

Centers for Medicare & Medicaid Services
Medicaid and CHIP Continuous Enrollment Unwinding:

What to Know and How to Prepare

August 24, 2022

12:00pm-1:00pm ET

Webinar recording: https://cms.zoomgov.com/rec/share/3YeS6Z9u-LKAZKxZ9NyIumS1-IHlTYbvITDqaol-3rKE5VEG6mLBo1NHkVNZgk_2--pxN3x1Vdlb625R?startTime=1661357006000

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Beth Lynk: Hello, and welcome. My name is Beth Lynk, and I lead Strategic Communications and External Affairs in the Office of the Administrator at CMS. Thank you so much for joining us today for the Stakeholder Webinar on the Medicaid and Children's Health Insurance Program (CHIP) Continuous Enrollment Unwinding. We are thrilled to have folks from across the country on the call from Kansas to Arizona, from California to Oregon to Vermont. Thank you for taking the time to be with us today. This is the fourth call in the HHS and CMS monthly series of webinars to keep partners informed and help them prepare for the eventual return to normal operations in Medicaid and CHIP after the COVID-19 public health emergency. During our webinar in July, we announced our Unwinding Back-To-School Mini Campaign to ensure parents and caregivers are aware of Medicaid unwinding during the back-to-school season. The Connecting Kids to Coverage National Campaign walked through their updated back-to-school toolkit, which includes messaging on unwinding, and some of our partners in Virginia joined us to share information about their Medicaid and CHIP enrollment and outreach during the back-to-school season. Thank you to all of you that were and have been standing up back-to-school activities to remind parents and caregivers to update their contact information with their state Medicaid agencies. Additional resources toolkits are available on our website. If you want to engage in back-to-school activities. Do check out the back-to-school toolkit which includes all of that messaging if you have not already. The recording, transcript, and slide deck from both the July webinar as well as our May and June webinars can be accessed on our national stakeholder calls webpage available. That is available at <https://www.cms.gov/outreach-education/partner-resources/cms-national-stakeholder-calls>. We encourage everyone to watch that recording if you were not able to attend and please share it with your colleagues and partners if you are looking to engage in back-to-school activities. A few housekeeping items before we fully get started. The webinar today is being recorded. By proceeding, you have accepted the recording provision of this call. The recording and slides will be available on our stakeholder calls webpage. That is at that <https://www.cms.gov/outreach-education/partner-resources/cms-national-stakeholder-calls> link. That is also going to be posted in the chat. While members of the press are welcome to attend this call, please note that any press or media questions should be submitted using our media inquiries form. That is available on [cms.gov/newsroom/media-inquiries](https://www.cms.gov/newsroom/media-inquiries). All participants

are going to be muted for the duration of the call, but that doesn't mean we don't want to hear from you. Thank you to folks for dropping your location in the chat. We will have time for questions and we are going to be using the Q and A function at the bottom menu bar for you to submit questions that we will answer during this call. Please submit those, and we look forward to engaging with you there. I will also note that closed captioning is available via the link that was shared in the chat by our Zoom moderator. So, if you need that accommodation, please look for that closed captioning link. Before I walk through our agenda, I wanted to note that the public health emergency is still in effect. The Biden-Harris administration has committed to providing states 60 days of notice before any planned expiration or termination of the public health emergency. The current public health emergency declaration was renewed on July 15, 2022 and is set to expire on October 13, 2022. Since we are now within that 60-day timeframe and the Administration has not issued a 60-day notice, we can assume the public health emergency will continue past October 13th. Right now, we ask that our partners use this time to begin preparing your organizations for thinking about how we can incorporate information around the Medicaid and CHIP continuous enrollment unwinding into your existing communications plans and outreach with your networks. That is why we continue these monthly series and really want to work with you on that engagement. I also want to highlight that last week, we also released new data from the Department of Health and Human Services on the impact of the eventual unwinding on the Medicaid and CHIP population. We will drop that report in the chat, which really provides some resources and data about the impact and who is at risk of losing coverage as well as some guidance on the impact that the recently passed Inflation Reduction Act will have on connecting folks to coverage. Everyone should be able to see today's agenda on the screen. We wanted to use this month's webinar to share information on the Health Insurance Marketplace and the process for transitioning people that are no longer eligible for Medicaid and CHIP to the Marketplace once states restart their eligibility renewals. We will start with an overview of the Marketplace and key features to be aware of. Next, we will walk through the consumer experience timeline and expect it outreach from the time the public health emergency ends to the point that a consumer would be transferred to the Marketplace if no longer eligible for Medicaid and CHIP. We will then hear from the CMS Center for Consumer Information and Insurance Oversight (CCIIO) about the process for transitioning people to the Marketplace or [HealthCare.gov](https://www.healthcare.gov), as many may know it, from Medicaid or CHIP. Lastly, we will share resources that partners can access to learn more about the Marketplace before opening up it for Q&A and some closing remarks. With that, I'm going to turn it to Megan Reilly from the CMS Office of Communications to start us off with a general overview of the Health Insurance Marketplace. Megan, thank you.

