pennsylvania
DEPARTMENT OF HUMAN SERVICES

Analysis of Length of Stay in Pennsylvania Medicaid Program and the Impact of Medicaid Expansion

October 2020

Issue Brief: Analysis of Length of Stay in Pennsylvania Medicaid Program

EXECUTIVE SUMMARY

Background:

Medicaid was created in 1966 to provide health coverage to uninsured, low-income Americans. Since then, the state-federal program has become a vital source of health care for children, adults, the elderly, and people with disabilities. Medicaid costs more than $600 billion a year and provides health care to more than 70 million Americans. In Pennsylvania, more than three million residents are covered by Medicaid.

While Medicaid provides stability and support for low-income Americans, the enrolled population is fluid – especially among adults who are able-bodied and of working age. The length of time someone is on Medicaid varies substantially, depending on the enrollment group (i.e., adults, children, the elderly, those with disabilities or Medicaid Expansion enrollees). This issue brief examines Medicaid trends at the state and national level, particularly the typical duration of enrollment for Medicaid beneficiaries. It includes data and findings from a recent Pennsylvania Department of Human Services' (DHS) data analysis supported by Deloitte Consulting entitled, "Medicaid Churn Analysis," which explores the reasons beneficiaries enter and exit the program.

Observations in the brief include:

- The Affordable Care Act (ACA) helped to mitigate some of the effects of churn in a few important ways:
  - The law created new Medicaid coverage (Medicaid expansion) opportunities for adults up to 138 percent of federal poverty level income guidelines (FPIG), and
  - Health Insurance Exchanges (either state-based or federally-facilitated) allow individuals that do not qualify for Medicaid, or receive health insurance through an employer, to access health insurance and, if they qualify, receive help paying their premiums. As a result, Medicaid beneficiaries whose incomes increase may now qualify for federal premium affordability tax credits to help defray the cost of private insurance.
- Prior to the expansion of Medicaid allowed by the ACA, this population of adults typically could not access Medicaid and they were unable to afford or access employer-sponsored or private health insurance without substantial federal and state subsidies. In 2018, approximately half the Medicaid expansion population was working either full- or part-time, according to Pennsylvania DHS data; employers typically did not offer health care coverage to lower income workers.
- Research suggests that Medicaid actually provides an incentive to employment. Many studies indicate that Medicaid Expansion has had a positive effect on keeping workers employed and helping the unemployed get a new job.
- While the ACA may have reduced the amount of churn, it has created issues for both the beneficiary and the state Medicaid program. On average, more than 55,000 people left the Medicaid program every month between 2014-2018, largely because their income increased or they did not provide some required information. The percentage of individuals leaving the program has been steadily rising since the Commonwealth of Pennsylvania expanded Medicaid in 2015.
- Adults in the Medicaid Expansion population have the shortest average duration on Medicaid – just under one year (355 days), which is almost three times less than people with disabilities who receive Medicaid.
- By the end of 2018, more than 60 percent of the Medicaid expansion group that had lost categorical eligibility had not returned to the program. Those who do return to Medicaid are often experiencing a period of job loss or other barrier to coverage.
- Workers with incomes of less than $30,000 a year are offered employer-sponsored insurance (ESI) less than 30 percent of the time.

1. INTRODUCTION

The health insurance status of American consumers changes as their lives and economic situations change. Obviously, individuals with long-term, stable employment who are able to purchase employer-sponsored insurance (ESI) have more stable coverage. Those without access to long-term ESI often move between different sources of public and private insurance coverage; many also experience some periods where they have no insurance.

Medicaid is the major safety net that creates access to health care for low-income workers, children, the elderly, and people with disabilities who cannot access or afford private medical insurance. Medicaid coverage can also provide continuity of care and help people maintain good health through routine visits and preventive screenings. Medicaid provides the opportunity for a stable source of care and reduces the need for low-income people to go without services or seek care in high-cost settings like hospital emergency rooms.

Enrollment in Medicaid is often temporary; many families and individuals with low incomes, especially those in the Medicaid Expansion group, access coverage during periods of unemployment or when their employer does not offer coverage or the coverage is unaffordable. Other enrollment groups, especially elderly beneficiaries and those with disabilities, typically have longer durations of coverage as they are less likely to have incomes that make them ineligible for the program.

However, sudden loss of coverage, or churning on and off the Medicaid program, can disrupt care and adversely impact the health and well-being of those in need, particularly seasonal workers who often have fluctuating incomes that rise and fall based on the amount of work they are able to perform. Medicaid eligibility is based on current monthly Modified Adjusted Gross Income (MAGI), and seasonal workers, such as those in construction, retail and other seasonal industries, will often churn on and off the program depending on the time of year.[1]

Conversely, one-way churn, when a beneficiary leaves the Medicaid program and does not return, can be positive for the individual. Some Medicaid beneficiaries will leave the program because they accept a job that provides health insurance coverage and/or their incomes increase enough for them to afford private, individual market coverage. This upward movement, often coinciding with an improved economy and labor market, can result in lower costs to state programs if fewer eligible residents require Medicaid coverage.

This brief, which builds off of a recent Pennsylvania Department of Human Services' (DHS) data analysis supported by Deloitte Consulting entitled, "Medicaid Churn Analysis," provides an overview of the Affordable Care Act's (ACA) impact on Medicaid coverage; the work and private insurance opportunities of the Medicaid population nationally and in Pennsylvania; the typical durations of enrollment in the Commonwealth's Medicaid program; and incidences of churn on and off Pennsylvania's program

[1] Swartz, K., Short, P. F., Graefe, D. R., & Uberoi, N. (2015). Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective. Health affairs (Project Hope), 34(7), 1180–1187. https://doi.org/10.1377/hlthaff.2014.1204

2. Affordable Care Act Impact on Medicaid coverage and Churn

The ACA created many avenues to reduce churn, especially among low-income adults. The expansion of Medicaid to cover uninsured adults up to 138 percent of the federal poverty level (FPL) helped millions of Americans who were uninsured gain health coverage through Medicaid.

