual, is a key element of the law's projected reduction in the number of uninsured (CBO 2012). Prior to the ACA, federal Medicaid law generally did not permit coverage of childless adults who were not pregnant, disabled, or at least age 65. This expansion therefore represents a departure for many state Medicaid programs, of which only five previously provided comprehensive Medicaid coverage of childless adults through waivers approved by the Secretary of the U.S. Department of Health and Human Services (the Secretary) (KFF 2010). The ACA defined these adults as a mandatory eligibility group as of 2014. However, the Supreme Court decision in *National Federation of Independent Business (NFIB) v. Kathleen Sebelius* in 2012 allows states to forgo the expansion without facing any penalty.

Besides the expansion of Medicaid to the new adult group, other ACA policies that streamline eligibility, enrollment, and renewal processes will increase insurance coverage. Thus, many new Medicaid and State Children's Health Insurance Program (CHIP) enrollees in 2014 will be individuals who were previously eligible but not enrolled. In 2014, Medicaid and CHIP enrollment is projected to increase by 8 million people because of the ACA, with another 7 million covered through health insurance exchanges (CBO 2013a). In 2022, Medicaid and CHIP enrollment is projected to increase by 12 million people because of the ACA, with exchange plans covering another 26 million (CBO 2013b).

Eligibility for Medicaid, CHIP, and other forms of public and private coverage has important implications beyond whether or not an individual receives coverage. These programs differ in the services they cover and the cost of those services to enrollees—through premiums, deductibles, and copayments. Federal and state spending on each enrollee also differs among these programs, as well as the level and source of payments to health care providers.

In addition to the expansion to adults up to 138 percent FPL, the ACA alters Medicaid and CHIP eligibility in several ways—changes that affect all states, even those choosing not to expand Medicaid in 2014. One key provision state Medicaid and CHIP programs must implement is the ACA's new income-counting methodology—modified adjusted gross income (MAGI)—for the purpose of aligning eligibility determinations for Medicaid and CHIP with those made for subsidized coverage through health insurance exchanges. The goal of this new method is to streamline eligibility determinations and to standardize income-counting methodologies across states and programs.

The design of the ACA—an expanded Medicaid program, a continuing CHIP program, and new options for accessing private coverage—is projected to substantially decrease the number of uninsured Americans but may create new challenges. For example, small changes in income may lead to individuals switching from one program to another or a loss of insurance—a phenomenon called churning, which can create barriers to access for enrollees, and burdens on providers, plans, payers, and states. One potential solution discussed in this chapter is 12-month continuous eligibility, a current state option that may no longer be available for some Medicaid and CHIP enrollees in 2014 as an unintended consequence of implementing the MAGI requirements.

Enactment of the ACA also creates new questions about Transitional Medical Assistance (TMA), a provision of Medicaid law that has been in place for nearly 40 years. TMA provides additional months of Medicaid coverage to millions of families who might otherwise become ineligible and uninsured due to an increase in earnings or hours of employment. In 2014, however, TMA may no longer be necessary to prevent uninsurance in states where the combination of Medicaid, CHIP, and subsidized exchange coverage extends to 400 percent FPL. In fact, its continuation could create unnecessary confusion and administrative burden for enrollees and eligibility workers. If states implementing the adult group expansion could opt out of TMA because of the presence of other coverage options, states would save money by no longer paying state matching funds for TMA.

This chapter focuses specifically on the issues of churning and TMA in 2014 and the Commission's recommendations to address these issues. To set the context for these issues, the chapter first describes specific aspects of Medicaid and CHIP eligibility affected by the ACA. It then turns to a discussion of churning—its extent and impact—followed by an analysis of various policy options to address the phenomenon. The final section presents the historical experience and rationale for TMA before turning to a discussion of its relevance in the new policy environment created by the ACA.

In its analysis and formulation of recommendations on both of these topics, the Commission was guided by the principles of promoting administrative simplification—for enrollees, providers, and payers, including the federal and state governments—and maximizing continuity of coverage and care, while attempting to minimize mandatory federal and state spending.

ACA Provisions Affecting Medicaid and CHIP Eligibility

Four provisions of the ACA that will have a substantial impact on Medicaid and CHIP eligibility, described in detail below, are:

- expanded coverage to the new adult group;
- a maintenance of effort (MOE) provision to prevent states from rolling back eligibility;
- MAGI, the new method for counting income for determining the eligibility of some individuals; and
- expanded Medicaid eligibility for children.

Coverage of the new adult group. Historically, Medicaid has primarily covered low-income children, parents, pregnant women, persons with disabilities, and individuals age 65 and older. However, income limits for these individuals have varied both by eligibility group and state, with parents often having the most restrictive income requirements to qualify for Medicaid. The ACA extended coverage to adults who fit into none of these categories. As written, adults with incomes at or below 138 percent FPL are defined as a mandatory eligibility group beginning in 2014. However, the Supreme Court decision in *NFIB v. Sebelius* ruled that the federal government may not penalize non-expansion states by withholding other federal Medicaid funding.[1]

It should be noted that in many states where the expansion is implemented, both adults without dependent children and some parents of dependent children will be considered newly eligible. Current Medicaid coverage of parents, under Section 1931 of the Social Security Act (the Act), varies widely by state, with upper-income eligibility currently as low as 10 percent FPL, as shown in Table 10 of MACStats. If parents are ineligible for Medicaid under Section 1931 because their income is too high, or because their assets exceed the threshold used in some states, they will be eligible for the new adult group if their income is below 138 percent FPL, in states that implement the expansion. For example, in a state with Section 1931 levels at 50 percent FPL, parents with incomes between 51 and 138 percent FPL may be considered newly eligible and may qualify for enhanced federal financing.

States will receive enhanced federal financing to support the costs of the new adult group. For spending on individuals in the new adult group who would not have been eligible under state rules on December 1, 2009, the federal government will bear the lion's share of these costs. Specifically, the federal medical assistance percentage (FMAP), frequently referred to as the federal match, will be as follows for newly eligible individuals:

- 100 percent in 2014, 2015, and 2016;
- 95 percent in 2017;
- 94 percent in 2018;
- 93 percent in 2019; and
- 90 percent in 2020 and each year thereafter.

States that delay implementing the expansion to 138 percent FPL to the new adult group until 2017 or after would not receive a 100 percent newly eligible FMAP, because this matching rate is tied in the statute to specific calendar years.

Since April 1, 2010, states have had a statutory option to cover the new adult group with their existing FMAP. By July 2012, seven states and the District of Columbia had taken up this state plan option (KFF 2012).[2] Beginning in 2014, states may be able to receive enhanced FMAP funding for these individuals.

