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Washington Health Benefit Exchange

Legislative report: Continuing health coverage for people losing Medicaid

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Legislative direction

By Dec. 31, 2024, the 2023-25 budget (Engrossed Substitute Senate Bill 5950¹) directs Washington Health Benefit Exchange (Exchange) to complete a study of options and recommendations to ensure continuous health care coverage through qualified health plans (QHPs) for Medicaid beneficiaries losing Medicaid coverage through Washington Healthplanfinder.² More specifically, the bill directs the Exchange to conduct a:

- ▶ State-based marketplace landscape scan: Review transitional solutions used in other states to continue coverage for individuals losing Medicaid.
- ▶ DSHS data analysis: In coordination with the Department of Social and Health Services (DSHS), analyze monthly enrollment rates and demographic and employment information for people who are determined no longer eligible for Medicaid and those who enroll in QHPs; and,
- ▶ Feasibility analysis: An analysis of automatically enrolling clients who lose Medicaid eligibility and are eligible for no-premium QHPs through Washington Healthplanfinder.

The report is organized into each of these three required sections, with additional information in the appendices.

Background

The Exchange operates Washington Healthplanfinder, the online integrated eligibility and enrollment portal for both Washington Apple Health (Medicaid) and QHPs used by over one in three Washington residents under the age of 65, with 1.7 million enrolled in Medicaid and an additional 270,000 in private health insurance.

Washington Healthplanfinder supports both QHP and Medicaid customers by verifying eligibility in real time, providing plan shopping tools, free enrollment and language assistance, securely transferring select data to issuers as well as state and federal agency partners, generating customer notifications and processing renewals.



¹ See Appendix A for relevant proviso text from Engrossed Substitute Senate Bill 5950.

² People losing Medicaid coverage through Washington Healthplanfinder are those with Modified Adjusted Gross Income (MAGI) based health insurance through Washington Apple Health.

Automated support for customers joining Medicaid and renewing Medicaid or QHP coverage

Through Washington Healthplanfinder, the Exchange helps Washingtonians maintain continuous health coverage by:

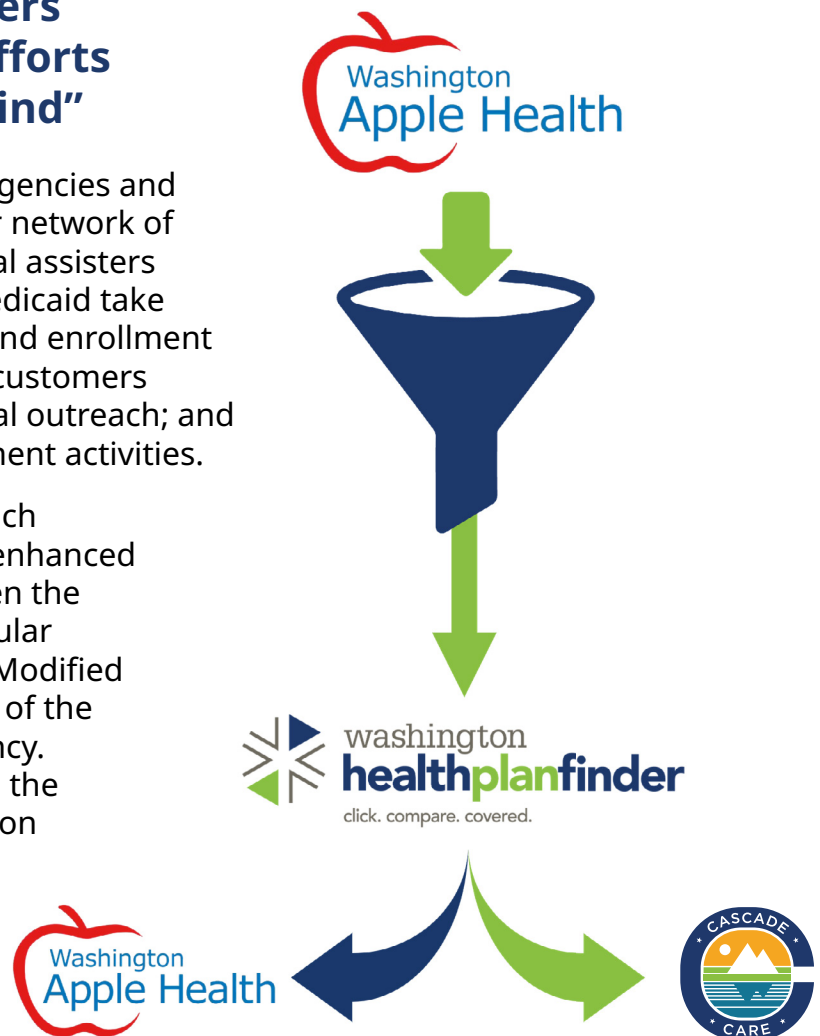
- ▶ Automatically enrolling eligible individuals and families into Medicaid plans and annually processing renewals;
- ▶ Automatically renewing coverage annually for the majority of QHPs customers; and
- ▶ Automatically enrolling QHP customers in discontinuing plans into similar plans.

Typically, about 88% of people who become eligible for Medicaid are automatically enrolled into coverage (12% choose to select their own plan); and more than 90% of existing QHP customers have their coverage automatically renewed each year.³ Individuals who become eligible for QHP coverage after leaving Medicaid are not similarly automatically enrolled. They must return to Washington Healthplanfinder to update their application and/or select a QHP.

Outreach support for customers exiting Medicaid; increased efforts during recent “Medicaid Unwind”

The Exchange, in partnership with state agencies and carriers, leverages our grassroots assister network of nearly 3,000 brokers, navigators and Tribal assisters across the state to help people exiting Medicaid take action to stay covered. Required actions and enrollment deadlines are communicated to affected customers through mailings; emails; social and digital outreach; and community-based outreach and engagement activities.

With support from the Legislature, outreach support for people exiting Medicaid was enhanced from April 1, 2023, until April 1, 2024, when the Health Care Authority (HCA) resumed regular Medicaid eligibility checks for those with Modified Adjusted Gross Income (MAGI) at the end of the declared COVID-19 public health emergency. The Exchange was an active participant in the “Medicaid Unwind,” during which 2.2 million Medicaid customers had their eligibility redetermined through Washington Healthplanfinder, with 1.6 remaining on or returning to Medicaid and 73,000 signing up for a QHP.



³ Washington Health Benefit Exchange. 2024 Spring Enrollment Report. <https://www.wahbexchange.org/about-the-exchange/reports-data/enrollment-reports-data/>

QHP uptake among exiting Medicaid customers

A record high number of people exiting Medicaid transitioned to QHP coverage through Washington Healthplanfinder following April 1, 2023, thanks to a collaborative effort by state agencies and community partners and the increased financial support available to customers through federal enhanced premium tax credits and state premium assistance (Cascade Care Savings).

National data from before the public health emergency unwind indicates fewer than one in 20 eligible individuals successfully transition to QHP coverage after losing their Medicaid eligibility.⁴ More recent data indicates the rate of successful transition during the unwind in Washington state was much higher; 28% of eligible customers selected a QHP during the unwind (up from 17% prior). Still, many eligible customers did not successfully make the transition.⁵

National and state-specific data, including the DSHS analysis described in this report, indicate that many people are at risk of becoming uninsured when they lose Medicaid coverage, despite qualifying for subsidized, low-cost coverage through Washington Healthplanfinder. National data shows that more than half of the uninsured nationally are eligible for subsidized coverage.⁶

The recent experience with Medicaid Unwind demonstrates how Washington Healthplanfinder could be leveraged to help prevent coverage gaps among those losing Medicaid.

Section I: State-based marketplace landscape scan

Transitional solutions and administrative burden

A growing body of research points to the negative effect administrative burdens have on use of public benefit programs.⁷ Many states are examining the effect of “churn,” or the transitioning of individuals between coverage programs (e.g., Medicaid and QHP), on insurance coverage, health outcomes and public spending.⁸ Research indicates that disruption in Medicaid coverage leads to uninsurance and delayed or missed care. The cumulative effect of churning between coverage programs leads to higher administrative costs, less predictable state expenditures and ultimately higher costs for individuals.⁹

⁴ McIntyre, A. & Shepard, M. (2022). Automatic Insurance Policies — Important Tools for Preventing Coverage Loss. NEJM. <https://www.nejm.org/doi/full/10.1056/NEJMp2114189>

⁵ Washington Health Benefit Exchange. (2024). Keeping People Covered: During the Medicaid Unwind: Summary Report. <https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/MedRed%20Data%20Snapshot%2020240821.pdf>

⁷ Herd, P. & Moynihan, D. (2018). Administrative Burden: Policymaking by Other Means. <https://doi.org/10.7758/9781610448789>

⁸ Gould, G. & Hensley-Quinn, M. (2022). Rhode Island Looks to Auto-Enrollment to Ease Transitions from Medicaid to Marketplace. National Association for State Health Policy. <https://nashp.org/rhode-island-looks-to-auto-enrollment-to-ease-transitions-from-medicaid-to-marketplace/>

⁹ Sugar, S., Peters, C., De Lew, N., & Sommers, B.D. (2021). Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. Assistant Secretary for Planning and Evaluation: Office of Health Policy. <https://aspe.hhs.gov/reports/medicaid-churning-continuity-care>

States are exploring opportunities to increase insurance rates by reducing the burden for individuals to enroll. One key interest area among state-based marketplaces (SBMs) is streamlining the eligibility and enrollment experience for customers transitioning from Medicaid to QHP coverage. These types of transitional solutions are commonly referred to as facilitated or automatic enrollment. States automatically select a designated QHP for eligible individuals once their Medicaid coverage ends, to provide them with a more direct opportunity to stay insured and avoid any gap in coverage. The customer then chooses whether to keep, change or decline the selected coverage.

Not covered in-depth in this report are similar types of transitional solutions that some states have enacted, that would require broader legislative changes to implement in Washington state. Some states have created state income tax return-based facilitated enrollment programs which allow eligible individuals to indicate on their state income tax form their interest in having their eligibility checked for free or low-cost health coverage through the state marketplace.¹⁰ Further discussion of these programs is not included in this study given Washington does not have a state income tax.

Additionally, California, Maryland and New Jersey have created programs that allow unemployment claimants to authorize the Department of Labor to share their information with the SBM so they can be screened for QHP and subsidy eligibility. More than 1,300 people in Maryland used this pathway to enroll in either a QHP or Medicaid during a four-month period in 2022.¹¹ Further discussion of this program is not included in this study because it is not specific to the transition from Medicaid to QHP coverage.

