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Medicaid Unwinding Winds Down: What We've Learned

State Medicaid programs are at the tail end of an unprecedented reduction in Medicaid enrollment. States are reinstituting normal Medicaid redetermination and renewal processes, which were paused during the height of the COVID-19 pandemic. Because of the pandemic pause, Medicaid rolls swelled to record highs from 2020 to 2023. Starting in April 2023, however, states slowly but surely worked their way through every Medicaid member to determine who was still eligible for the program, resulting in a massive exodus of individuals. Many of those who lost coverage had changes in circumstances that made them no longer eligible, but many otherwise were terminated for procedural reasons, meaning they simply did not complete the renewal process. These individuals may still be eligible for coverage.

Wait, remind me… what is Medicaid unwinding?

Medicaid unwinding refers to the end of federal requirements that state Medicaid programs provide continuous coverage during the COVID-19 public health emergency (PHE). At the beginning of the pandemic, Congress passed legislation that allocated extra funding for state Medicaid programs in return for suspending Medicaid renewals and most terminations of coverage during the PHE. As the COVID-19 crisis waned, Congress officially ended the continuous coverage requirements, requiring states to restart renewals for Medicaid beneficiaries in April 2023. States then had 14 months to complete renewals for all Medicaid members.

The Medicaid unwinding has been far from smooth sailing, creating administrative challenges for state Medicaid programs and confusion and disruptions in care and treatment for Medicaid members. The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, had to balance the need to provide support to state Medicaid programs as they tackle waves of renewals while also holding the line on enforcement of consumer protections.

Read on to learn more about what the unwinding has meant for systemically marginalized groups and what lessons we've learned from this experience that should inform future policy changes.

How Did Medicaid Unwinding Go?

By all accounts, the Medicaid unwinding has been an arduous undertaking. Even with a relatively long runway (state Medicaid programs had 14 months to complete renewals for Medicaid beneficiaries), the sheer volume of people whose Medicaid eligibility needed to be renewed created a daunting task. The majority of states will have completed unwinding-related renewals by the end of August, with a few outliers (North Carolina, Alaska, the District of Columbia, and New York) taking until later in 2024 or longer, according to a CMS timeline.

As we come to the end of the unwinding-related renewals, some key themes have emerged that begin to tell the story of how the process went and lessons learned that should impact Medicaid policy going forward.

- **Many beneficiaries were terminated from Medicaid for procedural reasons.** One of the primary worries of Medicaid advocates going into the unwinding was that for a variety of reasons—including changes of addresses over the course of the pandemic, reduced familiarity with the renewal process, and communication challenges for people with disabilities or limited English proficiency (LEP)—many enrollees would not complete the renewal process and would lose Medicaid coverage for procedural reasons rather than ineligibility. According to KFF, as of August 1, 2024, up to 69% of all people disenrolled had their coverage terminated for procedural reasons, making this a very common and an ongoing problem for federal and state Medicaid officials.
- **Ex parte renewals got a slow start, but gradually increased.** Ex parte renewals—where state Medicaid programs use available data sources to renew eligibility without relying on beneficiaries to submit renewal documents—were touted as an essential tool to reduce administrative burdens on Medicaid members and streamline renewals. While ex parte renewals got a bit of a slow start, KFF reports that of the people whose coverage had been renewed as of August 1, 2024, 61% were renewed on an ex parte basis. To streamline the renewal process, CMS required states to first attempt an ex parte renewal before requesting enrollees complete a renewal form. Compliance with this requirement was low at the outset, but states have made progress over the course of the unwinding, and advocates continue to push this important tool for reducing procedural terminations.
- **Marketplace policies that made it easier to access coverage and subsidies helped to ensure a smooth transition for many people no longer eligible for Medicaid.** The COVID-19 pandemic also prompted significant reforms to Marketplace coverage. Since 2020, there have been enhanced premium tax credits (PTCs) available to low- and moderate-income enrollees. For enrollees with income between 100 and 150% FPL, the enhanced PTCs mean that plans are now available to this group with zero premiums. Coupled with a Medicaid unwinding Special Enrollment Period (SEP) that allowed individuals who lost Medicaid to enroll in Marketplace coverage outside of the open enrollment period, the enhanced PTCs helped individuals to transition from Medicaid to Marketplace coverage more smoothly. The Office of Assistant Secretary for Planning and Evaluation (ASPE) had previously projected that of the 15 million people expected to lose Medicaid during the unwinding, nearly 2.7 million would enroll in Marketplace coverage, and researchers at Georgetown's Center for Children and Families now estimate that this number may be even higher. Because of how effective the enhanced PTCs have been in boosting marketplace enrollment, there are growing calls to make them permanent.
- **State Medicaid agencies were overwhelmed.** As state Medicaid programs took on the task of renewing eligibility, many hit significant staffing and capacity challenges that have resulted in backlogs for both renewals and new Medicaid applications. The delays in processing new applications are particularly concerning since many of the new applicants are believed to be individuals whose enrollment was terminated because of the unwinding. CMS is continuing to work with states who are taking longer than the prescribed 45 days to process a Medicaid application. In addition to processing delays, unwinding data has also revealed systemic eligibility determination errors that have led to erroneous disenrollment. One of the biggest errors was identified early in

