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# Preparing for the Biggest Coverage Event since the Affordable Care Act

## Perspectives from State Health Officials on the End of Medicaid's Continuous Coverage Requirement

*Sabrina Corlette*  
GEORGETOWN UNIVERSITY

*Linda J. Blumberg*  
URBAN INSTITUTE

*Megan Houston*  
GEORGETOWN UNIVERSITY

*Erik Wengle*  
URBAN INSTITUTE

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## Introduction

The United States government declared a public health emergency (PHE) on January 31, 2020, and has extended it eight times since then.<sup>1</sup> However, the government is expected to lift the PHE at some point in 2022. Allowing the PHE to expire represents more than the symbolic end of the pandemic; it will mean the termination of numerous federal policies that have had far-reaching effects across our health care system. One of those policies is the Medicaid continuous coverage requirement; it requires that state Medicaid agencies refrain from disenrolling people or tightening eligibility requirements during the PHE in exchange for enhanced federal Medicaid funding.<sup>2</sup> Once the PHE ends, the requirement will end and states will begin reassessing eligibility, resulting in a projected 13 to 16 million people being disenrolled from Medicaid (Buettgens and Green 2022). However, many of these people—an estimated one-third—could be eligible for a subsidized Marketplace health plan.

Helping several million people make the transition from Medicaid coverage to a Marketplace plan in 2022 will be an unprecedented challenge for state Medicaid and Marketplace officials. Many people have changed addresses since they first signed up for Medicaid, making it difficult for Medicaid agency staff to communicate with enrollees about eligibility redetermination. And some people will likely find applying for premium tax credits and selecting a Marketplace plan daunting. At the same time, many Medicaid agencies may face pressure to process eligibility determinations quickly to reduce states' fiscal obligations when the federal share of Medicaid costs returns to traditional levels. The uncertainty over when the federal government will end the PHE is also creating challenges for state officials trying to plan for the large number of redeterminations that will be needed.

If transitions from Medicaid to the Marketplace are not executed well, many of the millions of people eligible for subsidized Marketplace coverage could become uninsured. However, states that operate their own Marketplaces could be better positioned to help people successfully navigate this process, because they have significant autonomy and flexibility over their eligibility and enrollment systems, communications, and consumer assistance efforts. This brief examines preparations for the end of the PHE in 11 states with state-based Marketplaces (SBMs). We attempt to identify major challenges the state officials are facing and best practices for keeping people in coverage that could be adopted by the federally facilitated Marketplace and SBMs.

### About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

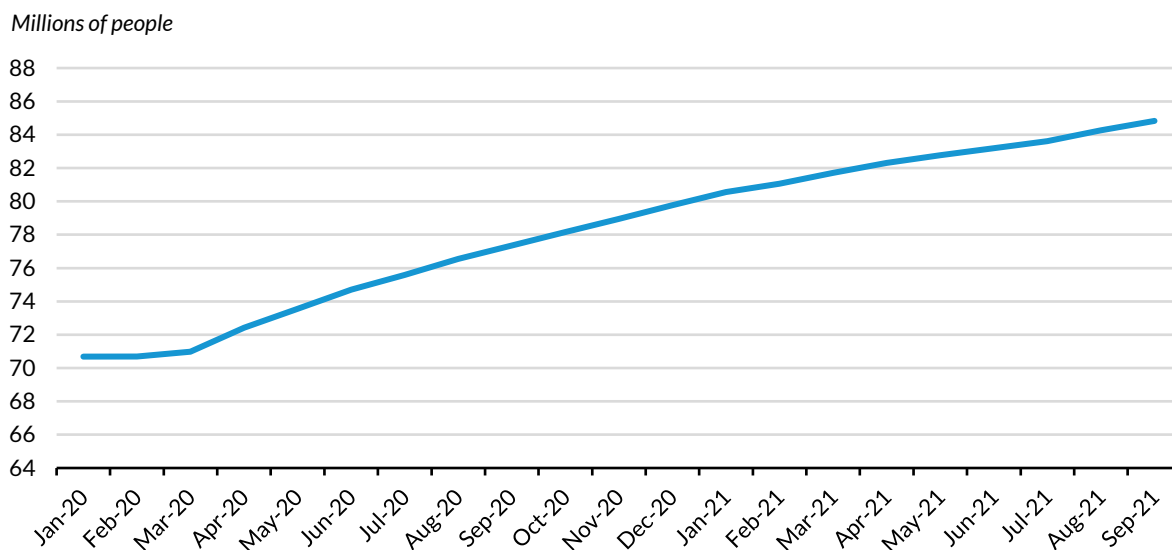
## Background

The onset of the pandemic prompted Congress to enact several measures to combat the public health crisis and ameliorate the economic fallout, including the losses of employer-based health insurance resulting from an estimated 23 million people having been laid off or furloughed by April 2020.<sup>3</sup> The first of those measures, the Families First Coronavirus Response Act, enacted on March 18, 2020, increased federal funds flowing to states to support Medicaid. To receive the enhanced matching funds, states are prohibited from disenrolling anyone who enrolled in Medicaid on or after March 18, 2020, until the PHE ends.<sup>4</sup> Specifically, the Families First Coronavirus Response Act increased the federal medical assistance percentage for states (which traditionally ranges from 50 to almost 78 percent) by 6.2 percentage points in exchange for states meeting maintenance-of-effort requirements through the end of the month in which the PHE ends. In general, states may only disenroll people if they are no longer state residents or they voluntarily terminate their own Medicaid coverage.<sup>5</sup>

