Millions of Americans Are Being Kicked Off Medicaid for No Reason

BY
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Now that Joe Biden and Congress have ended COVID-19 protections, millions of people are being kicked off Medicaid for procedural reasons like failing to respond to mail quickly. Many more are set to lose their health care coverage.

As states have begun clearing out their Medicaid rolls for the first time since the start of the COVID-19 pandemic, nearly three quarters of the Americans who've lost coverage have been terminated not because they're ineligible for the low-income health insurance program, but due to administrative reasons, such as failing to quickly respond to a piece of mail.

In February, President Joe Biden bragged in his State of the Union speech that "more Americans have health insurance now than ever in history." Biden made that comment six weeks after he set the stage to massively increase the United States' uninsured population, when he signed legislation from Congress ending the pandemic-era requirement that states maintain Medicaid beneficiaries' coverage in exchange for extra federal funding.

The measure, passed as part of a year-end spending bill, allowed states to begin mass disenrollments starting in April — a policy decision that is naturally a boon for government contractors that states pay to identify beneficiaries they could potentially remove from the program.

Now that states have resumed annual Medicaid eligibility reviews, an estimated 17 million people, and potentially up to 24 million, could lose Medicaid coverage. According to early data from the Kaiser Family Foundation, more than 1.3 million Americans have already lost coverage, and nearly one million have lost their health insurance for arbitrary reasons, not because they aren't eligible.

The Biden Health and Human Services Department (HHS) estimated last year that roughly 45 percent of people who would lose Medicaid coverage once states could begin disenrollments would have their insurance canceled for procedural reasons despite being eligible for the program. The actual proportion of Americans being terminated for such procedural reasons appears to be far higher — 71 percent — according to the latest Kaiser data.

At a health insurance industry conference last week, one lobbyist admitted that the country is witnessing "distressing levels of administrative procedural disenrollments." A top official from an organization representing state Medicaid directors downplayed those numbers, arguing that it's too soon to jump to any conclusions.

"In terms of the data we're starting to see, I think we need to proceed with caution," Dianne Hasselman, deputy executive director of the National Association of Medicaid Directors, said at a health insurance industry conference last week. "It is very early. We can't make huge assumptions about the data."

"Administrative Churning"

Medicaid, the national health insurance program for low-income Americans, offers better, more comprehensive coverage for patients than most health insurance offerings in the United States, but the program is aggressively means tested with strict income limits.

States are required to perform annual "redeterminations," in which they review Medicaid enrollees' eligibility to make sure they are still earning little enough money to qualify for the program. Enrollees who miss or fail to respond to mail, sometimes within ten days, can quickly lose coverage.

Medicaid redeterminations and disenrollments were paused for three years during the pandemic, after Congress passed COVID relief legislation that required states to provide continuous coverage for Medicaid recipients in exchange for more funding. That change temporarily made Medicaid a much more generous program, one in which adult enrollees grew by 13.5 million beneficiaries, or 39 percent.

Late last year, Congress started phasing out the enhanced Medicaid funding and allowed states to begin the process of removing recipients from their rolls this April. The measure was part of the $1.7 trillion annual government funding bill that Democrats passed in the final days of their legislative trifecta, before they turned over control of the House of Representatives to Republicans.

Medicaid redeterminations often result in states cutting off coverage to adults and children who are still technically eligible for the program. The government calls this "administrative churning."

As HHS explained in a brief last summer, "Administrative churning refers to the loss of Medicaid coverage despite ongoing eligibility, which can occur if enrollees have difficulty navigating the renewal process, states are unable to contact enrollees due to a change of address, or other administrative hurdles."

The agency predicted at the time: "Approximately 9.5 percent of Medicaid enrollees (8.2 million) will leave Medicaid due to loss of eligibility and will need to transition to another source of coverage. Based on historical patterns, 7.9 percent (6.8 million) will lose Medicaid coverage despite still being eligible ('administrative churning'), although HHS is taking steps to reduce this outcome."

Kaiser's Medicaid enrollment tracker, which is based on data from state websites and the federal Centers for Medicare and Medicaid Services (CMS), reports a much higher administrative churn rate: "Overall, 71 percent of disenrollments are due to procedural reasons, among states reporting as of June 20, 2023."

Some of these people may be able to reenroll or qualify for subsidized private insurance plans on the individual market, but those plans generally offer worse coverage and higher costs.

"Most of the people who are losing coverage for procedural reasons are going to be eligible for something else," said Arielle Kane, director of Medicaid initiatives at the consumer advocacy group Families USA:

> Whether they're still eligible for Medicaid, or they're eligible for subsidized coverage on the exchanges, or they now have employer-sponsored coverage, we want them to be either successfully reenrolled or transferred to another source of coverage. And we worry that when they just get procedurally disenrolled, they won't know they don't have coverage until something bad happens.

Kane added that "in an ideal world, the vast majority of these redeterminations would happen in a passive manner — the state would have the data to confirm their income, confirm their eligibility

status, and just re-enroll them without the consumer having to do anything." If that doesn't work, states can "reach out and then the beneficiary could confirm their information and add any details that were missing," she said. "We know this is possible."

Last week, HHS secretary Xavier Becerra wrote to governors urging them to work to limit procedural disenrollments and ensure that cancellations are actually based on eligibility.

"I am deeply concerned with the number of people unnecessarily losing coverage, especially those who appear to have lost coverage for avoidable reasons that state Medicaid offices have the power to prevent or mitigate," wrote Becerra:

> Given the high number of people losing coverage due to administrative processes, I urge you to review your state's currently elected flexibilities and consider going further to take up existing and new policy options that we have offered to protect eligible individuals and families from procedural termination.

Kane noted that under the year-end spending legislation, CMS secretary Chiquita Brooks-LaSure can put a state on a "corrective action plan" if it fails to comply with redetermination reporting requirements, and potentially halt the state's Medicaid disenrollments due to procedural reasons.

"At least publicly, we don't know of any corrective action plans," she said.

A CMS spokesperson said the agency "is deeply concerned with the numbers of eligible individuals losing coverage due to red tape," and added that "CMS will not hesitate to use the compliance authority provided by Congress, including requesting that states pause procedural terminations."

Bad Incentives and Distressing Data

At a conference last week held by the health insurance lobbying group America's Health Insurance Plans, or AHIP, the organization's vice president of Medicaid advocacy, Rhys Jones, noted that Kaiser's Medicaid tracker is showing "distressing levels of administrative procedural disenrollments where people lose coverage for process reasons, not because they actually lost eligibility."

Hasselman, deputy executive director at the National Association of Medicaid Directors, which represents state Medicaid officials, encouraged the audience not to worry about these numbers — yet.

“The thing that is keeping Medicaid directors up at night is the thought that they will remove someone from Medicaid coverage who should not be removed,” she said, before explaining that there “are a lot of different reasons” why someone might not have their coverage renewed — including earlier eligibility reviews by states.

“We can’t just assume that it’s because [beneficiaries] didn’t get a mailing, or they . . . started to go through the application and didn’t complete all the information that was needed to verify eligibility,” Hasselman continued. “I would urge everyone to proceed with caution, and assure you that Medicaid directors and their teams are looking at the data and trying to understand and make sense of it.”

Since the enhanced federal funding for an expanded Medicaid population is winding down, states have a financial interest in quickly trimming their rolls as much as they can — as do the contractors helping states find beneficiaries to terminate.

The country’s largest Medicaid eligibility and enrollment service provider, Maximus, is usually paid by states based on “volume flow and beneficiary interaction.” *Modern Healthcare*, a major health care industry news publication, recently wrote that Maximus has “a financial incentive to find as many people ineligible for Medicaid as possible.”

Maximus regularly sponsors conferences held by the National Association of Medicaid Directors.

Asked by *The Lever* about outside contractors like Maximus having a potential financial incentive to speed up procedural disenrollments, Hasselman said:

> I think that Medicaid directors are very independent in the decisions that they make. They are concerned about Medicaid beneficiaries, first and foremost, making sure that people who are eligible for Medicaid will stay on Medicaid. The last thing that they would do would ever be to be pressured into making a decision by a contractor.

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