the unwinding when state eligibility systems were programmed incorrectly, resulting in mistaken disenrollment of many children who were incorrectly deemed over income for Medicaid. CMS worked to suspend renewals in certain states as a result of this error while states corrected it.

- **The unwinding required CMS to play an active role issuing guidance and enforcing consumer protections.** CMS has released reams of guidance documents for state Medicaid agencies since well before April 2023, when the unwinding officially began. In July 2024, the Government Accountability Office (GAO) released a report on CMS unwinding oversight activities to date that highlighted priorities for CMS as it continues to oversee state eligibility and enrollment practices. The report detailed CMS's work to ensure that states followed CMS's requirements for unwinding protections as well as some of the lessons learned from the unwinding that could impact future Medicaid policy. For example, the GAO report found that some of the noncompliance issues identified during the unwinding were actually longstanding problems that existed even before unwinding. This points to the need to change how CMS monitors and enforces state compliance with Medicaid rules.
- **The unwinding exacerbated existing health disparities.** Survey data from KFF indicates that Black and Hispanic respondents were more likely to report having to submit proof of state residency, a potential barrier to getting renewals processed in a timely and efficient manner. CMS should look into this discrepancy and work with states to ensure that certain communities are not subject to more burdensome eligibility requirements. There is also data to suggest that individuals with limited English proficiency (LEP) experience barriers navigating Medicaid renewal and enrollment applications, especially where state Medicaid programs had limited translation services available. States' variability in the extent of LEP resources they provide suggests that CMS can do more to ensure states are meeting their obligations to provide meaningful LEP access.
- **Many people who lost Medicaid coverage during the unwinding remain uninsured.** The same KFF survey reported that as of the time of the survey (April 2024), nearly a quarter of respondents who lost Medicaid coverage over the course of the unwinding did not find other coverage. The primary reason cited by those who remained uninsured after the unwinding was cost. Bringing down the uninsured rate remains a key policy priority, and the bump in uninsured due to the unwinding has underscored both the need for Medicaid expansion in every state and the need to make the enhanced PTCs permanent.

What Medicaid Policy Changes Might We See as a Result of the Unwinding?

The COVID-19 pandemic laid bare gaping holes in our health care safety net systems, including in Medicaid. Renewing Medicaid eligibility for millions of beneficiaries also revealed outdated and ineffective eligibility and enrollment operations and procedures. While some of the flexibilities and protections that CMS announced during the unwinding are time-limited, there are also enrollment and eligibility processes that CMS may consider making permanent. In March 2024, for instance, CMS released a sweeping final rule aimed at removing burdensome administrative requirements for Medicaid eligibility and streamlining enrollment processes. Over the coming months, we are likely to see additional Medicaid guidance building from the final rule and providing more clarity on how states will be expected to comply with the new enrollment rules and data reporting requirements.

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