The Biden administration has extended the PHE to April 16, 2022, and could extend it again if other coronavirus variants arise.<sup>6</sup> As the PHE duration lengthens, state Medicaid enrollment continues to grow, as new enrollees significantly outnumber people leaving the program. Many people who lost their employer-based insurance at the start of the pandemic were able to enroll in Medicaid, and they have stayed with the program. As of September 2021 (the most recent estimate available), 84.8 million people were enrolled in Medicaid or the Children's Health Insurance Program (CHIP), an increase of more than 14.1 million since February 2020 (figure 1).<sup>7</sup>

FIGURE 1

Medicaid and Children’s Health Insurance Program Enrollment, January 2020 to September 2021



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Source: Centers for Medicare & Medicaid Services, “August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot,” accessed March 14, 2022, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.

Acknowledging that processing eligibility redeterminations for this number of people is unprecedented, the Centers for Medicare & Medicaid Services issued guidance to state Medicaid agencies giving them up to 14 months after the PHE ends to complete eligibility verifications, terminations, or renewals.<sup>8</sup> However, states that use the full 14 months must do so without the enhanced federal match, presenting a fiscal challenge for many states. At the same time, to reduce the risk that people eligible for Medicaid are erroneously dropped from the program, the Centers for Medicare & Medicaid Services will require states to newly review eligibility on the basis of an enrollee’s current circumstances before terminating Medicaid coverage.<sup>9</sup>

The House of Representatives has passed the Build Back Better Act, which includes provisions to (1) prescribe a timeline and process for states’ Medicaid eligibility redeterminations and (2) extend expanded premium tax credits for Marketplace enrollees previously enacted under the American Rescue Plan Act.<sup>10</sup> Without congressional action that provides a clear financial and procedural off-ramp for the Medicaid continuous coverage requirement, states’ decisions about whether to adhere to the Centers for Medicare & Medicaid Services’ guidance is likely to vary considerably. Furthermore, if Congress does not extend the American Rescue Plan’s enhanced premium tax credits, many fewer people losing Medicaid eligibility at the end of the PHE will have access to an affordable Marketplace plan, increasing the number of people likely to become uninsured.

## Determining and Redetermining Medicaid Eligibility

The Affordable Care Act sought to provide a “no-wrong-door” coverage eligibility process for consumers. The law requires that states use a single streamlined application for determining eligibility for subsidized health insurance coverage through the Marketplaces, Medicaid, CHIP, and the Basic Health Program.<sup>11</sup> The federally facilitated Marketplace and all SBMs must assess a person’s eligibility for Medicaid, and if a person is found to be eligible, their data must be transferred to the state Medicaid agency. In some states, the Marketplace is empowered to make the final determination of Medicaid eligibility. In other states, the Marketplace makes an initial assessment of eligibility and then refers a person to the relevant state agency, which makes the final determination (Rosenbaum et al. 2016).

When people initially apply for coverage through their state Medicaid agency or are enrolled in Medicaid and undergo an eligibility redetermination, federal law requires the state to assess their eligibility not only for Medicaid but for subsidized Marketplace insurance. If they are found ineligible for Medicaid but potentially eligible for Marketplace premium tax credits, the state must transfer the person’s account to the Marketplace.<sup>12</sup>

Within this federal framework, state systems and processes for conducting eligibility redeterminations vary. Before the pandemic, most states generally checked an enrollee’s Medicaid eligibility annually to process a renewal, although such checks can be conducted more frequently if data sources suggest an enrollee is no longer eligible or if an enrollee submits new information. Although states are required to try to verify eligibility for enrollees using their own data sources, Medicaid agency staff often must ask enrollees to submit information and documentation to prove they remain eligible for the program. Most states rely on mail for these communications, although most also have web-based accounts or permit enrollees to submit information through other electronic means (Serafi and Boozang 2021).

Many Medicaid enrollees with low incomes experience housing insecurity, and Black and Latino enrollees are disproportionately affected (Boozang and Striar 2021). This means enrollees’ addresses or phone numbers may change, leaving the Medicaid agency with outdated contact information. When a person does not respond to a Medicaid agency’s request for information necessary to conduct an eligibility redetermination, they can be terminated from the program, even if they remain eligible on the basis of their income. These are sometimes called “administrative” or “procedural” denials. Under the continuous coverage requirement during the PHE, many Medicaid enrollees may not have been in contact with a Medicaid agency since early 2020, increasing the likelihood that the agency lacks their current contact information.

## No-Wrong-Door Approach Is More Aspirational Than Actual; Most States Lack Integrated Eligibility Systems

The 33 states that use the federal Marketplace platform HealthCare.gov and many SBMs do not have an integrated eligibility system that allows consumers to (1) receive a real-time determination of eligibility for either Medicaid coverage or Marketplace premium tax credits and (2) seamlessly enroll in

the appropriate program. Rather, these states rely on account transfer systems that require consumers to newly apply for coverage with a different agency.

