Transitioning From Medicaid Coverage to Other Health Coverage

This job aid provides information and guidance for Navigators and Certified Application Counselors (collectively, Assisters) on helping individuals who are transitioning from Medicaid and the Children's Health Insurance Program (CHIP) to other health coverage when serving consumers in the Federally-facilitated Marketplaces (FFMs) – also known as the Health Insurance Marketplace®.

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Version 2.0. April 2025. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

Overview

Medicaid and CHIP are administered by states according to federal requirements and provide comprehensive health care coverage for tens of millions of individuals and families, including around half of all children in the United States. Generally, in states that have expanded their Medicaid programs under the Affordable Care Act (ACA), adults with incomes of up to 138 percent of the federal poverty level (FPL) may be eligible for Medicaid coverage, with many states covering children and pregnant women at higher income thresholds. In states that have not yet expanded their Medicaid programs, some people, like adults who live with and take care of a child, typically have to earn much less than 138 percent of the FPL to be eligible for Medicaid coverage.

Individuals may need to transition from Medicaid or CHIP to another coverage option because they are no longer eligible. For example:

- An individual may have a change in household income that makes them ineligible for Medicaid based on a state's specific requirements,
- An individual may no longer be eligible for pregnancy-related or medically needy Medicaid, or
- A child becomes too old to qualify for CHIP.

To avoid gaps in coverage once their Medicaid or CHIP coverage ends, consumers should consider other health coverage options available to them ahead of time.

Transitioning from Medicaid Coverage to Marketplace Coverage

Special Enrollment Periods (SEPs)

Individuals who are no longer eligible for Medicaid may qualify for a Special Enrollment Period (SEP) to enroll in coverage through the Marketplace outside of the annual Open Enrollment Period. In most cases, consumers have 60 days from the date of the qualifying event to enroll in coverage.

Members of federally recognized Tribes can enroll in a Marketplace plan at any time of year and change plans up to once a month.

Premium Tax Credits and Financial Assistance

Individuals who are no longer eligible for Medicaid coverage may also qualify for help paying for Marketplace coverage if their annual household income is between 100 percent and 400 percent of the FPL, if otherwise eligible. If a consumer is a lawfully present individual and is determined ineligible for Medicaid due to immigration status, they may be eligible for Marketplace coverage with financial assistance, even though their household income may be below 100 percent of the FPL.

NOTE: The American Rescue Plan Act (ARP) of 2021 and the Inflation Reduction Act (IRA) of 2022, made Marketplace coverage more affordable through plan year 2025. Premium tax credits (PTC) are available to consumers with household income above 400 percent FPL, and the amount a family's household will pay towards the premiums for a benchmark plan is capped at 8.5 percent of household income. Consumers at lower income levels are expected to contribute a smaller percentage toward monthly premiums.

Scenario #1: Wally is 59 years old and single. He works part-time, earning $14,124 per year. He applied for coverage through the Marketplace in 2024 and was determined eligible for Medicaid. In March 2025, Wally was promoted and now works full-time, earning $38,600 per year (approximately $3,208 per month). At this higher income level, Wally is no longer eligible for Medicaid and wants to know if he may be eligible for Marketplace coverage.

Wally should immediately report his change in income to the state Medicaid agency. If the Medicaid agency determines Wally is no longer eligible for Medicaid, after determining his eligibility on all other factors:

- He will receive a notice, and his account will be transferred securely to the Marketplace.
- Wally may be eligible for an SEP due to the loss of Medicaid coverage.
- The Marketplace will send Wally a notice instructing him to log in or create an account on HealthCare.gov to complete an application.
- He should complete the application and make any needed updates.
- If Wally has an offer of employer-sponsored coverage (ESC), he should report it to the Marketplace when completing his application.

For members of federally recognized Tribes buying a Marketplace plan with incomes between 100% and 300% of the federal poverty level, they can enroll in a "zero cost sharing" plan. This means they won't have to pay any out-of-pocket costs — like deductibles, copayments, and coinsurance — when they get care. If they get services from an Indian health care provider, they won't have any out-of-pocket costs, like deductibles, copayments, or coinsurance, regardless of income.

Transitioning from Medicaid Coverage: Choosing between Marketplace and Employer-Sponsored Coverage

If a consumer is offered employer-sponsored coverage (ESC) that is considered affordable and meets the minimum value standard, they are not eligible for APTC or cost-sharing reductions (CSRs) for their Marketplace coverage. Most ESC plans are considered affordable and meet minimum value standards.

- A plan is considered affordable for the employee if the employee's share of the annual premium for the lowest-priced self-only plan is no greater than 9.02 percent of annual household income.

- If a consumer has an offer of employer coverage that extends to their family members, the affordability of employer coverage for those family members will be based on the family premium amount, not the self-only employee premium cost.
- An employer plan generally meets the minimum value standard if the plan is designed to pay at least 60 percent of the total cost of medical services for a standard population.

Consumers can ask their employer to complete the Employer Coverage Tool at HealthCare.gov: Employer Coverage Tool to help determine if their plan is affordable and meets the minimum value standard.

