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MEDICAID: LOOKING BEYOND THE UNWINDING

Recommendations for Improving the Efficiency and Accuracy of Medicaid and CHIP Eligibility Determinations.

June 2024

Executive Summary

The Connecting to Coverage Coalition (CCC) is comprised of national organizations representing a diverse collection of stakeholders committed to being a single source of trusted information about the Medicaid redetermination process. The CCC convenes stakeholders to support information sharing, share and build on best practices, and develop solutions to ensure Americans can enroll in the coverage option that is right for themselves and their families. By working together, the CCC helps support a smooth transition back to normal Medicaid eligibility during this unprecedented redetermination process by connecting Americans to resources and helping them either maintain Medicaid eligibility or transition to other health insurance coverage, such as Medicare, Marketplace coverage, or employer-sponsored insurance (ESI). The member organizations of the CCC are committed to working with federal and state partners and protecting against individuals becoming uninsured as a result of the “unwinding” process, especially among children and at-risk adults.

During the COVID-19 public health emergency, Congress ensured that Medicaid beneficiaries would have continuous health coverage during the pandemic.[1] As a result of the continuous coverage requirement, total Medicaid enrollment grew from 71 million (as of December 2019) to approximately 94 million individuals enrolled in Medicaid and CHIP in March 2023.[2] When the COVID-19 pandemic was winding down, Congress passed the Consolidated Appropriations Act, 2023 to require states, to begin on April 1, 2023, the process over a 12-month period to return the Medicaid program to normal operations. As part of the unwinding process, state Medicaid programs have resumed verification of over 94 million individual’s continuing eligibility for Medicaid.

To mitigate procedural disenrollment for eligible individuals and support state Medicaid agencies’ compliance with federal renewal requirements as they resume Medicaid redeterminations, the Centers for Medicare & Medicaid Services (CMS) offered states a range of strategies and flexibilities, including making available waivers of certain federal Medicaid requirements under the authorities provided through 1902(e)(14)(A) of the Social Security Act (SSA). To date, nearly all states have adopted at least one 1902(e)(14)(A) waiver, which include strategies to: (1) increase ex parte renewal rates; (2) support enrollees with renewal form completion and automated submission; (3) update contact information; and (4) facilitate reinstatement of coverage for eligible individuals who were disenrolled for procedural reasons.[3]

[1] Families First Coronavirus Response Act (Pub. L. 116-127); CARES Act (Pub. L. 116-136)
[2] https://www.medicaid.gov/sites/default/files/2023-06/march-2023-medicaid-chip-enrollment-trend-snapshot_1.pdf
[3] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html

The CCC appreciates the historic and unprecedented nature of Medicaid unwinding and applauds the leadership that CMS has provided to address the ongoing challenges many states face during this time. We also acknowledge and are grateful for the immense work that states and advocates have done thus far to improve the Medicaid and CHIP redetermination process. At the same time, we recognize the logistical challenges that remain which often result in loss of coverage for those who are still eligible for these programs in many areas of the country.

We acknowledge that the unwinding period has caused a substantial number of disenrollments across the Medicaid population at rates worse than many expected, particularly in certain areas of the country. The Biden administration anticipated around 15 million individuals losing coverage during this period, with nearly half losing coverage despite continued eligibility.[4] However, as of June 4, 2024, reported data reveals that more than 22.8 million people have been disenrolled, with a notable 69 percent disenrolled due to procedural reasons.[5] To date, nearly 35 million Medicaid beneficiaries still have not had their redeterminations completed or reported. This high procedural disenrollment rate is concerning, especially considering that many of these individuals may still be eligible for Medicaid coverage and that it disproportionately impacts individuals from vulnerable patient populations, including communities of color, children, elderly adults, and individuals living with disabilities. We also know that maintaining continuous coverage is important to maintaining better health outcomes and reducing administrative costs for both patients and states.

As state Medicaid agencies, CMS, Congress, and other stakeholders look ahead to the immediate post-Unwinding period, the coalition believes this is an apt time to evaluate lessons learned during the Unwinding, including what tactics worked especially well, how to address historic disenrollments in the immediate aftermath, and which enrollment flexibilities provided by CMS should continue beyond this period.

The CCC believes that extending flexibilities to maximize ex parte renewals, continuing and expanding data collection efforts, and reducing churn by improving outreach and facilitating alignment across programs are crucial and effective strategies that should continue to be employed by states to reduce coverage gaps for eligible individuals during and beyond the unwinding period.

