Modern Medicaid ALLIANCE

Proposed Medicaid Eligibility Checks Mean More Bureaucracy, Less Coverage

The proposed policies included in the House reconciliation package – *One Big Beautiful Bill Act (H.R. 1)* – will destabilize providers and hospitals serving local communities, burden states and **lead to more than 7.8 million Americans losing their Medicaid coverage and benefits**.[1]

What's In The Bill

The House reconciliation bill will require states to conduct eligibility redeterminations for the Medicaid expansion population every six months, starting October 1, 2027. Currently, states are generally not permitted to redetermine Medicaid eligibility for the expansion population more than once every 12 months.

The bill also shortens Medicaid's retroactive eligibility period from 90 days to just 30, drastically narrowing the window during which patients would be protected from medical bills for care received before they were enrolled, even though they were eligible for Medicaid at the time. This change also increases the risk that providers won't be reimbursed for services delivered during that period.

Case Study: Red Tape Leads To Coverage Loss In Tennessee and Missouri

When Tennessee implemented a more complex and burdensome renewal process in 2016, **more than 148,000 individuals lost Medicaid coverage** – a nearly 10 percent decrease in Medicaid enrollment.[2] Many of these individuals likely lost coverage because they missed their renewal notice, encountered challenges filling out the required forms or their paperwork became stuck in an administrative backlog or lost in the mail.

In Missouri, when a new renewal process was implemented that involved a mailed renewal form, **70,000 Medicaid enrollees lost coverage in one year**.[3]

[1] https://www.cbo.gov/publication/61461
[2] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf
[3] Ibid.

Why This Matters

Increasing the frequency of eligibility checks places a significant burden on individuals to demonstrate their eligibility, which often results in eligible individuals losing coverage. Loss of coverage has been shown to force individuals to delay care, increase utilization of emergency rooms, contribute to worse health outcomes and raise overall health care costs for everyone. This new requirement also increases the administrative burden and costs to states.

Retroactive coverage is a critical safeguard that ensures people who need care before they are able to enroll are not stuck with crushing medical bills. Shortening the retroactive eligibility period means more medical debt for patients and more uncompensated care for hospitals and providers — a threat that's especially serious in emergency situations and for rural providers already operating on thin margins.[4]

Eligible People Lose Coverage

- Over the past several years, states have implemented stricter eligibility policies that resulted in people losing coverage, not because they were found to be ineligible for Medicaid, but because they did not navigate the complicated processes to remain enrolled.
- Rules are already in place to ensure ineligible people have their eligibility assessed between renewals. States are allowed to conduct periodic income data checks to assess whether enrollees have experienced changes that could impact their eligibility without any burden placed on the enrollee. Also, enrollees are required to report changes in their circumstances that may impact their eligibility for Medicaid (e.g., income changes).

Higher Administrative Burden For States

- Having to conduct a full eligibility review every six months, even for a subset of Medicaid enrollees, would increase the administrative burden on states. This will require processing additional paperwork, managing disenrollment and reenrollment cycles and utilizing more staff time and resources.
- Stricter renewal processes, including more frequent eligibility reviews, result in eligible people losing coverage, who then often "churn" back on to coverage a short period of time later.[5] **The estimated administrative cost of churning is between $400 and $600 per person**.[6]

[4] https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/
[5] https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip-abstract/
[6] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

Worse Health Outcomes For Patients

- Disruptions in Medicaid coverage impact an individual's ability to access the care they need. One study showed that people who experienced disruptions in their Medicaid coverage had **increased ER visits and hospitalizations and decreased use of prescription medications and outpatient doctor visits**.[7]
- Disruptions in coverage are even more impactful for those with chronic health conditions. One study found that after experiencing churn, **Medicaid enrollees were more than twice as likely to be hospitalized for COPD, asthma, diabetes complications and heart failure** than before they lost Medicaid coverage.[8]

Higher Costs For Everyone

- Individuals who lose Medicaid coverage and then churn back on to coverage are shown to have **higher monthly health care costs because of their pent-up demand** for services.[9]
- Higher uninsured rates are also associated with higher costs for health care providers and government spending associated with uncompensated care. KFF estimates that federal, state and local **government payments to offset the cost of uncompensated care for the uninsured totaled $33.6 billion in 2017**.[10]
- The Urban Institute estimates that the burden of increases in the cost of uncompensated care would fall on providers, including hospitals, physician practices and prescription drug providers.[11]

Limiting Retroactive Medicaid Coverage Increases Financial Burden On Patients And Providers

- Retroactive periods allow for individuals in nursing homes to have their care paid for by Medicaid while they wait for their application to be processed – which takes an average of 71 days.[12] By reducing the retroactive period, individuals and providers would face the burden of covering the cost of the care received while they navigate a complicated application process.[13]
- Covering the cost of uncompensated care because of shorter retroactive eligibility periods could disproportionately affect providers at trauma centers and rural hospitals.[14]

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[7] https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-195
[8] https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf
[9] https://www.communityplans.net/coverage-you-can-count-on/frequently-asked-questions-churning-and-continuous-eligibility/
[10] https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/
[11] https://www.urban.org/sites/default/files/2025-03/Health-Care-Providers-Would-Experience-Significant-Revenue-Losses-and-Uncompensated-Care-Increases-in%20-the-Face-of-Reduced-Federal-Support-for-Medicaid-Expansion.pdf
[12] https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients
[13] https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/
[14] https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients