



**Medicaid Retroactive Coverage:
What's at Stake for Older
Adults When States Eliminate
this Protection?**

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

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A visit to the emergency room or a hospital stay can leave families with limited or even moderate income facing unaffordable bills. Long-term nursing facility care or personal care services at home can be out of reach for older adults and their families because neither commercial insurance nor Medicare provide coverage. Many people in these situations turn to Medicaid when they face significant or unexpected health care costs.

Medicaid provides health insurance coverage for low-income and high-needs populations and is designed to meet the needs of this population. One particularly important element of this tailored design is to provide coverage for health care a person received prior to applying for or being enrolled in Medicaid. This policy, known as retroactive coverage, is a key financial protection for low-income, uninsured, and underinsured older adults, especially those who experience a health emergency, need long-term services and supports following an illness, or have other unexpected high-cost health care needs. It exists because Congress recognized that people cannot always apply for Medicaid as soon as they become eligible and often do not even know they might be eligible. Medicaid retroactive coverage saves many from devastating medical debt and opens the door to accessing necessary care. It also helps lessen the uncompensated care burden on providers, particularly nursing facilities and hospitals that serve a large percentage of low-income patients, making it possible for them to stay open and continue to serve the Medicaid population.

This issue brief examines how the Medicaid retroactive coverage policy protects older adults and their families and how some states are eliminating this protection through waivers of federal Medicaid law. These waivers threaten low- and moderate-income families' financial well-being, jeopardize providers' financial stability, and put people at risk of not receiving the care and services they need.

WHAT IS MEDICAID RETROACTIVE COVERAGE AND WHO DOES IT PROTECT?

Under federal Medicaid law, states are required to provide coverage for care and services received up to three months prior to the date an individual applied for Medicaid.¹ For example, if an individual submitted an application for Medicaid on July 20, 2019,² Medicaid could pay retroactively for Medicaid covered services the individual received on or after April 1, 2019 if the state determined they were eligible.³ There are two important limitations on this coverage: (1) the individual must have been eligible for Medicaid at the time care and services were provided; (2) the care and services must be covered under the state's Medicaid plan. In other words, Medicaid will not cover costs for an individual who was not eligible for Medicaid at the time they received the care or services, nor will Medicaid pay for care or services that the state's plan does not cover. In order to receive retroactive Medicaid coverage, an individual must show they met the state's financial and other requirements in each month. While the maximum retroactive eligibility is three months prior to the month of application, an individual may only be eligible for one or two of those months. Once determined retroactively eligible, Medicaid will pay the provider for unpaid bills. Many state Medicaid programs will also directly reimburse an individual who has already paid bills for covered services.

When Congress created the retroactive coverage guarantee in 1972, the Senate Finance Committee noted that the provision would “protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying.”⁴ This statement makes clear that Congress understood that Medicaid is not like commercial insurance and that the people Medicaid covers do not always know that they are eligible or what documentation they need to apply.⁵ The three-month retroactivity window is a rational and effective response to all these concerns. It protects people from financial ruin, and helps ensure prompt access to care when individuals experience an emergency or sudden illness, need long-term services and supports in a nursing facility or at home, or when a family is facing mounting routine medical bills including Medicare costs.

“The three-month retroactivity window protects people who experience sudden illness or mounting bills from financial ruin, while ensuring prompt access to care and long-term services and supports.”

Emergency or Sudden Illness

In many instances, a person who needs health care cannot be expected to apply for Medicaid coverage at the exact moment they become eligible. They may be hospitalized after an accident or unforeseen medical emergency and lack the capacity to apply. Providers cannot always immediately identify trauma patients. And even someone who has a family member who can apply for them may not be able to do so immediately. Without retroactive coverage, a person could fall or have a heart attack on July 31st and be liable for thousands of dollars in hospital expenses if they “fail” to file a Medicaid application within 24 hours, when July becomes August.

Long-Term Services and Supports

The retroactive coverage protection exists because instantaneous Medicaid applications are unrealistic; in the case of people needing long-term services and supports (LTSS), it is impossible. The need for these services may arise unexpectedly and when the person needing care and their family are already experiencing the stress of dealing with either a sudden or a prolonged illness. In some instances, families provide the bulk of needed services at home up until family caregivers are physically, emotionally, and financially exhausted. Alternatively, persons may be discharged directly to a nursing facility from a hospital after an emergency, such as a stroke or fall. In either situation, the transition to a nursing facility can be a confusing, overwhelming process for both the nursing facility resident and their family.

In addition, many older adults and their families assume nursing facility care will be covered by Medicare.⁶ They do not realize that Medicare coverage of skilled nursing facilities is restricted to follow-up from inpatient hospital stays⁷ and is limited to a maximum of 100 days, though often cut off much sooner.⁸ In other words, Medicare will not pay for nursing facility care for a beneficiary who is admitted from their home or other non-hospital setting.

