AMERICAN EXPERIMENT

What the Medicaid Undercount reveals about the Medicaid 'Unwinding'

Census surveys suggest continuous enrollment policy kept millions unknowingly on Medicaid even after they moved on to other coverage

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Executive Summary

At the beginning of the COVID-19 pandemic, the Families First Coronavirus Response Act increased federal Medicaid funding to states with the condition that states agree to keep people continuously enrolled in Medicaid until the end of the pandemic-related public health emergency. This is referred to as the continuous enrollment condition. As expected, Medicaid enrollment ballooned, which created the need to unwind this enrollment increase at the point when states resumed enforcing Medicaid eligibility requirements. This unwinding process began on April 1, 2023.

Much of the attention around the unwinding involves concerns over whether eligible people were being erroneously disenrolled from Medicaid during the unwinding. The main concern revolves around the high rate of procedural disenrollments due to an enrollee's failure to return a renewal form or other documentation to prove ongoing eligibility. The end of continuous enrollment has also been used to advocate for new continuous enrollment policies.

Surveys of health insurance coverage tend to undercount Medicaid coverage when compared to HHS administrative counts. This is commonly referred to as the "Medicaid undercount." Research shows the Medicaid undercount is mainly due to people misreporting not having Medicaid coverage on surveys. Thus, the Medicaid undercount largely represents people who don't know they have Medicaid coverage. Some people may mistake their Medicaid coverage for private coverage and use the coverage. But some may not know they have Medicaid coverage and never use the coverage.

In the years leading up to the pandemic, the U.S. Census American Community Survey reported a consistent Medicaid undercount rate. Yet, after the continuous enrollment condition started, the Medicaid undercount rate doubled from 2019 to 2021 and jumped again in 2022. Between 2019 and 2022, as the Medicaid undercount increased by 12.7 million, Medicaid enrollment increased by 18.2 million. These numbers reveal that the growth in the Medicaid undercount — largely people who don't know they have Medicaid coverage — represents 70 percent of the growth in total Medicaid enrollment.

Research from the State Health Access Data Assistance Center (SHADAC) studied people who were enrolled in Medicaid in 2020 and then misreported not having Medicaid in 2021 to the Census. They found that nearly 80 percent of this Medicaid undercount group reported having private or Medicare coverage in 2021. Together, this largely explains the high rate of procedural disenrollments. People are predictably ignoring the Medicaid renewals because they have other coverage and likely didn't remember they even had Medicaid. Therefore, the high rate of procedural disenrollments should be no surprise and does not represent a crisis.

The millions more who didn't know they had Medicaid coverage in 2021 and 2022 shines a spotlight on how the continuous enrollment condition failed to target federal funding to the people who needed to continue Medicaid coverage. The failure to effectively target Medicaid funding during the pandemic suggests billions of federal dollars went to pay premiums to private Medicaid managed care organizations (MCOs). As a result, Medicaid MCO profitability soared to a $9.1 billion net underwriting gain in both 2021 and 2022 after averaging around $1.5 billion in the years before the pandemic.

Overall, this experience demonstrates why federal and state lawmakers should not add new continuous enrollment policies to Medicaid. Continuous enrollment aims to reduce churn in and out of Medicaid from people who lose Medicaid only to re-enroll a short time later. Even if new continuous enrollment policies operate under shorter time limits, this approach to avoid churn will fail to target federal and state resources to the people who need help. Any new policy will continue to suffer from the overly simplistic design that largely keeps all people covered regardless of a change in life circumstances.

Introduction

In the first few months of the COVID-19 pandemic, federal lawmakers gave states additional Medicaid funding on the condition they maintained continuous enrollment in Medicaid through the end of the public health emergency. This is referred to as the "continuous enrollment condition." Predictably, Medicaid enrollment ballooned and created the need to, at some point, unwind this enrollment increase when states resumed enforcing Medicaid eligibility requirements. This "unwinding" began April 1, 2023. As of May 10, 2024, nearly 22 million people have been disenrolled from Medicaid health coverage through the "unwinding" process.[1] On net, Medicaid enrollment has fallen by over 13 million after accounting for people who reenrolled or newly enrolled during that time.[2]

Much of the media coverage on this unwinding focuses on concerns over how the process risks disenrolling people who are still eligible for Medicaid. These are legitimate concerns, but there are effective strategies in place to address them. The big story with 22 million being disenrolled should focus on how federal policies likely wasted billions of dollars to keep millions of people enrolled in health coverage they did not need or use. In fact, Census data suggests 12.7 million of the 18.2 million Medicaid enrollees added after the continuous enrollment condition began had no idea they were enrolled in 2022. This represents a complete failure to target Medicaid funding to people who need coverage during the pandemic and shows why the federal government and states should not adopt new continuous enrollment policies for Medicaid.

Medicaid enrollment balloons

Medicaid is a partnership between the federal and state governments that provides health coverage to America's most vulnerable, low-income populations. When the COVID-19 pandemic exploded in early 2020, Congress passed and President Trump signed the Families First Coronavirus Response Act (FFCRA) into law to help ensure that people retained access to health care coverage.[3]

One of FFCRA's major provisions offered to temporarily increase federal funding to state Medicaid programs on the condition that states agreed to keep people continuously enrolled in Medicaid through the end of the public health emergency. From the point the law passed, this continuous enrollment condition meant nearly everyone enrolled and who became enrolled in Medicaid on or after March 18, 2020 stayed enrolled. The only exceptions were for people who asked to be disenrolled or stopped being a state resident.

