The End of the COVID-19 Public Health Emergency & the Effect on Health Insurance Coverage

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INTRODUCTION

In the coming months it is anticipated that the end of the COVID-19 Public Health Emergency (PHE) will require the largest single effort to determine Medicaid eligibility for the most Medicaid enrollees in the history of the program. As states undertake this monumental project, they should be mindful of steps they can take to minimize coverage losses. We outline the task facing states and those opportunities below.

IMPACT OF THE END OF THE COVID-19 PUBLIC HEALTH EMERGENCY

On January 31, 2020, Secretary Xavier Becerra of the US Department of Health and Human Services (HHS) declared a nationwide PHE, effective as of January 27, 2020, related to the COVID-19 pandemic. In response to the PHE, the Families First Coronavirus Response Act (FFCRA) authorized the Continuous Coverage Requirement (CCR) that requires states to maintain enrollment of nearly all Medicaid enrollees.[1] As a result, Medicaid enrollment has reached a record high, with 88,274,847 enrollees in Medicaid and the Children's Health Insurance Program (CHIP) as of April 2022.

The PHE has been renewed every 90 days to maintain the CCR and certain health care flexibilities. It was most recently renewed on October 13, 2022 and is now set to expire on January 11, 2023. HHS has promised to provide 60 days' notice before terminating the PHE and it is now anticipated that the 60-day notice will be issued in November 2022. That notice will signal the impending wind-down of the PHE and, as a result, the CCR.

The potential major loss of coverage due to the end of the CCR is further fueled by the fact that states are required to develop their own plans for navigating the eligibility and renewal processes after the PHE. With the moratorium on disenrollment, these renewals and eligibility checks may have accrued over nearly three years. This could lead to major delays in processing renewals and a lack of responses from enrollees to confirm the information necessary to retain coverage. Enrollees may be unaware of the upcoming renewal/re-eligibility determinations and unaware that their coverage is now at risk.

Just this month, CMS released the COVID-19 Public Health Emergency FAQ that includes key insights and reminders for states about what can be done now and the timeline for future unwinding activities.

Medicaid enrollment **increased by more than 9 million people** between February 2020 and January 2021.

It is estimated that **15 million people under 65 could lose Medicaid** benefits post PHE, including **6.7 million children that will be at risk of losing coverage and becoming uninsured.**