Megan Reilly: Great. Thank you so much, Beth. You can go ahead and move to the next slide. We are going to do a whirlwind 101 of the Marketplace. If you have questions as we go, please put them in the chat and we will try to answer them later. Also, when we get to the resources and tips section towards the end of the agenda, we will also share other resources for if you are looking for more specific information or if you want more detail on topics we cover here. We have them all available online on [cms.gov](https://www.cms.gov), and we'll share the website with you when we get to the end. So, what is the Marketplace? The Health Insurance Marketplace is a place

for consumers who don't have health insurance through their job or Medicaid and CHIP or Medicare or other resources can come and purchase the health insurance and dental coverage that best meets their needs. They can do that online, over the phone or with the help of local assistance, whether that is an assister or an agent or broker. The Marketplace provides information around eligibility for whether a consumer can enroll in a Marketplace plan. Whether they might be eligible for extra financial assistance to help them afford the coverage in the form of a premium tax credit, which they can use to reduce the cost of their monthly premiums. There is also something called cost-sharing reductions, which I will cover a little bit more in depth a little later, that helps reduce what consumers have to pay out of pocket when they are using their Marketplace health insurance to get care and services. The Marketplace can also provide eligibility for Medicaid and CHIP. If a consumer comes to the Marketplace, we are also able to say, hey it looks like you might be able to qualify for Medicaid or the Children's Health Insurance Program in your state and help get the person over into that coverage. Next slide please. When we are looking at Marketplace operations and structures, there are really two versions, there's Marketplace, the federal government runs on behalf of the state known as the Federally Facilitated Marketplace (FFM) that is commonly thought of as [HealthCare.gov](https://www.healthcare.gov), that is what the Centers for Medicaid & Medicare – sorry Medicare & Medicaid Services really run across currently 33 states, and also states that run their own Marketplace. We tend to call them State-Based Marketplaces (SBM) places where the state runs the entire operational function, all of the customer service channels, and they provide the destination and the plans for consumers to go enroll in health insurance. Next slide please. Most of what we will be focusing on a little bit today is a little more specific to the federally facilitated version of the Marketplace. The core principles apply to all Marketplaces regardless of what state a consumer resides in. So, if they want to come and apply for health or dental coverage in a [HealthCare.gov](https://www.healthcare.gov) state, [HealthCare.gov](https://www.healthcare.gov) and our customer service channels, which we will cover a little bit more in depth later, are where those consumers can go or they can use their own state-based resources depending on where they live. Generally speaking, consumers can apply and enroll in coverage across a variety of channels. They can also get help if they need it, whether that is local resources in their area or they can reach out to somebody to talk to over the phone or in-person. The general process involves submitting an application to find out what they might be eligible for in terms of coverage as well as financial assistance, ways to help reduce costs for having health insurance. And once they get the eligibility decision, they have submitted their application, they get to move into that phase of comparing plans and enrolling in Marketplace coverage if that is what they're eligible for. Next slide, please. Who is eligible? In general, this covers the continental United States and our outlying areas. All other 50 states plus the District of Columbia. People must live where they are trying to apply for coverage, so they cannot apply at a different state from where they reside. It has to be within their residency. They also have to be U.S. citizens, U.S. nationals, or are lawfully present immigrants for the entire time they are planning to have the coverage. Consumers also need to not be incarcerated unless they are about to be released, in which case they could apply if they have a disposition date coming. Next slide please. Affordability programs, so this is where we get into a little bit of depth financial assistance. Next slide, please. Affordability programs, so this is where we get into a little bit of the depth of what some of those financial assistance that's available to consumers

provides. This is a lot of information. We are going to cover this very quickly, but there is tons more detail we can point you to and resources online to better understand this if you are looking for more information. Premium tax credits are a structure of an affordability program for Marketplace plans that help provide basically an advanced credit from a tax perspective in order to reduce the premiums that a consumer has to pay month to month while they are actually using their Marketplace insurance. The way that affordability works, looks at a person's household income when they apply for coverage. That uses standards on how much their income is based on federal poverty levels. Somebody that is from 100% to 400% of the federal poverty level would be able to qualify for some range of premium tax credits to be able to use in advance to lower the cost of their monthly Marketplace premiums. We have a chart on the right to give you a sense of where the bottom floor is. For example, a person that is currently in 2022 at that 100% mark would need to be making \$12,880 or more in order to qualify for premium tax credits. These tax credits can also be used in the sense of some, all, or none. Consumers can choose to use all of the and reduce their premiums by the whole amount they are eligible for, or maybe they decide that their income might be changing throughout the year, and they might want to not use all of the and just use some of it. That is a choice consumers can make when they go to enroll in a plan. How much of the tax credits do they want to use in advance to reduce their monthly premiums. Also, the American Rescue Plan extended the eligibility for premium tax credits to people that make above 400%. In the original Affordable Care Act, the ranges were set from 100% to 400% of the federal poverty level is the eligibility range for income. The American Rescue Plan extended that to folks that make more than 400%. That also was then reauthorized through the recently passed Inflation Reduction Act. That is still in place currently in our 2022 coverage year and will continue through 2025 as well. Next slide, please. The other core part of getting a premium tax credit is the concept of reconciling that tax credit. Since this is about to get a little too complex, the framework of tax is. When someone gets tax credits in advance to reduce their monthly premiums, they have to reconcile that when they go to file their federal income taxes the following year. For example, everybody that is currently enrolled in a Marketplace plan right now in 2022, that is getting an advanced payment of their premium tax credit, when they go to file their 2023 federal income taxes, they will have to reconcile that premium tax credit with their final income amount for the year. When the Marketplace is looking at income, consumers make an estimate of how much they think they will make for the whole year, and that is the basis for the calculation for the amount of premium tax credit they qualify for. On their taxes, they have their final income for the year. So, it might be different when the consumer has the final, here is everything I need for the current year, because it could be different from their estimates. When they are filing their taxes, consumers need to go through this reconciliation process between the estimate that was used to provide the tax credits in advance when they applied for coverage versus their final income amount and their final tax amount on their federal income taxes. That is a process that consumers would need to do every year that they have a Marketplace plan, and they are getting tax credits to help pay for the plan during the coverage year. They will reconcile that amount with the final tax credit based on their final income as a part of their federal income taxes. Next slide, please. One of the other great benefits within the financial assistance available to consumers is something called cost-sharing reductions. In essence, these are extra savings that some consumers may qualify for that

helps reduce other out-of-pocket expenses on their coverage for their Marketplace plan. While tax credits help reduce how much they have to pay in a monthly premium, cost-sharing reductions help reduce things like deductibles and other out-of-pocket expenses that they actually have when they go to use the care. This helps them actually be able to get a plan that costs them less money to actually use when they need health care services. Typically, these extra savings are available to consumers where their income is about 250% of the federal poverty level for themselves or their household. Also, for consumers that are a member of a federally recognized tribe, they are eligible for cost-sharing reductions regardless of their income, so they could be able to get them without having to meet those income requirements. The important part to note here is that these cost-sharing reductions are only available on a health plan category that is known as silver plans and we'll cover that in a moment. It is not all plans; only certain plans provide these extra savings for consumers that are eligible for it. It is really important when consumers go to look at plans, if they are able to get these extra savings or cost-sharing reductions to reduce their out-of-pocket expenses, they will find more plans in a silver category that actually offer those lower out-of-pocket expenses. That is something they will want to think about when they are enrolling in a plan. Next slide, please. Medicaid and the Marketplace. We will certainly cover more of this in the sense of unwinding. But a very high level, part of the Affordable Care Act made sure that we have something called a single streamlined application. In essence, it is really that there is a relationship between Medicaid and the Marketplace. The idea being that some consumers would be eligible for Medicaid, and if they are eligible for Medicaid based on their income, they are ineligible for tax credits in the Marketplace, so consumers would be able to just enroll in Medicaid. That generally covers in states that have expanded their Medicaid program to 133% of the federal poverty level for their income range, but there are other types of coverage for Medicaid as well that are not income based which states provide the application and eligibility process for. But if somebody happens to come to the Marketplace and their income range falls within eligibility for Medicaid or eligibility for the Children's Health Insurance Programs, which have different income ranges than just Medicaid in some states, then consumers are able to get from the Marketplace to Medicaid and vice versa. If somebody applied for Medicaid and their income is a little bit too high, Medicaid agency will transfer the consumer to the Marketplace to be able to apply for Marketplace coverage and enroll in a Marketplace plan hopefully with financial assistance. It kind of creates this process for consumers could apply in either program and still end up in the right place depending on their income and eligibility. Move to the next slide, please. When to apply and enroll. From a Marketplace perspective, there is an annual open enrollment period. It currently runs from November 1st to January 15th on [HealthCare.gov](https://www.healthcare.gov). States that operate their own Marketplace sometimes have different dates and deadlines. If you are working in a state that is not covered by [HealthCare.gov](https://www.healthcare.gov), take a look at your state's Marketplace website each year to find out what those dates and deadlines are. A really important in the middle deadline for consumers if you're looking for coverage to start next year. For example, when we get to November 1 this year in 2022, that will be for the 2023 coverage year for consumers to apply and enroll. People that do that by December 15, that means they can get full year coverage and their plan will start as soon as January 1. If they don't make it in time or did not realize, consumers still have until January 15