States are not eligible for the newly eligible FMAP until they expand to the new adult group up to 138 percent FPL. A partial expansion—for example, up to 100 percent FPL—will not entitle

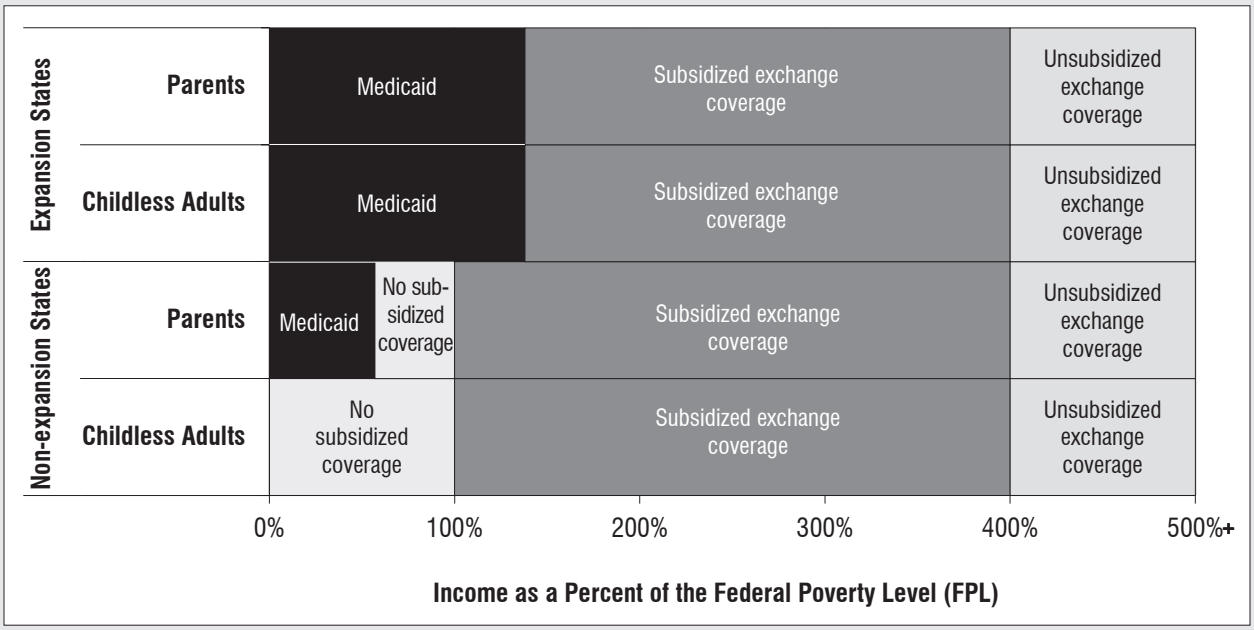
states to the higher matching rate (CMS 2012a). If a state decides to opt out of the expansion, childless adults and parents who otherwise would have been eligible for Medicaid beginning in 2014 may qualify instead for subsidized exchange coverage if their income is at least 100 percent FPL (Figure 2-1). If their income is below 100 percent FPL, many may not have access to federally subsidized coverage, although they would be exempt from the tax penalty for not having coverage (CMS 2013a).

Maintenance of effort. The ACA also includes an MOE provision that generally prevents states from reducing eligibility below what was in place when the ACA was enacted (March 23, 2010) until 2014 for adults and through fiscal year (FY) 2019 for children. This MOE applies even if the group had been covered at state option. According to the Centers for Medicare & Medicaid Services (CMS), the MOE does not apply if a state's waiver coverage ends and is not renewed; the MOE does not require states to extend existing waivers (CMS 2011a).

Through 2013, a state certifying that it has a budget deficit may obtain an exemption from the MOE for nonpregnant, non-disabled adults above 133 percent FPL. Three states used this authority in 2012. Hawaii reduced eligibility levels for parents and childless adults from 200 to 133 percent FPL; Illinois reduced eligibility for parents from 185 to 133 percent FPL; and Minnesota reduced eligibility levels for childless adults from 250 to 200 percent FPL (KFF 2013).

Modified adjusted gross income. MAGI is the new national income-counting methodology for subsidized exchange coverage that also applies to Medicaid and CHIP for children, their parents,

FIGURE 2-1. Medicaid and Exchange Coverage for Parents and Childless Adults, 2014



Notes: Although states' current Medicaid eligibility levels for parents vary by state, ranging from 10 to more than 133 percent FPL in many states, the median level is 37 percent FPL; most states do not currently cover childless adults (KFF 2013). Subsidized exchange coverage is available to individuals between 100 and 400 percent FPL who are not eligible for Medicaid or CHIP; thus, in states implementing the expansion, subsidized exchange coverage will be available between 138 and 400 percent FPL. Premium and cost-sharing subsidies available through exchanges phase down as income increases.

Source: MACPAC analysis

pregnant women, and the new adult group. For these populations, MAGI is intended to reduce the variation, complexity, and confusion created by multiple methods for counting income currently used by states. All states, even those not implementing the expansion to the new adult group, are required to use MAGI in 2014, necessitating modifications to state eligibility systems and processes. Thus, conversion to MAGI as the standard methodology for counting income may be the ACA provision affecting the greatest number of Medicaid and CHIP enrollees in 2014.

When determining eligibility under current law, states have flexibility to disregard whatever sources or amounts of income they choose. Once MAGI takes effect in 2014, for those populations, the flexibility for states to achieve new expansions using income disregards goes away. Instead, only one disregard will exist under MAGI. 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.

Shifting to MAGI will significantly change how state Medicaid and CHIP programs count income. The calculation of MAGI begins with adjusted gross income, generally following the Internal Revenue Service's (IRS's) Form 1040, plus tax-exempt interest and foreign earned income. This approach will be used even for individuals who do not file a tax return.[3] MAGI includes deductions from the 1040 that have never been used in Medicaid or CHIP (e.g., educator expenses, moving expenses, student loan interest deduction). To date, there has been little federal guidance on how state eligibility systems are to incorporate deductions taken for tax purposes that have never been used in Medicaid or CHIP. In addition, MAGI excludes income that has typically been included in Medicaid and CHIP eligibility determinations, such as individuals' pretax contributions to retirement accounts. While child support has historically been counted as income for low-income families seeking Medicaid (with a disregard for the first $50 per month), MAGI excludes child support payments altogether.

Beginning in 2014, asset tests are prohibited for MAGI-based populations. While only four states currently have asset tests for children, 27 states still use them for parents (KFF 2013). For individuals not subject to MAGI (e.g., individuals eligible on the basis of being age 65 and older, disabled, or needing long-term services and supports), asset tests and states' current income-counting flexibilities continue.

In order to accommodate these changes, states are modernizing their eligibility determination systems, for which the federal matching rate is now 90 percent (CMS 2011b). As of December 2012, 49 states had received CMS approval of their plans to implement upgrades to their Medicaid eligibility systems, for which they had nearly $2.1 billion in federal Medicaid spending (CMS 2012b).