Furthermore, many people are not familiar with Medicaid, nor do they know whether they meet eligibility requirements. Even if an individual or their family clearly understands they need to apply for Medicaid coverage, submitting an application is not a simple process. Medicaid eligibility rules are complex, and require financial

documentation and medical assessments, in the case of LTSS, that commercial insurance does not. Putting a Medicaid application together can take a significant amount of time, especially if the individual's finances are not well organized. Applications for LTSS may require gathering five years of bank records and information about other assets. For example, in Iowa, the average nursing facility application takes 71 days to assemble, file, and be approved.⁹ This is not an easy task for anyone but is particularly difficult for a nursing facility resident who likely does not have that information with them and who does not have a spouse, family member, or friend living nearby who is able to assist. This process can be further complicated if the applicant has Alzheimer's disease or another dementia.

“Medicaid eligibility rules are **complex**, and applications require **financial documentation and medical assessments**, in the case of LTSS, that commercial insurance does not.

Medicare Costs & Routine Medical Bills

Medicaid serves an important role in supporting low-income Medicare beneficiaries through the Medicare Savings Programs. These critically important programs reach older adults who are too poor to be able to afford Medicare, as well as people with disabilities who are working but need assistance with their Medicare premiums.¹⁰ More specifically, Specified Low-Income Beneficiaries (SLMB), Qualifying Individuals (QI), and Qualified Disabled Working Individuals (QDWI) are eligible for help with their Medicare premiums during the 3-month retroactive eligibility period.¹¹ These individuals have income between 100% and 135% FPL, so having Medicaid pay their \$135 monthly Medicare Part B premiums (or up to \$437 in Part A premiums for QDWI) frees up a significant portion of their monthly budget.

Retroactive coverage can also keep families afloat when routine medical bills have piled up. Older adults have a high prevalence of chronic conditions that require ongoing out-of-pocket costs such as doctor visits and prescription drugs. By covering lingering bills retroactively, Medicaid can prevent older adults and families with ongoing health care costs from choosing between filling a prescription or meeting their basic needs.

“By covering lingering bills retroactively, Medicaid can prevent older adults and families with ongoing health care costs from **choosing between filling a prescription or meeting their basic needs**.

HOW ARE STATES USING WAIVERS TO ELIMINATE RETROACTIVE COVERAGE?

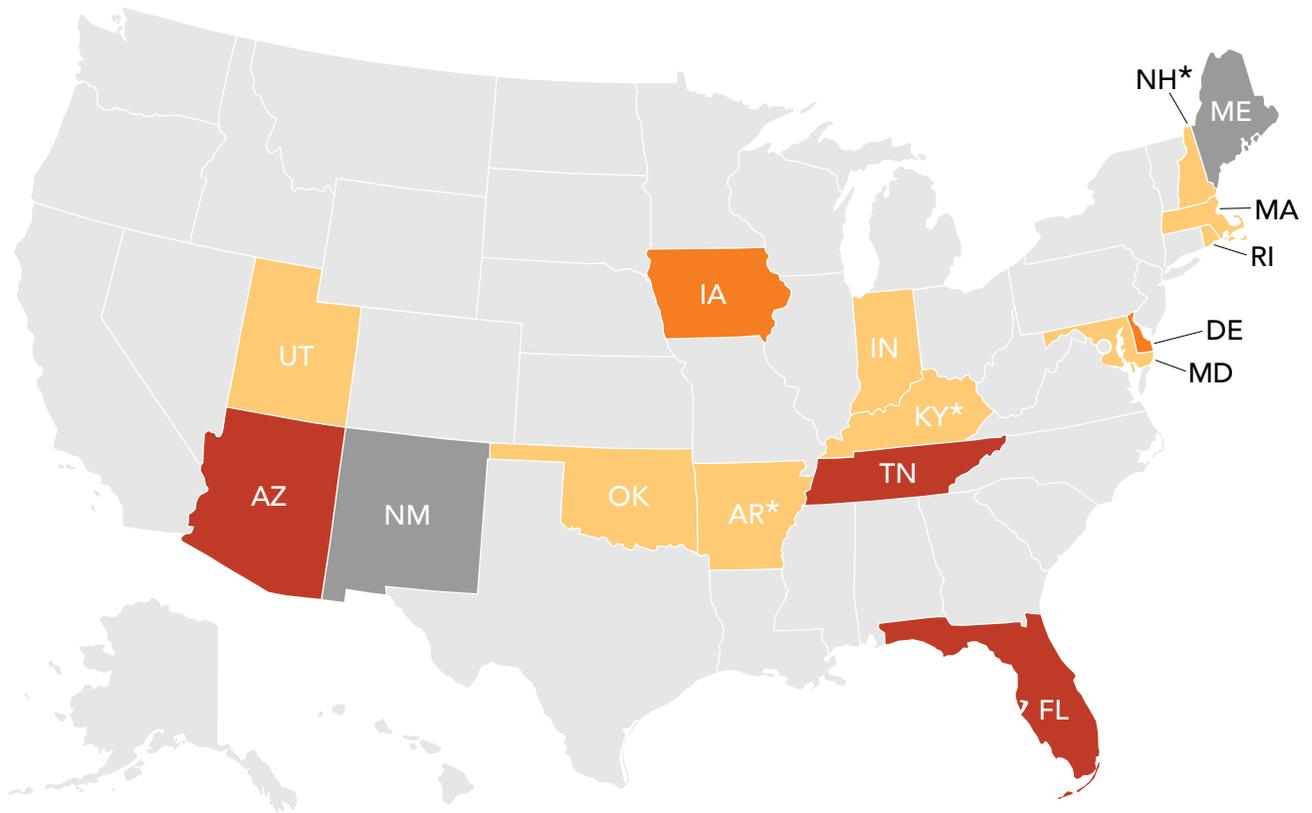
Because federal Medicaid law requires states to provide three months of retroactive coverage, states must ask the federal government for authority to reduce or eliminate this coverage. The formal way of seeking permission is to apply to the Centers for Medicare and Medicaid Services (CMS) for what is known as a demonstration waiver. Federal law provides that CMS can grant such a waiver to allow a state to implement an “experimental, pilot, or demonstration project ... [that] is likely to assist in promoting the objectives” of the Medicaid program.¹²

