Analysis of Montana SB 100 and Policies to Limit Medicaid 12-Month Continuous Eligibility

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Montana is considering changes to weaken the stability of Medicaid coverage, through legislative and administrative action. In the Fiscal Note for SB 100 (amended, dated March 22, 2021),the Department of Public Health and Human Services (DPHHS) indicates that the bill will result in the elimination of 12-month continuous eligibility for adults in Medicaid and for children in CHIP. We have conducted substantial research about continuous eligibility and hope our comments can help explain the potential effects of these policy changes.

Continuous eligibility helps stabilize Medicaid coverage for low-income adults and children. This makes Medicaid more like the health insurance coverage that Americans get through their jobs or through Medicare. Typically, workers with job-based insurance keep it for at least a year at a time, as long as they stay employed. Medicare beneficiaries usually keep their insurance for the rest of their lives after they turn 65 and those who get low-income subsidies for Medicare keep them for a year at a time. In contrast, Medicaid beneficiaries sometimes lose their insurance coverage more frequently (also called "churning") if they encounter paperwork problems or have minor fluctuations in income. Even if they are able to regain their insurance after reapplying, beneficiaries experience harmful gaps in their insurance coverage. Continuous eligibility reduces these paperwork problems by allowing beneficiaries to keep insurance for a year from the time they are determined eligible. This also streamlines paperwork for state agencies, by sharply reducing instances of reapplications when families lose coverage. Most (25 of 35) states that insure children through separate CHIP programs offer 12-month continuous eligibility for children in CHIP. [1]

Ensuring stable Medicaid coverage should not be a partisan issue

In recognition of the need for stable health protection during the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act, in March 2020 with broad bipartisan majorities (363-40 in the House and 90-8 in the Senate, including yea votes from then-Representative Gianforte and Senators Daines and Tester); the legislation was then signed by President Donald Trump. Section 6008 of that bill temporarily increased the federal Medicaid

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matching rate, provided that states maintain continuous eligibility for all current Medicaid beneficiaries until the end of the Public Health Emergency. The U.S. Department of Health and Human Services has informed governors that it expects the Public Health Emergency will be extended at least through December 2021.[2]

Strong bipartisan majorities supported the provision to provide continuous Medicaid coverage for a period that will end up lasting at least 20 months. It is too early to know the total impact of this policy, but most analysts would agree that it helped the United States avoid a disastrous loss of health insurance coverage during the COVID-19 pandemic, ensuring that millions of Americans and hundreds of thousands of Montanans maintained health coverage during a very challenging period, during which tens of millions lost work and faced serious problems meeting basic necessities like food and housing. While COVID-19 vaccines are being rolled out and the recession appears to be easing, the health and economic challenges of COVID-19 are ongoing as the nation struggles to recover.

The new proposals to terminate Medicaid continuous eligibility would reverse the bipartisan progress made in recent years in strengthening health insurance coverage for low-income Montanans, a group that continues to need help due to COVID-19, other widespread health problems like opioid abuse, and the continuing recession.

Estimates of the fiscal impact had flaws

We examined the Fiscal Note for the amended SB 100 (March 22, 2021). The Fiscal Note for SB 100 estimated that the loss of 12 month continuous eligibility for adults would lead to a 1.3% reduction in enrollment, equal to 1,837 person-years or 22,036 person-months. This was based on halving the estimate of 2.6% effect of continuous eligibility from the federal Centers for Medicare and Medicaid Services (CMS).

In fact, this estimate is based on our peer-reviewed research which examined the effects of implementation of continuous eligibility in several states.[3] The study found that continuous eligibility was associated with a 2.2% increase in children's enrollment stability. In discussions with CMS, we agreed that the effect of continuous eligibility would be somewhat higher for adults and the estimate established for adults was 2.6%. DPHHS appears to have cut the 2.6% reduction in half assuming that that a six-month verification has half the effect. This is a misinterpretation of the research; our estimates were based on comparing existing Medicaid enrollment policies prior to continuous eligibility – which typically used blends of six and 12 month certification periods and various verification periods –to a new standard policy of 12-month continuous eligibility. Based on the existing research, we believe the actual loss from SB 100 would be twice as high, or about 2.6%, leading to 3,674 person-years of coverage lost (44,072 person-months).

