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PRINCETON UNIVERSITY

COVID-19

Tracking Medicaid Enrollment Growth During COVID-19 Databook Overview

Manatt Health
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Summary of Analysis

As much of the nation's economic activity ground to a halt at the beginning of the COVID-19 pandemic, millions of people lost jobs and many also lost their job-based health care coverage.[1] Based on the experience in other economic downturns, the COVID-19-driven downturn triggered expectations that states would see substantial increases in Medicaid enrollment as individuals losing income and access to employer-sponsored health insurance coverage enrolled in Medicaid.[2,3] At the same time, states began to brace for significant fiscal pressures driven by declining tax revenues and potential increases in spending on safety net programs like Medicaid.

To address these pressures and protect coverage during the public health crisis, Congress passed legislation – the Families First Coronavirus Relief Act (FFCRA) – temporarily increasing the federal share of Medicaid funding (see here for a previous analysis from SHVS and Manatt Health of the sufficiency of the increased federal match rate under FFCRA).[4] The increase in the Federal Medical Assistance Percentage (FMAP) under FFCRA was tied to requirements that states not reduce Medicaid coverage through programmatic changes (known as the "maintenance of effort" requirement) and not disenroll people from the program (known as the "continuous coverage" requirement) for the duration of the U.S. Department of Health and Human Services (HHS) public health emergency (PHE).[5] Since a portion of Medicaid enrollees typically "churn" off of the program each month due to changes in circumstance, paperwork requirements related to renewals, or other reasons, the continuous coverage requirement effectively eliminated churn, resulting in immediate changes in enrollment relative to pre-COVID-19 state projections.[6,7]

The pace and duration of new enrollment growth, however, has been harder to predict. While the downturn has been severe, it has also been concentrated by industry, and Medicaid expansion has meant that many low-wage working adults in many states were already covered by Medicaid before the pandemic. Given state budget

[1] https://files.epi.org/pdf/206003.pdf
[2] https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf
[3] https://www.healthmanagement.com/blog/hma-updates-forecast-of-covid-19-impact-on-medicaid-marketplace-uninsured/
[4] FFCRA § 6008(a).
[5] The maintenance of effort requirement extends from January 1, 2020 through the end of the quarter in which the PHE ends. *Id.* § 6008(b)(1), (2). The continuous coverage requirement extends from March 18, 2020 through the end of the month in which the PHE ends. *Id.* § 6008(b)(3).
[6] https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by#:~:text=The%20continuous%20coverage%20provision%20does,experience%20fluctuations%20in%20their%20earnings.
[7] https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

constraints and the current stalemate in Congress with respect to the provision of additional FMAP relief,[8] understanding the trajectory of Medicaid enrollment growth has gained critical importance for state Medicaid agencies and budget officials as they seek to plan for an uncertain future and the likelihood of increasingly scarce public resources.

About the Databook

The Tracking Medicaid Enrollment Growth During COVID-19 Databook, which includes Medicaid enrollment data from over 40 states, provides a comprehensive, detailed look at 2020 Medicaid enrollment trends to-date, with certain limitations.[9] The databook provides enrollment detail by state across four eligibility categories: expansion adults, children (including those enrolled in CHIP), non-expansion adults, and aged, blind, and disabled individuals. It also compares enrollment trends across expansion and non-expansion states. The analysis is limited by the fact that it relies on state-reported data that are made public at varying frequencies and levels of detail; additionally, states often rely on different reporting methodologies. While these variations mean that the enrollment numbers in this report are not necessarily comparable across states (and should not be summed across states), the data reported do allow states and others to track enrollment trends.

The databook includes a total of eight tables, organized as follows:

- **Table 1 – 3:** Summary Trends of Medicaid and CHIP Enrollment Growth Rates
- **Table 4:** Total Medicaid and CHIP Enrollment by State
- **Table 5:** Medicaid Enrollment by State – Expansion Adult Eligibility Group
- **Table 6:** Enrollment by State – Non-Disabled Children Enrolled in Medicaid or CHIP
- **Table 7:** Medicaid Enrollment by State – Non-Expansion, Non-Aged, Non-Disabled Adult Eligibility Groups
- **Table 8:** Medicaid Enrollment by State – Aged, Blind, and Disabled Eligibility Groups

For a detailed description of the methodology, please refer to the appendix (below).

Key Findings

Our analysis finds that in recent months, Medicaid enrollment growth has substantially outpaced recent, pre-COVID-19 rates of growth in the program, particularly amongst non-elderly, non-disabled adults.

- From February through August 2020, the median state among the 24 states with available data for that period saw total enrollment growth of 8.3 percent, with the average state seeing monthly growth well above previous levels.
    - From February to March, enrollment growth was essentially flat in most states; however, growth began to spike in April, with the median state seeing a one-month growth rate of 2.1 percent from March. Month-to-month enrollment growth slowed somewhat in subsequent months, but has

[8] In H.R. 8406, the updated Heroes Act, the House proposes to increase the FMAP by a total of 14 percentage points starting October 1, 2020 through September 30, 2021; thereafter, a 6.2 percentage point increase in the FMAP would remain in effect for any calendar quarter during which the COVID-19 PHE period continues. As of this date, the Senate has not offered a proposal to extend or modify the FFCRA FMAP provision.