Conversely, several SBMs have integrated their eligibility systems to create a more seamless experience for consumers and reduce the risk that people will become uninsured when their program eligibility shifts from Medicaid to Marketplace coverage or vice versa. The ways in which states have integrated their systems vary. New York runs a single, unified eligibility engine for its subsidized coverage programs (Medicaid, the Marketplace, CHIP, and the Basic Health Program). The state also houses Medicaid and its Marketplace in the same agency (SHADAC 2018). Idaho's SBM relies on its Medicaid agency to conduct eligibility determinations, but once a person is deemed eligible for premium tax credits, they must proactively enroll in a plan through the Marketplace. In Rhode Island, the Medicaid agency works with the Marketplace to provide close-to-real-time eligibility decisions, but people deemed ineligible for Medicaid must still be transferred to the Marketplace to select a plan (Ario and Zhan 2020).

## Research Approach

To assess states' planning and preparedness for the end of the PHE and resumption of Medicaid eligibility redeterminations, we reviewed federal guidance and any relevant published state documents relating to the end of the PHE and interviewed Medicaid and SBM officials from 11 states: California, Colorado, Idaho, Kentucky, Massachusetts, Nevada, New Mexico, New York, Rhode Island, Virginia, and Washington. All but Virginia, which has an SBM that uses the federal HealthCare.gov platform, operate their own Marketplace eligibility and enrollment systems. Some of the states have highly integrated eligibility systems, whereas others' systems are more siloed. We selected these states to provide geographic diversity and to represent a range of approaches to system integration. We conducted interviews between October 7 and December 22, 2021.

## Findings

State officials we spoke with identified several significant challenges associated with unwinding the PHE, which we describe below. Some officials have begun to plan or implement solutions designed to improve their systems, policies, and business processes to minimize coverage losses.

### **Challenge #1: Huge Caseloads and Limited Budgets and Time**

Fifteen million or more current Medicaid enrollees will potentially be ineligible for Medicaid at the end of the PHE. Thus, states face a monumental task catching up on delayed renewals and redeterminations. Officials in most of our study states expected to take the full time period offered by the Centers for Medicare & Medicaid Services to complete the process. However, a few officials indicated they are facing budgetary pressure to complete redeterminations in less time because of the loss of enhanced

federal matching funds. “Not everyone is clear on whether 12 months is fiscally feasible,” said one Medicaid official. “It’s left uncertainty about whether...a shorter period will be in play.”

Medicaid officials were concerned about having sufficient staff to support the redetermination process, given the unprecedented volume. Some noted they intend to hire additional staff but are struggling to determine when to begin, given uncertainty over when redeterminations will recommence. “We don’t want a lot of people sitting around with nothing to do,” said one official. Other Medicaid representatives said that though they expect to need more staff, they do not have the budget to hire new employees. Still others thought their current staffing levels will be able to handle the caseload. A few hoped to resolve some of the volume concerns by using internal or external data sources to determine eligibility for as many beneficiaries as possible, a process known as *ex parte* renewals. This can also help relieve the demands on enrollees to submit documentation proving their eligibility.

Having sufficient staff is only one challenge. Another is training. One Medicaid official noted that many of their eligibility caseworkers have never processed a redetermination or renewal because they were hired after March 2020; for staff with longer tenures, it will have been at least two years since they have processed a renewal. Medicaid agencies will need to provide these caseworkers with new training on the rules and processes for managing redeterminations, renewals, and terminations.

Medicaid officials also identified system and technology challenges associated with processing the anticipated volume of redeterminations. States that continued processing redeterminations throughout the PHE (but stopped terminations) will likely be better off than those that stopped conducting redeterminations altogether. As one official put it, “We didn’t implement any system changes [to stop redeterminations], so everything is currently done manually every month....Even though it’s tedious...I think in the long run we’re better off than other states, because they are having to make huge system changes to get back on track.”

#### SEVERAL STATES WILL MINIMIZE ADVERSE EFFECTS BY TARGETING SUBGROUPS OF ENROLLEES FOR EARLIER OR LATER RENEWALS

Several state officials indicated they intend to manage post-PHE Medicaid eligibility redeterminations by triaging their populations. For example, one state will soon provide continuous 12-month enrollment for postpartum women enrolled in Medicaid. The Medicaid agency will therefore target these people for renewal at the time that continuous eligibility takes effect to avoid coverage losses among those eligible for a full year of coverage. “We don’t want to terminate anyone that might be able to continue [with Medicaid],” the official said. Officials in the state were also considering conducting redeterminations first for enrollees for whom the state pays managed-care organizations’ capitated rates but who do not use services. This would provide the state some fiscal relief while targeting for potential termination a group of people least likely to need medical services.

### **Challenge #2: Reducing the Number of People Who Fall through the Cracks**

A second central challenge the end of the continuous coverage requirement poses is limiting the number of people who become uninsured after their Medicaid coverage is terminated. If Congress

extends the American Rescue Plan’s enhancements to the Marketplace premium tax credits, a substantial share of this group will be eligible for Marketplace health plans with significant premium and cost-sharing subsidies (with many eligible for \$0 premium plans, at least in 2022; Branham et al. 2021). However, completing the eligibility determination and selecting a plan in the Marketplace can be challenging. In addition, a large number of people will lose Medicaid coverage for administrative reasons though they will remain eligible for the program on the basis of their incomes. Many of these people could ultimately become uninsured if they apply for Marketplace subsidies only to be rejected because their incomes make them eligible for Medicaid. Additionally, many children disenrolled from Medicaid will be eligible for CHIP, whereas their parents may be eligible for a Marketplace plan. These families will likely need targeted messaging and assistance to help each family member enroll in the appropriate coverage option.

