CONSUMER LIAISON COMMITTEE

Medicaid Unwinding and Best Practices

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Medicaid Unwinding and Best Practices

Consumer Liaison
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Where are we now?
Medicaid eligibility was determined:

- At time of application
- During regular redeterminations
  - For MAGI populations (most children, pregnant women, parents, expansion adults), once every 12 months
  - For non-MAGI populations (most blind, disabled, or elderly enrollees), at least once every 12 months
- When Medicaid agency received new eligibility information
  - Self-reporting by enrollees
  - State data-matching systems (for income, assets, disability, immigration status, etc.)
Pandemic-Era Changes

- At the beginning of Covid-19 Public Health Emergency (PHE), Medicaid annual redeterminations were paused & most computer checks were not done

- Medicaid terminations were also prohibited under the Families First Coronavirus Response Act (except in very limited circumstances)

- This was originally set to extend through the end of the PHE, but the Inflation Reduction Act of 2022 set March 31, 2023 as the end of this “continuous coverage” requirement
Resumption of Annual Recertifications

- States have 12 months to initiate (and 14 months to complete) recertifications for all current Medicaid enrollees
  - As of October 2022, 91.3 million Americans were enrolled in Medicaid or CHIP, 20.2 million (28.5%) more than in February 2020
- Most individuals no longer eligible for Medicaid have other coverage options
  - Employer-sponsored coverage
  - Marketplace plans
  - Medicare
- ASPE projects that as many as 15 million Americans will lose Medicaid coverage during unwinding
  - 8.2 million who have lost Medicaid eligibility
  - 6.8 million who will be disenrolled despite remaining eligible (administrative churn)
  - More than half of those expected to be disenrolled despite continuing eligibility are children under age 17
How will renewals take place?

• Ex Parte renewal
  • Done when Medicaid agency can verify income and all other eligibility information independently
  • Enrollee will be passively renewed and will simply receive a notice informing them of renewal

• Full renewal
  • Done when Medicaid agency does not have sufficient information for passive renewal, when individual has changed category, or when ex parte renewal processes have not been established
  • Requires that enrollee respond providing information and documentation to demonstrate continuing eligibility for Medicaid