



WHITE PAPER

*By Shanna Hanson, FHFMA, ACB
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NAVIGATING THE MARKETPLACE POST-PHE

The COVID-19 Public Health Emergency, declared by the Department of Health and Human Services (HHS) Secretary, is anticipated to extend past the mid-term elections and into January 2023. Over the course of the 14 months after the COVID-19 Public Health Emergency ends (“unwinding” period), an estimated 16 million people are expected to lose Medicaid/CHIP coverage.

The health insurance Marketplace, established by the Affordable Care Act, is expected to mitigate the loss of Medicaid/CHIP coverage. A recent analysis by [MACPAC](#) identified that only about 3 percent of adult and child beneficiaries who were disenrolled from Medicaid or CHIP in 2018 enrolled in exchange coverage within 12 months and had an average coverage gap of 3 months. The [Urban Institute](#) in 2021 estimated that 33 percent of adult beneficiaries who lose Medicaid would be eligible in 2022 for a Qualified Health Plan (QHP), sold on the Marketplace, with premium tax credits. Of the children losing Medicaid, 57 percent would be eligible for CHIP, and an additional 9 percent would be eligible for Marketplace coverage with premium tax credits. There is clearly work to be done to minimize loss of coverage and maximize continuity of coverage.

This white paper examines the transition between insurance affordability programs and the role of the Marketplace, Qualified Health Plans, and Medicaid Managed Care Organizations for the [88 million](#) Medicaid/CHIP beneficiaries who must renew their coverage during the unwinding period.

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INSURANCE AFFORDABILITY PROGRAMS (IAPS)

Section 1943 of the Social Security Act (the Act), added by section 2201 of the Affordable Care Act (ACA) and regulations at 42 CFR §§435.1200, 457.348, and 457.350, requires coordination of eligibility and enrollment among insurance affordability programs.

[Insurance Affordability Programs](#) or "IAPs" include:

1. A **Qualified Health Plan (QHP)** available through the Marketplace with Tax Credits and/or Cost Sharing Reductions (CSR)
2. The **Medicaid** program established under Title XIX of the Act
3. The **Children's Health Insurance Program (CHIP)** established under Title XXI of the Act
4. The **Basic Health Program (BHP)** established under § 1331 of the Patient Protection and Affordable Care Act (PPACA). A state option, BHP provides coverage to consumers with incomes below 200 percent of the federal poverty level (FPL), who are not eligible for Medicaid/CHIP. Only New York and Minnesota have exercised this state option.

States are required to assess their beneficiaries for all applicable IAPs if they no longer qualify for the coverage they are receiving. This assessment will vary by state and type of Marketplace the state uses.

MARKETPLACE

There are three [healthcare marketplace types](#), as defined by the Kaiser Family Foundation:

- **State-based Marketplace (SBM):** States running a State-based Marketplace are responsible for performing all marketplace functions for the individual market. Consumers in these states apply for and enroll in coverage through marketplace websites established and maintained by the states.
- **State-based Marketplace-Federal Platform (SBM-FP):** These states are considered to have a State-based Marketplace and are responsible for performing all marketplace functions for the individual market, except that the state will rely on the federal Healthcare.gov website for eligibility and enrollment functions. Consumers in these states apply for and enroll in coverage through Healthcare.gov.
- **Federally-facilitated Marketplace (FFM):** In a Federally-facilitated Marketplace, HHS performs all Marketplace functions. Consumers in FFM states apply for and enroll in coverage through Healthcare.gov.



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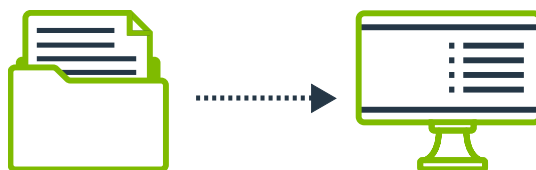
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There are [currently](#) 18 states with an SBM, three states with an SBM-FP, and 30 states using the FFM. Six of the states with an SBM have transitioned since 2020!

States with an SBM vary in their capabilities and process. Over half of the 18 states have [integrated systems](#) with Medicaid/CHIP. This allows them to conduct eligibility determinations for all IAPs with one system for new applicants and those requiring a renewal or redetermination. In 2021, these states were California, Connecticut, Massachusetts, Maryland, Minnesota, New York, Rhode Island, Vermont, and Washington. Other SBMs operate more like the FFP, as they lack the ability to process a Medicaid/CHIP renewal or redetermination.

States without an integrated SBM, along with those using the FFP or SBM-FP, are required to transfer the electronic account of Medicaid/CHIP beneficiaries determined ineligible, along with all their data, to the Marketplace in a timely manner. There are exceptions. For example, if the beneficiary was determined ineligible due to procedural reasons (did not comply, timeliness, etc.), does not attest to U.S. citizenship or lawful presence, or loses Medicaid but has Medicare.



The Centers for Medicare and Medicaid Services (CMS) published [Eligibility & Enrollment Processing for Medicaid, CHIP, and BHP During COVID-19 Public Health Emergency Unwinding. Key Requirements for Compliance](#) on May 17, 2022. Following are Examples of Accounts to Transfer to the (FFM) Marketplace.

Medicaid and CHIP agencies must transfer accounts for:

1. Parents with income verified as above the Medicaid limit, even though children may be eligible and remain enrolled in Medicaid or CHIP
2. Applicants determined ineligible for MAGI-based Medicaid, even if they are being evaluated for coverage on a non-MAGI basis
3. Children determined ineligible for CHIP during a "waiting period." (States must have safeguards in place to prevent loss of coverage at the end of the waiting period, when these children become eligible for CHIP.)
4. Applicants who are lawfully present but ineligible for Medicaid/CHIP based on immigration status (e.g., applicants within 5-year waiting period)
5. Individuals only eligible for coverage that is not Minimum Essential Coverage (MEC), such as coverage limited to family planning services or other limited-benefit programs



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SPECIAL ENROLLMENT PERIODS (SEP)

The Medicaid/CHIP agency is required to send a notice to the beneficiary letting them know that their coverage has not been renewed and making them aware of their appeal or review rights.

This non-renewal or termination notice begins a 60-day loss-of-coverage special enrollment period (SEP), allowing the individual to be reviewed for Marketplace coverage outside the open enrollment period (OEP). There is another SEP for individuals who miss the loss-of-coverage SEP and are under 150 percent FPL. *See Enhanced Premium Tax Credits below for more information.*

States have other options too. An Issue Brief published March 2022 and titled [The End of the Public Health Emergency Will Prompt Massive Transitions in Health Insurance Coverage: How State Insurance Regulators Can Prepare](#) put forth the following:

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.



ENROLLMENT

There are two options once an individual's account is electronically transferred to the Marketplace:

1. Individuals can wait to receive a notice and instructions from the FFM directing them to go to the Marketplace online or the call center to complete their electronically transferred application.
 - Pro:** Some data may be populated, avoiding extra work
 - Con:** Waiting on the notice and instructions, which could also impact the coverage start date
2. Individual can start a new application through the Marketplace online or the call center.
 - Pro:** Individual controls the timing of getting the application completed
 - Con:** Starting from scratch without prepopulated data



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This process can be daunting. Administrative barriers and denials, the time and effort involved, lack of education and understanding, and language, are all barriers to obtaining coverage.

Some state Marketplaces are paving an easier path to coverage. California's SBM, called Covered California, is a good example. Beginning late this year (2022), consenting Californians who lose Medicaid coverage will [automatically be enrolled](#) into zero-premium Marketplace plans. An [estimated 25 percent to 30 percent](#) of Californians losing Medicaid eligibility will qualify for marketplace enrollment through the new process.

[Massachusetts and Rhode Island are exploring](#) similar programs. There are [other strategies](#) to streamline the transition process, short of full auto enrollment, including using internal and external data sources to prepopulate consumers' applications and conduct preliminary eligibility determinations.



Typically, a Marketplace application made between the 1st and 15th of the month results in coverage that starts the 1st of the following month. Application made after the 15th of the month results in coverage that begins the 1st of the second following month.

The point here is that there could be a significant gap in coverage for an individual losing Medicaid/CHIP eligibility and obtaining Marketplace coverage. The [MACPAC](#) analysis found that 70 percent of adults and children moving from Medicaid to exchange coverage had gaps with an average gap of 3 months. A Marketplace can require an effective date of the 1st of the following month, even if the individual applies after the 15th. This can still leave a gap in coverage.

Issue Brief [The End of the Public Health Emergency Will Prompt Massive Transitions in Health Insurance Coverage: How State Insurance Regulators Can Prepare](#) addresses this under Continuity of 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.



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ENHANCED PREMIUM TAX CREDITS

The American Rescue Plan Act (ARPA) was signed into law by President Joseph Biden on March 11, 2021, to provide COVID-19 relief. ARPA includes subsidies that lower health care costs and expand access to health coverage. Starting January 1, 2021, for enrollees or re-enrollees on or after April 1, 2021, ARPA made several significant Marketplace changes as noted below:

- Bronze plans are available for free
- Benchmark silver-plans are available for free to enrollees with incomes between 100 and 150 percent of the FPL
- Gold plans are affordable to enrollees in many states
- For the first time, subsidies are available to people with incomes above 400 percent FPL
- Does not decrease cost sharing

[Table 1](#) below from the Kaiser Family Foundation, offers a good illustration of the before and after ARPA changes for the Benchmark Silver Plan.

Table 1: Percent of Income Paid for Marketplace Benchmark Silver Premium, by Income		
Income (% of poverty)	Affordable Care Act (before legislative change)	COVID-19 Relief (current law 2021-2022)
Under 100%	Not eligible for subsidies*	Not eligible for subsidies**
100% – 138%	2.07%	0.0%
138% – 150%	3.10% – 4.14%	0.0%
150% – 200%	4.14% – 6.52%	0.0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
Over 400%	Not eligible for subsidies	8.5%

NOTES: *Lawfully present immigrants whose household incomes are below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.
**In the COVID-19 relief law, lawfully present immigrants in states that have not expanded Medicaid would continue to be eligible for marketplace subsidies. In addition, people receiving Unemployment Insurance (UI) are treated as though their income is no more than 133% of poverty for the purposes of the premium tax credit. This could extend premium tax credits to some individuals with incomes below poverty.
SOURCE: KFF

Subsidies are tax credits available to qualified enrollees in advance or at tax filing. Advance credits are known as Advance Premium Tax Credits or APTCs. The qualifying amount comes off the premium to lower the monthly cost. Premium Tax Credits or PTCs do not come off the monthly amount but get reconciled at tax filing, resulting in a probable tax refund. APTCs and PTCs are both reconciled at tax filing and could result in a liability, refund, or break-even. The choice of tax credits is up to the enrollee and the professionals they wish to call on for advice or support.



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According to a [Fact Sheet](#) published by HHS on June 22, 2022:

- A record-breaking 14.5 million people signed up for health insurance coverage through both federal Marketplace (via HealthCare.gov) and State-Based Marketplaces during the 2021/2022 Open Enrollment period
- More than 90 percent of the people on HealthCare.gov received financial assistance
- 4 out of 5 people could find plans that cost less than \$10 per month on HealthCare.gov
- Families saw savings of \$67 per person per month in premiums in 2021



The enhanced subsidies available because of ARPA were due to expire on December 31, 2022, however, the Inflation Reduction Act, passed by Congress on August 12, 2022, renews them for three years. They are now set to expire December 31, 2025, unless Congress acts to extend them beyond that. Marketplace open enrollment begins November 1, 2022, for coverage to start as early as January 1, 2023.

MEDICAID MANAGED CARE

Medicaid Managed Care Organizations (MCOs) have the potential to play a leading role in Marketplace coverage transitions when the PHE ends. [42 CFR § 438.104 Marketing activities](#) clarifies that while an MCO cannot influence a beneficiary to enroll in their Medicaid product, that does not include communication to a Medicaid beneficiary from the issuer of a QHP about their QHP.

MCOs provide both [Medicaid and Marketplace coverage](#) in 67 percent of counties and for 81 percent of the population! "Overlap plans" are those where an MCO participates in both markets in the same [geography](#).

States provide the MCOs with a list of Medicaid/CHIP beneficiaries whose coverage is up for renewal. MCOs can help with renewal outreach to their members. States can also provide the MCOs with a list of non-renewals. The MCO can work with their members to transition them to their QHP.

MCOs can market their QHP to current or terminated Medicaid/CHIP beneficiaries and help them enroll. They do not have to wait until a loss of coverage occurs which means it can be avoided. In turn, this promotes coverage continuity.



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[CMS recommends](#) that states and MCOs carefully review their contracts to ensure clarity on this issue and consider whether any state-specific laws or contract requirements may prevent this activity.



SUMMARY

More than 88 million Medicaid/CHIP beneficiaries will need to renew their coverage during the 14-month unwinding period after the Public Health Emergency ends. Pre-pandemic, 25-30 percent of renewals resulted in disenrollment of beneficiaries who were eligible. That number could skyrocket after three years without states conducting renewals.

An estimated 16 million people are expected to lose Medicaid/CHIP coverage once the Public Health Emergency ends. Adults and children who lose Medicaid could be eligible for a Qualified Health Plan, sold on the Marketplace, with premium tax credits. Medicaid Managed Care Organizations with overlap plans can assist in this transition. It will take all of us working together to minimize loss of coverage and maximize continuity of coverage.

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