

Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

April 18, 2022

Health Care Access and the Public Health Emergency (PHE)

What happens when the PHE ends

The U.S. has now entered the third year of the COVID-19 pandemic. Since January 2020, the country has operated under a [public health emergency \(PHE\) declaration](#) that has allowed the federal government to more effectively respond to the pandemic. The Secretary of Health and Human Services has the [authority to extend the PHE](#) for up to 90 days at a time, and the PHE ends when the Secretary determines that the emergency is over or when the PHE period expires without renewal. So far, the PHE has been continuously renewed for over two years, [most recently](#) on Tuesday, April 12, 2022.

As the nation begins to shift to a new “living with the virus” phase of its pandemic response, it is likely that the federal PHE will officially end in the coming months. The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) included a number of emergency federal actions related to health coverage and access and explicitly tied to them to the PHE, meaning that some important consumer protections and health systems flexibilities may end in the coming months. In this installation of Health Care in Motion, we dive into what this means for people who have depended on PHE-related programs and flexibilities and how you can prepare for the end of the PHE.

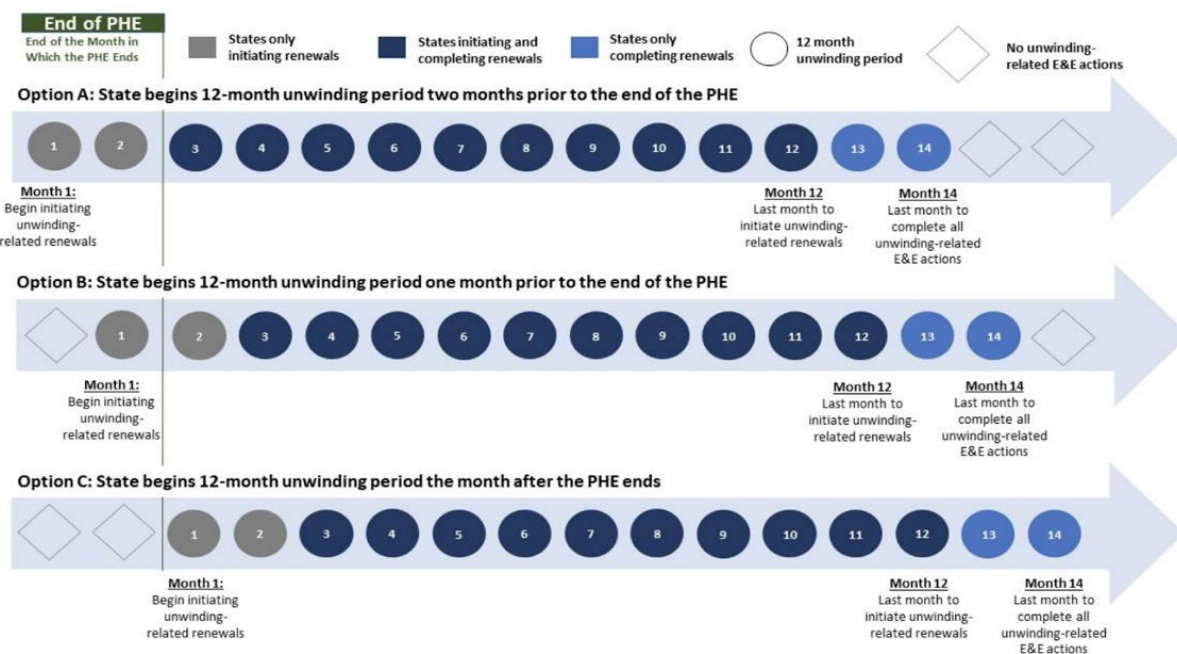
PHE and Medicaid

One of the many emergency responses tied to the PHE has been the federal requirements related to Medicaid coverage. As part of the FFCRA and in recognition of the fact that during a pandemic it was more important than ever to ensure people had uninterrupted access to health coverage, states received a significant bump in federal matching funds for Medicaid. In return, states were not allowed to disenroll individuals from Medicaid programs for the duration of the PHE. This protection has resulted in ever growing Medicaid rolls as normal redetermination processes have been on hold. [According to Kaiser Family Foundation](#), from February 2020 to November 2021, total Medicaid enrollment increased by 14.6 million people. Once the PHE ends and states no longer receive enhanced federal funding, Medicaid programs will restart their normal redetermination processes, which will likely lead to millions of people losing coverage.

1. What is the timeline for when Medicaid will restart renewal processes?

We don't yet know when the PHE will actually end, which means the timeline for when states restart their normal renewal processes is unclear. The current PHE expires July 16, 2022, and we know that the Department of Health and Human Services will give states at least a 60-day notice before the PHE ends (this notice hasn't yet been given).