Even if a consumer has an offer of ESC, they can still explore their options in the FFM. However, consumers should consider that:

- If they have an offer of ESC, the only way they (and any spouse or dependents) will qualify for savings on a Marketplace plan is if their employer's insurance offer does not meet the affordability and minimum value standards.
- With most job-based health insurance plans, the employer pays part of the monthly premium. If a consumer enrolls in a Marketplace plan instead, the employer won't contribute to their premiums.
- They (and any spouse or dependents) probably won't qualify for APTC if they enroll in a Marketplace plan instead, even if their income would qualify them otherwise. They'd have to pay full price for a Marketplace plan, even if they don't enroll in the insurance their employer offers.

If they enroll in ESC, consumers (including any spouse or dependents) are not eligible to receive a tax credit on a Marketplace plan, even if the ESC does not meet the affordability and minimum value standards.

Scenario #2: Consider the same facts as Scenario #1, except Wally's new employer offers him ESC that is affordable and meets the minimum value standard. Wally wants to compare his offer of ESC with Marketplace coverage.

- Note: An offer of ESC does not affect Medicaid eligibility. Some individuals may be eligible for both Medicaid and ESC depending on their income and household size, as well as factors such as disability. In this scenario, Wally is losing eligibility for Medicaid coverage due to an increase in income.

Wally should:

- Immediately report his change in income to the state Medicaid agency, and
- Report his offer of ESC to the Marketplace.
    - If he chooses to enroll in Marketplace coverage, he should continue through plan selection and enrollment, if otherwise eligible.
    - Since Wally has an offer of ESC which is affordable and meets the minimum value standard, he won't be eligible for financial assistance through the Marketplace.

People with Medicaid coverage may be unfamiliar with paying monthly premiums, out-of-pocket expenses, and high annual deductibles for medical services and medications. Assisters should help consumers:

- Compare benefits, costs, and whether a plan includes their preferred provider(s) in its network and any medications they take in its formulary.
- Consider costs that are their responsibility or the responsibility of their employer, as well as what costs the plan will cover overall, if the consumer decides to enroll in ESC.
- Make a plan to meet their monthly premium responsibilities.

Transitioning from Medicaid Coverage to Medicare Coverage

Medicare is a federal health coverage program for people aged 65 and older. Individuals may be eligible to get Medicare earlier if they are determined to have a disability (there is a shorter waiting period for disability benefits for individuals with ALS - also known as Lou Gehrig's disease), or End-Stage Renal Disease (ESRD). In most cases, individuals will be eligible for premium-free Medicare Part A if they have sufficient "quarters of coverage" based on how many months they worked and paid Medicare taxes. Individuals become eligible for Medicare Part B, which has a premium, if they are entitled to Part A coverage or are age 65 or older and 1) a U.S. citizen or 2) or a Lawful Permanent Resident with five years of continuous presence in the United States. Medicare Part B enrollees can also pay for Medicare Part A coverage if they are not entitled to premium-free Medicare Part A. Individuals may apply for and enroll in Medicare by contacting the Social Security Administration (or the Railroad Retirement Board) to sign up for Part A and Part B.

Individuals with Medicare Part A and/or Part B coverage can visit any Medicare provider and may be able to continue visiting their preferred provider under Medicaid if that provider is also a Medicare provider. To find a Medicare provider, consumers can use the search tool at Medicare: Find & compare providers near you.

Medicare Advantage (MA) plans are approved by Medicare but are run by private companies. All MA plans provide Part A and Part B with certain exclusions for hospice care, organ acquisitions for kidney transplants, and routine costs and any coverage for the diagnosis or treatment of complications from some clinical trials. Most MA plans also provide Part D, or Medicare prescription drug, benefits. Most MA plans offer extra benefits that Original Medicare doesn't cover – like some routine exams, vision, hearing, and dental services.

In states that have expanded Medicaid eligibility to low-income adults, this adult group covers individuals up to age 65. For beneficiaries enrolled in the adult group, the state Medicaid agency will re-evaluate their eligibility for Medicaid shortly before their 65th birthday to determine if the person may qualify for a different Medicaid eligibility group. These beneficiaries remain enrolled in Medicaid until the state agency completes its re-evaluation of their eligibility.

Dually Eligible Beneficiaries

Depending on their income and assets, an individual who becomes eligible for Medicare may continue to be eligible for Medicaid coverage.

"Dually eligible beneficiaries" generally describes these types of individuals – those enrolled in Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and getting full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through Medicare Savings Programs (MSPs).

- Full-benefit dually eligible individuals are Medicare beneficiaries who qualify for the full package of Medicaid benefits in addition to benefits available through Medicare. They may also qualify for Medicaid coverage of Medicare premiums and cost sharing through an MSP.
- Partial-benefit dually eligible individuals are Medicare beneficiaries who receive Medicaid coverage of Medicare premiums and, often, cost-sharing through the MSPs.

