OFFICE OF LEGISLATIVE RESEARCH
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ResearchReport

Medicaid Unwinding

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August 17, 2023 | 2023-R-0162

Issue

This report answers questions on the end of pandemic-related continuous enrollment for Medicaid and the process of redetermining Medicaid enrollee eligibility (i.e., "unwinding").

What is unwinding?

State and federal agencies are using the term "unwinding" to refer to plans and steps taken to plan for the end of the COVID-19 public health emergency. As described by the Department of Social Services (DSS), unwinding planning "seeks to ensure that states can transition back to normal operations while limiting coverage disruptions in a manner that minimalizes the burden for both states and individual enrollees."

With respect to Medicaid enrollment, unwinding generally refers to the resumption of annual eligibility redeterminations, which had paused while continuous enrollment was in effect (see below).

What is continuous enrollment and when did it end?

Generally, federal law requires states to redetermine eligibility for Medicaid enrollees at least annually. If a person no longer meets eligibility requirements (e.g., if income has increased above income limits or if a child has aged out of the household), state Medicaid agencies must disenroll the person from Medicaid.

In March 2020, Congress enacted the Families First Coronavirus Response Act (P.L. 116-127). Among other things, the act increased federal Medicaid matching funds paid to states and established certain requirements for states to receive the enhanced match. The "continuous enrollment provision" required that states allow people who were enrolled in Medicaid when the law was passed to remain enrolled until the federal public health emergency ends, with certain exceptions (e.g., if the person voluntarily terminates coverage or moves out of state) (§ 6008(b)(3)).

In December 2022, Congress passed the Consolidated Appropriations Act ((CAA) P.L. 117-328), which (1) required that continuous enrollment end on a specific date (March 31, 2023) rather than when the federal public health emergency ends (the emergency ended May 11, 2023) and (2) phased down the enhanced federal matching funds through December 2023. The CAA also required CMS to reduce federal matching funds for states that fail to report monthly data on redeterminations over this period (CAA, § 5131(b)).

How are Connecticut state agencies implementing the unwinding?

Unwinding Process

According to the federal Centers for Medicare and Medicaid Services (CMS), during the unwinding period states must initiate a renewal of every beneficiary enrolled in their Medicaid program as of the end of the month before the unwinding period starts. The unwinding period lasts for approximately one year. CMS allowed states to choose to begin their unwinding processes in February, March, or April 2023. (An archive of CMS letters and guidance to states is available here.)

In Connecticut, approximately 1.23 million people were enrolled in Medicaid as of the start of unwinding. During the state's unwinding process, approximately one-twelfth of this population (about 100,000 people) will be subject to an eligibility review each month, beginning with those who have been continuously enrolled the longest and ending with the last unwinding-related disenrollment on March 31, 2024.

DSS began the unwinding process by notifying the first cohort in March that they must act by the end of April to renew their coverage. The department begins renewals about 60 days before a person's eligibility period ends and first attempts a "passive renewal": the department uses information from the person's latest application and matches it against available electronic data sources. If DSS can validate the information or it is reasonably compatible, the department will automatically renew coverage. The enrollee does not need to take any further action, but DSS

advises the enrollee to report any changes in circumstances to the department. DSS estimates that more than half of the Medicaid population will be automatically re-enrolled this way.

For enrollees who cannot be renewed through the passive renewal process, DSS sends out renewal notices by the 15th of each month to members who need to renew by the end of the following month. HUSKY A, B, and D members may complete renewals or report changes through Access Health CT, the state's health insurance exchange. (HUSKY B is the Children's Health Insurance Program (CHIP). CHIP is funded separately from Medicaid but is subject to similar continuous eligibility and unwinding requirements.)

