Medicaid unwinding: options for states to help people with serious mental illness maintain treatment access

Part II of a series exploring how the unwinding of the pandemic-related Medicaid coverage requirements may impact health benefits coverage for people with SMI

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People with serious mental illness (SMI) are potentially at heightened risk of experiencing healthcare gaps from Medicaid coverage loss during the "unwinding" of the Medicaid continuous eligibility requirement established under the COVID-19 public health emergency. These individuals might be unable to afford other insurance types or may not qualify for employer-sponsored insurance and therefore may be unable to access needed services, medications, and other treatment. This paper examines strategies states can consider to support reenrollment in Medicaid or smooth transitions to other coverage sources.

Background

Key Takeaways

- States are beginning the process of unwinding their pandemic-related Medicaid continuous eligibility requirements.
- The U.S. Department of Health and Human Services has projected that around 15 million people will be disenrolled from Medicaid.
- People with SMI could be at heightened risk of losing coverage for procedural reasons, as opposed to ineligibility; but states might wish to consider options for individuals regardless of the reason for coverage loss.

This spring, states formally began the process of "unwinding" their pandemic-related Medicaid continuous eligibility requirements, under which they must reach out to all current beneficiaries to verify ongoing eligibility for the program, a process which was largely put on hold during the pandemic. As discussed in Part I of this two-part series, Potential Coverage Gaps Among Medicaid Beneficiaries With Serious Mental Illness, Congress passed legislation at the beginning of the COVID-19 pandemic to temporarily increase the funding provided to state Medicaid programs so long as they agreed not to terminate coverage for beneficiaries enrolled in Medicaid for the duration of the public health emergency (PHE), with the goal of supporting consistent access to healthcare during this unprecedented period.[1,2] During normal times beneficiaries must periodically undergo a check by the Medicaid program to assure they remain eligible, but these processes went indefinitely on hold during the pandemic. This meant that some people were allowed to keep Medicaid coverage despite no longer meeting the eligibility requirements (because the state was not allowed to disenroll any members). Because the end date of the PHE was unknown during that time, this put both states and beneficiaries in a holding pattern where they could not predict when the normal Medicaid eligibility redetermination processes would be allowed to resume. In December 2022, President Biden signed the

[1] Applegate, D., Bertolo, J., Wentworth, K. et al. (March 2023). Potential Coverage Gaps Among Medicaid Beneficiaries With Serious Mental Illness. Milliman White Paper. Retrieved May 30, 2023, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/3-7-23_coverage-gaps-medicaid-serious-mental-illness.ashx.
[2] The full text of the Families First Coronavirus Response Act is available at https://www.congress.gov/bill/116th-congress/house-bill/6201.

Consolidated Appropriations Act of 2023 (CAA), which gave certainty to the timeline by decoupling the unwinding process from the end of the COVID-19 PHE and setting a firm date for when the continuous eligibility requirement would end.[3] The CAA permitted states to restart their Medicaid eligibility renewals, post-enrollment verifications, and redeterminations as early as April 1, 2023, and granted states a total of 14 months to complete the process of returning to normal operations (ending no later than May 31, 2024).

States submitted their unwinding plans to the Centers for Medicare and Medicaid Services (CMS) in February and, at the beginning of March, CMS published the anticipated 2023 state timelines for the initiation of the unwinding-related renewals, with states generally expecting to begin processing actual disenrollments between April and July of this year.[4]

SIGNIFICANT COVERAGE LOSSES EXPECTED

The U.S. Department of Health and Human Services (HHS) anticipates that the unwinding of Medicaid continuous eligibility will be the largest coverage transition event since the first open enrollment of the Patient Protection and Affordable Care Act (ACA).[5] Between February 2020 and October 2022, it was estimated that more than 20 million people newly enrolled in Medicaid and the Children's Health Insurance Program (CHIP), which caused total Medicaid/CHIP enrollment to spike as high as 91.3 million in October 2022.[6] Due to the unwinding process, HHS now projects that about 15 million people will be disenrolled from the program, of which about 6.8 million individuals may inadvertently lose coverage despite still being eligible for the program.[7] **That means that around 45% of those who lose coverage will lose it for administrative and procedural reasons only—as opposed to being truly ineligible for Medicaid coverage**.

The American Psychiatric Association (APA). characterizes **serious mental illness (SMI)** as a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more life activities. Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder.[1]

People with SMI could be at heightened risk for being part of the group that may lose coverage for procedural reasons, in part due to the socioeconomic indicators and life circumstances they experience. For example, some reports have found the employment rate for people with mental illness to be as low as 20% and that a significant number of people with SMI live below the poverty line.[8,9] A disproportionate number of people experiencing homelessness also have SMI diagnoses, which can make communication and outreach to them for the purposes of redetermination procedures more difficult.[10] Additionally, people with SMI regularly face challenges with access to care and treatment non-adherence, which can contribute to an exacerbation of symptoms and other outcomes that can make daily living difficult.[11,12] These circumstances might also make it more likely for people with SMI to fall through the cracks of the communications and administrative processes related to renewals.

While some people with SMI may validly lose coverage due to no longer being eligible for Medicaid, that number might be relatively lower to the extent individuals gained eligibility through disability status and/or insofar as this population faces barriers to securing long-term employment. A sizable portion of adults with any type of behavioral health condition has Medicaid eligibility on the basis of

[3] The full text of the Consolidated Appropriations Act, 2023, is available at https://www.congress.gov/bill/117th-congress/house-bill/2617?r=1&s=3.
[4] Medicaid.gov. Anticipated 2023 State Timelines for Initiating Unwinding-Related Renewals, as of February 24, 2023. Retrieved May 30, 2023, from https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-02242023.pdf.
[5] Medicaid.gov. Unwinding and Returning to Regular Operations after COVID-19. Retrieved May 30, 2023, from https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.
[6] Tolbert, J. & Ammula, M. (April 5, 2023). 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision. Kaiser Family Foundation. Retrieved May 30, 2023, from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.
[7] HHS (August 19, 2022). Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. ASPE Issue Brief. Retrieved May 30, 2023, from https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.
[8] NAMI (2014). Road to Recovery: Employment and Mental Illness. Retrieved May 30, 2023, from https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/RoadtoRecovery.
[9] SAMHSA (November 15, 2016). Serious Mental Illness Among Adults Below the Poverty Line. The CBHSQ Report. Retrieved May 30, 2023, from https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.pdf.
[10] HUD Exchange. CoC Homeless Populations and Subpopulations Reports. Retrieved May 30, 2023, from https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/.
[11] SAMHSA (December 2022). Key Substance Use and Mental Health Indicators in the United States: Results From the 2021 National Survey on Drug Use and Health. Retrieved May 30, 2023, from https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.
[12] SMI Adviser. What are some factors that lead to medication non-adherence for people with serious mental illness? Retrieved May 30, 2023, from https://smiadviser.org/knowledge_post/what-are-some-factors-that-lead-to-medication-non-adherence-for-people-with-serious-mental-illness.

disability status (41%), while 59% become eligible based on having low income.[13] It is often challenging for people with SMI to remain employed (and thus possibly lose Medicaid eligibility as a result of higher income) due to stigma, discrimination, and broader socioeconomic factors that can serve as barriers to people with SMI from gaining employment and achieving economic stability.[14,15,16] For these reasons, it is probable that many people with SMI are more likely to remain Medicaid-eligible based on disability status and/or their low incomes.

However, even if a person with SMI qualified for Medicaid based on income, it is still possible that the incomes of those individuals may have fluctuated over the course of the past three years, making them ineligible for Medicaid moving forward. Regardless of the prevalence, such scenarios where people validly lose eligibility may merit consideration as states pursue strategies to connect people to other health coverage options after being disenrolled from Medicaid.

This paper explores strategies states could deploy to support these individuals and minimize healthcare disruptions associated with loss of Medicaid coverage. In coordination with a request from the sponsor of this white paper series, Karuna Therapeutics, a particular emphasis on schizophrenia and bipolar disorder due to the particular acute challenges—such as housing insecurity—that these individuals (and other similarly at-risk populations) are likely to face in the context of the Medicaid unwinding.

Coverage options to support maintaining access to care

As individuals lose Medicaid coverage as part of the redetermination process, states and other interested parties may consider a range of alternative coverage options that may be available to them given each individual's unique circumstances.

