

Fixing Unintended Pandemic Medicaid Policy Consequences: Lessons Learned and Insurance Coverage Implications for Recipients

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How we got here: Medicaid grows from continuous enrollment

Congress takes action to allow millions to retain access to affordable health insurance during pandemic.

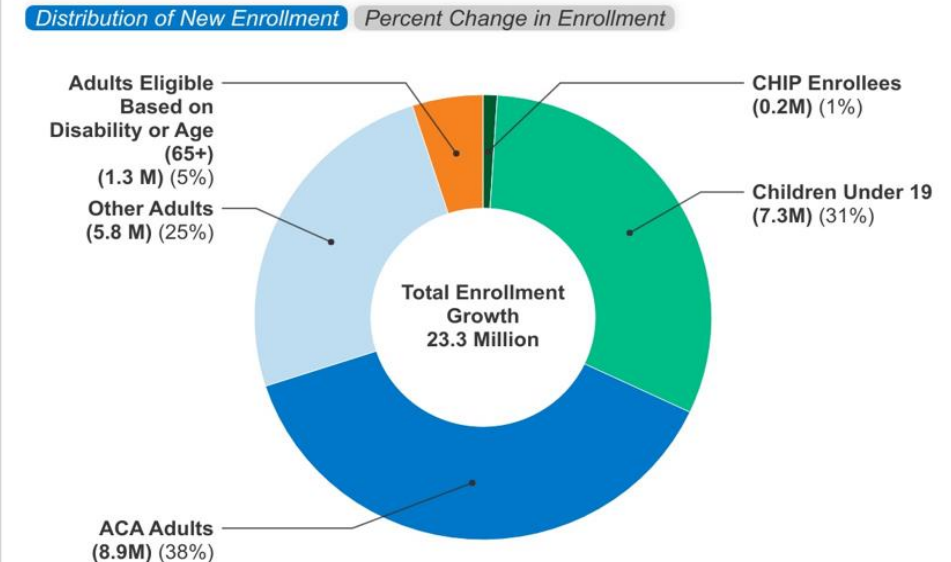
- Passes **Families First Coronavirus Response Act (FFCRA)** in 2020, requiring state Medicaid programs to maintain continuous enrollment through end of PHE in exchange for enhanced federal funding.
- Assisted those who became unemployed to ensure access to care.

Per KFF data, Medicaid enrollment grew by **23.3 million** individuals between Feb. 2020 to March 2023, when continuous enrollment ended and renewals resumed.

Continuous enrollment mitigated potential for “churn” (temporary coverage loss) among enrollees.

Medicaid Children, Adults Eligible through the ACA, and Other Adults Comprised the Vast Majority of Enrollment Growth.

Distribution of Total Enrollment Growth From February 2020 to March 2023



NOTE: Totals may not sum to 100% due to rounding. CHIP = Children's Health Insurance Program. ACA = Affordable Care Act. Enrollees with partial benefits were excluded. Regardless of how they became eligible, Medicaid children includes all enrollees under age 19 and all other groups include enrollees age 19 and older (except for adults ages 65+).

SOURCE: KFF estimates based on analysis of enrollment data from the Centers for Medicare and Medicaid Services (CMS) Performance Indicator Project (PI data), and the T-MSIS Research Identifiable Files, 2019. See methods of KFF's Medicaid Enrollment Growth: Estimates by State and Eligibility Group Show Who may be at Risk as Continuous Enrollment Ends for more information.

KFF

How we got here: Redetermination process resumes in March 2023

- **Consolidated Appropriations Act, 2023** delinked continuous enrollment provision from PHE, ending continuous enrollment and phasing down enhanced federal Medicaid matching funds through December 2023.
- States have resumed redeterminations and terminations of program enrollment for those ineligible (most states opted to take 12-14 months, and as of March, they are a little over halfway through).
- Data show wide variation in the number of people who have been disenrolled across states, some who are eligible for another form of coverage such as a federally-subsidized Marketplace plan or employer sponsored insurance.
- States have several options to mitigate inappropriate loss of Medicaid coverage, often referred to as “procedural” terminations and caused by (for example, an individual not receiving a paper form).
- CMS, States, and Health Plans have been working together for 2+ years to enhance systems, share ideas, and spread information to consumers to mitigate inappropriate coverage loss and to inform individuals of potential alternative coverage options.