Outreach Efforts

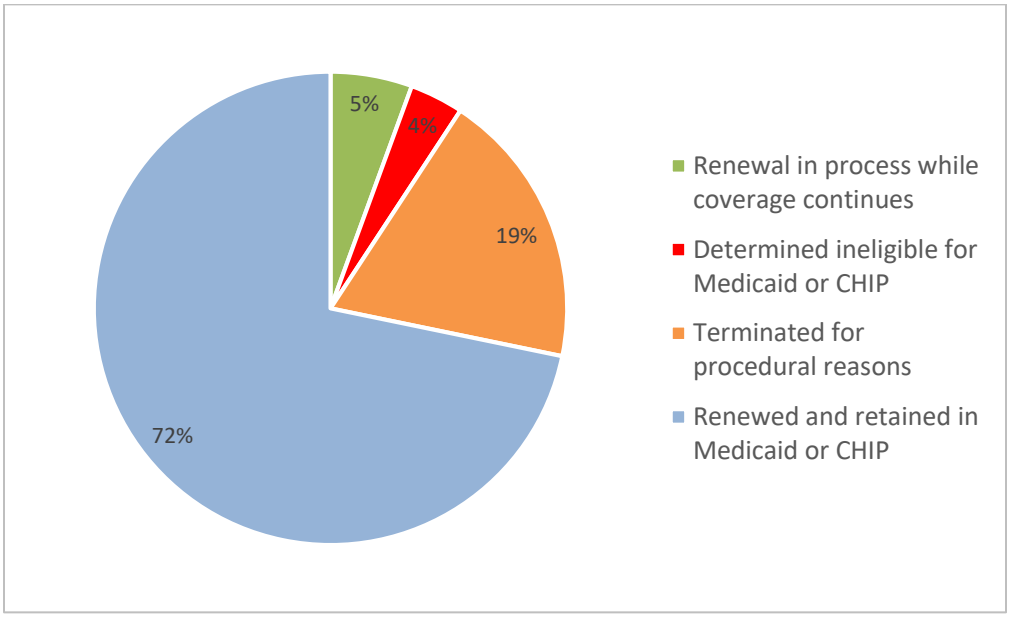
DSS has conducted an outreach campaign encouraging enrollees to update their contact information with the department in order to ensure they receive notices about redetermination requirements ("Update Us So We Can Update You"). The outreach included partner toolkits, webinars, flyers (in English and Spanish), billboards, bus ads, text messages, and other publications. Additionally, the administrative service organizations that contract with DSS have directly contacted Medicaid enrollees who would be at "high risk" if they had disrupted coverage (e.g., someone being treated for cancer).

How many people were disenrolled from Medicaid or CHIP from April to June 2023?

Redetermination Outcomes

In July, the CTMirror reported outcomes for cases processed from April to June, shown in Figure 1. Approximately 274,000 enrollees went through a redetermination during this period. Of these, approximately 23% (more than 62,000) were disenrolled either for procedural reasons or were determined ineligible. An additional 5% have renewals in process and generally are enrolled conditionally for up to 90 days pending DSS's receipt of verification documents.

Figure 1: April Through June 2023 Medicaid and CHIP Renewal Processing Outcomes



Source: CTMirror

According to DSS, the most common procedural reasons for termination were failure to renew and voluntary withdrawal. DSS believes that people may fail to renew for any of the following reasons:

1. having insurance through employers;
2. having significantly more income than when they enrolled;
3. life changes that make them ineligible (e.g., a child leaving the household); or
4. not receiving notice of their coverage ending, despite the department's outreach efforts.

DSS may determine someone ineligible for Medicaid or CHIP for various reasons (e.g., aging out of coverage or having income over eligibility limits).

Those able to renew their Medicaid or CHIP will retain their coverage. DSS will redetermine their eligibility for coverage at least annually, in accordance with existing state and federal requirements in effect before the pandemic.