Since Congress added the retroactive coverage benefit, at least 16 states have sought and been granted waivers to limit or eliminate it for some or all Medicaid populations. Five of these states currently have waivers in effect that take away retroactive coverage from some or all Medicaid-eligible seniors age 65 and older. Prior to the Affordable Care Act (ACA), CMS granted waivers of retroactive coverage in Delaware, Massachusetts, Maryland, Tennessee, and Utah. More recently, several states have asked to waive retroactive eligibility in conjunction with expanding Medicaid under the ACA to newly eligible, non-elderly adults with income below 138% FPL.¹³ In addition, in the past two years CMS has granted waivers to three states (Iowa, Arizona, and Florida) to eliminate retroactive coverage for nearly all of their Medicaid populations, including seniors age 65 and older, people with disabilities, and individuals needing long-term services and supports (LTSS) at home or in an institution such as a nursing facility.¹⁴

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States That Waive Medicaid Retroactive Coverage



- MOST RESTRICTIVE**
AZ, FL, TN
3 states are taking away retroactive coverage from nearly every Medicaid population including people over age 65 and residents of nursing facilities.
- RESTRICTIVE**
DE, IA
2 states still provide retroactive coverage to nursing facility residents.
- LEAST RESTRICTIVE**
AR, IN, KY, MA, MD, NH, OK, RI, UT
9 states do not eliminate retroactive from age 65+ or people needing LTSS.
- WAIVER WITHDRAWN**
ME, NM
2 states have withdrawn waivers.

*Waivers in Arkansas, Kentucky, and New Hampshire have been vacated by a federal court and are therefore not currently in effect.

The [map above](#) and [table in the appendix](#) show which states have been approved for retroactive coverage waivers and who those waivers apply to. Three states (Arizona, Florida, Tennessee) have eliminated retroactive coverage for nearly every population its Medicaid program serves, including older adults and people with disabilities who need long-term services and supports. Tennessee is the only state that waives retroactive coverage for all populations, including seniors and people with disabilities. Two states (Iowa and Delaware) have eliminated retroactive coverage for older adults and people with disabilities, but make exceptions for nursing facility residents. Delaware also exempts people enrolled in Program of All Inclusive Care for the Elderly (PACE), adults with disabilities who buy in to Medicaid, as well as Specified Low-Income Beneficiaries, Qualifying Individuals, and Qualified Disabled Working Individuals who are eligible for retroactive coverage of their Medicare premiums.

Six states (Arkansas, Indiana, Kentucky, New Hampshire, Massachusetts, Rhode Island) have targeted their waivers to eliminate retroactive coverage for adults newly eligible through expansion, and in some states, low-income parents as well. Oklahoma explicitly exempts people eligible through the aged/blind/disabled pathway (including people needing LTSS), and Utah only eliminates retroactive coverage for adults under age 65 eligible for its Primary Care Network demonstration.¹⁵ Maryland's waiver is the most narrow, only waiving retroactive coverage for certain children eligible through a targeted coverage pathway.

In addition, two states (New Mexico and Maine) recently withdrew or suspended their approved waivers of retroactive coverage. Finally, the waivers in Arkansas, Kentucky, and New Hampshire have been vacated by a federal court and are therefore not currently in effect.¹⁶

For the most part, these states limit retroactive coverage to the month of application. For example, if an individual applied for coverage on February 5th, retroactive coverage would be limited to services received on or after February 1st. An individual who applied on March 30th could be eligible for retroactive coverage beginning March 1st. A few states however, eliminate retroactive coverage altogether and only provide prospective coverage, meaning coverage does not begin before the date of application.

WHAT REASONS DO STATES PUT FORWARD TO ELIMINATE RETROACTIVE COVERAGE?

