Beyond the Basics

Unwinding the Medicaid COVID-19 Continuous Coverage Requirement

February 21, 2023
• All attendees are muted and in listen-only mode

• To ask a question:
  ▪ Click on the Q&A icon in the control panel at the bottom of your webinar screen
  ▪ Type your question into the box

• We will monitor questions and pause to answer a few during the presentation and once more at the end

• You can also email questions to beyondthebasics@cbpp.org

• All webinars are recorded and will be available for viewing at www.healthreformbeyondthebasics.org
Agenda

• We’ll discuss:
  • Continuous coverage requirement
  • Unwinding
  • Risk to eligible enrollees
  • Minimizing coverage losses
  • Managing transitions to the marketplace and employer coverage
What Is the Medicaid Continuous Coverage Requirement?
Continuous Coverage Requirement

• Part of 2020 COVID legislation, requires states to keep most enrollees on Medicaid during the public health emergency (PHE)
  ▪ Condition of 6.2% FMAP increase

• Continuous coverage requirement ends March 31st

• States will resume conducting full renewals and terminating coverage as early as April 1st –known as “unwinding”
  ▪ States will determine their own timelines
  ▪ Eligible people could lose coverage *if states don’t act carefully*
What Is Unwinding?
“Unwinding”

- Largest health care event since ACA implementation
- All enrollees will have to complete a full renewal
- Coverage ends if renewal not completed
- Experts estimate over 18 million people will lose coverage, *millions of whom will still be eligible*
- State agencies (already understaffed) will experience substantial workload increase
- States can focus on improving their renewal processes to minimize this risk
  - Find out more about your state's plans and relevant materials [here](#)
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Available at: [https://docs.google.com/spreadsheets/d/1tOxmngYs7jDPTGltp-di1SGvHzVJOm3G2YuUq0btg/edit](https://docs.google.com/spreadsheets/d/1tOxmngYs7jDPTGltp-di1SGvHzVJOm3G2YuUq0btg/edit)
Initial Unwinding Timeline

- **February 1st, 2023**: First day in which states may initiate renewals for April terminations
- **March 31st, 2023**: Continuous coverage requirement expires
- **April 1st, 2023**: Terminations may begin
Who Will Be Affected?
Potential Outcomes

- **71.7 million**: Eligible for Medicaid & successfully renewed.
- **3.8 million**: Ineligible for Medicaid, Can transition to job-based coverage.
- **2.6 million**: Ineligible for Medicaid, Need to transition to marketplace.
- **6.8 million**: Eligible for Medicaid BUT lose coverage for procedural reasons.
- **383,000**: Ineligible for Medicaid & marketplace, In non-expansion state.

- May need help with application and enrollment process.
- May need help with application and enrollment process.
- Try to complete renewal process w/in 90 days of termination to reinstate coverage (otherwise start new application).
- Likely uninsured; connect with safety net providers.

*ASPE estimates that 2.6 million people with income <400% FPL will be eligible for marketplace coverage with APTC and an additional 1.4 million people will be eligible for other coverage without APTC (marketplace, Medicare, military, individual nongroup).

Source: Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches, HHS Assistant Secretary for Planning and Evaluation, August 2022
“Unwinding” and Risk of Eligible People Losing Coverage

• Enrollees might not:
  ▪ Receive renewal notice
  ▪ Understand renewal notice
  ▪ Submit information on time

• Medicaid agencies may not be able to process documents on time

• Some people will reapply, leading to additional work for agencies, gaps in coverage, and increased costs

• People of color and children are at greater risk of losing coverage during the unwinding process
Helping People Keep Medicaid
Steps in the Medicaid Renewal Process

1. Medicaid enrollee to be redetermined
   - If state can, redetermine using *ex parte* process
   - Enrollee can’t be determined using *ex parte*; agency will mail a request for additional information
   - Enrollee determined to still be eligible, no action needed

2. Enrollee must respond in 30 days
   - If enrollee does not respond on time, will be procedurally denied

3. Still eligible
   - Need to enroll in job-based or marketplace coverage

4. Determined no longer eligible
   - If still eligible, 90 days to get coverage reinstated following procedural denial
   - If believe still Medicaid eligible, can reapply or appeal

States cannot terminate Medicaid coverage based on an *ex parte* review alone.
Reinstating Medicaid coverage after procedural denial

• Required for most Medicaid enrollees

• A renewal form and/or requested information returned within **90 days** of termination date serves as application

• Agency must determine eligibility within 45 days

• **Coverage effective date:** Date renewal was submitted or first day of the month the renewal form was returned depending on state’s Medicaid plan
  • Up to three months of retroactive coverage available

Assisters can support enrollees who need to submit this information to the Medicaid agency for their coverage to be reinstated
Opportunities to Minimize Coverage Loss

Massive coverage loss isn’t inevitable!