to utilize open enrollment, apply and choose any plan that is right for them, and their plan will then start the first of the following month from when they enroll. Members are federally recognized tribes can enroll throughout the year. They don't need to apply only in open enrollment, and they don't need to have what is known as a Special Enrollment Period (SEP). There are lots of different reasons where somebody could be eligible for Special Enrollment Period. What that means is somebody merely becomes uninsured, let's say they had employer coverage and lost that employer coverage, that makes them eligible for Special Enrollment Period in the middle of the year to come in and enroll in coverage. We have lots of information online about other types of Special Enrollment Periods that consumers are eligible for. One other important thing to note is that Medicaid is not subject to open enrollment or Special Enrollment Periods. That is year-round enrollment in those state health insurance programs. Next slide, please. How to apply for coverage. This is focused on the Federal Marketplace here for [HealthCare.gov](https://www.healthcare.gov) and [CuidadoDeSalud.gov](https://www.cuidadoDESALUD.gov). We have our online resources in English and Spanish. That is a comprehensive application and enrollment experience online on either version of our website. We also have the Marketplace call center. We have what is known as Marketplace enrollment assisters. These are folks that range from grantees to volunteers who have applied, registered, and become certified through the Marketplace to be able to help consumers work through that application, answer any questions they might have about the process or about their eligibility, and help them enroll in coverage. We also have Marketplace registered agents and brokers who can serve the same assistance through application and enrollment experience. We have certified enrollment partners, such as web brokers, who offer their own enrollment experiences online, and we also have insurance companies that have been certified to do that as well. Consumers can also apply through a paper application if they would prefer. We have language assistance available through our call center and print and web resources as well across all of these multitudes of customer service channels. And also, if you are looking for resources for consumers that maybe need a little bit of additional assistance or other partners that are looking for job aids, we do have those available in 33 additional languages beyond English and Spanish. Next slide, please. A quick high-level overview of Marketplace plans. What is this coverage and what does it provide and how is it beneficial to consumers? At the core, it provides coverage for comprehensive medical or health benefits, called essential health benefits. The goal of this is to make sure these are quality health plans that are going to cover all of the major services that someone would need from a health insurance plan. It establishes limits on what plans can charge for things like deductibles and copayments and how the cost-sharing between a person and health insurance plan works to make sure that we have defined requirements and levels to make sure that these are comprehensive healthcare plans that consumers are enrolling in. Plans are also required to meet nondiscrimination requirements, and they have to meet requirements around things like how their network is structured in terms of the breadth of providers and facilities and their formularies for prescription drug coverage to make sure that these are health care plans covering the different needs that a consumer may need in their insurance. They are also required to follow state specific rules. Every state has their own regulations around health insurance products. Each plan in a state that is currently registered in also has to follow the state specific rules in addition to the federal guidelines and requirements that we establish. Next slide, please. This is just a

quick overview of the 10 essential health benefit categories. They cover everything from making sure that prescriptions, maternity care, emergency services, hospital services, rehab facilities, preventive and wellness care are covered, pediatric care, and rehabilitative services. So, there is quite a list and a depth here. I won't spend too much time on it. We have a lot more information online if you are interested in learning more about what these different categories cover. Next slide, please. When consumers are enrolling in health plans, there are four different categories or levels. There is a bronze level, a silver level, a gold level, and a platinum level. What that really means is how much of the cost of care is a consumer sharing with the insurance plan. A bronze level means that consumers are paying about 40% of the costs of a service or care and health insurance plan is covering the other 60%. That changes across these different categories: bronze, silver, gold, or platinum. A silver plan actually means that the insurance company is covering a little bit more of those costs and the consumer has to cover a little bit less of those costs. Usually, those trade-offs come in the form of varying premiums between the levels. As consumers take a look at what they're eligible for, they want to consider what types of cost-sharing they want to have and how much they're willing to pay in their premium versus their out-of-pocket expenses. And as a reminder, the silver plan is also the one for consumers that have eligibility for extra savings through cost-sharing reductions. This is that health plan category that those consumers may want to really take a look at when they're considering their options. There is also another health plan category known as catastrophic plans. We won't cover this in too much detail. In general, they are generally designed for younger adults who are under 30, they provide reduced benefits but they do cover all medical costs up to an annual limit on cost-sharing and three primary care visits and a couple other things. It is a protection mechanism against high costs, but they are not as comprehensive of a health plan in terms of some of the other categories in terms of bronze, silver, gold, and platinum. Next slide, please. Finally, we get to premium payments. After a consumer has picked a plan, it is really important that they make that first premium payment. That helps them actually, what we term, effectuate coverage. It means that they are an active enrollee, they have set up their billing structure with their health plan, and now they are in a place where they can start using the health insurance throughout the year. The health insurance company or issuers do offer a variety of different payment methods, they at least have to accept a paper check, cashier's check, a money order, electronic funds transfer, or a general purpose pre-paid debit card. Issuers can also have different mechanisms for setting up billing arrangements, some are accepted online, some accept credit card and other debit card payments, this is something that the consumer will need talk to their plan about and set up for their premium payment process for next year. Next slide. Coverage to care is a hybrid thing that we have where this is materials and information and support for consumers that are enrolled in coverage, but this also provide really helpful resources for partners as well. If you want more information about how to help somebody who is enrolled in Marketplace health insurance how to use their coverage, that is really what Coverage to Care is focused on. It provides consumer-facing, plain language materials about how to use their insurance, things to think about with their health care costs and we have additional resources like videos, toolkits, and community materials to help consumers once they have gotten through the "I have health insurance, now what," phase, that is what Coverage to Care really helps us do. That is the end of our 101. I will do a quick timeline for Medicaid