As expected, Medicaid enrollment ballooned. Enrollment sat at 71.7 million in March 2020 when continuous enrollment became law.[4] By April 2023 when continuous enrollment ended, enrollment reached a record 94.4 million — an increase of 22.7 million enrollees from March 2020.[5]

The great 'unwinding'

From the beginning, it was well understood that this enrollment boom would need to be unwound. States are used to conducting regular Medicaid redeterminations. Before the continuous enrollment condition, federal regulations required states to conduct eligibility renewals once every 12 months for the typical Medicaid enrollee.[6] This process spreads redeterminations throughout the year based on the dates people enroll. The 12-month cadence ensures ineligible people are removed regularly. These aspects minimize the burden of the redetermination process.

The continuous enrollment condition paused these redeterminations, or rather, paused the need to conduct them. This pause meant there would eventually need to be a great "unwinding" of Medicaid enrollments at some point in the future when the continuous enrollment condition ended. At that time, every single Medicaid enrollee would be subject to redetermination. While the redetermination process would be familiar to states, the scale would be unprecedented.

Under FFCRA, the continuous enrollment condition was set to end at the end of the month in which the public health emergency ended. However, Congress passed and President Biden signed the Consolidated Appropriations Act, 2023 which delinked the continuous enrollment condition from the end of the public health emergency and, instead, ended it on March 31, 2023.[7] With that, the great unwinding began on April 1, 2023.

‘Procedural’ disenrollments

Even before the unwinding was underway, the media,[8] liberal advocacy organizations[9] and the Biden administration were flagging concerns over people losing coverage due to procedural reasons. In August 2022, the U.S. Department of Health and Human Services (HHS) published a report on unwinding that projected 6.8 of the 15 million people — 45 percent — would be disenrolled from Medicaid despite being eligible due to “administrative churning.”[10] The report’s reference to administrative churn is what HHS now calls procedural disenrollments.

What exactly is procedural disenrollment? According to recent emergency regulations issued by HHS in December, a procedural disenrollment is a termination of Medicaid eligibility for a reason unrelated to whether an individual meets eligibility requirements, “including for failure to return a renewal form or documentation needed by the State to make a determination of eligibility.”[11] So, this is the process in place to disenroll people when they don’t respond and provide the necessary information to stay enrolled.

... procedural disenrollment is a routine and necessary process for removing ineligible people to ensure that Medicaid funding remains available and targeted for the truly eligible.

Much of the reporting and analysis on procedural disenrollments creates the impression that people subject to them are only losing coverage for process reasons, not because they are ineligible. For instance, Amy Goldstein, reporting on this issue for the *Washington Post*, referred to Medicaid enrollees “jettisoned” due to being “truly ineligible vs. removed for procedural reasons.”[12] Without saying more, this strongly suggests procedural disenrollments are careless process oversights. More recent posts at the Georgetown Center for Children and Families blog also continue to falsely suggest all procedural disenrollments involve kicking eligible people off Medicaid.[13]

Yet, procedural disenrollment is a routine and necessary process for removing ineligible people to ensure that Medicaid funding remains available and targeted for the truly eligible. People who fail to return renewal forms or other necessary documentation may do so because they are no longer eligible. People move, get jobs, get raises, get married, and experience other life events that make them ineligible for Medicaid all the time. Sometimes eligible people are removed, but, in these situations, people can generally reenroll and receive retroactive coverage.[14]

Study finds ‘Medicaid undercount’ doubled in 2021

The continuous enrollment condition kept people enrolled for over three years regardless of whether they experienced any of the life events that made them otherwise ineligible. As enrollment ballooned by nearly 23 million over that time, it should be expected that millions of people who enrolled in Medicaid have since moved on as their life circumstances changed and yet stayed enrolled. Thus, millions of procedural disenrollments due to people moving on in life and ignoring renewals should be expected. That is exactly what U.S. Census Bureau surveys and HHS administrative data show.

Surveys of health insurance coverage tend to undercount Medicaid coverage when compared to HHS administrative counts. This is commonly referred to as the “Medicaid undercount.” Accurate survey estimates are important to assessing the Medicaid program and so this undercount has been widely studied. Several factors can contribute to this undercount, but research shows the main factor involves response errors from survey participants.[15] There are various reasons why a survey respondent might misreport not being covered by Medicaid—a false negative. They may mistake their Medicaid coverage for private coverage, which is more likely when their Medicaid coverage is provided through a private Medicaid managed care organization (MCO).[16] They may mistake their Medicaid coverage for Medicare coverage. They may not know they are enrolled in Medicaid because they enrolled in other coverage and assumed

Medicaid no longer covered them. They may simply not know they are covered and assume they are uninsured. These false-negative reports are also offset by false positives to varying degrees depending on the survey.