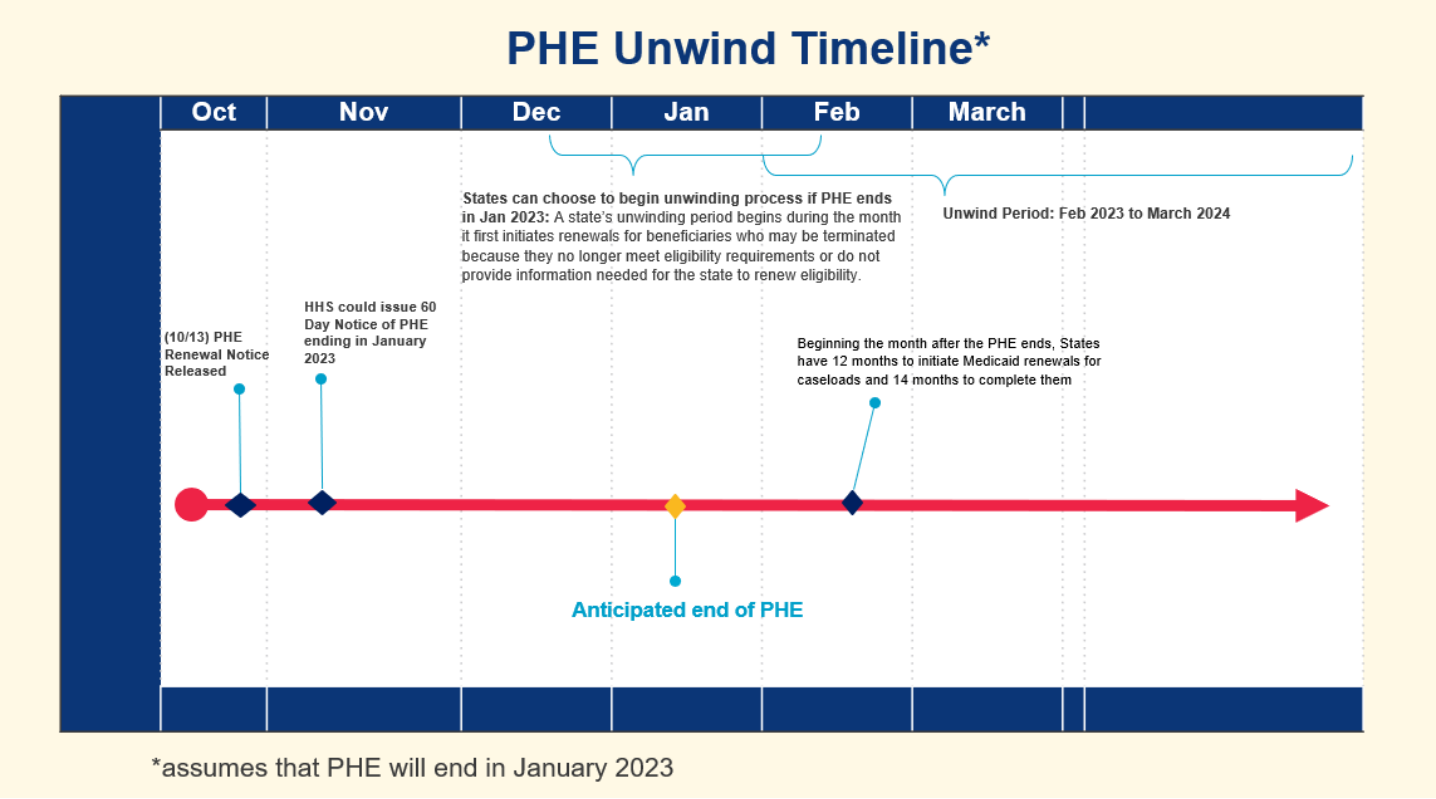
PHE UNWIND TIMELINE

One pertinent reminder included in the FAQ explained that states may choose to begin their unwinding period in one of three months:

- One month prior to the month in which the PHE ends
- The month in which the PHE ends
- The month following the month in which the PHE ends

[1] As a part of this continuous coverage, states also received a temporary 6.2 percentage point Federal Medicaid Assistance Percentage (FMAP) increase.

The graphic below displays how these three options would take effect with the current expiration month of January 2023.



CMS GUIDANCE

States should consult and be informed on the guidance issued to date by CMS, which we have included short summaries of below.

Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP, and BHP Upon Conclusion of the PHE	• Describes how states may distribute eligibility and enrollment work in the post-PHE period, mitigate churn for eligible beneficiaries who lost coverage and later reenroll, and smoothly transition individuals between coverage programs. • Reiterates options for states to align work on pending eligibility and enrollment actions after the PHE ends and provides that states must *initiate*, rather than complete, all pending actions during the 12-month unwinding period. • Informs states that they are at risk of inappropriately terminating coverage for eligible individuals if they plan to initiate a high volume of renewals in a given month and that CMS intends to collect information on all states' plans to adopt strategies that will promote continuity of coverage and guard against inappropriate terminations
Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the PHE	• Outlines policy changes CMS is making to better support states as they address the large volume of pending eligibility and enrollment actions they will need to take after the PHE ends and minimize beneficiary burden • Provides guidance to states on planning for the eventual return to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent in certain circumstances, procedures for ending coverage and policies authorized under expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE.
Top 10 Fundamental Actions to Prepare for Unwinding and Resources to Support State Efforts	•Highlights 10 fundamental actions states should complete to prepare for unwinding and provides links to the relevant existing CMS guidance and other resources to support state planning efforts •Tool does not announce new policies or guidance, but merely compiles existing tools and guidance into a more accessible format to help states quickly find helpful resources
Medicaid and CHIP COVID-19 Emergency Eligibility and Enrollment Pending Actions Resolution Planning Tool	•Highlights the areas of work states may need to address in their planning efforts, and key state planning domains and strategies. •Recommended that states use this tool to validate their readiness to completely eligibility and enrollment pending actions and resume normal operations, and comprehensiveness of their planning
General Transition Planning Tool for Restoring Regular Medicaid and CHIP Operations after Conclusion off the PHE	•Guides the state through an assessment of actions, which will be needed to ensure a smooth transition as federal approval for each flexibility or waiver approved during the COVID-19 PHE expires upon the conclusion of the PHE or other specified date •Supports cross-cutting planning for states by concisely outlining steps states may need to take to return to regular operations and enabling states to assess how the actions required for each area may complement or compete with other in order to develop an optimal overarching plan
Program Integrity Considerations for Restoring State Medicaid and CHIP Operations Upon Conclusion of the PHE	•Guidance document to support state Medicaid agency efforts to identify and address program risks related to COVID-19 PHE waivers and flexibilities •Used to assess potential program risks for any aspect of Medicaid and/or CHIP

PRESERVING HEALTH INSURANCE COVERAGE

There are steps states can take to ease the coverage loss and its various impacts following the end of the PHE. First, the option to expand Medicaid with primarily federal funding (and, under the American Rescue Plan of 2021 (ARPA), expanded federal funding) could make significant headway in addressing coverage losses in the remaining "holdout" states. Second, all states can work to ensure that those that are deemed no longer eligible for Medicaid are aware of options for no and low-cost coverage on the Marketplaces via the newly expanded and enhanced Advance Premium Tax Credits currently in place.