Pennsylvania's decision to opt into Medicaid expansion in 2015 allowed over 1.7 million additional adults to gain coverage through Medicaid through 2018; about 800,000 of which were enrolled in December 2018.[2] This new coverage stability helped provide beneficiaries with continuous 12-month coverage and an ability to access primary and specialty care through the managed care program.

In addition, the new state-based Health Insurance Exchanges and the federal Health Insurance Exchange run through Healthcare.gov allowed Americans with incomes between 100-400 percent of the FPL to purchase private qualified health plans (QHPs) with federal advanced payment tax credits (APTCs). These credits, available based on income, helped to make the individual insurance market more affordable to working adults.

The exchanges also helped to provide a new source of coverage when an individual's or family's income increased above the Medicaid threshold. Before 2014, this could lead to a period of uninsurance if the individual/family did not have access to employer-sponsored coverage, which is typically not offered to most lower income Americans. In some other cases, parents became uninsured but their children may have remained covered through the Children's Health Insurance Program (CHIP), which is available to all children at a price determined by their family's income.

Moving from Medicaid to health coverage purchased through the exchange now creates less hardship for many consumers because of the new coverage options. In addition, some states operating a state-based marketplace were initially more adept at coordinating coverage—and preventing coverage gaps—when an individual or family moved from Medicaid to a commercial plan through the exchange. Pennsylvania's transition to a state-based exchange could make integrating coverage easier than the current coordination with the Federally-facilitated Marketplace (FFM).

For example, Washington state analyzed churn between Medicaid and its state-based Exchange in 2014 and 2015, the first two years of the exchange and Medicaid expansion under the ACA. Washington found that 30,000 individuals transitioned in either direction between Medicaid and a QHP between April 2014 and May 2015.[3] Only 0.7 percent of its Medicaid population experienced churn *to* a QHP, while 8.5 percent of the QHP population became enrolled in Medicaid within the 13-month period.[4] The expansion of Medicaid and the Health Insurance Exchanges have created a bit of a backstop for individuals that previously may have become uninsured if their incomes increased or they lost their private insurance coverage.

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[2] Pennsylvania Department of Human Services. "Medicaid Churn Analysis (Deliverable 3)," March 13, 2020.
[3] https://www.wahbexchange.org/wp-content/uploads/2015/12/HBE_EN_160112_Medicaid_QHP_Churn_Analysis.pdf
[4] Ibid

2.1. PROFILE OF THE MEDICAID EXPANSION POPULATION

The number of adults gaining coverage through Medicaid Expansion significantly changed the program in states across the country. Prior to the ACA-authorized expansion, most states did not use Medicaid to cover childless, non-disabled or non-pregnant adults at any income level; for parents in the Medicaid program, coverage was extremely limited. For example, eligibility for parents in Pennsylvania in 2013 was 58 percent of the FPIG.[5] Parents in a family of four earning more than about $14,000 a year would not have qualified for Medicaid coverage.

More than 12 million adults nationwide were not eligible for Medicaid before the ACA provided the Medicaid expansion option.[6] More than three million additional Americans who were previously eligible, but unenrolled, subsequently gained coverage through the expansion group. This is often referred to as the "welcome-mat" effect, where individuals who may not have known they were already eligible enroll following a publicized coverage expansion.[7]

2.1.1. WORK CHARACTERISTICS OF EXPANSION POPULATION

With the income eligibility of the expansion population extending up to 138 percent of the FPIG, the employment status of these new adult beneficiaries varies, and it can be difficult to ascertain accurate and current information.

State and federal estimates of working population

In Pennsylvania, the most reliable point-in-time estimate is from the Commonwealth's administrative data that shows approximately 50 percent of the expansion population is working in any given month.[8] This percentage fluctuates somewhat depending on macro factors such as the state unemployment rate, but continues to show a consistent picture of most working Medicaid beneficiaries.

Although the state's data provides a good baseline for understanding the current work status of the expansion population, analysis of federal census data indicates that a somewhat higher percentage may be working at some point during the year. A Kaiser Family Foundation analysis of the 2018 Census Current Population Survey (CPS) found that approximately 60 percent of Pennsylvania's population worked either full- or part-time in 2018 (63 percent nationally).[9]

The difference between the state data and federal survey data may be explained by the CPS survey question, which asks if respondents were employed at any point during the year.[10] State data is a monthly point-in-time snapshot. The delta between the state data and federal surveys may

[5] Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011-2020

[6] https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[7] Julie L. Hudson and Asako S. Moriya. "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," Health Affairs 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347

[8] Internal Pennsylvania DHS dashboard metrics for the Medicaid Expansion population

[9] Kaiser Family Foundation analysis of March 2018 Current Population Survey: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/

[10] https://www.kff.org/medicaid/fact-sheet/what-do-different-data-sources-tell-us-about-medicaid-and-work/

indicate that many Medicaid beneficiaries go in and out of jobs throughout the year, such as seasonal workers or students.

