Medicaid Unwinding:

Roles of Stakeholders Across the Healthcare Ecosystem

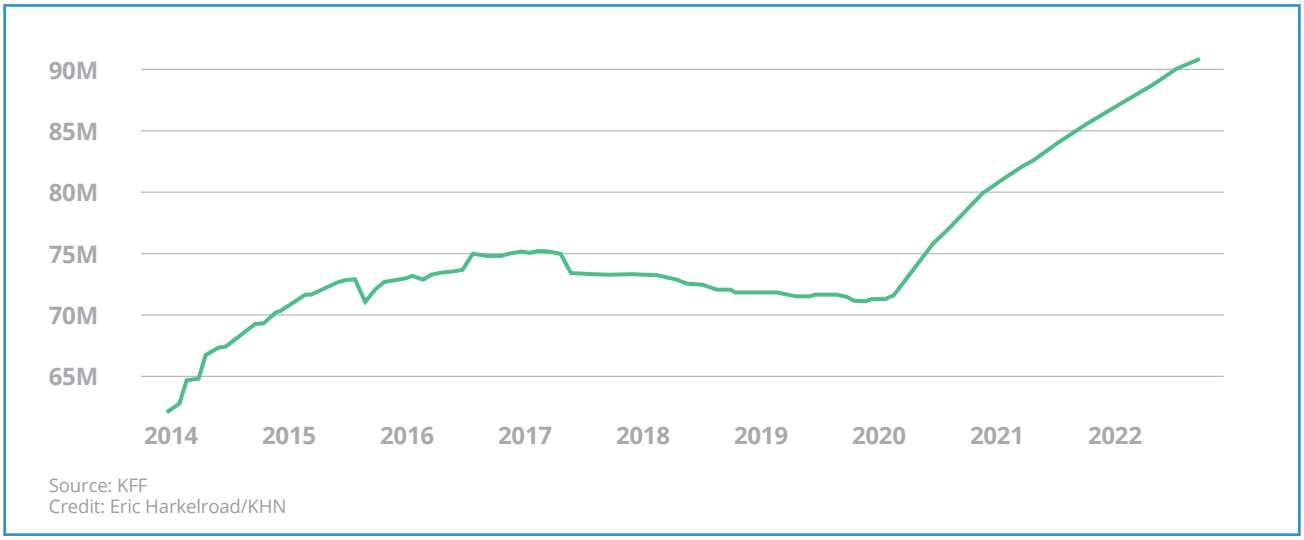
Medicaid enrollment rose 28 percent through the pandemic[1] due in large part to the emergency measure Congress put in place aiming to ensure at-risk individuals had access to health coverage. As part of the legislation, states agreed to keep people continuously enrolled in Medicaid programs, even if their eligibility changed, in exchange for enhanced federal funding.

That provision helped push down the uninsured rate to roughly 8 percent[2] resulting in more people gaining health coverage than ever before. Now, that historic low is threatened with the prohibition on dropping beneficiaries from Medicaid rolls ending March 31, 2023. Medicaid Redetermination, referred to as "Medicaid unwinding," means states can return to regular eligibility and enrollment for the first time since March 2020. It's estimated that up to 18 million people could lose coverage.[3]

Medicaid/Children's Health Insurance Program (CHIP) enrollment soared during pandemic

Medicaid rolls nationwide increased by more than 20 million people after states were prohibited from dropping anyone as a condition for receiving federal COVID-relief money starting in 2020. This prohibition ends March 31, 2023.

Number of Medicaid/Children's Health Insurance Program (CHIP) enrollees:



Source: KFF
Credit: Eric Harkelroad/KHN

Several factors could lead to disenrollment from Medicaid, including (1) ineligibility based on the states' qualifications, (2) inability of states to reach beneficiaries to requalify them, even though they are still eligible (aka, "administrative churn"), and (3) people reporting already being enrolled in a Group Plan or intend to enroll in one.