Eligibility for 6- to 18-year-olds. Although Medicaid coverage was originally available only to children receiving cash assistance, the Congress has expanded eligibility over the years to children based on income as a percentage of the federal poverty level. Currently, state Medicaid programs are required to cover children under age 6 up to 133 percent FPL, and children age 6 to 18 up to 100 percent FPL.

Effective January 1, 2014, states must extend Medicaid eligibility up to 138 percent FPL for 6- to 18-year-olds. This change will only affect the 19 states currently using separate CHIP coverage for these children.[4] In meeting this requirement, states will enroll these children in a Medicaid-expansion CHIP program—that is, these children will be enrolled in Medicaid, but the state will continue to

receive the enhanced FMAP from federal CHIP funds. CHIP-funded coverage separate from Medicaid will continue to be a state option for children above 138 percent FPL.

Enrollment in a Medicaid-expansion CHIP program rather than a separate CHIP program has several implications. Children in Medicaid-expansion CHIP programs are subject to federal Medicaid benefits requirements and cost-sharing limitations, and thus are entitled to all of Medicaid's mandatory services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, generally without any enrollee cost sharing. Moreover, if a state's federal CHIP funding is exhausted, it can fall back to federal Medicaid funds at the regular Medicaid matching rate for children enrolled in a Medicaid-expansion CHIP program—an option not available for separate CHIP programs without a waiver.

Churning

The eligibility policy changes highlighted above are considerable and will result in individuals moving from Medicaid or CHIP to exchange coverage—and vice versa—as their eligibility for these programs changes. Minimizing frequent coverage changes, which have the potential to negatively affect health, costs, and administrative burden, is in the best interests of enrollees, providers, plans, and states.

Churning refers to individuals enrolling and disenrolling in different sources of health insurance, often in a relatively short period of time. Research on churning has historically focused on transitions from Medicaid or CHIP to uninsurance. For purposes of this chapter, churning is defined to also encompass enrollment transitions between Medicaid, CHIP, and subsidized exchange coverage. It should be noted, however, that even in states where the combination of Medicaid, CHIP, and subsidized exchange coverage extends to 400 percent FPL, income changes will cause many individuals to move from Medicaid to coverage without direct public subsidies. These are generally projected to be individuals whose income rises above 138 percent FPL and who have an offer of employer-sponsored insurance (ESI) considered affordable under the ACA (§1401 of the ACA, 26 CFR 1.36B-2(c)(3)(v), Buettgens et al. 2012).

As people switch between programs, churning can lead to disruptions in continuity of care if provider networks differ among programs. Likewise, churning can lead to changes in covered benefits and cost sharing. As described in greater detail below, research indicates that, under such circumstances, individuals are more likely to forgo primary and preventive care. Persons with chronic conditions or behavioral health issues are more likely than others to be affected by the disruptions that may result from churning. Delayed care may result from changes in provider networks and confusion on the part of plans, providers, and enrollees about who is covered and under which benefits package. In addition, churning may make it more difficult for plans to coordinate care effectively and can increase administrative burden and costs as individuals who were disenrolled attempt to re-enroll. Churning may also create increased administrative burden for states and the federal government as they process and track eligibility determinations for Medicaid, CHIP, and exchange coverage.

Prior research has shown that significant churning occurs during enrollees' regularly scheduled redeterminations (Fairbrother and Schuchter 2008). This is often because of administrative burdens and barriers to renewal (Czajka and Mabli 2009). While many of these individuals re-enroll within a few months, churning interrupts their coverage and is a burden to payers, providers, and plans—especially since these individuals were often

eligible for Medicaid or CHIP during their period without coverage (Summer and Mann 2006). Many states have taken administrative steps to reduce churning at redeterminations, such as eliminating requirements for face-to-face interviews and using data available to the state rather than obtaining new paperwork from enrollees (KFF 2013). Several new policies to reduce churning will be required in 2014 for populations whose eligibility is assessed based on MAGI—for example, face-to-face interviews cannot be required, regular redeterminations can only be scheduled at 12-month intervals (not every six months, as in some states), and families cannot be required to provide information already available to the state (CMS 2012c).

Although churning often takes place at regularly scheduled redeterminations, a significant source of churning in 2014 may result from income changes that occur between annual redeterminations. One study estimated that within a six-month period, 35 percent of adults with incomes below 200 percent FPL would have income changes that would shift their eligibility from Medicaid to exchange coverage or the reverse; within a year, an estimated 50 percent—28 million people—would have income changes requiring a program change (Sommers and Rosenbaum 2011).

To reduce churning that occurs from income changes within a year, states have the option to implement 12-month continuous eligibility in their Medicaid and CHIP programs. This allows states to waive the requirement in federal regulations that enrollees report changes in income during the year that could affect their eligibility. It is not clear what percentage of enrollees actually report required income changes.

Extent of churning. Churning is a well-documented phenomenon in Medicaid and CHIP. In 2007, depending on the state and the size of its programs, between 11 and 67 percent of children who were enrolled in a separate CHIP program at any point during the year were also enrolled in Medicaid-financed coverage at some time during the same year (Czajka 2012). An analysis of data from the Medical Expenditure Panel Survey for 2000–2004 found that 49 percent of adults and 43 percent of children were uninsured six months after disenrolling from Medicaid (Sommers 2009).

Although the ACA creates new programs to reduce the number of uninsured, these new programs also increase the opportunity for churning between programs. Particularly in states where no eligibility gap will exist in 2014 between Medicaid, CHIP, and subsidized exchange coverage, churning between programs may be more prevalent than churning off of coverage altogether.

Shifts in coverage may not all be detrimental or inappropriate—for example, when individuals shift out of Medicaid to ESI because of a new job and an increase in income. Another example of a potentially beneficial shift in coverage may occur when a child enrolled in a separate CHIP program switches into Medicaid (if a decrease in income makes the child eligible) in order to access more generous benefits and cost sharing.

Based on the policies of the ACA, if annual redeterminations show that individuals are no longer eligible for Medicaid but are eligible for subsidized exchange coverage, they will need to switch programs. As described in greater detail below, states may be able to minimize the potential adverse effects of such transitions.

Estimates on the extent of churning in 2014. As previously mentioned, it was estimated that within a six-month timeframe, more than 35 percent of all adults with family incomes below 200 percent FPL would experience a change in income that would cause them to lose eligibility for Medicaid but gain eligibility in the exchanges, or the reverse (Sommers and Rosenbaum 2011). An estimated 50 percent of these adults (28 million)

would experience a change in eligibility between the programs within one year, according to the study. This study was conducted prior to the Supreme Court's decision allowing states to forgo the expansion and thus assumed that all states would expand coverage. The authors also note that actual churning will depend on the extent to which individuals report income changes, states capture such changes, and those changes are processed to effectuate a change in enrollment. Box 2-1 provides examples of churning that could occur in 2014.