[4] https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf
[5] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/

We offer the following recommendations:

Recommendation #1

- Building upon efforts made by states during the unwinding period, CMS should continue to explore ways to increase and streamline Medicaid ex parte renewal rates.

Recommendation #1a

- CMS should leverage existing authorities to make the ex parte flexibilities available beyond the end of the statutory unwinding period.
- Specifically, the CCC calls on the federal government to permanently extend flexibilities to:
    - Renew eligibility, without requesting additional information from the beneficiary, when SNAP, TANF, or another need-based program has already found the beneficiary to have income and (if applicable) assets below Medicaid limits.
    - Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on $0 income.
    - Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on income at or below 100% of the federal poverty line (FPL).
    - Renew eligibility, without requesting additional information from the beneficiary, for older or disabled (non-MAGI) Medicaid beneficiaries for whom asset information is not returned to the state within a reasonable timeframe by the state asset verification system.
    - Renew eligibility, without checking other data sources, when the Medicaid beneficiary's income is from stable sources, including Social Security payments, pension income, or life insurance policies.

Recommendation #1b

- CMS should also continue to provide additional guidance to states to encourage the further adoption of these ex parte flexibilities.

Recommendation #2

- CMS should work with all states to report and publicly release data pertaining to the Medicaid termination and renewal rates for the following populations
    - Children;
    - Dually-eligible individuals;
    - Pregnant and postpartum women,
    - People who are aged, blind, or disabled;
    - People who indicate that their preferred language is not English;and
    - Medicaid beneficiaries whose coverage has been reinstated after being previously terminated during the Unwinding.
    - CMS should also work with states to include the release of data disaggregated by race and ethnicity as part of broader efforts to support such data disaggregation.

Recommendation #3a

- CMS should continue to explore and promote additional opportunities to streamline enrollment and reduce the administrative burden for individuals moving between Medicaid coverage and other federal programs such as CHIP and the ACA Marketplace.

Recommendation #3b

- Congress should permanently extend the ACA premium tax credits and policy changes to ensure that eligible individuals and families may continue to enroll in comprehensive insurance coverage through the federal Marketplace and state exchanges, promoting continuous access to quality, affordable coverage for prescription drugs, treatments, and other health care services.

Priority 1: Extend Flexibilities to Maximize Ex Parte Renewals

Federal law and regulations have long required that states first attempt to confirm continued Medicaid eligibility using existing information available to the state Medicaid agencies before requesting information from the beneficiary. This process is typically referred to as **ex parte renewal**.[6] In conducting such an ex parte renewal, the agency is required to rely on recent and reliable data that was previously verified by the agency. However, if such information is not sufficient, available, or reliable, the agency may send a renewal form to request additional information from the beneficiary.

While the requirement to determine Medicaid eligibility using ex parte has been longstanding, the rate at which states successfully completed such Medicaid renewals varied prior to the Unwinding. For example, 18 states reported that they ordinarily conducted at least half of their renewals using ex parte processes, while nearly half of all states have performed fewer than 25 percent of their Medicaid renewals via the ex parte process.[7] Leveraging the ex parte renewal process presents opportunities to improve the accuracy of Medicaid eligibility determinations, streamline burdensome redetermination requirements for states and beneficiaries alike, reduce associated costs, and ensure timely completion of redeterminations to avert coverage gaps.[8]

Timely completion of redeterminations is crucial to maintaining health care coverage for eligible individuals, significantly impacting the health outcomes of low-income individuals,[9] including addressing behavioral health issues that were exacerbated during the COVID-19 pandemic. Maintaining health care coverage for eligible individuals ensures uninterrupted access to essential behavioral health services, improving patient well-being. Streamlined redetermination processes also prevent the need for costly care interventions such as emergency room visits and hospitalizations.[10]

Ex parte has also helped preserve coverage for vulnerable populations, including children under the age of 19. As of March 2024, more than 3.3 million children have lost Medicaid coverage, representing approximately four in ten Medicaid disenrollments in the 21 states providing age breakouts.[11] This disenrollment rate is significantly higher than was observed pre-pandemic, raising substantial concerns among health care stakeholders. According to CMS' data snapshot of Medicaid and CHIP enrollment from December 2023, increased use of ex parte redeterminations during the unwinding period is correlated with smaller declines in enrollment among children under 19.[12]

[6] https://www.medicaid.gov/sites/default/files/2022-10/ex-parte-renewal-102022.pdf
[7] https://www.brookings.edu/articles/medicaid-and-the-great-unwinding-a-high-stakes-implementation-challenge/
[8] https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf
[9] https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[10] https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap
[11] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/
[12] https://www.medicaid.gov/sites/default/files/2023-12/medicaid-unwinding-child-data-snapshot.pdf

To manage the unprecedented levels of Medicaid renewals that must be completed during the "unwinding" of the continuous coverage requirements, states have increased their rates of ex parte renewals with assistance from the variety of new flexibilities provided by CMS under the authority of section 1902(e)(14)(A) waivers. For example, CMS granted specific (e)(14) waiver authority to renew Medicaid eligibility without requesting additional information from the beneficiary if other means-tested benefits programs — such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) — have already determined that the individual's gross income is at or below applicable Medicaid income limits, notwithstanding technical differences between program rules for household definition and income counting.[13] In addition, CMS provided flexibilities to states under 1902(e)(14)(A) to conduct a Medicaid income determination at renewal when certain income data is not returned within a reasonable timeframe, or at all. [14]

Figure 1: 1902(e)(14)(A) flexibilities allow states to

- ☑Renew eligibility, without requesting additional information from the beneficiary, when SNAP, TANF, or another need-based program has already found the beneficiary to have income and (if applicable) assets below Medicaid limits.
- ☑Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on $0 income.
- ☑Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on income at or below 100% of the federal poverty line (FPL).
- ☑Renew eligibility, without requesting additional information from the beneficiary, for older or disabled (non-MAGI) Medicaid beneficiaries for whom asset information is not returned to the state within a reasonable timeframe by the state asset verification system.
- ☑Renew eligibility based on a simplified asset verification process.
- ☑Renew eligibility, without checking other data sources, when the Medicaid beneficiary's income is from stable sources, including Social Security payments, pension income, or life insurance policies.

During the unwinding period, CMS also reminded states of additional longstanding federal authorities available to increase the rate of ex parte renewals during and after the unwinding period, including:

- Implementing Express Lane Eligibility for children under a state plan amendment.
- Renewing eligibility if able to do so based on available information; and
- Establishing a new eligibility period whenever contact is made with hard-to-reach populations.

To date, CMS has approved a total of 397 1902(e)(14)(A) waivers, 203 of which are designed to

[13] https://www.medicaid.gov/resources-for-states/downloads/state-strategies-to-prevent-procedural-terminations.pdf
[14] https://www.medicaid.gov/media/167441

specifically assist states in increasing ex parte renewal rates.[15] In significant part due to these additional flexibilities and guidance provided by CMS, 42 states have experienced increased rates of successful ex parte renewals since the resumption of Medicaid unwinding redeterminations and renewals.[16] Notably, final data from December 2023 indicates that 47 percent of all renewals nationwide were conducted via ex parte compared to an average ex parte renewal rate of 24.7 percent in May 2023,[17] demonstrating the utility of the additional flexibilities during Medicaid unwinding to complete timely redeterminations of Medicaid eligibility.

In a roundtable of state Medicaid representatives and CMS officials convened by the Medicaid and CHIP Payment and Access Commission (MACPAC) and Mathematica, several participants highlighted the utility of the 1902(e)(14)(A) waiver flexibilities including those enabling streamlined processes for asset verification, ex parte renewals for individuals with zero income, and the use of SNAP and TANF eligibility information for ex parte Medicaid renewals in particular.[18] Notably, states were able to use SNAP and TANF information for ex parte renewals under state plan amendment authority prior to the Medicaid unwinding. However, under the new (e)(14)(A) waiver authority, states may automatically renew eligibility for a beneficiary whose gross income, as determined by SNAP or TANF, is below the Medicaid threshold permitted under the waiver without taking extra steps to certify eligibility required under the original state plan authority, lessening the burden of pursuing ex parte renewals this way.[19]

The CCC believes that increasing ex parte rates is a crucial and effective strategy that should be employed by states to reduce coverage gaps for eligible individuals through the end of the unwinding. Such data-based renewals allow eligible families to retain health coverage without administrative burdens that often prove unmanageable. Such policies can be particularly beneficial in communities of color and for people with disabilities and older adults, given the disproportionate impact on such populations.[20] By preventing procedural terminations of eligible individuals, ex parte renewal policies increase the accuracy of eligibility outcomes, strengthening program integrity. And by reducing the need for caseworker action to reinstate coverage retroactively, these policies save patients money, as well as state administrative dollars, allowing often understaffed agencies to