Implications for incentives to work

Several recent studies suggest that Medicaid provides an incentive to employment. For instance, Ohio found in 2018 that over 83 percent of expansion beneficiaries who were employed found it easier to keep a job, while 60 percent of the unemployed believed that Medicaid made it easier for them to look for employment.[11] A study of Michigan's Health Michigan Plan (the state's Medicaid Expansion) found that beneficiaries reported improved health status and, like Ohio, an improved ability to work and look for a new job.[12]

It is important to acknowledge that a significant percentage of Medicaid beneficiaries in the expansion population who are not working are primary caregivers of a young child that would make work difficult without childcare assistance, are medically frail (but not technically disabled), or are full-time students. Of the approximately 37 percent of Medicaid recipients that indicated in the 2018 Current Population Survey that they did not work at all that year, 30 percent were unable to work because of caregiving, a medical issue, or school attendance. Only 7 percent of the Medicaid adult population, according to the analysis of the CPS by the Kaiser Family Foundation, were not working due to an inability to find work or because of retirement.[13]

2.1.2. WORK NO GUARANTEE OF PRIVATE INSURANCE COVERAGE

While many Medicaid beneficiaries are working regardless of the metric, full-time employment is no guarantee that someone will earn enough to exceed the 138 percent threshold. A family of three (one adult, two children) would need to earn almost $30,000 ($14/hr) to no longer qualify for Medicaid in an expansion state. Data available through the Current Population Survey indicate 35% of adult civilian workers in Pennsylvania earn less than $30,000 per year.[14] For those that remain Medicaid-eligible and work for an employer that offers insurance, they may qualify for their state's Medicaid Premium Assistance Program that would allow them to participate in the employer plan with Medicaid paying for the employee's share.

However, full-time Medicaid-enrolled adult workers are unlikely to be offered insurance (or afford it if provided). Without employer-provided insurance, many low-income workers will likely

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[11] The Ohio Department of Medicaid, *2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment,* (The Ohio Department of Medicaid, August 2018), https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[12] Renuka Tipirneni et al., "Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: a Mixed Methods Study" *Journal of General Internal Medicine* 34, no. 2 (February 2019): 272-280, https://link.springer.com/article/10.1007/s11606-018-4736-8

[13] Kaiser Family Foundation analysis of March 2018 Current Population Survey: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/

[14] Table created at https://www.census.gov/cps/data/cpstablecreator.html after selecting Pennsylvania from the State filter and selecting 'Adult Civilian Workers' for the rows. After taking the sum of all incomes below $29,999, 2,275 (in thousands) out of 6,522 (in thousands) adult civilian working Pennsylvanians earn less than $30,000 per year.

continue to rely on access to Medicaid or coverage on the individual market with advance payment tax credits (APTC) to make the private coverage affordable.

Employers typically do not offer coverage to lower income workers. In 2018, only 30 percent of private sector employers (28.5 percent in Pennsylvania) offered health insurance to workers with wages in quartile 1, approximately $30,000 or less, according to data from the Agency for Healthcare, Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS).[15] The major industries covered by the survey included:

- **Agriculture, Fishing and Construction**
- **Mining and Manufacturing**
- **Retail and Other Services**
- **Professional Services**

Since large firms are more likely to offer health insurance, approximately 51 percent of workers nationally and 59 percent in Pennsylvania in quartile 1 were eligible for coverage in 2018. Of those workers eligible for coverage, fewer than 30 percent of workers across the U.S. - and 26.4 percent in Pennsylvania - earning less than $30,000 enrolled in coverage.[16]

Certain industries are less likely to offer health insurance. For instance, in 2018, only 40 percent of retail firms in Pennsylvania offered coverage to their workers. And fewer than half of all retail workers eligible for health insurance were enrolled in 2018.[17]

A separate analysis of the 2018 U.S. Census Bureau's Current Population Survey showed that nationwide, fewer than one-quarter of working age adult workers (not dual-eligible or receiving Supplemental Security Income) with incomes less than 100 percent of the FPIG are offered health insurance through their employer. For people earning between 100 and 250 percent of poverty, offer rates are slightly higher, but still less than 40 percent.[18] Fewer than half of all full-time workers are even offered health care coverage if their incomes are less than 250 percent of the FPIG

[15] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2018 Medical Expenditure Panel Survey-Insurance Component. https://www.meps.ahrq.gov/data_stats/summ_tables/insr/state/series_8/2018/tviiia2.htm

[16] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2018 Medical Expenditure Panel Survey-Insurance Component. https://www.meps.ahrq.gov/data_stats/summ_tables/insr/state/series_8/2018/tviiib2b.htm

[17] Agency for Healthcare Research and Quality. *Percent of private-sector employees eligible for health insurance that are enrolled in health insurance at establishments that offer health insurance by industry groupings and State* (Table V.B.2.a.1), year 1999-2018

[18] Kaiser Family Foundation analysis of March 2018 Current Population Survey.

2.1.3. EXPANSION STATES SAW A REDUCTION IN CHURN RELATIVE TO NON-EXPANSION STATES

It appears that Medicaid expansion has led to a reduction in both coverage loss (moving from Medicaid to the uninsured) and coverage disruptions (moving from Medicaid to another form of coverage) since 2014. A January 2020 study in Health Affairs [19] found that among low-income non-elderly adult Medicaid beneficiaries, coverage losses and coverage disruptions were lower in expansion states than in those states that chose not to expand Medicaid under ACA authority.

Analyzing MEPS data, the study found that between 2014 and 2016, Medicaid expansion states' coverage disruptions and losses each declined by 4.3 percentage points relative to non-expansion states. And states that expanded Medicaid have had more success providing continuity of coverage for beneficiaries, with fewer gaps and/or coverage losses.