[9] The Centers for Medicare and Medicaid Services (CMS) provides enrollment data on a monthly basis; however, these data are typically lagged by approximately three to four months and do not provide detail on enrollment growth by eligibility category. Other organizations have used state data to provide useful insights into enrollment growth, but critical gaps in the data remain (see here, here, and here for recent examples).

remained significantly elevated in most states; from May through August, the median monthly enrollment growth rate across states was 1.4 percent.
    - These monthly enrollment growth rates are substantially faster than what many states had been experiencing prior to the pandemic; over the past several years, many states have seen flat or even negative month-to-month changes in enrollment (the median monthly enrollment growth rate in 2019 was -0.07 percent).[10,11]
    - Taken together, total enrollment growth from February through August in the median state was 8.3 percent; growth was substantially faster some states, including Kentucky (17.2 percent) and Oklahoma (13.7 percent).
- Enrollment growth has been the fastest amongst non-elderly, non-disabled adults in most states.
    - Through August 2020, the median expansion state saw growth in the Affordable Care Act (ACA) adult expansion group of 15.6 percent; this rate was substantially higher in some states, including in Maine (39.2 percent from February through September) and Minnesota (24.2 percent from February through September).
    - Across all states with reported data, enrollment of non-expansion adults (i.e., parents and pregnant women eligible through pathways other than the ACA expansion) grew at a median rate of 18.7 percent from February through August. As of the most recent month of reported data, at least eleven states – including Kansas, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, Oklahoma, Texas, Utah, and Wisconsin – had seen growth of over 20 percent.
    - Since expansion states tend to enroll a larger share of non-elderly, non-disabled adults in Medicaid, these states have seen slightly faster overall enrollment growth compared to non-expansion states; through August 2020, the median expansion state saw total enrollment grow by 8.5 percent, compared to 6.9 percent in the median non-expansion state.
- Enrollment growth has been substantially slower, though is still rising, amongst child and aged, blind, and disabled eligibility categories.
    - Between February and August 2020, child enrollment[12] in the median state grew by 5.2 percent.
    - For aged, blind, and disabled groups, enrollment grew by only 1.9 percent in the median state over this time period.

Conclusion

The pandemic has led to historic levels of job losses, and the number individuals entering the unemployment ranks for the first time remains stubbornly high.[13] While the economy appears to be recovering some jobs lost during the initial outbreak of the pandemic, our analysis indicates that states are still seeing robust growth in Medicaid enrollment relative to normal times.[14] This is likely being driven both by the extraordinary level of job losses (and associated losses of job-based health insurance) and the continuous coverage provision in the FFCRA, which requires states to keep Medicaid coverage intact for the duration of the PHE.[15] Given continuing job losses, States are likely to see enrollment continue to rise for the foreseeable future. As states grapple with significant reductions in tax revenue due to the pandemic, the implications of continued Medicaid enrollment

[10] https://www.macpac.gov/wp-content/uploads/2019/11/Changes-in-Medicaid-and-CHIP-Enrollment.pdf
[11] https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme/data
[12] Including children enrolled in Medicaid and CHIP.
[13] https://www.dol.gov/ui/data.pdf
[14] https://www.bls.gov/news.release/empsit.nr0.htm
[15] https://www.dol.gov/ui/data.pdf

growth on state budgets and on access to coverage for millions of people will continue to be front and center issues for policymakers.

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ABOUT MANATT HEALTH

This document was prepared by Cindy Mann and Adam Striar. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit https://www.manatt.com/Health.

Appendix – Methodology

Manatt Health developed this databook through a comprehensive review of state websites and enrollment databases.[16] Through this review, we were able to locate 2020 enrollment data for over 40 states. Where possible, in addition to total enrollment by state, we also collected data by Medicaid eligibility category.

Constructing Eligibility Categories

For the eligibility category analysis, Manatt analyzed available state data and categorized state-specific eligibility categories into the following four groups: expansion adults, children, non-expansion adults, and aged, blind, and disabled individuals. In general, we followed the following principles when assigning eligibility categories:

- "Expansion Adults" includes adults enrolled in the ACA new adult group (i.e., the "VIII Group").
- "Children" includes Medicaid-financed children, CHIP-financed children enrolled in Medicaid, and children enrolled in CHIP. Disabled children are included in the "Aged, Blind, and Disabled" category.
- "Non-expansion Adults" includes all non-expansion, non-aged, non-disabled adults. In general, this includes parents and caretaker relatives, pregnant women, and certain other categories.
- "Aged, Blind, and Disabled" includes individuals eligible for Medicaid on the basis of being blind or disabled, individuals receiving supplemental security income (SSI), those receiving long-term care services, individuals enrolled in home and community-based (HCBS) programs, and certain others.

Since states construct eligibility categories differently and supply data with differing levels of detail, we were not always able to classify eligibility categories into one of these four categories. Individuals in eligibility categories that could not be classified are counted in total enrollment, but do not appear in the eligibility category-specific tables.

Limitations

This analysis is limited by the variable availability, robustness, and specifications of state data. While we were able to locate 2020 enrollment data for over 40 states, only 25 had reported monthly data from February through August and only eight had reported data through September. States also supply varying levels of detail and use different enrollment counting methods, preventing us from being able to calculate overall growth rates by summing enrollment totals across states (we instead compare individual state growth rates across states). Not all states provide eligibility category detail (or provide data on only some eligibility categories), while other states report data for managed care populations but not their fee-for-service programs. States also use varying methods of counting enrollment (or do not specify how they are counting). For example, some states use "point-in-time" methods, where monthly enrollment is counted as of a specific date. Others use "ever-enrolled" methods, where all individuals enrolled at any point in time during the month are counted in the total. For these reasons, enrollment number totals in this databook are not necessarily comparable and should not be summed across states.

[16] Sources and state-specific data notes can be found in the "References" tab of the databook.