INSURANCE COVERAGE OPTIONS

Medicaid. As discussed above and in Part I**,** a substantial amount of people who lose Medicaid coverage during the unwinding process may remain eligible for Medicaid despite having been disenrolled for procedural reasons. Therefore, a natural first option for this group—i.e., those who are disenrolled from Medicaid despite still being eligible—is to consider reenrolling in Medicaid.

Key Takeaways

- States and other interested parties may consider alternative coverage options dependent on individuals' unique circumstances.
- Given the increased risk of people with SMI losing coverage inadvertently, an ideal solution may be reenrolling eligible individuals into Medicaid; but for individuals who are not eligible, commercial plans—such as those available on the ACA marketplace—might be an option.
- As a point of reference, there is a higher prevalence of schizophrenia and bipolar disorder among adults on Medicaid relative to commercial plans—pointing to the important role of Medicaid in providing coverage to people with SMI.

Many people who are disenrolled from Medicaid experience a gap in coverage after losing this coverage, potentially because they are unaware that their coverage was terminated, or they do not know what other coverage options exist. Assuming Medicaid is truly no longer an option, the appropriate next choice for coverage will depend on the individual's circumstances. Coverage types will generally fall into the categories outlined in the table in Figure 1.

[13] Zur, J., Musumeci, MB., & Garfield, R. (June 29, 2017). Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals. Kaiser Family Foundation. Retrieved May 30, 2023, from https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/.
[14] Tee-Melegrito, R.A. (January 18, 2023). Can people with schizophrenia work? Medical News Today. Retrieved May 30, 2023, from https://www.medicalnewstoday.com/articles/can-people-with-schizophrenia-work-2.
[15] Guhne, U. et al. (April 2021). Employment status and desire for work in severe mental illness: Results from an observational, cross-sectional study. *Social Psychiatry and Psychiatric Epidemiology*. Retrieved May 30, 2023, from https://link.springer.com/article/10.1007/s00127-021-02088-8.
[16] Brouwers, E.P.M. (April 2020). Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: Position paper and future directions. *BMC Psychology*. Retrieved May 30, 2023, from https://bmcpsychology.biomedcentral.com/articles/10.1186/s40359-020-00399-0.

FIGURE 1: SUMMARY OF HEALTH BENEFIT COVERAGE CONSIDERATIONS

Coverage Type	Considerations
Medicaid	Individuals with SMI are at heightened risk of being disenrolled from Medicaid for procedural reasons and might remain eligible for Medicaid and can be reenrolled. These individuals may also be dually eligible for Medicare.
Marketplace/health insurance exchange	Individuals disenrolled due to validly losing Medicaid eligibility can purchase plans on a health insurance exchange and might be eligible for premium tax credits or, potentially, zero premium plans to the extent they are not eligible for affordable employer-sponsored insurance.
Employer-sponsored health plans	Individuals who have gained employment since enrollment in Medicaid may have the option of enrolling in an employer's health plan.
Basic Health Program (BHP)	As an alternative to exchange coverage for the population with household income up to 200% of the federal poverty level, individuals who live in New York or Minnesota may be eligible for their state's BHP (if not eligible for affordable employer-sponsored coverage). Oregon is implementing a BHP for July 2024 and has established a "Bridge Health Care Program" for persons who have become ineligible for Medicaid.[17]

The non-Medicaid options are described in more detail below.

Employer-sponsored health plans. Individuals who have gained (or regained) employment since their Medicaid enrollment might have the option of enrolling in an employer-sponsored plan. As discussed above, individuals with SMI oftentimes face barriers to stable employment that can be related to their health condition, stigma, discrimination, and/or broader socioeconomic indicators. For this reason, it is less likely that employer-sponsored health insurance will be an option for individuals with SMI. Regardless, for those who are employed, it is possible that they were already enrolled in their employer's plan (in addition to Medicaid) or that it is available as a potential new option.

Marketplace/health insurance exchanges. The terms "health insurance marketplace" and "health insurance exchange" are used interchangeably to describe the shopping and enrollment platform for medical insurance created by the ACA in 2010. (Here, we will generally use "exchange" although the federal exchange is typically called the "federally facilitated marketplace.") Each state offers one official exchange, either operated by the state or using the federal platform.[18] HHS projects that nearly one-third of those who lose Medicaid eligibility during the unwinding will qualify for premium tax credits for qualified health plans (QHPs) available through health insurance exchanges.[19] This means that for individuals who validly lose Medicaid eligibility for programmatic reasons and for whom an employer-sponsored plan is not an option (e.g., either due to not being eligible or because the coverage is unaffordable), there could be insurance options available to them on the exchange. Similar to reenrolling eligible individuals in Medicaid, there are some strategies states and interested parties might want to consider with regard to supporting people with SMI and other vulnerable populations, discussed more below.

A **qualified health plan (QHP)** is an insurance plan that is officially certified by the exchange where it operates, provides the 10 essential health benefits, follows cost-sharing limits, and generally meets the requirements established by the ACA.[20] QHPs must cover ambulatory services, emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive services, pediatric services, and behavioral health services.[21]

Basic health programs. The ACA created an option for states to develop a Basic Health Program (BHP) that provides benefits to low-income individuals whose Medicaid eligibility oscillates.[22] At the moment, only two states have active BHPs—New York and

[17] Wyatt, S. (April 4, 2023). Oregon gears up to become the third state to establish a Basic Health Plan. Statesman Journal. Retrieved May 30, 2023, from https://www.statesmanjournal.com/story/news/health/2023/04/04/oregon-health-plan-insurance-medicaid-eligibility-enrollment-coverage-pandemic/70069958007/.
[18] HealthInsurance.org. What is a health insurance marketplace? Glossary. Retrieved May 30, 2023, from https://www.healthinsurance.org/glossary/health-insurance-marketplace/.
[19] HHS (August 19, 2022). Unwinding the Medicaid Continuous Enrollment Provision, op cit.
[20] HealthCare.gov. Qualified health plan. Glossary. Retrieved May 30, 2023, from https://www.healthcare.gov/glossary/qualified-health-plan/.
[21] HealthCare.gov. Health benefits and coverage: What Marketplace health insurance plans cover. Retrieved May 30, 2023, from https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.
[22] Medicaid.gov. Basic Health Program. Retrieved May 30, 2023, from https://www.medicaid.gov/basic-health-program/index.html.

Minnesota—while Oregon has put forth a plan to seek federal approval to implement a BHP starting in July 2024.[23] Beyond the two existing state BHPs, this coverage program is not an immediately viable option for those who lose coverage during the unwinding process. Nonetheless, as a longer-term strategy, creating a BHP may be a coverage option states wish to consider for low-income individuals, including those with SMI. A key value proposition for the BHP is that it may allow a state to offer individuals with income up to 200% of the federal poverty level (FPL) health insurance coverage that has lower out-of-pocket expense requirements (in terms of both premiums and cost-sharing) relative to exchange coverage. Note that, similar to the exchange, BHP coverage is not available to individuals with access to affordable employer-sponsored insurance.