The State Health Access Data Assistance Center (SHADAC) at the University of Minnesota regularly conducts research on the Medicaid undercount. In December 2022, SHADAC published the first research analyzing the impact of the continuous enrollment condition on the Medicaid undercount.[17] Their analysis shows the Medicaid undercount consistently ranged from 6.8 to 8.5 percent in the U.S. Census Bureau's American Community Survey (ACS) in the years leading up to the pandemic. However, they find the Medicaid undercount nearly doubled to 15.5 percent in 2021. The authors conclude that this "dramatic increase … related, at least in part, to misreporting resulting from the Medicaid continuous coverage requirement under the COVID-19 PHE."[18]

People who have moved on to other coverage naturally ignored Medicaid renewal letters and were appropriately disenrolled.

People moved on to other coverage and did not know they kept Medicaid

The SHADAC report then investigated why so many people misreported not having Medicaid coverage. Their report benefits from having access to Census data linking survey respondents across multiple years. They studied people who reported Medicaid coverage in 2020 and then reported not having Medicaid coverage in 2021 who were likely still covered by Medicaid due to the continuous enrollment condition. They find that a majority of this Medicaid undercount population reported having private coverage. Specifically, they find "57.2% had some form of private coverage, 42.2% had any employer-sponsored or military coverage, 16.2% had any direct-purchase coverage, 24.5% had any Medicare coverage, and 20.6% were uninsured all of 2021."

In their conclusion, the authors of the SHADAC report note that "[t]hese results seem to indicate that despite having continuous coverage, many enrollees … did not know they were covered and therefore were not able to take advantage of their coverage."[19] This highlights a serious concern for people who mistakenly thought they were uninsured. However, SHADAC acknowledges how a large portion who misreported Medicaid coverage in 2021 "had plausible reasons for doing so," including assuming they lost Medicaid eligibility after moving on to private or Medicare coverage. They further conclude: "Most reported that they had private health insurance in 2021, suggesting a continuation of coverage and benefits."

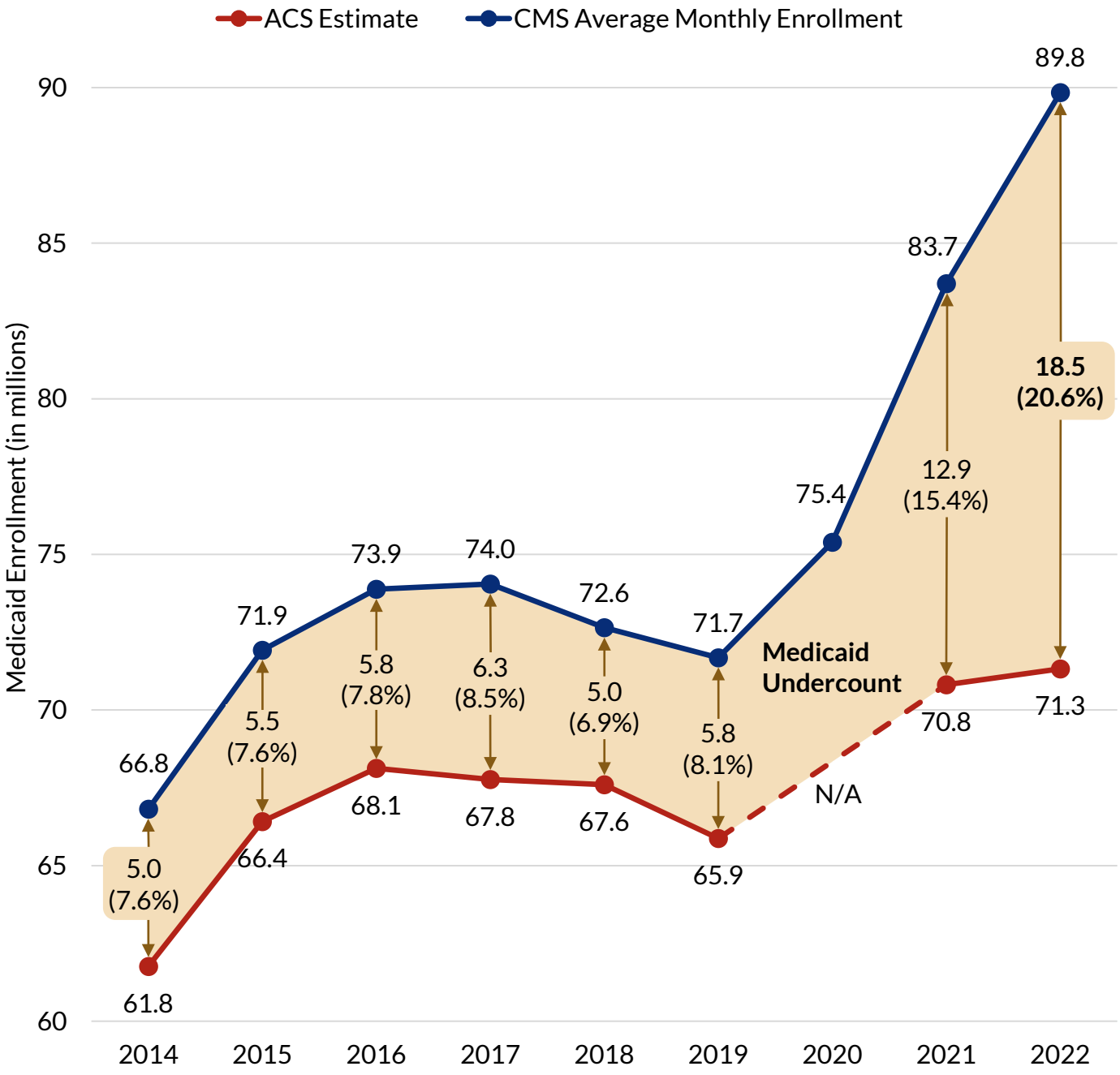
The fact that so many people did not know they were covered by Medicaid and reported having other coverage provides important insights on procedural disenrollments. These findings suggest a large portion of people subject to procedural disenrollments during the unwinding had moved on to other coverage and were no longer eligible for Medicaid. People who have moved on to other coverage naturally ignored Medicaid renewal letters and were appropriately disenrolled.