[15] https://www.medicaid.gov/media/164611
[16] https://ccf.georgetown.edu/2024/01/26/most-states-show-improvement-in-automated-ex-parte-medicaid-renewal-rates/
[17] https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end?item=28539
[18] https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf
[19] See CMS SHO #15-001, which describes that, when states use SNAP criteria to automatically renew beneficiaries for Medicaid, they must ensure that: (1) the beneficiary has gross income, as determined by SNAP, at or below the applicable Medicaid MAGI standard; (2) the beneficiary is under age 65; (3) all members of the household qualify for SNAP; (4) no one in the household qualifies from SNAP transitional benefits solely; (5) no one in the household has any income that counts for MAGI purposes but is disregarded for SNAP purposes, among numerous other requirements; (6) no one in the SNAP household is part of a tax household that includes people who live outside the home; (7) no one in the household receives self-employment income (a requirement that does not apply in certain states); (8) no one in the household has an exclusion from SNAP-countable income based on payment of child support for children living outside the home; and (9) either the SNAP-counted household income does not exceed the Medicaid standard for a household of one, or the household consists entirely of a single person, parents who live with their children, or a married couple (with or without children)..
[20] See https://aspe.hhs.gov/sites/default/files/documents/a892859839a80f8c3b9a1df1fcb79844/aspe-end-mcaid-continuous-coverage.pdf

devote limited resources elsewhere. These ex parte flexibilities complement other flexibilities such as permitting managed care organizations (MCOs) to help beneficiaries complete the paperwork needed for renewal. Both strategies address the problem of administrative burdens, which many overburdened and under-resourced families find unsurmountable.

Based on the lessons learned during this unprecedented time, the CCC believes that increasing ex parte rates is a crucial and effective strategy that should be employed by all states to reduce coverage gaps for eligible individuals during the unwinding period and beyond. Unfortunately, many of these flexibilities are currently set to expire with the end of the Medicaid unwinding period. Therefore, the CCC offers the following recommendations:

Recommendation #1
Building upon efforts made by states during the unwinding period, CMS should continue to explore ways to increase and streamline Medicaid ex parte renewal rates.
Recommendation #1a
CMS should leverage existing authorities to make the ex parte flexibilities available beyond the end of the statutory unwinding period. Specifically, the CCC calls on the federal government to permanently extend flexibilities to: ☑ Renew eligibility, without requesting additional information from the beneficiary, when SNAP, TANF, or another need-based program has already found the beneficiary to have income and (if applicable) assets below Medicaid limits. ☑ Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on $0 income. ☑ Renew eligibility, without requesting additional information from the beneficiary, when there is no recent data showing any income paid to beneficiaries who originally qualified for Medicaid based on income at or below 100% of the federal poverty line (FPL). ☑ Renew eligibility, without requesting additional information from the beneficiary, for older or disabled (non-MAGI) Medicaid beneficiaries for whom asset information is not returned to the state within a reasonable timeframe by the state asset verification system. ☑ Renew eligibility, without checking other data sources, when the Medicaid beneficiary's income is from stable sources, including Social Security payments, pension income, or life insurance policies.
Recommendation #1b
CMS should continue to provide additional guidance to states to encourage the further adoption of these ex parte flexibilities.

Priority 2: Expand Data Collection and Reporting Efforts

On December 13, 2023, CCC coalition members encouraged CMS to continue working with state Medicaid agencies to publish and distribute publicly available data to help inform the Medicaid redetermination and renewal process.[21] Collection and publication of this data adds important context to help highlight areas of success, inform states and CMS about which new strategies have effectively supported individuals through the Medicaid eligibility determination, as well as identify areas for improvement. Continued collection and release of this data is critically important to provide needed transparency into the efforts states have undertaken during the Medicaid redeterminations process to ensure all individuals have access to health insurance coverage for which they are eligible, particularly vulnerable populations.

In recognizing the utility of this data, CMS recently announced that states will be required to continue reporting on certain Medicaid enrollment and renewal metrics beyond the Medicaid unwinding period, including data on renewals initiated, renewals due, fair hearing requests pending for more than 90 days, and outcomes on pending renewals from prior months.[22] While the continued reporting of this data is important to understanding the Medicaid redetermination and renewal process, CCC has identified key populations that CMS and states should specifically focus on in their data collection efforts to provide important context. While a wide range of data would be helpful, the coalition's recommendation targets as a starting point populations already identified as particularly vulnerable.

Recommendation #2

CMS should work with all states to report and publicly release data pertaining to the Medicaid termination and renewal rates for the following populations:

- ☑ Children;
- ☑ Dually-eligible individuals;
- ☑ Pregnant and postpartum women,
- ☑ People who are aged, blind, or disabled;
- ☑ People who indicate that their preferred language is not English;and
- ☑ Medicaid beneficiaries whose coverage has been reinstated after being previously terminated during the Unwinding.

CMS should also work with states to include the release of data disaggregated by race and ethnicity as part of broader efforts to support such data disaggregation.

[21] https://www.connectingtocoverage.org/uploads/9/8/8/2/98821524/ccc_final_letter_to_cms_121223.pdf
[22] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24002.pdf

Priority 3: Reduce "Churn" by Improving Outreach and Reducing Enrollment Barriers, Including for Other Federal Programs

Medicaid "churn" refers to the disruptive cycle of coverage loss, reapplication, and re-enrollment that strains the federal health care system on multiple fronts. Reducing churn is crucial to maintaining coverage for eligible beneficiaries, which significantly impacts the health outcomes of low-income individuals.[23] This also includes increased administrative costs and barriers to care as beneficiaries experience gaps in coverage. These added costs, coupled with the costs of avoidable medical care, are ultimately borne by taxpayers.[24] The surge in renewals from disenrolled individuals since unwinding began is stretching state resources, causing processing delays, and exceeding acceptable application timelines.[25]

While churn can stem from temporary changes in income or circumstances, the substantial disenrollment attributed to procedural reasons suggests that many who lose coverage are likely still eligible for Medicaid. Notably, some recent data suggests that approximately 69 percent of individuals disenrolled had their Medicaid coverage terminated for procedural reasons, and while some individuals are finding their way to marketplace coverage, others still remain eligible for Medicaid.[26][27] Of particular concern is the disproportionate impact of churn on children, the majority of whom were enrolled in Medicaid at the start of the unwinding period.[28] In 2022, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) highlighted that most children who are administratively churned out of coverage remain eligible for either Medicaid or CHIP.[29] However, their transition experience varies significantly based on state-level CHIP policies. For example, states imposing greater administrative barriers like enrollment fees or premiums associated with separate CHIP programs are less likely to automatically enroll children in CHIP after losing Medicaid eligibility.[30] ASPE notes that states with combined Medicaid and CHIP programs demonstrate more seamless transitions, thereby minimizing coverage gaps for children.

Further, while many remain eligible for Medicaid and CHIP after losing coverage, approximately one-third of those affected by Medicaid disenrollment during unwinding are projected to qualify for ACA marketplace coverage with premium tax credits.[31] The ACA envisioned a "no wrong door" system for these situations, where individuals complete a single application and end up in the appropriate

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[23] https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/pdf/nihms708512.pdf
[25] https://www.cbpp.org/blog/lessons-learned-from-unwinding-can-improve-medicaid
[26] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/
[27] https://www.medicaid.gov/media/172506
[28] https://ccf.georgetown.edu/2023/07/19/the-medicaid-unwinds-impact-on-children-are-they-moving-to-chip/
[29] https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf
[30] *Id.*
[31] *Id.*

federal health program. However, the transition from Medicaid to marketplace coverage is not as seamless as was envisioned, with few individuals utilizing this system for their Medicaid enrollment.[32] This issue has become increasingly evident during the Unwinding period, as highlighted in CMS' monthly snapshots which reveal significant barriers to enrollment and indicate flaws in the system. For example, while 85 percent of individuals who lost Medicaid or CHIP coverage in April 2023 had their accounts transferred by their state Medicaid agency to HealthCare.gov, only 11 percent applied for marketplace coverage, with a mere seven percent ultimately selecting a plan.[33]

To address these churn-related challenges, CMS and various state Medicaid agencies have taken steps to improve outreach and education efforts, streamline enrollment, and reduce entry barriers to enroll in other federal programs.