unwinding. Go to the next slide. And have covered Marketplace from a Medicaid unwinding perspective this is all of the things that start beforehand. When I get to the end of this slide, it will be a seamless transition into our next part of the agenda. From a Medicaid unwinding lens, this is more of a consumer look at Medicaid unwinding. Right now, we do not have the 60-day announcement as Beth covered in the beginning, but states are currently going through a campaign to get consumers to update their address and contact information. Because of the public health emergency, a lot of people may have not kept their information up to date with their states. States are currently reaching out to consumers trying to say hey, something is coming. We need to contact you, please let us know if we need to update any of your information, whether that is an address, a phone number, an email address, etc. That is an ongoing process that our state Medicaid and CHIP Agencies are engaged with now, that will keep going even when we get to the start of the Medicaid unwinding with the 60-day announcement. Once that 60-day announcement kicks off, this is really when some of those eligibility years start turning from Medicaid unwinding. Behind the scenes, at that moment, states can start doing some back-office functions, checking on eligibility and enrollment. States have access to data within their own processes across different state programs, so they can start doing some of that eligibility readiness beforehand, but at the point in time when the 60-day announcement starts. Then states start sending renewal form letters, so that is going to be the process where the state says, "okay, we need to check to see if you are still eligible for a Medicaid or your Children's Health Insurance Program coverage. Here is what we need from you. Please send it back." That starts a flow basis of states sending out renewal forms and consumers sending information back. In some state processes, this may be a digital process as opposed to paper, so there are a variety of mechanisms some states might be using to help consumers get through the renewal process. The end of that process results in the state making an eligibility decision. By and large, lots of people will likely still be eligible for Medicaid and CHIP, and the state will communicate that in a letter saying, "Great. Thanks for providing your info. Your coverage is continuing." We have consumers, which we'll be talking about in the next segment, who based on their information, particularly if their income has increased, they are not eligible for Medicaid or CHIP anymore, and the state will transfer them to the Marketplace. There is a segment of consumers that the state was not able to get a hold of who do not respond and provide anything. For those consumers, their coverage is going to end, but they do not get transferred because the state does not have enough information to figure out what they may be eligible for. The key thing in looking at this timeline is from the 60-day announcement, the first cohort or the first segment of consumers who could lose Medicaid or CHIP coverage and be transferred to the Marketplace could happen on the first day the public health emergency ends. We will have states with a segment of consumers that come through the first batch, and on the day that the public health emergency ends, we could have consumers who are no longer eligible for Medicaid or CHIP and get transferred to the Marketplace. We also want folks to understand that there are a lot of timelines here. They will have their Medicaid or CHIP coverage ending the month that the PHE ends. If the public health emergency has an end date midmonth, (inaudible) when we get into the transfers to the Marketplace, this starts going on a flow basis. Everything passed the first segment, states will be processing renewal forms, they are going to be sending eligibility letters, and they are going to be transferring

consumers over to the Marketplace on a day to day basis. This doesn't follow a week or month or any other particular segment of people. This will be an ongoing process across the states and across the Marketplace. Once the Marketplace gets the consumer, we have operations to communicate with them and get them to come in. And with that, I will transfer it to Ellen to talk about that next process.

