

Episode 5: Why Millions of Medicaid Enrollees May Lose Their Health Insurance

SPEAKERS

Kate McEvoy, Dr. Kemi Alli, Heather Howard

Heather Howard 00:00

Hi, and welcome to the Princeton Pulse Podcast. I'm Heather Howard, professor at Princeton University and former New Jersey Commissioner of Health and Senior Services. On campus and beyond, I've dedicated my career to advancing public health. That's why I'm excited to host this podcast and shine a light on the valuable connections between health research and policy.

Our show will bring together scholars, policymakers, and other leaders to discuss today's most pressing health policy issues, domestically and globally. We'll highlight novel research at Princeton, along with partnerships aimed at improving public health and reducing health disparities. I hope you'll listen in as we put our fingers on the pulse, and examine the power and possibilities of evidence informed health policy.

Welcome. Today's episode spotlights health insurance in the U.S., and why an estimated 15 million Medicaid enrollees are at risk of losing their health insurance coverage and access to care. In 2020, Congress enacted legislation that gave states extra Medicaid funds to help address the raging pandemic. But they attached a condition to that funding that prevented states from disenrolling individuals from Medicaid during the pandemic. That came to a halt on March 31 2023, when the requirement expired and states began to return to normal eligibility and enrollment operations. It's often referred to as the Medicaid unwinding, and it represents the biggest health insurance coverage event since implementation of the Affordable Care Act.

On today's show, we'll discuss how states and health care providers are preparing for this unprecedented transition and their strategies for maximizing continuity of coverage for consumers. We'll also talk about who is most likely to slip through the cracks, who could suffer the most, and the potential impact on public health. Joining me from Washington D.C. is Kate McEvoy, Executive Director of the National Association of Medicaid Directors. And I'm also delighted to welcome Dr. Kemi Alli, a pediatrician and Chief Executive Officer of Henry J. Austin Health Center, a federally qualified health center in Trenton, New Jersey. Kate, Dr. Alli, welcome to the show.

Kate McEvoy 02:13

Thank you. Wonderful to be here.

Heather Howard 02:15

Thank you. Kate and Kemi are old friends, so this is just going to be a fascinating discussion. Kate, can you set the table? Tell me about your role with the National Association of Medicaid Directors and your background with the Medicaid program.

Kate McEvoy

Sure, thank you again for the invitation to participate. I have the honor of serving as the new executive director of the National Association of Medicaid directors. You may know that we represent all states and U.S. territories in the shared interest of championing the Medicaid program and the folks who administer and operationalize it every day.

I really have been involved with Medicaid instrumentally my entire career. I served as Medicaid director in Connecticut for about 10 years. That was on the advocacy side. And I did Medicare work from an early point in my career, which remains my passion.

Heather Howard 03:19

So delighted you could join because you've got that deep experience as Medicaid director in Connecticut, but now you're seeing what's going on around the country. Now let's turn to Dr. Alli. Can you tell us about your work at Henry J. Austin, and maybe explain a little bit about what an FQHC is?

Dr. Kemi Alli 03:39

Yes. I also would like to say thank you for the invitation. I'm honored to be speaking with you this afternoon. So I often say federally qualified health centers are like the hidden gems in each of their communities. They provide comprehensive wrap-around services to those who are most vulnerable within their communities. They are established by the federal government and receive some funds from the federal government, and in doing so help those who are uninsured and those who are under-insured. So again, in almost every vulnerable community within the United States, there is the community health center providing a full array of services, from pediatrics to adult care, dental care, vision care, mental and behavioral health services -- with all of those enabling services as well, like transportation support, translation support, case management, care coordination -- really looking at the whole individual in order to wrap them with all the services they need to be healthy, supportive individuals within their communities.

Heather Howard 04:49

Kemi, what is the patient mix? What insurance types do you have at your center in Trenton?