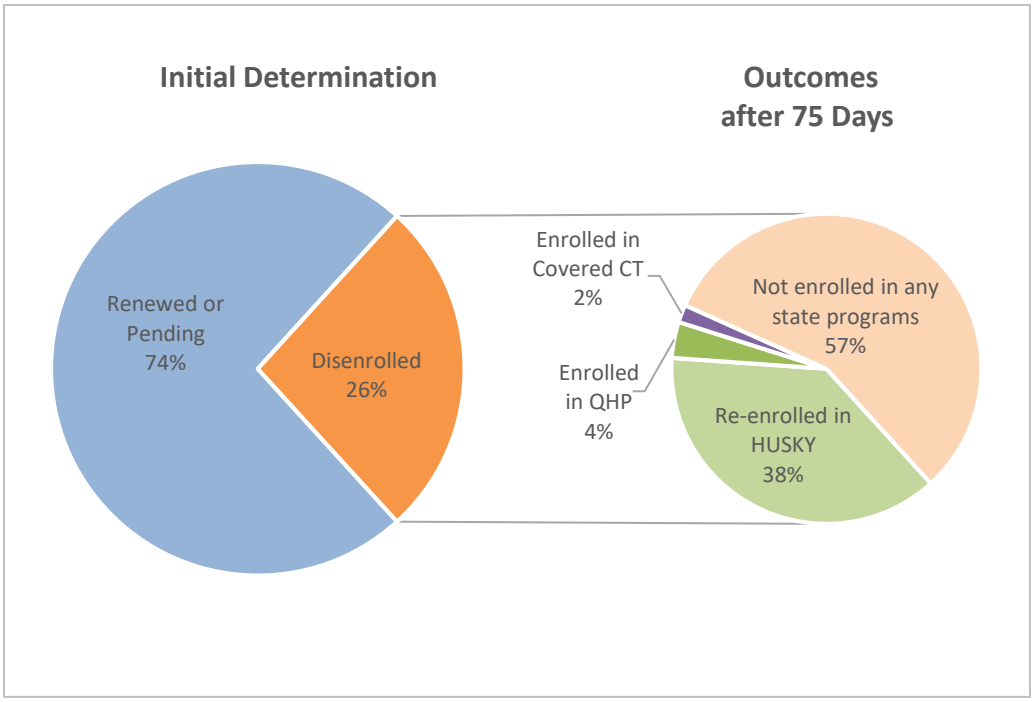
Subsequent Re-Enrollment

Based on available information, it appears that some portion of people disenrolled during unwinding so far have either re-enrolled in Medicaid or CHIP or enrolled in other coverage (e.g., Covered Connecticut or a qualified health plan (QHP)). (Unlike other health insurance, Medicaid

does not have an “open enrollment” period. Those who lose coverage for procedural reasons but are still eligible may reapply at any time.)

According to DSS, more than 40% of the April cohort has re-enrolled in HUSKY or some other coverage, as shown in Figure 2. Specifically, of the 85,332 people who went through redeterminations in April, 62,738 renewed coverage and 22,594 were disenrolled. Within 75 days after this initial determination, of those who were disenrolled, 8,560 re-enrolled in HUSKY (i.e., Medicaid or CHIP), 849 enrolled in a QHP, and 416 enrolled in Covered Connecticut. DSS noted similar trends emerging for the May and June cohorts.

Figure 2: April Cohort Outcomes 75 Days After Initial Determination



DSS also used various data sources to examine household income for people who did not renew for procedural reasons in April and May and found that about 60% had income exceeding HUSKY income limits (suggesting that these households may not be taking action to renew coverage because they believe they are ineligible or may now have employment that includes health benefits).

What information is available about people who were disenrolled?