Increase in Medicaid undercount represents a substantial portion of Medicaid enrollment growth

How many people did the continuous enrollment condition add to the Medicaid undercount? How many people within this undercount misreported Medicaid coverage because they moved on to other coverage? To start understanding these numbers, Figure 1 reports similar data on the ACS Medicaid undercount as a figure from the SHADAC report. In addition, the figure specifically reports the numbers involved and extends the analysis to 2022. This provides a window covering two full years of the continuous enrollment condition.

The Medicaid undercount was consistent from 2014 to 2019 — ranging from 6.9 to 8.5 percent — and then nearly doubled to 15.4 percent in 2021. This closely aligns with SHADAC's findings. Extending the analysis to 2022 shows the extra year of the continuous enrollment condition increased the undercount to 20.6 percent, another substantial jump. The

Figure 1
Medicaid Undercount, CMS Administrative Counts versus ACS Estimates



Sources: Centers for Medicare & Medicaid Services, Monthly Application, Eligibility, and Enrollment Data; and American Experiment analysis of U.S. Census Bureau, American Community Survey using the U.S. Census Microdata Access Tool.
Note: The U.S. Census Bureau did not release its standard 1-year ACS estimates for 2020 due to issues with collecting the data during the COVID-19 pandemic. Therefore, the figure does not report an estimate of the 2020 Medicaid undercount. In addition, there were a small number of months in 2014 and 2015 which were not reported in the CMS enrollment data for Arkansas, Connecticut, Maine, North Dakota, and Vermont. The missing data were imputed from the average of the months reported in the given year.

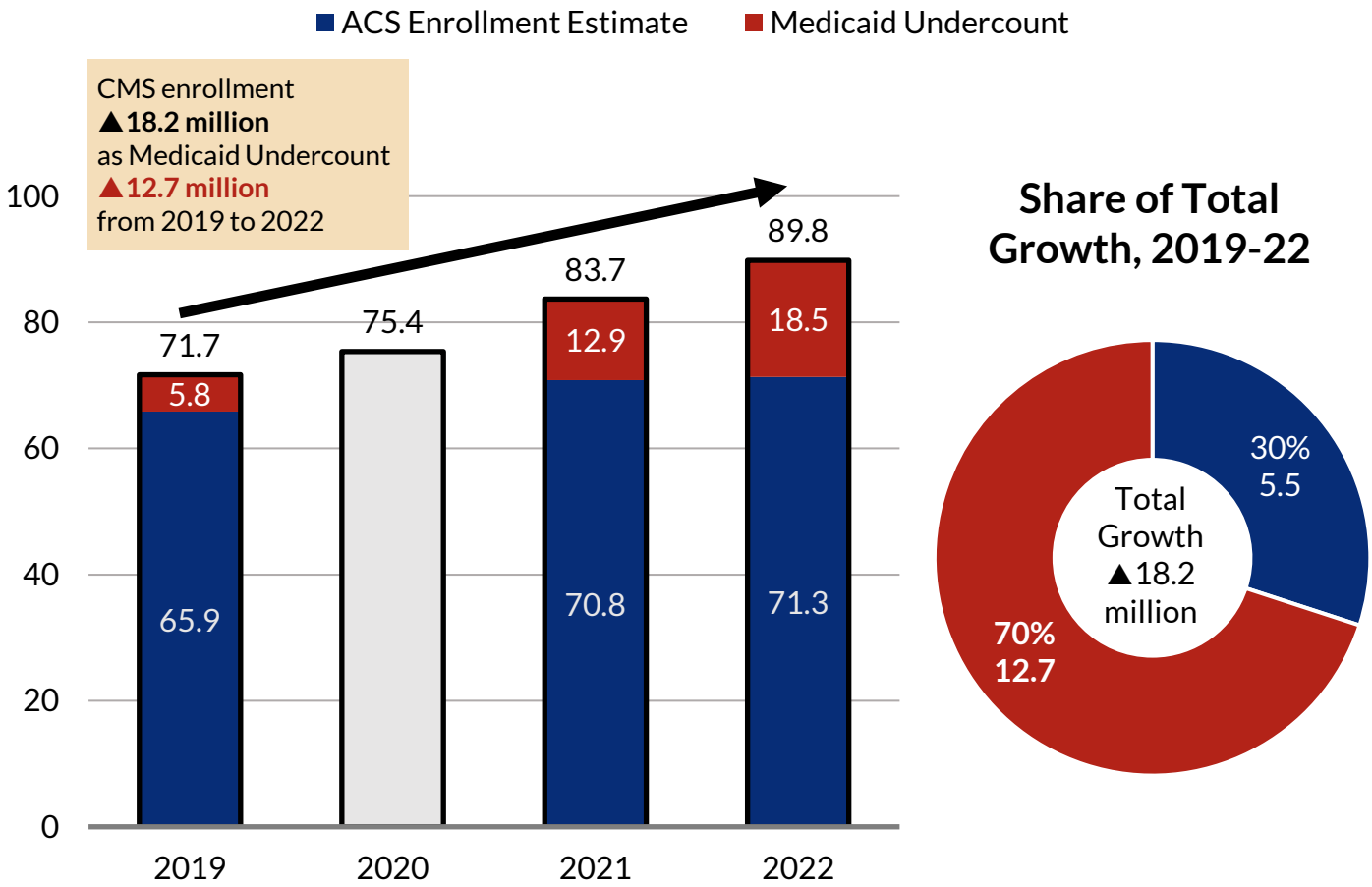
increase in the Medicaid undercount rate translates to some very large numbers. Figure 2 pulls from the data in Figure 1 to compare the growth in the Medicaid undercount to the growth in total Medicaid enrollment from 2019 to 2022. During this time the Medicaid undercount grew from 5.8 million to 18.5 million for a total increase of 12.7 million. At the same time, Medicaid enrollment grew by 18.2 million. This comparison reveals that the growth in the Medicaid undercount — the widening distance between the lines in Figure 1 — makes up 70 percent of the growth in total Medicaid enrollment after the continuous enrollment condition began in 2020.