The reduction is more pronounced for adult men, who generally had fewer coverage opportunities than women prior to Medicaid expansion. For men, there was an 8.2 percent reduction in coverage disruptions in non-expansion states and a 7.2 percent reduction in coverage losses in expansion states. The differences for women were comparatively smaller, at 2.2 and 2.3 percentage points respectively.

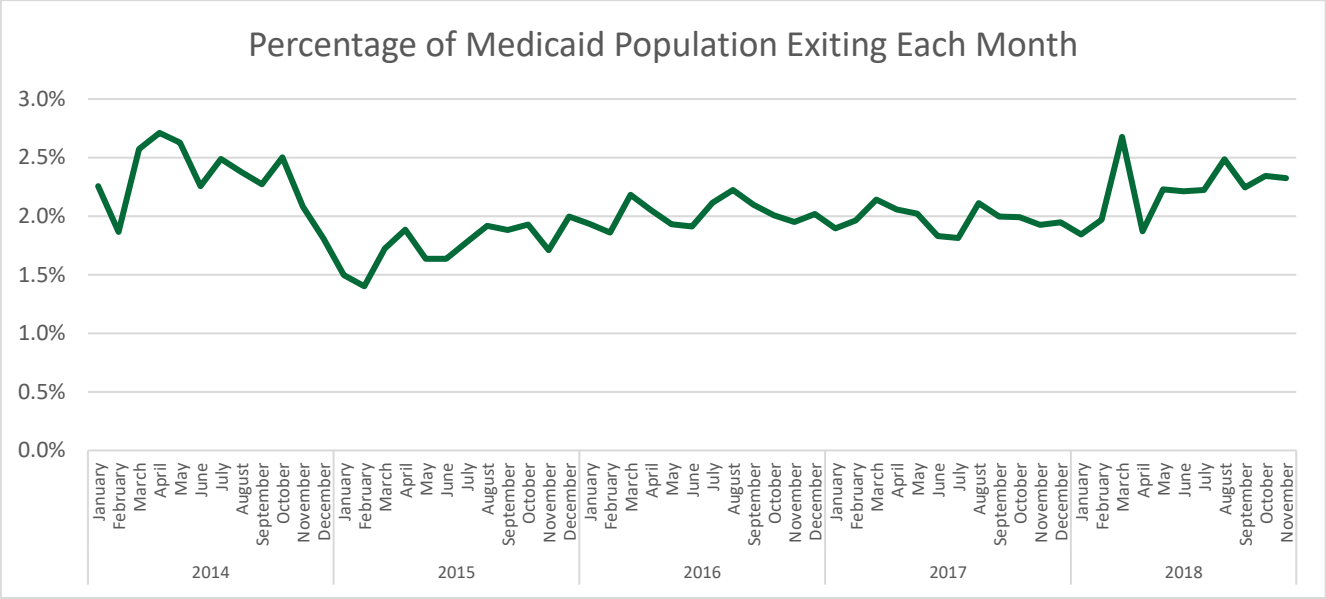
Although Pennsylvania's Medicaid expansion began a year later than most other states, the Commonwealth likely saw a similar but smaller effect. As **Figure 1** shows, the percentage of Pennsylvanians leaving the Medicaid program begin to fall in November/December 2014 as the state began enrollment for newly eligible adults[20], falling to 1.4 percent from a high of 2.7 percent earlier in 2014.

The percentage leaving Medicaid between 2015 and 2018 increased somewhat over time but remained below 2014 levels. The percentage leaving the program saw an uptick in 2018, perhaps due to continued declines in unemployment and gradual increases in average wages.

[19] 10.1377/hlthaff.2019.00378 HEALTH AFFAIRS 39, NO. 1 (2020): 85–93 ©2020 Project HOPE— The People-to-People Health Foundation, Inc.: "Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act

[20] Pennsylvania Medicaid Expansion enrollment commenced in December 2014 for a January 1, 2015 effective date. The "welcome mat" effect, where people already eligible apply for coverage when they learn of new eligibility options, likely contributed to this early decline in coverage disruptions.

Figure 1. Monthly Enrollment in Pennsylvania Medicaid



2.1.4. ENHANCED MATCH HELPS FINANCE MEDICAID EXPANSION COVERAGE

The ACA attempted to make Medicaid coverage more consistent and easier for states to manage, as well as more consumer-friendly and easier for eligible residents to access. For instance, the establishment of MAGI income eligibility standard, with a national and consistent set of deductions and income disregards, standardized the income criteria for enrollment, regardless of the state.

In addition, under the ACA, states implementing Medicaid Expansion are eligible for Federal Medical Assistance Percentages (FMAP) funding which pays 90 percent of the costs to cover the new adult population. This is well above the normal Medicaid FMAP rate for all states. For example, Pennsylvania's normal FMAP is 52.25 percent.

The increased federal funding makes it advantageous for states to continue to cover adults under Medicaid Expansion, especially if the alternative is more uninsured individuals who will seek care in high-cost settings like hospital emergency rooms. Uncompensated care places increased burdens on providers, especially when compounded by cuts to federal Disproportionate Share Hospital (DSH) funding.[21]

3. MEDICAID IN PENNSYLVANIA

Pennsylvania Medicaid has undergone a significant transformation since the state expanded Medicaid in 2015. Almost 3 million are now enrolled in the program, including more than 1 million

[21] https://www.congress.gov/bill/116th-congress/house-bill/748/text#toc-HC0B8507E6BAE472B8EDCEC05B1A379E9 (Section 3813)—DSH payments are expected to be cut by 4 percent in December 2020

non-disabled, non-elderly adults[22] and more than 1.1 million children. The program has become a vital safety net option for low-income uninsured Americans, including the elderly, those with disabilities, children, pregnant woman and childless adults.