Finally, states can take steps to ensure Medicaid redeterminations run smoothly and do not result in losses of coverage due to administrative burdens.

MEDICAID EXPANSION

Despite being given significant incentive to expand Medicaid under ARPA, 12 of the 14 "holdout" states (AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY) still have not expanded Medicaid. In these states, expansion provides a significant opportunity to address post-PHE coverage losses. Through data collected by the Kaiser Family Foundation on coverage in these states, it is understood that for every 276,000 Medicaid recipients, there are 1,801 that could be covered with Medicaid expansion. That's an additional one person that could gain overage for every 153 Medicaid recipients in these 12 states. Individuals that would otherwise lose coverage at the end of the PHE could be recaptured as part of the new expansion population. If all of the remaining holdout states were to expand Medicaid, 1.8 million residents across the 12 states would likely become newly eligible under the Affordable Care Act's (ACA) 138% Federal Poverty Level (FPL) cut-off for Medicaid Expansion.

The holdout states are offered further federal support to expand. Under ARPA, non-expansion states seeking to expand Medicaid can receive a temporary five percentage point FMAP increase for their non-expansion populations, on top of the 90 percent FMAP available for the Medicaid expansion populations in all states. The enhanced federal match under ARPA would continue for two years from the date that the state expands coverage. In addition to the federal support, the new Medicaid expansion states would benefit from significant cost savings as a result of reductions in uncompensated care.[2]

Unfortunately, while many non-expansion states introduced legislation and ballot initiatives in an effort to expand Medicaid, most of these attempts were ultimately unsuccessful. The figure below includes a rundown of the approaches to expansion/bill status. In most of the non-expansion states, legislation has failed to progress further than its originating chamber. However, it is important to note that in South Dakota, a Medicaid expansion initiative has successfully made it onto the November ballot for a statewide vote during the November 2022 general election.

Recent Legislative Medicaid Expansion Efforts

States	Legislation	Bill #	Ballot initiative	Initiative #
Alabama	Failed in house committee	HB 183		
Florida	Failed in senate committee	SJR 276	Currently not verified by Florida Supreme Court	Initiative 18-16
Georgia	Failed in house committee	HB 209 HB 72		
Kansas	Failed in senate committee	SB 252		
Mississippi			Failed due Mississippi Supreme Court ruling the ballot initiative process inoperable due to errors	Initiative 76
North Carolina	Failed in opposing chambers	HB 470 HB 149 SB 408		

[2] In FY18, uncompensated care made up 3% of hospital operating expenses in expansion states and 7% of hospital operating expenses in non-expansion states.

South Carolina	None			
South Dakota			On the ballot in November 2022	Initiative 28
Tennessee	Failed in house and senate committees	HB 2821 SB 2676		
Texas	Failed in house and senate committee	HB 1730 SB 118		
Wisconsin	Failed in senate and in special session	SB 439		
Wyoming	Failed in senate committee and house introduction	HB 162 HB 20		

A couple of states have realized the full financial potential of Medicaid expansion under ARPA. In 2021, Missouri's and Oklahoma's expansion efforts were approved via ballot initiatives. Since expanding Medicaid, 275,000 Missourians and 190,000 Oklahomans are predicted to have become newly eligible. The financial boost from ARPA and the incentives under the law have also been significant for these new Medicaid expansion states. By virtue of expanding their Medicaid programs, both Missouri and Oklahoma are eligible to receive $968 million and $500 million, respectively, in enhanced federal matching funds under ARPA for their Medicaid programs during the first two years of Medicaid expansion.

EXPANDED AND ENHANCED PREMIUM TAX CREDITS

The vast majority of those individuals who will become ineligible for Medicaid due to income changes will be newly (or again) eligible for federal Advance Premium Tax Credits (APTCs) to purchase no-cost or lower-cost private insurance from Qualified Health Plans (QHPs) on Marketplaces. As a result of two recent policy changes, more individuals are now eligible for APTCs than in the past and those who were previously eligible will now receive higher levels of subsidies.

