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Last 11 States Should Expand Medicaid to Maximize Coverage and Protect Against Funding Drop as Continuous Coverage Ends

By Laura Guerra-Cardus and Gideon Lukens

Beginning April 1 state Medicaid agencies can once again act on eligibility redeterminations, subjecting a record-high number of people to a process that could lead to unprecedented coverage losses and significantly higher uninsured rates if states don't adequately prepare.[1] This "unwinding" from the Medicaid continuous coverage protection — a requirement that states maintain enrollees' coverage while getting a funding boost for doing so — will present challenges for all states, but particularly for the 11 that have so far rejected the Affordable Care Act's (ACA) expansion of Medicaid to adults with low incomes. Leaders in these states should prioritize expanding Medicaid to protect people's coverage, and to take advantage of a well-timed boost in federal incentive funding available to states that newly expand.

Under year-end federal legislation, March 31, 2023, will be the end date for the continuous coverage requirement, a key provision that has kept states from terminating most people's Medicaid coverage since the pandemic began in March 2020. To ease the transition, the legislation also included a year-long phase-down of additional federal Medicaid funding tied to the requirement and provided certain protections for enrollees.

Nevertheless, with one estimate saying 18 million people could lose their coverage during the unwinding, this is arguably the largest coverage event since the ACA's enactment and implementation slashed the nation's uninsured rate. (The 18 million estimate predates the year-end legislation but assumes a similar timeline).[2] That makes it critical for states to do what they can to

[1] For discussion on more general steps states should be taking to ease the transition into eligibility determinations, see Farah Erzouki, "States Must Act to Preserve Medicaid Coverage as End of Continuous Coverage Requirement Nears," CBPP, January 17, 2023, https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverage. Also see Centers for Medicare & Medicaid Services, "Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023," January 5, 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf.

[2] Matthew Buettgens and Andrew Green, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," Urban Institute, December 5, 2022, https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage.

protect coverage levels, which reached record highs in 2021. For all states, that means taking steps such as conducting outreach, improving systems to transition people no longer eligible for Medicaid to alternatives, and reviewing and improving renewal processes so that people who remain eligible for Medicaid do not lose coverage for procedural reasons.

For non-expansion states, this moment brings fresh reasons to expand Medicaid. As Medicaid enrollees undergo redeterminations, the majority of those living in expansion states will have an affordable coverage option available, no matter their new income or circumstances. The 11 holdout states should give their residents that same opportunity. If they don't, hundreds of thousands of people in these states stand to lose their Medicaid coverage, with no other affordable coverage option available to them. States have significant time — up to 12 months — to start renewals for all Medicaid enrollees, meaning that newly expanding states that act quickly will likely be able to enroll expansion-eligible people during the unwinding, if not on its first day.

Expanding Medicaid would be especially important for low-income adults who are in the coverage gap: those whose income is too low to qualify for subsidies in the ACA marketplace but above the extremely low Medicaid thresholds in non-expansion states. People of color make up 60 percent of people in this gap, reflecting systemic racism embedded in the nation's educational, economic, and other systems that has made them disproportionately likely to have lower incomes.[3] Postpartum people with low incomes, parents with low incomes, and young adults turning 19, again many of them people of color, are also especially likely to fall in the coverage gap. Expanding Medicaid would be a crucial source of coverage continuity for these groups now, and an investment in their well-being and that of their children for the future.

Both new and long-time expansion states will have an easier time protecting people's coverage during the unwinding and maintaining low uninsured rates over the long term; expansion states consistently have lower uninsured rates than states haven't expanded. And newly expanding states may actually lower their rate even in the face of broader Medicaid coverage losses nationwide. Take Alabama, which during unwinding faces a projected 16.6 percent rise in the number of non-elderly adults who are uninsured.[4] But expansion would lead to a projected *45 percent drop* in Alabama's uninsured rate.[5]

States that expand will get billions in federal incentive funding for newly expanding states — $14.5 billion over two years across all non-expansion states, according to a CBPP estimate.[6] That does not

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[3] CBPP estimates based on 2021 American Community Survey data.

[4] Buettgens and Green, *op. cit.*

[5] Matthew Buettgens and Urmi Ramchandani, "3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility," Urban Institute, August 3, 2022, https://www.urban.org/research/publication/3-7-million-people-would-gain-health-coverage-2023-if-remaining-12-states-were. Estimates of the impacts of unwinding and of Medicaid expansion are derived from separate Urban Institute reports with different baseline assumptions and are thus not directly comparable. Also, the people who would gain coverage from Medicaid expansion would only partly overlap with the people who would lose coverage during the unwinding. However, it is likely that the total number of people gaining coverage through Medicaid expansion would be far larger than the number of people losing coverage in non-expansion states during the unwinding.