Transitional solutions implemented in other states

There are currently four SBMs that have implemented automatic solutions to help customers losing Medicaid transition to a QHP — California, Maryland, Massachusetts and Rhode Island. The Exchange reviewed available public information on these programs and conducted in-depth interviews with each state (See Appendix B for a full list of interviewees).

The four states differ regarding additional policy levers that have been used to expand coverage and population/individual market dynamics. There are, however, common themes with automatic enrollment solutions that have been implemented, summarized in Table 1. In each state, the SBM automatically connects eligible individuals to designated plans. The customer then chooses to keep, change or decline coverage.

¹⁰ Connect for Health Colorado. How Tax Time Enrollment Works. <https://connectforhealthco.com/get-started/how-tax-time-enrollment-works/>

Maryland Health Connection. Easy Enrollment Program. <https://www.marylandhealthconnection.gov/easyenrollment/Pennie.Path.to.Pennie.https://pennie.com/learn/pathtopennie/>

¹¹ Maryland Health Benefit Exchange. (2022). Maryland Easy Enrollment Health Insurance Program Advisory Work Group Meeting. See slide 7. <https://www.marylandhbe.com/wp-content/uploads/2022/10/MEEHP-Work-Group-Presentation-10.14.22.pdf#page=7>

Table 1. Summary of state transitional enrollment solutions for people losing Medicaid

	California	Maryland	Massachusetts	Rhode Island
Start	May 2023	April 2023	April 2022	May 2023
Who People losing Medicaid	QHP-eligible customers who qualify for federal premium tax credits.	All QHP-eligible customers.	QHP-eligible customers up to 150% of the federal poverty level (FPL) who qualify for federal premium tax credits and selected auto-enrollment option when applying.	QHP eligible customers <200% FPL who qualify for federal premium tax credits.
What Customer put in plan then chooses to keep, change or decline coverage	Exchange selects QHP; Customer confirms enrollment by paying (>\$0 premium) or contacting Exchange (\$0 premium).	Exchange selects QHP; Customer confirms enrollment by paying (>\$0 premium) or contacting Exchange (\$0 premium).	Exchange enrolls into QHP.	Exchange enrolls into QHP.

Key learnings from other states

- ▶ Obtaining customer consent is important for states operating these programs. In two states, this occurs prior to automatic plan selection (Massachusetts and Rhode Island), and in two states it occurs afterward (California and Maryland). The states where it occurs prior to plan selection have a narrower scope (e.g., income cap); the states where it occurs afterward are more inclusive (e.g., do not limit to only those who can access a \$0 plan).
- ▶ All states exclude people who are not QHP eligible (e.g., moved out of state, death, incarceration, other minimum essential coverage, etc.).
- ▶ Most states do not require the customer to complete their Medicaid renewal to be included. Maryland, Massachusetts and Rhode Island use the latest information from available data sources to assess who is QHP eligible.
- ▶ Most states prioritize affordability when designating the auto-selected plan (California, Massachusetts and Rhode Island designated plan is at the Silver level (\$0, lowest cost or second-lowest cost Silver plan).
- ▶ All states dedicated significant attention to communicating clear messages to customers automatically assigned a plan (new and/or updated notices; online application updates).
- ▶ All states allow people to select a different plan from the plan automatically assigned to them.
- ▶ Two of the four states passed legislation to establish their program (California through a policy bill and Rhode Island through the state budget).

See Appendix B for additional resources about the transitional coverage solutions that have been implemented in these states.

Initial data on program effects in other states

All four SBMs that have implemented automatic enrollment programs report general customer satisfaction, enrollment increases and a significant portion of automatically enrolled customers retained coverage.

All four states implemented their programs to prepare for a large influx of customers eligible for QHPs following their Medicaid coverage ending once COVID-19 public health emergency protections ended. Early data indicates their programs were successful in helping eligible individuals transition from Medicaid to QHP coverage. All four states report record-high enrollment following the Medicaid Unwind, though it is difficult to determine the extent to which their transitional programs are responsible for enrollment gains. The higher volume of people leaving Medicaid coverage during the Medicaid Unwind, and the availability of enhanced premium subsidies to significantly reduce the cost of the QHPs available to them also played a role.

California has the most robust data. From July 2023 through June 2024, more than half a million people (518,000) had a plan automatically selected for them following their Medicaid coverage ending. About one-third of those people confirmed the automatic plan selection and enrolled in coverage (175,000 or 34%). This rate was only slightly higher (36%) among those eligible for a \$0 net premium plan. Customers with a new premium greater than \$0 make up 68% of those who enrolled in coverage after automatic plan selection. Most customers (70%) stayed in the plan selected for them, the lowest-cost Silver plan.¹²

Customers enrolled through California's automatic plan selection program were more likely to be from communities of color, prefer to communicate in Spanish, have lower levels of education and have lower incomes. Fifty-four percent of people who enrolled through the automatic plan selection program were Latino, compared with 33% who selected a plan during open enrollment. A customer experience survey found 77% supported the automatic plan selection program.¹³

While limited, currently available data on transitional solutions that streamline the eligibility and enrollment experience for customers transitioning from Medicaid to QHP coverage indicate that it shows some promise as a strategy to help expand coverage and address coverage disparities.

Section II: DSHS analysis of health coverage outcomes for persons leaving Medicaid

The Exchange contracted with DSHS' Research and Data Analysis (RDA) division to conduct a comprehensive analysis of persons leaving Medicaid coverage in 2019 and 2023, using Exchange eligibility and enrollment data and RDA's Integrated Client Data Repository. Detailed findings from the DSHS analysis are available in Appendix C, and topline are noted below.

¹² Covered California. (2024). Executive Director's Report.

https://board.coveredca.com/meetings/2024/November%202024/2024.11.21_ED_Report.pdf

¹³ Covered California. (2024).

Methods overview

The DSHS analysis focused on adults exiting categories of Medicaid coverage that determine eligibility based on the MAGI methodology.

People exiting Medicaid in 2019 were followed over the subsequent 12 months to determine their post-exit coverage status, and in 2023 were followed over the subsequent six months. DSHS used data from multiple administrative databases to examine how many people exiting Medicaid:

- ▶ Are potentially uninsured;
- ▶ Transitioned to a QHP;
- ▶ Returned to Medicaid;
- ▶ Enrolled in Medicare;
- ▶ Are likely to have employer-based coverage; or
- ▶ Are unlikely to be eligible for a QHP or Medicaid.

Results highlight: Coverage status after exiting Medicaid

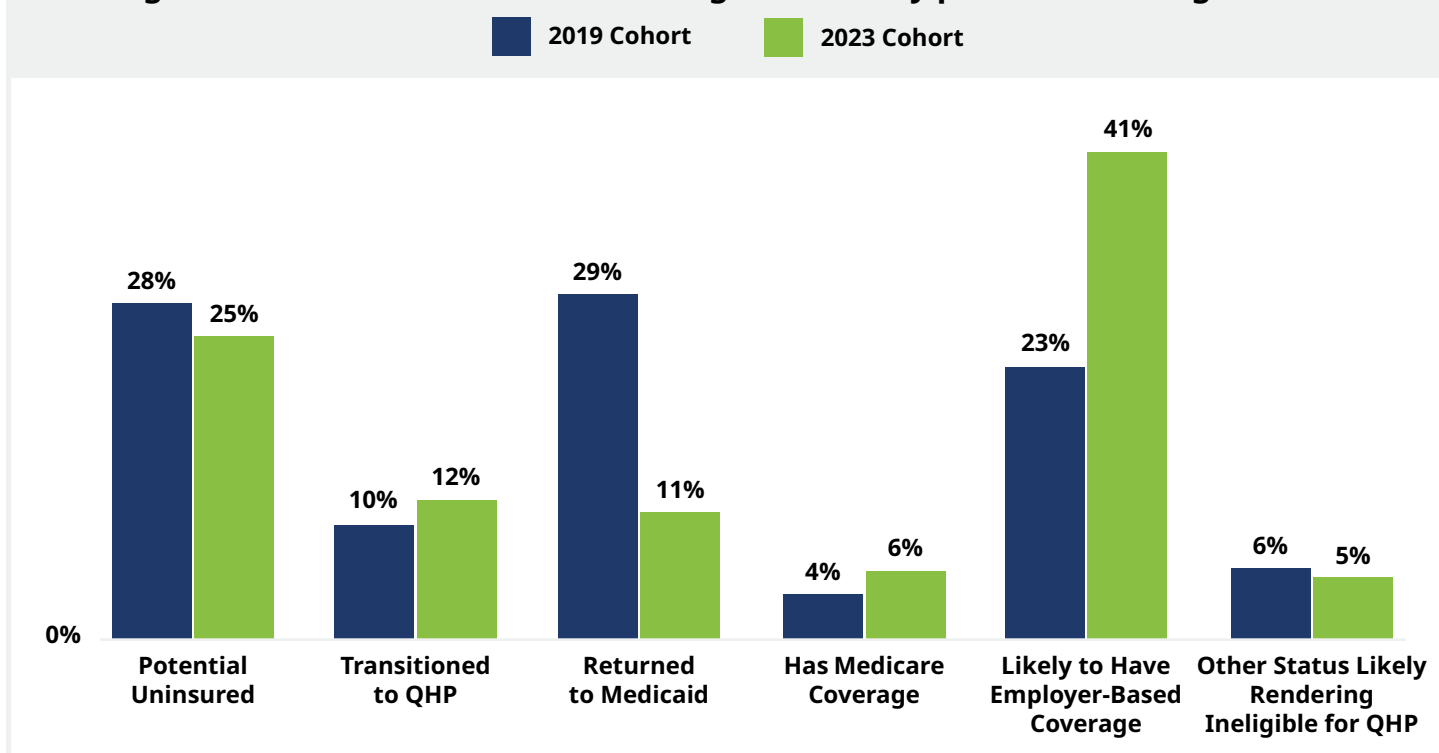
The DSHS analysis found that about a quarter of the 2019 and 2023 cohorts fell into the “potentially uninsured” category. **In 2019, almost 80,000 former Medicaid beneficiaries became potentially uninsured after exiting Medicaid. In 2023, that number grew to nearly 100,000.** See Table 2 and Figure 1 for additional details.

