WHAT YOU NEED TO KNOW

Moving from Medicaid to Employer-Provided Coverage

Now that the COVID-19 emergency is over, the government is restarting the yearly process of making sure people on Medicaid or CHIP are still qualified for these programs. The process is called Medicaid Redetermination. It helps make sure Medicaid stays strong and can serve those who need it most.

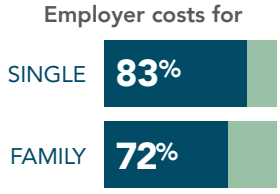
Since COVID began in 2020, things may have changed for you, including where you live, or work, and how much you earn. As a result, some people may lose their Medicaid or CHIP coverage, but you still have other options. You may be able to get health insurance from your employer. Or you may be able to buy a plan — with financial help if you qualify — from the state insurance marketplaces.

What Is Employer-Provided Coverage?

Things may have changed for you since the start of the COVID-19 pandemic – including where you live, where you work, and how much you earn. As a result, it's possible you are no longer eligible for Medicaid. But you may be able to get health insurance through your job. This type of health insurance is called "employer-provided coverage." While up to 18 million people are expected to no longer be eligible for Medicaid, more than half of them (9.5 million) will be able to get coverage through their employer.[1]

Medicaid is health coverage provided by states to people with very low or no income. Employer-provided coverage is offered by an employer to their employees, as well as to employees' spouses or partners and dependents. Employer-provided coverage can go a long way to protecting your financial stability and peace of mind.

About 90% of all American employees work for an organization that offers employer-provided coverage.



On average, employers pay for 83% of the health insurance costs for a single person, and 72% of the health insurance costs for a family.

TAKE ACTION NOW!

If you have coverage through Medicaid, or if your children are covered by CHIP, you must take action NOW to keep your coverage, or to move to another type of health insurance.

1. **UPDATE** Your information with your state's Medicaid program
2. **WATCH** In your email, mail, and texts for more information about how to renew your coverage
3. **REPLY** As soon as you get information so there's no drop in your health coverage

More about Medicaid in your state: Renew Your Medicaid or CHIP Coverage | Medicaid

If you are eligible for health insurance through your job, ***you have 60 days to enroll*** *after the date you lose Medicaid coverage.*

1 https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage_0.pdf

AHIP
Guiding Greater Health

Key Differences Between Medicaid and Employer-Provided Coverage

	Medicaid	Employer-Provided Coverage
Costs	Paid for by the government and taxpayers. Most people enrolled in Medicaid do not pay a monthly premium or for services when they get health care or medications.	Employees pay a monthly premium, which is largely subsidized by their employer. Employees also pay a portion of costs when they get health care or medications. These out-of-pocket costs—the deductible, copay, and coinsurance—vary by employer and plan. Be sure to know what each plan offers and what important terms mean so you can choose the plan that best fits your needs.
Benefits	Covers most health care, like hospital and doctor visits, lab tests and X-rays, mental health care, home health services, and prescription drugs. Medicaid covers annual check-ups, immunizations, preventive care, and other wellness services. In some states, Medicaid covers other services like dental care, vision services, eyeglasses, and routine medical transportation.	Covers most health care, like hospital and doctor visits, lab tests, and X-rays, annual check-ups, immunizations, preventive care, mental health care, and prescription drugs. Most employers also offer access to telehealth services —which allows you to access care from the convenience of your home. Many employers offer dental or vision insurance as separate policies. Benefits vary from employer to employer and plan to plan, so be sure you know what benefits and services are included in your coverage, and which are not. For more information on your plan benefits, reach out to your employer.
Types of Coverage	Most people with Medicaid get their care through Managed Care Organizations (MCO). People can choose their MCO, but there are very few differences in benefits and out-of-pocket costs. The main differences are the specific providers available through each MCO. Ten states do not use MCOs – in those states, people with Medicaid all choose from the same providers chosen by the state.	You may be able to choose from a variety of different plan types, such as Health Maintenance Organizations (HMO) or a Preferred Provider Organization (PPO). Choosing between an HMO or a PPO health plan doesn't have to be complicated. The main differences between the two are the size of the health care provider network, the flexibility of coverage or payment assistance for doctors in-network versus out-of-network, and your monthly premium amount. Typically, the monthly payment for an HMO plan is lower than for a PPO plan. However, an HMO plan will have less flexibility around which services are covered, and you will have to pay for out-of-network services.

How Do I Enroll in Employer-Provided Coverage?

If you are no longer eligible for Medicaid, you should reach out to your employer immediately. You are eligible for a special enrollment period (SEP) to enroll in coverage through your employer. Employees typically **only have 60 days from the date they lose Medicaid coverage** to request an SEP - but if you lose Medicaid eligibility on or before July 10, 2023, you can request an SEP until September 8, 2023.

Employers also offer an annual open enrollment period at another time during the year, when all employees can re-examine their coverage choices and make changes that are right for them.

How Do I Choose Coverage that's Right for Me?

Ask yourself a few questions about what kind of health care you want to be covered, and what costs you are most comfortable paying. Typically, plans cover similar services but will have different costs and cost structures. For example, if you are willing to pay more toward your premium – or the amount you contribute to your health insurance every month, after your employer contributions are deducted – you are likely to pay less out of pocket for health care services, and vice versa. Your employer may have other resources – like an expert in HR, or an insurance broker – to help you through this process.

Learn answers to questions like these:

Are my doctors and hospitals in network?

Health insurance providers negotiate lower prices for you with hospitals, health systems, doctors, and other providers. These providers are considered "in network." Going to in-network providers helps you save money with your health plan. If a doctor or facility does not contract with your health plan, they're considered out-of-network and can charge you full price. If you see an out-of-network provider, you will likely pay significantly more than you would pay in-network. In cases of emergency services, you will owe only the in-network cost-sharing amount regardless of who you see.

Are my prescription drugs covered?

Each employer-provided plan has its own "formulary," which is a list of prescription drugs that it covers. Some drugs may be 100% covered, while others may require some payment from you. Before enrolling, check the plan's formulary to see if your medications are covered and what your costs would be.

Do I have a chronic health condition that I need help managing?

If you have a chronic condition – such as a heart condition, or diabetes - make sure services, treatments, or benefits you expect to use are covered by the health plan.

What are the costs for my employer-provided coverage?

A **premium** is the amount you pay monthly to keep your coverage. Employers pay the majority of monthly premiums, and employees pay the rest.

A **deductible** is the amount you pay for most eligible medical services or medications before your health plan begins to share the cost of covered services.

A **copay (or copayment)** is a flat fee that you pay on the spot each time you go to your doctor or fill a prescription. Copays cover your portion of the cost of a doctor's visit or medication.

Coinsurance is a portion of the medical cost you pay after your deductible has been met. Coinsurance is a way of saying that you and your insurance carrier each pay a share of eligible costs that add up to 100 percent.

Do I want a lower monthly premium but higher out-of-pocket costs when I get care – or a higher premium and lower out-of-pocket costs when I get care?

Think about how you are most comfortable paying for your health care. Higher out-of-pocket costs can mean lower costs if you don't get a lot of care. Higher premiums can mean more predictability in your costs, even when you experience an emergency or health issue you didn't expect.

Is employer-provided coverage right for my family?

Employer-provided coverage is the right choice for millions of Americans and their families. But some employees choose to enroll themselves in employer-provided coverage, and their families in coverage through the health insurance marketplaces. As you make your decision, you may want to determine whether your spouse (or partner) and dependents are eligible for financial assistance from the federal government to enroll in coverage through the health insurance marketplaces.

How Do I Use Employer-Provided Coverage?

Once you have enrolled in employer-provided coverage, be sure you understand your benefits and the costs for various procedures and services. Here are a few important things to remember when using your new employer-provided coverage:

- Contact your providers and pharmacy to make sure they have your updated insurance information.
- If you don't already have a primary care provider, find a doctor that is in your network. If you do have a primary care provider, be sure to make sure your doctor is in-network before seeking care.
- Be sure to get regular check-ups, ask your doctor about preventive screenings, and consider enrolling in a workplace wellness program to help you stay healthy.
- Keep track of your health care spending so you can use that information during the next open enrollment period to ensure you have a plan that best fits your needs.

Visit AHIP.org/health-insurance-terms for a full glossary and definitions of frequently used terms. Always reach out to your employer or health insurance provider if you have specific questions about your coverage.

Everyone deserves affordable access to comprehensive coverage that protects their health and financial stability. Health insurance providers are committed to working to help you enroll in coverage that best fits your needs.