• Assisters can spread the word about unwinding through outreach and education to consumers
  ▪ Encourage people to update address and contact information with state Medicaid agency (and assist them in doing so!)
  ▪ Difficult to know when someone might receive a notice; be on the lookout

• Lean on existing partnerships and cultivate new ones

• Join coalitions focused on this issue

• Establish feedback loops with partners, state agency
Helping Someone Affected by Medicaid Unwinding:
Some Questions to Ask

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**Has the person received information from the state Medicaid agency?**
If yes, is it a request for more information? Or a termination notice?

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**If the person’s Medicaid has been terminated, can you determine why?**

**Was this appropriate?**
→ Because they are no longer eligible

**Should they pursue a reinstatement?**
→ Because it was a procedural denial, e.g. for not responding to a request for more information

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**If the person no longer has Medicaid but needs another form of coverage:**

**Do they have an offer of employer coverage?**
→ If yes, does the employer coverage meet the minimum value and affordability standards?
→ If yes, is the offer also available and affordable for other family members?

**Do they need help applying for a marketplace plan?**
Example: Moving Into Different Category of Medicaid Coverage

- Examples of Medicaid categories: children, pregnant women, parents and caretakers, low-income adults, medically needy, older adults, people with disabilities

- Hana, age 16 in 2020, lives in a Medicaid expansion state and is enrolled in children’s coverage as of March 2020 when continuous coverage goes into effect.

- By the time unwinding begins and her case is reviewed in May 2023, Hana is now an adult (19).

- The state reviews Hana’s information using electronic data sources. They may reach out to ask for additional information (e.g. about her household size). If she responds to the request within 30 days, and her income is <138% FPL, she will remain enrolled, but she will now be enrolled as part of the adult category, rather than the child category.
Helping People Transition to Job-Based Coverage
Special Enrollment Periods in Employer Sponsored Insurance

- 30 days
  - Loss of coverage or loss of employer contributions
  - Qualifying events (marriage, birth, adoption, placement for adoption)
- 60 days
  - Loss of Medicaid or CHIP

• Remember, people are not eligible for a PTC if they have an offer of employer sponsored insurance that meets minimum value and affordability standards
• Starting with 2023 coverage, changes in the affordability test made more people eligible for PTCs (“family glitch fix”)
• Encourage people to act quickly to enroll in employer-based coverage
  ! Missing the 60-day window to enroll in ESI does not trigger an SEP for marketplace coverage

Resource: FAQ: Employer-Sponsored Insurance and PTC Eligibility
Eligibility for Employer-Sponsored Insurance (ESI)

A person cannot get APTC if their ESI offer is:

- An "eligible employer-sponsored plan"
  - Not indemnity or accident coverage
  - and -

- Affordable
  - An offer is considered affordable if it costs less than 9.12% of household income. This bars eligibility for APTC.
  - and -

- Comprehensive
  - An offer is comprehensive if it meets the "minimum value" standard

If the offer fails to meet one or more of these requirements, the employee might be eligible for APTC (assuming all other tests are met)

Resource: MEC Reference Chart
ESI Affordability

- ESI is “affordable” for the employee if the employee contribution for self-only coverage is up to 9.12% of household income (in 2023)
- ESI is “affordable” for the spouse and dependents if the employee contribution for family coverage is up to 9.12% of household income (in 2023)
- If ESI is considered unaffordable, the employee and/or spouse and dependents can qualify for APTC
- A family member can also get APTC if:
  - They aren’t offered coverage through the employee (e.g. no family coverage offer)
  - They aren’t on the employee’s tax return (e.g. a child claimed by an ex-spouse instead of the employee)

Resource: FAQ: Family Glitch Fix
Affordability of Family Coverage

The Marketplace will ask applicants to enter the lowest-cost, employee share of the premium for self-only and family ESI coverage, and will then determine:

1. Does the person have access to adequate, affordable, self-only employer-sponsored coverage?

2. Do the person's household members have access to adequate, affordable family coverage through the subscriber's employer?

3. Do any of the person's household members have access to adequate affordable, coverage through a different employer?

If a person does not have an offer of affordable, adequate insurance through an employer – whether it is through their own employer or through the employer of a household member – that person may now be eligible for APTCs.
Help people understand their options and how their costs – premiums, deductibles, and out of pocket maximums – may add up.

