Why ‘kicking 15 million people off Medicaid’ is a good thing

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After three years, states are once again verifying Medicaid eligibility for their citizens. Although some media reports are framing this as a disaster for beneficiaries, it is an opportunity to help rein in chronic federal deficits and bolster state finances as revenues begin to flag.

The Medicaid and Children’s Health Insurance Program (CHIP) grew from 71 million beneficiaries before the pandemic to over 92 million in December 2022, the most recent month for which data is available. And, according to estimates from the Kaiser Family Foundation, the rolls may have peaked at 95 million last month.

The Department of Health and Human Services expects that redeterminations will result in the combined Medicaid and CHIP rolls declining by 15 million, still leaving these programs larger than they were pre-pandemic despite the fact that unemployment has retuned to early 2020 levels.

Redeterminations, if done properly, do not remove anyone who is eligible for Medicaid or CHIP from the rolls based on their income or other special needs. Beneficiaries are just being asked to confirm their eligibility with their state of residence.

Meanwhile, because Medicaid redeterminations were suspended back in March 2020, the rolls are filled with ineligible individuals. Some have died, others have relocated to other states, and still others lost their jobs at the beginning of the pandemic and then obtained new employment as the economy recovered. Some of those regaining employment have high incomes and are eligible to participate in their new employer’s health plan.

Why should we worry about those who are deceased, who have relocated, or who now have access to private insurance, since these individuals would not be expected to seek covered medical services anyway?

There are two reasons. First, unscrupulous providers can use identifying information from inactive Medicaid beneficiaries to make false claims.

Second, it is necessary to consider the impact on managed Medicaid programs. When Medicaid started in the 1960s, it was a purely fee-for-service system. Eligible patients would get care from a doctor or hospital, and that provider would then file a claim with the state Medicaid program.

But, to control costs, most states have included managed care options in their Medicaid programs. Today, more than 70 percent of Medicaid enrollees are in a managed care plan. Under Medicaid managed care, the state typically pays a for-profit or not-for-profit system a fixed rate per enrollee.

So, if an ineligible beneficiary is on Medicaid managed care, the state is paying his or her Medicaid provider a monthly fee to provide no care. Since many of these providers are for-profit companies, progressives who might normally oppose redeterminations should instead welcome them, because they reduce the amount of money hitting corporate bottom lines.

Just how much unearned revenue corporate Medicaid managed care organizations have received during the pandemic is difficult to assess because their detailed financial records are private. But there is one large publicly owned Medicaid managed care organization in California that did respond to a public records act request on this matter. LA Care, which provides Medicaid services in Los Angeles County, told me that 327,000, or 29 percent, of its enrollees did not receive any health services during the year ended June 30, 2022.

Both before and during the pandemic, Medicaid cost growth routinely outstripped the rate of inflation by a large margin, and, by FY2021, total spending of Medicaid and CHIP reached $773 billion. Containing the growth of these programs is important for both federal and state fiscal policy.

At the federal level, deficits are expected to remain above $1 trillion annually and adjustments to other large-ticket items including Social Security, Medicaid, and Defense appear to be off-limits from a political standpoint.

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Meanwhile, states will once again shoulder their full share of Medicaid costs as pandemic-era federal support phases out. At the same time, states dependent on income tax revenues from high earners are experiencing revenue pressure as weakness in the technology sector and on Wall Street reduces these taxpayers' incomes. Clearing the Medicaid rolls of ineligible beneficiaries is a step these states can take to balance their budgets without cutting other programs.

So far from being a plague, Medicaid redetermination should be seen as a welcome relief at the state and federal levels. And it is a step that does not remove anyone from the rolls that can demonstrate his or her continued eligibility.

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