

December 8, 2022

Transitions in Coverage Between Medicaid and Other Insurance Affordability Programs

Linn Jennings and Rob Nelb



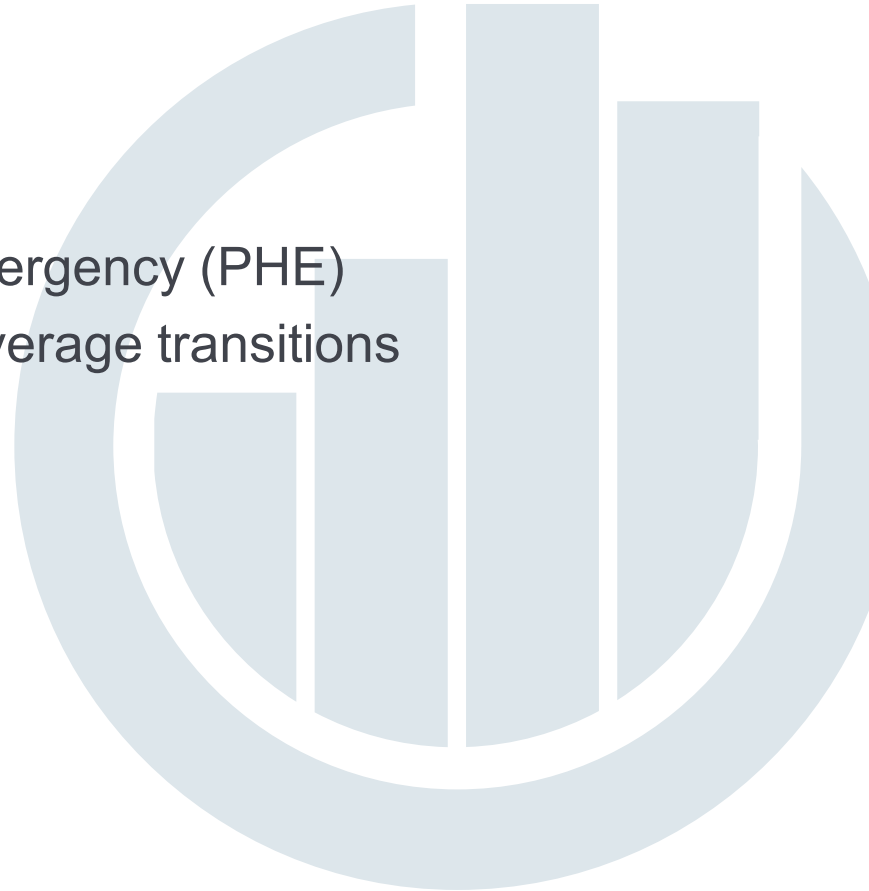
Medicaid and CHIP Payment and Access Commission



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Overview

- Background
 - Unwinding of the public health emergency (PHE)
 - Requirements for coordinating coverage transitions
- Challenges and policy issues
- Monitoring efforts
- Next steps