The Urban Institute estimates roughly half (9.5 million) of the individuals will qualify for employer-sponsored insurance, and a much smaller portion (3.2 million children) will transition from Medicaid to separate CHIP. But that still leaves nearly 5 million individuals who will lose coverage and enter the uninsured population if they don't transition to another form of coverage.[3]

> **"Medicaid unwinding represents the single largest health coverage transition event since the first open enrollment of the Affordable Care Act and Medicaid expansion."**

The impact on millions of Americans

Those who lose coverage will have until July 31, 2024 to enroll in Individual & Family coverage as part of the Special Enrollment Period (SEP) the Centers for Medicare and Medicaid Services (CMS) granted in a January 2023 letter.[4]

Some former Medicaid beneficiaries may be more healthcare savvy when it comes to alternative coverage options. However, healthcare is notoriously complex. Many individuals may not know where to begin with the ACA Marketplace, assume premiums are too high, or not realize they may qualify for premium tax credits or other lower-cost coverage.

And then there's another subset of individuals who may not immediately realize they are ineligible for Medicaid coverage. Only at the point of seeking health care services when their coverage is denied will they realize they no longer have benefits.

The unfortunate result is that many of these individuals will refrain from seeking care when needed and may feel unequipped to explore other health care options. Taken together, it has the propensity to destabilize a large population of at-risk individuals both personally and financially. Additionally, this potentially large uninsured population puts more strain on an already stressed healthcare system.

Medicaid Unwinding: a look at the numbers

91.7M
individuals enrolled in Medicaid and CHIP as of November 2022[3]

18M
individuals at risk of losing Medicaid coverage[2]

4.8M
individuals will become uninsured or enroll in an Individual & Family Plan[2]

What must be done across the healthcare ecosystem

Medicaid unwinding represents the single largest health coverage transition event since the first open enrollment of the Affordable Care Act and Medicaid expansion. And millions of Americans could fall through the cracks — but not if the healthcare ecosystem steps in to catch them. It'll take a coordinated, collective effort to reach every Medicaid beneficiary affected by this change, and inform and educate them on their options.

Physicians, hospitals, and pharmacies are often considered the front-line, providing direct care and service to beneficiaries. Taking an extra step to alert those individuals through direct conversation or on-site materials can help catch and guide consumers before it's too late.

Similarly, health plans have a responsibility (and opportunity) to help direct this population. For health plans with Medicaid beneficiaries as part of their member base, connecting them to alternative coverage helps those individuals remain insured and supports member retention for the health plan. For those that don't, engaging with and educating this population means the potential to grow your membership. Additionally, health plans have the opportunity to educate and leverage their provider networks to support outreach efforts.

Agents and brokers, on the other hand, may not have had Medicaid beneficiaries on their radar traditionally. Yet now, they have an opportunity to help an at-risk population while becoming a trusted advisor.

Regardless of where a stakeholder resides in the healthcare ecosystem, guiding this population of at-risk Medicaid beneficiaries to education and enrollment options begins with understanding what's happening at the state level.

How states are responding

States had until February 2023 to submit their unwinding plans to CMS. They could begin eligibility redeterminations as early as Feb 1, 2023, and as late as April 1, 2023, and will have 14 months (March 31, 2024) to complete all pending redeterminations. States can terminate Medicaid enrollment for ineligible individuals beginning April 1, 2023.[5]

That said, states' response to Medicaid unwinding is all over the map as each state determines its own process. And many factors influence it, including:

- **the date the process was initiated**
- **timing of the state's unwinding process (i.e., some states will try to complete within six months, others over the course of 14 months)**
- **prioritization of members for eligibility verification**
- **if and to what extent the state uses the ex parte process**
- **method and timing for communicating loss of eligibility to Medicaid beneficiaries**
- **information sharing with Medicaid plans**

A note on ex parte renewals

States use different terms to describe ex parte renewals. Some refer to them as automated, passive, or administrative renewals whereby states can check members' income eligibility via available data sources to automatically renew coverage without having to contact the beneficiary. If this process fails, states will send beneficiaries a renewal packet to complete. Others use the term "automated renewal" to describe a process where mailing the form is automated; however, the enrollee must still return a form or take other action to maintain coverage.[6]

That said, the degree to which a state processes ex parte renewals plays a role in Medicaid unwinding, as it has the potential to streamline the renewal process and alleviate the workload on frontline eligibility workers. However, historically, the share completed on an ex parte basis is low.