Dr. Ellen Montz: Thanks, Megan. And I should note, the sun just started streaming through my window, so apologies for the lighting here. Good afternoon and for me, I am on the West Coast today. Good morning to those of you who are on the West Coast. I really enjoyed seeing folks chime in with where they are calling in from. It feels great to be communicating across the country and partnering, more importantly, with you all today in our work and to prepare for the eventual end to the public health emergency, and I will say massive amount of work that we have been really incredibly engaged in from a whole of CMS, from a whole of HHS, from a whole our Administration perspective to ensure – to help ensure – that individuals don't needlessly lose coverage. As we have communicated in these webinars with you – with these meetings – a large part of the success of ensuring that individuals correctly remain in Medicaid and CHIP or transition to new coverage that they are eligible for, including the coverage program that my team runs. The federal Marketplace. That will really benefit from all of your help out there. Before I jump into all of this, I want to say thank you and thank you for being so engaged here as I look at the numbers on the call today. Today, I want to do a couple of things, one, give the lay of the land, the context of how coverage transitions work today. From a system perspective as well as how the consumer experiences it. And also talk about our strategies and what more we are trying to do to prepare for the end of the public health emergency and this effort to ensure that our coverage transitions are more successful than ever before. So why don't we go to the next slide and we'll jump in here. Alright, so just as Megan did, I should note that I will talk generally from the federal Marketplace, the HealthCare.gov perspective, noting that many of the themes are similar. In some cases, the state-based Marketplace are approaching things in new or even different, innovative ways across the states. We are learning from one another. I will touch on some of the state-based Marketplace initiatives a little later on. How does a consumer experience this transition between -- to the Marketplace from Medicaid or CHIP coverage? How does that work? Megan talked about this from a top level, I will take you a touch deeper. Just so you are better equipped to help consumers as they experience this. When a Medicaid agency determines an individual is either no longer eligible for Medicaid or CHIP, or if an individual has come to the Medicaid-CHIP Agency and apply for coverage and the agency has determined that the individual is not eligible for their program, in either of those two scenarios, the information about those consumers, whether they are currently enrolled and about to be no longer eligible or newly applying but not eligible, the information about those consumers are transferred from the Medicaid agency through a secure, electronic transfer to the federal Marketplace or State-Based Marketplace. There are rules about the data that the Medicaid and CHIP agencies must securely send via this inbound account transfer about what is mandatory and what is optional. I can say -- I say because we have made incredible improvements, when we started looking at the completeness and data quality across our states, many months ago, we had a bit of work to do in

terms of the quality and being able to really extract good contact information from the data. CMS has worked hand-in-hand with the states and has been incredibly successful partnerships on improving the completeness and accuracy of the contact information that comes to us. Many states have implemented system changes and really dug in to ensure that the information is handed off to the Marketplace so that we can start our job of getting folks to come in. What we know is our best bet here in terms of helping consumers transition is to get quality, accurate, recent, current contact information about those individuals no longer eligible. Harness the power of our CMS systems, our partners, and our successful outreach and enrollment engine we have here to get folks to come through to [HealthCare.gov](https://www.healthcare.gov) to sign up. Although, a few states are working towards a goal of automatically enrolling individuals that come over from a Medicaid and CHIP agency, the reality of where we are is that the federal Marketplace and for most states, this transfer of coverage does not happen. People do not get automatically enrolled in Marketplace coverage from Medicaid and CHIP. There needs to be the active action taken by consumers in order to enroll. We will talk about our strategies to make sure that we get to that active action. What we have seen, particularly in the past few years, is that once you get people to [HealthCare.gov](https://www.healthcare.gov), they sign up. The teams have made an incredible improvement on the electronic flow of application, the apparatus we have of the assisters and brokers, navigators, partners in the community, volunteers. To really quickly and easily take folks through the application process onto the selection process. Next slide, please. What does this look like from the consumer perspective? When we receive – any by we I mean the Marketplace – when we receive the information about consumers from Medicaid and CHIP, we directly send consumers a notice that says – and we’ve revamped it – “Hey, we received your information, you are likely eligible for some pretty quality, valuable coverage in the Marketplace. You can come to [HealthCare.gov](https://www.healthcare.gov) or we provide the ability to come to the link for assisters, how do you find help in enrolling, the call center, etc.” I will note here that as you are working with consumers, consumers do not need to wait to get this notice to sign up for a Marketplace coverage. If they know and receive a notice from their Medicaid and CHIP Agency, there will no longer be eligible and no longer enrolled in Medicaid or CHIP, on a date that is coming up, they do not need to wait until they lose coverage from Medicaid and CHIP to sign up for coverage on [HealthCare.gov](https://www.healthcare.gov). I would use this opportunity to say to everyone do not wait, tell folks that you are helping and do not need to wait until you have lost coverage. As soon as you know that your Medicaid and CHIP coverage is ending and what date that is, you can come in and apply on [HealthCare.gov](https://www.healthcare.gov) to make sure that you limit or even eliminate, hopefully any gap in coverage that may occur between transferring across programs. Next slide, please. A quick logic flow here for the inbound account transfer process and the consumer perspective. This is just a schematic of what I just described. We received information from the Medicaid and CHIP Agency. Once we receive that information, we send out communications, we the Marketplace, send out communications saying come on into [HealthCare.gov](https://www.healthcare.gov). Once an individual does come in to [HealthCare.gov](https://www.healthcare.gov), either they got their notice, they’re receiving help. They can start a new application and submit it. More than likely, more likely than not, given at that just about over 90% of our customers and members here on [HealthCare.gov](https://www.healthcare.gov) and on the federal Marketplace have financial help, more likely than not. Individuals will perform their eligibility and find that they are eligible for some really great assistance and particularly great financial