3.1. ENROLLMENT GROUPS

The volume of Medicaid enrollees, the duration they are on the program and the costs of coverage varies substantially by enrollment group. Prior to the implementation of the ACA, Medicaid program enrollment was dominated by children and adolescents who made up more than 40 percent of overall Medicaid beneficiaries. [23] Enrollment among non-disabled, non-pregnant adults was very small in states, almost entirely limited to parents in deep poverty. Enrollment for the elderly and those with disabilities accounted for between 35-40 percent of total Medicaid enrollment nationally.

Although Medicaid enrollment is skewed toward children—whose costs per member are much lower than other enrollment groups—state and federal Medicaid spending was largely driven by the cost of care for beneficiaries who are older or have disabilities. In 2014, prior to the Commonwealth's expansion of Medicaid, people with disabilities and elderly Pennsylvanians[24] accounted for almost 78 percent of Medicaid expenditures, despite these groups only accounting for approximately 41 percent of program enrollments. Conversely, families made up 56 percent of total enrollment in Pennsylvania, but only 20 percent of total expenditures. [25]

By December 2018, with the expansion of Medicaid, families accounted for just 43 percent of enrollments (about 1.2 million), while elderly and disabled adults reduced to 30 percent of enrollments.[26] As **Figure 2** shows, most Medicaid enrollment stayed steady over the five-year Medicaid churn study period from 2014-2018 (except for the Expansion population, which added almost 800,000 to the program).

[22] Includes both the Expansion and Adult categories

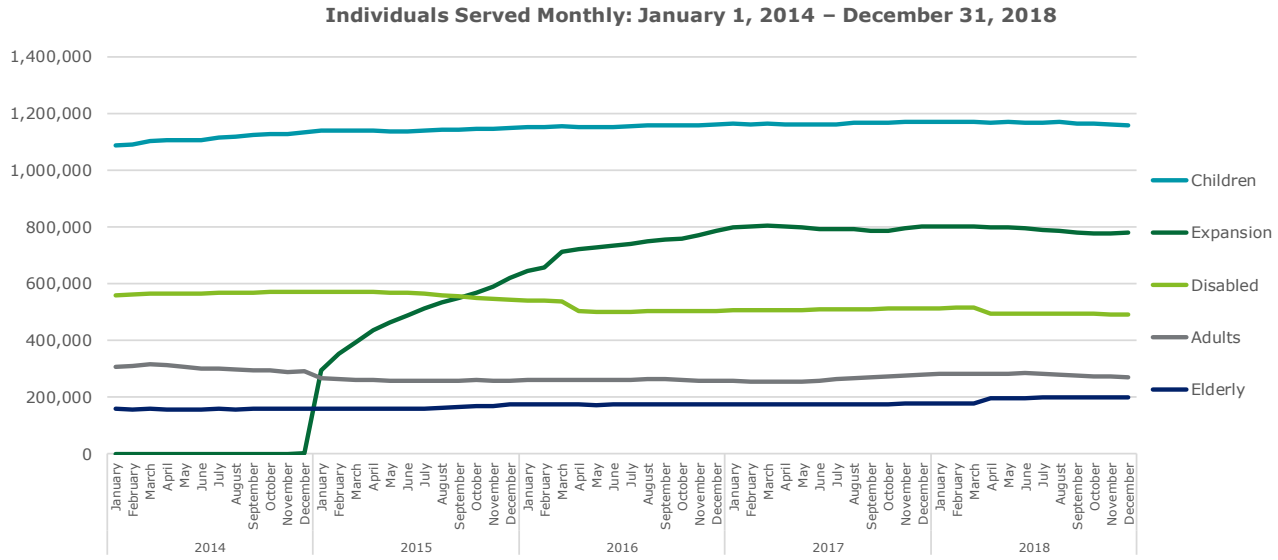
[23] In addition to Medicaid, children and adolescents at higher incomes also were able to enroll in the Children's Health Insurance Program (CHIP).

[24] Mostly dual eligible seniors in need of long-term care

[25] 2014-15 Governor's Executive Budget, page e-37-15, available at https://www.budget.pa.gov/PublicationsAndReports/Documents/2014-15%20Budget%20Document%20WEB.pdf#page=687&zoom=100,0,0

[26] 2018-2019 Governor's Executive Budget, pageE22-20, available at https://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Documents/2018-19%20Proposed%20Budget/2018-19%20Governor%27s%20Executive%20Budget%20-%20Web.pdf