[6] CBPP estimates using 2021 data from the Medicaid Budget Expenditure System, May 2022 Congressional Budget Office baseline projections, and the Medicaid and CHIP Payment and Access Commission's Medicaid and CHIP Data Book.

include the potential to lower uncompensated care costs that non-expansion states now face as a result of allowing more residents to go uninsured, or a variety of other state fiscal savings and revenue increases that result from Medicaid expansion. States should not miss out on these funding opportunities, especially given the pending phase-out of the higher federal Medicaid funding match tied to the continuous coverage requirement.

Extent of Coverage Disruptions Hinges on States' Preparation

To prevent coverage loss and help people stay connected to health insurance during the COVID-19 public health emergency (PHE), federal policymakers included a Medicaid continuous coverage requirement in the Families First Coronavirus Response Act of 2020. The provision prevented states from disenrolling people from Medicaid during the official PHE (a provision that now applies until March 31, 2023), regardless of most changes in people's circumstances. (Ordinarily enrollees are subject to eligibility reviews based on factors such as income.) In exchange, states received a 6.2 percentage point increase in their state's regular Federal Medical Assistance Percentage (FMAP) rate to help cover the cost of increased Medicaid caseloads.

The continuous coverage requirement has been a critical source of support for millions of people during the pandemic and its resulting economic hardships. Preliminary data show nearly 91 million people enrolled in Medicaid or the Children's Health Insurance Program (CHIP) as of September 2022, an increase of 19.8 million people or 27.9 percent since February 2020, right before the pandemic began.[7] The continuous coverage requirement is a major reason that the overall uninsured rate in the U.S. reached a record low in 2021.[8]

The requirement helped eliminate disruptions in coverage due to procedural denials at a time when people and states may have had trouble processing redeterminations. And it reduced people experiencing churn — when they lose Medicaid and then have to re-enroll — which can be harmful even over short periods. Churn happens too often during normal times when people lose coverage due to administrative reasons or have fluctuating incomes, which are common in low-paid work.[9]

The end-of-year omnibus spending bill, the Consolidated Appropriations Act of 2023, sunsets the continuous coverage requirement as of March 31, 2023.[10] When states begin to unwind, they will have one year to begin redetermining eligibility for their entire Medicaid caseload. This will be an

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[7] Center for Medicaid and CHIP Services, U.S. Department of Health and Human Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," January 2023, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

[8] Gideon Lukens, "Census: Uninsured Rate Matches a Record Low in 2021, Driven by Relief Provisions," CBPP, September 15, 2022, https://www.cbpp.org/blog/census-uninsured-rate-matches-a-record-low-in-2021-driven-by-relief-provisions.

[9] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing 'Churn,'" CBPP, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by.

[10] Allison Orris, "Year-End Bill Invests in Kids' Health Coverage, Makes Tradeoffs in Area of Medicaid Continuous Coverage," CBPP, December 21, 2022, https://www.cbpp.org/blog/year-end-bill-invests-in-kids-health-coverage-makes-tradeoffs-in-area-of-medicaid-continuous.

enormous undertaking, with redeterminations ranging from several hundred thousand in states like West Virginia and Montana to 5-10 million in states like Texas, New York, and California.[11]

How well states can minimize coverage losses will depend on how well they have prepared for the unwinding and what actions they take as it gets underway. States can use many tools and strategies to minimize coverage losses for people who will remain eligible for Medicaid and help those who are no longer eligible to transition to other forms of available coverage, such as the ACA's marketplace.[12] States can provide outreach and clear communication with enrollees, strengthen their current renewal process, and ensure adequate staffing to handle the increased volume of work ahead.

Expansion Can Help Stem Rise in Uninsured Rate During the Medicaid Unwinding

Another key factor that will determine how well states can curb a rise in their uninsured rates during and after the continuous coverage unwinding is whether they have expanded — or newly expand — Medicaid to adults up to 138 percent of the poverty line (or $31,781 for a family of three), as provided under the ACA. As expansion states review eligibility for their Medicaid enrollees, no matter the individual's new income or circumstances, most people will have an affordable coverage option available to them.