Table 2: Distribution of adults leaving Medicaid by post-exit coverage status

	Potentially Uninsured	Transitioned to QHP	Returned to Medicaid	Has Medicare Coverage	Likely to Have Employer-Based Coverage	Other Status Likely Rendering Ineligible for QHP	TOTAL
Adult MAGI Exits							
Number of Exits							
2019 Exit Cohort	78,418	27,277	80,421	11,085	63,736	16,947	277,884
Percent of Exits							
2019 Exit Cohort	28%	10%	29%	4%	23%	6%	100%
Adult MAGI Exits							
Number of Exits							
2023 Exit Cohort	98,464	45,948	41,771	22,696	158,507	20,707	388,093
Percent of Exits							
2023 Exit Cohort	25%	12%	11%	6%	41%	5%	100%

Note: The total number of MAGI exits reported by DSHS only includes individuals who had at least a one-month gap in their Apple Health coverage. Anyone who completed their renewal during the 90-day grace period and had their coverage reinstated without a gap in coverage was not included.

Figure 1: Distribution of adults leaving Medicaid by post-exit coverage status



Note: The 2023 cohort was affected by the unwinding of pandemic-era Medicaid eligibility rules. As a result, this cohort experienced a high rate of transitions to employer-based coverage, relative to the 2019 exit cohort. The rate of transition to employer-based coverage should be expected to be lower in subsequent cohorts, and the proportion exiting to the status of “potentially uninsured” should be expected to be higher, in the absence of policy changes to impact these rates.

Results highlight: Health disparities among potentially uninsured

DSHS found significant disparities in the health and sociodemographic characteristics of persons leaving Medicaid who became potentially uninsured, transitioned to a QHP and returned to Medicaid. For example, when comparing people who transitioned to a QHP plan with the potentially uninsured, DSHS found that Asian and White beneficiaries were overrepresented in the QHP-enrolled group, while American Indian and Alaska Native, Black and Hispanic beneficiaries were underrepresented in the QHP-enrolled group.

Relative to people transitioning to a QHP or exiting Medicaid with employer-based coverage, people in the potentially uninsured group were also:

- ▶ More likely to be male;
- ▶ More likely to be under age 35; and
- ▶ More likely to be homeless, to have a substance use disorder or to have prior criminal legal system involvement.

The potentially uninsured group also had the lowest health risk score when exiting Medicaid, across all coverage categories. Table 3 includes detailed characteristics, by post-exit coverage status, for the 2019 cohort.

Table 3. Characteristics of adults age 18+ exiting MAGI Medicaid in CY 2019, by post-exit coverage status

CHARACTERISTICS	TOTAL—ALL EXITS						
	Other Status Likely Rendering Ineligible for QHP						
	Likely to Have Employer-Based Coverage						
	Has Medicare Coverage						
	Returned to Medicaid						
	Transitioned to QHP						
	Potentially Uninsured						
Number	78,418	27,277	80,421	11,085	63,736	16,947	
Age category							
18-24	28.9%	13.8%	25.2%	0.7%	20.6%	16.7%	22.6%
25-34	32.9%	29.3%	35.3%	3.4%	38.7%	35.4%	33.6%
35-44	18.6%	19.1%	20.2%	5.5%	22.2%	20.8%	19.6%
45-54	11.8%	16.3%	11.8%	8.7%	12.2%	14.6%	12.4%
55-64	7.8%	21.2%	6.8%	27.6%	6.3%	12.6%	9.6%
65+	0.0%	0.2%	0.7%	54.1%	0.0%	0.0%	2.4%
Gender							
Female	50.5%	60.5%	54.5%	53.0%	54.0%	56.2%	53.9%
Male	49.5%	39.5%	45.5%	47.0%	46.0%	43.8%	46.1%
Race/ethnicity							
AIAN	7.0%	3.4%	9.9%	5.1%	5.6%	7.2%	7.1%
Asian	6.6%	13.4%	6.8%	8.2%	8.3%	4.7%	7.7%
Black	9.0%	4.2%	11.8%	4.9%	8.9%	10.3%	9.2%
Hispanic	17.9%	9.4%	18.5%	9.9%	16.4%	12.1%	16.2%
Missing	3.0%	5.0%	0.9%	3.9%	2.9%	2.5%	2.6%
NHPI	3.0%	2.9%	2.1%	1.6%	2.7%	2.2%	2.6%
White Alone Not Hispanic	52.4%	60.5%	49.5%	65.8%	54.1%	59.9%	53.7%
Unknown	1.0%	1.1%	0.6%	0.6%	1.0%	1.1%	0.9%
PRISM health risk score at exit							
Health risk score	0.25	0.37	0.36	0.94	0.26	0.68	0.35
Homeless in 12 months prior to exit?							
Yes	9.7%	1.3%	15.9%	4.6%	3.9%	18.9%	9.7%
Homeless or unstably housed in 12 months prior to exit?							
Yes	11.0%	1.6%	17.7%	5.9%	4.6%	22.6%	11.0%
Child welfare system involvement in 12 months prior to exit?							
Yes	4.8%	2.0%	8.5%	2.2%	4.0%	5.9%	5.4%
Arrest in 12 months prior to exit?							
Yes	3.5%	0.1%	12.5%	0.3%	0.3%	0.5%	4.7%

Detailed findings

Additional detailed information for the 2019 and 2023 exit cohorts, including monthly trend data on the post-exit coverage status of adults exiting MAGI Medicaid and information on the percentage of adults leaving Medicaid with Employment Security Department-reported earnings, is available in Appendix C.

Section III: Feasibility analysis

To maintain continuous coverage for people exiting Medicaid in Washington state, the Exchange explored the feasibility of transitional solutions into QHP coverage that would:

- ▶ Leverage the information currently available in Washington Healthplanfinder (including verified income information);
- ▶ Leverage the state's Cascade Care program (including available federal premium tax credits and state premium assistance);
- ▶ Clearly inform customers of their automatically selected plan, and how to confirm, switch or decline coverage;
- ▶ Provide straightforward pathways for customers, and those who may be assisting them, to confirm, switch or cancel the pre-selected coverage;
- ▶ Securely and seamlessly communicate enrollment information to carriers; and
- ▶ Enable continued monitoring and evaluation of program outcomes.

Key considerations were explored related to equity, customer experience, system stability and cost. Data was gathered and analyzed from national and state-specific research studies, state-specific unwind data and the Exchange data warehouse.

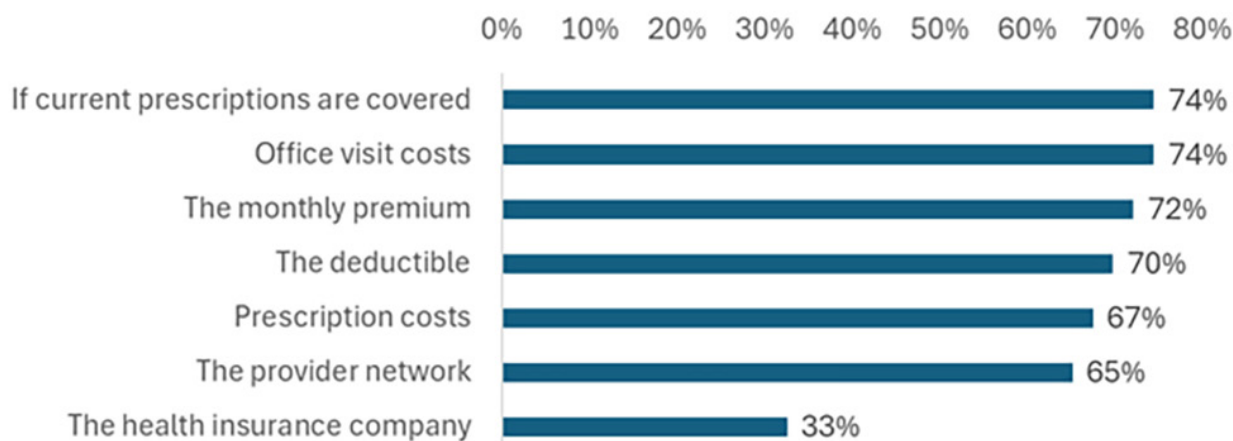
Feedback was solicited from potentially affected customers (via a new customer survey); state agency partners (DSHS and HCA); SBMs with transitional solutions (California, Maryland, Massachusetts and Rhode Island); an information technology vendor with direct implementation experience; and actuarial consultants.

Exchange data, consistent with national data, illustrates cost is the most important factor in driving customer decisions about health coverage.

- ▶ [A recent analysis of plan selections during the Medicaid Unwind](#) found that most former Medicaid customers who selected a QHP changed insurance carriers. Only 26% chose a QHP offered by their former Medicaid carrier. Three quarters of former Medicaid customers selected a QHP from one of the three carriers with the lowest average premiums.

- ▶ A recent Exchange customer survey of people who recently lost Medicaid coverage and were determined eligible for QHP coverage but did not select a plan similarly showed cost was the most important factor.¹⁴
 - When asked about the most important factors to them when looking for health insurance, the top responses were coverage for prescription drugs, office visit costs and the monthly premium. **More than 70% of respondents rated those factors as either important or very important** (see Figure 2). In contrast, only 33% of respondents rated the health insurance company as important or very important.
 - Notably, when asked about the most important factors to them when considering potential future improvements to the QHP shopping experience, **the top responses** (rated as either important or very important) were **lowering the costs of available plans (65%)** and **automatically enrolling them into a \$0 or low-cost plan (56%)**.

Figure 2. Percent of survey respondents rating plan features as important or very important (2024)



¹⁴ To conduct the survey, the Exchange identified a sample of 15,540 people who had recently lost their Apple Health (Medicaid) coverage, were subsequently determined eligible for QHP coverage, but did not select a plan. Of those sampled, 43 people completed the survey.

Program design assumptions

Based on available data and the feedback provided, the Exchange focused on assessing the feasibility of a transitional solution that would:

- ▶ Focus on people exiting Medicaid who are determined QHP eligible and/or have a verified income above Medicaid limits;
- ▶ Exclude people who are ineligible for QHP coverage (e.g., have moved out of state, become incarcerated, enrolled in Medicare, etc.);
- ▶ Not limit program eligibility based on household income or access to a \$0 net premium plan;
- ▶ Automatically select a plan for eligible customers, the lowest-cost Silver Cascade Care plan in their county (to maximally leverage available federal premium tax credits);
- ▶ Generate a new, simple notice for affected customers describing how to keep, change or decline the automatically selected coverage; and
- ▶ Provide a new, streamlined pathway for customers to confirm or cancel the selected coverage.