Just this month, the Department of Treasury finalized a rule to address what has been referred to as "the Family Glitch." Individuals who meet income standards for APTCs are ineligible for the subsidies if they are offered employer-sponsored insurance (ESI) as an employee or a dependent of an employee and the cost of that ESI to the individual meets federal affordability and minimum value standards. Previously, all members of a family would have been deemed to have access to "affordable" ESI, and therefore were determined ineligible for APTCs, if the ESI cost for the employee met affordability standards. This excluded many families without access to affordable coverage from financial assistance. Under the new rule, as of 2023, affordability of ESI and access to APTCs will be determined separately for employees and their family members. This means that if family coverage does not meet affordability standards, family members will now be eligible for APTCs even if the employee is not eligible because employee-only coverage is considered affordable.

Additionally, the size of the subsidies available as APTCs for Marketplace QHPs have increased, most recently through 2025 under the Inflation Reduction Act of 2022 (IRA).[3] APTC subsidies are calculated to limit an individual's contribution toward coverage to a set percentage of their income. For some individuals, the expected contribution is $0. And, because APTCs are calculated based on the premiums for a benchmark plan (the second-lowest cost silver plan in their coverage area), other individuals can

[3] The IRA also extends APTC eligibility to those with incomes above 400 percent of the Federal Poverty Line, though that eligibility change is unlikely to be applicable to those losing Medicaid coverage at the end of the PHE.

use that subsidy to "buy down" to less expensive silver or bronze coverage through the Marketplace and also receive $0 coverage. Originally under ARPA, and extended under the IRA, subsidies to fully cover the cost of a benchmark plan now extend to individuals up to 150 percent of the Federal Poverty Level (FPL) (previously ending at 138 percent FPL). Additionally, no one is expected to pay more than 8.5 percent of their income for health insurance coverage (previously 9.83 percent). Most eligible individuals will see a savings of between 3 and 4 percent of their income.

It is likely that many of those people losing coverage through Medicaid have previously been part of the "churn" between Medicaid and QHPs/APTCs. Because the enhanced subsidies went into effect while the PHE Medicaid CCR was in effect and the "family glitch fix" is going into effect for 2023, it is very possible that those individuals are unaware that subsidy eligibility and amounts have increased, and they may now be eligible for very low-cost or no-cost coverage when they may not have been previously. As states do outreach regarding the redeterminations, they have an opportunity to carefully message about the new increased APTCs to ensure individuals who may have found QHP coverage unaffordable previously take another look. Doing so can ensure that individuals that may otherwise go without coverage find options that fit within their budgets.

APPROACHES TO ELIGIBILITY AND REDETERMINATION

States can take steps in designing and implementing their redetermination process to minimize inappropriate or administrative losses in coverage. One approach for re-determinations/renewals of note included in the October 2022 CMS FAQ is related to easing the administrative burden on enrollees and urges states to utilize ex-parte eligibility. States should consider starting non-MAGI ex-parte eligibility reviews using the reliable information available to the state, including the state's Asset Verification System (AVS). The state must include the following in ex-parte renewal notices: the determination, the information upon which the agency relied in making the determination, the basis of the beneficiary's continued eligibility, and the beneficiary's obligation to inform the agency if any of the information contained in the notice upon which the state relied is inaccurate or subsequently changes. Beneficiaries are not required to sign or return any documents in which the information contained in the notice is accurate.

Another best practice to ease administrative burden is to exercise state discretion when it comes to asset verification attestations. For example, the state could determine that the value of assets previously verified by the state and in the record is reliable, and thus use that previous value for ex-parte renewal purposes.

These are just two examples of approaches states should utilize to avoid unenrollment for administrative reasons and ease the unwind administrative burden for both eligibility staff and beneficiaries.

Some other best practices collected from states and CMS guidance issued to date include:

- Work to collect updated contact information now
- Launch coordinated outreach and communications campaigns, including leveraging social media, and coordinating with other trusted sources (other agencies, community organizations and managed care organizations)
- Mark and/or track cases that are being kept open to easily identify when they need to begin processing redeterminations, and/or begin to process redeterminations in their systems without moving forward with eligibility changes
- Train new staff that may have never processed redeterminations
- Create work aids and toolkits now so new and existing eligibility staff have access to the most up-to-date processes and procedures prior to any unwind activities
- Streamline procedures, including via waivers

- Space out the timing of redeterminations for a more consistent workflow and hold likely eligible cases for later in the timeline when any kinks in the process are more likely to have been addressed
- Assign client outreach leads and go door-to-door to process redeterminations on-site

CONCLUSION

There is no doubt that states face significant challenges as the end of the PHE approaches. In addition to the administrative burden of processing redeterminations for the first time in nearly two years, they also face significant coverage challenges as a result of the end of the Medicaid CCR. However, there are opportunities and tools states can leverage to minimize those challenges. By leveraging all federal dollars available for coverage and making sure those individuals losing coverage have the information to remain insured, and by thoughtfully taking on the redetermination effort, states can ensure as few individuals as possible lose coverage.