So what happens then? Beginning the first month after the end of the PHE, states will have a 12-month "unwinding period" to restart normal Medicaid renewal processes. [Recent federal guidance](#) from the Centers for Medicare and Medicaid Services (CMS) clarifies that Medicaid programs must begin the process within 12 months and will have a total of 14 months to actually complete unwinding activities. States may begin the renewal process up to 2 months before the end of the month that the PHE ends; but if they choose to start early, they cannot terminate coverage until the first day of the month after the PHE ends. CMS is strongly urging states to stagger renewal activities (i.e., states should only process one-ninth of their renewals in any given month) to avoid an unnecessarily rushed redetermination process and ensure that individuals are not inappropriately terminated. The CMS guidance provides the following chart describing the timeline and the different options states have.



2. How can Medicaid enrollees and their advocates maintain continuity of coverage?

One of the most important ways for Medicaid enrollees to prepare for the end of the PHE is to make sure contact information (including addresses) are updated with state Medicaid programs. Many Medicaid officials and advocates are concerned that notices alerting enrollees of renewal and redetermination processes will go unseen and unread, as many people who have been on Medicaid

throughout the duration of the PHE have moved or changed contact information. Ensuring that updated information is on file with Medicaid will ensure that consumers are alerted when they need to submit documentation.

Assisters should also be prepared to help clients transition to other forms of coverage if they are no longer eligible for Medicaid. Many individuals may be eligible for Marketplace coverage, and, because of the enhanced subsidies available through the American Rescue Plan Act (ARPA), they could be eligible for hefty advance premium tax credits (APTCs) that could bring their monthly premium to \$0. Loss of Medicaid coverage triggers a Special Enrollment Period (SEP) on the Marketplace, and with education and enrollment assistance, many consumers could transition from Medicaid to the Marketplace once the PHE ends. Enrollees interested in seeking coverage on the Marketplace can begin now to [review plan options](#) available in their zip code and assess plans for coverage of necessary treatment and care.

Congress Must Preserve Enhanced Marketplace Subsidies and Address the Medicaid Coverage Gap

As previously reported in [Health Care in Motion](#), the American Rescue Plan Act (ARPA) provided expanded subsidies to improve affordability and access to private plans on the Marketplace. These subsidies are more generous and available to more people than ever before. Since the passage of ARPA, anyone making between 100% and 150% of the Federal Poverty Level (FPL) is eligible for \$0 premiums, and subsidies are available for the first time to people making over 400% of the FPL. These subsidies will be critical for many individuals who will no longer be eligible for Medicaid after the end of the PHE and will need to access affordable health care.

However, these enhanced subsidies are set to expire at the end of 2022. (Enhanced subsidies for individuals who receive unemployment compensation already expired in December 2021.) Furthermore, in states that have failed to expand Medicaid, people who are disenrolled from Medicaid coverage at the end of the PHE may find themselves in the [Medicaid coverage gap](#) – making too much to be eligible for their state Medicaid program, yet unable to access Marketplace subsidies.

Congress has the opportunity to extend enhanced Marketplace subsidies and to address the Medicaid coverage gap through reconciliation legislation. (Read more in the AIDSWatch late-breaking brief [here](#).) It is critical that Congress acts now. Millions of people who are about to lose access to Medicaid are counting on it.

Advocates should also encourage states to make the redetermination process as seamless as possible, including through [ex parte redetermination](#) (where the state agency reviews existing data sources to confirm eligibility) and robust consumer education. Advocates should put pressure on states to help facilitate any necessary transitions in member coverage. For example, in addition to facilitating transitions to the Marketplace, the Ryan White HIV/AIDS Program, including the AIDS Drug Assistance Program, should be preparing to provide coverage for individuals living with HIV who are losing Medicaid coverage.

3. Are there state Medicaid advocacy priorities to help guide PHE unwinding activities?

Despite multiple federal guidance documents urging states to develop transition plans, a recent [survey from Kaiser Family Foundation](#) found that only about half of states had actually developed a comprehensive plan for how they will prioritize eligibility and renewal actions when PHE ends. Advocates in states should engage with their state Medicaid program to ensure there is a plan in place for a staggered approach to renewals and protections for individuals living with chronic conditions and disabilities for whom transitions can cause dangerous interruptions in care and treatment.

PHE and Telehealth

Another major area impacted by the PHE is telehealth. In response to the need for individuals to continue receiving services while socially distancing, the federal government (and many state governments) loosened telehealth regulations to expand access to services via telehealth. This has included [federal flexibility](#) with regard to compliance with the privacy protections of Health Insurance Portability and Accountability Act (HIPAA) and temporary waivers for providers serving individuals enrolled in Medicaid and Medicare to provide telehealth services.