Interview respondents with state Medicaid agencies and SBMs reported that before the start of the PHE, transfers from Medicaid to subsidized Marketplace coverage were considerably less successful than transfers from a Marketplace plan to Medicaid. “If someone’s income goes down...it works quite well,” one SBM official said. “They are determined eligible for Medicaid...and they move over to the Medicaid program. But if it goes the other direction...in our experience, only a small percentage of people come in that direction; we generally don’t get them.” This could be because many people coming from Medicaid are unused to paying the premiums often required for Marketplace plans. It could also be that Marketplace consumers experience “choice overload” from the large volume of plans they must navigate and compare (compared with only one or two choices in Medicaid). When confronted with an overwhelming volume of complicated plan choices, many consumers make no decision at all (Taylor et al. 2016). In this particular circumstance, the consumer will likely become uninsured.

Although many SBM officials acknowledged that the end of the PHE presents an opportunity to increase the rate of people transitioning out of Medicaid coverage, they also frequently noted that they are not in control. “The Medicaid agencies have to make the first move,” one SBM official said. Several expressed particular concerns about the inaccurate, inadequate data they have received from their state Medicaid agency’s account transfers.

#### **STATES WITH INTEGRATED ENROLLMENT SYSTEMS WILL LIKELY FARE BETTER**

SBMs that have eligibility systems well integrated with the state’s Medicaid system will likely better identify and transfer people from Medicaid into Marketplace plans than will states without integrated systems. California will roll out a new autoenrollment system for Marketplace coverage beginning in mid-2022. This new program was authorized in 2019, so it is only coincidentally likely to be operationalized just as the PHE ends. However, the program is ideally suited to help smooth the transition for people losing Medicaid when the continuous coverage mandate expires. California’s novel approach will preliminarily enroll people losing Medicaid eligibility into the lowest-priced silver-level plan available to them, notify them of the enrollment, and then require enrollees to confirm or decline the autoenrollment. Those who take no action will not ultimately be enrolled. Such a program would not be feasible without the integrated eligibility system between Medi-Cal and Covered California.

Officials from other states with integrated systems were confident in their abilities to identify transferees and access the necessary data to connect them with the most appropriate coverage option. According to one official, “We don’t have to ‘talk to’ another system, transfer a file, or worry about files being in two different [computer] languages. The [data] are all just right there.” Another SBM official in a state with an integrated system observed that the ability to see why someone is disenrolled from Medicaid can better help SBM staff identify who would benefit from eligibility and enrollment assistance. For example, the SBM would not need to devote resources to someone terminated from Medicaid because they had gained eligibility for Medicare; it could instead use those resources to focus on people more likely to be eligible for Marketplace subsidies on the basis of their incomes. Having an integrated system also makes it easier for an SBM to prepopulate a prior Medicaid enrollee’s Marketplace application, reducing the time and effort needed for the consumer to enroll.

States without integrated eligibility systems will face greater hurdles in maximizing insurance coverage as the PHE ends. For these SBMs, the only data staff can see about terminated Medicaid enrollees are from the files the Medicaid agency actively transfers to them. Officials in these states frequently reported that these files are often incomplete and slow to arrive and lack critical data, including the reason someone is disenrolled from the program. As one SBM director said, “We only receive account transfers for [people with] income changes....That is the only group of people I can do anything with...and probably only 1 out of every 30 [files] will have a phone number.” Another Marketplace official reported that they have not received data on terminated enrollees in a way that is actionable or timely. They added, “I don’t think we get a lot of detail. We don’t get something saying, ‘Here are the people you should reach out to because...they will benefit from [advanced premium tax credits] due to their income.’ We don’t know that.”

These Marketplace officials also noted that they have no way to know who is being terminated from Medicaid for administrative reasons, such as failure to respond to a mailing. Consequently, the Marketplace has limited ability to initiate outreach or leverage its assister workforce to encourage these people to update their account information or reapply for Medicaid.

#### **MOST SBM OFFICIALS IDENTIFY BARRIERS TO AUTOMATING ELIGIBILITY DETERMINATIONS AND MARKETPLACE ENROLLMENT**

One way to increase the number of people who successfully transition from Medicaid to Marketplace coverage is to reduce the time and effort they must put into the process. However, among SBMs, California’s appears to stand alone with its autoenrollment system described above. Most interview respondents flagged significant challenges in establishing automated programs in their states. For many, the costs and effort associated with the necessary system changes are too high; some pointed out that the PHE will likely end well before any such changes can be implemented. Others were uncomfortable with autoenrolling people into plans they had not actively shopped for and enrolled in (although California would require consumers to actively opt into the plan before effectuating enrollment). These officials felt greater discomfort over people receiving premium tax credits that they might have to return to the IRS during the annual reconciliation process if their projected income is miscalculated. As one SBM director put it, “There are things we could engineer in our system that would



make it easier for someone to check a box saying, ‘If I’m coming out of Medicaid and qualify for a \$0 premium [plan], put me in it.’ The question is, can we do that from a legal perspective, and could we do that in our [IT] system?”