assistance thanks to the passage of the Inflation Reduction Act which has continued these additional premium subsidies – premium tax credits – beyond what the ACA created for an additional three years. Really timely for our unwinding population that the Inflation Reduction Act was passed. Individual will receive their eligibility and then they will sign up for a plan for coverage. Next slide. I want to talk a little bit about how we are focusing on improving on the processes that exist today as it relates to the consumer experience and transferring -- transitioning between Medicaid and CHIP coverage over to Marketplace. I want to emphasize that HHS, CMS, the Administration, we are laser focused on a robust plan for mitigating coverage loss wherever possible during the unwinding process. We are doing that by making sure that we are not -- we do not care about which program, you want to make sure that individuals wind end up in coverage they are eligible for. Whether that is continuing in Medicaid or CHIP. Whether that is the Marketplace or that is employer-sponsored coverage. We take each extension of the public health emergency incredibly seriously, and we redouble our efforts to make sure what more can we do in order to prepare. On the Marketplace, we specifically have three-pronged approach for improving these coverage transitions. We have taken a look at our systems and policy to make improvements. Second, as we mentioned time and time again, we have harnessed the power of our partnerships. How can we use our partners on the ground and in our system to help consumers make that successful cover transition? Third, our pretty impressive outreach and enrollment efforts, particularly coming off of our successes and the Special Enrollment Period and the open enrollment period last year, really harnessing what we have learned and are new skills from that piece and applying them to our approach for getting folks enrolled in coverage in enrollment Marketplace coverage during the unwinding process. On systems, specifically, as I noted before, we are trying to improve the contact information we get from states so that we can effectively provide that outreach. We have also made some policy changes that mean that less need for paper verifications, etc. will result as folks go through that eligibility process. Folks can find out their eligibility in one sitting and do not need to get additional documentation. There is also revamped notices to make it more clear where folks should go and we have been thinking about, and I have said this on a few venues, we are thinking about how we make sure the individuals transitioning from Medicaid and CHIP have enough time to sign up for Marketplace coverage. As it relates to our stakeholder engagement and partnership, I should say we are working with state and Medicaid agencies, State-based Marketplaces, consumer advocates, health plans, navigators, assisters, agents, brokers, departments of insurance, and many of you on this call to really leverage the robust outreach system partnership to get folks enrolled in coverage. Finally, we are planning for a very robust outreach and enrollment campaign around the unwinding. Next slide, please. A little bit more detail here. As Megan mentioned, Medicaid and CHIP, you can sign up for and enroll at any time of year. The Marketplace is a little different, and the Marketplace has an open enrollment period in which anyone can come in and sign up if they are eligible and begin coverage. That runs from November 1 to January 15 of every year. In addition, we have these things call Special Enrollment Periods, and importantly for unwinding, when an individual loses coverage for Medicaid or CHIP, they have 60 days from the time they lose coverage to sign up for coverage at [HealthCare.gov](https://www.healthcare.gov). They also have 60 days before they lose that coverage to sign up. As soon as an individual knows their coverage may be ending, come into [HealthCare.gov](https://www.healthcare.gov). I

will say again that we do continue to look at that 60-day timeframe in terms of getting people enrolled within 60 days of losing their Medicaid or CHIP coverage and figuring out whether we do need to do an extension of that, during the unwinding, more to come there. I do want to acknowledge we are absolutely working, we have heard from Medicaid agencies, departments of insurance, that is something a lot of folks are interested in and we are absolutely taking a look at what time frame would be appropriate. Next slide, please. I want to drill in a little bit on specifics, the mechanisms for helping individuals get the assistance they need to enroll in [HealthCare.gov](https://www.healthcare.gov). I should note, the really incredible thing about the Inflation Reduction Act is that one of the largest barriers we have found throughout the years of successful transitions between Medicaid and the Marketplace is one that is financial. The additional subsidies provided first under the American Rescue Plan and now under the Inflation Reduction Act really going to help eliminate or almost eliminate the financial barrier that folks face between Medicaid and the Marketplace coverage. There is the barrier to the administrative process of signing up for coverage. I want to point out that we will continue to have really aggressive investment in our navigator and our assister programs. Look for a few additional announcements coming soon on the navigator program and what help we are looking to provide for individuals through our navigators and other assistance programs through unwinding and say look out for more information there. Next slide, please. I want to note that we are absolutely leveraging our work that our health plans can do. Particularly, our insurers in the market that provide coverage in a state for Medicaid but also provide coverage in a state on the Marketplace and how those health plans can be really important and use their relationships with their consumers to help ensure successful transitions across programs as well as the agents and brokers that health plans, give a financial incentive to help individuals enroll in coverage. We have been providing, doing a lot of outreach and training and discussions and both health plans and agents and brokers to ensure that they are best equipped to help us successfully transition people across Medicaid and the Marketplace coverage. Next slide. Finally, I want to say a few words on our state-based Marketplaces. Areas where states are running their own Marketplace. Eighteen state Marketplaces that fully run their own platform. A lot of really incredible work and preparatory work being done in those states by the Marketplaces in partnership with their Medicaid agencies. I want to call that out here, the great work they are doing. Also point out that we have published a punch list helping encourage and point out areas of flexibility that state-based Marketplaces can take advantage of in order to best leverage and create successful outcomes for transitions. With that, I will turn back to Megan Reilly for a brief closing segment.