As mentioned above, the purpose of Section 1115 demonstration waivers is to test an experimental or pilot project that will promote Medicaid coverage. Therefore, in applying for these waivers, states must include the intended purpose and what they are trying to test. The reasons states have put forward for waiving retroactive coverage fall into four categories: (1) aligning Medicaid with commercial insurance and encouraging continuous enrollment when healthy and first eligible; (2) cost savings to the state; (3) low utilization; and (4) availability of other coverage and presumptive eligibility.

Most states cite two or more of these reasons. For example, Arizona's application states that its demonstration would promote the objectives of the Medicaid program by "(1) encouraging members to obtain and continuously maintain

health coverage, even when healthy; (2) encouraging members to apply for Medicaid without delays to promote continuity of eligibility and enrollment for improved health status; and (3) containing Medicaid costs.”¹⁷

None of these reasons alone or together justify eliminating the retroactive coverage protection, especially when compared with the benefit to individuals who are eligible to use it. Nor do they hypothesize to promote Medicaid coverage, as Section 1115 demonstrations should do.

Align Medicaid with Commercial Insurance

Most states applying to waive retroactive coverage since 2017 have stated that they are doing so in an effort to align Medicaid coverage with commercial insurance and encourage individuals to maintain coverage even when they are healthy. For example, in its application, Kentucky explained, “consistent with the commercial market and federal Marketplace policies, coverage and benefits will only begin after the member’s initial premium payment is made. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy.”¹⁸

This rationale makes little sense, given the substantial differences between Medicaid and commercial insurance. A principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program’s financing relies on premium payments in advance, before a person knows the medical services that they may require in any particular month. The same is not true in Medicaid, which is financed by the federal government and states and does not rely on premiums.

Moreover, this rationale cannot be applied to the LTSS context. First, commercial health insurance does not cover LTSS. Second, an individual is only eligible for Medicaid LTSS if they meet the functional eligibility criteria, which generally means they require an institutional level of care. In other words, it is impossible to enroll in Medicaid LTSS coverage before needing it.¹⁹ Commercial health insurance has no such functional or medical eligibility requirement, nor does an individual’s need trigger an enrollment opportunity. Nonetheless, in their waiver applications, Arizona²⁰ and Iowa both cited this reason without acknowledging that it does not support eliminating retroactive coverage for individuals eligible for LTSS.²¹

Cost Savings to the State

Several states cite costs savings as the reason for eliminating the retroactive coverage benefit. For example, Florida’s application says, “The objective of this amendment is to enhance fiscal predictability by eliminating the three month retroactive eligibility period for non-pregnant adults.”²²

Reducing Medicaid expenditures is antithetical to the purpose of the Medicaid program, which is to protect low-income persons who otherwise cannot afford needed health care. Furthermore, reducing expenditures for retroactive coverage may increase costs elsewhere in terms of unnecessary hospitalizations and uncompensated care. Some of these costs will be born by the state. Even if waiving retroactive coverage may save the state some amount of money, this “goal” does not legitimize a Section 1115 demonstration project because that reduction in spending is accomplished by denying health care coverage to people who desperately need it.

The Retroactive Coverage Benefit is Not Utilized

Several states point to low-utilization of the existing retroactive coverage benefit as a reason for eliminating it. For example, Florida's waiver amendment request states that in the 2015-2016 fiscal year, less than 1% of all Florida Medicaid recipients were made retroactively eligible.²³ Similarly, Indiana justified elimination of its prior claims payment program²⁴ by citing the fact that only 455 individuals actually used it.²⁵ However, the costs reimbursed were over \$1,500 per person.²⁶ And in New Hampshire, about 10% of the Medicaid expansion population used retroactive coverage over a 16 month period from August 2014 to November 2015, incurring over \$1,000 in costs per person.²⁷

This data demonstrates the significance of the benefit to each individual. In 2015, \$1,000 was almost 75% of the monthly income for an individual and more than a third of the monthly income for a household of four with income at the Medicaid expansion eligibility limit of 138% FPL.²⁸ Given that nearly three in ten U.S. households have less than \$1,000 in savings²⁹ and four in ten U.S. adults do not have enough on hand to cover a \$400 emergency,³⁰ any unexpected costs, much less \$1,000 or \$1,500 in medical bills, are simply unaffordable. On top of this, with the proportion and number of seniors on the rise, the need for Medicaid and retroactive coverage is also growing. The bottom line is: states should measure the necessity or effectiveness of retroactive coverage by the individual benefit, not by the number or percentage of Medicaid enrollees who utilize it.

Availability of Marketplace Coverage & Presumptive Eligibility

Finally, several states, including Kentucky,³¹ Indiana,³² and Iowa,³³ cite the availability of Medicaid expansion, premium tax credits in the individual market, and expansion of Medicaid presumptive eligibility to say that retroactive eligibility is no longer necessary. While many people who were previously uninsured gained coverage through Medicaid expansion or subsidized Marketplace plans, these coverage expansions are not a replacement for retroactive Medicaid. Retroactive coverage only applies in months when the person meets Medicaid financial eligibility standards and by definition cannot afford to pay for health care or commercial health insurance. Moreover, none of these coverage expansions provide LTSS.

