Unwinding the Medicaid Continuous Coverage Requirement—Transitioning to Employer-Sponsored Coverage

State Health Access Data Assistance Center (SHADAC)

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction

Medicaid and the Children's Health Insurance Program (CHIP) have played a key role in the response to the COVID-19 pandemic, providing a vital source of health coverage for millions of people. The Families First Coronavirus Response Act (FFCRA) implemented a continuous coverage requirement in Medicaid, coupled with an increase in federal payments to states. The requirement has prevented states from disenrolling Medicaid enrollees, except in limited circumstances, allowing millions of Americans continued access to healthcare services during the pandemic. Enrollment in Medicaid and CHIP has grown sharply since February 2020, with more than 20 million enrollees added to state rosters as of September 2022. Continuous coverage can also likely be credited for the decrease in the number of people who were uninsured in 2021, down to 8.6% from a pre-pandemic level of 9.2% in 2019. This was driven by a 1.4 percentage point increase in public coverage in 2021, to 36.8% from 35.4% in 2019. These trends were mirrored across states, with 28 states experiencing significant decreases in their rates of uninsurance. Meanwhile, 36 states saw rising rates of public coverage with none seeing a decline in public coverage.

When the unwinding of the Medicaid continuous coverage requirement begins, states will restart eligibility redeterminations, and millions of Medicaid enrollees will be at risk of losing their coverage. Estimates vary, but most approximate that in the range of 15 million to 18 million people will lose Medicaid coverage, with some portion exiting because they are no longer eligible, some losing coverage due to administrative challenges despite continued eligibility, and some transitioning to another source of coverage. While much attention has been paid to how states can approach the unwinding of the continuous coverage requirement to prioritize the retention of Medicaid coverage and transitions to marketplace coverage, less attention has been paid to the role of employer-sponsored insurance.

Employer-Sponsored Insurance and Medicaid Transitions

Despite the COVID-19 pandemic's impact on life and work, employer-sponsored health insurance (ESI) remains the largest single source of coverage in the United States, with more than half of Americans getting coverage through an employer in 2021. For workers in private firms, almost half received an offer of coverage, and among those who were eligible, the large majority (70%) chose to enroll in employer-sponsored coverage in 2021.

When the continuous coverage requirement ends and individuals exit Medicaid, many Americans will have ESI as a coverage option. In fact, since the availability of affordable ESI disqualifies consumers from accessing subsidies on the marketplace, it may be their only option for coverage. While estimates vary, analysis indicates that up to 9.5 million individuals may have an offer of employer-sponsored coverage and close to 4 million individuals could transition to employer-sponsored coverage when they exit Medicaid.

Not surprisingly, the largest barrier in the transition to employer-sponsored coverage is cost. Premiums for employer-sponsored coverage have increased over time, consistently increasing faster than the overall cost of living. Among private sector workers, average annual premiums for employer-sponsored family coverage were $21,381 in 2021, and workers were responsible for almost 30% of this cost. On top of this, average deductibles for family coverage were close to $4,000. The definition of affordability for ESI is different than compared to subsidized marketplace coverage. Marketplace premiums are capped at 8.5% of income; however, a person is not eligible for marketplace subsidies if their ESI premiums are below 9.12% of family income.

Another barrier is the limited ability for states to provide tailored outreach and enrollment support to those at risk of losing coverage, leaving many individuals who lose Medicaid coverage but who might be eligible for ESI to fend for themselves when trying to navigate enrolling in private coverage within the time-limited special enrollment period. A new SHVS issue brief discusses opportunities for states to help consumers navigate this coverage transition.

To get a sense for the size of the group that might have employer-sponsored coverage as an option, Table 1 shows the proportion of individuals with an offer of employer-sponsored coverage by income (% of the federal poverty guideline (FPG)). The table also shows how this proportion declines if you only estimate the number of individuals in that income group with an affordable offer of coverage based on premium cost (defined as the proportion of ESI-covered individuals whose out-of-pocket premium costs did not exceed 9.12% of their family's income or non-ESI-covered individuals who were offered ESI but did not enroll because of a reason other than high cost). As shown in the table, even among individuals with the lowest incomes (incomes up to 100% FPG), roughly 20% of individuals (national average) have access to an affordable offer of ESI coverage. Among individuals in states that have not expanded Medicaid (shaded in grey) at least 15% of individuals in the lowest income group have access to affordable coverage (ranging from a low of 15% in Mississippi to a high of 37% in South Dakota – while South Dakota voters approved a Medicaid expansion measure in 2022, the expansion has yet to be implemented). The rates of an ESI offer and an affordable offer increase for higher income groups. In most states, more than 40% of individuals with household incomes between 101% to 250% FPG have an affordable offer of ESI and in the slightly higher income group (251% to 400% FPG), well over half of individuals have an affordable offer. In 15 states 75% of individuals with household incomes between 251% to 400% FPG have an affordable offer. When we examine the highest income group (401%+ FPG), close to 90% of individuals have an affordable offer. This is an upper bound estimate. While we know that, depending on income and state of residence, some of these individuals will qualify for Medicaid and others will qualify for subsidized coverage through the marketplace, this demonstrates the positive impact that ESI could have in covering people who exit Medicaid when the continuous coverage requirement ends. And, while cost is certainly the largest barrier, a significant portion of people may have an ESI offer that is affordable.