Should an automated solution move forward, additional Tribal and stakeholder engagement would be needed to further inform program design and implementation.

Estimated program effects

Based on the DSHS analysis, available data and known market conditions, consulting actuaries estimated the potential impact of implementing a program that automatically selects the lowest-cost Cascade Care Silver plan for eligible people exiting Medicaid for designated scenarios. For each scenario, it is assumed that federal enhanced premium tax credits expire at the end of 2025 (current law), and that current funding levels for the state premium assistance program (\$55 million annually) are maintained.

All scenarios include a “best” estimate, and a range of possible outcomes (low–high) based on varied uptake assumptions. All scenarios project how many customers exiting Medicaid would be eligible for automatic plan selection; among them, how many will choose to enroll in coverage; and among those who enroll, how many are newly covered due to the automatic plan selection program (e.g., would not have gotten QHP coverage otherwise). All scenarios are projected for plan year 2028.

Scenario 1: Includes all people exiting Medicaid who are determined QHP eligible and/or have a verified income above Medicaid limits. Results for the “best” estimate indicate nearly 40,000 new individuals and families could gain QHP coverage annually. See Table 4 for details.

Table 4. Automatic plan selection effect estimates

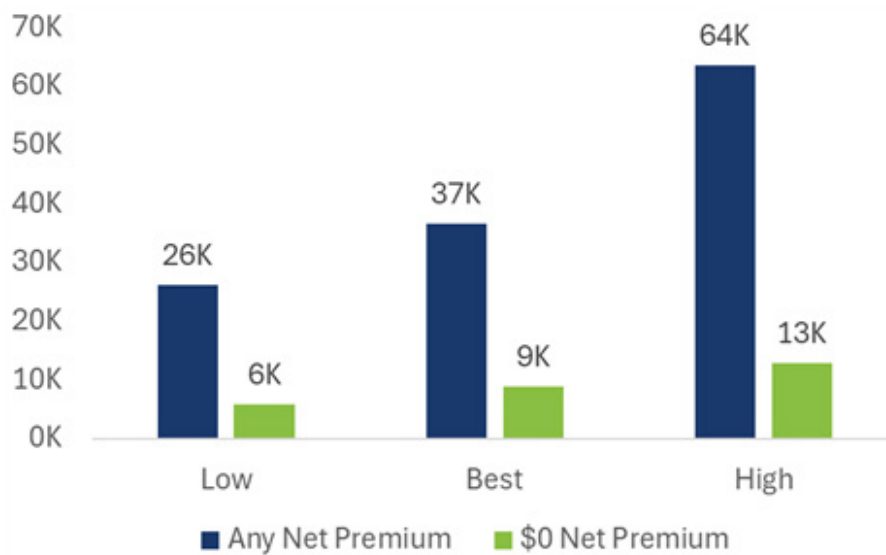
	Best estimate	Low estimate	High estimate
Total eligible for automatic plan selection	145,310	101,161	233,607
Total who enroll	75,854	53,360	126,585
Total net new enrollees	36,685	26,094	63,614

Scenario 2: Includes only people exiting Medicaid who are determined QHP eligible and/or have a verified income above Medicaid limits and who can access the lowest-cost Cascade Care Silver plan for a \$0 net premium. The results indicate a significant reduction in program effects without a significant reduction in program costs. See Table 5 and Figure 3 for details.

Table 5. Automatic plan selection effect estimates – Limit eligibility to those who can access \$0 net premium plan

	Best estimate	Change from Scenario 1	Percent change from Scenario 1
Total eligible for automatic plan selection	64,326	-80,984	-56%
Total who enroll	26,242	-49,612	-65%
Total net new enrollees	8,810	-27,875	-76%

Figure 3. Annual net new QHP enrollment due to automatic plan selection



Estimated start-up timing and costs

- ▶ **Timing:** Implementing an automated solution in partnership with affected stakeholders is expected to take up to two years.
 - The timeframe to initiate and complete this work is contingent on the scope and timing of other potential projects directed by the State Legislature and federal administration during the 2025-27 biennium.
- ▶ **Cost:** Building and launching this program is expected to require a one-time appropriation of up to approximately \$4 million from the Exchange's 17T account (no General Fund-State). Associated 17T revenue from increased enrollments is projected to cover ongoing expenses (e.g., customer notices, customer support, translations, etc.).

Conclusion

Implementing a transitional solution in Washington state would leverage the Exchange's integrated platform Washington Healthplanfinder, which already serves as the eligibility portal for both MAGI Medicaid and the QHP market. Available data suggests doing so could result in meaningful coverage gains, address health disparities among the uninsured and help mitigate coverage losses if federal Medicaid changes are implemented that restrict eligibility.

Appendix A:

SSB 5950 (Section 214(9))

Substitute Senate Bill 5950 (Section 214(9)), Chapter 376, Laws of 2024

- ▶ (9)(a) \$300,000 of the health benefit exchange account—state appropriation is provided solely for staff and consultants to complete a study of options and recommendations for the state to ensure continuous health care coverage through qualified health plans for Medicaid beneficiaries losing Medicaid coverage through Washington Healthplanfinder. In coordination with the health care authority and department of social and health services, the study must include, but not be limited to:
 - (i) An analysis of transitional solutions used in other states to continue coverage for individuals losing Medicaid eligibility;
 - (ii) In coordination with the department of social and health services' research and data analysis division, an analysis of monthly enrollment rates for persons who are determined no longer eligible for Medicaid, including demographic and employment information, and those who enroll in qualified health plans, including demographic and employment information; and
 - (iii) A feasibility analysis of auto-enrolling clients that lose Medicaid eligibility and are eligible for a no-premium qualified health plan through Washington Healthplanfinder.
- ▶ (b) The study must be submitted to the office of financial management and appropriate committees of the legislature by Dec. 31, 2024.

Appendix B:

Transitional Coverage

Solutions Resources

The following are useful resources for additional reading on automatic transitional coverage solutions to help customers losing Medicaid transition to a QHP.

▶ **Resource Pages:**

- A page of resources on state facilitated enrollment strategies, compiled by State Health & Value Strategies. ([link](#)).

▶ **Reports and Studies:**

- Overview of State Based Marketplace efforts to expand health coverage through facilitated enrollment programs by the Urban Institute. ([link](#)).
- Overview of California's auto-assignment program published by researchers at Georgetown University Center of Health Insurance Reforms. ([link](#)).
- Academic analysis of Massachusetts' auto-enrollment program, which found the program increased the flow of new enrollments by 48%. ([link](#)).
- Overview of Rhode Island's auto-enrollment program by the National Academy for State Health Policy. ([link](#)).

▶ **Relevant State Legislation and Regulatory Guidance**

- California Senate Bill 260, which required Covered California to create an auto-assignment program. ([link](#)).
- Maryland regulation defining the Medicaid to Private Plan Enrollment Program. ([link](#)).
- The Massachusetts program was established using existing authority; no bill or regulation was required.
- Rhode Island HB 7123 appropriations bill created the auto-enrollment program. ([link](#), see page 48).
- Rhode Island regulations defining auto-enrollment program parameters ([link](#)).

Transitional coverage solution experts – State interviews

State	Organization	Roles
California	Covered California	<ul style="list-style-type: none">• Director of Policy, Eligibility & Research• Deputy Director, Program Policy & Eligibility• Assistant Deputy Directory, Eligibility & Enrollment
Maryland	Maryland Health Benefit Exchange	<ul style="list-style-type: none">• Director, Policy and Plan Management• Senior Health Policy Analyst
Massachusetts	Massachusetts Health Connector	<ul style="list-style-type: none">• Chief of Policy and Plan Management• Manager of Member Enrollment & Retention
Rhode Island	Health Source Rhode Island	<ul style="list-style-type: none">• Director of Policy, Plans & Applied Research

Appendix C: DSHS Analysis of Health Coverage Outcomes for Persons Leaving Medicaid

Analysis of Health Coverage Outcomes for Persons Leaving Medicaid

As Required by Engrossed Substitute Senate Bill 5950 (Section 214(9), Chapter 376, Laws of 2024)

December 2024



Analysis of Health Coverage Outcomes for Persons Leaving Medicaid

This analysis was prepared by the Department of Social and Health Services Research and Data Analysis Division under a contract with the Washington Health Benefit Exchange

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Summary

This study examined the health coverage status of persons leaving Medicaid coverage in calendar year (CY) 2019 and calendar year 2023. This analysis was prepared by the DSHS Research and Data Analysis Division under a contract with the Washington Health Benefit Exchange (HBE). Data from multiple administrative databases was used to categorize Medicaid exits into one of the following six categories:

1. Transitioned to a QHP,
2. Returned to Medicaid,
3. Enrolled in Medicare,
4. Likely to have employer-based coverage,
5. Unlikely to be eligible for a QHP or Medicaid, or
6. Potentially uninsured.

Analyses focused on adults exiting categories of Medicaid coverage that determine eligibility based on the Modified Adjusted Gross Income (MAGI) methodology.

We found significant disparities in the health and sociodemographic characteristics of persons leaving Medicaid who (a) transitioned to a QHP, (b) returned to Medicaid, and (c) became potentially uninsured. For example, when comparing those who transitioned to a QHP plan with the potentially uninsured, Asian and White beneficiaries were overrepresented in the QHP-enrolled group, while American Indian and Alaska Native, Black, and Hispanic beneficiaries were underrepresented in the QHP-enrolled group. These disparities narrowed somewhat in the 2023 exit cohort, relative to the 2019 exit cohort.

Persons returning to Medicaid were more likely to have risk factors such as mental illness, substance use disorder, homelessness, and criminal legal system involvement (as indicated by arrest rates). Relative to persons transitioning to a QHP plan or exiting Medicaid with employer-based coverage, persons in the potentially uninsured group were:

- More likely to be male;
- More likely to be under age 35; and
- More likely to be homeless, to have a substance use disorder, or to have prior criminal legal system involvement.

A significant proportion of persons transitioning to a QHP, returning to Medicaid, or becoming potentially uninsured had ESD-reported earnings in the quarters following their Medicaid exit. Roughly one in ten persons exiting Medicaid and becoming potentially uninsured continued to receive Basic Food Program benefits following their Medicaid exit. These findings indicate that a significant proportion of Medicaid leavers in the potentially uninsured group have information in ESD wage data and the Automated Client Eligibility System (ACES) that would be relevant for determining QHP eligibility after exit from Medicaid.