Redeterminations results by the numbers

According to KFF,

- States have thus far renewed **43%** of March 2023 Medicaid enrollees, disenrolled **20%**, and **36%** of renewals remain.
- As of March 2024, at least **18,220,000** Medicaid enrollees have been disenrolled from Medicaid coverage (though may have found alternative coverage).
- Across all states, **70%** of the cohort disenrolled have been terminated for procedural reasons (this varies widely by state and has improved over time).
- In the states reporting, Children account for **38%** of Medicaid disenrollments.
- Majority (**59%**) who retain coverage are renewed via ex parte (automated renewal via data matching).

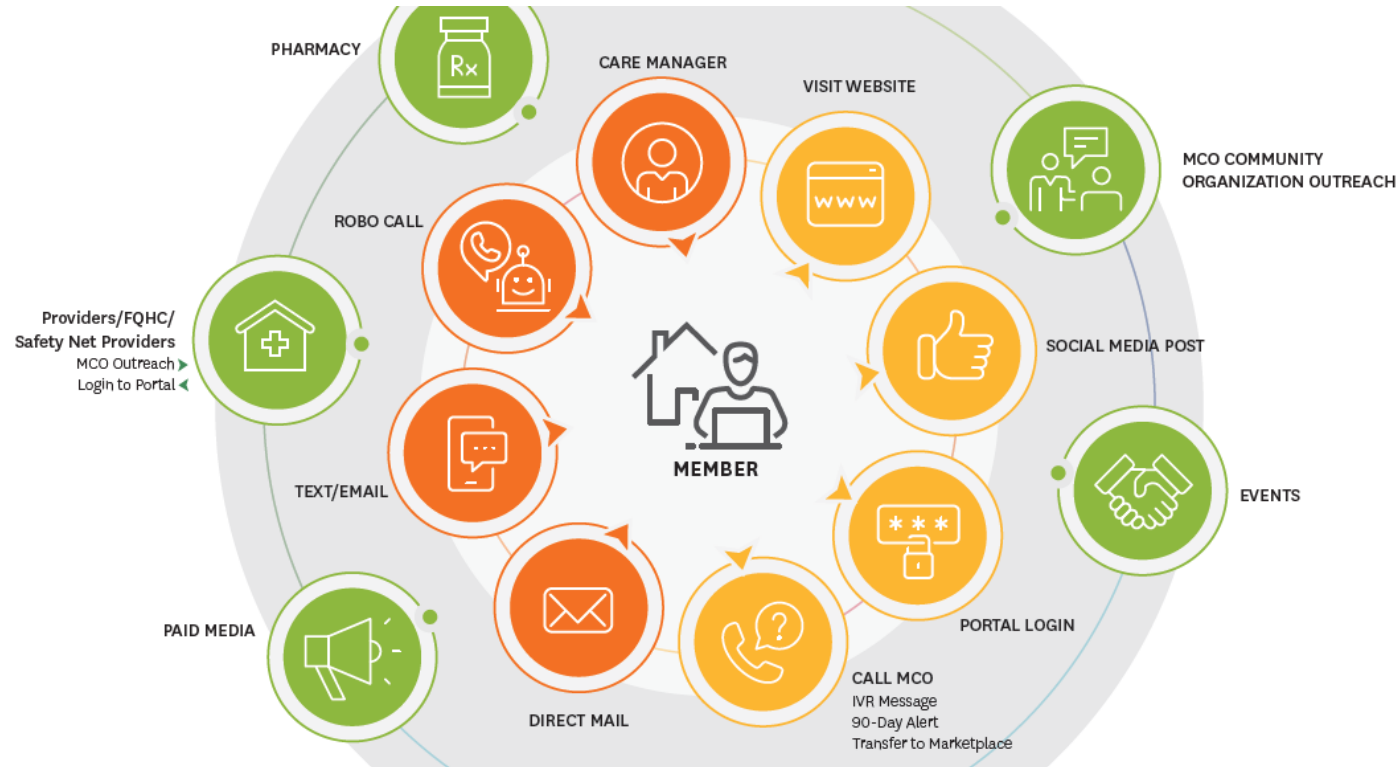
Health plans continue to play essential role in Medicaid redeterminations