Likewise, allowing hospitals and other providers to enroll individuals in Medicaid through presumptive eligibility³⁴ has similar benefits to retroactive eligibility, such as reducing hospitals' uncompensated care,³⁵ it is not a complete replacement for retroactive eligibility. First, presumptive eligibility does not extend to seniors or anyone who needs Medicaid coverage of LTSS because, as explained above, these applications require complex financial documentation and medical assessments. Second, not every hospital, much less every state, has implemented this process.³⁶

HOW DOES LOSING RETROACTIVE COVERAGE HARM OLDER ADULTS, LOW-INCOME FAMILIES, AND COMMUNITIES?

By eliminating retroactive coverage, states are effectively cutting benefits for people who are in fact Medicaid eligible. This cut falls hardest on older adults, people with disabilities, and anyone with significant short-term or long-term health care needs. Even when states only eliminate retroactive coverage for Medicaid expansion enrollees, they are exposing people living on the margins to crushing financial burden, blocking access to non-emergency care, and putting unnecessary strain on hospitals and other providers that may not get any reimbursement for services they provide.

Exposes Seniors & Families to Crushing Debt

Two out of three people who have difficulty paying medical bills report that the bills resulted from an accident or hospital stay.³⁷ Such individuals who experience a medical emergency or need care unexpectedly may be uninsured or underinsured, most likely because they cannot afford insurance, are not eligible for financial assistance, are unaware of Medicaid or other coverage options, or some combination of all three.³⁸ Without retroactive coverage, a person who is in a car accident could owe the hospital thousands of dollars for expenses incurred in a matter of hours before anyone could be expected to file a Medicaid application on their behalf. Even more bills could pile up while their Medicaid application is pending.

Denying Medicaid retroactive coverage can also start or continue a cycle that leads to poorer health. The chronic stress caused by medical debt can lead to adverse health outcomes, such as increased blood pressure.³⁹ Moreover, the amount of unsecured debt is a predictor of depressive symptoms and lower psychological well-being.⁴⁰ People with medical debt are less likely to get follow-up care and may avoid taking their child or family member to the doctor because they fear being turned away or facing more debt. They may cut back on other basic needs such as food and safe shelter in order to repay their debt. The ripple effect is devastating for seniors and younger families alike—directly jeopardizing their health, destroying their credit and finances, and making it impossible to secure what they need to support their well-being and plan for the future.⁴¹

By eliminating retroactive coverage, states are effectively **cutting benefits for people who are in fact Medicaid eligible**. This cut falls **hardest on older adults, people with disabilities, and anyone with significant short-term or long-term health care needs**.



REAL PEOPLE, REAL IMPACT

Medical debt most heavily burdens those who can least afford it. Nearly half of people who are uninsured have income below 200% of poverty.⁴² In 2016, medical debt pushed over 11 million Americans into poverty, according to the supplemental poverty measure.⁴³ A recent study of people who were sued for unpaid medical bills by a Baltimore hospital showed that they were disproportionately poor and unable to afford hundreds or thousands of dollars in medical bills.⁴⁴

Medical debt also disproportionately burdens people of color, people with disabilities, and women due to multiple reasons, including that they are more likely to have lower incomes and be uninsured, and that they face higher health care costs on average.⁴⁵

The stories below illustrate how Medicaid retroactive coverage is a lifeline for people in emergencies.

Carol was hospitalized after an accident in August. She applied for Medicaid to cover emergency hospitalization and medical bills in October, but her application was initially denied. Between the initial denial and the time that she was declared eligible for benefits, Levy paid over \$8,000 to cover some of the nearly \$50,000 in medical bills incurred during the retroactive-coverage period. A court later required Michigan Medicaid to pay the bills retroactively.⁴⁶

In 2019, John, an uninsured, low-income patient stayed in a Miami hospital for 86 days and incurred total charges exceeding \$1 million. The hospital's staff prepared John's Medicaid application, which took 65 days to complete. The Florida Medicaid agency approved the application and covered bills for the previous 90 days, including a payment to the hospital of \$82,000, based on the state's limit of 45 covered hospital days per year. If Florida's retroactive coverage waiver had been in effect, the hospital would have received no reimbursement. The hospital estimates eliminating retroactive coverage will cost it at least \$4 million a year in uncompensated care, and likely far more.⁴⁷

Prevents Access to Necessary Care

Without retroactive coverage, many low- and middle-income older adults would not receive care in the first place. A nursing facility or other provider will require assurance that payment will be made before admitting someone or providing services. Medicaid retroactive coverage provides that assurance, especially in the context of nursing facility care. Nursing facilities are accustomed to working with Medicaid and assisting residents with applications. If a state takes away the assurance that it will pay a facility back for the services rendered while an applicant gathers documentation and the state processes the application, facilities might very well deny admission until an individual has been determined eligible for Medicaid.⁴⁸ Delaying nursing facility admission and other LTSS endangers older adults and persons with disabilities. This could also result in unnecessarily long hospital stays, as hospitals would be unable to discharge individuals to a facility that meets their needs. Even worse, individuals may return home after discharge without the supports they need and end up back in the hospital in poorer health.