### **MOST STATE-BASED MARKETPLACES INTEND TO OFFER YEAR-ROUND ENROLLMENT TO PEOPLE WITH LOW INCOMES**

Another strategy to help people remain insured after losing Medicaid eligibility is ensuring they have sufficient time to understand their options and take the necessary steps to enroll in other coverage. But until 2022, most people who lose access to Medicaid, employer-sponsored insurance, or other coverage were given only a two-month special enrollment period (SEP) to sign up for a Marketplace plan.

Beginning in January 2022, however, people enrolling in coverage via the federal Marketplace with incomes below 150 percent of the federal poverty level, or FPL, (\$39,750 for a family of four) are eligible for an SEP each month of the year.<sup>13</sup> This year-round opportunity to enroll will apply for as long as the American Rescue Plan’s enhanced subsidies that make people with low incomes eligible for \$0 premium silver-level plans remain in place. In adopting the monthly SEP for people with low incomes, the Biden administration noted that the SEP would help ensure people who lose Medicaid after the PHE’s continuous coverage mandate expires have sufficient time to shift to Marketplace coverage.<sup>14</sup>

The SBMs can, but are not required to, implement this new monthly SEP for people with low incomes. Most of our interview respondents intended to do so, but several indicated it is not high on their lists of priorities. Providing this SEP will require changes to state IT systems that will cost money and take time. Several officials further noted that the SEP would benefit a very small subset of potential enrollees (those with incomes between 138 and 150 percent of FPL who miss the standard 60-day SEP). Massachusetts, Minnesota, and New York already provide year-round enrollment for people with low incomes (under 200 percent of FPL in New York’s and Minnesota’s Basic Health Programs and under 300 percent of FPL in Massachusetts’ ConnectorCare). Another SBM official reported they are advocating to expand the monthly SEP to people with incomes up to 200 percent of FPL. New Jersey has already done so.<sup>15</sup>

### **Challenge #3: Building Awareness and Assisting Consumers with Coverage Transitions**

For consumers losing Medicaid to successfully transition to new coverage, they must be aware of the coverage options available to them. Such consumers can also benefit from assistance with enrolling in new coverage and, once enrolled, assistance with navigating the benefits and requirements of their new coverage, which will differ from those in Medicaid. Stakeholders highlighted several tactics for supporting consumers through coverage transitions.

#### **THE NEED FOR MULTILAYERED, COORDINATED, AND TARGETED COMMUNICATIONS**

State officials wishing to minimize coverage losses must communicate early and often with affected people. Current Medicaid enrollees need to know their eligibility will be reassessed and what to do to

ensure the Medicaid agency has accurate and up-to-date information about them. Inaccurate contact information is a huge problem; one Medicaid official reported that roughly half of the mailings they send to enrollees are returned because of incorrect addresses.

People who lose Medicaid coverage will need to know what their coverage options are. This will require a mix of direct-to-enrollee and broader community-level communications and, to the extent possible, coordination between Medicaid and SBMs to ensure consistent messaging and to reduce consumer confusion.

Given limited resources, SBM officials will need to target their community-level communications to the most affected areas and populations. A disproportionate share of people terminated from Medicaid for administrative reasons, such as failing to respond to a mailing, are people of color (Boozang and Striar 2021). States will need to identify the communities in which many nonrespondents live, tailor messaging strategies, and leverage trusted intermediaries to ensure their outreach has an impact.

Officials from two of our study SBMs indicated that they were not, at the time of the interviews, crafting a communications campaign specifically tied to the end of the PHE. “We’re waiting for [the Medicaid agency] to let us know what their plans are,” one official said. However, most of the state respondents recognized the magnitude of the effort needed and the importance of developing and refining their strategies as early as possible. In general, officials from both Medicaid agencies and SBMs told us SBMs are better staffed and resourced to conduct such proactive public outreach than Medicaid agencies are. “[The Medicaid agency] just doesn’t have that same infrastructure and doesn’t prioritize things like that,” one official said. “The exchanges know that you have to advertise insurance.” Many Medicaid agencies have no budget or ability to do any paid media.

Officials from several states reported that their SBMs are gearing up to develop and implement a multilayered communications campaign associated with the PHE’s unwinding, and they are doing so in close coordination with the state Medicaid agency. This includes efforts to modernize the ways in which Medicaid agencies and SBMs communicate with enrollees. Whereas representatives of several Medicaid agencies reported that they primarily communicate via mailings, several others discussed coordinated efforts with their SBMs to use email, text messaging, and outbound phone calls to reach people. “We’re trying to reach people in more ways they are receptive to,” said one state official.

Several SBM officials agreed that it will be important to target their outreach to populations of color, and a few have identified strategies for doing so. One SBM official discussed their work to create “health equity zones,” which are “community-based groups that work together and provide a web of agencies in particular neighborhoods.” Another SBM official similarly reflected on the importance of having people embedded in targeted communities to conduct effective outreach. “Our best champions are people in the community,” they said. “No one knows better what the community needs.” Representatives of several of the study states reported that this community-level outreach workforce starts with their Navigator program grantees. However, although some state representatives indicated they would develop training materials and other resources for navigators and other assisters, few had

concrete plans to provide supplemental funding to support PHE-related work, nor did any report they would expand the number or types of organizations to whom they issue Navigator grants.