People who enrolled before and during the pandemic in traditional Medicaid eligibility categories and had a change in circumstances could be eligible for their state's Medicaid expansion program. That includes very low-income parents who typically qualify for traditional Medicaid in all states but had a slight rise in their income during the pandemic, as well as young adults who were enrolled as children and have since aged out of their coverage category. If a person's income has risen above the Medicaid expansion eligibility threshold, they can find low-cost coverage through the ACA marketplaces. And with enhanced premium tax credits available through 2025 under the Inflation Reduction Act, many people on the lower end of the income scale who are most likely to be transitioning from Medicaid have access to zero-dollar premiums.[13]

In contrast, many people in non-expansion states who no longer qualify for traditional Medicaid will fall into the Medicaid coverage gap — they will have no pathway to affordable coverage because they have income above state Medicaid eligibility levels but below the federal poverty line, which is the minimum income needed to qualify for financial assistance in the marketplace. The existence of

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[11] Buettgens and Green, *op. cit.*

[12] Jennifer Wagner and Farah Erzouki, "Time to Get It Right: State Actions Now Can Preserve Medicaid Coverage When Public Health Emergency Ends," CBPP, May 18, 2022, https://www.cbpp.org/research/health/time-to-get-it-right-state-actions-now-can-preserve-medicaid-coverage-when-public; Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, https://aspe.hhs.gov/reports/unwinding-medicaid-continuous-enrollment-provision.

[13] Gideon Lukens, "Health Premiums Will Rise Steeply for Millions if Rescue Plan Tax Credits Expire," CPBB, May 26, 2022, https://www.cbpp.org/research/health/health-premiums-will-rise-steeply-for-millions-if-rescue-plan-tax-credits-expire; Sharon Parrott, "Inflation Reduction Act Takes Important Steps Forward and Should Be Enacted," CBPP, August 5, 2022, https://www.cbpp.org/press/statements/inflation-reduction-act-takes-important-steps-forward-and-should-be-enacted.

the coverage gap is a fundamental injustice in our country and in our health care system, especially when considering the disproportionate impact the gap has on people of color, who make up 60 percent of the more than 2 million people in it.[14] If the unwinding proceeds with no additional states expanding Medicaid, an estimated 383,000 people in those non-expansion states are expected to lose coverage and fall into the Medicaid coverage gap.[15]

Those most likely to fall into the coverage gap during the Medicaid unwinding include:

- **Parents whose income has risen above their state's very low income thresholds.**[16] Most non-expansion states have thresholds at or below 50 percent of the federal poverty level for parents; the lowest thresholds are in Texas and Alabama with 16 and 18 percent, respectively. In Texas, for example, to keep her Medicaid coverage a mother with two children could make no more than $307 a month.
- **Young adults who have turned 19 and thus no longer qualify for Medicaid as children.** Many young adults are in school or work low-paid jobs. While many young people in higher-income families have access to their parent's health plan until age 26 due to the ACA, in non-expansion states young adults in families with low incomes often have uninsured parents and become uninsured themselves when they turn 19.
- **People who received Medicaid during their pregnancy but are past their state's postpartum eligibility coverage period.** It's promising that seven of the 11 non-expansion states adopted 12 months of postpartum coverage (rather than the 60 days required by long-standing law), under a temporary American Rescue Plan provision that took effect on April 1, 2022 and was subsequently made a permanent option by the end-of-year omnibus spending bill.[17] However, many postpartum people with low incomes in non-expansion states will fall into the coverage gap on or before their child's first birthday, depending on the duration of the postpartum coverage period. Research shows a significant negative impact to the health and well-being of children when parents do not have access to health coverage.[18] Research also shows poorer maternal and infant outcomes for postpartum people who experience disruptions in coverage before, after, and in between pregnancies.[19]

For a low-income parent, young adult, or postpartum person to avoid falling into the Medicaid coverage gap and instead qualify for financial assistance in the ACA marketplace, their income would need to increase, often significantly, because marketplace subsidies are not available to people

[14] CBPP analysis based on 2021 American Community Survey data.

[15] ASPE, *op cit.* Estimate includes South Dakota, which plans to implement expansion in July 2023.

[16] Kaiser Family Foundation, "Medicaid Income Eligibility Limits for Parents, 2002-2022," https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[17] Kaiser Family Foundation, "Medicaid Postpartum Coverage Extension Tracker," January 20, 2023, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/; Orris, *op. cit.*

[18] Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children," CBPP, updated June 14, 2021, https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and.

[19] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," CBPP, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

with income below the federal poverty line. For example, the Texas mom described above would need to see her income rise sixfold, from about $3,700 per year to over $23,000, to have an affordable coverage option in the marketplace.