Denies Medicare Affordability Assistance to Low-Income Seniors

In states with broadly applicable waivers such as Arizona, Iowa, Florida, and Tennessee, eliminating retroactive coverage denies coverage of previous months' Medicare premiums for beneficiaries who have an income between 100% and 135% FPL through the Medicare Savings Programs.⁴⁹ The cost savings are significant for these low-income individuals. For example, the \$135 monthly Part B premium can easily consume more than 10% of an individual's income, and 3-months of retroactive eligibility can provide a net benefit of over \$400. In addition, many low-income seniors who are eligible for Medicare Savings Programs are not enrolled,⁵⁰ so ensuring they can get retroactive coverage of their Medicare premiums when they do enroll is a tangible benefit.

“The \$135 monthly Part B premium can easily consume **more than 10% of an individual's income**, and 3-months of retroactive eligibility can provide a **net benefit of over \$400**.”

Weakens Provider Networks and Increases Uncompensated Care

Finally, not paying providers for delivering care to a person made ineligible for coverage under a waiver of retroactive coverage weakens states' ability to maintain an adequate network of providers, decreases access to care for all Medicaid enrollees, and increases uncompensated care. In Indiana, 16% of providers said they saw charity cases and bad debt increase after the state eliminated retroactive coverage.⁵¹ One analysis estimates that eliminating the retroactive coverage provision nationwide would result in hospitals losing \$13.3 billion in revenue over 2017 to 2026.⁵² Nonetheless, these hospitals would still incur the cost of treating uninsured patients, thus increasing uncompensated care.⁵³ This may be particularly dangerous for rural hospitals, which are already struggling to remain

open.⁵⁴ Eliminating retroactive coverage and this Medicaid revenue jeopardizes the ability of hospitals and other providers to treat people most in need of care.

CONCLUSION

Retroactive Medicaid coverage is a financial lifeline for older Americans, people with disabilities, and families living on the margins. By intentional design, it differs from commercial insurance by providing coverage for people who can otherwise not afford it and fills in gaps that are most likely unavoidable. Eliminating this protection will only increase medical debt, which can push people into poverty and jeopardize their health. Simply put, neither older adults and their families nor our healthcare system can afford to lose this vital protection.

“Eliminating retroactive coverage and this Medicaid revenue **jeopardizes the ability of hospitals and other providers to treat people most in need of care.**”

States With Waivers of Retroactive Coverage

State	Earliest Day Coverage Can Start Under Waiver	Waiver Applies to Adults Through Aged/Blind/Disabled Pathway	Waiver Applies to Expansion Adults	Waiver Applies to Residents of Nursing Facilities/Institutions	Waiver Applies to HCBS Recipients	Waiver Status
Arizona	First day of month of application	Yes	Yes	Yes	Yes	In effect
Arkansas	First day of month of application	No	Yes	No	No	Vacated by Court
Delaware	First day of month of application for expansion enrollees; Application date for all other populations	Yes (except Medicare Savings Program)	Yes	No (individuals in hospital for 30-consecutive days also excluded)	Yes (except for PACE)	In effect
Florida	First day of month of application	Yes	N/A	Yes	Yes	In effect (expires June 30, 2020)
Indiana	First day of month of application	No	Yes	No	No	In effect
Iowa	First day of month of application	Yes	Yes	No	Yes	In effect
Kentucky	First day of month of enrollment in Kentucky HEALTH	No	Yes	No	No	Vacated by Court
New Hampshire	45 days before date of application	No	Yes	No	No	Vacated by Court
Massachusetts	10 days before date of application	No	Yes	No	No	In effect
Maryland	Application date	No	No	No	No	In effect

State	Earliest Day Coverage Can Start Under Waiver	Waiver Applies to Adults Through Aged/Blind/Disabled Pathway	Waiver Applies to Expansion Adults	Waiver Applies to Residents of Nursing Facilities/Institutions	Waiver Applies to HCBS Recipients	Waiver Status
Oklahoma	First day of the month of application	No	N/A (applies to adults under age 65)	No	No	In effect
Rhode Island	Application date	No	Yes	No	No	In effect
Tennessee	Date application is filed or all eligibility requirements are met, whichever is later	Yes	N/A	Yes	Yes	In effect
Utah	Application date	No	N/A (applies to certain adults under age 65)	No	No	In effect (pending waiver removes application to Primary Care Network enrollees)
Maine	First day of the month of application	Yes	N/A (Maine implemented expansion after waiver was approved)	No	No	Withdrawn
New Mexico	Phased in: one month before month of application in first year, then first day of month of application; prospective coverage only for individuals required to pay premiums	Yes	Yes	No	Depends (certain HCBS recipient are not part of demo)	Withdrawn