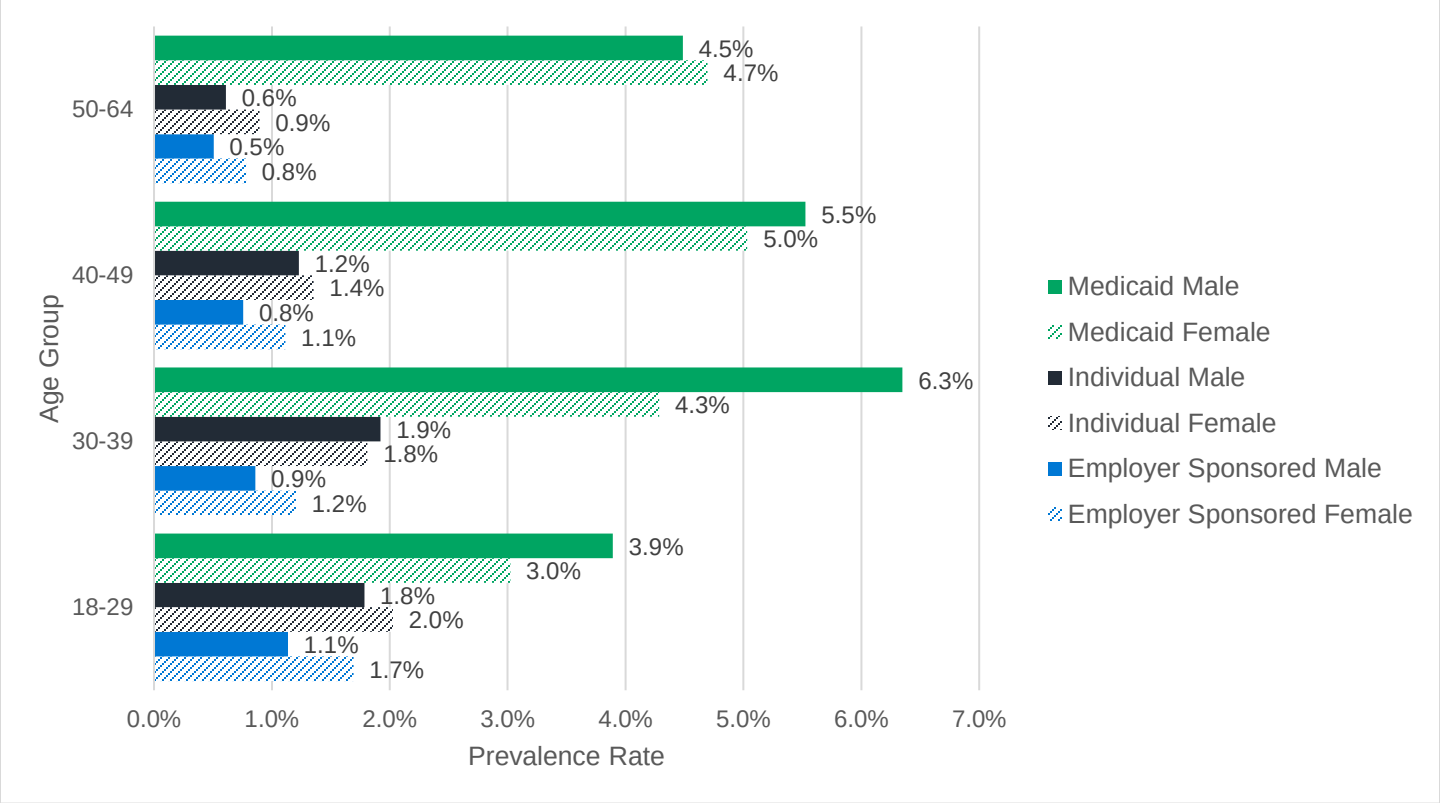
SMI PREVALENCE BY COVERAGE TYPE

As we discuss how individuals with SMI may be affected by the potential loss of Medicaid coverage, it is important to understand the prevalence of schizophrenia and bipolar disorder across plan types and which individuals may be most in need of seeking alternative coverage options to maintain access to care.

An analysis of Milliman's healthcare claims research database illustrates a higher prevalence of schizophrenia and bipolar disorder among adults with Medicaid coverage compared to adults with exchange or other commercial plans (see methodology underlying this analysis in the Appendix). In 2021, about 4.4% of Medicaid-enrolled adults aged 18 to 64 were diagnosed with schizophrenia or bipolar disorder, compared to only 1% of adults enrolled in commercial health insurance in the same age group (in individual or employer-sponsored plans).

Figure 2 illustrates the diagnosis-based prevalence of schizophrenia and bipolar disorder by gender and age group across three different coverage types—employer-sponsored, individual plans (ACA-compliant plans obtained on or off an exchange), and Medicaid non-elderly adults who do not have Medicare coverage. It is important to note that the illustrated prevalence rates for each insurance market are influenced by the likelihood of individuals at varying health risk levels enrolling in coverage. In general, healthier individuals are less likely to purchase insurance.

FIGURE 2: PREVALENCE RATE OF SCHIZOPHRENIA AND BIPOLAR DISORDER BY AGE GROUP AND PLAN TYPE, 2021



[23] Zhan, A., Ario, J.S., & Straw, T.R. (February 15, 2023). Oregon's Glide Path to a Basic Health Program Following the End of Medicaid Continuous Coverage. Manatt. Retrieved May 30, 2023, from https://www.manatt.com/insights/newsletters/health-highlights/oregons-glide-path-to-a-basic-health-program-foll.

Across all genders and age groups, the prevalence of individuals with schizophrenia and bipolar disorder was the highest for Medicaid-enrolled individuals, compared to those with employer-sponsored health insurance or individual plans. Within Medicaid, there was also a higher prevalence of these conditions for men as compared to women for all age groups except 50 – 64 years old. In contrast, the prevalence rate is similar (for all age groups) among men and women in the individual market. In employer-sponsored plans, the prevalence rate was similar for genders ages 30 to 64. However, a slightly higher proportion (1.7%) of women aged 18 to 29 were diagnosed with schizophrenia or bipolar disorder compared to men of the same age group (1.1%). Other factors such as gender, race, and ethnicity may influence an individual's diagnosis and may contribute to the differences across the three markets.

Commercial insurance coverage: Ramifications for SMI population

Key Takeaways

- Transitioning from Medicaid to commercial insurance can have various implications for individuals with SMI in terms of their ability to access care.
- Individuals are likely to have higher cost-sharing obligations in commercial plans relative to what they experienced while covered by Medicaid.
- People's ability to access certain drugs, services, and providers might also differ to the extent there is variance in formulary design, benefit packages, and provider networks between their previous Medicaid plan and new commercial plan.

COMMERCIAL COVERAGE FEATURES

For individuals with SMI disenrolled from Medicaid who have access to commercial coverage, such as health insurance exchanges and employer-sponsored plans, they may experience differences in plan choice, premium rates, and cost-sharing requirements relative to their previous Medicaid coverage.

Cost overview. Whether through insurance purchased on a health insurance exchange or through an employer-sponsored plan, cost-sharing in commercial plans is likely to be higher relative to what individuals previously on Medicaid are accustomed to, where they are more likely to have little to no costs at the point of service. While coverage choices, premiums, and cost-sharing vary widely among commercial coverage options, the table in Figure 3 provides an overview of typical member financial requirements in the exchange and among employer-sponsored coverage.

FIGURE 3: OVERVIEW OF PLAN CHOICES AND MEMBER FINANCIAL REQUIREMENTS BY COMMERCIAL COVERAGE TYPE

Coverage Type	Plan Choice	Premiums	Cost-Sharing
Marketplace/health insurance exchange	Individuals may choose from any QHP offered on the exchange. Nationally, 72% of counties have at least three insurers offering exchange coverage in calendar year 2023.[24] These 72% counties represent 92% of QHP consumers.[25]	In most states, premiums vary by a 3:1 ratio from ages 21 to 64 (if a 21-year-old premium is $300, the 64-year-old premium is $900). Federal premium subsidies limit the out-of-pocket premium to a specified percentage of household income for the "subsidy benchmark plan." More detail on subsidy value is provided in the next section.	Cost-sharing requirements (deductibles, copays, coinsurance) for QHPs offered in the exchanges vary widely. However, for consumers with incomes up to 200% of the federal poverty level, QHPs with deductibles below $1,000 are readily available,[26] with out-of-pocket cost-sharing limited to $3,000 by statute for certain plans.[27]
Employer-sponsored health plans	The typical employer offers one to three plan choices, with large firms having a greater likelihood of offering multiple plans relative to small firms.[28]	Employees may be required to make a premium contribution to enroll on the plan. For single coverage, employee contributions are typically in the range of $500 to $2,000 annually. For family coverage, premium contributions typically range from $3,000 to $7,500.[29]	Approximately 90% of workers are enrolled in a plan with a deductible, with an average deductible of approximately $1,800 for single coverage[30] and an annual out-of-pocket maximum typically between $3,000 and $6,000.[31]

Exchange subsidy enhancements during the COVID-19 PHE. Under the health insurance exchanges, individuals are potentially eligible for premium tax credits that are intended to make coverage more affordable by reducing the amount of enrollees' monthly payments.[32] Eligibility for—and the size of—the tax credits is generally a matter of whether the individual is able to access affordable coverage via an employer, Medicare, Medicaid, or CHIP, and household income relative to the FPL.[33] For context, the income established as the 2022 FPL is $13,590 for an individual and $27,750 for a family of four.[34,35] The ACA allowed states to expand Medicaid eligibility up to a threshold of 138% of the FPL, but, as of publication of this paper, 10 states had not expanded Medicaid. In the non-expansion states, the median income threshold for Medicaid eligibility is only 38% of the FPL (which equates to $5,164 for an individual and $10,545 for a family of four, using the 2022 FPL mentioned above).[36] The table in Figure 4 provides a high-level overview of how income determines eligibility for Medicaid as well as exchange premium tax credits. While these subsidies help make exchange coverage more affordable, a gap remains in non-Medicaid-expansion states for individuals whose income is higher than the maximum Medicaid eligibility limit yet below 100% FPL, where they cannot qualify for Medicaid and also cannot qualify for exchange subsidies.