In states that forgo the expansion, the nature of churning will likely be different due to gaps in eligibility between Medicaid and subsidized exchange coverage. Consider, for example, a state where low-income parents are eligible for Medicaid up to 50 percent FPL. Because subsidized exchange coverage is only available to those with income between 100 and 400 percent FPL, an individual whose income drops from 125 to 75 percent FPL could churn from subsidized exchange coverage to having no insurance. Most states do not offer Medicaid coverage to childless adults, so many non-expansion states in 2014 may see childless adults eligible for substantial exchange subsidies between 100 and 400 percent FPL, but no coverage below 100 percent FPL.

Effects of churning

Churning may result in changes in provider networks, covered benefits, and cost sharing for enrollees. Changes in provider networks may force individuals to seek new providers or to face higher out-of-pocket costs for retaining relationships with providers that are out of network for their new source of coverage. Changes in covered benefits may result in breaks in care. Dental coverage, for example, may vary greatly between Medicaid, CHIP, and exchange coverage. Changes in cost sharing may be confusing for individuals and lead to higher out-of-pocket spending. Moving from exchange coverage to Medicaid would lead to lower out-of-pocket costs, however.

Individuals who churn may be more costly and prone to forgo preventive and primary care. A 2008 study conducted in California found that adults under age 65 who experience interruptions in Medicaid are at increased risk of hospitalizations that could have been prevented with adequate primary and preventive care (Bindman et al. 2008). Not only might this have detrimental effects on the health of the enrollee, it may be financially burdensome for states to pay for this more expensive form of treatment.

In Florida, diabetic Medicaid enrollees who experienced a brief lapse in coverage returned to the program with greater use of hospital care, including emergency room visits. As a result, average Medicaid spending on these enrollees was 75 percent higher in the three months following their re-enrollment, compared to the three months prior to their lapse in coverage (Hall et al. 2008). Similar results were also found for Medicaid enrollees with depression (Harman et al. 2007).

Churning may create additional administrative burden for states, providers, and plans. Moving back and forth between programs may involve additional paperwork and processing, which can be costly for states and plans. The amount of these increased costs is difficult to quantify, but state officials consistently report that large numbers of people disenrolling and then re-enrolling proves to be more costly than if enrollment had been stable (Summer and Mann 2006).

Interruptions in care affect quality monitoring and improvement activities. For many health care quality measures, individuals must be enrolled in the plan for 12 months. Otherwise, health care

BOX 2-1. Examples of Churning

Churning between Medicaid and exchange coverage. In 2014, Alice is a healthy 19-year-old who recently graduated from high school. She has a part-time job at a retail clothing store, where she is not offered health benefits. With her gross income of about $1,200 a month, or 125 percent FPL, she is enrolled in Medicaid. As business picks up, her manager offers her additional hours, which increases her income to about $1,400 a month, or 150 percent FPL. Because the information she has received from Medicaid clearly requires her to report any change in income that could affect eligibility, she notifies the Medicaid agency in her state. Based on this information, the state redetermines her eligibility, finding that she is eligible for subsidized exchange coverage rather than Medicaid. She churns to exchange coverage, for which she pays $60 per month out of her own pocket. Because her Medicaid managed care plan does not participate in the exchange, she must choose a new plan among the several offered in the exchange. After some research, she finds an exchange plan that includes her current primary care provider.

After eight weeks of augmented hours, business wanes, Alice returns to her previous work schedule, and her income goes back to 125 percent FPL. She contacts the state Medicaid agency again and is determined eligible for Medicaid once more. Ultimately, she will be back in her previous Medicaid plan. Had 12-month continuous eligibility been available in her state, Alice could have remained in her Medicaid plan, without the state and affected health plans having to process her changes.

Churning between Medicaid and CHIP. In 2014, Bobby is an 8-year-old Medicaid enrollee with autism who attends weekly behavior therapy sessions. He lives with his dad, who has a gross income of $1,900 a month (150 percent FPL for a family of two). His dad then begins working an additional eight hours per week, which he hopes will be permanent, increasing the family's monthly income to $2,400 (185 percent FPL). Because their state does not have 12-month continuous eligibility, Bobby's father is required to report any income changes affecting eligibility, and Bobby is now ineligible for Medicaid but eligible for CHIP. (The out-of-pocket premiums for Bobby's dad's subsidized exchange coverage will increase by approximately $60 per month to $140 per month.)

In Bobby's state, the health plans available through CHIP do not include the clinic where he receives therapy. In addition, the CHIP program in his state covers fewer therapy visits than Medicaid. For additional therapy visits at the new provider they find, his dad will need to pay out of pocket. Because they cannot afford the additional therapies, even with the additional hours, Bobby's father considers reducing his hours to ensure Bobby can continue getting his therapy visits.

quality could appear poor in a plan where new enrollees need care that was preventable but was not addressed prior to their current coverage. Researchers note that individuals enrolled for less than 12 months have not been exposed to enough care to experience its health-promoting effects, thus making it difficult to assess the quality of the care they receive (Ku et al. 2009). Similarly, plans may be unwilling to seek long-term savings from care management if individuals are covered for short periods of time.

State approaches to address churning and its effects

States have experience with churning in their current programs and are exploring a number of options for minimizing the effects of churning,

beginning in 2014, as individuals move among Medicaid, CHIP, and exchange coverage.

Plan requirements. Some states are taking steps in their contracts with health plans to mitigate the increased challenges that churning may pose. Massachusetts, for example, has constructed managed care contract language to ensure that enrollees receive adequate care when transitioning between programs. The state requires managed care organizations (MCOs) receiving transitioning individuals to complete a transition plan for the enrollee that is tailored to the individual's specific health care needs (Ingram et al. 2012).

States may also decide to take a multi-market approach, encouraging health insurance carriers to participate in Medicaid, CHIP, and exchange coverage. If carriers have a single plan that participates simultaneously in Medicaid and exchanges, then individuals may remain with the same insurer and network of providers when their eligibility shifts, even if their benefits and cost sharing change. A carrier may have separate plans in the Medicaid and nongroup markets but try to align the networks between the plans as much as possible, depending on factors such as providers' willingness to participate in Medicaid (Lovelace 2013). However, when carriers have separate plans in these markets, provider networks and plan payments to those providers may differ significantly between plans.

Minnesota currently requires all commercial MCOs in the nongroup market to also participate in Medicaid, but it is not clear whether this requirement will be in place in 2014 (Leitz 2013). In the 1990s, California aligned plan requirements in the Medicaid and nongroup markets so that carriers could easily participate in both, if they won contracts to do so. In both states, however, some counties run their own Medicaid managed care plan, which is often the sole source of Medicaid for residents in those counties (Leitz 2013, Finocchio 2012). Thus, in those counties, a multi-market plan may not be available even if the state has aligned plan requirements. Moreover, states may have reasons to continue contracting with Medicaid-focused plans without a multi-market presence despite the potential effects on churning—for example, if those plans have developed competencies around the unique needs of Medicaid enrollees.