ENDNOTES

- 1 Section 1902(a)(34) of the Social Security Act, codified at 42 U.S.C. § 1396a(a)(34), requires states to “provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished[.]”
- 2 Note that some states consider the date an application is received as the application date, rather than the date an application was submitted. This can impact the retroactive eligibility period if an application is submitted near the end of the month but the state does not receive it until the next month.
- 3 *See, e.g.*, Iowa Dept. of Human Svcs., Medicaid Application Processing Manual (Rev. Apr. 19, 2019), dhs.iowa.gov/sites/default/files/8-B.pdf;080220191706.
- 4 Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).
- 5 It is important to note that Congress has continued to support retroactive coverage by rejecting recent legislative efforts to eliminate it. *See* H.R. 1628, 115th Cong. § 114(b) (2017); H.R. 180, 115th Cong. § 1 (2017); H.R. 5626, 114th Cong. § 1 (2016); S. Amdt. 270 to S. Amdt. 267, 115th Cong., Tit. I of Better Care Reconciliation Act of 2017, § 127(a) (2017), in 163 Cong. Rec. S4196, S4205 (July 25, 2017).
- 6 *See, e.g.*, T. Thompson et al., Associated Press-NORC Ctr. or Public Affairs Research, Long Term Care: Perceptions, Experiences, and Attitudes Among Americans 40 or Older, 7 (2013) (survey shows Americans “overestimate the long-term care services that Medicare will cover”), apnorc.org/PDFs/Long%20Term%20Care/AP_NORC_Long%20Term%20Care%20Perception_FINAL%20REPORT.pdf.
- 7 Under current Centers for Medicare and Medicaid Services (CMS) policy, an individual is only eligible for post-acute skilled nursing facility care if they had a qualifying inpatient hospital stay of at least three days. This restriction further limits Medicare coverage of nursing facility care because hospitals often categorize Medicare beneficiaries as being on “outpatient observation status” rather than “inpatient” for billing purposes. *See* Ctr. for Medicare Advocacy, HHS Inspector General: Observation Status is a Growing Problem for Patients (Jan. 4, 2017), medicareadvocacy.org/hhs-inspector-general-observation-status-is-a-growing-problem-for-patients/.
- 8 42 C.F.R. §§ 409.30(a), 409.31(b), 409.32, 409.61(b). In 2016, the average length of stay under Medicare was only 27.6 days. Medicare Payment Advisory Commission (MedPAC), A Data Book: Health Care Spending and the Medicare Program 112, Chart 8-4 (June 2016), medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf
- 9 Harris Meyer, New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients, Modern Healthcare (Feb. 9, 2019), modernhealthcare.com/article/20190209/NEWS/190209936/new-medicare-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.
- 10 Nat’l Center on Law & Elder Rights, Legal Basics: Medicare Savings Programs (Dec. 2017), ncler.acl.gov/pdf/Legal%20Basics%20-%20Medicare%20Savings%20Programs%20-%20Chapter%20Summary.pdf.
- 11 Note that under federal law, retroactive coverage does not apply to Qualified Medicare Beneficiaries who have income below 100% of FPL. *See* 42 U.S.C. § 1396d(a).
- 12 42 U.S.C. § 1315. This provision is Section 1115 of the Social Security Act and the waivers are often referred to as “Section 1115 waivers.”
- 13 For example, under the Obama Administration, CMS granted waivers of retroactive eligibility for Medicaid expansion populations in New Hampshire, Arkansas, and Indiana. In each of these states, CMS required certain terms and conditions to be met before or concurrent with implementation. Under the Trump Administration, CMS has not denied any state’s request to eliminate retroactive coverage or expand their current waivers, and approved eliminating the conditions the Obama Administration imposed on New Hampshire, Arkansas, and Indiana.
- 14 Since CMS’s approval in 2017, Iowa has restored retroactive coverage for nursing facility residents and is currently seeking approval of an amendment to reflect that change in its waiver. Extension of Iowa Wellness Plan Section 1115 Demonstration Waiver (Jun. 19, 2019), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa5.pdf.
- 15 Utah’s August 2017 Waiver amendment application states that in response to public comments expressing concern about increasing uncompensated care, it would not eliminate retroactive coverage for Primary Care Network enrollees. *See* Utah Dept. of Health, Utah 1115 PCN Demonstration Waiver Amendment # 20 (Aug. 15, 2017), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf.