Importantly, this flexibility included loosening licensing requirements so providers providing telehealth services across state lines can still bill Medicaid and Medicare for these services without necessarily being licensed in every state. Before the pandemic, Medicare beneficiaries had to be living in rural areas to use telehealth to access care and had to travel to another health center for the visit. During the pandemic, Medicare beneficiaries anywhere in the country have been able to use telehealth and have been able to participate in the visit from home. This relaxation of rigid rules that limited access to telehealth was coupled with congressional allocation of millions of dollars in federal funds to help providers improve their telehealth infrastructure and capacity.

When the federal PHE ends, the federal flexibilities with regard to HIPAA and temporary telehealth waivers across federal programs will also end with some short-term solutions in place. Medicare, for instance, will have [151 days](#) to transition away from the flexibilities that allowed Medicare beneficiaries to access telehealth from any site.) Congress could act to make these [flexibilities](#) permanent, but it is unclear if there is enough political support to make this happen.

States also used flexibility flowing from state-level declarations of public health emergencies to lift their own state laws and regulations regarding telehealth services. This has included relaxing what can be onerous state-specific provider telehealth licensing requirements and fees, so that providers could more easily offer services across state lines. Grappling with what telehealth will look like after state public health emergencies have ended, many state legislatures and agencies have or are considering state statutory and regulatory changes to make pandemic-era telehealth flexibilities permanent

Using Telehealth to Tackle Health Disparities

Telehealth not only offers an opportunity to maintain access to care during a crisis, but it also [offers a potential pathway](#) to address racial, ethnic, and geographic disparities in health outcomes that long pre-date the pandemic. Telehealth helps people access health care services while eliminating barriers related to transportation, childcare, and lost wages, which can disproportionately impact Black, Indigenous, and Latinx communities. Notably, the promise of telehealth to make health care access more equitable only works if all people have adequate internet and technology access. For example, we know that during the pandemic, Black individuals, older individuals, and people living in rural areas were less likely to take advantage of telehealth, due to a combination of [internet access and digital literacy issues](#). Therefore, future efforts to address disparities through the use of telehealth must both increase the availability of telehealth services as well as the infrastructure necessary to support them.

PHE and Cost Sharing for COVID-19 Services

The FFCRA and the CARES Act included emergency provisions requiring public and private payers to cover COVID-19 services without cost sharing for the duration of the PHE. These requirements differed a bit from payer to payer, and whether they extend beyond the PHE also varies by payer.

- *Medicaid*
Medicaid [will cover](#) COVID-19 testing, vaccines, and treatment for most enrollees through the PHE and for a little more than a year after it ends.
- *Medicare*
Medicare will [cover COVID-19 vaccines and testing](#) (including at-home tests) without cost sharing through the PHE. Beneficiaries may still face some cost sharing for treatment.
- *Private insurance*
Similarly, federal law also requires most private insurance to cover [COVID-19 testing](#) (including at-home tests) as well as [COVID-19 vaccines](#) without cost sharing. Some, but not all, of these cost-sharing protections are slated to end when the PHE ends. However, because many of the COVID-19 vaccines are now approved by the Advisory Committee on Immunization Practices (ACIP), the Affordable Care Act requires most plans to continue to cover them without cost sharing even after the PHE ends. While there was no federal requirement for private insurers to provide COVID-19 treatment without cost sharing, many entered into agreements to voluntarily waive these costs and some insurers directly regulated by [states](#) were required at the state-level to waive these costs. Many of the state requirements for issuers to cover COVID-19 treatment without cost sharing and the voluntary agreements by issuers [have already ended](#).
- *Uninsured*
The federal government also set up a program to enable providers to provide COVID-19 testing, treatment, and vaccines to uninsured individuals. This was done through an uncompensated care fund administered through the Health Resources and Services Administration (HRSA) that allowed providers to seek reimbursement for administration of COVID-19 services provided to uninsured individuals (the federal government provides the testing, vaccine, and medication supplies). Because

federal COVID-19 funding was not included in the federal FY22 budget passed by Congress in March 2022, there are [no longer funds](#) in the uncompensated care fund to reimburse providers for administration costs of COVID-19 services. This means that individuals could start receiving bills for these services over the coming weeks and months unless and until Congress provides additional COVID-19 relief funds.

Even with the end to some of the federal mandates for public and private payers to cover COVID-19 related services without cost sharing, we could still see states decide to continue these protections through state action.

In short, the PHE ending will be monumental. But there are transition periods to enable systems to manage the changes in ways that minimize disruptions to consumers. In addition to tracking federal developments, advocates, providers, and consumers should check with their states about how they are planning for the end of the PHE and weigh in to ensure policies protect people with chronic conditions and disabilities.

Subscribe to all Health Care in Motion Updates

Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Maryanne Tomazic, Clinical Instructor; Rachel Landauer, Clinical Instructor; Julia Harvey, Clinical Fellow; and Suzanne Davies, Clinical Fellow. This issue was written with the assistance of Amy Killelea of Killelea Consulting.

For further questions or inquiries please contact us at chlpilaw@law.harvard.edu.