Figure 2. Monthly Enrollment in Pennsylvania Medicaid



3.2. DURATION OF MEDICAID ENROLLMENT

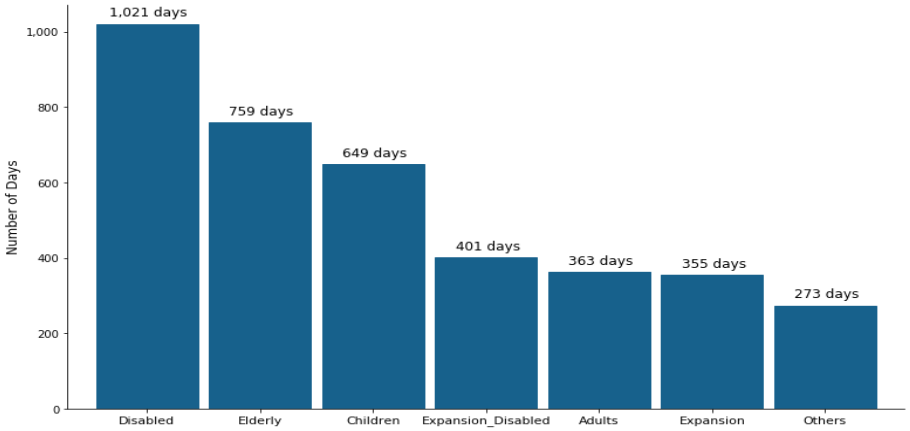
The Pennsylvania Department of Human Services' March 2020 report, "Medicaid Churn Analysis, " found that an average of more than 55,000 people leave the Medicaid program each month. This turnover is consistent with the experience of many other states, and perhaps less than some analyses that have suggested up to 50 percent of Medicaid beneficiaries may churn off the Medicaid program within 12 months.[27]

However, while children and adults comprise a majority of the program enrollment, they do not tend to stay enrolled nearly as long as beneficiaries who are older or have a disability. As **Figure 3** illustrates, people with disabilities have the longest average duration of any enrollment group - almost three years (1,021 days). The average enrollment duration for the elderly is over two full years (approximately 759 days). Children were enrolled, on average, for 649 days between 2014-2018.

Adults experience the shortest enrollment - 355 days, on average, for the expansion population and 363 days for non-expansion adults. This is almost three times less than Medicaid beneficiaries who have disabilities and twice as low as the average duration for Medicaid recipients.

[27] Sommers BD , Graves JA , Swartz K , Rosenbaum S . Medicaid and marketplace eligibility changes will occur often in all states; policy options can ease impact . Health Affairs (Millwood) . 2014 ; 33 (4): 700 – 7 .

Figure 3. Average Duration of Each Enrollment by Program Type, 2014-2018



The shorter duration of adults in the program may be the result of several factors, including:

1) Working age adults are more likely to see a fluctuation of income that could make them ineligible for Medicaid (or they may change jobs and get access to insurance through their employer). Seniors and people with disabilities are less likely to be in the workforce and earning additional income that would make them ineligible. In fact, less than seven percent of both elderly and disabled beneficiaries leaving Pennsylvania Medicaid do so because of an increase in income over the eligibility limit.

   Approximately one-third of the expansion adult beneficiaries in Pennsylvania are between 20-29 years of age. Over time, they are more likely to advance in their jobs and see an increase in income that will make them ineligible for Medicaid.

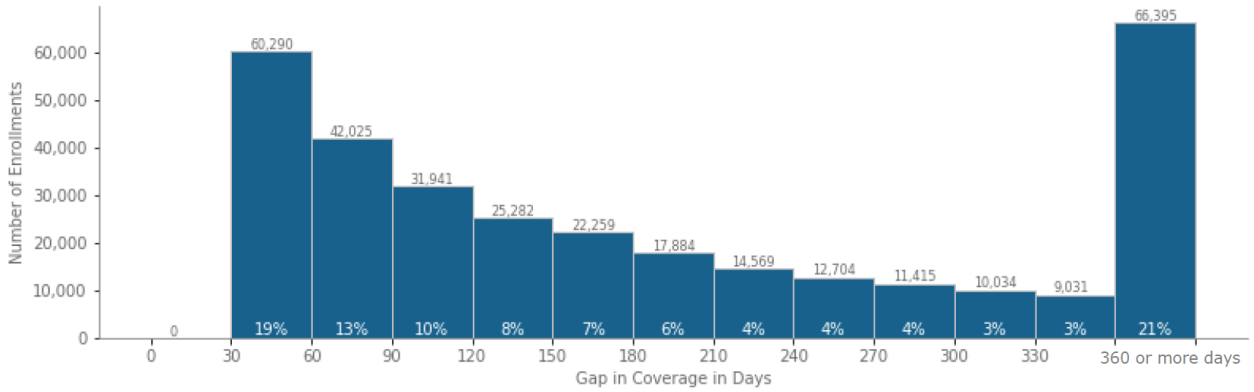
2) Non-elderly adults and children are healthier and use less health care, making them more likely to forego renewal requirements and/or ignore other requests for information from the state. This population is also more likely to move.

3.2.1. Expansion Adults Leaving Program/Coverage Gaps

Expansion adults have the shortest average continuous duration on the Medicaid program. Some of the coverage gaps are brief, as many may lose coverage because they didn't provide documentation in the first month after disenrollment. While 19 percent the Expansion population that leave Medicaid return to the program within 30 days, **as Figure 4 indicates**, approximately 21 percent leave the program for one year or more.

Essentially, beneficiaries either return to the program within 90 days (often likely from an oversight in submitting required documents) or experience a much longer duration off the program. The coverage gaps are consistent for 19-64 year olds, with each age group (20-29, 30-39 etc…) seeing between 20-21 percent of those leaving the program remaining off for at least a year.

Figure 4. Coverage Gaps Among the Expansion Population



The most common reason that expansion beneficiaries leave the program for at least a year is because of an increase in income from a new job. As **Figure 5** illustrates, when all income-related exit reasons are considered collectively (highlighted in green in Figure 5), approximately 41 percent of expansion beneficiaries leave the program because their income exceeds the limit of 138 percent of FPIG.