To limit coverage loss and potentially even improve their uninsured rate during the unwinding, non-expansion states should expand Medicaid. While a state may not be ready to enroll individuals in the Medicaid expansion group early in the unwinding — depending on how long it takes for a state to implement Medicaid expansion — states and their residents would still benefit. States have up to 12 months to start renewals for all enrollees, meaning that the unwinding can take place over a significant period of time and can be staged to minimize disruptions in coverage for the newly eligible group.

If a state moves ahead with Medicaid expansion early in 2023, expansion coverage could be made available at some point during the unwinding period. States that expand soon can adopt policies to allow enrollees to transition into the new expansion group without a gap in coverage. For example, states could schedule renewals to redetermine people most likely to move into Medicaid expansion in the later part of the unwinding process, when the Medicaid expansion coverage option would be up and running. When the state has implemented expansion, it could utilize streamlined processes such as *ex parte* renewals — the process of using available data to renew coverage — to transition people into the newly expanded coverage, reducing the workload for people and state agencies.

The financial incentive for states to quickly implement expansion is strong. The sooner states transition eligible populations into Medicaid expansion, the sooner they would receive the higher federal match rate of 90 percent available to all expansion states, plus a two-year, 5 percentage point increase in their regular FMAP rate, which is available to newly expanding states under the Rescue Plan.

Non-Expansion States Could Lower Their Uninsured Rate Below Current Levels if They Expand Medicaid

While recent Census numbers show historic lows in the number of uninsured people, the data also show stark and persistent differences between expansion and non-expansion states.[20] In 2021 their respective uninsured rates were 6.6 percent and 12.7 percent.[21] The five states with the highest uninsured rates in the country are non-expansion states. Non-expansion states also continue to have higher rates of uninsured children and of women of reproductive age than expansion states.[22] This

[20] Douglas Conway and Breauna Branch, "Health Insurance Coverage Status and Type by Geography: 2019 and 2021," American Community Survey Briefs, September 2022, https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr-013.pdf.

[21] 2021 American Community Survey.

[22] Adam Searing, Alexandra Corcoran, and Joan Alker, "Children Are Left Behind When States Fail to Expand Medicaid," Georgetown University Center for Children and Families, February 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/02/Kids-and-Medicaid-expansion_2-19.pdf; Maggie Clark, Ema Bargeron, and Alexandra Corcoran, "Medicaid Expansion Narrows Maternal Health Coverage Gaps, But Racial Disparities Persist (Online Chartbook)," Georgetown University Center for Children and Families, September 13, 2021, https://ccf.georgetown.edu/2021/09/13/medicaid-expansion-narrows-maternal-health-coverage-gaps-but-racial-disparities-persist-online-chartbook/#heading-3.

means that even through the pandemic, millions of people in non-expansion states went without access to health care coverage.

By expanding Medicaid, non-expansion states would not only help prevent coverage loss for low-income parents, young adults, and postpartum people during the unwinding, they could also increase overall access to health coverage, potentially lower their uninsured rate below current levels, and catch up to the far lower uninsured rates in the rest of the country. For example, new estimates from the Urban Institute project that if Alabama does not expand Medicaid before or during the unwinding, some 61,000 more non-elderly Alabamans will be uninsured, causing the state's uninsured rate to rise 16.6 percent.[23] (See Table 1.) However, if Alabama were to expand Medicaid, 217,000 fewer people would be uninsured, leading to a 45 percent drop in the state's uninsured rate, a separate Urban Institute study found.[24] While these unwinding and expansion projections use different baselines and are therefore not directly comparable, the magnitudes of the projected impacts illustrate that expansion would go a long way toward reducing the state's uninsured rate, even in the face of broader Medicaid coverage losses nationwide. (See Table 2.) Expanding Medicaid would move Alabama's projected uninsured rate from the highest quartile to the lowest quartile among all states.

If all non-expansion states were to expand Medicaid, the Urban Institute estimates that 3.7 million uninsured people would gain coverage.[25] Groups with the largest coverage gains would include non-Hispanic Black people, young adults, and women, particularly women of reproductive age.

TABLE 1

Estimated Increases in People Uninsured Among Non-Expansion States During Unwinding

	Increase in Uninsured	
	Number of People	Percent Change
Alabama	61,000	16.6%
Florida	342,000	19.8%
Georgia	167,000	17.1%
Kansas	16,000	5.5%
Mississippi	43,000	16.5%
North Carolina	155,000	19.4%
South Carolina	72,000	19.3%
Tennessee	90,000	16.5%
Texas	514,000	14.4%
Wisconsin	49,000	19.9%
Wyoming	7,000	10.3%
Total	**1,516,000**	**16.5%**

Note: Estimates for non-elderly people rounded to the nearest thousand. Estimates represent the increase in the number of uninsured people from April 2023, when Urban Institute assumed the Public Health Emergency and the continuous coverage requirement would end, to June 2024, when the unwinding is assumed to be complete.

