Invited Commentary
Evidence-Based Outreach Strategies for Minimizing Coverage Loss During Unwinding
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The number of uninsured Americans has fallen to a historic low—and Medicaid enrollment has grown to a historic high—a trend largely explained by a continuous coverage policy implemented in response to the COVID-19 pandemic.1 Per this policy, states are suspending disenrollment from Medicaid due to eligibility changes, but the provision will sunset when the federal public health emergency (PHE) officially ends. The process of resuming eligibility determinations, also called unwinding, is expected to cause approximately 15 million people to lose Medicaid in the year after the PHE expires.2 Experts and consumer advocates are concerned that many people will lose benefits despite remaining eligible for the program. According to a recent federal report, nearly half of people losing Medicaid during unwinding will fall into this category and are likely to become uninsured, at least temporarily.2

But appropriate terminations—among those who are truly no longer eligible for Medicaid—are likely to swell the ranks of the uninsured, too. In states that use the federal HealthCare.gov platform, only 3% of people exiting Medicaid transitioned to marketplace coverage within a year of program exit, and most of these transitions involved coverage gaps.3 Other research similarly found that approximately 5% of people referred from county Medicaid offices to Covered California, the state's marketplace, took up coverage.4,5 Although some people may leave Medicaid for offers of employer-sponsored coverage, it beggars belief that this would be true in 95% of cases. Moreover, even short spells of uninsurance can produce negative outcomes regarding access to medical care.2 Aggressive and effective outreach will be critical to promote successful transitions during unwinding among people who have gained eligibility for subsidized marketplace coverage.

However, there is remarkably limited evidence on which strategies work best to reach enrollees at these critical junctures. Research using randomized clinical trials (RCTs) estimated that reminder letters, sent by postal mail during open enrollment, can boost coverage by between 7% and 16%.4,6 A separate RCT in California tested the effect of personalized phone outreach and enrollment assistance during open enrollment. Receiving a call increased take-up by 23%, with substantially more pronounced effects among those transitioning from Medicaid (a 54% increase in take-up) and individuals who preferred their assistance be provided in Spanish (a 74% increase in take-up).5

In this issue of JAMA Health Forum, Ravel et al7 expanded this literature through another outreach RCT focused on households that had exited Medicaid and qualified for subsidized coverage through Covered California. The evaluation, which was implemented in 2017, compared the effect of email reminders, personalized phone calls, and the combination of both types of outreach. All interventions were done in addition to the required eligibility determination notice, which was sent to enrollees using their preferred mode of communication. The email-based intervention served to remind households to enroll ahead of their deadline; the phone call both reminded prospective enrollees about their new coverage options and offered enrollment assistance.

Unlike most prior research, these interventions occurred outside the standard open enrollment period, targeting enrollees who qualified for a mid-year enrollment window.7 To my knowledge, this is also the first study to directly compare different marketplace outreach modalities (email, phone, and a hybrid of both) rather than a single modality.

In the control group, which only received the standard eligibility determination notice, take-up was approximately 15%.7 The email-only intervention did not have a statistically significant effect;
the resulting point estimate was close to zero. The phone-only intervention was estimated to increase enrollment by 4.4 percentage points, a relative increase of 30%, though this finding was only marginally significant. The phone-plus-email group increased enrollment by a statistically significant 6.9 percentage points, translating to a 47% relative increase. Although the point estimates are different, the study was not sufficiently powered to determine whether the hybrid phone-plus-email intervention was superior to the phone-only intervention.

These findings have important policy relevance as states contemplate how to approach the unwinding of the Medicaid continuous coverage provision at the end of the PHE. Low-cost, low-touch outreach—like postal mail and email—is the easiest for states and marketplaces to execute, but the evidence is increasingly conclusive that associated coverage gains are much more marginal than higher-touch (and higher-cost) strategies. Given the small sample size and correspondingly wide CIs in the study by Ravel et al., we should not rush to the conclusion that email reminders have absolutely no effect. However, the 95% CI rules out a coverage increase greater than 3.6 percentage points (corresponding to a 25% relative increase at the outer limits of plausibility), which is smaller than the point estimates for both the phone and phone-plus-email groups.

One notable feature of the phone interventions evaluated by Ravel and colleagues is that the calls were not mere reminders; they connected prospective enrollees to service center representatives, who could directly assist with the enrollment process. It might be the case that the phone is a better modality than postal mail or email for reaching enrollees, but it seems highly unlikely that reminder calls (or texts) would have the same effect as outreach explicitly designed to help individuals overcome the confusion and hassle of enrollment. But standing up or expanding contact centers is labor intensive and resource intensive, and uncertainty about when the PHE will end complicates coordination and staffing.

The navigators created and funded through the Affordable Care Act to assist individuals with the enrollment process would seem to be a natural solution to this problem. However, these organizations are subject to certain rules around what types of outbound outreach they can conduct. Given abysmal transition rates from Medicaid to marketplace coverage and the clear efficacy of phone-based enrollment assistance, federal regulators should help states think creatively about how they can best leverage navigators after the PHE ends and develop template strategies that states can adopt into their operational plans for unwinding.

Managed poorly, unwinding Medicaid continuous coverage at the end of the PHE could lead to millions of Americans becoming uninsured. Results presented by Ravel and colleagues highlight how important it will be for states to conduct coordinated outreach campaigns during this time—and underscores that not all outreach is created equal. Although states may consider it necessary to send letters and emails to people exiting Medicaid during unwinding, these strategies will not be sufficient to bridge most people to new sources of coverage. Phone-based enrollment assistance is a promising, evidence-based approach for minimizing coverage loss. Implementation will require state and federal policy makers to act swiftly to ensure that sufficient guidance, resources, and capacity are in place when the PHE expires.
REFERENCES