The CY 2023 cohort was impacted by the unwinding of pandemic-era Medicaid eligibility rules. As a result, this cohort experienced a high rate of transitions to employer-based coverage, relative to the CY 2019 exit cohort. The rate of transition to employer-based coverage should be expected to be lower in subsequent cohorts, and the proportion exiting to the status of “potentially uninsured” should be expected to be higher, in the absence of policy changes to impact these rates.

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Methods

Data for this study were drawn from HBE enrollment and eligibility data and RDA's Integrated Client Data Repository. Medicaid exit cohorts were created for persons with a break of at least 1 month in full-benefit Medicaid coverage in CY 2019 and CY 2023. In cases where persons experienced multiple exits from Medicaid in the cohort period, each exit was treated as a separate observation in the analysis. Gaps in Medicaid coverage that were ultimately covered by a retroactive eligibility determination were not included in the exit cohorts studied in these analyses.

Medicaid exits in 2019 were followed for 12 months to determine their "post-exit coverage status", according to the criteria defined below. Due to data completeness limitations, the 2023 Medicaid exit cohort was followed over 6 months to determine post-exit coverage status. The CY 2023 exit cohort is significantly larger than the 2023 cohort due to the "unwinding" of pandemic-era eligibility rules. The implications of the different follow-up windows and the impact of "unwinding" are discussed below.

Analyses focus on the experience of adults aged 18 and above at the time of exit. Analyses were stratified into MAGI and non-MAGI cohorts. MAGI exit cohorts primarily include persons covered (in their last month prior to exit) under the "New Adult" coverage group created by the Affordable Care Act, along with adults in "Family Medical" Medicaid coverage groups. The non-MAGI cohort includes persons enrolled in Aged or Disabled Medicaid coverage groups prior to exit. As we discuss in more detail below, because most non-MAGI Medicaid leavers are not eligible to enroll in a QHP after their exit from Medicaid (e.g., because they have Medicare coverage), analyses focus on MAGI exits.

Linked administrative data were used to classify each Medicaid exit into one of the following groups based on experiences in the first 12 months after exit (2019 cohort) or 6 months after exit (2023 cohort):

1. Transitioned to a QHP,
2. Returned to Medicaid,
3. Enrolled in Medicare,
4. Likely to have employer-based coverage,
5. Unlikely to be eligible for a QHP or Medicaid, or
6. Potentially uninsured.

A hierarchy based on the order listed above was imposed to ensure each exit was classified into a single category. For example, if a person died while enrolled in Medicare, they were classified as "enrolled in Medicare" at the time they exited Medicaid coverage.

Linked HBE enrollment information was used to identify Medicaid exits transitioning to QHP coverage. Figure 1 shows the timing of these transitions, relative to the exit month, for the 2019 exit cohort. Figure 2 provides comparable information for the CY 2023 exit cohort, with post-exit follow-up limited to 6 months for this group. Month "0" is the first month off Medicaid and is referred to as the exit month. By definition, it is impossible for a return to Medicaid to happen in the exit month because in this circumstance no break in Medicaid coverage (i.e., no exit) would have occurred. In contrast, most transitions to QHP coverage occur in the Medicaid exit month. In the 2019 exit cohort, 87 percent of transitions to QHP coverage and 70 percent of returns to Medicaid happen within 6 months of exit. This indicates that most

QHP transitions and returns to Medicaid that would have occurred in the CY 2023 exit cohort over the full 12 months of follow-up are captured within the first 6 months.

Figure 1. Timing of Transitions to QHP Coverage and Returns to Medicaid, 2019 Exit Cohort

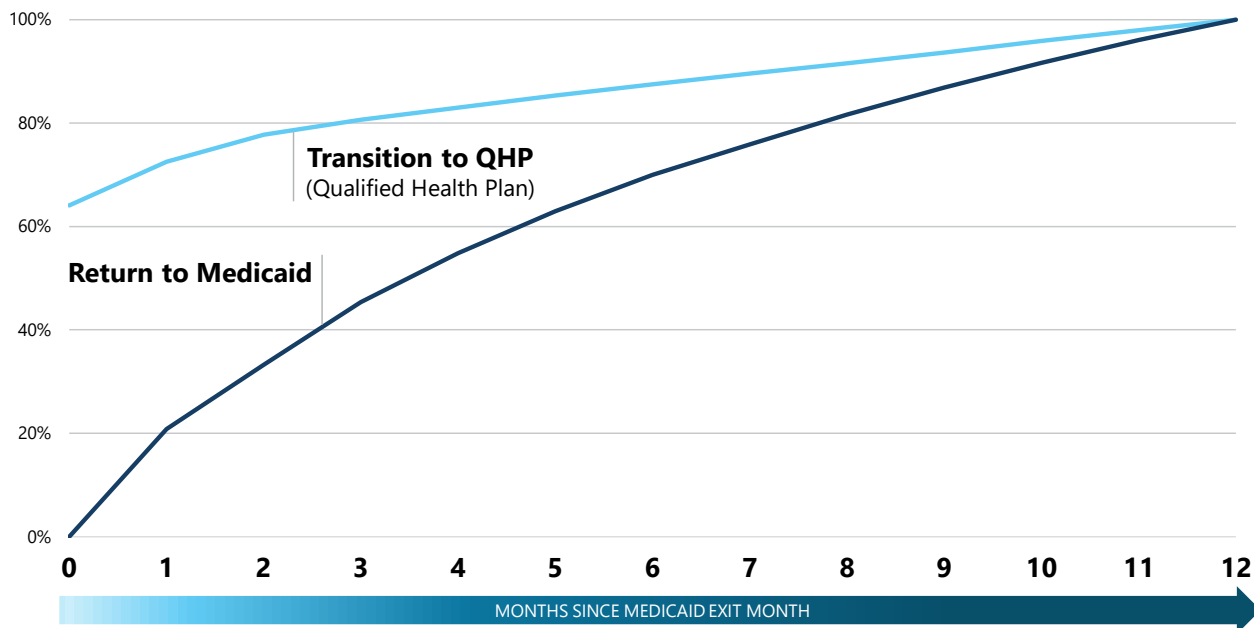
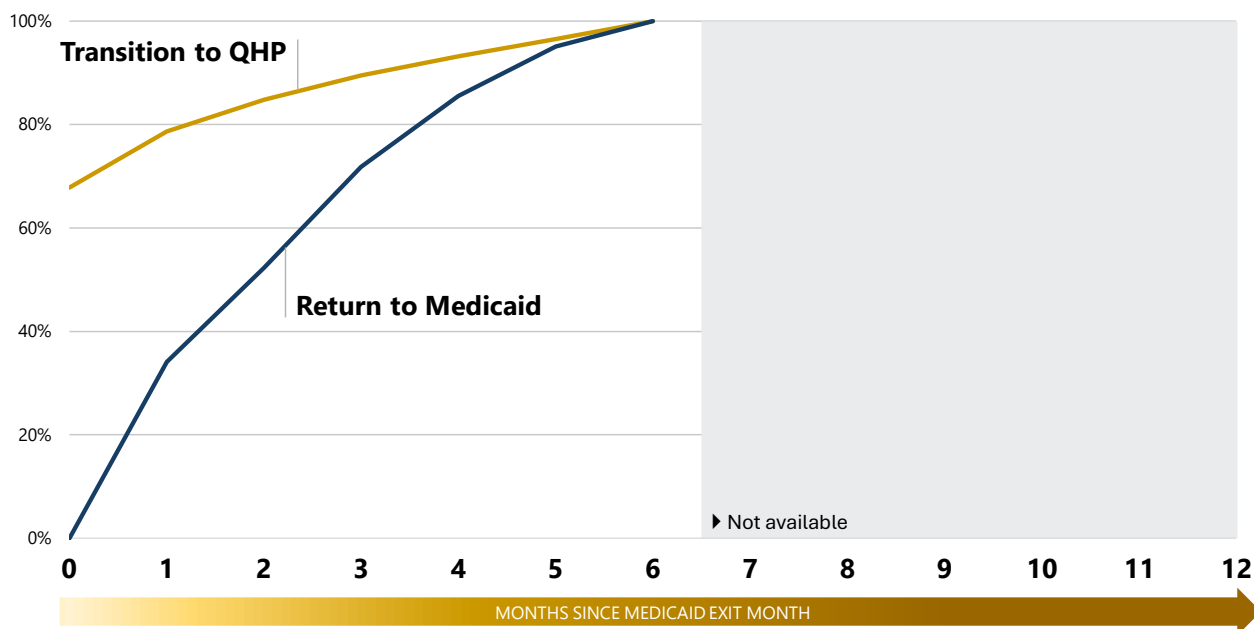


Figure 2. Timing of Transitions to QHP Coverage and Returns to Medicaid, 2023 Exit Cohort



Post-exit enrollment in Medicare was identified if any of the following criteria were met:

- The beneficiary was a full- or limited-benefit dual (Medicare and Medicaid) eligible at the point of exit from Medicaid coverage,
- Medicaid coverage “end reason” codes indicated the presence of Medicare coverage, or
- The beneficiary turned 65 around the time of exit from Medicaid.

Exits were classified as being likely associated with employer-based coverage if any of the following criteria were met:

- Linked ESD wage data indicated earnings at or above 250 percent of the federal poverty level for a household of 1;
- For beneficiaries subsequently determined by HBE to be QHP-eligible (but who did not enroll in a QHP plan), income was determined to be at or above 250 percent of the federal poverty level;
- Income associated with the beneficiary’s last pre-exit Medicaid coverage month was at or above 250 percent of the federal poverty level; or
- The beneficiary was observed to have full third-party coverage in their last pre-exit Medicaid coverage month.

Medicaid exits associated with leavers “unlikely to be eligible for a QHP or Medicaid” met one or more of the following criteria:

- Incarceration in a DOC facility in the 12-month (2019 cohort) or 6-month (2023 cohort) post-exit window;
- Medicaid coverage “end reason” codes indicated any of the following:
 - Death,
 - Moved out of state,
 - Incarcerated, or
 - The Medicaid beneficiary was admitted to an institution subject to the “IMD Exclusion”, causing a break in Medicaid coverage; or
- Were observed to have died in linked DOH death certificate records.

The residual group of Medicaid exits failing to meet any of the criteria listed above were classified as “potentially uninsured.”