Figure 5. Exit Reason Codes for the Pennsylvania Medicaid Expansion Population 2015-2018

Expansion Population Exit reasons	
Exit Reason - Description	**# Enrollments**
1) Failure to Furnish Required Information	273,395
2) MAGI Medical Assistance – Income Exceeds Income Limit	228,917
3) Full Time Employment – Income Exceeds Income Limit	120,972
4) Voluntary Withdrawal – Requested Closure of Benefits [2]	73,243
5) Whereabouts Unknown – Unable to Locate Recipient	64,768
6) Other Institutionalization, Including Imprisonment – Institutionalization (Entered Prison, Nursing Facility, etc.)	52,240
7) Combined Income – Income Exceeds Income Limit	48,676
8) Permanent Move Out of State – Moved to Another State / No Longer Residing in PA	38,926
9) No Reason Provided [1]	23,508
10) Part Time Employment – Income Exceeds Income Limit	21,668
11) Other Change in Number of Persons – Change in Household Size / Composition	15,724
12) Death of Payee	14,156
13) Transition [3]	14,141
14) Supplemental Security Income – No Longer Eligible for Supplemental Security Income (SSI)	8,759
15) PCO – No Longer Eligible for Private Coverage Option (Healthy PA)	6,443

16) All other exit reasons	25,668
Total Enrollments	*1,031,204*

Notes: A total of 1,031,204 enrollment records with an end date prior to 12-31-2018 and no subsequent enrollment within 30 days of the exit are included in this analysis. Rows highlighted in green indicate the exit reason is related to income. Collectively, income-related exit reasons are the most common reason an expansion beneficiary exits the program.
[1] Unable to categorize
[2] There have been previous system issues where "Voluntary Withdrawal" is erroneously assigned to closures. This number may skew higher because of this.
[3] All individuals with a "Transition" reason code would have opened in another MA category.

The data suggests that Medicaid Expansion is largely used as a temporary health coverage option for low-income Pennsylvanians that are transitioning into the workforce; by seasonal workers with low monthly incomes; and by other adults that are in a job transition that might have lowered their income for a period of time.

3.2.2. REASONS FOR LEAVING MEDICAID

There is no singular reason why an individual or family exits Medicaid; sometimes it is as simple as permanently moving out of state and becoming ineligible. There are multiple reasons why a person might no longer be eligible to receive coverage through Medical Assistance.

When considering each exit reason individually, the top reasons for leaving Pennsylvania Medicaid, according to the DHS study, are 1) "Failure to Furnish Required Information" and 2) an increase in income that makes a person or family ineligible for the program. However, if all income-related exit reasons are considered collectively, this becomes the most frequent exit reason.

Failure to Furnish Required Information

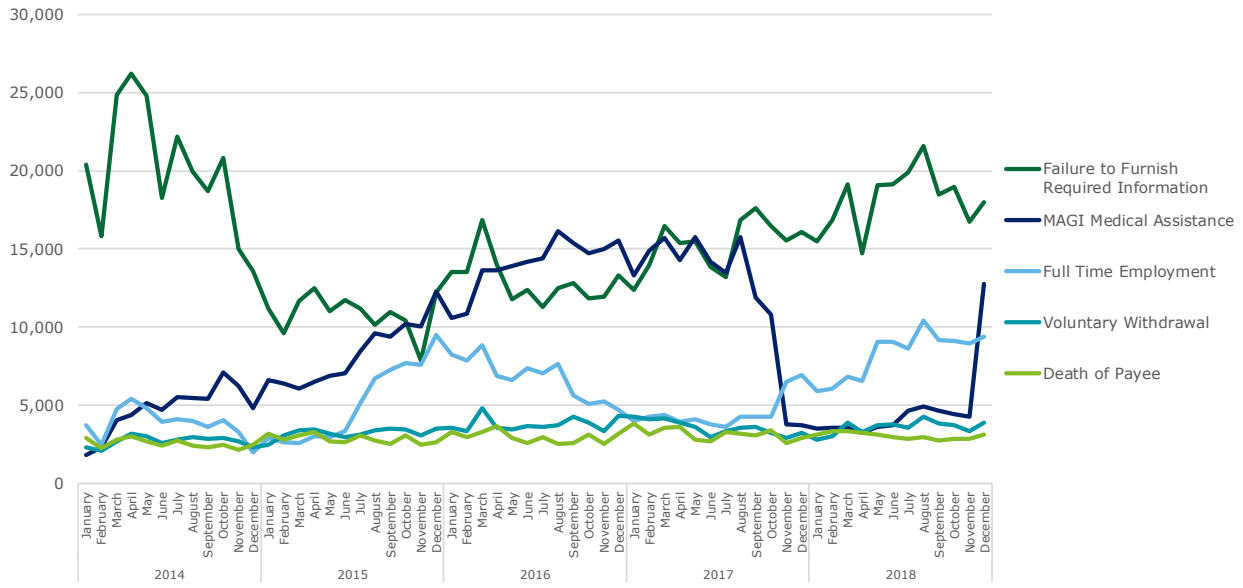
The largest singular reason that individuals—regardless of enrollment type—churn off Medicaid is failure to furnish the required information. This is the exit reason for approximately 33 percent of children, 27 percent of the expansion population, and about 22 percent of beneficiaries with disabilities.

This could happen in several ways, including a beneficiary ignoring a renewal form; delays in furnishing verification documents; or an income discrepancy with electronic data sources that cannot be resolved before disenrollment occurs.

Increase in Income Above Eligibility Limit

As the Medicaid Expansion program has stabilized, fewer people, on average, are failing to produce information than were at the early stages of the ACA implementation in 2014, as shown in **Figure 6**. MAGI income above the legal limit or gaining full-time employment with ESI (or income above the MAGI limit) now account for a greater share of total failure reasons in many months, especially at year-end when a greater share of renewals occur.