One state official observed that insurance brokers, not navigators, facilitate most of their Marketplace enrollment. However, many Marketplace plans pay brokers only a nominal commission, or in some cases no commission, for enrollments outside the annual enrollment period (typically November 1 through mid-January). This significantly limits brokers' financial incentives to help people transition from Medicaid to the Marketplace at the end of the PHE, which will likely occur outside open enrollment.

Similarly, few state officials reported concrete plans to increase call center staffing, although many believed they can quickly ramp up capacity if needed. Officials pointed to uncertainty over the timing of the end of the PHE and how quickly the Medicaid agency would be conducting eligibility redeterminations. No one wanted to pay for call center operators to sit idle. As one state representative put it, "It will be difficult for us to assess whether we need additional staffing until we have a better sense of how spread out people will be rolling off [of Medicaid]."

Some SBM and Medicaid agency officials also told us about their efforts to enlist outside organizations, such as managed-care organizations and Marketplace plans, consumer advocacy groups, and providers, to help spread messages about how to prevent Medicaid termination if a person remains eligible and what to do if one's coverage is terminated. However, others pointed to challenges engaging some of these stakeholders, particularly insurers that offer both Medicaid and Marketplace plans. These insurers are uniquely incentivized to ensure terminated Medicaid enrollees retain coverage, and states could provide them with data on recently terminated Medicaid enrollees and their eligibility for Marketplace coverage. These companies could then use their own workforces and customer support infrastructures to conduct outreach and encourage people to sign up for a Marketplace plan, relieving some of the strain on state resources. However, some state officials flagged potential legal and market-related risks associated with sharing enrollee data. SBM officials, in particular, expressed concerns about giving these insurers a competitive advantage over those that do not participate in Medicaid.

## THE NEED FOR POSTTRANSITION CONSUMER ASSISTANCE WITH NAVIGATING COVERAGE CHANGES

Although most state officials focused on limiting the number of people who become uninsured after losing Medicaid coverage, officials in 2 of the 11 study states flagged another challenge: ensuring people who switch to a Marketplace plan can successfully navigate a different insurance product. Compared with Medicaid, Marketplace plans can have premiums, higher enrollee cost sharing, and different provider networks and benefits. As one official noted, "People have had free health care [in Medicaid] and see they have to pay something, even a small amount...That's not good." Rhode Island's governor has proposed automatically transitioning some residents who lose Medicaid into a Marketplace plan, with the state providing financial support to cover the first month's premium.<sup>16</sup> The higher cost sharing associated with Marketplace plans is also a concern. For people with low incomes, even a small deductible or low cost sharing can be a significant deterrent to obtaining needed care.

Additionally, the transition from Medicaid to Marketplace coverage may end long-standing patient-provider relationships. “We have seen a frightening narrowing of [provider] networks in [Marketplace plans] over the years,” said one SBM official. “If you have 200,000 people coming out of Medicaid and they can’t keep their providers...this is not acceptable.” However, although they recognized this as a potential concern, most SBM officials had not yet considered policies or strategies to help consumers maintain access to providers, even consumers who may be in treatment when they lose eligibility for Medicaid. In early March 2022, Oregon’s legislature passed a bill requiring a state task force to create a “bridge program” to “improve the continuity of coverage” for those terminated from Medicaid.<sup>17</sup>

#### **Challenge #4: Expect the Unexpected**

Representatives from all of our study states were attempting to prepare for the end of the PHE without knowing when that will be or when Medicaid will resume eligibility redeterminations.<sup>18</sup> Uncertainty over federal requirements and standards for how eligibility redeterminations will be processed compounds uncertainty about timing. The Build Back Better Act would unlink the Families First Coronavirus Response Act’s continuous coverage requirement from the PHE, but it would place new requirements on states if they wish to retain the enhanced federal matching rate as it phases down. The legislation would, for example, bar states from disenrolling anyone on the basis of returned mail until the state makes at least two attempts to contact the person through different modalities (e.g., mail and telephone). States would also have to provide at least a 30-day notice before terminating coverage (Park et al. 2021). Policymakers are still debating this legislation, meaning state officials must plan without knowing what may be required of them.

State legislatures could also inject themselves into the process. In most of our study states, legislators have taken little to no action related to the end of the PHE and the potential termination of Medicaid coverage for thousands (and in some cases millions) of their constituents. No Medicaid official reported any pressure from legislators to speed up redeterminations for fiscal reasons. A few state legislatures are considering providing additional funding to either Medicaid or the SBM to aid in outreach and enrollment assistance. With the 2022 legislative sessions underway, state agencies’ planning and preparedness may start to receive more attention. Ohio’s legislature has already required the state Medicaid agency to complete its redeterminations within 60 days of the PHE ending.