Bridge plans. Tennessee proposed a specific multi-market plan approach to CMS, which would allow individuals of the same family who would otherwise have coverage under different programs to receive coverage through the same health plan. In particular, the state sought approval of having Medicaid MCOs cover Medicaid enrollees' family members who themselves are not eligible for Medicaid. This is commonly referred to as a bridge plan (Tennessee IEPI 2011). CMS has announced its support for this approach (CMS 2012a). While the exchange-eligible family member could be enrolled in the Medicaid plan, the exchange benefits and cost sharing would still apply.

Premium assistance. While the bridge plan allows an exchange-eligible family member to be enrolled in a Medicaid plan, CMS recently described an opportunity for Medicaid and CHIP enrollees to be enrolled in a family member's exchange plan (CMS 2013b). As proposed, a state could use existing authority in Medicaid and CHIP for premium assistance to pay the premiums and cost sharing for Medicaid- or CHIP-eligible individuals enrolled in nongroup coverage, including exchange coverage. In describing this option, CMS reiterated that individuals eligible for Medicaid or CHIP cannot receive exchange subsidies and that the premium assistance must be cost effective (CMS 2013b). To be cost effective, the state payments for premium assistance (including administrative expenditures and the costs of providing wraparound benefits) must

be comparable to the cost of providing direct Medicaid coverage.

Basic Health Program. Some states are exploring the option of implementing a Basic Health Program, through which states could provide coverage for individuals between 138 and 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.

The purpose of these programs is 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. Prior to the Supreme Court's decision allowing states to forgo the expansion, one study found that 4 percent fewer adults (1.8 million individuals) would churn between Medicaid and exchange coverage if states offered the Basic Health Program option (Hwang et al. 2012). This assumes that the Basic Health Program would be comparable to Medicaid in terms of participating plans and covered benefits, so that the first income-based transition point between markets would be at 200 rather than 138 percent FPL.

In February, CMS announced it plans to issue proposed rules on the Basic Health Program later this year, and that states will not be able to implement a Basic Health Program until 2015 (CMS 2013c).

Twelve-month continuous eligibility. Another avenue by which states may reduce churning is by opting for 12-month continuous eligibility for Medicaid and CHIP enrollees. 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. Twelve-month continuous eligibility allows states to enroll individuals in Medicaid or CHIP for 12 months, regardless of changes in family income or composition that occur in the interim. Under continuous eligibility, families are not required to report changes in income. There are certain conditions, however, that must still prompt a review of eligibility, such as when a child reaches the age limit.

Twelve-month continuous eligibility is an explicit statutory option for children in Medicaid (§1902(e)(12) of the Act) and is used by 23 states, as shown in Table 2-1 (HHS 2012). Besides using waivers, states are permitted to effectively implement continuous eligibility for adults in Medicaid using current state flexibility to disregard changes in income. However, once MAGI takes effect in 2014, this income-counting flexibility goes away and thus also the flexibility to implement 12-month continuous eligibility for adults in Medicaid without a waiver (CMS 2012c). As with adults in Medicaid, no explicit statutory authority exists for separate CHIP programs to have 12-month continuous eligibility. However, 33 states currently use 12-month continuous eligibility in CHIP (HHS 2012), and CMS is proposing to codify 12-month continuous eligibility for CHIP through regulations so states can be assured of that option continuing in 2014 (CMS 2013b).

Twelve-month continuous eligibility would be of particular importance for individuals with serious and chronic health conditions who receive broader coverage in Medicaid that they might not receive in exchange coverage. Even in subsidized exchange coverage, the costs of needed yet uncovered benefits—or benefits with higher out-of-pocket cost sharing—could be very high for these individuals. Additional costs could also

TABLE 2-1. States Providing Continuous Eligibility to Children

The following states provide 12-month continuous eligibility to children in Medicaid or CHIP.

State	CHIP	Medicaid	State	CHIP	Medicaid
Alabama	Yes	Yes	New Jersey	Yes	Yes
Alaska	Yes	No	New Mexico	Yes	Yes
Arizona	Yes	No	New York	Yes	Yes
California	Yes	Yes	North Carolina	Yes	Yes
Colorado	Yes	No	North Dakota	Yes	Yes
Delaware	Yes	No	Ohio	Yes	Yes
Florida	Yes	No	Oregon	Yes	Yes
Idaho	Yes	Yes	Pennsylvania	Yes	No
Illinois	Yes	Yes	South Carolina	Yes	Yes
Iowa	Yes	Yes	Tennessee	Yes	No
Kansas	Yes	Yes	Texas	Yes	No
Louisiana	Yes	Yes	Utah	Yes	No
Maine	Yes	Yes	Virginia	Yes	Yes
Michigan	Yes	Yes	Washington	Yes	Yes
Mississippi	Yes	Yes	West Virginia	Yes	Yes
Montana	Yes	Yes	Wyoming	Yes	Yes
Nevada	Yes	No			

Note: See source document for some exceptions in Arizona, Pennsylvania, Tennessee, Texas, and Virginia.
Source: CMS 2013d

apply if individuals underestimate their income for purposes of the exchange premium tax credits and then must repay certain amounts at reconciliation during the tax filing process. If individuals are likely to churn between Medicaid and subsidized exchange coverage, it may be beneficial for them, their providers, and the federal and state governments for such individuals to remain in Medicaid for the entire 12-month period.

A study conducted in 2009 found that average monthly Medicaid expenditures were lower the longer children were enrolled in Medicaid (Ku et al. 2009). Continuously enrolled children were found to have more regular preventive care, which improves health and reduces the likelihood of inpatient hospital admissions or costly emergency room visits (Ku et al. 2009). It was also noted that this reduction in costs over time was partly due to the fact that newly enrolled children may have had pent-up demand for services compared to children with consistent coverage.

Commission Recommendation

Recommendation 2.1

In order to ensure that current eligibility options remain available to states in 2014, the Congress should, parallel to the existing Medicaid 12-month continuous eligibility option for children, create a similar statutory option for children enrolled in CHIP and adults enrolled in Medicaid.

Rationale

This recommendation ensures continued flexibility for states to implement 12-month continuous eligibility. States have used this option for years for children in Medicaid and separate CHIP programs. Although CMS is proposing to codify 12-month continuous eligibility in CHIP through regulations (CMS 2013b), explicit statutory authority would further guarantee this state option.