Table 1. Proportion of Individuals with an Offer of Employer-Sponsored Coverage by Income and State, 2021 % of the total non-elderly population

	Total		Household Incomes up to 100% FPG		Household Incomes 101%-250% FPG		Household Incomes 251%-400% FPG		Household Incomes 401%+ FPG	
	ESI Offer	ESI Affordable Offer	ESI Offer	ESI Affordable Offer	ESI Offer	ESI Affordable Offer	ESI Offer	ESI Affordable Offer	ESI Offer	ESI Affordable Offer
United States	69%	62%	30%	20%	55%	44%	77%	69%	92%	89%
Alabama	71%	63%	32%	24%	64%	54%	90%	83%	92%	88%
Alaska	69%	59%	35%	18%	63%	50%	75%	72%	92%	87%
Arizona	68%	61%	30%	20%	57%	46%	76%	66%	92%	88%
Arkansas	62%	54%	27%	18%	55%	46%	79%	67%	90%	87%
California	65%	59%	27%	18%	49%	42%	72%	67%	90%	87%
Colorado	75%	66%	28%	18%	65%	45%	78%	67%	92%	87%
Connecticut	72%	63%	26%	16%	57%	43%	73%	64%	91%	87%
Delaware	69%	60%	33%	19%	52%	39%	84%	75%	93%	91%
District of Columbia	75%	70%	22%	12%	59%	46%	83%	72%	96%	95%
Florida	60%	53%	27%	19%	52%	41%	69%	62%	83%	79%
Georgia	67%	60%	30%	19%	55%	45%	75%	67%	93%	91%
Hawaii	76%	69%	39%	27%	74%	66%	89%	83%	94%	92%
Idaho	69%	61%	36%	23%	56%	45%	78%	68%	87%	83%
Illinois	74%	66%	37%	25%	61%	48%	78%	67%	93%	90%

Indiana	72%	63%	37%	24%	56%	45%	84%	73%	91%	86%
Iowa	75%	66%	39%	24%	64%	49%	79%	68%	94%	92%
Kansas	77%	69%	34%	25%	60%	47%	87%	74%	92%	90%
Kentucky	66%	59%	22%	11%	60%	49%	85%	78%	92%	90%
Louisiana	66%	57%	27%	19%	60%	46%	79%	69%	93%	87%
Maine	71%	63%	27%	18%	53%	43%	79%	70%	94%	88%
Maryland	75%	69%	34%	27%	61%	52%	81%	73%	92%	90%
Massachusetts	75%	69%	33%	23%	54%	44%	77%	70%	94%	91%
Michigan	75%	66%	36%	23%	65%	52%	86%	76%	94%	90%
Minnesota	74%	67%	36%	27%	53%	39%	77%	71%	91%	88%
Mississippi	61%	53%	24%	15%	59%	48%	78%	67%	87%	85%
Missouri	72%	63%	33%	20%	55%	43%	88%	79%	92%	88%
Montana	69%	62%	26%	16%	53%	36%	77%	70%	91%	88%
Nebraska	79%	73%	38%	28%	70%	61%	84%	77%	94%	91%
Nevada	70%	60%	28%	14%	61%	51%	84%	74%	89%	84%
New Hampshire	78%	70%	38%	26%	64%	52%	79%	63%	93%	90%
New Jersey	74%	67%	43%	29%	49%	37%	73%	66%	96%	93%
New Mexico	61%	53%	25%	14%	52%	40%	77%	67%	92%	91%
New York	63%	57%	28%	16%	40%	33%	65%	58%	90%	88%
North Carolina	70%	60%	35%	22%	55%	42%	75%	60%	92%	88%
North Dakota	79%	70%	37%	19%	71%	55%	83%	72%	92%	90%
Ohio	72%	65%	31%	24%	59%	48%	84%	78%	94%	90%
Oklahoma	63%	56%	21%	14%	57%	46%	73%	62%	88%	86%
Oregon	74%	69%	32%	21%	60%	53%	73%	68%	92%	89%
Pennsylvania	72%	66%	30%	23%	54%	41%	86%	78%	93%	91%
Rhode Island	74%	67%	30%	23%	56%	41%	83%	79%	93%	90%
South Carolina	70%	61%	30%	19%	65%	49%	83%	77%	91%	88%
South Dakota	80%	73%	44%	37%	69%	57%	86%	75%	92%	89%
Tennessee	68%	63%	24%	16%	53%	45%	86%	78%	90%	89%
Texas	65%	59%	27%	21%	54%	43%	73%	64%	91%	88%
Utah	76%	69%	37%	22%	63%	51%	76%	70%	95%	92%
Vermont	71%	65%	30%	23%	48%	36%	72%	62%	91%	90%
Virginia	78%	70%	33%	21%	66%	52%	87%	75%	96%	93%
Washington	73%	68%	27%	19%	50%	43%	74%	68%	92%	90%
West Virginia	64%	55%	22%	12%	55%	44%	81%	71%	94%	91%
Wisconsin	75%	67%	31%	21%	59%	45%	85%	76%	93%	89%
Wyoming	73%	63%	39%	23%	64%	47%	78%	68%	90%	86%