SBMs must also grapple with uncertainty over the market impact of the huge volume of people shifting from Medicaid coverage to commercial Marketplace plans, potentially in a short time frame. In addition to questions about the capacity of SBMs’ infrastructure to support this inflow of enrollees, states must consider the capacity of participating Marketplace plans. These plans may need to increase their customer service staff to respond to consumers’ questions, particularly from former Medicaid enrollees unused to commercial insurance. Insurers may also want to consider adjusting broker commissions so their broker workforce has sufficient financial incentives to assist transitioning consumers outside of the annual enrollment period.

Another concern is that Marketplace plans have narrow provider networks that may be inadequate to meet the needs of the large influx of new enrollees.<sup>19</sup> If a large share of people in a given service area

gravitate to just one or two narrow-network plans in a short period of time, they may face delays or difficulties accessing timely appointments for needed services.

Additionally, Marketplace insurers have already locked in their premium rates for 2022. If the nongroup insurance market receives unanticipated new enrollment that leads to higher-than-average medical claims, it could incur financial losses. Representatives of almost all of the SBMs in our study had yet to engage with their respective departments of insurance on these issues, but most were confident that their plans can absorb additional enrollment without any adverse effects.

## Discussion

How well integrated Medicaid and Marketplace agencies are, how much planning is taking place, and how agencies coordinate data sharing and outreach strategies vary significantly across states. However, most of our state respondents recognized the significant concern that millions of current Medicaid enrollees could become uninsured at the end of the PHE. They also acknowledged that they are on the front lines of trying to ensure as many of these people as possible transition into appropriate new coverage. As the end of the PHE approaches, state officials identified several potential risks.

**Lack of lead time.** State officials were concerned that the federal government will not provide them with sufficient time and policy certainty to undertake the planning and IT system changes required to execute a smooth redetermination process and warm hand-offs to their SBMs. A few also noted concerns that their legislatures will require them to complete redeterminations in an unrealistically fast time frame because of fiscal pressures.

**Workload and staffing challenges.** State Medicaid agency staff are bracing for a significant increase in their workloads to process redeterminations, respond to consumer questions and complaints, and provide enrollment assistance. At the same time, all are facing the same labor shortages as private-sector employers, and few expected significant increases in funding from the state to support hiring additional staff or augmenting their Navigator grants.

**Lack of data.** State Medicaid officials expressed concerns about inaccurate and outdated contact information for current enrollees, and SBM officials worried that the account transfers they receive from Medicaid frequently lack the information needed to determine Marketplace and premium tax credit eligibility.

**Technology glitches.** Several Medicaid officials noted that turning their systems back on to process redeterminations is not easy. Doing so could result in technical glitches, such as enrollees being inundated with outdated messages or receiving inaccurate data. On the Marketplace side, most SBM officials expressed confidence in the capacities of their systems to absorb new applications and enroll a significant number of new consumers.

**Market instability.** A few SBM officials noted that a rapid influx of new enrollees, particularly if concentrated in one insurance plan, could result in challenges for plans and delays or difficulties for enrollees trying to access in-network services.

## **Strategies to Mitigate Risks Associated with the End of the PHE**

Medicaid and Marketplace officials are attempting to mitigate these risks by conducting as much cross-agency planning as feasible; many state respondents reported weekly or even daily communications with their interagency counterparts. In several states, officials were also developing a coordinated communications campaign to ensure current and former Medicaid enrollees receive consistent and unified messages about what they need to do to retain coverage or transition to new coverage. Many also said they intend to leverage the infrastructure and workforce of external stakeholders, including Medicaid managed-care organizations, Marketplace plans, navigators and other assisters, and providers, to assist with consumer education and provide enrollment assistance.

One state, California, will be launching a new automatic enrollment program that should significantly reduce the time and effort transitioning consumers must undertake to maintain coverage. Although none of the state officials in our study were planning a similar program, the looming end of the PHE has prompted several to explore implementing more automation in their eligibility and enrollment processes, such as greater use of prepopulated applications.

Fewer people may become uninsured at the end of the PHE in states with their own Marketplaces than in states using the federally facilitated Marketplace. SBMs have greater abilities to closely coordinate with state Medicaid agencies and to be nimble in the face of unexpected policies or events. The SBMs with eligibility and enrollment systems fully integrated with Medicaid appear to be in the strongest position to successfully transition eligible people into subsidized Marketplace coverage.

That said, the end of the continuous coverage requirement for Medicaid will inevitably result in coverage losses in all states. The federal government can assist by ensuring state officials have clear and timely policy guidance, encouraging cross-agency collaboration, and providing real-time technical assistance both in preparation for and during the unwinding of the PHE.

The risk of coverage losses at the end of the PHE is considerable, but it may also offer a silver lining. A key goal of the Affordable Care Act was to ensure consumers would face no wrong door in their search for affordable insurance options. Eleven years later, that goal has not been fully realized in most states. However, many of the state officials we spoke with have begun to reprioritize the consumer experience in transfers from one coverage option to another and to invest in system changes and processes designed to make the transition as easy as possible. If the end of the PHE brings more states closer to that no-wrong-door goal, the long-term benefits will be considerable.