Results

Non-MAGI exits are from Medicaid eligibility groups covering persons with disabilities or persons aged 65 and above. As described in Table 1, most non-MAGI leavers have Medicare coverage and, as expected, few transition to QHP coverage. A larger proportion of non-MAGI leavers also exit to the “Other Status Likely Rendering Ineligible for QHP”, of which exits due to death are a significant proportion. Based on these considerations, the discussion that follows focuses on the experience of MAGI leavers.

Table 1. Distribution of Adult Medicaid Leavers by Post-Exit Coverage Status

							TOTAL
Other Status Likely Rendering Ineligible for QHP							
Likely to Have Employer-Based Coverage							
Has Medicare Coverage							
Returned to Medicaid							
Transitioned to QHP							
Potentially Uninsured							
Adult MAGI Exits							
Number of Exits							
2019 Exit Cohort	78,418	27,277	80,421	11,085	63,736	16,947	277,884
Percent of Exits							
2019 Exit Cohort	28%	10%	29%	4%	23%	6%	100%
Adult Non-MAGI Exits							
Number of Exits							
2019 Exit Cohort	2,208	142	7,751	18,486	1,448	4,421	34,456
Percent of Exits							
2019 Exit Cohort	6%	0.4%	22%	54%	4%	13%	100%
Adult MAGI Exits							
Number of Exits							
2023 Exit Cohort	98,464	45,948	41,771	22,696	158,507	20,707	388,093
Percent of Exits							
2023 Exit Cohort	25%	12%	11%	6%	41%	5%	100%
Adult Non-MAGI Exits							
Number of Exits							
2023 Exit Cohort	4,348	335	5,184	31,827	4,275	3,907	49,876
Percent of Exits							
2023 Exit Cohort	9%	0.7%	10%	64%	9%	8%	100%

Figure 3 shows the proportion of Medicaid exits falling into the various post-exit coverage status categories for the MAGI population, by cohort. About a quarter of each cohort falls into the “potentially uninsured” category. Ten percent of the 2019 exit cohort transitioned to QHP enrollment, increasing to 12 percent in the 2023 exit cohort. We estimate that 14 percent of the 2023 MAGI exit cohort would have been observed to transition to a QHP, if a full 12 months of follow-up data were available.

The major difference between the 2019 and 2023 cohorts is the shift towards a higher proportion of likely exits to employer-based coverage in the 2023 cohort (from 23 percent to 41 percent), and the counterbalancing decline in the proportion returning to Medicaid (from 29 percent to 11 percent). This is primarily due to the “unwinding” of pandemic era eligibility rules in the spring of 2023, which had allowed higher income persons to continue on Medicaid coverage during the pandemic. We estimate that 14

percent of the 2023 MAGI exit cohort would have been observed to return to Medicaid, if a full 12 months of follow-up data were available.

Figure 3. Distribution of Adult Medicaid Leavers by Post-Exit Coverage Status

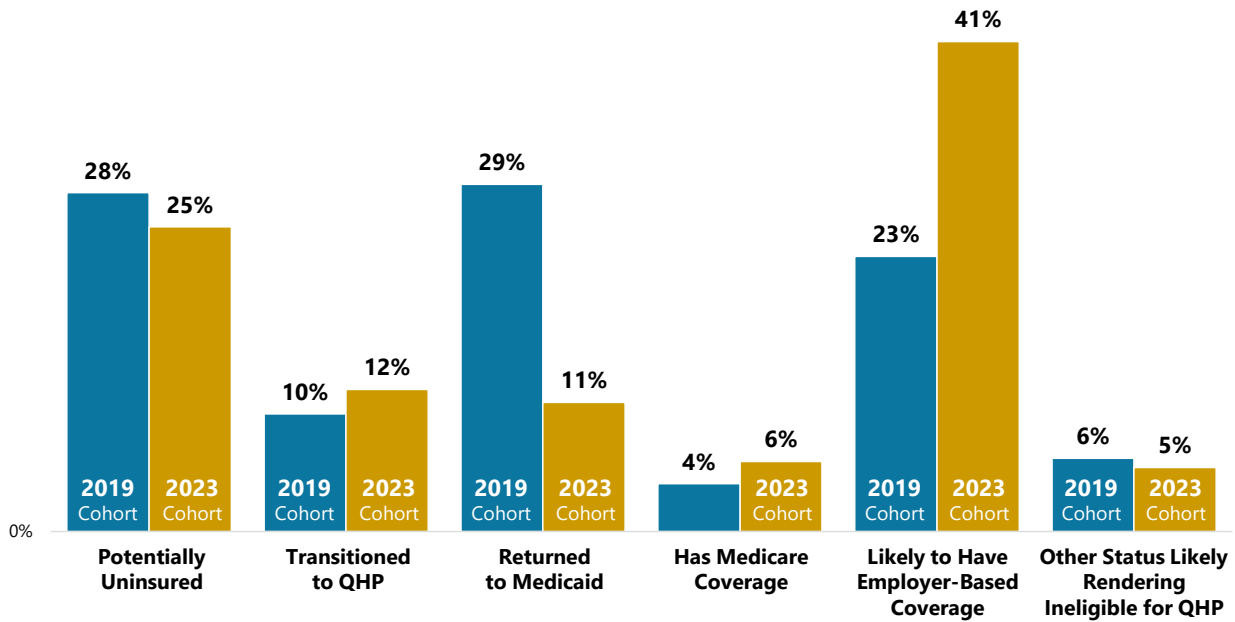


Table 2 (2019 cohort) and Table 3 (2023 cohort) contrast the characteristics of MAGI exits falling into each post-exit coverage status group. Comparing the demographic characteristics of persons transitioning to a QHP plan and the potentially uninsured, there are significant disparities in QHP enrollment by race. Asian and White beneficiaries are overrepresented in the QHP-enrolled group, while American Indian and Alaska Native, Black, and Hispanic beneficiaries are underrepresented. These disparities narrowed slightly in the 2023 exit cohort, relative to the 2019 exit cohort.

Persons transitioning to a QHP or likely exiting with employer-based coverage tend to be the most favorably situated in terms of risk factors, while persons returning to Medicaid have relatively high rates of mental illness, substance use disorder, homelessness, and criminal legal system involvement (as indicated by arrest rates). Relative to persons transitioning to a QHP plan or exiting with employer-based coverage, persons in the potentially uninsured group are more likely to be male and under age 35. The potentially uninsured are also more likely to be homeless, to have a substance use disorder, or to have prior criminal legal system involvement.

Among the potentially uninsured, we examined the characteristics of persons determined to be QHP eligible, based on QHP eligibility data provided by HBE. Twenty-eight percent of the potentially uninsured in the 2019 cohort and 19 percent of the potentially uninsured in the 2023 cohort were determined by HBE to be QHP eligible following their Medicaid exit, but did not enroll in a QHP. About a third of the QHP-eligible potentially uninsured in the 2023 exit cohort were determined eligible for a “zero dollar” plan. Relative to other potentially uninsured Medicaid leavers, those determined QHP eligible were more likely to be women and to be employed, and less likely to be homeless, to have a substance use disorder, or to be involved in the criminal legal system.

Table 2. Characteristics of Persons Age 18+ Exiting MAGI Medicaid in CY 2019, by Post-Exit Coverage Status

CHARACTERISTICS	TOTAL—ALL EXITS						
	Other Status Likely Rendering Ineligible for QHP						
	Likely to Have Employer-Based Coverage						
	Has Medicare Coverage						
	Returned to Medicaid						
	Transitioned to QHP						
	Potentially Uninsured						
Number	78,418	27,277	80,421	11,085	63,736	16,947	
Age category							
18-24	28.9%	13.8%	25.2%	0.7%	20.6%	16.7%	22.6%
25-34	32.9%	29.3%	35.3%	3.4%	38.7%	35.4%	33.6%
35-44	18.6%	19.1%	20.2%	5.5%	22.2%	20.8%	19.6%
45-54	11.8%	16.3%	11.8%	8.7%	12.2%	14.6%	12.4%
55-64	7.8%	21.2%	6.8%	27.6%	6.3%	12.6%	9.6%
65+	0.0%	0.2%	0.7%	54.1%	0.0%	0.0%	2.4%
Gender							
Female	50.5%	60.5%	54.5%	53.0%	54.0%	56.2%	53.9%
Male	49.5%	39.5%	45.5%	47.0%	46.0%	43.8%	46.1%
Race/ethnicity							
AIAN	7.0%	3.4%	9.9%	5.1%	5.6%	7.2%	7.1%
Asian	6.6%	13.4%	6.8%	8.2%	8.3%	4.7%	7.7%
Black	9.0%	4.2%	11.8%	4.9%	8.9%	10.3%	9.2%
Hispanic	17.9%	9.4%	18.5%	9.9%	16.4%	12.1%	16.2%
Missing	3.0%	5.0%	0.9%	3.9%	2.9%	2.5%	2.6%
NHPI	3.0%	2.9%	2.1%	1.6%	2.7%	2.2%	2.6%
White Alone Not Hispanic	52.4%	60.5%	49.5%	65.8%	54.1%	59.9%	53.7%
Unknown	1.0%	1.1%	0.6%	0.6%	1.0%	1.1%	0.9%
PRISM health risk score at exit							
Health risk score	0.25	0.37	0.36	0.94	0.26	0.68	0.35
Homeless in 12 months prior to exit?							
Yes	9.7%	1.3%	15.9%	4.6%	3.9%	18.9%	9.7%
Homeless or unstably housed in 12 months prior to exit?							
Yes	11.0%	1.6%	17.7%	5.9%	4.6%	22.6%	11.0%
Child welfare system involvement in 12 months prior to exit?							
Yes	4.8%	2.0%	8.5%	2.2%	4.0%	5.9%	5.4%
Arrest in 12 months prior to exit?							
Yes	3.5%	0.1%	12.5%	0.3%	0.3%	0.5%	4.7%
Behavioral Health Conditions							
Psychotic disorder	1.6%	0.8%	3.6%	3.4%	0.6%	4.9%	2.2%
Mania/bipolar disorder	2.3%	2.5%	4.3%	4.7%	2.0%	6.1%	3.2%
Depression	13.8%	16.9%	21.1%	29.1%	14.1%	24.6%	17.5%
Anxiety	14.3%	18.1%	22.0%	25.7%	15.3%	26.0%	18.3%
Trauma/Stressor Disorder	6.8%	7.2%	11.2%	13.3%	6.4%	13.1%	8.7%
Substance Use Disorder	12.4%	6.6%	23.8%	15.8%	8.5%	25.4%	15.1%