The statutory option to provide 12-month continuous eligibility to children enrolled in Medicaid has functioned under explicit statutory authority since 1997. Although no explicit statutory authority exists for 12-month continuous eligibility in CHIP or for adults in Medicaid, 33 states use existing flexibility to implement it in CHIP (HHS 2012). CMS is proposing to codify 12-month continuous eligibility in CHIP through regulations so states can be assured of that option continuing in 2014 (CMS 2013b).

In making this recommendation, the Commission wants to emphasize the importance of accurate eligibility determinations and meaningful verification of applicants' self-reported information. If states will have the option to keep individuals in Medicaid and CHIP regardless of what are typically modest income changes, then it is critical for both initial determinations and regular redeterminations to reflect the most accurate information available. To accomplish this, it is critical that the executive branch successfully establish the proposed federal data services hub, an electronic service by which applicant information will be verified by authoritative sources—for example, citizenship by the Social Security Administration, immigration status by the Department of Homeland Security, and income data from the IRS (CMS 2012c). While pursuing streamlined, simplified application processes, newly promulgated federal regulations make it appropriately clear that "(n)othing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits" (CMS 2012c, 42 CFR 435.940).

While no state has implemented 12-month continuous eligibility for adults in Medicaid,[5] states could accomplish it using their current income-counting flexibility, by disregarding income changes within enrollees' 12-month eligibility period. Under MAGI in 2014, however, this flexibility goes away; 12-month continuous eligibility will not be a state plan option for adults in Medicaid beginning in 2014 (CMS 2012c). While states could provide 12-month continuous eligibility through the use of Section 1115 waivers, these waivers must be periodically renewed, meet tests of budget or allotment neutrality, and be subject to evaluation and reporting requirements—all of which would increase states' administrative burdens. Although many policies may be implemented through waivers, the Commission believes that providing sound policy choices through state plan options is preferable to relying on waivers.

As described earlier, 12-month continuous eligibility reduces churning and the negative health effects that may result. Twelve-month continuous eligibility ensures access to care for these enrollees and allows them to maintain their same provider network for the year. This may lead to better health outcomes and help minimize the use of more expensive care, such as costly emergency room visits or avoidable hospital admissions.

While analyses and evaluations of 12-month continuous eligibility are limited, the U.S. Government Accountability Office (GAO) assessed churning within a one-year period under ACA rules in place in 2014, estimating that in states with 12-month continuous eligibility, 3 percent of children with Medicaid or CHIP would experience a change in household income

within the year that would affect their eligibility, compared to 30 percent of children in states without 12-month continuous eligibility (GAO 2012a). GAO also noted, "Changes in eligibility caused by income fluctuations could deter children's enrollment in relevant programs if the process for changing enrollment is burdensome for the families and could further complicate other eligibility complexities, such as variation in eligibility within households" (GAO 2012a).

MACPAC has examined continuous eligibility from another perspective, focusing on the average length of children's enrollment in Medicaid in states with 12-month continuous eligibility compared to those without.[6] In states with 12-month continuous eligibility, children were enrolled for an average of 10.01 months per year, compared to 9.66 months for those without—a difference of nearly 4 percent. However, other state-level factors may also affect these numbers, and the effect may be substantially different, depending on the state. For example, when Colorado decided in 2009 to pursue 12-month continuous eligibility for children in Medicaid, the state projected that average length of enrollment would increase by 25 percent—from 8.5 to 10.7 months (Colorado Legislative Council 2009).[7] This large projected change could be driven by the state's relatively low average length of enrollment or other state-specific characteristics.

With respect to adults with income below 200 percent FPL, one study projected that if continuous eligibility were not in place and all states expanded Medicaid, 35 percent of these adults would have income changes that would shift their eligibility from Medicaid to exchange coverage or the reverse in a six-month period in 2014. Within a year, an estimated 50 percent—28 million people—would have income changes requiring a program change (Sommers and Rosenbaum 2011). The authors acknowledge that these estimates do not account for the extent to which people would not actually report such a change.

In a follow-up analysis by the lead author, among adults projected to have an income increase from below to above 138 percent FPL by the end of a 12-month period, 43 percent would still have income below 200 percent FPL, 39 percent would have income between 200 and 400 percent FPL, and 18 percent would have income above 400 percent FPL (Sommers 2013). It is important to note that these estimates make no projections of individuals' coverage—either what they began the year with or, in 2014, what they would obtain after the income change. They simply show the size of income changes for this particular group of individuals. Many of those whose income rises above 400 percent FPL would be younger, better-educated individuals—potentially young adults finishing school or getting new jobs. Notwithstanding any 12-month continuous eligibility, these individuals would no longer be eligible for Medicaid or subsidized exchange coverage if their income were still above 400 percent FPL at their annual redetermination.

Implications

Federal spending. This recommendation would increase federal spending in 2014 by $50 million to $250 million. Over the five-year period of 2014 to 2018, this recommendation would increase federal spending by approximately $1 billion. These are the smallest non-zero categories of spending used by the Congressional Budget Office (CBO) when making budget estimates.

States. This recommendation would continue to provide states the option to offer 12-month continuous eligibility through a state plan option, without needing to obtain waiver approvals and renewals. States taking up this option would face additional costs from enrollees' increased tenure

in the program; however, this could be offset to some extent by less spending from medical expenses avoided by consistent coverage. It would also be offset by reduced administrative burden resulting from fewer within-year redeterminations. Nationally, the projected impact on state spending from this recommendation would be less than half of the federal spending.

Enrollees. In states that implement 12-month continuous eligibility, this recommendation would reduce churning by allowing enrollees to maintain their Medicaid or CHIP coverage, thus keeping the same provider network and benefits. This would allow for more consistent access to primary and preventive care. While enrollees would not be required to report income changes, individuals wanting to move between programs because of an income change would still be afforded that opportunity. If implemented, 12-month continuous eligibility would also help ensure parents and their children share the same coverage periods—for example, so that renewal paperwork for the family would come at the same time, regardless of whether some family members are enrolled in Medicaid and others in CHIP. It would also reduce the likelihood that individuals would transition back and forth between Medicaid and subsidized exchange coverage, where they could be liable to repay premium credits if their income projections were not accurate.

Providers. Allowing for 12-month continuous eligibility would reduce administrative burden on providers dealing with individuals' moves between sources of coverage or uninsurance. Consistent coverage can ensure that plans' and providers' efforts to improve the management of enrollees' care are not lost through churning. Because many health care quality measures require individuals to be enrolled in a plan for 12 months, continuous eligibility can improve efforts to measure quality.

Other considerations

The Commission considered a recommendation to require states to institute 12-month continuous eligibility for populations eligible for Medicaid or CHIP based on MAGI. This policy would not have applied to individuals eligible on the basis of being age 65 and over or disabled. Requiring states to provide 12-month continuous eligibility to adults and children enrolled in Medicaid and CHIP would help reduce churning between programs over the course of the year. However, if required of all MAGI-based populations, this policy would increase federal spending by approximately $10 billion over five years. MACPAC plans to conduct additional analyses of 12-month continuous eligibility in the future, to assess its impact on enrollees' duration of coverage and continuity of care, as well as the cost impact on states. Such analyses may provide additional support in the future for a recommendation to implement mandatory 12-month continuous eligibility for certain populations.