Source: Urban Institute, December 2022. Totals calculated by CBPP using Urban Institute state estimates.

[23] Buettgens and Green, *op. cit.*

[24] Buettgens and Ramchandani, *op. cit.*

[25] *Ibid.* This estimate is the net reduction in the number of people who are uninsured and includes enrollment changes in Medicaid and other forms of health insurance.

TABLE 2

Reduction in People Uninsured and Increase in Federal Funding in States, if Non-Expansion States Expand Medicaid, 2023

	Reduction in Uninsured		Increase in Federal Funding	
	Number Of People	Percent Change	Millions	Percent Change
Alabama	-217,000	-45.0%	$1,972	32.0%
Florida	-799,000	-30.9%	$5,047	18.6%
Georgia*	-448,000	-32.1%	$3,631	29.5%
Kansas	-101,000	-31.6%	$791	33.9%
Mississippi	-147,000	-42.0%	$1,518	29.0%
North Carolina	-346,000	-30.5%	$5,069	29.5%
South Carolina	-200,000	-36.6%	$1,944	31.3%
Tennessee	-220,000	-31.0%	$1,838	19.5%
Texas	-1,158,000	-24.0%	$11,913	32.5%
Wisconsin**	-54,000	-16.5%	$479	8.4%
Wyoming	-20,000	-24.8%	$66	10.2%
Total	**-3,710,000**	**-29.1%**	**$34,268**	**26.6%**

* Estimates do not include the Section 1115 waiver that Georgia is set to implement beginning July 1, 2023. This waiver is projected to cover only a small subset of adults in the coverage gap — those under 100 percent of the federal poverty level (FPL) who meet a work-reporting requirement of 80 hours a month from a list of qualifying activities. People who do not report these hours each month would lose coverage under the waiver. Georgia's waiver application estimates roughly 25,000 people would enroll in the first year, rising to about 53,000 people in year 5. In contrast, the Urban Institute estimates that full Medicaid expansion in Georgia would reduce uninsurance by 448,000 people in 2023.

** Wisconsin's Medicaid program covers people up to 100% of the FPL through its BadgerCare Section 1115 demonstration. While affordability issues persist, because people under 100% of the FPL are covered by Medicaid and individuals over 100% of the FPL are eligible for subsidized marketplace coverage, Wisconsin is the only non-expansion state without a Medicaid coverage gap.

Note: Estimates for people aged 0-64. Federal funding includes net federal spending on Medicaid, CHIP, and ACA marketplace premium tax credits. Estimates do not include the Rescue Plan federal match rate incentive. Estimates assume the Rescue Plan's premium tax credits enhancements, recently extended in the Inflation Reduction Act through 2025, had expired. Estimates also assume that the Medicaid continuous coverage provision has expired and that eligibility determinations have returned to historical norms.

Source: Urban Institute, July 2022. Estimates rounded to nearest thousand. Totals calculated by CBPP using Urban Institute state estimates. Georgia Section 1115 Demonstration Waiver Application submitted to the U.S. Department of Health and Human Services on December 23, 2019.

Non-Expansion States Should Also Adopt 12 Months of Medicaid Postpartum Coverage

In addition to Medicaid expansion, non-expansion states should adopt 12 months of postpartum coverage to help protect postpartum people from disruptions in care during the unwinding process.[a] Long-standing Medicaid law requires only 60 days of postpartum coverage; the American Rescue Plan gave states the option to provide 12 months of coverage and the recently enacted end-of-year omnibus spending bill established such coverage as a permanent state option.[b] To date, seven of the 11 non-expansion states have enacted 12-month postpartum coverage.[c] (See Table 3.) Taking advantage of this option could help protect postpartum people from disruptions in coverage within the critical postpartum period during the unwinding process. It would also help improve child and maternal health outcomes in non-expansion states long term, especially for Black people, whose subjection to systemic inequities in the nation's health, economic, and other systems makes them likelier to be harmed in the maternal health crisis.

The omnibus bill also took an important step forward in protecting children's health coverage by making 12 months of continuous eligibility for kids mandatory in Medicaid and CHIP, starting in January 2024. This will help children in families with the lowest incomes stay connected to health care coverage by reducing gaps in coverage. Coverage gaps disproportionately impact kids in low- and moderate-income families and children of color, and lead to harmful delays in care and poorer outcomes.