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Table 3. Characteristics of Persons Age 18+ Exiting MAGI Medicaid in CY 2023, by Post-Exit Coverage Status

CHARACTERISTICS	TOTAL—ALL EXITS						
	Other Status Likely Rendering Ineligible for QHP						
	Likely to Have Employer-Based Coverage						
	Has Medicare Coverage						
	Returned to Medicaid						
	Transitioned to QHP						
	Potentially Uninsured						
Number	98,464	45,948	41,771	22,696	158,507	20,707	
Age category							
18-24	31.2%	18.1%	26.8%	0.5%	21.7%	15.2%	22.6%
25-34	30.6%	27.3%	30.2%	1.9%	36.2%	33.8%	30.9%
35-44	19.6%	20.7%	21.8%	2.7%	22.3%	24.1%	20.3%
45-54	11.1%	15.1%	11.7%	4.2%	12.6%	14.5%	12.0%
55-64	7.5%	18.1%	7.3%	18.6%	7.3%	12.3%	9.6%
65+	0.0%	0.7%	2.2%	72.1%	0.0%	0.0%	4.5%
Gender							
Female	48.6%	59.9%	51.8%	50.8%	51.8%	54.2%	52.0%
Male	51.4%	40.1%	48.2%	49.2%	48.2%	45.8%	48.0%
Race/ethnicity							
AIAN	7.6%	4.0%	10.4%	5.2%	5.8%	8.1%	6.6%
Asian	6.8%	11.9%	7.0%	8.6%	8.7%	5.3%	8.2%
Black	9.4%	5.9%	13.0%	5.5%	8.5%	11.4%	8.9%
Hispanic	20.1%	13.2%	20.8%	10.9%	18.2%	11.7%	17.6%
Missing	3.0%	3.5%	0.9%	4.5%	2.6%	2.6%	2.7%
NHPI	3.4%	2.1%	3.1%	2.1%	3.1%	3.6%	3.0%
White Alone Not Hispanic	48.5%	58.2%	43.9%	62.6%	52.0%	56.2%	51.8%
Unknown	1.3%	1.2%	0.8%	0.8%	1.0%	1.1%	1.1%
PRISM health risk score at exit							
Health risk score	0.22	0.35	0.36	0.75	0.24	0.52	0.31
Homeless in 12 months prior to exit?							
Yes	8.7%	1.5%	16.9%	4.3%	3.5%	17.4%	6.8%
Homeless or unstably housed in 12 months prior to exit?							
Yes	9.7%	1.9%	18.5%	5.1%	3.9%	19.5%	7.6%
Child welfare system involvement in 12 months prior to exit?							
Yes	4.0%	2.2%	7.6%	1.7%	2.8%	4.8%	3.6%
Arrest in 12 months prior to exit?							
Yes	3.5%	0.1%	15.5%	0.2%	0.2%	0.4%	2.7%
Behavioral Health Conditions							
Psychotic disorder	1.8%	0.9%	5.2%	2.1%	0.6%	5.3%	1.8%
Mania/bipolar disorder	2.2%	2.9%	5.0%	2.8%	2.1%	5.7%	2.8%
Depression	12.7%	19.7%	21.3%	20.3%	14.1%	21.1%	15.9%
Anxiety	14.9%	23.3%	24.2%	19.8%	17.1%	24.3%	18.6%
Trauma/Stressor Disorder	6.6%	9.7%	12.6%	8.8%	6.5%	12.7%	8.0%
Substance Use Disorder	11.3%	8.0%	25.6%	13.2%	7.6%	23.8%	11.7%

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Figure 4 (2019 cohort) and Figure 5 (2023 cohort) present information on the percentage of adult Medicaid leavers with ESD-reported earnings, by quarter relative to the quarter including the exit month (quarter 0). Notably, a significant proportion of persons transitioning to a QHP, returning to Medicaid, or becoming potentially uninsured have ESD-reported earnings in the quarters following the exit month. Figure 6 (2019 cohort) and Figure 7 (2023 cohort) present information on the percentage of adult Medicaid leavers receiving benefits through the Basic Food Program, by month relative to the exit month (month 0). About 10 percent of persons exiting Medicaid and becoming potentially uninsured continued to receive Basic Food Program benefits following the exit month.

These findings indicate that a significant proportion of Medicaid leavers in the potentially uninsured group have information in ESD wage data and the Automated Client Eligibility System (ACES) that would be relevant for determining eligibility for a QHP after exit from Medicaid.

Figure 4. 2019 MAGI Exits: Percent of Medicaid Leavers Age 18+ with ESD Wage Data By Quarter Relative to Exit Quarter

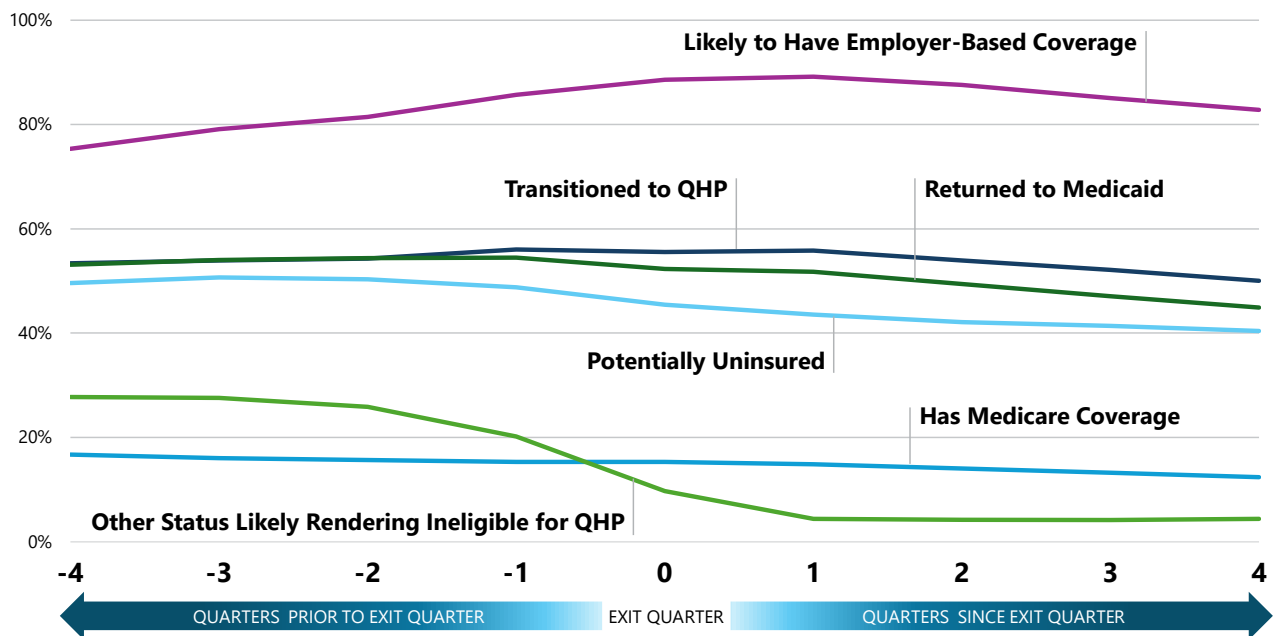


Figure 5. 2023 MAGI Exits: Percent of Medicaid Leavers Age 18+ with ESD Wage Data By Quarter Relative to Exit Quarter

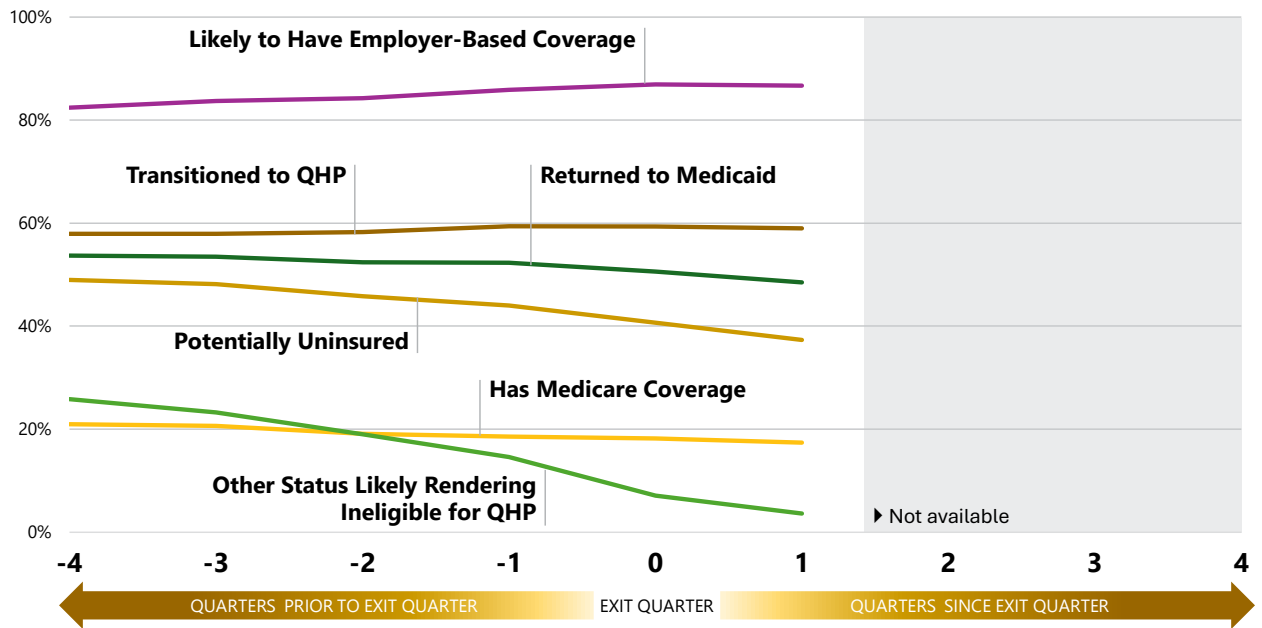


Figure 6. 2019 MAGI Exits: Percent of Medicaid Leavers Age 18+ Receiving Basic Food By Month Relative to Exit Month