The increase in the Medicaid undercount reflects the increase in people with Medicaid who moved on to private or Medicare coverage

While various factors may have contributed to the increase in the Medicaid undercount, an increase in people who mistakenly report not being enrolled in Medicaid because they moved on to other private or Medicare coverage likely accounts for most of it. Sampling, imputation, and data processing errors do impact the undercount.[20] But

Figure 2

Medicaid Undercount and ACS Enrollment Estimates as a Share of Total Medicaid Enrollment Growth, 2019 to 2022 (in millions)



Sources: Centers for Medicare & Medicaid Services, Monthly Application, Eligibility, and Enrollment Data; and American Experiment analysis of U.S. Census Bureau, American Community Survey using the U.S. Census Microdata Access Tool.

Note: The U.S. Census Bureau did not release its standard 1-year ACS estimates for 2020 due to issues with collecting the data during the COVID-19 pandemic. Therefore, the figure shows only a gray bar representing the total CMS enrollment count for 2020.

nothing appears to have changed with the survey design and administration after 2019 which would increase the rate of these types of errors.[21] Therefore, if these rates of error remained the same, then an increase in misreporting errors likely accounts for much and possibly all of the change.

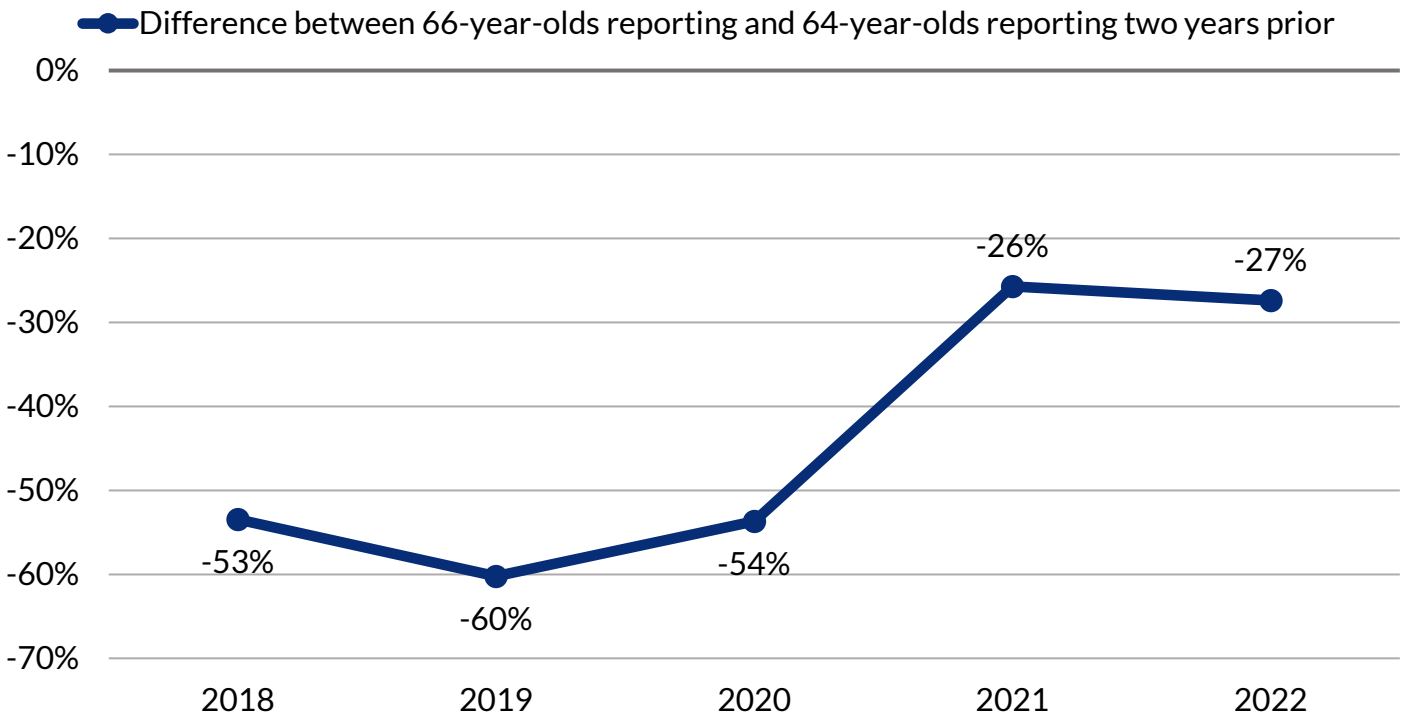
As noted previously, there are several reasons for a false-negative reporting error. A review of these reasons suggests most of the increase in the Medicaid undercount can be linked to people who have moved on to private or Medicare coverage.

- A key reason people might misreport not having Medicaid coverage is because they enrolled in other coverage and assumed Medicaid no longer covered them. Research shows rates of employer coverage declined through the first year of the pandemic — even as employment recovered — while rates of public coverage increased.[22] This research suggests approximately 5 million lost employer coverage in the first 12 weeks of the pandemic. Many millions more also experienced breaks in employer coverage during the continuous enrollment condition period. Those with any break in employer coverage who enrolled in Medicaid and then regained employer coverage likely assumed they lost Medicaid coverage.
- Census data also suggest that many people mistakenly assumed they lost Medicaid coverage when they aged into Medicare. By design, a large portion of people on Medicaid at age 64 shift to Medicare when they turn 65. However, nearly everyone enrolled in Medicaid who turned 65 after January 1, 2020 should still be enrolled in Medicaid during the continuous enrollment condition and so the proportion should stay largely the same on surveys if people are reporting correctly. Yet Figure 3 still shows a substantial drop the proportion of 66-year-olds enrolled in Medicaid during the continuous enrollment condition. Specifically, the figure compares the difference between 66- and 64-year-olds in the same age cohort as they age across survey years — e.g., 64-year-olds in 2020 versus 66-year-olds in 2022. While the drop is lower in 2021 and 2022, it still represents more than a 25 percent decline. As there should be no or only a limited decline under the continuous enrollment condition, this likely reflects the level of Medicaid enrollment misreporting as people age into Medicare.
- It is possible that the continuous enrollment condition increased the error rate from people misreporting Medicaid as private subsidized coverage — a false negative. As discussed in more detail later, most of the Medicaid enrollment increase is from people enrolling in Medicaid MCOs. Thus, the continuous enrollment condition increased the portion of the Medicaid population enrolled in a Medicaid MCO which is easier to mistake for subsidized private coverage. However, the SHADAC analysis shows subsidized private coverage represents only a small portion — 9.2 percent — of the reported coverage among people who report not having Medicaid.
- To the extent there is a higher rate of false-negative reports of subsidized private coverage, it is likely offset, at least partially, by false positives from people who mistake subsidized private coverage for Medicaid. In 2021, there was a substantial increase in enrollment in federally subsidized individual market coverage after federal premium tax subsidies were temporarily expanded. This likely increased false-positive reports. Research shows this overreporting is more common in the ACS versus other surveys.[23]
- It's not clear how the continuous enrollment condition should impact the false negative rate for people misreporting being uninsured. The longer people are continuously enrolled under these unique circumstances may increase the rate of people being disconnected from their coverage due to a move. However, research shows longer Medicaid enrollment reduces the chance of a false-negative survey response.[24]

Overall, the most likely source of the higher rate of misreporting comes from people who forgot they had Medicaid or assumed they were disenrolled after gaining coverage through an employer or Medicare. It's not clear what else would contribute to this dramatically higher rate except for an increase in the portion of Medicaid enrollees covered by a private Medicaid MCO who are more likely to report a false-negative response. Yet this increase is likely offset in part by the higher portion of people with private subsidized coverage who report a false-positive response.

Figure 3

Percent difference between the portion of people who report Medicaid enrollment in the year before (age 64) and the year after (age 66) they become eligible for Medicare



Source: American Experiment analysis of U.S. Census Bureau, Current Population Survey Annual Social and Economic (March) Supplement using the U.S. Census Microdata Access Tool.

Considering the possible increase in false positives, it seems reasonable to assume any departure from the Medicaid undercount trend mostly reflects an increase in people who misreport not having Medicaid due to gaining private or Medicare coverage.

Therefore, the increase in the Medicaid undercount by 12.7 million between 2019 and 2022 largely represents people who stayed enrolled in Medicaid after gaining private or Medicare coverage and were never disenrolled due to the continuous enrollment condition. Again, that represents about 70 percent of the increase in overall Medicaid enrollment from 2019 to 2022. This percentage likely continued to increase until the continuous enrollment condition ended on April 1, 2023.

Impact of paying Medicaid managed care premiums for people who did not know they had coverage

The most recent Medicaid managed care enrollment data shows enrollment in comprehensive Medicaid MCOs accounted for 93 percent of the 9.7 million increase in total enrollment from July 2020 to July 2021.[25] This suggests Medicaid MCOs make up most of the enrollment increase due to the continuous enrollment condition. Thus, it is possible billions of state and federal dollars were spent on paying Medicaid MCO premiums to private companies for people who did not need or use the coverage due to the continuous enrollment condition in place from 2020 to 2023.

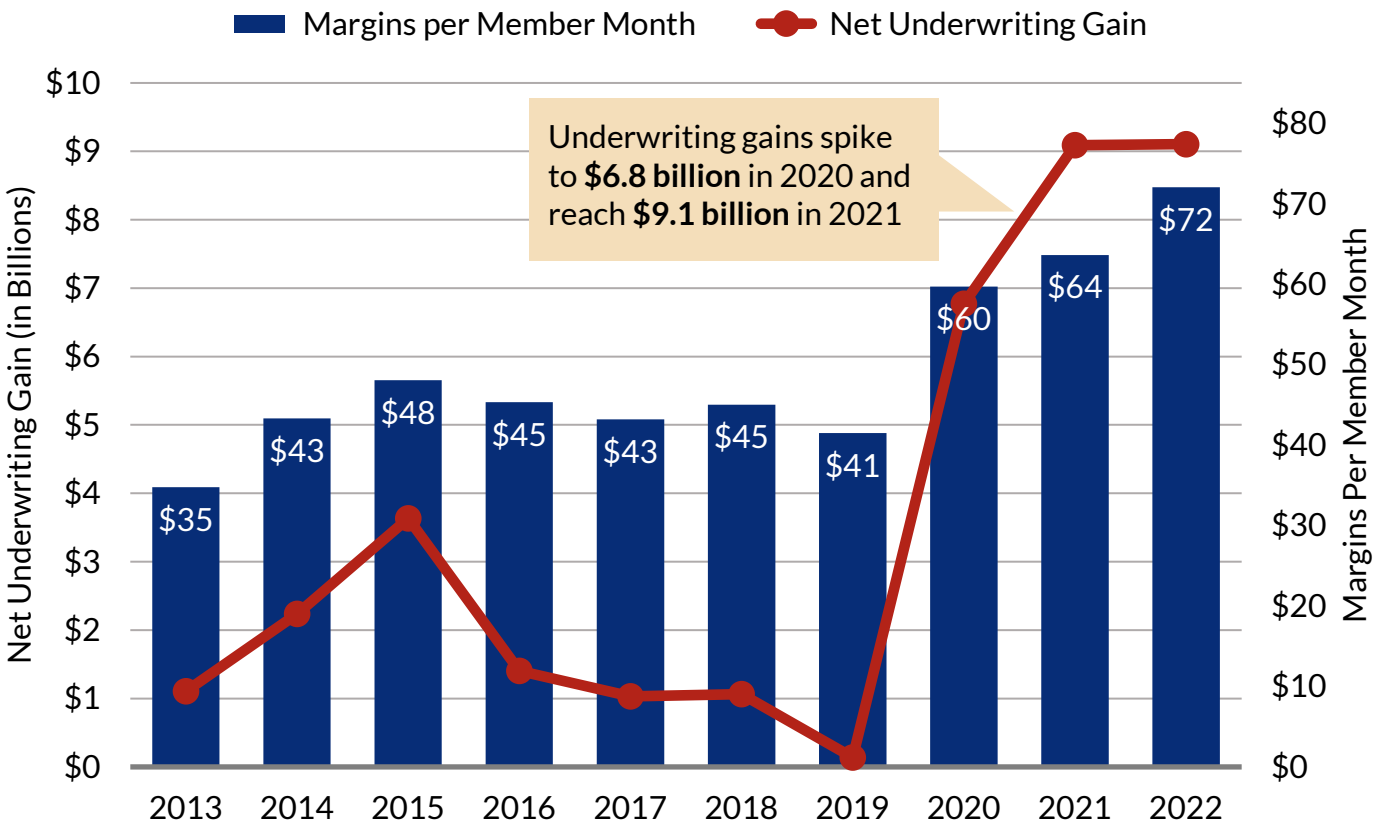
The actual impact on state and federal taxpayers is difficult to measure. The National Association of Insurance Commissioners publishes an annual report with data on the profitability of the U.S. health insurance industry. As shown in Figure 4, this data reveals that margins per member month (premiums minus claims) increased from $41 to $60 when the continuous enrollment condition began in 2020 — a 44 percent jump. The combination of higher margins per member month and higher enrollment contributed to a dramatic spike in net underwriting gains — a measure of profitably based on premiums earned minus claims and administrative costs. After averaging around $1.5 billion from 2013 to 2019, net underwriting gains jumped to $6.8 billion in 2020 and reached 9.1 billion in both 2021 and 2022.

While higher margins and underwriting gains suggest Medicaid MCOs are accruing a windfall from the continuous enrollment condition, there are policies that can modify how much a state pays Medicaid MCOs and how much Medicaid MCOs pay providers. Thus, both the premiums and the claims paid under a Medicaid MCO contract may be adjusted to reduce or eliminate any windfall.

States have two main tools to adjust the payments they make to Medicaid MCOs. First, they can require Medicaid MCOs to pay remittances if they fail to meet minimum medical loss ratio (MLR) standards. The MLR reflects the ratio of premiums collected to medical claims paid. States must set premium rates to "reasonably achieve" an 85 percent MLR. States have the option to set a minimum MLR of at least 85 percent and to require plans to pay a remittance if the minimum is not met.[26] Second, a state may establish risk corridors that allow the state and the Medicaid MCO to share in profits and losses after the coverage year has ended.

Figure 4

Medicaid MCO Underwriting Gains and Margins



Source: National Association of Insurance Commissioners, 2022 U.S. Health Insurance Industry Analysis Report (2023).

On the claims side, states also have the discretion to amend contracts with Medicaid MCOs to adjust how much they pay providers. During the pandemic, the federal government gave states more flexibility in using these tools.[27]

However, each of these tools has limits. Remittance is only triggered if the plan does not achieve a minimum MLR and most plans achieve MLRs well in excess of 85 percent. A federal review of MLRs submitted between 2017 and 2019 shows over 70 percent achieved an MLR exceeding 90 percent.[28] Thus, there is substantial room for Medicaid MCOs to increase profit from a lower MLR without triggering remittance. Similarly, risk corridors are only triggered if profits or losses exceed a certain threshold, which leaves room for Medicaid MCOs to take advantage of the continuous enrollment condition. While increasing provider payment rates may reduce Medicaid MCO profits, it does not protect taxpayers. During the pandemic, these higher provider payments may have helped sustain providers but there were certainly more efficient and transparent ways to deliver this support.

Medicaid undercount increase shows adopting new continuous enrollment policies is an excessively wasteful way to address churning

Some argue the substantial number of procedural disenrollments makes a strong case for adopting new continuous enrollment policies.[29] The Consolidated Appropriations Act, 2023 already required states to provide continuous enrollment for children for one year. States have also used Medicaid waivers to provide continuous enrollment to adults and to extend the continuous enrollment period for children beyond a year.[30] Proponents of continuous enrollment argue it reduces churn that can happen when people lose Medicaid coverage and then re-enroll.

Yet, the Medicaid undercount data adds important context to the unwinding which suggests the disenrollment process is working as it should. The high rate of procedural disenrollments does not make the case for expanding continuous enrollment. Quite the opposite, the high percentage of people who did not know they were covered by Medicaid — as the Medicaid undercount data suggests — shows how expanding continuous enrollment is likely to be an excessively wasteful policy that fails to target people in need.

Maybe the most instructive data comes from 2021 because it reflects what two years of continuous enrollment looks like. By 2021, the Medicaid undercount had increased by 7.1 million over 2019 and total Medicaid enrollment had increased by 12.0 million. This suggests nearly 60 percent of the additional people who stay enrolled in Medicaid under a two-year continuous enrollment policy won't know they are enrolled. States could reduce the number who don't know they have Medicaid through better communication. However, as the SHADAC research shows, most of the people — around 80 percent — who don't know have moved on to other coverage. Keeping these people continuously enrolled in Medicaid is a clear waste of taxpayer dollars.

Moreover, higher spending to keep people continuously enrolled would crowd out spending on other priorities, including health care spending on people who demonstrate a clear benefit from Medicaid coverage. For instance, research shows the Affordable Care Act's expansion of Medicaid to low-income, non-disabled adults is "associated with a shift of Medicaid program financial resources in expansion states away from children and toward other beneficiary groups."[31]

Conclusion

The Medicaid undercount offers important insights into the Medicaid continuous enrollment condition implemented during the pandemic. Comparing the increase in the Medicaid undercount to the increase in actual Medicaid enrollment suggests that people who don't know they have Medicaid coverage account for around 70 percent of the increase in Medicaid enrollment from 2019 to 2022. The SHADAC analysis further suggests that most of this group had gained private or Medicare coverage. Together, this largely explains the high rate of procedural disenrollments. People are predictably ignoring the Medicaid renewals because they have other coverage and didn't remember they had Medicaid. Therefore, the high rate of procedural disenrollments does not represent a crisis of eligible people

being erroneously "jettisoned" from Medicaid. However, it does shine a spotlight on how the continuous enrollment condition failed to target federal funding to the people who needed to continue Medicaid coverage.

The failure to effectively target Medicaid funding during the pandemic suggests billions of federal dollars went to pay premiums to private Medicaid MCOs. As a result, Medicaid MCO profitability soared during the pandemic. Unfortunately, there is no clear accounting for the size of this financial windfall to Medicaid MCOs. That's because every state has its own unique set of policies to adjust premium payments and provider reimbursement rates. Overall, this experience demonstrates why federal and state lawmakers should not add new continuous enrollment policies to Medicaid. Even if new continuous enrollment policies operate under shorter time limits, this approach to avoid churn will fail to target federal resources to the people who need help. Any new policy will continue to suffer from the overly simplistic design that largely keeps people covered regardless of a change in circumstances. ■

Endnotes

1 KFF, "Medicaid Enrollment and Unwinding Tracker," at https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/ (accessed on May 13, 2024).

2 Id.

3 Public Law No. 116-127, Families First Coronavirus Response Act, Sec. 6008, March 18, 2020.

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5 Id.

6 42 CFR § 435.916.

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9 *See e.g.*, Tricia Brooks, "Unwinding Wednesday #26: As the Medicaid Continuous Coverage Protection Ends This Week, It's Important to Understand Procedural Disenrollments and Why They Occur," *Georgetown Center for Children and Families Say Ahhh! blog*, March 29, 2023, at https://ccf.georgetown.edu/2023/03/29/unwinding-wednesday-26-as-the-medicaid-continuous-coverage-protection-ends-this-week-its-important-to-understand-procedural-disenrollments-and-why-they-occur/.

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