Most recently, CMS finalized several changes to the eligibility determination, beneficiary notification, enrollment, and renewal process for the Medicaid and CHIP programs. In a final rule[34] issued on March 27, 2024, CMS aimed to improve efforts to reach beneficiaries and decrease administrative barriers to renew or enroll in these programs, particularly for vulnerable communities, specifically by:

- Prohibiting states from requiring in-person interviews for those whose eligibility is based on having a disability or being older than 65;
- Allowing flexible renewal methods for this population;
- Disallowing states from imposing “lock-out periods,” which temporarily block families from re-enrolling after a missed CHIP premium payment;
- Requiring Medicaid agencies to check categories of available data prior to coverage terminations when beneficiaries cannot be reached by mail;
- Requiring Medicaid agencies to provide potential beneficiaries a minimum of 15 or 30 calendar days to return supplemental information requested during an enrollment or renewal application, respectively; and
- Requiring states to use electronic data they already have to update contact information.

CMS also extended of the "unwinding Special Enrollment Period" (SEP) in specific states to minimize coverage gaps and facilitate transitions from Medicaid to the marketplace.[35] Several states with their own marketplaces have also implemented effective strategies, such as matching individuals with zero-net-premium plans, automatically enrolling certain populations, or waiving CHIP premiums/enrollment fees during the unwinding period.[36]

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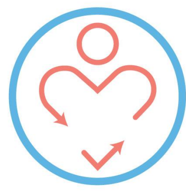
[32] https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end?item=28533
[33] *Id.*
[34] https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health
[35] https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end?item=28893
[36] https://www.healthaffairs.org/content/forefront/unwinding-should-call-action-fix-fragmented-system

Congress has also taken steps to reduce the number of people losing coverage, especially for disenrolled individuals who are ineligible for Medicaid or CHIP. The Affordable Care Act (ACA) provided financial aid to Marketplace enrollees, including a premium tax credit to lower monthly payments and a cost-sharing reduction (CSR) to reduce out-of-pocket costs when accessing care. Despite this provision of subsidized health insurance, millions have remained uninsured due to various reasons, such as being priced out of subsidies based on income or lacking awareness of available financial assistance.[37] Congress enhanced these ACA subsidies through the American Rescue Plan Act (ARPA) in 2021, eliminating the upper income eligibility limit and increasing financial aid for eligible beneficiaries. In 2022 Congress further extended these enhanced tax credits, aiding in a more affordable transition from Medicaid to private coverage and supporting existing enrollees. As a result, Marketplace enrollment has grown substantially while the enhanced tax credits have been in effect, with enrollment reaching 21.3 million in 2024 compared to 11.4 million in 2020.[38] Enhanced tax credits reduce the cost of marketplace plan premiums, making coverage more affordable, particularly for people who are determined ineligible for Medicaid and CHIP. The enhanced tax credits will expire at the end of 2025 and would require legislative action to extend. The extension would continue to assist eligible individuals obtain ACA coverage, including those who are transitioning from Medicaid because they are no longer eligible.

Thus, CCC recommends continued protection for eligible individuals' access to coverage under federal health care programs and offers the following two-part recommendation.

Recommendation #3a
CMS should continue to explore and promote additional opportunities to streamline enrollment and reduce the administrative burden for individuals moving between Medicaid coverage and other federal programs such as CHIP and the ACA Marketplace.
Recommendation #3b
Congress should permanently extend the ACA premium tax credits and policy changes to ensure that eligible individuals and families may continue to enroll in comprehensive insurance coverage through the federal Marketplace and state exchanges, promoting continuous access to quality, affordable coverage for prescription drugs, treatments, and other health care services.

[37] https://www.kff.org/affordable-care-act/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/
[38] https://www.kff.org/policy-watch/another-year-of-record-aca-marketplace-signups-driven-in-part-by-medicaid-unwinding-and-enhanced-subsidies/



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Members of the Connecting to Coverage Coalition: (*in alphabetical order)*

AHIP
Alliance of Community Health Plans
American Association of People with Disabilities
American Cancer Society Cancer Action Network
American Health Care Association
American Hospital Association
American Pharmacists Association
American Speech-Language-Hearing Association
Association of Maternal and Child Health Programs
Association for Community Affiliated Plans
BlueCross BlueShield Association
Catholic Health Association of the United States
Community Catalyst
Federation of American Hospitals
Healthcare Leadership Council
Huntington's Disease Society of America
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National Association of Benefits & Insurance Professionals
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