Being dually eligible means a person can benefit from unique Medicaid and Medicare benefits. Medicaid coverage may offer access to services that Medicare may not cover, including nursing-facility care beyond the 100-day limit for Medicare-only coverage, prescription drugs, eyeglasses, and hearing aids. Note: Some individuals who qualify for Medicaid because their state expanded eligibility under the adult group will no longer qualify under this eligibility group once they turn 65. However, their state Medicaid agency will re-evaluate their eligibility for other Medicaid eligibility groups shortly before their 65th birthday to determine if the person may qualify for a different Medicaid eligibility group.

For dually eligible beneficiaries, Medicare pays for covered medical services first, then Medicaid pays the difference between the provider's allowable charge and Medicare's payment, up to the state's payment limit. Medicaid may cover some services that Medicare does not cover or only partially covers (such as nursing-home care, personal care, and home- and community-based services). For more information on how Medicare and Medicaid work together, individuals may contact their local State Health Insurance Assistance Program (SHIP) office, which can be found using the SHIP Locator.

Medicare Savings Programs (MSPs)

Medicare-eligible individuals with limited income and resources may be eligible for help paying Medicare costs. The four primary MSP eligibility groups are:

- The **Qualified Medicare Beneficiary (QMB) Group** helps pay for Medicare Part A premiums, Medicare Part B premiums, Medicare deductibles, coinsurance, and copayments. An individual can qualify for the QMB program if their monthly income is 100 percent FPL or less.
- The **Specified Low-Income Medicare Beneficiary (SLMB) Group** helps pay for Medicare Part B premiums for people who have Medicare Part A. The SLMB monthly income limit is 120 percent FPL.

- The **Qualifying Individual (QI) Group** helps pay for Medicare Part B premiums for people who have Medicare Part A. The QI monthly income limit is 135 percent FPL.
- The **Qualified Disabled & Working Individual (QDWI) Group** helps pay for Medicare Part A premiums only for people who have a disability, are working, and lost their Social Security disability benefits and Medicare premium-free Part A because they returned to work.

NOTE: Many states have set higher income limits and resource limits for their MSPs. Some states have eliminated resource limits entirely. Individuals should check with their state to learn if they qualify.

If individuals qualify for the QMB, SLMB, or QI eligibility group(s), or qualify for the full package of Medicaid benefits, they automatically qualify to get Extra Help paying for Medicare drug coverage. For more information about Extra Help, visit Medicare: Help with drug costs.

Every state Medicaid program must provide MSP assistance.[i] For more information on MSPs, individuals may visit Medicare Savings Programs. States have authority to disregard certain income and resources to effectively raise the income and/or resource standards for the MSPs. Many states have used this authority.

Medigap Plans

Medigap is Medicare Supplement Insurance that helps fill "gaps" in Original Medicare (Part A and Part B) and is sold by private companies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. A Medigap policy can help pay some of the remaining health care costs, like copayments, coinsurance, and deductibles. To find Medigap plans available in a specific state, individuals should contact their state's Department of Insurance or use the Medicare plan finder. For more information on Medigap, visit What's Medigap?.

Medicare Prescription Drug Coverage

Medicare drug coverage (Part D) helps pay for prescription drugs that consumers need. To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Individuals in Original Medicare can receive prescription drug coverage through a stand-alone Prescription Drug Plan (PDP). Individuals may also choose to join an MA plan that includes prescription drug coverage. Individuals must have Medicare Part A and/or Medicare Part B to join a Medicare drug plan. Individuals must have both Medicare Part A and B to join an MA plan. Most MA plans include Medicare drug coverage but certain MA plans (like Medical Savings Account Plans and some Private Fee-for-Service Plans) do not include drug coverage, so an individual can join a separate Medicare drug plan if they enroll in one of these types of MA plans.

Extra Help is a Medicare program that provides financial assistance to low-income Medicare beneficiaries to help with their prescription drug costs.

For more information about available Medicare coverage options, people can call 1-800-Medicare (1-800-633-4227) or use the Medicare plan finder at Medicare: Explore your coverage options. Individuals can also contact their local SHIP office, which can be found using the SHIP Locator.

Additional Resources

- CHIP: Medicaid.gov/CHIP
- CMS.gov:
  - Ensuring Access to Medicaid Services Final Rule (CMS-2442-F): CMS.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f
  - Medicaid and CHIP Overview webinar: CMS.gov/files/document/medicaid-and-chip-overview-webinar-may-2025.pdf
  - Medigap Policy Guide: CMS.gov/medicare/health-drug-plans/medigap
- Employer Coverage Tool: Healthcare.gov/downloads/employer-coverage-tool.pdf
- Medicare.gov:
  - Explore your Medicare coverage options: Medicare.gov/plan-compare/#/?year=2025&lang=en
  - Find and compare providers near you: Medicare.gov/care-compare/?redirect=true&providerType=Physician
  - Help with drug costs: Medicare.gov/basics/costs/help/drug-costs
  - Medicare Savings Programs: Medicare.gov/basics/costs/help/medicare-savings-programs
  - Medicare Supplement Insurance (Medigap): Medicare.gov/health-drug-plans/medigap
- State Health Insurance Assistance program (SHIP): SHIPhelp.org/

[i] Income limits may vary by state. For more information refer to Medicare.gov/basics/costs/help/medicare-savings-programs.