[a] Laura Guerra-Cardus and Laura Harker, "Congress Needs to Act Now to Reduce Coverage Losses When Public Health Emergency Ends," CBPP, April 26, 2022, https://www.cbpp.org/blog/congress-needs-to-act-now-to-reduce-coverage-losses-when-public-health-emergency-ends.

[b] Allison Orris, "Year-End Bill Invests in Kids' Health Coverage, Makes Tradeoffs in Area of Medicaid Continuous Coverage," CBPP, December 21, 2022, https://www.cbpp.org/blog/year-end-bill-invests-in-kids-health-coverage-makes-tradeoffs-in-area-of-medicaid-continuous.

[c] Tricia Brooks et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey," Kaiser Family Foundation, March 16, 2022, https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey-report.

TABLE 3

Postpartum Coverage in Non-Expansion States

	12 Months Postpartum Coverage (Planned or Implemented)
Alabama	Yes
Florida	Yes
Georgia	Yes
Kansas	Yes
Mississippi	No
North Carolina	Yes
South Carolina	Yes
Tennessee	Yes
Texas	No (proposed waiver to cover 6 months postpartum only after delivery or experiencing an involuntary miscarriage)
Wisconsin	No (proposed waiver to cover 3 months postpartum)
Wyoming	No

Source: Georgetown University Health Policy Institute Center for Children and Families, "Medicaid and CHIP Continuous Coverage for Children," October 7, 2022; Kaiser Family Foundation, "Medicaid Postpartum Coverage Extension Tracker," December 8, 2022.

Medicaid Expansion Would Reduce Funding Drop as Federal Funding Tied to Continuous Coverage Ends

The end of the continuous coverage requirement will not only impact health coverage but will also have fiscal impacts for states. Under Families First, states have received a 6.2 percentage point increase in their FMAP beginning in the first quarter of 2020, a temporary boost that was tied to the continuous coverage requirement.[26] Under the recently enacted end-of-year omnibus spending bill, this temporary boost will phase out from April 1, 2023 through the end of the calendar year, after which states will revert to their regular FMAP rates.[27]

The Kaiser Family Foundation estimated that the 11 remaining non-expansion states gained over $26 billion from fiscal years 2020 through 2022 as a result of the FMAP increase, well over double the roughly $11 billion additional state cost for enrollment associated with the continuous coverage requirement.[28]

[26] The enhanced federal matching funds apply to most Medicaid spending, but do not apply to spending that is already subject to an increased match or to other smaller categories of expenditures. Families First authorized states to receive the enhanced match funds beginning in March 2020 for expenses incurred as early as January 2020.

[27] The phase-down will occur as follows: down to 5 percentage points, from April 1 through June 30; to 2.5 percentage points from July 1 through September 30; and to 1.5 percentage points from October 1 through December 31. Without the 6.2 percentage point FMAP increase, in fiscal year 2023 these rates would range from 50 to 78 percent, depending on the state. Federal Register, November 26, 2021 (Vol. 86, No. 225), pp. 67479-6748, https://www.govinfo.gov/content/pkg/FR-2021-11-26/pdf/2021-25798.pdf.

[28] Elizabeth Williams, Robin Rudowitz, and Bradley Corallo, "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends," May 10, 2022, https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/.

While all states will need to adjust to the expiring boost in the federal match, states that have not expanded Medicaid have a unique opportunity to offset much of the loss for an additional two years through a separate FMAP incentive. In addition to the 90 percent matching rate for the expansion population that all expansion states now receive, the Rescue Plan provides a two-year, 5 percentage point increase in the regular FMAP for non-expansion states if they expand Medicaid.[29] If all non-expansion states were to expand Medicaid, this FMAP increase would give them some $14.5 billion combined in federal funding over two years, according to the latest CBPP estimates. (See Table 4.)

These additional federal funds from the Rescue Plan's FMAP incentive would offset much of the loss from the expiration of Families First's enhanced federal funding. And while states cover 10 percent of expansion costs (the federal government covers the other 90 percent), studies consistently demonstrate that expansion generates state fiscal savings and revenue increases that nearly or fully offset the state share, as discussed below.