Megan: Great thank. I think because we are running very close on time, one of the things he wanted to make sure that people are aware of if we jump to our [Marketplace.cms.gov](https://www.Marketplace.cms.gov) slide, this one. A lot of the information we presented today is actually available already on [Marketplace.cms.gov](https://www.Marketplace.cms.gov). We have a wealth of resources about the Marketplace program. This is where we publicly release our training materials for our assisters and agents and brokers. All of the information we walked through with them about different parts of the Marketplace program are all available online here. We have sample letters, I know that there are some questions about a sample notices, those are available under applications, forms, and notices. We also have outreach and education materials and toolkits. This is specific to Marketplace, this does

not have a crossover with Medicaid unwinding. The Medicaid Unwinding toolkits and materials are available on [Medicaid.gov](https://www.Medicaid.gov), which I think we have shared previously. This is a great resource if you are looking for more information or want to review some of our 101 materials. It is all here. I think I am turning it back to Jonathan and Hailey.

Jonathan Blonar: Thanks, Megan. I know we are very tight on time, I think we have time for a couple of questions. I want to thank everybody who joined today, we had over 150 questions in the Q&A chat. Thank you for submitting all those questions. We did have a lot of questions about where people can get the recordings, transcripts and slides, I will ask Hailey if she can drop the link into the chat. They are available on our partner website. They will drop that into the chat. Just give us a few days to get them up there. There will be a transcript and a link to a recording and the slide deck should be out there as well. The previous calls are currently out there. Some folks asked for the link to sign up for these calls. We do send out a reminder before each call, there is a link in there to register. If you are not getting those emails check your junk folder or spam folder to make sure that they are not going into that folder. If you are still not getting those emails, send us an email at the partnership mailbox and Hailey can drop that email address into the chat as well. I will ask a couple of questions for Jessica Stephens we saw that came up a few times. Jessica, regarding Medicaid or determinations, is there a standard method by which agencies will attempt to contact individuals and does this include by email, phone, or by paper mail? Folks have heard that some state Medicaid agencies do not collect email information.

Jessica Stephens: It varies. All Medicaid agencies are required to have the ability to provide the option for people to respond by mail, online, by phone, or in-person. Many individuals still choose to do so by mail. You would expect that most of the communication still happens that way. But, individuals should also have the opportunity to respond information by phone, or if they have signed up for an online account, by online as well.

Jonathan Blonar: Great, thank you Jessica. One last question for you while we have time. Would be the specific date an individual enrolled in Medicaid should start receiving the request for address information, etc.?

Jessica Stephens: Now. I think it depends specifically on what. States are working to get addressed and other information updated, it is an area that I think we've talked about that is important to start doing now. Many states are doing renewals now for both Medicaid and CHIP. With respect to the end of the public health emergency, the first terminations of coverage cannot occur until the month after the month that the PHE ends. So, expect that some of the work would start before then for termination that occur, even though just to reiterate, a lot is already happening right now.

Jonathan Blonar: Great, thank you Jessica. I am going to turn it over to Beth. I do want to let folks know thought before I turn it to Beth that the questions we did not get to today that were in the Q&A, we will use them to help us inform further topics on future calls as well as

any additional outreach and education that we do put out. With that, I will turn it back to Beth Lynk to close us out. Thank you.

Beth Lynk: Thank you so much, Jonathan. Thank you everyone for such a robust participation in today's call. We appreciate your time and your partnership here. On the screen are going to be some resources and links and we wanted to, in closing, highlight some resources you can refer to. If you want to learn more about Unwinding and plan how you can engage in this work. You will see the unwinding homepage on [Medicaid.gov/Unwinding](https://www.Medicaid.gov/Unwinding). There is also Medicaid and CHIP beneficiary research page on [Medicaid.gov/Renewals](https://www.Medicaid.gov/Renewals) that you can access. The Unwinding Communications toolkit and graphics are available in English and Spanish. We highly encourage everyone to check it out if you have not done so already. We have seen many of you use those resources. We appreciate that and as always continue to resource those and elevate those. As mentioned, the recording, transcripts, and slides from the previous webinars are available on our National Stakeholder Calls webpage, and the recording, slides, and transcript from today's call will be made available. Finally, if your organization is holding a webinar or an educational event about these activities, and would like a speaker from CMS, we would love to help you and provide a speaker there. There is a speaker request form that you can see on the screen. We encourage folks to fill that out. With that, I really want to thank everyone for attending today's call. We encourage you to share these resources, share this call information with your friends and partners. If we look on this following slide, I want to remind you about the dates for the upcoming webinars. We will be monthly with the exception of November, which for the holidays will be consolidating the November and December webinars. I really appreciate your partnership, your commitment to helping ensure the people are connected to the best health care coverage that they are eligible for. We look forward to working alongside you. Thank you so much, and this concludes our call today.