"Of the 42 states processing ex parte renewals for MAGI groups (people whose eligibility is based on modified adjusted gross income), only 11 states report completing 50% or more of renewals using ex parte processes. Twenty-two states complete less than 50% of renewals on an ex parte basis, including 11 states where less than 25% of renewals are completed using ex parte processes", as KFF notes.[7]

Ex parte processes may not have been widely adopted previously. However, that may change as states commit a major part of their communications overhaul to fortify automated enrollment systems.[8] This is ideal as a quarter of state Medicaid programs have a staffing vacancy rate of 20 percent or more, with some states facing 30 or 40 percent vacancies.[9]

The transient nature of the population under the Medicaid umbrella can make them particularly difficult to reach. To combat issues with out-of-date contact information, some states are partnering with the United States Postal Service and the National Change of Address Database to get updated contact info. Some states are also accepting updated beneficiary contact information from Medicaid Care Organizations (MCOs) without having to get confirmation from the beneficiary.

They also tend to have limited access to technology or reliable internet, using a smartphone as their primary means of digital communication. That's why many states plan to use digital means of outreach through social media, mobile apps, and websites. In addition, states like California have communications toolkits for their ambassadors to use to target the local level with impactful communications.

Michigan has set up its own web portal to keep residents informed on Medicaid benefits as well as launching action teams responsible for collaborating with health plans, community organizations, and other partners to assist residents affected by this massive change.

Of course, call centers play a significant role in assisting individuals with eligibility and enrollment. In fact, the Consolidated Appropriations Act includes a requirement for states to provide monthly call center reports, including wait times, volume, and abandonment rate. If found noncompliant, states could be forced by CMS to take corrective action or stop disenrollments.[8]

States also plan to use more traditional ways of connecting, such as television, radio, billboards, letters, and emails.

No matter how states approach Medicaid unwinding, they must make sure not to lose anyone in the process who may still be entitled to Medicaid while connecting others to alternate sources of coverage. They cannot tackle this alone.

What should agencies and health plans know and consider?

Whether or not a health plan has Medicaid beneficiaries as part of its member base, it's beneficial to provide guidance around coverage options. For those with beneficiaries, connecting them to alternative coverage equals member retention. And for those who don't, engaging and educating this population means the potential to add new members.

When it comes to agents and brokers, they traditionally may not have engaged in this aspect of the healthcare ecosystem. Now, they have an opportunity to help an at-risk population while becoming a trusted advisor.

How agencies and health plans can help guide this population

Every American deserves access to affordable health coverage that protects their health and financial stability. Medicaid Redetermination stands to throw that into chaos. With millions of individuals dropped from Medicaid, the individual market offers an opportunity for them to find affordable coverage. In 2021, the American Rescue Plan and Inflation Reduction Acts were passed to increase the size of premium tax credits, allowing more Americans to be eligible through the end of coverage year 2025. With these premium tax credits, coverage is more affordable for a broader range of people, making it easier to attract those who've been chronically uninsured and may not have turned to the marketplace to explore individual or family coverage previously.

Agencies and health plans are a key part of that equation and can take advantage of the opportunity to help minimize coverage gaps, connecting across other key stakeholders to help a population in need.

Here's how agencies and health plans can be proactive:

Build partnerships.