**Option 1**
- Employee coverage
- Marketplace coverage w/PTC

**Option 2**
- Marketplace coverage (no PTC)
- Marketplace coverage w/PTC

**Option 3**
- Employer coverage

*Note: This is just an example. Different households will have different options.*
Helping People Transition to the Marketplace
In HealthCare.gov states:

Treat people transferring to the marketplace like any new applicant. The account transfer will not generate a prepopulated application.
People may receive:

- A notice from the marketplace encouraging them to apply. This may also include local Navigator contact information.
- Direct phone calls from a local Navigator encouraging them to apply and offering assistance.
Unwinding Special Enrollment Period

• New SEP for anyone who loses Medicaid/CHIP any time between 3/31/23 – 7/31/24
• Access through HealthCare.gov
• Attestation accepted; no documentation required
• 60 days to choose a plan after submit or update application

Resource: SEP Reference Chart
• **Unwinding SEP:** First of the month following plan selection

• **Intersection with other SEPs:** Follow unwinding SEP effective date unless person qualifies for retroactive effective date
  - Call the marketplace call center if do not want retroactive effective date
Darren and his daughter Lila have been enrolled in Medicaid since 2020. They moved to a different part of the state recently for Darren’s new job.

Darren’s annual income from his job is about $28,000 (or roughly 150% FPL). He is not offered health insurance through his job.

Darren gets a notice in the mail from the state Medicaid agency in March stating that he didn’t respond to previous requests for information, so the state is terminating Medicaid for him and for Lila effective May 1.
**Example: Reinstating Medicaid**

**Darren**

- Because his household income is 150% FPL, Darren is no longer eligible for Medicaid.
- He can get a Special Enrollment Period to enroll in marketplace coverage (with APTC and CSR) any time between now and July 31, 2024. If he acts quickly, he could arrange to have coverage start effective May 1 and avoid a gap in coverage.

**Lila**

- With an income of 150% FPL, Lila is still eligible for Medicaid in their state.
- Darren gathers the income documentation requested in the notice from the state and mails it in right away. The state agency receives it and processes it.
- Lila’s Medicaid coverage is reinstated, with retroactive coverage for any covered health expenses during the period between the termination notice and the coverage reinstatement date.
• Jon and Nania, a married couple who file taxes jointly, have been enrolled in Medicaid since July 2020 when Jon lost his job-based coverage.

• In October 2022, their son Luca was born. Luca is also enrolled in Medicaid.

• Jon got a new job in 2022 that offers health coverage. His annual salary is $45,000. Nania is caring for Luca and isn't working outside the home right now.

• Jon and Nania get a notice from their Medicaid agency requesting updated income information. They respond to the notice and learn that with income at about 195% FPL, Luca remains eligible for Medicaid, but Jon and Nania are no longer eligible. Their Medicaid will be terminated in May.
Example: Transitioning to Employer Coverage

### Summary of Plan Costs and Household Income

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<tr>
<td>Household Income:</td>
<td>$45,000</td>
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<tr>
<td>Employee-only premium cost:</td>
<td>$300/month</td>
</tr>
<tr>
<td>Employee + spouse premium cost:</td>
<td>$450/month</td>
</tr>
<tr>
<td>Minimum value (MV):</td>
<td>✓ 80% AV</td>
</tr>
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### Can Jon or Nania get APTC?

#### Employee test:

**Is Jon’s plan affordable?**
(So, is his lowest-cost premium for a minimum value plan less than 9.12% of household income?)

- Yes, Jon’s share of the premium for coverage just for him is 8% of household income

✗ Jon is not eligible for PTC

#### Family test:

**Is Jon’s plan affordable for Nania?**

- Employee + spouse coverage costs 12% of income
- Because it costs more than 9.12% of income, spouse coverage is considered unaffordable

✓ Nania is eligible for PTC

### Tip: If the family qualifies for PTCs, but not the employee, the employee may still need to buy ESI or a full-cost marketplace plan. Help families understand how their premium costs will add up.
Helping Jon and Nania Understand their Options

• Luca remains eligible for Medicaid.

• Jon can enroll in full-cost marketplace coverage or transition to job-based coverage. **He only has 60 days after his Medicaid ends to enroll in job-based coverage.**

• Nania can enroll in marketplace coverage, likely with a PTC and cost-sharing reductions. **She has until July 31, 2024 to enroll in a marketplace plan.**

  * If Jon and Nania enroll in the same marketplace plan as a group, they would forfeit CSRs Nania would otherwise qualify for if she enrolled on her own.

• If the family lived in a state that has elected the 12-month postpartum option in Medicaid, Nania would likely also remain eligible for Medicaid until October 2023.
Q & A
FAQs:

• Unwinding Medicaid Continuous Coverage

• Changes Coming to Medicaid: Tips for Community Partners (Available in English, Spanish, Simplified Chinese, Korean, Vietnamese, Tagalog, Russian, and Arabic)

Public Education Resources

• CMS Communications Toolkit and Supporting Materials (zip file)

• Community Catalyst Outreach Toolkit

Administrative Advocacy Resources

• Unwinding the Continuous Coverage Protection: Tips and Best Practices

• Elevating the Medicaid Enrollment Experience
Contact

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