Transitional Medical Assistance

Nearly every year, the Congress appropriates funding for a Medicaid provision known as Transitional Medical Assistance (TMA). The most recent extension was included as part of the fiscal cliff legislation enacted at the end of 2012, providing funding for TMA through December 31, 2013 (P.L. 112-240). TMA requires states to provide at least six months, and up to 12 months, of Medicaid coverage to enrollees under Section 1931 (i.e., low-income parents and their children) when the family's income has risen above a state's current eligibility levels. Current eligibility levels for Section 1931 vary widely by state, from 10 percent FPL in Alabama—which is less than $2,000 in annual income for a family of three—to 133 percent FPL or more in several states.

If family income rises above these levels, TMA continues coverage when parents might otherwise become uninsured. TMA is less critical to preventing loss of coverage for children, because other Medicaid and CHIP eligibility pathways exist for children above Section 1931 eligibility levels. In 2014, however, TMA may no longer be necessary to prevent uninsurance in states where the combination of Medicaid, CHIP, and subsidized exchange coverage extends to 400 percent FPL. The remainder of the chapter describes TMA and how its role merits changes beginning in 2014.

Background

Since 1974, TMA has provided extended Medicaid coverage to members of low-income families who would otherwise lose Medicaid and potentially become uninsured because of an increase in hours from employment or increased income from child or spousal support. This coverage is primarily available to parents and their children. The historical purpose of TMA was to provide "protection against loss of Medicaid because of increased earnings" (U.S. House of Representatives 1972). TMA has served as a "key protection offered to families at a critical juncture in their efforts to move from welfare to work" (GAO 2002).

Current TMA enrollment and spending. Information on TMA enrollment and spending is not systematically reported by states. The Secretary was required by a 2009 law to collect information on TMA enrollment and spending through annual reports to the Congress. To date, no such report has been published. According to GAO, "While CMS officials report having received data from some states, officials indicated that they have not enforced the requirement because of competing agency priorities" (GAO 2012b).

In 2012, GAO surveyed states for their TMA enrollment and spending from 2006 through the most current year available. In FY 2011, there were 3.5 million TMA enrollees in 41 states (GAO 2012b). Including states' reported spending following publication of its report, GAO's preliminary findings indicate that TMA spending in FY 2011 totaled $4.1 billion in 36 states.

TMA as originally enacted. Prior to the 1996 enactment of welfare reform, families who were enrolled in the cash welfare program Aid to Families with Dependent Children (AFDC) were automatically eligible for Medicaid. Eligibility levels for AFDC varied by state but were generally only a fraction of the federal poverty level. As a result, relatively small amounts of earnings could disqualify these families from Medicaid. TMA was designed to ensure that these families would retain Medicaid coverage for some time, even with an increase in income that made them ineligible for AFDC. As originally enacted, TMA required states to provide four months of coverage to individuals who had been enrolled in AFDC for at least three of the past six months. This original version of TMA is permanently funded in the Medicaid statute.

Selected major changes in TMA. In 1988, the Congress required states to provide six months of TMA (P.L. 100-485). States were also required to provide an additional six months of TMA—for a total of 12 months—for families below 185 percent FPL who provided quarterly reports of their earnings and work-related child care expenses in the 4th, 7th, and 10th months of TMA enrollment. Unlike most Medicaid policies, this TMA change was not permanently funded; funding was provided for 10 years, through September 30, 1998.

The 1988 legislation also provided states with a "wrap-around option" (§1925(a)(4)(B) of the Act). This permits the state to pay for the premiums and cost sharing for ESI that may be available to a person eligible for Medicaid through TMA. Indeed,

the state may require such individuals to enroll in that employment-based coverage as a condition of receiving TMA. In GAO's recent survey, 23 states reported using this premium assistance option for some of their TMA enrollees (GAO 2012b).

The 1996 welfare reform law replaced AFDC with Temporary Assistance for Needy Families (TANF) and broke the automatic eligibility link between welfare and Medicaid. In its place, Section 1931 was added to Medicaid so that individuals who would have been eligible based on the AFDC rules in place on July 16, 1996, would be eligible for Medicaid. Since then, TMA has been available to individuals losing eligibility through Section 1931 rather than the defunct AFDC program.

Current eligibility levels for parents vary widely by state, from 10 percent FPL in Alabama to 133 percent FPL or more in several states. Coverage under Section 1931 and TMA are virtually the only current state plan options for non-disabled, low-income parents. Since the enactment of TMA, however, additional pathways for children have been added such that Medicaid and CHIP coverage is at or above 200 percent FPL in the vast majority of states. Thus, TMA has a much smaller role in preventing uninsurance for children than it does for their parents.

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) made numerous changes to TMA. Consistent with a GAO recommendation (GAO 1999), ARRA gave states the option to waive the requirements unique to TMA enrollees in the second six-month period (i.e., requirements to report earnings and child care and to remain below 185 percent FPL)—sometimes referred to as the 12-month option. ARRA also provided states with the option to waive the requirement that individuals be enrolled in Medicaid for three out of the past six months in order to qualify for TMA. Several states have implemented these state plan options (CMS 2012d):

- Alaska, Colorado, Maryland, Ohio, and Oregon permit the second six-month period of TMA to be treated like the first, without additional reporting requirements; and
- Oregon also permits individuals to be eligible for TMA after only one month of Section 1931 enrollment, rather than three out of the last six months.

Prior to these state plan options, some states achieved these policy changes through waivers (Grady 2008).

For the past several years, funding for current TMA has continued through short-term extensions. For example, one law extended its funding from December 31, 2011, to February 29, 2012, and another from February 29 to December 31, 2012. Most recently, P.L. 112-240 extended TMA funding through December 31, 2013.

As these extensions have been perennial issues for the Congress, they have also been perennial issues for states faced with the uncertainty of whether current TMA would continue or would revert to the permanently funded four-month TMA. This uncertainty concerning TMA's future has also affected federal guidance. Recent proposed regulations only addressed four-month TMA, not the current TMA that has been in effect for years (CMS 2013b).

TMA in 2014

Beginning in 2014, the primary role of TMA to prevent uninsurance may no longer be applicable in states where parents could be eligible for Medicaid up to 138 percent FPL and for subsidized exchange coverage up to 400 percent FPL. Nevertheless, CMS has noted that the ACA did not remove any of the current requirements of TMA (CMS 2012c, CMS 2012e). Because of the Supreme Court's decision that effectively allows states to opt out of the Medicaid expansion, TMA

will still be relevant in those states to prevent uninsurance.