As of 2020, 72 percent of Medicaid beneficiaries were enrolled in managed care contracts managed by private insurers, according to Kaiser Family Foundation.[10] For those health plans with Medicaid beneficiaries, it's important to work alongside state agencies to determine how the beneficiaries are prioritized for redetermination. For example, MCOs can request state Medicaid agencies provide monthly redetermination files in advance so they can understand who is receiving a print application in the mail and plan their outreach. Also, MCOs can request to get files before an individual's disenrollment date to help them find other coverage.

Of course, communication goes for both sides. Health plans have likely had more frequent contact with beneficiaries than the state during the past few years. So plans should also pass over updated contact information to the state, if the state allows for it.

Finding ways to collaborate with partners can make it easier for everyone, especially the at-risk beneficiary. Plus, it can go a long way in building trust to add a new member to the base or retain them as a member, whether they maintain eligibility or need to transition to a new plan.

Focus on bolstering your contact database and email list.

Around 4 in 10 health plans said the data they received from state agencies was correct "most of the time," meaning there's low confidence the information health plans have on Medicaid beneficiaries is correct, especially with renewals suspended for three years.[1]

With the goal to ensure eligible beneficiaries retain coverage, there has been some relaxation around the rules regarding seeking enrollee contact information. As KFF notes, "states may direct Managed Care Organizations (MCOs) to seek updated contact information from enrollees. If plans contract with a third party to collect this information, they must confirm the accuracy of updates with enrollees directly."[1]

But shoring up the contact database doesn't just pertain to health plans with managed care contracts. Before the pandemic, Medicaid beneficiaries were more apt to churn due to short-term income changes or other circumstances. As those circumstances changed, it wasn't uncommon for individuals to move between different types of coverage – Medicaid, marketplace plans, periods of uninsurance, or re-enrollment in Medicaid. Therefore, it's critical for any health plan to make sure its contact database is up to date to reach members and consumers with targeted communications.

Similarly, for agencies, marketing to their email list is one key way to promote services. So, agencies should focus on their distribution lists and capturing new contacts through social media, digital advertising, and more.

Promote client or member experience.

Today, experience plays a significant role in whether a consumer decides to work with a specific agency or health plan. And it can also make the difference in connecting a beneficiary to coverage and care during a time of change.

For the Medicaid population, that means providing the relevant capabilities they need and have come to expect. That may look like promoting Spanish language capabilities or finding a technology partner who can support additional language translation and get up and running quickly. Additionally, with digital being the primary means of communication, agencies and health plans should invest in channels like text messaging, live agent call centers, and chatbots.

Consider additional outreach opportunities.

Some communities rely more heavily on different communication channels than others, which is why it's important to consider cultural relevance when considering how and where to conduct outreach. For example, Vietnamese and some Spanish-speaking populations rely more heavily on radio. Placing ads in that medium and using primary language can go far in reaching a population that might not have had as much access to information otherwise.

Additionally, agents and brokers may have previously assisted mixed coverage households where one member of the household may have a Marketplace plan while another is covered under Medicaid. Agents and brokers can review their book of business to identify any of those individuals who previously qualified for Medicaid to see if they need assistance in the event they lose coverage.

Take advantage of the opportunity to help millions of Americans affected by Medicaid Redetermination find and enroll in new health coverage before it's too late. Stride can help! Contact Christie Helvey at christie.helvey@stridehealth.com to find out more.

About Stride

Since 2013, Stride has combined innovative SaaS technology, health insurance expertise, and a customer-first approach resulting in an insurance recommendation and enrollment platform utilizing proprietary decision support tools to modernize the healthcare market. This customizable and configurable solution enables health plans, agents, and consumers to navigate complex health insurance decisions confidently. Our seamless, secure, and end-to-end solutions combine an intuitive shopping and quoting experience, eligibility verification, and Phase 3 Enhanced Direct Enrollment (EDE) integration.

Stride offers peace of mind when making one of life's most important decisions, so you're confident you and your family are protected with insurance that fits your health care needs and budget.

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