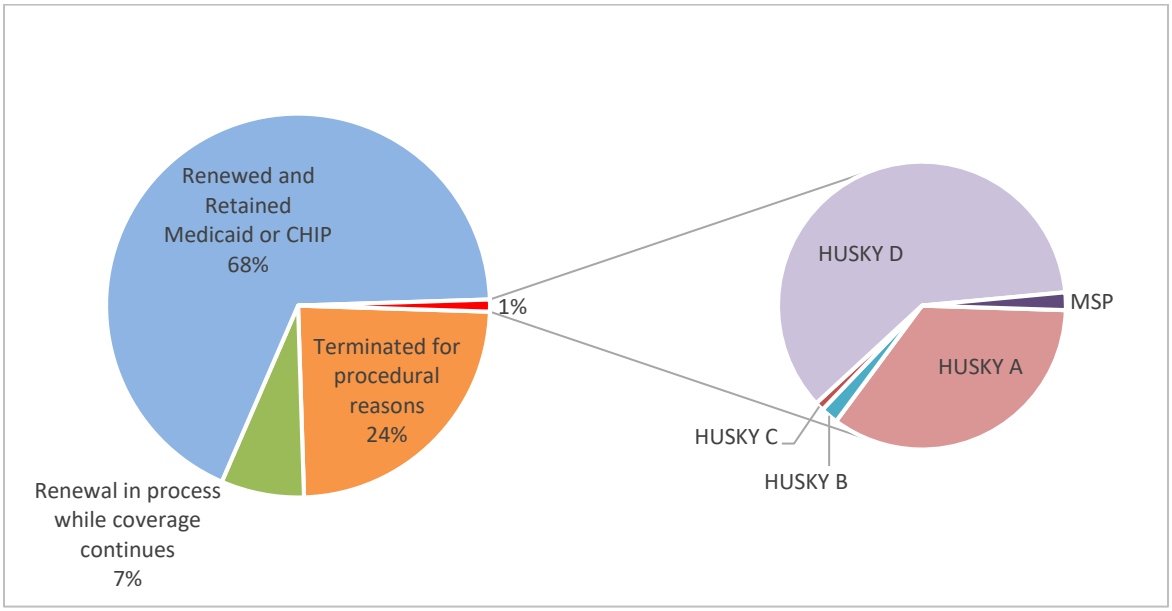
Types of Coverage Lost

At the June MAPOC meeting, DSS presented data on the health plans (or coverage groups) for the April cohort, which has the most available information because it was the first group to be disenrolled in Connecticut's unwinding process. About 25% of this cohort lost coverage, either for procedural reasons or an ineligibility determination. They were previously enrolled under one of the following coverage groups (all Medicaid, except for HUSKY B, which is CHIP):

1. HUSKY A for children, parents, caretaker relatives, or pregnant women;
2. HUSKY B for children from households with income too high to qualify for Medicaid;
3. HUSKY C for people (a) age 65 and older or (b) ages 16 to 65 and either blind or living with a disability;
4. HUSKY D for low-income people ages 19 to 65; or
5. the Medicare Savings Program (MSP) for low-income Medicare beneficiaries (covers Medicare cost-sharing only).

For the April cohort, 1% of cases were determined ineligible for Medicaid or CHIP. Of these, most had coverage under HUSKY D (61%) or HUSKY A (35%), as shown in Figure 3. (HUSKY A and HUSKY D are also the largest Medicaid coverage groups by enrollment according to DSS's dashboard.)

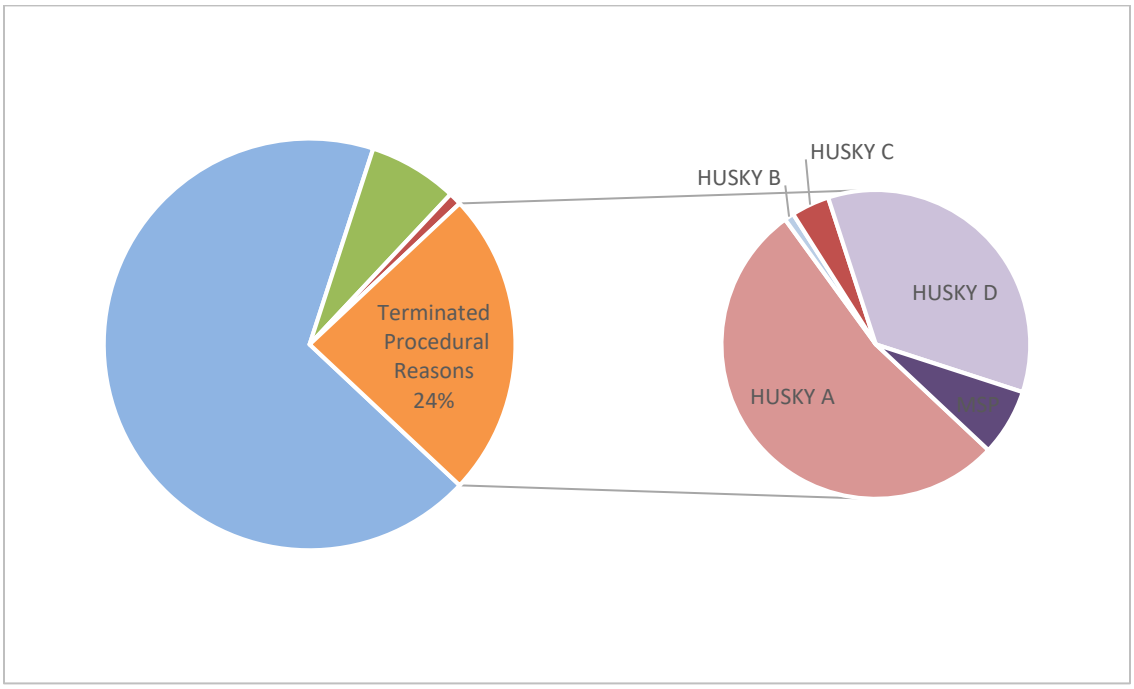
Figure 3: Previous Health Plans for People Determined Ineligible for Medicaid or CHIP in April 2023



Source: DSS

For the same month, 24% of cases were terminated for procedural reasons. Similarly, most had coverage under HUSKY A (53%) or HUSKY D (35%), as shown in Figure 4.

Figure 4: Previous Health Plans for People Terminated for Procedural Reasons in April 2023



Children Who Lost Coverage

At the June MAPOC meeting, DSS reported on renewal outcomes for children in the April cohort. According to this information, 17,224 children in the April cohort renewed their coverage, 423 were pending renewal, 521 were determined ineligible, and 6,940 lost coverage for procedural reasons (see slide 12). This information does not take into account children in households that have subsequently re-enrolled or enrolled in other coverage as discussed above.

What does Medicaid cover? How does it compare with other options for people who lose coverage?

Federal law requires that state Medicaid programs cover certain services ("mandatory benefits") and allows them to cover others ("optional benefits"). Mandatory benefits include inpatient and outpatient hospital services, laboratory and x-ray services, and non-emergency medical transportation (NEMT), which provides transportation for Medicaid enrollees to and from medical appointments. In addition to mandatory benefits, Connecticut's Medicaid program provides a number of optional benefits, including prescription drugs, physical and occupational therapy, dental

services, and home- and community-based services. The HUSKY Health Member Handbook and DSS's benefit grids provide more information. This applies for HUSKY A, C, and D.

Coverage options for people who lose Medicaid eligibility will depend on their circumstances, and DSS notes that households should complete the renewal process even if increased income or life changes have occurred, because households may qualify for other types of coverage.

Those who lose HUSKY A coverage may be eligible for Transitional Medical Assistance (TMA), which provides continued Medicaid coverage for one year after losing eligibility. Families with income exceeding HUSKY A limits may be able to receive coverage for their children under HUSKY B, which provides benefits as described in the HUSKY B Member Handbook and benefit grid. Unlike Medicaid enrollees, HUSKY B enrollees may have to pay co-pays or other cost sharing. HUSKY A income limits are higher for children, meaning that households that lose HUSKY A coverage for the parents or caregivers may be able to retain it for the children.

Those who lose Medicaid coverage may be eligible for Covered Connecticut, which is supported by Medicaid funds through a recently approved 1115 demonstration waiver. Covered Connecticut offers health, dental, and NEMT benefits, at no cost. They may also purchase other health insurance through Access Health CT. QHPs offered on the exchange must provide coverage for essential health benefits.

Resources

CMS, "Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023," January 5, 2023.

CTMirror, "Most CT Residents Enduring Medicaid 'Unwinding' Keep Coverage," July 12, 2023.

DSS, "HUSKY Health Continuous Enrollment Unwinding Frequently Asked Questions," undated.

DSS, "Public Health Emergency Unwinding: Human Services Committee and Insurance and Real Estate Committee Joint Forum," February 2, 2023.

DSS, "Public Health Emergency (PHE) Unwinding: Preparing for the End of the COVID-19 Public Health Emergency," June 2023.

Kaiser Family Foundation, "Medicaid Enrollment and Unwinding Tracker," August 15, 2023.

Kaiser Family Foundation, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," June 9, 2023.

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