[24] CMS. County by County Plan Year 2023 Insurer Participation in Health Insurance Exchanges. Retrieved May 30, 2023, from https://www.cms.gov/files/document/py2023-county-coverage-map.pdf.
[25] CMS (October 26, 2022). Plan Year 2023 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces. Retrieved May 30, 2023, from https://www.cms.gov/cciio/resources/data-resources/downloads/2023qhppremiumschoicereport.pdf.
[26] Ibid., Figure 6.
[27] CMS (December 28, 2021). Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2023 Benefit Year, Table 1. Retrieved May 30, 2023, from https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf.
[28] Kaiser Family Foundation (2022). Employer Health Benefits: Annual Survey, Figure 4.1. Retrieved May 30, 2023, from https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.
[29] Ibid., Figure 6.13 and Figure 6.14.
[30] Ibid., Figure 7.3.
[31] Ibid., Figure 7.45.
[32] HealthCare.gov. Premium tax credit. Glossary. Retrieved May 30, 2023, from https://www.healthcare.gov/glossary/premium-tax-credit/.
[33] Ibid.
[34] The 2022 FPL is used to determine eligibility for premium tax credits for 2023 plans.
[35] HealthCare.gov. Federal poverty level (FPL). Glossary. Retrieved May 30, 2023, from https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.
[36] Rudowitz, R. et al. (March 31, 2023). How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion? Kaiser Family Foundation. Retrieved May 30, 2023, from https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

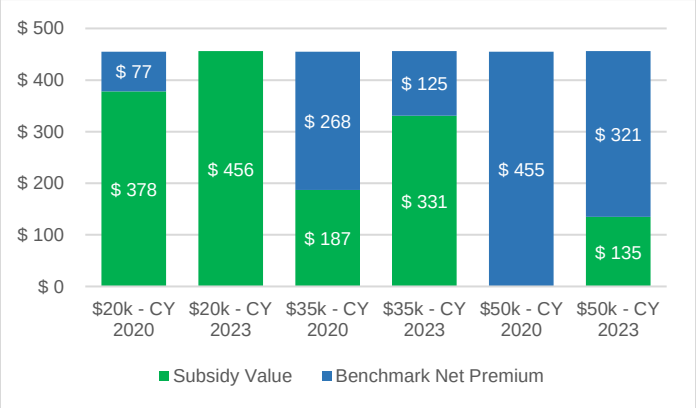
FIGURE 4: EXCHANGE PREMIUM TAX CREDIT ELIGIBILITY

Income as percentage of FPL	Premium tax credit eligibility
Below 100% FPL	▪ Not likely eligible for premium tax credits. ▪ Eligibility for Medicaid coverage depends on individual state requirements.
Below 138% FPL	▪ Eligible for Medicaid in expansion states.
Between 100% to 400%	▪ Eligible for premium tax credits if not eligible for Medicaid or affordable employer-sponsored coverage.
Above 400%	▪ May qualify for premium tax credits due to ARPA and IRA temporarily increasing availability (more below).

Just as Congress acted to keep more people eligible for Medicaid during the pandemic, it also passed laws to make exchange coverage more affordable to promote ongoing coverage. As the result of two pieces of legislation—first the American Rescue Plan Act (ARPA) and then the Inflation Reduction Act (IRA)—Congress provided for enhanced exchange premium subsidies, beginning in calendar year (CY) 2021, which will continue through at least calendar year 2025.[37] Premium subsidies provide consumers the ability to purchase QHP plans at a capped percentage of income, with the subsidy covering the rest of the cost.

Milliman queried the Kaiser Family Foundation premium subsidy calculator for calendar years 2020[38] and 2023[39] to illustrate how the increased subsidies under the IRA have reduced the cost of the subsidy benchmark plan for calendar year 2023 relative to CY 2020. This query was for select income levels ($20,000, $35,000, and $50,000) for a single 40-year-old based on national average premiums. As shown in Figure 5, while the illustrated benchmark QHP premiums increased by $1 from CY 2020 to CY 2023, the consumer net premiums for the subsidy benchmark plan decreased significantly over this period, due to the increased subsidies implemented by ARPA and sustained by the IRA.[40] For example, a single 40-year-old with $35,000 in annual income would have been required to pay $268 in monthly net premiums during CY 2020, but only $125 in monthly net premiums during CY 2023. This is the result of the individual's federal premium subsidy increasing from $187 to $331 per month under the enhanced subsidy structure. Particularly for persons who have been enrolled in Medicaid since the initial stages of the COVID-19 PHE, communicating during the Medicaid redetermination process about improved exchange QHP affordability that has recently become available may reduce the likelihood of consumers becoming uninsured upon disenrollment from Medicaid. However, as mentioned previously, individuals who live in non-Medicaid expansion states and whose income is below 100% FPL but is higher than their state's maximum Medicaid eligibility limit, would not be eligible for enhanced subsidies.

FIGURE 5: MONTHLY NET PREMIUM AND SUBSIDY VALUE VARIATION BY HOUSEHOLD INCOME, SUBSIDY BENCHMARK PLAN, SINGLE 40-YEAR-OLD, NATIONAL AVERAGE PREMIUMS – CY 2020 AND CY 2023



Costs for persons with bipolar disorder or schizophrenia. Medicaid programs typically operate with zero or very low member cost-sharing (and are typically limited to copays and, in some cases, small monthly premium-like payments). While Medicaid members with SMI are often accustomed to minimal or no cost-sharing requirements, members who transition to an exchange plan or employer-sponsored coverage may experience material differences in their cost-sharing obligations when accessing services (including a more complex range of payments like premiums, deductibles, coinsurance, and copays), depending on their insurance plan design.

The extent of financial obligations for health insurance could potentially limit the ability of some individuals to afford care, even though their coverage is considered "affordable" under the law. This is particularly true for persons with bipolar disorder or schizophrenia, due to the chronic nature of their health condition and need for ongoing monthly care. If cost-sharing obligations are felt to be unaffordable, it may cause medication adherence lapses or cause individuals to delay or skip other types of care. To assess typical member cost-sharing requirements in the commercial health insurance markets, we analyzed the

[37] Keith, K. (August 9, 2022). Congress Poised to Extend Enhanced Marketplace Subsidies Through 2025. Health Affairs. Retrieved May 30, 2023, from https://www.healthaffairs.org/content/forefront/congress-poised-extend-enhanced-marketplace-subsidies-through-2025.
[38] Kaiser Family Foundation (October 1, 2020). 2020 Health Insurance Marketplace Calculator. Retrieved May 30, 2023, from https://www.kff.org/interactive/subsidy-calculator-2020/.
[39] Kaiser Family Foundation. Health Insurance Marketplace Calculator. Retrieved May 30, 2023, from https://www.kff.org/interactive/subsidy-calculator/.
[40] Note that the net premiums are also influenced by changes in the federal poverty level each calendar year, but the vast majority of the change is attributable to premium subsidy enhancements under the IRA.

