Protect Medicaid Funding Issue #3: Enrollment and Continuity (Updated March 2023)

David Machledt and Michelle Yiu

Introduction

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.[1] Medicaid coverage is tailored to the unique needs of individuals and families with low incomes, but still costs less per beneficiary than private insurance.[2] Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and people with disabilities. Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 91.8 million people who benefit from Medicaid and CHIP.[3]

This fact sheet considers one such set of protections, Medicaid enrollment and continuity rules, and examines their importance to Medicaid beneficiaries and how Medicaid funding caps would undermine them.

Why Medicaid Enrollment and Continuity Protections are Important

Medicaid enrollment rules protect low-income applicants. Medicaid enrollment rules are specifically designed to protect low-income applicants, who may have urgent care needs and no other options to access services. Medicaid law requires that all eligible applicants be enrolled with "reasonable promptness," meaning states cannot impose barriers such as waiting periods.[4] Medicaid also accepts applications and enrolls applicants anytime. The limited "annual enrollment period" used by Medicare and the Marketplace does not exist in Medicaid, where individuals by definition have too few financial resources to pay for care on their own while waiting for annual enrollment. They can enroll at any time of the year. Once an individual is found eligible, Medicaid makes coverage effective the date of application and in

most cases, offers retroactive coverage for the three prior months.[5] This ensures rapid access to coverage and is a vital protection for hospitals and other providers who provide emergency treatment to individuals prior to enrollment.

Medicaid includes special continuity provisions for certain beneficiaries, including pregnant people and children. Pregnant people in Medicaid are covered for a postpartum period of at least sixty days even if the pregnant person's household income changes.[6] Twenty-nine states have adopted a continuous coverage extension to twelve months postpartum, with more in process.[7] Infants born to Medicaid beneficiaries are automatically enrolled in Medicaid as of their date of birth, meaning families have no administrative obligation that could delay starting a newborn's coverage.[8] Moreover, the baby automatically remains eligible for Medicaid for a full year as long as the family's income does not increase substantially.[9] Then, in December 2022, Congress established a permanent full year continuous coverage requirement for all children under age nineteen in Medicaid and CHIP starting in 2024.[10]

The COVID-19 pandemic also highlighted the critical importance of coverage stability to maintain access to testing and care, bolster health equity, and provide financial stability. In early 2020, Congress reacted by offering enhanced federal funding to states that agreed to maintain continuous eligibility for all beneficiaries during the public health emergency. As eligibility renewals phase in again over 2023, Medicaid protections will help minimize unwarranted loss of coverage for the millions of people that Medicaid has supported. For example, prior to being terminated from any category of coverage, an individual must be screened for all other possible eligibility categories.[11]

Medicaid law prohibits states from adopting arbitrary eligibility limits. States generally may not cap the number of individuals eligible for Medicaid or invent arbitrary eligibility criteria. For example, when Arkansas briefly implemented a work requirement in its Medicaid expansion in 2018—leading to over 18,000 Arkansans losing Medicaid coverage in just a few months—courts found those eligibility requirements illegal. Studies have repeatedly shown that adding such additional conditions of eligibility—from premiums to work requirements to burdensome asset tests or healthy behavior requirements—results in lower Medicaid participation rates and higher levels of churn, often due to poor outreach about the added requirements and the extra red tape to report compliance.[12]

Reducing coverage gaps improves health outcomes. Churning on and off coverage can worsen health outcomes, particularly for people with chronic conditions. A 2022 MACPAC study found that people with diabetes complications, heart failure, asthma, and chronic obstructive pulmonary disease (COPD) who experienced a gap in coverage more than doubled their

emergency department visits and hospitalizations related to these conditions in the month after they reenrolled in Medicaid compared to their baseline rates.[13] Previous research found similar results.[14] More frequent costly emergency events like this may end up costing more than regular chronic care with stable coverage.

