The End of the Public Health Emergency Will Prompt Massive Transitions in Health Insurance Coverage: How State Insurance Regulators Can Prepare

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STATE Health & Value STRATEGIES

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Introduction

The United States has been under a public health emergency (PHE) due to the COVID-19 pandemic since January 2020. With the virus beginning to retreat, it is likely the Biden administration will let the PHE expire, although it has yet to announce when that will be. The end of the PHE not only symbolizes the waning of the pandemic, it also terminates a range of federal health policies enacted to help combat COVID-19 and its associated economic effects. One of the most significant of these is a requirement that states provide continuous coverage for Medicaid enrollees, in exchange for enhanced federal financing. Once the PHE ends, state Medicaid agencies will need to recommence Medicaid eligibility redeterminations and renewals. As a result, up to 16 million people are projected to lose their Medicaid coverage. While many of these will have gained access to employer-sponsored insurance, Medicare, or other sources of coverage, an estimated one-third will be eligible for subsidized coverage in the Affordable Care Act (ACA) Marketplaces. These shifts would represent the largest change in coverage status since implementation of the ACA.

Furthermore, states have a clear imperative to center health equity in their planning for the end of the continuous coverage requirement. People of color are overrepresented in Medicaid and consequently at higher risk of coverage loss when the PHE continuous coverage requirement ends. The state agencies working to help people retain coverage must focus on this population's needs, whether individuals remain Medicaid-eligible or shift to subsidized coverage in the ACA Marketplace or other sources of coverage.

To date, federal officials and advocates have aimed much of their attention at state Medicaid agencies, which will be responsible for processing the redeterminations and renewals of an unprecedented number of people. The Centers for Medicare & Medicaid Services has released three rounds of guidance for state Medicaid agencies (here, here, and here). States are encouraged, but not required, to take up to 14 months to complete the redetermination process, and to proceed at a measured pace in order to ensure a smooth and accurate redetermination process during and after the post-PHE period. However, the enhanced federal financing for Medicaid will stop at the end of the quarter in which the PHE ends. While federal financing will still be available at the standard matching rate, states may face fiscal pressure to perform redeterminations as quickly as possible.

Preparing for Transitions in Coverage: The Role of State Insurance Regulators

Whether a state's Medicaid agency moves swiftly or slowly to process eligibility redeterminations, the commercial insurance market–and particularly the ACA Marketplaces–could experience a significant growth in enrollment. Not only will insurers and the Marketplaces need to be prepared to manage a potential surge in coverage applications, but insurers, brokers, navigators, and others who work with the transitioning population will need to help them understand their options and navigate new provider networks and benefit designs. The potentially massive shift in enrollment could also require that regulators consider the short-term market impact as well as longer term considerations for premiums, enrollment, and market stability. Below we identify several areas in which state departments of insurance (DOIs) may want to coordinate with other agencies or external stakeholders, issue new regulations or guidance, and establish means for minimizing gaps in coverage or access to services.

Financial Stability and Rate Review

Most observers expect the Biden administration to end the PHE during plan year 2022. Individuals who lose their Medicaid eligibility will generally have 60 days after Medicaid coverage ends to enroll in a Marketplace plan. Marketplace insurers could thus face an unexpected and substantial increase in their 2022 enrollment, particularly those insurers offering lower cost plans with $0 premiums for subsidized enrollees. The population transitioning from Medicaid into a Marketplace plan is unlikely to have a significant pent up demand for healthcare services, but there could be some adverse selection as those who most need services will be the most motivated to complete the Marketplace application. In the meantime, individual market insurers are locked in to their current premium rates during plan year 2022. Regulators may want to pay particular attention to the financial status of the lower-cost insurers in their markets to ensure they are sufficiently capitalized to absorb significant new enrollment in the midst of plan year 2022.

Furthermore, because many Medicaid agencies are likely to take up to 14 months to complete the eligibility redeterminations, regulators will need to consider the effect of this large coverage transition on insurers' 2023 proposed rates. At the same time, Congress is debating whether to extend the enhanced premium tax credits provided under the American Rescue Plan Act, which are set to expire at the end of this year. Insurers' assumptions about how many people ultimately enroll–or remain enrolled–in Marketplace plans in 2023, as well as their health status, will affect their proposed premium rates and deserve a close look during the rate review process.