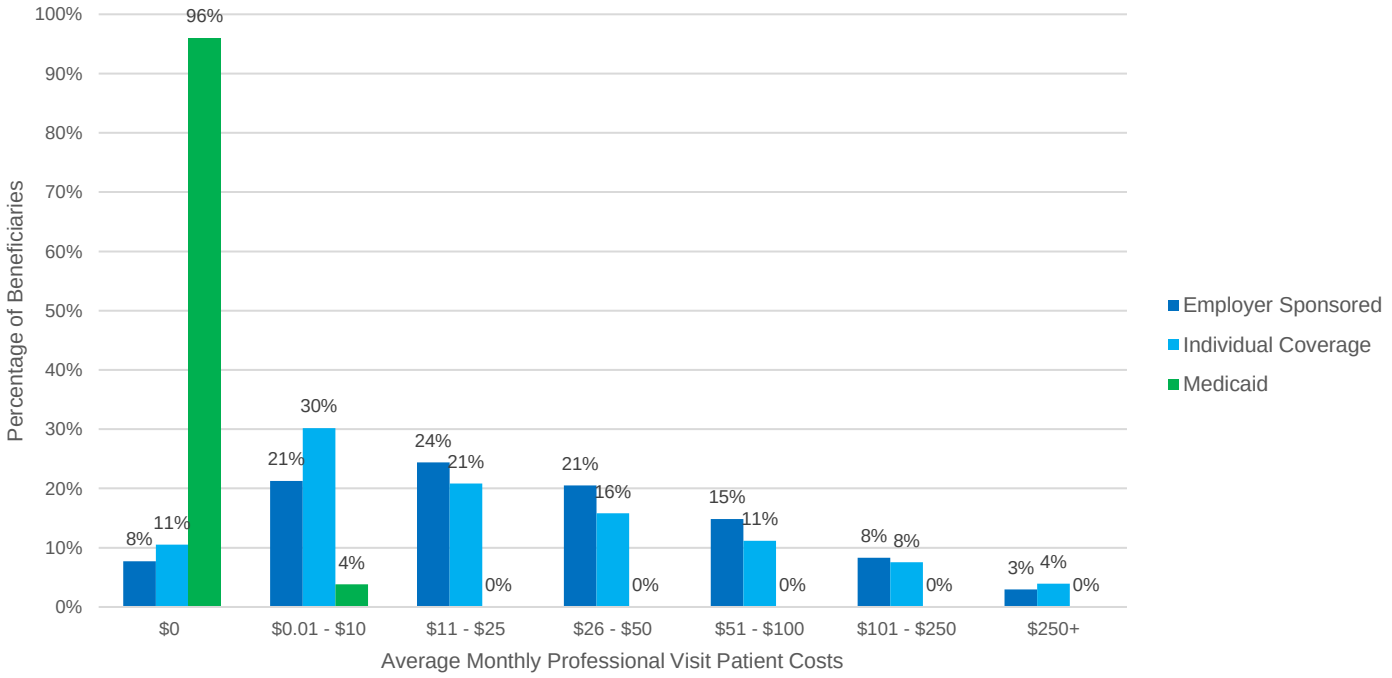
distribution of monthly out-of-pocket costs related to visits for select medical services and prescription drugs for persons with bipolar disorder or schizophrenia. Note that these services do not reflect an individual's total cost-sharing obligations for commercial coverage. We have highlighted these specific services to illustrate cost-sharing obligations for services that are intended to support stability in persons with SMI and avoid crisis-related inpatient and emergency room visits.

Cost-sharing expenses for select medical services. Utilizing Milliman's healthcare claims research database, the following services were analyzed:

- Professional outpatient psychiatric visits
- Professional outpatient treatment for substance use disorders
- Professional office or home visits with a specialist or primary care physician

Figure 6 illustrates the monthly professional visit cost-sharing requirements for adults with schizophrenia or bipolar disorder, separately for persons covered by Medicaid, employer-sponsored, and individual coverage. A majority of members pay an average of $0 to $25 per month for professional visits in both markets (Medicaid and commercial), and the vast majority of Medicaid beneficiaries pay less than $10 per month. However, nearly half of people on commercial plans pay substantially more. For example, 47% of beneficiaries with employer-sponsored plans and 39% with individual plans pay over $25 per month, while 3% (employer-sponsored) and 4% (individual) of beneficiaries spend over $250 per month on professional visits alone.

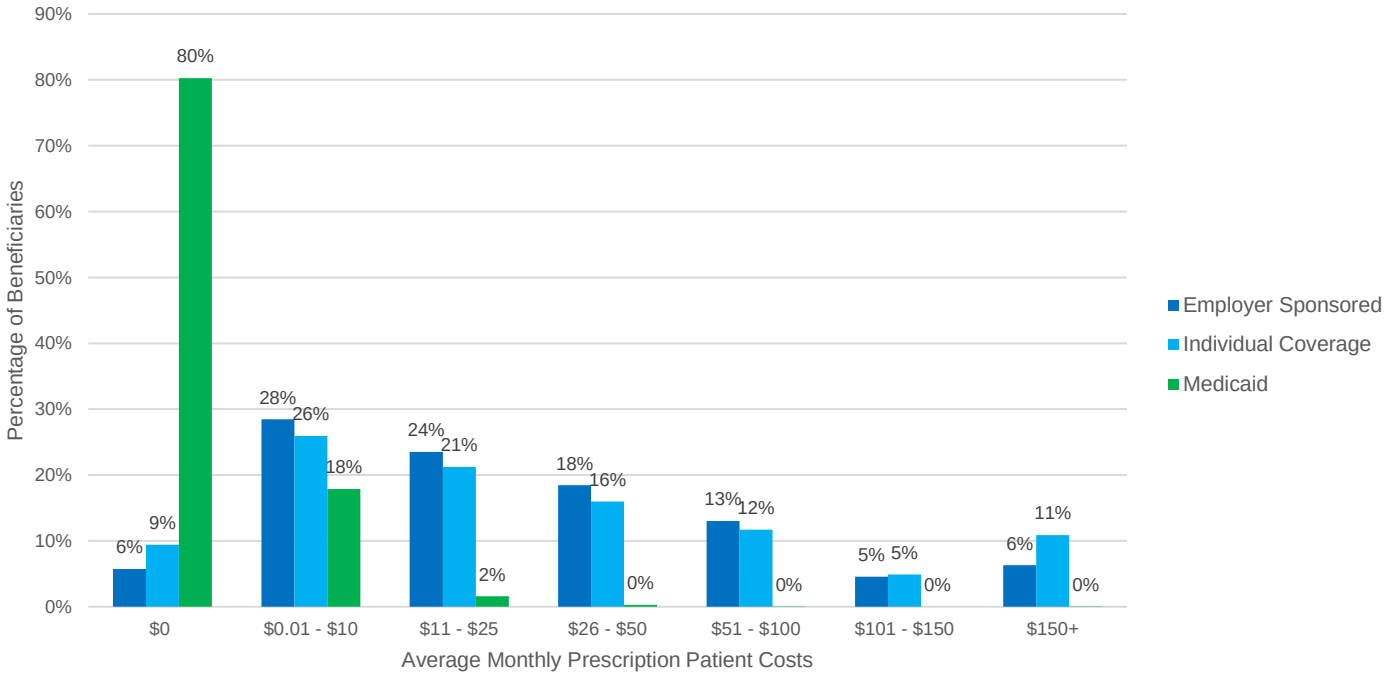
FIGURE 6: DISTRIBUTION OF PROFESSIONAL VISIT COST-SHARING BY INSURANCE TYPE – ADULTS WITH SCHIZOPHRENIA OR BIPOLAR DISORDER (CALENDAR YEAR 2021)



Prescription drugs. Cost-sharing obligations for covered prescription drugs may also vary significantly between Medicaid and commercial plans. Medication adherence plays a critical role in maintaining stable health and well-being for persons with bipolar disorder or schizophrenia and, to the extent increased cost-sharing makes the ability to afford prescriptions more challenging, it can potentially make medication adherence more difficult. For example, a consumer may be accustomed to having zero copayment when filling prescriptions for their medications under Medicaid but, depending on the drug in question or plan design, that is unlikely to be the case on a commercial plan.

When Medicaid beneficiaries lose coverage, have a lapse in coverage, or transition to a new coverage source, they could experience an increase in out-of-pocket costs to maintain treatment. Nationwide, 98% of Medicaid beneficiaries spend between $0 and $10 monthly on prescription drugs. In contrast, Figure 7 highlights the monthly prescription out-of-pocket costs for adults on employer-sponsored and individual coverage who have schizophrenia or bipolar disorder, with 58% of beneficiaries on employer-sponsored and 56% of beneficiaries on individual plans having costs between $0 and $25 per month. Though most beneficiaries on commercial plans have monthly prescription patient costs between $0 and $25, 42% of beneficiaries on employer-sponsored plans and 44% of beneficiaries on individual plans will have costs above $25 per month, including 6% and 11% of beneficiaries, respectively, whose costs are over $250 per eligibility month out of pocket for prescriptions.

FIGURE 7: DISTRIBUTION OF PRESCRIPTION DRUG COST-SHARING BY INSURANCE TYPE – COVERED ADULTS WITH SCHIZOPHRENIA OR BIPOLAR DISORDER (CALENDAR YEAR 2021)



As shown by Figures 6 and 7, **when adults with bipolar disorder or schizophrenia lose Medicaid coverage, most will experience material differences in their financial responsibilities as they attempt to access both professional services and prescription drugs.** While individual cost-sharing will primarily be influenced by insurance plan design and utilization of services with cost-sharing requirements, increased costs for professional visits or prescription drugs could hinder members from seeking care from providers at the same rate as when they were enrolled in Medicaid coverage. According to the 2021 National Health Interview Survey,[41] 6% and 9% of respondents, respectively, reported either delaying or forgoing care for prescription drugs and medical care.