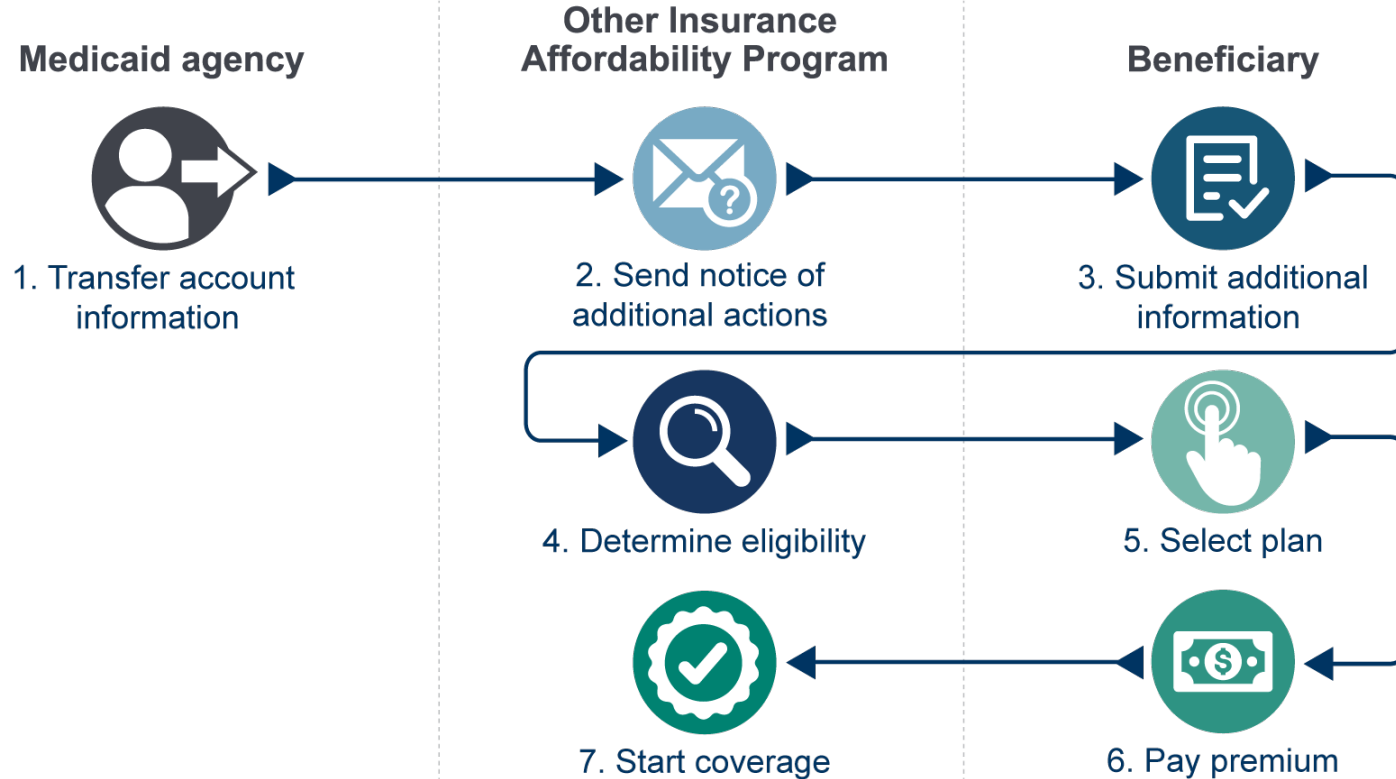
Unwinding of the PHE

- The COVID-19 PHE is currently authorized through January 11, 2023, but it is expected to be extended further
- The Commission has been monitoring the unwinding of the PHE in anticipation of states resuming routine eligibility redeterminations
 - In September, a panel with state officials and beneficiary advocates discussed unwinding plans, strategies to mitigate coverage loss, and stakeholder engagement
 - In October, staff presented on the role of data in monitoring state progress during the unwinding and identifying potential issues
- The Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that about one-third of Medicaid beneficiaries who may lose coverage at the end of the PHE may be eligible for subsidized coverage on the health insurance exchange

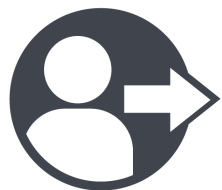
Coverage Transition Requirements

- States and federal government operate multiple insurance affordability programs (IAPs) for families and individuals at different income levels
 - Medicaid
 - The Children’s Health Insurance Program (CHIP)
 - Basic Health Program (BHP)
 - Health insurance exchange (through a federally-facilitated marketplace (FFM) or a state-based marketplace (SBM))
- The Affordable Care Act (ACA) included several provisions to help coordinate transitions between these programs
- However, MACPAC’s prior analyses found that few beneficiaries who lose Medicaid coverage move seamlessly to other IAPs

Steps in Transitions from Medicaid Coverage to Other IAPs



Notes: Insurance affordability programs include Medicaid, Children’s Health Insurance Program (CHIP), Basic Health Program (BHP), and the exchange. Not all steps are required for all individuals in all states.



1. Account Transfer

- If an individual is potentially eligible for another IAP, the state Medicaid agency transfers the individual's account information to the other program
- Some states have fully integrated eligibility systems with SBM and store all program eligibility data in one system
- States without integrated systems have challenges sending and receiving complete account information
 - The FFM can only accept the individual's name and contact information
 - States without integrated SBMs also face challenges sending critical information needed to determine eligibility



2. Send Notices of Additional Information to Determine Eligibility

- If an IAP does not have complete information to determine eligibility after the account transfer, then the program is required to send the beneficiary a notice of required actions
 - The IAP may have challenges reaching these individuals if the contact information is outdated
 - Individuals may receive inconsistent messaging from Medicaid and the other IAPs, leading to miscommunication about required next steps
- CMS has published guidance to states and exchanges, encouraging these IAPs to improve outreach to update contact information in advance of the unwinding and to update notices to provide individuals with consistent messaging and clear next steps



3. Applicant Submits Additional Information

- If additional information is needed to determine eligibility, individuals need to respond to notices to continue the coverage transition process
 - Individuals may have challenges responding if notices do not consistently include clear and actionable next steps
- The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) are implementing approaches to improve navigator assistance
 - In August 2022, HHS announced that they will invest in grant funding to Navigator organizations to improve enrollment and transitions between IAPs
 - CMS is also launching a pilot program to connect individuals to a navigator if they have their account transferred to the FFM



4. Determine Eligibility for New Program

- Although IAPs use a common income standard, program-specific differences can be a barrier
 - Medicaid, CHIP, and BHP determine income at a point in time, while the exchange determines income on an annual basis
 - Some IAPs have different methods for verifying whether income information submitted on applications is reasonably compatible with information available from electronic sources
- Determining the availability of employer-sponsored insurance is also a barrier to accessing exchange subsidies, especially for families without an offer of affordable family coverage