Figure 6. Top Five Most Common Failure Reasons by Month



While only approximately 5 percent of churn is related to death of a payee, it is a more significant reason for elderly and disabled beneficiaries. Approximately 14 percent of the disabled population died while still enrolled in Medicaid during the 2014-2018 period.

An even greater percentage, 54 percent of enrollments, in the elderly category ended due to death of a payee. This is not unexpected, since Medicaid is the primary payer of nursing home care for the dual-eligible Medicare/Medicaid population, serving over 60 percent of nursing home residents.[28] Medicaid expenditures on long-term care services and supports account for approximately 30 percent of Medicaid budgets nationally.[29]

Additionally, while the program experiences consistent turnover each month as beneficiaries move out and back into the program, the effects are not equally distributed by population groups. Non-elderly, non-disabled adults are more likely to churn both out of Medicaid coverage and within different coverage groups according to the Pennsylvania DHS study.

Since eligibility is largely predicated on current monthly income, the working age population will tend to have fluctuating income throughout their career that can cause them to leave and re-enter the program, depending on their employment status. In addition, healthier adults may have less incentive to remain covered, which can lead to a greater non-compliance with requests for information than disabled and elderly beneficiaries that consistently need health care services.

[28] Harris-Kojetin L, Sengupta M, Lendon JP, Rome V, Valverde R, Caffrey C. Long-term care providers and services users in the United States, 2015–2016. National Center for Health Statistics. Vital Health Stat 3(43). 2019. https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf

[29] Ibid

3.2.3. CHURN WITHIN AND OUT OF MEDICAID

Churn can occur when individuals leave the program and/or return after disenrolling. Since Medicaid eligibility is based on current monthly income, people leave the program each month even if efforts to mitigate churn are implemented by a state.

As mentioned, adults in the expansion group experience a significant amount of churn compared to other enrollment groups. And, as **Figure 7** shows, the churn is both within the program and in leaving Medicaid all together. Over 60 percent of the expansion group that lost categorical eligibility churn to enrollments outside of Medicaid and did not return at all through a four-year period. This population could include individuals that now have a plan purchased through the exchange, private coverage through an employer, moved, became incarcerated or are uninsured.

For the 30 percent of those that churn off exchange coverage and return to either the expansion or the adult categories (almost 680,000 individuals), Medicaid Expansion remains a valuable safety net. This may be especially true for those experiencing an extended period of unemployment like many are now due to the COVID-19 pandemic. A December 2019 working paper by economists at the University of Michigan and the Federal Reserve Bank of San Fransisco suggested that, nationally, Medicaid Expansion helped reduce the uninsured rate substantially among unemployed Americans. Expansion states saw a net 22.8 percentage point drop in the uninsured rate for unemployed workers between 2013-2017, compared with a 10.8 percentage point drop in non-expansion states.[30]

Figure 7. Next Enrollment After Initial Expansion Coverage Ends

Enrollment type following Expansion	Number of Enrollments	Percentage of Total Expansion Enrollments
Expansion to None (no subsequent enrollment in MA)	1,353,796	60.80%
Expansion to Adults	355,779	15.98%
Expansion to Expansion	323,829	14.54%
Expansion to Disabled	131,745	5.92%
Expansion to Others	39,825	1.79%
Expansion to Children	13,986	0.63%
Expansion to Elderly	7,549	0.34%
Total	*2,226,509*	*100%*

Of the 60 percent going from expansion to non-Medicaid status, it is likely that many people gain new coverage through a private qualified health plan (QHP) purchased through the Federally-Facilitated Marketplace (FFM) accessed at healthcare.gov, get covered through ESI, or experience a period of uninsurance.

[30] Medicaid Expansion and the Unemployed. Thomas C. Buchmueller, Helen G. Levy, and Robert G. Valletta, NBER Working Paper No. 26553, December 2019, JEL No. I13,I18,J18,J2,J6. While the specific study did not have state-by-state data on the unemployed, Pennsylvania's overall uninsured rate was reduced by 50% between 2013 and 2017. As mentioned earlier, the state expanded Medicaid to low-income adults beginning in 2015.

However, while approximately 40 percent of Pennsylvania Medicaid adult enrollees work full-time and an additional 20 percent work part-time[31], it is unclear whether many are gaining employer-sponsored insurance coverage. As discussed earlier, low-income workers are the least likely to be offered health insurance.[32] Employer surveys by AHRQ show that fewer than half of workers in the lowest income quartile (less than $30,000 a year) access insurance from their employer even when offered.

4. CONCLUSION

Medicaid is a valuable safety net coverage option for low-income children, the elderly, people with disabilities, and adults. Pennsylvanians enter and leave the Medicaid program each month, and adults covered due to Medicaid Expansion have the shortest length of coverage of any enrollment group. A substantial percentage of able-bodied Medicaid adults, approximately half in any given month, are working either full- or part-time. Additionally, the Medicaid program provides valuable support in many cases to beneficiaries seeking work or those trying to maintain a job. Low-income workers are the least likely to be offered insurance through their employers and often cannot afford private coverage.

As incomes fluctuate, many in the workforce transition off Medicaid. Approximately 60 percent of the adult Medicaid Expansion population in the Pennsylvania DHS study between 2015-2018 did not return at any point once they left the Medicaid program. Additional analysis on income, employment, and private insurance coverage trends for former adult Medicaid beneficiaries could provide insights that could inform future policy decisions.

[31] http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work-What-Does-the-Data-Say

[32] Kaiser Family Foundation analysis of March 2018 Current Population Survey.