However, it is important to understand that a person-year is not a person. A "person-year" represents a loss of 12 months of coverage, but this loss could be spread out over many people.

Accordingly, termination of continuous eligibility will lead to gaps in coverage for a far larger number of actual people. A conservative estimate is that six times as many people will be harmed, assuming that the loss of continuous eligibility means that each person affected loses two months of coverage; some would have shorter gaps while others would have longer period. ***Thus, we estimate that about 22,000 Medicaid and CHIP beneficiaries would be harmed by the loss of 12-month continuous eligibility policies each year.*** As detailed below, even relatively short gaps in coverage can cause harm, particularly for those with chronic conditions.

Montana should not expect much savings in SFY 2022

The Fiscal Note for SB 100 indicates savings will occur in State Fiscal Year 2022. In reality, Montana cannot begin to shorten or terminate coverage for Medicaid beneficiaries during the Public Health Emergency and CMS policy guidance about the conclusion of the Public Health Emergency indicates that states should follow a deliberative approach to phasing down the extended coverage, to minimize the number of people who incorrectly lose coverage because of inaccurate or outdated information.[4] The federal rules mean that Montana would not be able to discontinue coverage for any beneficiaries before Dec. 31, 2021 and would need to act gradually over the following several months***. Even if SB 100 is adopted soon, it is unlikely to yield meaningful fiscal savings during State Fiscal Year 2022.*** In fact, as noted in the Fiscal Note, SB 100 would impose additional administrative costs associated with the new automated verification system planned as well as the additional efforts of managing new enrollment operations.

Health benefits of continuous eligibility

Recent research that we have conducted, as well as numerous studies in the past, demonstrates the harm of disrupting Medicaid coverage and the benefits of continuous eligibility. Even brief periods without insurance can disrupt patient-doctor relationships and make it impossible to get medical care or prescription medications during the months without coverage.

In a new study, which we expect will be published in a peer-reviewed journal soon, we examined health outcomes for children living in states with 12-month continuous eligibility policies vs. states without such policies.[5] Continuous eligibility policies are associated with reduced levels of uninsurance, fewer insurance gaps and fewer administrative problems applying for coverage. More important, low-income beneficiaries living in states with continuous eligibility policies were more likely to be in good to excellent health than those in states without these policies. Moreover, children with more serious health care needs (e.g., asthma, etc.) were more likely to have received medical care, preventive health visits or specialist care in states with continuous eligibility.

These findings are consistent with other research showing how churning and disruptions in Medicaid coverage can lead to health problems and how continuous Medicaid coverage can improve cancer care, immunizations, and use of prescription medications and other treatments

for preventable problems like asthma or diabetes, as documented by researchers at Harvard,[6] the University of California[7], University of Minnesota[8] and Stanford.[9]

Continuity of eligibility helps low-income patients get better access to preventive and primary care services that can help prevent serious health problems that may ultimately require emergency medical care or hospitalizations. Our research has also found that as people have stabler enrollment in Medicaid, their monthly health care costs decline.[10]

For example, patients with diabetes may require regular medical care and prescription medications, such as insulin, to keep their blood sugar levels in the desired range and to prevent acute problems such as heart attacks, hypoglycemic or hyperglycemic comas, as well as longer term problems like eye disease or amputations of limbs. Even a short spell without medical care or access to medications can have grave consequences and lead to costly emergency or inpatient hospital care. For children, consistent access to medications for asthma can help avoid emergency department use due to acute asthma attacks. Those who are addicted to opioids can help control their addictions through regular care and use of medications like buprenorphine and even brief loss of coverage can lead to renewed use of opioids and even overdoses. The COVID-19 pandemic has increased stress, anxiety and depression for millions of Americans. Mental health services and use of medications can help reduce mental health problems but disruptions in coverage can harm mental health and even lead to suicidal thoughts or actions. These harmful consequences not only harm health, but they lead to unnecessary and costly medical care in the form of emergency room visits or hospitalizations for conditions that could be prevented with stable medical care.