Enrollment periods. When the ACA created the health insurance exchanges, a key component was the establishment of a designated period every year, known as open enrollment, when people can sign up or change their health insurance plans. These open enrollment periods typically occur in the fall and last through the beginning of the year. In the most recent year, 16.3 million people purchased health insurance through a health insurance exchange.[42] In addition to the annual open enrollment period, the law created special enrollment periods (SEPs) that

[41] Rakshit, S. et al. (January 30, 2023). How does cost affect access to healthcare?. Peterson-KFF Health System Tracker. Retrieved May 30, 2023, from https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#Percent%20of%20adults%20(age%2018%20years%20and%20older)%20who%20report%20delaying%20and/or%20going%20without%20care%20due%20to%20costs,%20by%20type%20of%20care,%202020-2021.

[42] CMS (January 25, 2023). Fact Sheet: Marketplace 2023 Open Enrollment Period Report: Final National Snapshot. Retrieved May 30, 2023, from https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot.

allow people to sign up for health insurance due to certain changes in their life (e.g., losing health insurance including Medicaid coverage, getting married, change in income, having a baby). The open enrollment period for employer-sponsored insurance is typically set by the employer and may vary depending on the company and type of plan offered. Unlike Medicaid, which permits year-round enrollment, individuals are not able to enroll in employer-sponsored insurance or coverage through health insurance exchanges outside of their open enrollment periods, except when they experience changing life circumstances as described above.

Covered services and prescription drugs. The availability of certain services and drugs might also differ relative to Medicaid to the extent that commercial plans have different benefit packages and formulary designs. Individuals might find that some services and drugs covered by their previous Medicaid plans are not covered by their new commercial plans or as discussed above, might have higher cost-sharing obligations. For example, analysis conducted by the Kaiser Family Foundation demonstrated that in some states Medicaid coverage provided more comprehensive behavioral health benefits than the states' QHPs (exchange plans).[43] It is also quite typical for different insurance plans to offer differing arrays of preferred or covered prescription drugs. Therefore, regardless of whether there are increased cost-sharing obligations, it is possible that individuals could lose access to certain services or drugs as a function of moving to a coverage program with a formulary. In contrast, state Medicaid programs are generally required by the Medicaid Drug Rebate Program (MDRP) to cover all participating manufacturers' drugs when prescribed for a medically accepted indication as soon as the U.S. Food and Drug Administration (FDA) has approved the drug and it has entered the market. As commercial insurers are not bound by MDRP rules, it is therefore possible that access to certain drugs, such as emerging therapeutic approaches, might be different between Medicaid and commercial plans.

Provider networks. Individuals who transition from a Medicaid plan to a commercial plan might also encounter different provider networks and different standards for member access (broader or narrower networks), which could mean that individuals might be forced to find a new provider that accepts the new plan. There are no national standards for network adequacy; states have varying rules and regulations.[44] As a general matter, employer-based plans might be more likely to have more robust networks relative to other options.[45] This is not necessarily the case for QHPs offered in the exchanges, where an analysis by the Center on Health Insurance Reforms at Georgetown University found that Medicaid beneficiaries experience increased network adequacy standards compared to individuals enrolled in QHPs.[46] In the states that were analyzed, Medicaid plans were generally more likely to have in place regulations around time and distance standards, provider-to-enrollee ratios, and appointment wait times relative to exchange QHPs. As such, individuals with QHPs might face greater challenges in finding available providers relative to their experience with Medicaid plans. Regardless of whether the individual transitions to an exchange plan or commercial plan, or whether the network is more or less robust, it is possible that the networks will be different, and they might need to transition to a new provider.

Provider access could be further exacerbated by more general workforce shortages of behavioral health providers, meaning certain provider types are less available or simply don't exist nearly.[47] Faced with the challenge of finding a new provider and given the large behavioral health workforce shortages in communities across the country, these circumstances may combine during this time of coverage transition to limit access to care for individuals with SMI (alongside the existing challenges stemming from their illness and broader socioeconomic hurdles that we have previously discussed).

[43] HealthCare.gov, Qualified health plan, Glossary, op cit.
[44] Pollitz, K. (February 4, 2022). Network Adequacy Standards and Enforcement. Kaiser Family Foundation. Retrieved May 30, 2023, from https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.
[45] Ibid.
[46] Corlette, S. et al. (March 1, 2022). Access to Services in Medicaid and the Marketplaces. Robert Wood Johnson Foundation. Retrieved May 30, 2023, from https://www.rwjf.org/en/insights/our-research/2022/03/assessing-federal-and-state-network-adequacy-standards-for-medicaid-and-the-marketplace.html.
[47] Health Resources and Services Administration. Health Workforce Shortage Areas. Retrieved May 30, 2023, from https://data.hrsa.gov/topics/health-workforce/shortage-areas.

State coverage strategies and considerations for interested parties

Key Takeaways

- States and other interested parties have several strategies to consider that can assist beneficiaries who are disenrolling from Medicaid at the end of the continuous coverage requirement to reduce the risk of disruption to their access to treatment and care.
- States can develop education materials and intentional outreach efforts to individuals with SMI to ensure individuals understand and are connected to coverage options that make sense for them. Possible partners include enrollment navigators and state eligibility staff as well as collaboration with other groups such as health plans, community organizations, providers, and other social service providers.
- States can also consider how to make enrollment in a commercial plan or Medicaid easier or support individuals transitioning to a new plan. Options may include retroactive or presumptive eligibility policies and policies to streamline eligibility and enrollment or potentially cost-sharing support for individuals newly enrolled in commercial insurance.

Policymakers, providers, and patient advocacy organizations have expressed concerns that the Medicaid continuous coverage unwinding may result in significant disruption in maintaining treatment and access to care, especially for vulnerable and underserved populations. States and interested parties may wish to consider the following options to support individuals to reenroll in Medicaid when they lose Medicaid eligibility for procedural reasons or to transition from Medicaid to health insurance exchanges if they are no longer Medicaid-eligible for programmatic reasons.

Targeted communication and outreach strategies. Understanding the challenges that people with SMI face and designing specific outreach and enrollment campaigns to create awareness and provide assistance may help reduce unnecessary gaps in coverage during this period. Targeted outreach by enrollment Navigators and state eligibility staff may help individuals who lose Medicaid eligibility to understand more fully their coverage options and support their enrollment into health insurance exchanges or other available coverage, or to reenroll in Medicaid if still eligible. States can support or supplement these outreach and consumer assistance activities to promote seamless coverage transitions. In particular, easy-to-understand communication about special enrollment periods, availability of premium subsidies, education on the unwinding process, and support through enrollment activities for people with SMI and other at-risk population groups may help reduce Medicaid churn and boost enrollment for eligible individuals into QHPs.

Community organizations, providers, and those health and social services systems that have already established trust, confidence, and acceptance with people with SMI are partners with which Navigators and state enrollment staff could prioritize engagement, as well as sharing the educational materials that individuals will be receiving, so these groups can help reach individuals where they are, and in culturally and linguistically appropriate ways.

Navigators are individuals or organizations that are trained to help consumers find coverage on an exchange.[48] In August 2022, the Biden administration invested $98.9 million in grant funding to support Navigator organizations ahead of the 2023 ACA Open Enrollment period.[49] As part of the special enrollment period established for the unwinding, CMS intends to provide technical assistance and training to Navigators to help consumers who have been disenrolled in Medicaid learn about how they can enroll in a health insurance exchange plan.[50] In many cases, these staff are also well versed in Medicaid enrollment rules and can serve as a resource to consumers for both programs.

Special enrollment periods. In January 2023, CMS announced a temporary special enrollment period (SEP) for the federally facilitated exchange outside of the annual open enrollment period for individuals losing Medicaid or CHIP coverage due to the unwinding of the Medicaid continuous eligibility requirement.

