Protect Medicaid Funding Issue #3: Enrollment and Continuity

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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 more than 80 million people who benefit from Medicaid and CHIP.[3]

This fact sheet considers one 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 and enrolls applicants at any time of the year. The time limited "annual enrollment period" used by Medicare and the Marketplace does not exist in Medicaid. 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 treat individuals in emergencies prior to their Medicaid 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] Nearly all states have adopted a longer continuous coverage period of twelve months postpartum. Forty-seven states implemented the twelve month postpartum period with two more states in process.[7]

Babies born to Medicaid beneficiaries are automatically enrolled in Medicaid as of their date of birth, meaning individuals and 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 substantially increase.[9] Also, in December 2022, Congress established a permanent full year continuous coverage requirement for all children under age nineteen in Medicaid and CHIP, which took effect January 1, 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 resumed for the first time in over 3 years in 2023 and 2024, Medicaid protections helped minimize unwarranted coverage loss for millions of people that Medicaid supported. For example, prior to being terminated from any category of coverage, an individual must be screened for all other possible eligibility categories.[11] In April 2024, HHS permanently implemented several continuous coverage protections that were temporarily in effect during the public health emergency and Medicaid unwinding.[12]

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.[13] 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.[14]

Reducing coverage gaps improves health outcomes. Churning on and off coverage can worsen health outcomes, particularly for people with chronic conditions. This churn effect was exacerbated during the Medicaid unwinding because many beneficiaries had their coverage

terminated for procedural or paperwork reasons while remaining eligible for the program. Nationwide, around 70% of all disenrollments were for procedural reasons, and many of those who were disenrolled reenrolled shortly thereafter.[15] For example, in Alabama, about a quarter of enrollees who were discontinued during the unwinding reenrolled within 90 days.[16] Health coverage churns have damaging health consequences; a recent MACPAC study found that people with serious health conditions 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.[17] Previous research found similar results.[18] 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.[19] Also, beneficiaries who miss premium payments are disenrolled from coverage and are punitively disqualified from re-enrolling for 6 months. 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.[20] 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.

[1] Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid* (June 30, 2023), https://www.kff.org/mental-health/issue-brief/10-things-to-know-about-medicaid/. MACPAC, *Access in Brief: Children's Experience in Accessing Medical Care* (Nov. 2021), https://www.macpac.gov/wp-content/uploads/2016/06/Access-in-Brief-Childrens-Experiences-in-Accessing-Medical-Care.pdf.

[2] Heidi Allen et al., *Comparison of Utilization, Costs and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults,* JAMA Netw Open 2021 (Jan. 5, 2021); 4(1):e2032669, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583 (". . .overall health care spending was more than 80% higher among Marketplace-eligible adults than among Medicaid-eligible adults. This difference was no longer significant when claims were adjusted to Medicaid prices, indicating that the cost differences were driven by higher prices for the same services in the Marketplace compared with Medicaid."). *See also* Arkansas Center for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration waiver Interim Report* (Jun. 16, 2016), https://achi.net/wp-content/uploads/2018/10/Arkansas-Health-Care-Independence-Program-Section-1115-Demonstration-Waiver-Interim-Report-June-2016.pdf (noting a 78.3% difference between the commercial and Medicaid per patient per month payments).

[3] CMS, *May 2024 Medicaid & CHIP Enrollment Data Highlights* (Aug. 30, 2024), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/february-2024-medicaid-chip-enrollment-trend-snapshot.pdf.

[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/ (Wisconsin did not extend postpartum coverage to 12 months and instead opted to extend coverage through 90 days postpartum).

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

[9] *See* 42 C.F.R. § 435.117(b).

[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(d).

[12] CMS, *Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*, 89 Fed. Reg. 22780 (Apr. 2, 2024).

[13] *See,* NHeLP, *Appeals Court Rebukes Administration's Attempt to Force Work Requirements, Other Barriers on Medicaid Program, https://healthlaw.org/news/appeals-court-rebukes-administrations-attempt-to-force-work-requirements-other-barriers-on-medicaid-program/;* Court documents in the case, *Gresham v. Becerra,* are available at:

https://healthlaw.org/resource/gresham-v-azar-united-states-district-court-district-of-columbia-and-united-states-court-of-appeals-district-of-columbia/.

[14] 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.

[15] KFF, *Medicaid Enrollment and Unwinding Tracker* (Aug. 23, 2024), https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/#:~:text=The%20net%20changes%20in%20Medicaid,The%20enrollment%20decline%20is%20measured.

[16] Phil Galewitz, KFF Health News, *Halfway Through 'Unwinding,' Medicaid Enrollment Is Down About 10 Million* (Feb. 7, 2024), https://kffhealthnews.org/news/article/medicaid-unwinding-chip-disenrollments-halfway-through-pandemic/.

[17] Medicaid & CHIP Payment & Access Comm'n, *Effects of Churn on Potentially Preventable Hospital Use* (July 2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf.

[18] Ritesh Banerjee et al., *Impact of Discontinuity in Health Insurance on Resource Utilization*, 10 BMC Health Servs. Res. 195. (2010), https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-195.

[19] CMS, *Healthy Indiana Plan Section 1115 Medicaid Demonstration Fact Sheet* (Feb. 1, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/healthy-indiana-plan-2/in-healthy-indiana-plan-support-20-fs.pdf.

[20] 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.