TABLE 4

Additional FMAP Funding Under Rescue Plan Incentive for States That Expand Medicaid

	Additional Federal Funding From Two-Year Rescue Plan Fiscal Incentive (in Millions of Dollars)
Alabama	634
Florida	2,834
Georgia*	1,205
Kansas	408
Mississippi	563
North Carolina	1,667
South Carolina	665
Tennessee	1,128
Texas	4,449
Wisconsin**	844
Wyoming	60

* Estimates do not include the Section 1115 waiver that Georgia is set to implement beginning July 1, 2023. This waiver is projected to cover only a small subset of adults in the coverage gap — those under 100 percent of the federal poverty level who meet a work-reporting requirement of 80 hours a month from a list of qualifying activities. People who do not report these hours each month would lose coverage under the waiver. Georgia's waiver application estimates roughly 25,000 people would enroll in the first year, rising to about 53,000 people in year 5. In contrast, the Urban Institute estimates that full Medicaid expansion in Georgia would reduce uninsurance by 448,000 people in 2023.
** The Wisconsin estimates assume that childless adults currently enrolled in BadgerCare are shifted to the Medicaid expansion group, allowing Wisconsin to access the higher expansion population FMAP. This shift reduces our estimate of the Rescue Plan's FMAP increase. The impacts of moving BadgerCare enrollees from the current FMAP to the expansion population FMAP are not estimated.
Note: FMAP = federal medical assistance percentage. We assume expansion occurs on September 1, 2023. Estimates include the two-year federal fiscal incentive only, not other costs and savings associated with Medicaid expansion.
Source: CBPP estimates using 2021 data from the Medicaid Budget Expenditure System, May 2022 Congressional Budget Office baseline projections, and the Medicaid and CHIP Payment and Access Commission's Medicaid and CHIP Data Book

[29] Like the FMAP increase in Families First, the Rescue Plan's enhanced federal matching incentive applies to most Medicaid spending but not to groups that are already subject to an increased match or to other smaller categories of expenditures.

If all non-expansion states were to expand Medicaid, federal funding for non-expansion states would increase by $34.3 billion in 2023, Urban estimates.[30] (See Table 2.) States would face an additional cost of $2.7 billion, but even this modest amount would be mostly offset by a decrease of $1.7 billion in state and local government uncompensated care costs — the cost of care that goes unpaid by insurers or patients.[31]

The Urban Institute's estimates about Medicaid expansion don't include the $14.5 billion in additional federal funding due to the Rescue Plan's FMAP increase, nor do they include a variety of other state fiscal savings and revenue increases that result from Medicaid expansion. When including state cost offsets and revenue gains, along with the high federal match rate (90 percent) for Medicaid expansion enrollees, studies of over a dozen states have consistently demonstrated substantial fiscal savings when states expand Medicaid. Most states with comprehensive analyses found that expansion would lead to net fiscal gains at the state level, even prior to the Rescue Plan's FMAP incentive.[32]

One reason for these savings is that, when states expand, a substantial number of Medicaid enrollees who would be covered under the regular federal match rate are instead covered under the much higher 90 percent federal match for the expansion group.[33] Another reason is that Medicaid expansion leads to offsetting savings from state-funded programs that serve uninsured populations who under expansion receive increased support through Medicaid.[34] These include programs that treat mental health conditions and substance use disorders, health care for people who are incarcerated and require inpatient care outside of prison or jail, and other programs for populations in vulnerable circumstances. Moreover, when states expand Medicaid, health care utilization increases among people newly insured, generating higher revenues from state taxes on health care providers.[35] Health care provider taxes are already in place in all non-expansion states, so state

[30] This estimate includes the net impact on federal spending on Medicaid, CHIP, and ACA marketplace premium tax credits. Buettgens and Ramchandani, *op. cit.* CBPP calculated the $34.3 billion total based on Urban Institute state estimates in order to exclude South Dakota, which plans to implement Medicaid expansion in July 2023.

[31] Uncompensated care estimates from Urban Institute were reported only as national totals and include South Dakota, which plans to implement Medicaid expansion in July 2023, as a non-expansion state.

[32] Bryce Ward, "The Impact of Medicaid Expansion on States' Budgets," Commonwealth Fund, May 5, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets; Buettgens and Ramchandani, *op. cit.* For a cross-state comparison, see Benjamin Sommers and Jonathan Gruber, "Federal Funding Insulated State Budgets from Increased Spending Related to Medicaid Expansion," *Health Affairs*, Vol. 36, No. 5, May 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1666.

[33] Examples include some enrollees who obtain coverage through pregnancy, disability, breast and cervical cancer treatment, family planning, and limited coverage programs for low-income adults under waivers.