[48] HealthCare.gov. Navigator. Glossary. Retrieved May 31, 2023, from https://www.healthcare.gov/glossary/navigator/.
[49] HHS (August 26, 2022). Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period. Press release. Retrieved May 31, 2023, from https://www.hhs.gov/about/news/2022/08/26/biden-harris-administration-makes-largest-investment-ever-in-navigators-ahead-of-healthcare-gov-open-enrollment-period.html.
[50] CMS (January 27, 2023). Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition – Frequently Asked Questions (FAQ). Retrieved May 31, 2023, from https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

Individuals and families attesting to their last date of Medicaid or CHIP coverage will be able to submit new applications or update existing applications on the federally facilitated marketplace at HealthCare.gov between March 31, 2023, and July 31, 2024. Eligible individuals will then have 60 days to select a QHP after submitting an application.[51]

It should be noted that this temporary SEP will not apply in states that operate their own exchange. While not required, state-based exchanges can offer this same unwinding SEP to permit enrollment through July 31, 2024, for those individuals who lose Medicaid eligibility or develop their own SEP.[52,53]

Partner with health plans to support Medicaid reenrollment and transitions to other coverage sources. States with Medicaid managed care delivery systems can require managed care plans to support efforts to promote coverage continuity when individuals lose Medicaid eligibility. CMS has issued guidance indicating that federal regulations do not prevent state Medicaid agencies and managed care plans from working together to help individuals who have been terminated from Medicaid transition to another coverage source or back to Medicaid.[54]

When individuals lose coverage for procedural reasons but otherwise remain Medicaid-eligible, states can provide Medicaid managed care plans with monthly termination files and require plans to conduct outreach to the terminated individuals to assist with the Medicaid renewal process on behalf of the state. This outreach is not considered a prohibited marketing activity as long as the information is not intended to influence the individual to enroll in a specific plan.

Additionally, for individuals who do not remain Medicaid-eligible, states may encourage their contracted Medicaid managed care plans to do outreach to assist these individuals to enroll in an exchange plan offered by the same carrier, even before they lose Medicaid coverage. If the QHP is offered by the same Medicaid managed care plan, this outreach and assistance is also not considered prohibited marketing.[55]

States also typically require coordination of care between an individual's former Medicaid plan and their new source of coverage. However, the individual must consent to sharing of their member data outside of the individual's Medicaid managed care plan or that plan's associated QHP.[56]

A corollary to this strategy is for states to incentivize health insurers to participate in both Medicaid and the exchange. States can leverage their Medicaid managed care procurements to either require respondents to offer a companion exchange plan or offer bonus points in the procurement scoring rubric to those plans that do. Health plans that offer products across the coverage continuum may help promote continuity of care and maintain access to treatment. However, to the extent carriers are not currently participating in both programs, this represents a longer-term strategy for supporting individuals through coverage transitions.

Retroactive and presumptive eligibility. For individuals who lose Medicaid coverage but later reenroll, states have options to reduce the duration of their periods of uninsurance. The typical rule for retroactive Medicaid coverage is to provide coverage up to three months prior to the enrollment date. However, some states have used 1115 demonstration waivers to shorten or eliminate this period of retroactive coverage for certain beneficiaries, particularly uninsured adults. States that had previously waived retroactive eligibility through 1115 waivers could restore full retroactive eligibility to cover the healthcare expenses for the three months prior to an individual's application date, provided the individual would have been eligible during that time period. This action could be taken on a temporary basis (e.g., during the unwinding only) or for select at-risk populations.[57]

[51] Ibid.
[52] See § 155.420 Special enrollment periods, in the Code of Federal Regulations, at https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-E#p-155.420(d)(9).
[53] National Governors Association (January 19, 2023). State Strategies to Support Marketplace Plan Enrollment as the Medicaid Continuous Coverage Requirement Winds Down. Retrieved May 31, 2023, from https://www.nga.org/publications/state-strategies-to-support-marketplace-plan-enrollment-as-the-public-health-emergency-coverage-provisions-wind-down/.
[54] CMS (January 2023). Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations. Retrieved May 31, 2023, from https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy.pdf.
[55] Ibid.
[56] Ibid.
[57] Shafer, P. et al. (May 8, 2020). Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible for Coronavirus Treatment Costs. Health Affairs. Retrieved May 31, 2023, from https://www.healthaffairs.org/do/10.1377/forefront.20200506.111318/#.

Retroactive eligibility allows states to retrospectively cover and pay for healthcare expenses for individuals on Medicaid three months prior to the date of their actual application. **Presumptive eligibility** allows states to authorize "qualified entities" to screen individuals for Medicaid and CHIP eligibility and immediately prospectively enroll those who appear eligible prior to their application being fully processed.[58]

To expand the range of locations that can assist with the enrollment procedure, states can also implement presumptive eligibility policies to allow specific qualified entities (such as providers, hospitals, schools, and community-based organizations) to screen individuals for Medicaid eligibility and temporarily enroll them while they complete the application process.[59]

Streamline eligibility and enrollment administrative processes. Simplifying and aligning the eligibility determination and enrollment processes across Medicaid, CHIP, and health insurance exchanges may create application efficiencies and facilitate enrollment into QHPs for those individuals found ineligible for Medicaid. While the ACA already requires all states to use a common income standard, have a single, streamlined application, and follow standardized procedures for transferring eligibility data between Medicaid, CHIP, and subsidized health insurance exchange coverage,[60] some states may wish to consider further system integration opportunities as a way to facilitate greater enrollment. Utilizing consistent language and messaging across health insurance coverage options and including links to federally facilitated marketplace messaging may help understanding and increase individual participation in the enrollment process.[61]

States with state-based exchanges could consider creating a single eligibility system or integrating eligibility systems across agencies to transition individuals between coverage sources. Automatic enrollment of eligible individuals who are no longer Medicaid-eligible into subsidized coverage through the exchange is another option for states with state-based exchanges (to the extent permitted by state law). For example, California automatically enrolls individuals into the lowest-cost silver plan available when they lose Medicaid coverage and gain eligibility for subsidized coverage through a QHP. Individuals with a monthly net premium must then pay their first month's premium in order to effectuate this new QHP coverage. Individuals without a monthly net premium must effectuate coverage online or by phone.[62]

In states without a state-based exchange, the Medicaid program can electronically refer individuals to the federally facilitated marketplace when they are determined to be no longer Medicaid-eligible.[63]

Cost-sharing support. As noted above, individuals transitioning from Medicaid coverage with little (or no) cost-sharing may face financial barriers to enrolling in QHPs with premiums, deductibles, and copays. While recent federal legislation[64] provides additional cost-sharing support to individuals who wish to enroll in exchange coverage, states may seek to provide further assistance, particularly for those individuals who may not be eligible for federal subsidies. Six states have established state-funded subsidies in addition to the federal subsidies as a way to further make exchange plan premiums and cost-sharing even more affordable for consumers in their states.[65,66]

[58] Medicaid.gov. Presumptive Eligibility. Retrieved May 31, 2023, from https://www.medicaid.gov/medicaid/enrollment-strategies/presumptive-eligibility/index.html.
[59] Ibid.
[60] MACPAC (July 2022). Transitions Between Medicaid, CHIP, and Exchange Coverage. Issue Brief. Retrieved May 31, 2023, from https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.
[61] CMS (February 2, 2023). Strategies for SBMs to Improve Medicaid to Marketplace Coordination and Maximize Enrollee Transitions at the End of the Continuous Enrollment. Retrieved May 31, 2023, from https://www.medicaid.gov/resources-for-states/downloads/sbm-strategies-03162022.pdf.
[62] Covered California. Fact Sheet: Medi-Cal to Marketplace Automatic Enrollment Program. Retrieved May 31, 2023, from https://hbex.coveredca.com/data-research/library/CoveredCA-Medicaid-to-Marketplace-AutoenrollmentStrategy-FactSheet-v1.pdf.
[63] Scotti, S. (March 8, 2023). States Hope to Ease Medicaid Enrollees' Transition to Marketplace Health Plans.NCSL. Retrieved May 31, 2023, from https://www.ncsl.org/resources/details/states-hope-to-ease-medicaid-enrollees-transition-to-marketplace-health-plans.
[64] The Inflation Reduction Act of 2022 (IRA) extends through 2025 the enhanced premium tax credit that was originally authorized through the American Rescue Plan Act (ARPA) and that would have otherwise expired at the end of 2022. Specifically, ARPA made premium tax credits temporarily available to individuals with incomes above 400% FPL and increased the subsidy available for those with incomes below 400% FPL. See https://www.nga.org/publications/state-strategies-to-support-marketplace-plan-enrollment-as-the-public-health-emergency-coverage-provisions-wind-down/; and https://www.cms.gov/blog/inflation-reduction-act-tax-credits-improve-coverage-affordability-middle-income-americans.
[65] Levitis, J. (March 11, 2021). Supporting Insurance Affordability With State Marketplace Subsidies. State Health and Value Strategies. Retrieved May 31, 2023, from https://www.shvs.org/supporting-insurance-affordability-with-state-marketplace-subsidies/.
[66] National Governors Association (January 19, 2023), op cit.