Dr. Kemi Alli 04:55

So in Trenton, about 60% of our patients are Medicaid, primarily through one of the managed care organizations. Another 10% or so are through Medicare. And then we probably have about 25% who are uninsured. The last remaining 5% or so is commercial insurance or private insurance. I was going to say the same thing -- that Medicaid is our most significant payer. We are fortunate, in the state of New Jersey, that we do have dollars for those who are uninsured, called the charity care program. So like our sister hospitals, community health centers receive funds for those individuals who are uninsured. And again, we are fortunate here in New Jersey, because I understand that not every state

does that. So between the charity care program and our Medicaid reimbursement program, and the dollars that we receive from the federal government to support those individuals who are uninsured, that's how we make up our revenue stream. There's this certain nursery rhyme... how do you make \$1 out of 15 cents? Health centers are really good at doing that, and sort of stretching that dollar. And we do that with donations. We do that with grant support, as well.

Heather Howard 05:23

So Medicaid is your largest payer and uninsured is your second largest payer -- but unfortunately, not paying, right? From a perspective of running a business, how are you making it work with that mix? And Kate, you must have had history, with your time in Connecticut, of working with FQHCs up there.

Kate McEvoy 06:54

Yes, very honored to have worked with both community health center associations in Connecticut. They were really a fulcrum point of so much of the primary, medical, and behavioral health care work, the integration work, early stewards of community health workers and other means of meeting people where they are, and really serving that totality of needs, just as Dr. Alli said.

Heather Howard 07:16

So Kate, before we get into the challenges of the unwinding, let's lay some groundwork. Can you tell listeners about the Medicaid continuous coverage requirement? Can you give a little bit history on that?

Kate McEvoy 07:31

Sure. I think you effectively previewed it in your introduction. The basis is that Congress became aware that the pandemic was already presenting significant access barriers for folks to get the health care that they needed -- folks with chronic conditions, folks with behavioral health conditions, people who cannot afford to go any length of time without those supports -- and also a lot of needs among older adults and people with disabilities, again, for continuity of those services. So Congress, recognizing the realities of the pandemic and wanting to put in place some means of smoothing people's experiences -- even as Medicaid programs were adopting strategies like telehealth -- did, as you said, require states to maintain the eligibility of all folks who became part of the program through the duration of the public health emergency. And they recognized that States needed additional resources to do that. So they enhanced the federal share of the Medicaid payment to correspond with what states would need to make good on that.

Heather Howard 08:48

I know from my time as a state official (I was New Jersey's Commissioner of Health and Senior Services), that often when Congress is giving there are strings. And this was the string that was attached: we're going to give you extra funding because the Medicaid program is a vital safety net, but you can't disenroll anybody. Kate, what's been the consequence of this? What are the latest numbers? Medicaid enrollment is at an historic level, right?

Kate McEvoy 09:17

It is. It's in an apex of enrollment, over 90 million people served by Medicaid. And so that has illustrated, obviously, the extent of the need during a pandemic. Obviously, with the significant loss of

jobs across the country, the overall volatility for the economy that really ground to a halt. Medicaid is always a program that is flexible enough to accommodate those types of shocks to the system and many, many more folks needed the assistance. They were able to access the program and have remained on through the course of the pandemic.

Heather Howard 09:51

Dr. Alli, what have you seen over the last three years? Have you seen the number of patients who have Medicaid grow?

Dr. Kemi Alli 09:59

Definitely. It's mirrored that national experience. My health center, our community, is sort of a microcosm of that. You can actually look at the curves between Medicaid individuals and the uninsured. And you can see where they intersect and cross, where the number of uninsured individuals is going down and the number of Medicaid individuals went up a year or so after the pandemic began. It was quite significant.

Heather Howard 10:32

Is it possible, Dr. Alli, that people don't even know about this? Do they know that there's been this pause?

Dr. Kemi Alli 10:40

Not at all. And it's interesting, because I'm not sure if we were even aware that there was technically this pause, because we don't necessarily talk to Medicaid about this. Our registration teams don't really discuss it in that level of detail. I'm not really sure that administrators and providers understood that there was this pause until there was a lot of discussion around the unwinding. Everybody is now quite aware and beginning to be proactive and sort of averting the crisis as best we can.

Heather Howard 11:16

So let's go there. Kate, last year states started sending the message to Congress... we need to know when this is going to end because we need to plan for it. Can you talk about why states wanted that clarity and how that led to Congress finally acting before the end of 2022 to set this deadline that just passed?

Dr. Kemi Alli 11:39

Yeah, I really appreciate that question. As you might imagine, although the Biden administration signaled that it would give states a certain amount of advance notice of the end of the public health emergency -- so that they would know, essentially, when those continuous coverage requirements were going to be winding down -- there are very significant operational demands at the state level. In resuming those historically, typical eligibility processes, states had to stage their computer systems, they had to contend with workforce constraints and their eligibility teams, they had to really get a state of readiness for what is an historically unprecedented volume of activity -- redetermining the eligibility of every single person in the program within a defined period of time. So we did, as an association, at the request of our membership, send a letter that said that it would be very useful to have a definitive date, so that states could actively plan, could start issuing their communications to members, most notably,

but also to providers, as Dr. Alli said. In one sense, I think it's great that folks didn't have to be burdened during the pandemic with understanding the mechanics of this continuous coverage. But now, of course, it's extremely vital that folks understand that that status is changing. So it is important to communicate these plans to members and providers, but also other interested stakeholders, so we can really saturate the messages and be ready for the redetermination process.

Heather Howard 13:13

Let's give our listeners a sense of what normal operations look like. Most people in the Medicaid program are redetermined eligible every year, right? And that's a process. And states have a cycle for that. And it smooths out over a year. But the challenge here is that all of a sudden, everybody will now need to be done. Can you talk about what normal operations look like?

Kate McEvoy 13:39

Yeah, so as you said, folks come on to the program and they have, essentially, a start date for eligibility. And each 12 months, the majority of folks on the program have to be reassessed for eligibility. In many states, there are means through which to renew eligibility that are a very low lift for the member of Medicaid, essentially using existing information sources. That is a practice that has been endorsed by the federal government and all states are now assertively moving to do as much of that as possible. But that type of redetermination would occur on a staggered basis. So each and every month, a proportion of the program membership was being renewed. This is a different matter with the unwinding process. It is really over a 12 month period, redetermining, as I said, every single person served by the program, so it is a very significant volume compared to what's typical.

Heather Howard 14:36

And from a consumer perspective, Dr. Alli, it's been three years. People who've been on the program might have understood there was an annual process and they would expect to hear from the state, if the state were reaching out. But it sounds like you're saying, after three years, maybe people don't know this is coming?

Dr. Kemi Alli 14:55

Well, from the individuals we spoke with, no they didn't. And so one of the things we've been doing within our community is working with various community organizations, social organizations, other community-based organizations to get the word out with a shared message. So it's all consistent with what has been provided by the state Medicaid office, and trying to get as many people and patients in the community as possible to really understand what is needed and required at this time. I think the biggest challenge has been how we communicate, because so often the state communicates via the mail. And as we know, addresses change and change frequently within lower income communities. And so that's been one of the biggest hurdles that we're trying to address. What are the other means and modalities in which we can communicate effectively to our communities?

Heather Howard 16:01

That's such an important point, because when you're in a normal annual process, it's easier to track if people are moving, to know people's correct addresses. But now that there's been a three-year lag, there's been increased housing instability. So the fear, Kate, is that states are going to be sending out

letters to people saying, "Hey, we need you to fill this out. We need we need to confirm that you're still eligible." And those letters are going to get returned because that's no longer the correct address, right?

Kate McEvoy 16:34

Yes, there is significant concern about return mail, even kind of revisiting the premise. Dr. Alli, I think, talked in a very real way about the way that programs tend to communicate is through formal legal letters. That can be very alienating to folks receiving a notice that they presume is not going to have good news; folks may set that aside, they may not prioritize it. And so much of what needs to be conveyed in that letter is legally required. I think there's not that much latitude for states. This is an important juncture, as Dr. Alli said, to be examining every possible way to communicate with and meet people where they are – to use email, to use texting, to rely on trusted community partners, like the health centers, who really are in a position of trust and also have the cultural capacity to know what messages are going to translate best with folks from their own lived experience. And really taking the view that we saturate the airwaves and the kind of personal communication channels so that the central message to people is that they must be in touch with the Medicaid agency to make sure their contact information is up to date. That's really the bottom line.

Heather Howard 17:52

Dr. Alli, is that consistent with what you're seeing and the approach you've taken?

Dr. Kemi Alli 17:56

Exactly. The pandemic provided a perfect example of how community-based organizations worked collaboratively with the health centers, the faith-based institutions, the school institutions -- all coming together to share a message about what was happening during the pandemic, whether it was about testing or vaccines. It was using all the modalities that we have to get to those hard to reach individuals within communities. And I think we have to do the same thing with Medicaid. As Kate said, using that same model now – going into the faith-based institutions, the adult daycares, the social service agencies and other community-based organizations to try to get to everyone that we possibly can with the same consistent message -- that they need to open the letter.

Heather Howard 19:02

Right, right. And how many of our listeners open their mail every day, especially when it may look like a form letter, right?

So let's talk about is procedural denials, a term that sounds really wonky but gets used a lot. The concern here is that people who are eligible for Medicaid and should stay on Medicaid will lose their Medicaid because they can't comply with the renewal requirements, right? Because you're redetermining Medicaid eligibility, not everybody will continue to be eligible. Maybe they've changed jobs and they're making more money now, their incomes above eligibility level, or they have a job that provides them employer-sponsored insurance. How do you think about the types of people that states are trying to protect, and who's at risk?

Kate McEvoy 19:55

Well, I really liked the way that you framed that question, because this isn't the same for everyone served by Medicaid. There are very different profiles that can be individualized based on the member's situation. I think states are very conscious of this. I want to start by saying that the states do have a view into whether folks have been able to qualify for other types of coverage, because there have been existing processes around third-party coverage that have given some insight into that. We view that as a positive. If someone is able to gain either Marketplace coverage or employer-sponsored insurance, it's great, it's often a sign of improved economic security. And that's a really good scenario.

More challenging are the folks who either set the letter aside, or have moved and, as you said, the letter is actually returned to the Medicaid agency. There's that really blank space where the agency is not necessarily aware of that person's present address. If there aren't ways of intercepting, that can result in someone losing eligibility, who may otherwise remain eligible. And that's something that we want to avoid at all costs. So what are state's doing? They're examining a lot of the capacity that they have to redetermine people's eligible eligibility using existing sources of information. We have the federal hub as a source of information. We have other information, like the US Postal Service change of address database, that states are using as maximally as they can to reduce the burden of going back to people and saying they need additional information. The federal government has also put in some protective pieces with the unwinding, including a reconsideration period. So let's say someone loses coverage and they do remain eligible, they can come back in and essentially say, without further effort, "I still qualify" and can be restored eligibility. But there is still a significant risk that folks who are not able to be reached could lose coverage. And I think one of the most important examples of that is children whose parents may have legitimately lost coverage, but the children remain eligible. So states are trying to do a lot of communication around that.

Heather Howard 22:22

Dr. Alli, there are estimates from ASPI, this Assistant Secretary for Planning and Evaluation at the Federal Health and Human Services Department, that up to 15 million people could be coming off Medicaid. But as Kate just said, not everybody who's coming off is a bad news story. Right? Some people may be going off because they now have employer-sponsored insurance, or maybe they've turned 65 and they're going on Medicare. Maybe they're going to the marketplace in New Jersey to get covered. The most concerning, of course, are the people who just may be losing coverage that they should be eligible for. How do you think about those different groups? And how do you think about helping people get coverage? As a safety net provider, how do you see your role in helping people get the coverage that's appropriate for them?

Dr. Kemi Alli 23:25

Yes, among the things that I think about most are the challenges in that process. We're going to try to be proactive and plan. For us, the safety net institutions, it really comes down to having the appropriate processes and systems to be able to help most people, because I think a lot of them will not recognize that they are in that gap until they come in and seek care. So whether they're going to the community health center, or they're going to their outpatient center, or they're going to the acute care hospital, it's when they walk in for service that they will realize that they don't have coverage. And so all of these systems are going to have to be activated. They're going to have to have the resources and the

workforce and the capacity to help those individuals navigate the systems -- whether it is going to the Marketplace, whether it is re-enrolling with Medicaid, whether it is now being uninsured, and what's the process for the charity care programs. But that's a new capacity, along with the states, that the health care industries now have to build. And I'm not sure we are ready. I'm not sure we're all quite there yet.

Heather Howard 24:39

I see exciting efforts across the country. Even on the issue of the mailers, I noted recently that New Mexico announced that their letters are going out in turquoise envelopes, and Texas is sending their letters in yellow envelopes so that they stand out and don't look like another piece of junk mail. Kate, I know that you and the National Association of Medicaid Directors are very focused on protecting consumers from scams. Can you talk about that?

Dr. Kate McEvoy 25:12

Yes, it's an incredibly disturbing thing to have to report. But some opportunistic folks are already trying to take advantage of Medicaid members by contacting them and offering to walk them through the redetermination process or handle redetermination for them in exchange for a fee, which, as we all know, is absolutely not how a state agency would ever operate. We had to circle around immediately, once the unwinding started, to provide standard messaging for states to broadcast to membership that this is always going to be a scam, this is never going to be an official act of the Medicaid agency. So definitely a further complication for this whole effort.

Heather Howard 25:58

And, Dr. Alli, you mentioned texting. There are requirements that letters need to be sent, but can you talk about how texting has been more effective in reaching people?

Dr. Kemi Alli 26:11

It has. In our community, we are always pleasantly surprised by the number of individuals who have a phone, even in the lower income communities. And so texting more so than email has really been a way to stay connected. And again, we experienced that during COVID. Texting has offered a way to stay connected and share information.

Heather Howard 26:38

Among the things we like to explore on this podcast are the health equity implications of policy decisions. It seems to me that the equity implications here are tremendous, right? We established that. We know that people of color are overrepresented in the Medicaid program. We talked earlier about housing instability, and employment instability, especially during COVID. So, Kate, starting with you, how do you think about the equity implications of this unwinding?

Kate McEvoy 27:10

Well, I first want to affirm what you observed. And that is really that the pandemic has starkly illuminated longstanding disparities, especially for people of color. And I also want to call out experiences for people with disabilities in the program, where they faced unique access barriers. And in the case of people of color, again, it's hard to make monolithic comments about this. But overall, the economic security of many populations really suffered during a pandemic, which exacerbated the

challenges of access and continuity of care. So there is an acute awareness and a real sense of urgency among Medicaid officials, particularly tailoring messaging to communities of color, and also just being conscious of unintended consequences of policies, really taking special care and attention around unintended loss of coverage.

Heather Howard 28:12

Dr. Alli, what worries you as a vital safety net and anchor institution in Trenton? How do you see this question playing out?

Dr. Kemi Alli 28:24

Those gaps and deficiencies and disparities that were already within the communities were exacerbated by COVID. And so this could be something very similar for those individuals who are most vulnerable -- when they go to seek care and all of a sudden will not have the coverage that they need. Only time will tell us what that number, what the number is going to look like. But that is the biggest concern -- that those who are most in need and most vulnerable won't have the coverage that they need when they actually do go to seek care and services. The ramifications of that are my biggest worry.

Heather Howard 29:11

So let me just highlight a few other strategies. Dr. Alli, you talked about the right message getting out. I noticed, early on, that some states used language about when the public health emergency ends. And nobody's using that language now. Right? Because I think that is confusing to people. People don't know that there's a legal termination. What is the right way to talk about this?

Dr. Kemi Alli 29:38

Real simple. The message is stay covered, maintain your health insurance. Those are some of the things that we see really resonate. Just stay covered. Make sure that you have your health insurance coverage. Just keep it really simple -- three or four words -- so that everyone is being consistent and staying on that message of staying covered and maintain health insurance.

Heather Howard 30:09

And do you find, here in New Jersey, that there's that constant across different communicators, from the state to community-based organizations, to providers?

Dr. Kemi Alli 30:21

In my community, yes. And in the communities that I've been working with, in the microcosms that I've been working with, yes. I think we've done a particularly good job. The state has put out its toolkit, so that all community organizations can be sharing the same message, the same look, the same tone, the same feel, and then translating that message so that it is culturally and linguistically appropriate for all of the various communities across the state. I think that's one of the lessons probably learned from the pandemic. Keep it simple, keep it consistent, stay on the same page.

Heather Howard 31:02

That's great. And, Kate, for you, one thing that I've been struck by is that a number of states have developed dashboards and are publicly reporting how they're doing. And that includes how many people are being redetermined. Some are even talking about the wait times on their help lines? Are you seeing that? And why do you think states are doing that? Is that helpful?

Kate McEvoy 31:31

It's extremely helpful. I first want to say that the federal government is planning to create a national dashboard that will become available in June. And that will pull together a lot of those data points that you talked about, not only the eligibility activity, but the experience and timeliness of the call centers that are supporting people in this process. Then there are many states that are standing up their own corresponding dashboards. Some have actually maintained this as a longstanding practice, and are just building out additional features. But we, as an association, believe that type of transparency is extremely helpful, not only for the interested parties who want to make sure that there are good outcomes, but also as a means of assessing performance over time, and really giving a beat into where there might be areas that need special attention, giving the state a chance to adjust some strategies.

Heather Howard 32:37

So this has been an amazing discussion. And so timely. As we wrap up, Dr. Alli, where do you think we'll be in a year? Do you think people will have found coverage, whatever the right coverage is for them? And you'll have stability in your patient mix as you run your organization and your clinic?

Dr. Kemi Alli 32:57

I would hope so. You know, I'm very cautious about giving predictions. But I would definitely hope so. I think we've put some proactive plans in place and all the things we've discussed, within our various communities, working together, working collaboratively, having a consistent message. I think we're fortunate in New Jersey that we do have the Marketplace. We do have organizations that help navigate people to the Marketplace. We have an enrollment institution. And so I would hope that things have stabilized by this time next year.

Heather Howard 33:41

It's great to bring this back to New Jersey in discussing many of the elements for success. We'll be looking forward to that. And, Kate, as you look ahead a year from now, as challenging as this great unwinding will be, do you see the promise of strengthening eligibility and enrollment procedures and the Medicaid program overall?

Kate McEvoy 34:06

Ye., I think this is a watershed point in time, where the federal government and state Medicaid programs are collectively working to ensure that eligibility standards that help folks access the program and retain coverage are adopted consistently across the country. And I think that's all to the good. There's a lot involved in gaining that point of compliance across the country, but a tremendous amount of shared commitment to it. And I think that is really the centrality of the effort, really in support of the Medicaid program always being there, as I said earlier, at the ready when we have a downturn. I think

predicting ahead a year is very difficult and we have some uncertain signals around our economy. Medicaid will always be there and flexible to support people as they need it.

Heather Howard 35:00

Well, this has been a terrific conversation. And I'm so grateful to you both. And I really am struck by the watershed moment in our time. So thank you both for all that you do to serve so many people and to strengthen the healthcare safety net. Thank you both.

Kate McEvoy 35:19

And thank you for your leadership, Heather.

Dr. Kemi Alli 35:21

Yes, thank you.

Heather Howard 35:24

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