States that do not expand Medicaid. In states that do not expand Medicaid in 2014, an eligibility gap will likely exist between Section 1931 coverage and subsidized exchange coverage, as previously discussed and illustrated in Figure 2-1. For these states, TMA would help bridge that gap for Medicaid enrollees whose income increases and should therefore be preserved, consistent with TMA's intent of preventing uninsurance.

States that expand Medicaid. In states that expand Medicaid to the new adult group such that there is no eligibility gap with subsidized exchange coverage, TMA will no longer be as necessary to prevent uninsurance. Compared to the relatively low Section 1931 eligibility rates for parents, Medicaid coverage in these states will be available to parents (and childless adults) up to at least 138 percent FPL and subsidized exchange coverage up to 400 percent FPL. Under current law, however, TMA eligibility would override eligibility for coverage through the new adult group or through exchanges. For example, individuals eligible for TMA will be ineligible for subsidized exchange coverage (§36B(c)(2)(B) of the Internal Revenue Code, as added by §1401(a) of the ACA). While extending TMA will provide these individuals with Medicaid's more generous benefits and cost-sharing protections regardless of their income, it will be at additional state cost, since TMA requires state matching payments while subsidized exchange coverage does not.

Commission Recommendation

Recommendation 2.2

The Congress should permanently fund current Transitional Medical Assistance (TMA) (required for six months, with state option for 12 months), 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.

Rationale

For years, TMA has reduced churning and prevented uninsurance by providing low-income families with six months or more of Medicaid when their income rises above Section 1931 levels. In states that expand Medicaid to the new adult group such that there is no eligibility gap with subsidized exchange coverage, TMA may no longer be as necessary to prevent uninsurance. Its continuation could create unnecessary confusion and administrative burden for enrollees and state governments. Its elimination in states expanding to the new adult group would reduce their Medicaid spending and simplify eligibility by removing the federal statutory requirement to provide TMA.

Although subsidized exchange coverage will exist in every state, the Medicaid expansions to the new adult group may not. In those states where an eligibility gap will exist between Medicaid and subsidized exchange coverage, TMA in its current form should continue for those parents who would otherwise become uninsured. This change should be made permanent so that states do not have to perennially question whether current TMA will be available.

Implications

Federal spending. This recommendation would increase federal spending in 2014 by $50 million to $250 million. Over the five-year period of 2014 to 2018, this recommendation would decrease federal spending by less than $1 billion.

The two components of the recommendation have offsetting effects on federal spending. Extending current TMA provides small federal savings. Federal savings occur because extending TMA puts people in Medicaid who would otherwise have gone to subsidized exchange coverage, which is projected to be more expensive to the federal government than Medicaid (CBO 2012). The other component of the recommendation would have some individuals go into exchange coverage rather than remain in TMA, which increases federal spending by a relatively small amount. Combining these two components, the recommendation's one-year and five-year cost estimates are in the smallest non-zero categories used by the CBO. In both cases, the estimates are in the lower end of the range.

States. If current TMA were allowed to expire, states would have to change their eligibility systems to adapt to the permanently funded four months of TMA. In states that implement the expansion to the new adult group, TMA could create unnecessary confusion and administrative burden for state governments. For example, if at a redetermination enrollees are determined eligible for subsidized exchange coverage rather than Section 1931 Medicaid, the extension of TMA would require those individuals to remain in Medicaid for at least another six months, after which they would undergo another redetermination.

In states that do not implement the expansion to the new adult group, the extension of TMA would essentially continue the status quo. However, because the CBO's baseline assumption is that TMA reverts to its original four-month duration on January 1, 2014, its extension is treated as a state cost of about $300 million in 2014 and $3 billion over five years. Nevertheless, as with past TMA extensions, many states are likely planning on TMA continuing and may not consider this new spending. For states implementing the expansion and opting out of TMA, state spending would be reduced by approximately $100 million in 2014 and $200 million over five years.

Enrollees. In states that do not implement the expansion, this recommendation would ensure TMA exists to provide six months or more of Medicaid—coverage that could prevent uninsurance. In states implementing the expansion, TMA could create unnecessary confusion and administrative burden as TMA provides an additional six months or more of Section 1931 coverage. On the other hand, in the absence of TMA, individuals moving from Medicaid into exchange coverage, even when subsidized, will face higher out-of-pocket cost sharing than required in Medicaid. This is also true of individuals whose income is above 138 percent FPL but who do not qualify for exchange subsidies because their ESI is considered affordable under the ACA.

Providers. Effects on providers would be largest where TMA's extension prevents uninsurance. Otherwise, effects on providers should be minimal.

Endnotes

1 The Court's ruling held that "the Medicaid expansion violates the Constitution by threatening States with the loss of their existing Medicaid funding if they decline to comply with the expansion" (*NFIB v. Sebelius*, p. 4). Section 1904 of the Social Security Act—a provision of Medicaid law that has been in existence unaltered since Medicaid's enactment in 1965—says that if a state Medicaid program is out of compliance with federal requirements, the Secretary has the authority to withhold federal funding for the part that is out of compliance or from the state's entire Medicaid program. In *NFIB v. Sebelius*, the Court determined that the Secretary cannot withhold all Medicaid funds from states not implementing the expansion. The Court did so by reasoning that the expansion is, in fact, a new program separate from current Medicaid because the new adult group (1) is a new eligibility group inconsistent with Medicaid's historical eligibility categories, (2) is reimbursed at a federal matching rate inconsistent with Medicaid's typical matching rate, and (3) will receive a mandated benefit package unique from any other required for an eligibility group at the federal level (*NFIB v. Sebelius*, pp. 53–54).

2 Several other states cover childless adults by using Section 1115 waivers (KFF 2012).

3 Even for applicants who file tax returns, their Medicaid eligibility is to be determined based on their current income (§1902(e)(14)(H) of the Act, 42 CFR 603(h)). Thus, for Medicaid purposes, the use of information from previous tax returns will likely be limited to verifying that it is reasonably compatible with current income (42 CFR 952).

4 Nineteen states use a separate CHIP program to cover 6- to 18-year-olds between 100 and 133 percent FPL: Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming. In 2012, New Hampshire and New York modified their CHIP programs to place these children in a Medicaid expansion.

5 New York has approval under its Section 1115 waiver to provide 12-month continuous eligibility to parents (CMS 2012f) but has not yet implemented this provision (KFF 2013).

6 This analysis used data from the FY 2009 Medicaid Statistical Information System annual person summary data from CMS. Only states with 12-month (rather than 6-month) renewal periods were included. States' Medicaid renewal periods and continuous eligibility policies were from the Kaiser Family Foundation (KFF 2009).

7 Colorado has not yet implemented 12-month continuous eligibility for children in Medicaid.

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