Policies planned under SB 100 anticipate using automated data checks to monitor income and other aspects of Medicaid beneficiaries' eligibility between annual renewals. But experience has shown that these systems do not necessarily work right and lead many to lose coverage due to red tape. When automated data checks were implemented in Texas' Medicaid program, about 4,000 children lost Medicaid coverage each month. [11] Most children lost coverage not because they were confirmed to be no longer eligible but because of paperwork issues. Over half of children regained coverage in the next year, suggesting that they were actually eligible the whole time; they just lost coverage due to paperwork burdens. Recent testimony about a similar bill in Ohio which explains that the cost of making and implementing automated system changes like these can be extremely expensive and much more than anticipated.[12]

Data from the Montana Medicaid Expansion Dashboard[13] show how Montana's Medicaid expansion has improved access to cancer screening, diabetes care, mental health services and substance use services for tens of thousands of Montanans. HR 676 and SB 100 place those gains at risk.

Changes for SNAP will cause Montana to lose money

We also note that SB 100 would also apply these new verification efforts to SNAP (Supplemental Nutrition Assistance Program, formerly the food stamp program). Since SNAP benefits are 100% federally funded, denying SNAP benefits will not save Montana any money, but will mean that there are higher administrative costs and that less federal funding will come to Montana, reducing revenue that flows to Montana's grocery stores and food producers. This will also be unfortunate given the growth in food insecurity that has afflicted low-income Americans and Montanans in the wake of the COVID pandemic.

Termination of Medicaid continuous eligibility will deepen health disparities

Medicaid serves low-income adults and children, so termination of continuous eligibility creates an inequitable harm on needy residents. But certain Montanans are likely to be more seriously affected because they may encounter more difficulties keeping up with the additional paperwork burdens. For example,

- Native Americans/American Indians often lack internet connections that can enable them to submit eligibility information and tend to live remotely, away from welfare offices they can visit for enrollment.
- Others living in rural and frontier areas will have similar difficulties with communications and logistics associated with more frequent eligibility checks.
- Those with mental health problems or substance use disorders could have more difficulties maneuvering the enrollment systems to retain their coverage.

The COVID pandemic has already created stress, particularly for those with low incomes. This is not the time to impose new barriers that keep needy Montanans from getting health care.

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[1] Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey (see Table 11) http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf

[2] Letter from Acting HHS Secretary Norbert Cochran to All Governors, Jan. 22, 2021.

[3] Ku L, Steinmetz E, Bruen, B. Continuous Eligibility Policies Stabilize Medicaid Coverage for Children and Could Be Extended to Adults with Similar Results, *Health Affairs*, 32(9): 1576-82, Sept. 2013.

[4] Anne Marie Costello of CMS, Letter to State Health Officials, SHO-20-004, Dec. 22, 2020.

[5] Brantley E, Ku L. Continuous Eligibility for Medicaid Is Associated with Improved Health Access, manuscript under review, 2021.

[6] Sommers B, et al. Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many. *Health Affairs*. 10: 1816-24. Oct. 2016.

[7] Bindman A, et al. Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions: *Medical Care*, 2008, *46*(10), 1049–1054.

[8] Blewett L, et al. The Impact of Gaps in Health Insurance Coverage on Immunization Status for Young Children. *Health Services Research*, 2008, *43*(5 Pt 1), 1619–1636.

[9] Dawes A, et al. The Impact of Continuous Medicaid Enrollment on Diagnosis, Treatment, and Survival in Six Surgical Cancers. *Health Services Research*, 2014, *49*(6), 1787–1811

[10] Ku L, Steinmetz E, Bysshe T. Continuity of Medicaid Coverage in an Era of Transition. Association for Community Affiliated Plans. November 2015. http://www.communityplans.net/Portals/0/Policy/Medicaid/GW_ContinuityInAnEraOfTransition_11-01-15.pdf

[11] Byrne E. Red tape removes thousands of Texas children from Medicaid each month, records show. *El Paso Times.* Apr. 22, 2019. https://www.elpasotimes.com/story/news/2019/04/22/medicaid-texas-house-bill-looks-keep-kids-program/3542811002/

[12] See testimony by Joel Potts, Director of the Ohio Jobs and Family Services Director Association, before the Ohio Government and Reform Committee, Feb. 10, 2021. https://www.legislature.ohio.gov/legislation/legislation-committee-documents?id=GA134-SB-17

[13] https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard