Health Insurance Coverage After the COVID-19 Public Health Emergency Ends
Gail R. Wilensky, PhD

On January 27, 2020, the US Department of Health and Human Services (HHS) declared the COVID-19 public health emergency (PHE), and has renewed it every 3 months. Since then, the Centers for Medicare & Medicaid Services (CMS) gave clinicians and health care institutions broad flexibility, such as in the use of telehealth and in Medicaid’s continuous enrollment guarantee that protects beneficiaries from interruptions in coverage. HHS Secretary Xavier Becerra, JD, has committed to giving states and the broader health care community 60 days’ notice before ending the PHE.1 Such notice is important, given that the substantial flexibilities available during the PHE are expected to be phased out and public and private insurers are likely to reintroduce many of the restrictions that had been in place prior to the pandemic.2

The embrace of telehealth presents a marked example of how much flexibility was introduced during the COVID-19 pandemic. For example, to expand access to telehealth services for patients, the CMS made changes to Medicare policies that waived restrictions.3 Although coverage before the pandemic limited telehealth services to people living in rural areas and at qualifying sites rather than in their own homes, the loosening of restrictions meant that people covered by Medicare could use telehealth at home or in urban areas.

At least some of this flexibility will be eliminated for Medicare fee-for-service, although Medicare Advantage plans have and will continue to have substantial amounts of flexibility as long as the benefits provided under traditional Medicare are also being provided in Medicare Advantage. In addition, the 2021 Consolidated Appropriations Act4 codified into law some of the measures allowing expanded access to telehealth—such as expanded access to telehealth services for the diagnosis, evaluation, and treatment of mental health disorders—and thus this coverage is not at risk for being discontinued when the PHE ends.

Among other measures (such as increasing payments under the physician fee schedule), the Consolidated Appropriations Act also ensures a 151-day extension of telehealth policies beyond their original expiration dates. But after this period, Medicare will require in-person visits within 6 months of an initial assessment and every 12 months thereafter, as it had before the PHE. Medicare payments will also no longer be available for telehealth services provided by physical therapists, occupational therapists, and audiologists, which will reduce the number of nonphysician clinicians providing telehealth services to Medicare beneficiaries.

The largest effect of ending the PHE for COVID-19 is likely to be the end of the continuous enrollment requirement in Medicaid. This requirement has meant that states could not reassess eligibility for Medicaid during the pandemic if they wanted to maintain the enhanced federal Medicaid match rate providing an additional 6.2% in federal funding.2 Under the PHE, once someone had qualified for Medicaid, they remained qualified for coverage under Medicaid as long as the PHE is in effect. The continuous coverage requirement for Medicaid is a significant factor that contributed to Medicaid reaching a record enrollment of 85 million.5

Approximately half the states report that they have a plan for how they will prioritize eligibility and renewal actions after the end of the continuous coverage requirement, but many of the remaining states have not made key decisions about how they will proceed with reviewing eligibility and renewal determinations. The CMS has said it will give states up to 14 months to complete the redeterminations, which should allow states to finalize decisions regarding eligibility and renewals.
The HHS projects that approximately 15 million people will lose coverage when the PHE ends and eligibility redeterminations are allowed to occur once again. The agency also estimates that an additional 6.8 million people will lose coverage because of "administrative churning" (temporary loss of Medicaid coverage despite ongoing eligibility, which can occur due to administrative hurdles).

The CMS has proposed overhauling the enrollment process used in Medicaid, perhaps in part to counter some of the expected decrease in the number of people receiving Medicaid coverage. This would have the effect of standardizing certain eligibility and enrollment policies for a program that historically has exhibited substantial variability across states in both of these domains. Some proposed changes include provisions limiting Medicaid renewals to once every 12 months, which would allow recipients to remain on Medicaid even if their income during some months increases to a level that would suggest a total annual income above the Medicaid eligibility threshold in their state; giving people applying for Medicaid 30 days to respond to requests for additional information; as well as generally directing states to create clear and consistent processes for ways in which beneficiaries can renew their coverage.

States have used a variety of innovative ways to reach enrollees during the pandemic. Arkansas set up a new call center for outreach to enrollees to help them update their contact information; Kansas conducted a social media campaign to encourage Medicare enrollees to ensure their contact information was up to date. New Mexico made available $35 million to help people no longer eligible for Medicaid to transition to coverage in the health insurance marketplace. Tennessee used a digital ad campaign through Facebook, Instagram, and Google Search that resulted in more than doubling the number of enrollees who completed renewals. These efforts make clear that states that are aggressive in reaching enrollees can be successful in their efforts, even during a pandemic. Whether they will continue their aggressive posture after the PHE ends, and when some of the current flexibilities and funding may no longer be available, remains to be seen.

It is also unclear whether some of the regulatory flexibility allowed during the pandemic will continue after the PHE ends. For example, permitting pharmacists to administer COVID-19 vaccines helped increase the number of people who were vaccinated during the pandemic. Because receiving an annual booster along with an annual influenza vaccine will remain an important part of bolstering public health, this regulatory flexibility may be useful to continue. The COVID-19 PHE is currently expected to be in place until January 2023. But given that the US Centers for Disease Control and Prevention says that tens of thousands of new cases of COVID-19 infections are still being reported daily, COVID-19 itself is expected to remain a part of the landscape—with or without the PHE—for some time to come.

ARTICLE INFORMATION
Published: September 29, 2022. doi:10.1001/jamahealthforum.2022.4207

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Corresponding Author: Gail R. Wilensky, PhD, Project HOPE, 7500 Old Georgetown Rd, Ste 600, Bethesda, MD 20814 (gwilensky@projecthope.org).

Author Affiliation: Project HOPE, Bethesda, Maryland.

Conflict of Interest Disclosures: None reported.

REFERENCES