Network Capacity

Many Marketplace plans have narrow provider networks, and these plans are often among the lowest cost options in their service areas. For many subsidy-eligible individuals, these plans may be able to offer $0 premiums. However, a narrow network plan's ability to meet enrollee needs could be strained by a large influx of unexpected enrollment. Many health plans maintain estimates of their maximum enrollment capacity given their network size. Insurance regulators should review those estimates before the PHE ends, so that they can work with Marketplace officials to monitor whether a plan is at risk of reaching its capacity limit. In rare cases, it may be necessary to temporarily suppress enrollment for a plan via HealthCare.gov or the state-based Marketplace website. Insurance regulators will also want to proactively monitor enrollees' network access and ensure that Marketplace insurers remain in compliance with network adequacy standards.

Marketing

Protecting Against Discriminatory Practices

Many insurers who have Medicaid managed care enrollees also market plans in the ACA Marketplace. These insurers will have unique insights into the claims experience of their Medicaid enrollees, as well as access to eligibility and other demographic information. Some may be tempted to steer higher risk individuals away from their Marketplace plans. State insurance regulators may want to remind these insurers that the ACA prohibits insurers from using marketing practices or communicating with enrollees in ways that could discourage the enrollment of people with significant health needs, or based on an individual's race, color, national origin, disability, age, or sex.[1]

Limiting the Deceptive Marketing of Non-ACA Compliant Insurance Products

Insurance regulators should also be prepared to monitor and crack down on marketing tactics that steer former Medicaid enrollees to products that do not comply with the ACA and could expose them to significant financial risk if they need healthcare services. Some insurers and brokers that sell products such as fixed indemnity, short-term plans, and healthcare sharing ministries have been shown to engage in aggressive, and sometimes deceptive

[1] The Biden administration has proposed regulations defining "sex" to include sexual orientation and gender identity, effective plan year 2023.

marketing practices. The marketing of these products tends to increase during the annual open enrollment period, when significant numbers of people are seeking coverage. Although many people transitioning off of Medicaid will be using a special enrollment opportunity, insurers and brokers selling non-ACA compliant products are likely to increase their marketing during this period as well.

Leveraging the Broker Workforce

Many individuals transitioning off of Medicaid will be not be familiar with commercial insurance products, which often have different provider networks and cost-sharing structures than Medicaid does. Navigators, brokers, and other consumer assisters will play a critical role helping people understand their options and use their new coverage. Many state-based Marketplaces are planning to increase their investment in their navigators and call centers to help with this transition. Brokers can be another important part of the consumer assistance workforce, but often insurers pay zero or nominal commissions for brokers to mediate enrollments outside of the annual open enrollment period. State insurance regulators can require Marketplace insurers to adjust their commission schedules for mid-year enrollments so that brokers are adequately compensated for advising people on coverage transitions after the PHE ends.

Special Enrollment Periods (SEPs)

Consumers losing Medicaid coverage will need a SEP to enroll in Marketplace coverage outside the normal open enrollment period, which generally permits enrollment only with a January or February start date. Consumers losing Medicaid should qualify for the "loss-of-coverage SEP," which permits enrollment up to 60 days after Medicaid coverage ends. However, many Medicaid enrollees are expected to be disenrolled because the Medicaid agency no longer has an accurate address or way to contact them; these individuals may learn that they have lost Medicaid only after receiving healthcare services and thus may miss the SEP window.

For individuals who miss their window for a loss-of-coverage SEP, the Biden administration and most state-based Marketplaces have established a year-round SEP for individuals under 150 percent of the federal poverty level. This SEP is only available while the enhanced premium tax credits are available and thus is set to expire at the end of 2022.

Other Medicaid enrollees may be informed of their disenrollment from the program late in a given month. Under federal rules, if an individual enrolls via a loss-of-coverage SEP in a Marketplace plan after the 15th of the month, the Marketplaces can either require an effective coverage date of the first of the following month or the first of the second following month. In other words, in some states if a person is told on August 15 that they are no longer eligible for Medicaid and enrolls in a Marketplace plan on August 16, their Marketplace plan enrollment may not be effective until October 1.