- As noted, Medicaid coverage renewal is an often **complex and convoluted process** involving antiquated paper forms, particularly for those with limited English proficiency.
- Our **states have been strong partners** throughout the unwinding period, and many have taken advantage of **new CMS flexibilities and MCO partnership strategies**, enabling us to better assist our members in efforts to retain coverage.
- Centene is working to **reach individuals** who may be affected by Medicaid redeterminations in several ways, as permitted by each state's regulations:
 - Connecting members and providers to information, resources, state renewal systems.
 - “Meeting the member where they are” by partnering with CBOs like food pantries, homeless shelters, community health centers, and state and local health departments.
 - Working with states to track operational challenges, remove outreach barriers.
- Plans with Marketplace options are playing a pivotal role in ensuring **smooth coverage transitions** for those eligible.

Centene's commitment to keeping members covered

Centene's goal is to ensure members will have the appropriate health coverage by providing timely education across multiple interaction points on actions they need to take stay covered

Meeting the Member Where They Are



Member interactions

- ✓ Proactive, timely direct to member outreach via multiple channels **(including text and email)**
- ✓ Responsive support through trained call centers and clinical staff
- ✓ Self service tool & information on portals
- ✓ Mass community awareness
- ✓ Provider partnerships & support
- ✓ Community partnerships & support

Key messages

- ✓ Awareness
- ✓ Education
- ✓ Reminders
- ✓ Urgent Action Needed
- ✓ Other Product Availability

State and local collaboration efforts

Plan participated in successful pilot to update member contact info in state system

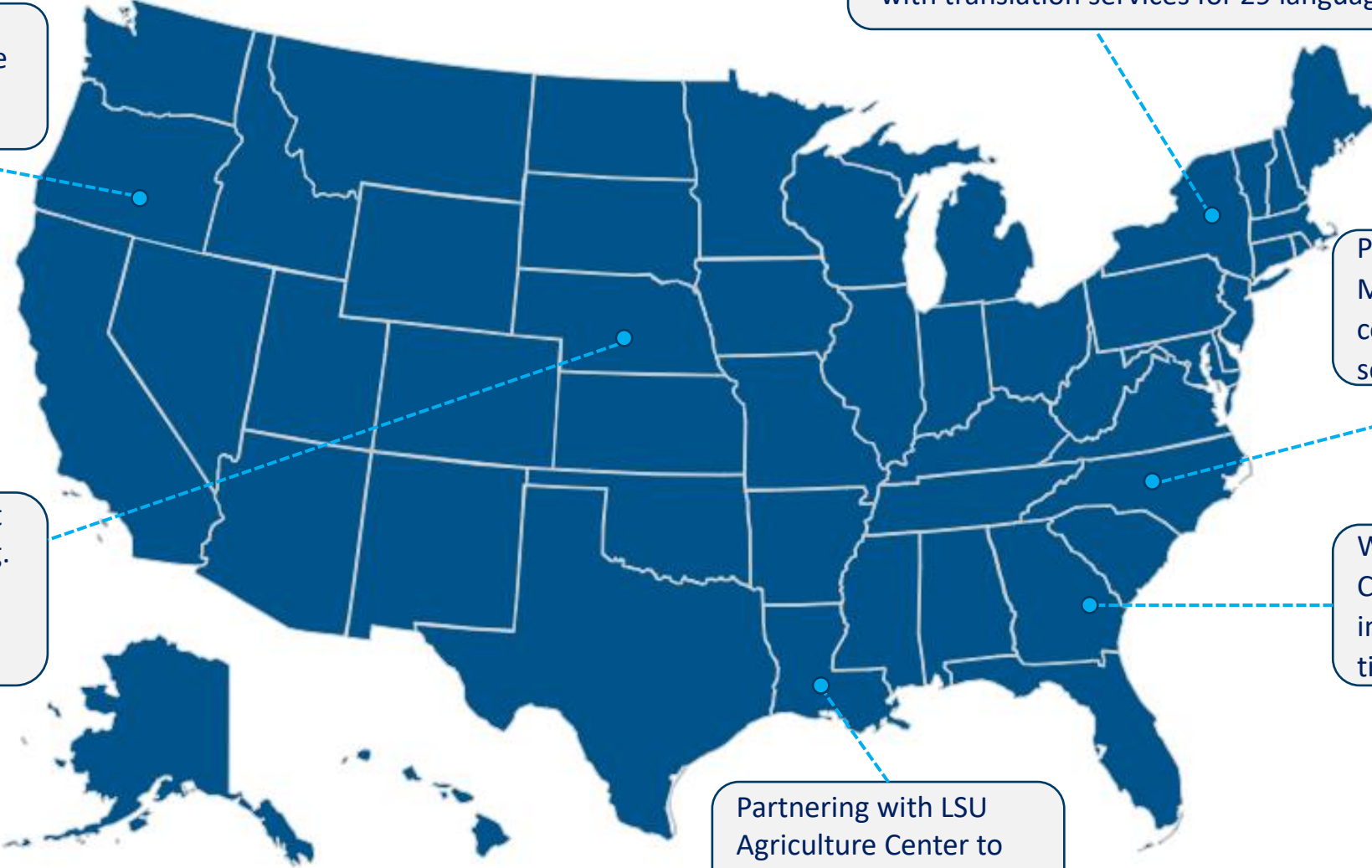
Mobile RVs travel the state to directly assist members with renewal paperwork, with translation services for 29 languages.