Source: SHADAC analysis of the Current Population Survey's Annual Social and Economic Supplements (CPS) public use microdata files.

Notes:

Grey shading indicates that the state has not adopted the Affordable Care Act Medicaid expansion as of November, 2022. While South Dakota voters approved a Medicaid expansion measure in 2022, the expansion has yet to be implemented.

Offer defined as having ESI as the primary source of coverage or working at an employer that offers coverage that the employee is eligible to purchase. Affordable means those who took up and spend less than 9.12% of their family income (calculated using the SHADAC Health Insurance Unit) on premiums AND those who did not take up coverage but did not list cost as the reason for not purchasing. The analysis is limited to the civilian noninstitutionalized nonelderly population.

Medicaid Disenrollment Survey

Many states may be interested in monitoring the coverage transitions associated with the unwinding. Policymakers, advocates, and other key stakeholders are focused on the state activities that can be employed to provide a smooth transition and are sure to seek information to inform this. While states typically have access to data on why people exit Medicaid and whether they transition to CHIP or the marketplace, they often have little insight into people who transition to employer-sponsored insurance. One of the only options for enumerating and monitoring the experiences of these individuals is to field a disenrollment survey.

A disenrollee survey would also allow the states to capture both quantitative and qualitative data that could be used to understand whether people enrolled in employer-sponsored coverage; the enrollee's experience navigating the processes; and even the cost and access related to that coverage. Questions could include current coverage status; whether the individual has had recent gaps in coverage; reasons/motivations to enroll or not enroll; ease of the transition; cost of employer-sponsored coverage; and details about their coverage, benefits, and access to care. By collecting demographic information along with these questions, states can also get a sense for whether there are population differences between those who successfully transitioned to employer-sponsored coverage and those who remain uninsured.

In the interest of better understanding coverage transitions, along with access to employer-sponsored coverage and the cost of that coverage, these disenrollment surveys could rely on a convenience sample of respondents. An online survey could be sent to disenrolled individuals via text or email, greatly reducing the cost and limiting burdens on staff time. If a state has in-house expertise, funding, or can leverage an existing partnership (e.g., a state–university partnership), they could also consider a more robust, mixed-methods survey that supplements a mailed survey (and online option) with interviews. For example, in 2019, Iowa conducted a survey of members who were disenrolled from its Iowa Health and Wellness Plan—the program Iowa used under its 1115 waiver to expand Medicaid to individuals with income up to 138% of FPG. Among other findings, the state was able to estimate the number of disenrollees waiting for employer-sponsored health insurance and those who currently had employer-sponsored health insurance.

Conclusion

The end of Medicaid's continuous coverage requirement will force millions of people to navigate new coverage options – a process that will lead to the loss of coverage for some. Understanding where consumers are finding coverage and where gaps may be in a state's coverage system will be a critical information point in managing the healthcare of a state's population.

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ABOUT STATE HEALTH ACCESS DATA ASSISTANCE CENTER

This issue brief was prepared by Elizabeth Lukanen and Robert Hest. State Health Access Data Assistance Center (SHADAC) is an independent, multi-disciplinary health policy research center, housed in the School of Public Health at the University of Minnesota, with a focus on state policy. SHADAC produces rigorous, policy-driven analyses and translates its complex research findings into actionable information for states.