The US uninsurance rate hit an all-time low of 8% this year, continuing the steady decline since the Affordable Care Act (ACA) was passed. The most recent drop was spurred by another 5 states joining the ACA Medicaid expansion (for a total of 38 states plus the District of Columbia), as well as improved subsidies for Health Insurance Marketplace coverage in the American Rescue Plan Act of 2021 (extended through the Inflation Reduction Act of 2022).

But the low rate is mainly due to the Medicaid continuous enrollment provisions of the Families First Coronavirus Response Act (FFCRA) in 2020. Under the FFCRA, states that allowed Medicaid beneficiaries to remain continuously covered until the COVID-19 Public Health Emergency ends received an increase by 6.2 percentage points in their Medicaid match rates. Every state took up that offer, and today, an estimated 18.7 million more people are enrolled in Medicaid than would have been the case without this provision.

Historically, participation in the Medicaid program required stringent and frequent (even monthly) eligibility evaluations, focused especially on increases in income. These frequent evaluations generate what is known as Medicaid churn where people cycle off and on the program due to fluctuating incomes during the year or just administrative errors. The ACA, building on several earlier improvements in child Medicaid eligibility, substantially reduced the extent of Medicaid churn. It simplified eligibility rules and required determinations only annually (continuous eligibility) for some groups unless a beneficiary’s circumstances (income or household size) change.

Since the ACA was passed, the US federal government has been encouraging states to make the annual re-enrollment process as easy as possible, including by prepopulating Medicaid eligibility forms using information from other state sources and by requiring significant outreach to those already enrolled. The FFCRA’s continuous enrollment provision has gone further—beneficiaries retain Medicaid regardless of changes in their circumstances.

When the FFCRA provision ends with the end of the COVID-19 Public Health Emergency, however, beneficiaries will, over a period of months, need to document their continued eligibility for Medicaid or, if they can no longer document eligibility, find an alternative source of coverage. Because of the ACA, almost everyone affected will continue to be eligible either for Medicaid or for alternative coverage—subsidized insurance through the Marketplace plans or coverage through an employer. Research shows that most will either re-enroll in Medicaid or sign up for alternative coverage, but it also shows that many will slip through the remaining cracks in the system. Some will be deterred by the financial obligations associated with alternative plans, whether subsidized premiums for the Marketplace plans or premiums for employer plans. Others, including some who would be eligible for Medicaid if they applied, will be dissuaded by the application processes themselves.

Estimates of how many people will lose coverage and become uninsured are quite uncertain. The number will depend on how well states manage the unwinding of the continuous enrollment requirement and assist people who are still eligible to remain enrolled. Estimates suggest that between 5.3 million and 15 million people will lose Medicaid coverage, including up to 6.8 million who will still be eligible but need to recertify their eligibility. Based on estimates from the Assistant Secretary for Planning and Evaluation’s Office of Health Policy that 4.1 million adults and 1 million children have gained coverage since 2020 (of whom 2 million adults gained Marketplace coverage,
leaving 2.1 million adults and 1 million children who gained coverage through Medicaid), we calculate that in total, up to 3 million people, including about 1 million children, will become uninsured.

Although these FFTRA-related increases in uninsurance will be particularly noticeable because they will happen over a compressed timetable, the underlying phenomenon of coverage churn is an enduring problem. Among low-income households, variations in monthly income are common. Households qualify for Medicaid during some low-income months but work too many hours a few months later to retain eligibility, and then lose hours and become eligible again. Under standard Medicaid rules, these income fluctuations must be accompanied by contemporaneous health insurance transitions, leaving many uninsured for months at a time.

What if FFTRA-like provisions continued and people were allowed to maintain continuous eligibility for Medicaid for a full year regardless of within-year income variations? Some 23 states already do that for children (with Oregon, Washington, and New Mexico extending eligibility even longer) and New York State has done it for all Medicaid populations since 2014 under a Social Security Act §1115 demonstration project.

New York’s experience is telling. Allowing people to remain enrolled in Medicaid increased the share of people with continuous enrollment over 12 months from 53% to 72% and the average months of enrollment increased from 8% to 13%. Most of those who benefited were relatively healthy, so the overall increase in Medicaid spending from the policy was about 2.5% to 3.1%, much of it likely offset by administrative savings for individuals, care providers, and the state.

The insistence by policy makers on classifying everyone into the right insurance slot is intended to keep the public costs of the health care system down, even at the human cost of coverage disruptions because of Medicaid churn. But because Medicaid is the least costly coverage available for low-income adults, churning thwarts that objective. Shifting people into other, costlier programs will raise total health spending and may increase public sector health expenditures as well. That means that providing 12 months of continuous Medicaid coverage to adults once they are deemed eligible could generate substantial gains in coverage stability at an affordable public cost.

The upcoming end of the COVID-19 Public Health Emergency, presumably this winter, will highlight the problem of Medicaid eligibility churning once again. That unexpected attention offers an opportunity for state and federal policy makers to make enduring changes to address this usually invisible challenge.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: None reported.

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