iPad “stations” posted at community locations (e.g. libraries) to ensure easy access to state renewal portals

Partnering with Charlotte-Mecklenburg Schools to connect with parents and school administrative staff

Working with Boys & Girls Clubs to spread educational information at child pick-up times

Partnering with LSU Agriculture Center to spread information via local Food Banks



Unwinding lessons learned: We're all in this together

There is a need to further modernize the Medicaid Eligibility and Enrollment process

- Despite collaborative efforts and many positive state actions, **barriers to reducing friction in the enrollment process** remain:
 - Ex parte system improvements must continue.
 - Data inaccuracies and lack of standardization (e.g. contact information) cause complexities.
 - Post-disenrollment outreach is not allowed in all states.
 - *Nationwide, 71% of those disenrolled as of March 2024 have been terminated for procedural reasons (KFF).*
- We are continually advocating for enhanced **MCO and state waiver flexibilities** and renewal **system enhancements**.
 - Academic research may be starting to show that states with more waivers have lower disenrollment rates.
 - Future studies should examine factors including state timelines, strategies, and communication methods.
 - MD has demonstrated strong [Medicaid to Marketplace transition outcomes](#)*, possibly a factor of enhanced flexibility.

*According to a recent analysis from Maryland Health Benefit Exchange, “14,089 individuals statewide that were no longer eligible for Medicaid enrolled in a QHP during open enrollment between November 1, 2023, through January 15, 2024, a 375% increase from 2,966 individuals in calendar 2023”.

Implications: Unwinding presents an opportunity for continued state, MCO collaboration

- Unwinding has highlighted importance of **modern state and MCO outreach flexibilities and renewal assistance**.
- Consumers should have accessible, affordable options. For example, **Medicaid to Marketplace transitions should be streamlined**.
 - Permanent **eAPTC extension** would maintain access to affordable coverage.
- Opportunity to continue **state and MCO collaboration** to share usable information to target and **address SDOH challenges**.

Implications: Traditional Medicaid Churn and the PHE Unwinding Provide an Opportunity to Ensure Continuity of Coverage for Those who Become Marketplace-Eligible

Centene's Medicaid & Marketplace Footprint*