# Notes

- <sup>1</sup> “Public Health Emergency Declarations,” US Department of Health and Human Services, last reviewed January 14, 2022, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>.
- <sup>2</sup> [The Families First Coronavirus Response Act](#), Pub. L. No. 116-127 (2020).
- <sup>3</sup> “Tracking COVID-19 Unemployment and Job Losses,” Georgetown University Center on Education and the Workforce, accessed January 24, 2022, <https://cew.georgetown.edu/cew-reports/jobtracker/>.
- <sup>4</sup> [Pub. L. No. 116-127](#), 134 Stat. 178 (2020). The Families First Coronavirus Response Act’s continuous coverage requirement does not extend to CHIP or the Basic Health Program.
- <sup>5</sup> Tricia Brooks and Andy Schneider, “Families First Coronavirus Response Act Medicaid and CHIP Provisions Explained,” *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, March 22, 2020, <https://ccf.georgetown.edu/2020/03/22/families-first-coronavirus-response-act-medicaid-and-chip-provisions-explained/>.
- <sup>6</sup> “Renewal of Determination That a Public Health Emergency Exists,” US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, January 14, 2022, <https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx>.
- <sup>7</sup> Centers for Medicare & Medicaid Services, “August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot,” accessed March 14, 2022, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.
- <sup>8</sup> Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, letter to state health officials, regarding “Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) upon Conclusion of the COVID-19 Public Health Emergency,” March 3, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.
- <sup>9</sup> Centers for Medicare & Medicaid Services, letter regarding “Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP, and BHP Operations.”
- <sup>10</sup> [Build Back Better Act](#), H.R. 5376, 117th Cong. (2021).
- <sup>11</sup> 45 C.F.R. § 155.40 and § 435.907.
- <sup>12</sup> 42 C.F.R. § 435.1200(e).
- <sup>13</sup> 45 C.F.R. § 155.420.
- <sup>14</sup> 86 Fed. Reg. 35170 (Jul. 1, 2021).
- <sup>15</sup> State of New Jersey Department of Banking and Insurance, “Governor Murphy and DOBI Commissioner Caride Announce Record Health Insurance Sign-Ups during Open Enrollment, Introduce Effort to Further Expand Health Care Access for NJ Residents,” news release, February 23, 2022, <https://www.state.nj.us/dobi/pressreleases/pr220223.html>.
- <sup>16</sup> Office of the Governor of Rhode Island, “Governor McKee Proposes Initiative to Help Keep Rhode Islanders Insured,” news release, February 4, 2022, <https://www.ri.gov/press/view/43002>.
- <sup>17</sup> H.B. 4035, 81st Gen. Assemb. (Or. 2022).
- <sup>18</sup> [Am. Sub. H.B. 110 § 5163.52](#), 134th Gen. Assemb. (Oh. 2021).
- <sup>19</sup> See, for example, Dafny and colleagues (2017); McKinsey Center for US Health System Reform (2016); Polsky, Ciday, and Swanson (2016); and Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan, “Plans with More Restrictive Networks Comprise 73% of Exchange Market,” news release, Avalere Health, November 30, 2017, <https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market>.

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## About the Authors

**Sabrina Corlette** is a research professor and founder and codirector of the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy. At CHIR, she directs research on health reform issues, with a focus on state and federal regulation of private health insurance. She provides expertise and strategic advice to individuals and organizations on health insurance laws and programs and provides technical support through the publication of resource guides, white papers, issue briefs, blog posts, and fact sheets. She has testified numerous times before Congress and is frequently quoted in the news media on emerging health care issues. She has published dozens of papers relating to the regulation of private health insurance and health insurance marketplaces. Before joining the Georgetown faculty, Corlette was director of health policy programs at the National Partnership for Women & Families, where she provided policy expertise and direction for



the organization's advocacy on health care reform. From 1997 to 2001, Corlette worked for the US Senate Health Education, Labor and Pensions Committee, where she served as health legislative assistant to Senator Tom Harkin. After leaving the Hill, Corlette served as an attorney at the law firm Hogan Lovells, where she advised clients on health care law and policy. Corlette is a member of the DC Bar and received her JD with high honors from the University of Texas at Austin and her undergraduate degree with honors from Harvard University.

**Linda J. Blumberg** is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *King v. Burwell* case, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a "Road Map to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed that state's comprehensive health reforms in 2006. Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute's advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy. Blumberg received her PhD in economics from the University of Michigan.

**Megan Houston** is a research fellow at the Center on Health Insurance Reforms (CHIR) in Georgetown's Health Policy Institute. Her research focuses on state efforts at health care cost containment and monitoring of insurance reforms at the state and federal levels. Before joining CHIR, she worked as a research analyst in the Massachusetts state legislature's Joint Committee on Health Care Financing, where she conducted policy research, drafted and analyzed legislation, and worked on bills related to community hospital financing and the cost of prescription drugs. Before completing graduate school, Houston worked for the Massachusetts Medical Society and the Health Federation of Philadelphia. She was also a member of AmeriCorps, where she served as an insurance specialist, helping consumers with eligibility and enrollment in Medicaid, the Marketplace, and other coverage options. Houston earned her master of public health degree and a certificate in health policy and law from Boston University's School of Public Health and holds a BA in psychology from the University of San Francisco.

**Erik Wengle** is a research analyst in the Health Policy Center at the Urban Institute. His research is focused primarily on the implementation of the Affordable Care Act and the future outlook of the health insurance Marketplaces. Wengle graduated from the University of Maryland in 2013 with a BS in environmental science and policy.

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