5. Select Plan

- Because of the large number of health plan offerings on the exchange, it can be difficult for individuals to select a plan once they are eligible
- Some states are implementing new auto-enrollment strategies
 - Medicaid, CHIP, and BHP can auto-enroll beneficiaries by default
 - Individuals must opt-in to an exchange plan because of the potential tax liability
- Some Medicaid managed care plans that also offer plans on health insurance exchanges are helping beneficiaries enroll, but they cannot direct individuals to enroll in a specific plan



6. Pay Premium

- Many IAPs require premiums in order to effectuate enrollment
- States and the federal government are taking steps to reduce or eliminate premiums
 - Congress has expanded federal exchange subsidies through 2025
 - Some states have programs to supplement federal exchange tax credits
- New Mexico is planning to pay the first month's premium for individual enrolled in exchange coverage to help them enroll more quickly



7. Start Coverage

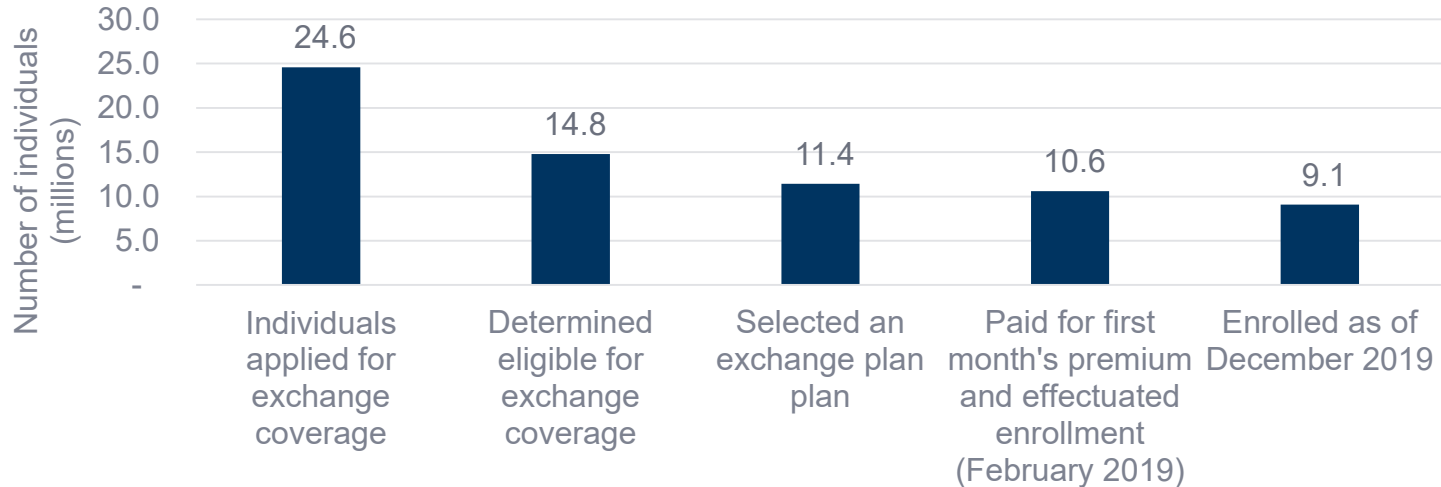
- Each IAP determines the start date of coverage depending on program-specific rules
 - Medicaid provides retroactive coverage before the date of application
 - CHIP and BHP generally provide coverage the same date of application
 - Exchange coverage is generally effective the month after an individual applies, but some states are providing coverage the same month of application, similar to CHIP and BHP
- States with integrated eligibility systems can more easily coordinate the end of Medicaid coverage and the start of the other IAP

Monitoring

- CMS does not currently report much information about coverage transitions
 - States are required to submit information on the number of account transfers to other IAPs, but not whether individuals ultimately enrolled in the other program
 - CMS is exploring ways to collect information on coverage from multiple sources
- Exchanges do collect information about the number of individuals who complete each step of the application process but do not regularly share this information with Medicaid agencies
- Some states are exploring dashboards and other tools to track coverage transitions during the unwinding of the PHE

Data on Each Step of the Enrollment Process Can Help Inform Monitoring of Coverage Transitions

Number of Individuals Completing Steps of Exchange Enrollment Process During the 2019 Open Enrollment Period



Notes: Analysis includes the federally facilitated marketplace and state-based exchanges. The 2019 open enrollment period for the federal marketplace began November 15, 2018 and ended December 2018. The timing of open enrollment for state-based exchanges varies by state.

Sources: MACPAC, 2022, analysis of Forsberg 2021 and Marketplace Open Enrollment Period Public Use Files.

Next Steps

- Commissioner feedback on the issues raised in this memo will help inform our future work
- During the unwinding of the PHE, we plan to continue to monitor the (limited) information that is available
- As part of our ongoing eligibility policy work, we can further examine specific Medicaid and CHIP policy levers of interest to the Commission

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