Leveraging safety net resources for the newly uninsured population

Key Takeaways

- Despite best efforts to ensure that individuals who lose Medicaid coverage are supported in finding other coverage, it is still likely that some people will experience a gap in coverage. People with SMI could be considered as high risk for coverage disruption.
- Community health providers like Federally Qualified Health Centers (FQHCs), community mental health centers, and free and charitable clinics are among the options to care for uninsured individuals.
- States may wish to review funding capacity to support these safety net providers and increase their ability to serve a potential influx of uninsured individuals.

Despite efforts to ensure that individuals who lose Medicaid coverage are supported in finding other coverage, there is a strong possibility that some people will experience a gap in coverage following the Medicaid unwinding. The Kaiser Family Foundation found, when examining health insurance changes in the 2016-2019 period, that approximately 65% of people experienced a period of uninsurance in the year following a disenrollment from Medicaid or CHIP.[67] Without subsequent insurance coverage, options for these uninsured individuals to receive healthcare may be limited to safety net providers. As a result, the impact of these uninsured people, particularly those individuals with SMI, on state safety net programs may be significant following the unwinding. The demand for safety net services may exceed the capacity of these programs, leading to long waiting lists, limited access to care, and reduced quality of services. Additionally, lacking coverage that helps pay for healthcare services, uninsured individuals may delay seeking care until their conditions have become more severe, placing further strain on the resources of state or local safety net programs and emergency departments.

Barring insurance or other healthcare coverage options, the state healthcare safety net system is likely the remaining source of access to care for individuals who are disenrolled from Medicaid due to the unwinding. Federally Qualified Health Centers (FQHCs) and community mental health providers can access federal grants to support care for individuals who are uninsured or underinsured.[68,69] Another local option is ensuring individuals are aware of free and charitable clinics in their communities and, where possible, supporting those clinics in providing needed services to those individuals.[70] Finally, as a last resort, individuals are able to utilize emergency departments if there are no other options available to them. Limitations to the usefulness of these safety net options may include the absence of preventive care services and lack of access to prescription drugs, both of which are particularly important for individuals with ongoing healthcare needs like SMI.

Summary

States may want to review their existing funding and capacity within healthcare safety net programs to ensure that these systems are prepared to meet the potential increase in demand as individual needs rise. This could involve identifying additional sources of funding or resources, such as state-level or grant funding, or considering opportunities for collaboration with community organizations. It may also involve developing contingency plans or strategies to address potential gaps in capacity. States have officially started the process of unwinding the Medicaid continuous coverage requirement that was initiated at the beginning of the COVID-19 pandemic. As they do so, certain populations, like people with SMI, may lose coverage either because they are validly ineligible or, possibly even more likely, due to challenges related to procedural or administrative processes. Special considerations for this population may be warranted to help ensure continuity of care and access to therapies, as well as decrease the risk and cost of unintended consequences on the state's healthcare infrastructure should people living with SMI fall out of care.

Regardless of the reason for coverage loss, states whose objective is to support continued access to healthcare for this population might wish to consider the different coverage options available to individuals disenrolled from Medicaid. As is discussed in this paper, supporting eligible individuals in reenrolling in Medicaid might be the ideal option when possible. For individuals who are no longer eligible, states might consider connecting these individuals to other coverage options, such as commercial plans on the exchange.

[67] Corallo, B. et al. (January 25, 2023). What Happens After People Lose Medicaid Coverage? Kaiser Family Foundation. Retrieved May 31, 2023, from https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/.
[68] Rosenbaum, S. et al. (March 26, 2019). Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained. Kaiser Family Foundation. Retrieved May 31, 2023, from https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/.
[69] SAMHSA. Substance Abuse and Mental Health Block Grants. Retrieved May 31, 2023, from https://www.samhsa.gov/grants/block-grants.
[70] NAFC. Get Care. Retrieved May 31, 2023, from https://nafcclinics.org/get-involved/get-care/.

As Parts I and II of this paper series explore, Medicaid serves as a particularly important pathway to healthcare relative to other coverage types in the context of people with SMI. As such, transitioning to commercial coverage from Medicaid brings with it certain implications around access to care that states might wish to consider, such as increased cost-sharing obligations and potentially different or reduced access to certain drugs, services, and providers. Therefore, states and other stakeholders concerned with maintaining coverage and access to care during the unwinding process might consider state investments in targeted supports for people with SMI who lose coverage during the redetermination process. Such supports would align with broader state and federal efforts around supporting access to behavioral healthcare.

States face a significant challenge to manage their unwinding activities for Medicaid continuous eligibility over the next year. Though many of the difficulties that will arise might be unavoidable, this paper series provides states and other stakeholders with considerations and options for how to approach the Medicaid unwinding process in a way that may minimize unnecessary coverage loss for people with SMI and support appropriate continued access to healthcare in the future.

Caveats and limitations

This paper was commissioned by Karuna Therapeutics, a manufacturer of medicines for people living with psychiatric and neurological conditions. The discussion and/or analysis in this paper does not constitute legal advice. We recommend that users of this material consult with their own legal counsel regarding interpretation of applicable laws, regulations, and requirements.

Milliman has developed certain models to calculate values included in this paper. The intent of the models was to summarize professional and prescription drug utilization for Medicaid beneficiaries with schizophrenia or bipolar disorder. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Paul Houchens is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this paper.

In performing this analysis, we relied on publicly available data and other information found in research. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Appendix

Milliman's proprietary Consolidated Health Cost Guidelines™ Service Database (CHSD) was used to summarize historical utilization and cost for a subset of the SMI population on Medicaid, employer-sponsored plans, and ACA-compliant individual plans obtained through or off the insurance exchanges. The SMI subset was limited to members with a schizophrenia or bipolar disorder ICD-10 primary or secondary diagnosis code. Specific diagnosis codes for each condition cohort are provided in the table in Figure 8. The SMI cohorts are not mutually exclusive.

FIGURE 8: ICD-10 DIAGNOSIS CODES

ICD-10	DIAGNOSIS CODE DESCRIPTION
Schizophrenia	
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
Bipolar Disorder	
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3177	Bipolar disord, in partial remis, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified

Enrollment and incurred claims were analyzed for calendar year 2021. We have reviewed the SMI prevalence rates contained in the CHSD for the analysis cohort, approximately 4% for calendar year 2021, and believe it is reasonable in relation to published national statistics for the Medicaid age 18-64 population when considering that our analysis was limited to a subset of the SMI population. Prevalence rates for the employer-sponsored and individual plans was 1% and 1.3%, respectively. Additionally, utilization and prevalence rates within an individual state may vary materially relative to national values presented in this report.

We identified approximately 119,000 unique Medicaid-enrolled members with SMI ages 18 through 64. The enrollees reflect approximately 1.3 million member-months. As a proxy for dual-eligible enrollees and other enrollees with third-party coverage under age 65, we excluded enrollees with more than $100 in identified cost-sharing or coordination of benefits during a calendar year from our analysis for the Medicaid population.

The comparison population was identified as similarly aged adults enrolled in employer-sponsored or individual plans in calendar year 2021. Among the employer-sponsored population, the SMI analysis cohort identified approximately 113,000 unique enrollees and 1.2 million member-months. Among people with individual plans, the SMI analysis cohort identified approximately 13,000 unique enrollees and 130,000 member-months. Enrollees in all plan types represent members from across more than 20 states.

For the purposes of summarizing cost-sharing for commonly used professional services, professional visits were defined based on utilization in the following service categories (defined by Milliman's Health Cost Guidelines - Grouper): Outpatient Psychiatric, Office/Home Visits – Primary Care Physician, Office/Home Visits – Specialist, Outpatient Substance Abuse Disorders. The costs of professional visits were not limited to services with an SMI-associated ICD-10. The costs of prescription drugs were not limited to SMI-related medications.

The CHSD is a multiyear, multi-line-of-business, longitudinal claims, and enrollment data structure assembled by Milliman for its use in product production, internal research, and client engagements. National and regional health plans contribute their annual enrollment and claims detail. The CHSD is not a fully representative sample of the nationwide Medicaid or commercially insured populations. The prevalence and cost-sharing results given in this report will vary relative to actual nationwide values by an unknown extent based on population differences between the CHSD and the nationwide population insured in these markets.

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