[34] Gideon Lukens, "Montana's Fiscal Gains From Medicaid Expansion Are a Model for Wyoming," CBPP, September 15, 2022, https://www.cbpp.org/research/health/montanas-fiscal-gains-from-medicaid-expansion-are-a-model-for-wyoming.

[35] Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020," Kaiser Family Foundation, March 17, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/.

revenues would grow as utilization increases, even without any policy changes to increase those tax rates.[36]

Medicaid Expansion Would Reduce Uncompensated Care and Improve Hospital Finances

Uncompensated care costs are tied closely to states' insured rates, which is not surprising because hospitals' uncompensated care costs are mostly composed of charity care and debt expenses for people who are uninsured.[37] Uncompensated care is a particularly pressing issue for non-expansion states: according to the most recent data (from 2019, pre-pandemic), uncompensated care costs for non-expansion states were more than twice as large as those in expansion states as a share of hospital operating expenses.[38]

As the continuous coverage requirement ends, increases in uninsured rates could increase states' uncompensated care costs. For example, in non-expansion states, the 383,000 people who are projected to lose Medicaid coverage and be in the coverage gap may face a higher likelihood of having unpaid medical bills given their lack of coverage and low incomes.[39]

Increases in uncompensated care would create additional pressure on health care providers such as hospitals and community health centers. But if non-expansion states were to expand Medicaid, health care providers would save an estimated $2.3 billion in uncompensated care costs, not including state and federal government savings.[40] That represents a 24 percent decrease in uncompensated care costs borne by health care providers.

In addition to reducing uncompensated care costs, studies have shown that Medicaid expansion improves providers' financial performance and reduces the risk of hospital closures, especially in rural areas.[41] Rural hospital closures have been a particularly acute problem in non-expansion states. A recent report from the American Hospital Association found that 74 percent of rural hospital

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[36] Kathleen Gifford *et al.*, "State Medicaid Programs Respond to Meet COVID-19 Challenges: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2020 and 2021," Kaiser Family Foundation, October 2020, https://www.kff.org/medicaid/report/state-medicaid-programs-respond-to-meet-covid-19-challenges/

[37] Gideon Lukens, "Medicaid Expansion Cuts Hospitals' Uncompensated Care Costs," CBPP, April 20, 2021, https://www.cbpp.org/blog/medicaid-expansion-cuts-hospitals-uncompensated-care-costs.

[38] Medicaid and CHIP Payment and Access Commission, March 2022 Report to Congress on Medicaid and CHIP, "Chapter 3: Annual Analysis of Disproportionate Share Hospital Allotments to States," https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-3-Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf.

[39] ASPE, *op. cit.*; Sara R. Collins, Lauren A. Haynes, and Relebohile Masitha, "The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey," Commonwealth Fund, September 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey. People who have low incomes and lack health coverage are more likely to face unpaid medical bills and hold medical debt.

[40] Buettgens and Ramchandani, *op. cit.* Uncompensated care estimates from Urban Institute were reported only as national totals and include South Dakota, which plans to implement Medicaid expansion in July 2023, as a non-expansion state.

[41] Guth, Garfield, and Rudowitz, *op. cit.*

closures between 2010 and 2021 were in states where Medicaid expansion was not in place or had been in place for less than a year.[42]

Support From State Leaders Is Needed to Increase Federal Funding and Prevent Coverage Loss

When continuous coverage unwinding begins, people will lose access to their doctors and medications. Children will lose access to treatments and therapies they need to grow and keep learning in school. New mothers will lose access to mental health services and medications they need to stay healthy and care for their newborns. Young adults will lose access to preventive and reproductive services. This loss of coverage will take an enormous toll on the lives of millions of people as they lose the financial security, protection against medical debt and catastrophic medical costs, and access to life-saving treatment that Medicaid provides.[43]

Now is the time for state policymakers to ensure their states use every means available to avoid massive coverage losses when the continuous coverage requirement ends. This includes providing support to state agencies so that they can use the many tools made available to them by the federal government to streamline enrollment and maximize efficiencies during the redetermination process.[44] It also means taking action — and taking advantage of significant federal funding — to ensure the people of their state can access health care coverage, no matter their income, by expanding Medicaid.

[42] American Hospital Association, "Rural Hospital Closures Threaten Access," September 2022, https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.

[43] Guth, Garfield, and Rudowitz, *op. cit.*; Inna Rubin, Jesse Cross-Call, and Gideon Lukens, "Medicaid Expansion: Frequently Asked Questions," CBPP, June 16, 2021, https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions.

[44] Wagner and Erzouki, *op. cit.*