State insurance regulators may wish to discuss with Marketplace officials whether other or expanded SEPs would be appropriate to help people transition from Medicaid to Marketplace coverage. This could include:

- Exercising the "exceptional circumstances" SEP authority to extend the "low-income" SEP to individuals at higher income levels, such as up to 200 percent FPL (as New Jersey has done) or extending it past 2022.
- Using "exceptional circumstances" SEP authority more generally for individuals who lose Medicaid eligibility post-PHE. Many states used this SEP to enable Marketplace enrollment at the start of the COVID-19 pandemic.
- Generously interpreting the SEP for individuals who did not receive timely notice of a triggering event. In this case, the Marketplace could allow individuals who were not immediately aware of their disenrollment from Medicaid to attest that they did not receive timely notice and receive a 60-day window to enroll.
- Ensuring that Marketplace plan coverage is effective on the first day of the month after a person losing Medicaid coverage enrolls, even if that person enrolls after the 15th of the month.

Continuity of Care

Many individuals disenrolled from Medicaid after the PHE ends will be in the middle of a course of treatment. Yet they will need to enroll in a new insurance product that likely has a different provider network. This could leave many people at significant financial risk for the cost of out-of-network services at a time when they are least able to manage the disruption in coverage and care. The federal government and 39 states have enacted “continuity of care” laws that require insurers to cover services as if they are “in network” for enrollees in the middle of treatment, terminally ill, or in the last trimester of pregnancy. These continuity of care protections are most often triggered when a provider is terminated from an enrollee’s network. But in 13 states, insurers must also provide the protection when an enrollee is switching from Medicaid to a new health plan. State insurance regulators could assess their existing continuity of care laws and determine whether the protections could be expanded to ensure that people who are disenrolled from Medicaid and in the middle of treatment or have other significant healthcare needs do not immediately lose access to critical in-network providers. These protections could also be temporarily extended to people who make good faith efforts to enroll in Marketplace coverage after losing Medicaid eligibility, but due to SEP effective date rules still experience a short gap in coverage.

Similarly, many people losing their Medicaid eligibility will have had the use of services or prescription drugs approved by their Medicaid plan. In general, when a person switches to a new plan, they must re-initiate any requests for prior authorization or formulary exceptions. These processes can impose significant burdens on patients and hinder access to critical and often life-saving services and drugs. For individuals transitioning from Medicaid to the Marketplace at the end of the PHE, insurance regulators should assess their authority to require or encourage Marketplace plans to honor the prior authorizations and/or formulary exceptions granted by an enrollee’s prior Medicaid plan.

Many people will also likely need to transition to a Marketplace plan in the middle or late in the plan year, meaning that they will face an annual deductible and out-of-pocket maximum that is not prorated to reflect the months they are covered. As a result, many who enroll later in the year could find that their coverage is effectively illusory. State insurance regulators should work with Marketplace plan insurers to consider options for prorating deductibles and out-of-pocket maximums, on a temporary basis, for individuals who lose Medicaid eligibility later in the plan year. Public communications may also be helpful to explain this dynamic to consumers, who may be confused given that Medicaid typically has no deductible. Insurance regulators may also want to ensure their state Medicaid agency is aware of this dynamic and discuss potential mitigations, such as timing eligibility redeterminations for this population to be as close as possible to the beginning of the plan year.

Conclusion

The end of the PHE could trigger a significant loss of health insurance coverage for the almost 86 million people currently enrolled in Medicaid. But this is not inevitable; the planning and efforts of state agencies will determine whether and how people fare after their Medicaid eligibility is reassessed. With an estimated one-third of those losing Medicaid eligible for subsidized commercial market insurance, state DOIs are critical actors in these state efforts.

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This issue brief was prepared by Sabrina Corlette. CHIR is comprised of a team of experts on private health insurance and health reform. Based at Georgetown University's McCourt School of Public Policy, CHIR conducts research and policy analysis and provides technical assistance to federal and state policymakers, regulators, and consumer advocates. Learn more at *https://chir.georgetown.edu/*.

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