How Funding Caps Threaten Medicaid Enrollment and Continuity Protections

Funding caps would likely weaken federal Medicaid enrollment and continuity protections. Funding caps would reduce federal Medicaid funding and shift costs onto states. Faced with less money to provide the same Medicaid coverage, states would likely seek to weaken enrollment requirements in two ways. First, in exchange for accepting less federal money, states will demand that funding cap legislation directly scale back federal standards. Second, once caps are implemented, states will pursue waivers to further reduce these standards. For example, Indiana uses a waiver to ignore Medicaid's requirement to promptly enroll eligible individuals and instead requires them to pay a premium to enroll immediately. This extra waiting period (as long as sixty-five days) represents the kind of policy that would multiply under funding caps. Such provisions dramatically harm individuals with low incomes who may have serious or even urgent care needs.

Funding caps will lead states to manipulate enrollment. Under block grants, states will only receive a preset Medicaid payment, regardless of enrollment changes. Under per capita caps, states get funding on a per-person basis, but because the per-person allocation will likely grow slower than actual costs, states will still face an ever-widening resource gap.[15] Either version of funding caps gives states a strong incentive to create barriers to stifle enrollment. Funding caps would likely spawn more waiting periods, lockouts, enrollment caps, and more complicated application and renewal procedures. States may also seek to avoid enrolling the most costly applicants or to impose added eligibility conditions like work requirements.

Funding caps will lead to more churning and uncompensated care. Medicaid protections for enrollment and continuity of care help people get enrolled quickly and maintain steady coverage. Enrollment barriers like waiting periods disrupt coverage, increase the chance that people will not get needed care or end up with medical debt, and result in the entire health care system losing money on uncompensated care.

ENDNOTES

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015), http://care.diabetesjournals.org/content/38/5/833 (Medicaid coverage improves diabetes screening and treatment initiation); Owen Thompson, *The Long-Term Health Impacts of Medicaid and CHIP*, 51 J. HEALTH ECON. 26 (2017), https://www.sciencedirect.com/science/article/abs/pii/S0167629616305136?via%3Dihub; Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage*, 54 J. HUMAN RES. 785-824 (2019), http://jhr.uwpress.org/content/54/3/785 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage*, 106 AM. J. PUB. HEALTH 1416, 1420 (2016), http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.303155 (Medicaid expansion reduced health care disparities); Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid: Setting the Facts Straight* (March 6, 2019), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/; Hannah Katch, Ctr. on Budget & Pol'y Priorities, *Medicaid Works: Millions Benefit from Medicaid's Effective, Efficient Coverage* (June 2, 2017), https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaids-effective-efficient-coverage.

[2] Hannah Katch et al., Ctr. on Budget & Pol'y Priorities, *Frequently Asked Questions About Medicaid* (Nov. 22, 2019), https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid (Private insurance costs twenty-two percent more than covering the same low-income individual with Medicaid).

[3] CMS, November 2022 Medicaid & CHIP Enrollment Data Highlights (Feb. 28, 2023), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[4] 42 U.S.C. § 1396a(a)(8).

[5] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.

[6] 42 U.S.C. §§ 1396a(e)(5) and (e)(6).

[7] Kaiser Fam. Found., Medicaid Postpartum Coverage Extension Tracker, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[8] 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.

[9] *Id.*

[10] Consolidated Appropriations Act, 2023 § 5112, 42 U.S.C. § 1396a(e), Pub. L. 117-328 (2022); *See also* Edwin Park et al., Georgetown Univ. Health Pol'y Inst. Ctr. for Children & Families, *Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained* (Jan.

5, 2023), https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

[11] 42 C.F.R. § 435.916(f)(1).

[12] Benjamin D. Sommers et al., *New Approaches in Medicaid: Work Requirements, Health Savings Accounts, and Health Care Access*, 37 HEALTH AFF. 1099 (2018), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0331; HHS Asst. Sec. Planning & Eval., *Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence*, (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265161/medicaid-waiver-evidence-review.pdf.

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[15] Edwin Park, Ctr. on Budget & Pol'y Priorities, *Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries* (Feb. 27, 2017), https://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of.