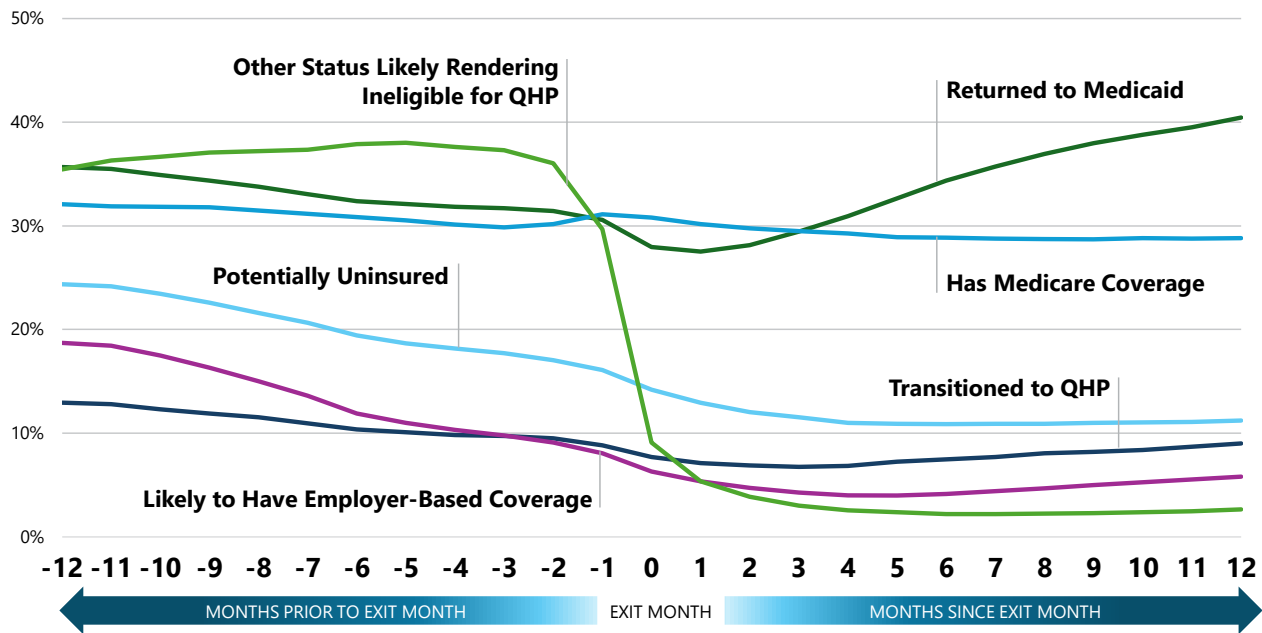
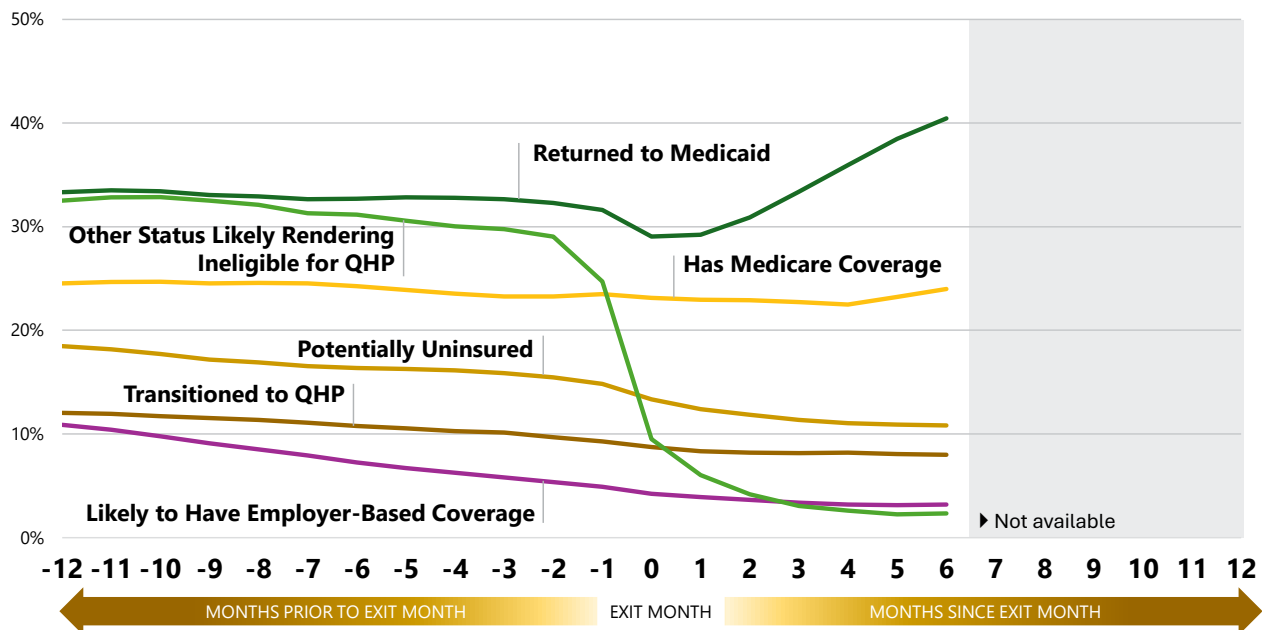


Figure 7. 2023 MAGI Exits: Percent of Medicaid Leavers Age 18+ Receiving Basic Food By Month Relative to Exit Month



Tables 4 and 5 below provide monthly trend data on the post-exit coverage status of adult MAGI Medicaid exits in the 2019 and 2023 exit cohorts. Note that the “exit month” is defined to be the first month off Medicaid, rather than the last month on Medicaid. Most notably, the monthly trends reported in Table 5 show the impact of the unwinding of pandemic-era eligibility rules.

In the January to May 2023 period prior to the unwinding, monthly Medicaid exits were far below levels observed in CY 2019. Unwinding began with the June 2023 exit month, which was the first of three consecutive months of extremely elevated exit volumes. In this peak unwinding period, exit volumes were particularly elevated among both the potentially uninsured and higher-income persons likely exiting with employer-based coverage.

Throughout the remainder of CY 2023, transitions to QHP coverage and likely exits to employer-based coverage remained significantly elevated relative to CY 2019 levels. Over the last 4 months of CY 2023, exits to being potentially uninsured and exits with Medicare coverage remained somewhat elevated relative to CY 2019 levels. In contrast, over the final 4 months of CY 2023 returns to Medicaid were roughly half the monthly volume observed in the comparable time period in CY 2019.

Table 4. Monthly Trend in Post-Exit Coverage Status of Adults Exiting MAGI Medicaid in CY 2019

EXIT MONTH	TOTAL—ALL EXITS						
	Other Status Likely Rendering Ineligible for QHP						
	Likely to Have Employer-Based Coverage						
	Has Medicare Coverage						
	Returned to Medicaid						
	Transitioned to QHP						
	Potentially Uninsured						
Total	78,418	27,277	80,421	11,085	63,736	16,947	
January 2019	8,736	4,191	6,823	1,001	6,786	899	28,436
February 2019	6,876	2,233	6,269	903	5,097	1,587	22,965
March 2019	7,624	2,304	6,687	898	5,837	1,836	25,186
April 2019	6,998	2,270	6,851	1,331	5,583	1,046	24,079
May 2019	6,161	2,022	6,719	896	5,019	2,401	23,218
June 2019	5,821	2,007	6,598	861	4,758	862	20,907
July 2019	5,704	1,911	6,230	854	4,889	888	20,476
August 2019	5,920	1,775	6,853	923	5,208	1,175	21,854
September 2019	5,906	1,783	6,822	829	5,225	2,202	22,767
October 2019	6,372	2,028	7,084	856	5,026	897	22,263
November 2019	6,243	2,099	6,959	846	5,317	2,419	23,883
December 2019	6,057	2,654	6,526	887	4,991	735	21,850

Table 5. Monthly Trend in Post-Exit Coverage Status of Adults Exiting MAGI Medicaid in CY 2023

EXIT MONTH	TOTAL—ALL EXITS						
	Other Status Likely Rendering Ineligible for QHP						
	Likely to Have Employer-Based Coverage						
	Has Medicare Coverage						
	Returned to Medicaid						
	Transitioned to QHP						
	Potentially Uninsured						
Total	98,464	45,948	41,771	22,696	158,507	20,707	
January 2023	1,763	2,755	1,103	285	1,922	2,539	10,367
February 2023	2,082	1,930	1,214	231	2,000	1,099	8,556
March 2023	1,777	1,257	1,079	193	1,583	984	6,873
April 2023	1,931	1,486	1,303	284	2,249	2,849	10,102
May 2023	2,589	3,051	1,698	1,316	4,541	1,023	14,218
June 2023	19,766	5,309	6,664	5,024	35,765	1,432	73,960
July 2023	19,351	6,064	6,990	5,810	35,326	970	74,511
August 2023	18,237	5,924	6,768	4,824	33,983	1,055	70,791
September 2023	7,846	4,063	3,965	1,215	10,324	3,341	30,754
October 2023	6,724	3,956	3,442	1,139	8,912	1,873	26,046
November 2023	7,663	4,448	3,711	1,169	9,951	1,093	28,035
December 2023	8,735	5,705	3,834	1,206	11,951	2,449	33,880

Analysis of Health Coverage Outcomes for Persons Leaving Medicaid
December 2024

Limitations

Follow-up time for the CY 2023 exit cohort was limited to 6 months, which has the effect of decreasing the observed volume of both transitions to a QHP and returns to Medicaid, relative to what would have been observed with a 12-month follow-up window. However, based on the experience of the CY 2019 exit cohort, the vast majority of subsequent transitions to a QHP and returns to Medicaid occur within 6 months of exit from Medicaid. Consequently, biases introduced by this limitation are likely to be minimal.

The CY 2023 cohort is impacted by the unwinding of pandemic-era Medicaid eligibility rules. As a result, relative to the CY 2019 exit cohort this cohort experienced a high rate of transitions to employer-based coverage and a low rate of transitions to being potentially uninsured. In the absence of policy changes to impact these rates, the proportion of transitions to employer-based coverage should be expected to be lower in subsequent cohorts, and the proportion exiting to the status of “potentially uninsured” should be expected to be higher.

It is important to be aware of the limitations of our linked administrative data. First, we were not able to identify post-exit health insurance coverage status with absolute certainty for all Medicaid exits, and relied on income-based proxies where post-exit coverage was not directly observed. ESD wage data captures most earned income in Washington State but does not include self-employment or federal employment. Consequently, some persons with earned income above the 250 percent FPL threshold through self-employment or federal employment may be classified as potentially uninsured. Finally, we note that Medicaid coverage end-reason codes are unlikely to be sufficient to identify all outmigration from Washington State among persons leaving Medicaid. Exits associated with unidentified outmigration will tend to be classified as potentially uninsured.