- 16 *Stewart v. Azar*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) (Kentucky); *Gresham v. Azar*, 363 F. Supp. 3d 165, 169 (D.D.C. 2019) (Arkansas); *Philbrick v. Azar*, Memorandum Opinion, Civil Action No. 19-773 (JEB), filed July 29, 2019, available at healthlaw.org/wp-content/uploads/2019/07/47.-Mem-Opin.pdf (New Hampshire). The Arkansas and Kentucky decisions are on appeal to the Federal Court of Appeals for the D.C. Circuit.
- 17 Arizona Health Care Cost Containment System (AHCCCS), Arizona Section 1115 Waiver Amendment Request: Proposal to Waive Prior Quarter Coverage, at 3 (April 6, 2018), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf. The appendices to this request include an earlier draft waiver request stating that a purpose of this proposal is “[t]o better align Medicaid policies with commercial health insurance coverage.”
- 18 Commonwealth of Kentucky, KENTUCKY Health Application (Aug. 24, 2016), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa3.pdf. Both Maine and New Mexico used similar rationale in their applications.
- 19 For example, Utah’s Medicaid manual states that for both nursing facility services and HCBS, retroactive coverage is allowed but services received prior to the date the person met the medical criteria cannot be paid. Iowa Dept. of Human Svcs., Medicaid Application Processing Manual (Rev. Apr. 19, 2019), dhs.iowa.gov/sites/default/files/8-B.pdf?080220191706.
- 20 AHCCS *supra* note 17.
- 21 For example, Iowa’s application states, “the State seeks to more closely align Medicaid policy with that of the commercial market, which does not allow for an individual to apply for retroactive health insurance coverage. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when healthy. . . Further, by more closely aligning Iowa Medicaid policy with policy in the commercial insurance market, members will be better prepared if they are eventually able to transition to commercial health insurance.” State of Iowa, 1115 Demonstration Waiver Amendment Iowa Wellness Program (Aug. 2, 2017), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf.
- 22 Florida Managed Medical Assistance Waiver Amendment Request—Low Income Pool and Retroactive Eligibility (April 27, 2018), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf.
- 23 Florida Agency for Health Care Administration, Managed Medical Assistance Waiver Amendment Request—Low Income Pool and Retroactive Eligibility, at 15 (April 27, 2018), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf. Moreover, low utilization contradicts Florida’s other rationale that eliminating retroactive coverage will save money and ensure the Medicaid program is sustainable.
- 24 CMS under the Obama Administration required Indiana to implement a prior claims payment program as a condition of approving its waiver to eliminate retroactive coverage. The program was limited to parents enrolled in the Healthy Indiana Plan who had not been enrolled for the previous two years and were not enrolled through presumptive eligibility.
- 25 Letter from Indiana Governor to CMS, “HIP 2.0 Outstanding Issues” (Apr. 28, 2016), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-prior-claims-pymt-04282016.pdf. The prior claims payment program was limited to parents enrolled in the Healthy Indiana Plan (HIP) who had not been enrolled for the previous two years and were not enrolled through presumptive eligibility. The 455 individuals accounted for 13.9% of the eligible population.
- 26 Jul. 29, 2016 Letter from CMS to Indiana, medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.
- 27 Letter from New Hampshire Dep’t of Health & Human Servs. to CMS, New Hampshire’s Conditionally Approved Waiver of Retroactive Coverage Submitted to the Centers for Medicare & Medicaid Services (2015), medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf; AARP, The New Medicaid Waivers: Coverage Losses for Beneficiaries, Higher Costs for States (June 2019), aarp.org/content/dam/aarp/ppi/2019/06/the-new-medicaid-waivers-coverage-losses-for-beneficiaries-higher-costs-for-states.doi.10.26419-2Fppi.00066.001.pdf.
- 28 In 2015, 138% FPL was \$16,243/year or \$1,353.58/month for an individual and \$33,465/year or \$2,788.75/month for a household of four.
- 29 Magnify Money, How Much Does the Average American Have in Savings? (Apr. 28, 2019), magnifymoney.com/blog/news/average-american-savings/.
- 30 Fed. Reserve Bd., Report on the Economic Well-being of U.S. Households in 2017 (May 2018), federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf.

- 31 KENTUCKY Health, *supra* note 18.
- 32 “First, due to the expanded HIP [Healthy Indiana Program] program and availability of tax credits, more individuals are moving to HIP from other coverage, meaning less individuals are enrolling in HIP with unpaid medical bills. . . . Third, the expanded presumptive eligibility process has been very successful in enrolling uninsured individuals into coverage quickly at the site of care prior to the individual incurring non-covered claims.” State of Indiana, 2017 HIP 1115 Waiver Extension Application (Jan. 31, 2017), [medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-02152017.pdf#page31](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-02152017.pdf#page31).
- 33 State of Iowa, *supra* note 21.
- 34 42 U.S.C. 1396a(a)(47). Presumptive eligibility policy authorizes states to allow qualified entities to make a temporary Medicaid eligibility determination to expedite access to care while the state processes a full application. The ACA expanded this authorization to hospitals nationwide to presumptively determine Medicaid eligibility for all non-disabled individuals under age 65 and also allows states to extend other qualified entities’ authority to determine presumptive eligibility beyond children and pregnant women to parents, adults, and other groups. As of January 2017, 46 states have implemented hospital-based presumptive eligibility but fewer than half of states expanded presumptive eligibility groups other than children and pregnant women. Kaiser Family Foundation, Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey (Jan. 12, 2017), [kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-looking-ahead/](https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-looking-ahead/).
- 35 The Commonwealth Fund, The Financial Impact of the American Health Care Act’s Medicaid Provisions on Safety-Net Hospitals (Jun. 28, 2017), [commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-american-health-care-acts-medicaid-provisions](https://www.commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-american-health-care-acts-medicaid-provisions).
- 36 Only 38 states reported that hospitals were submitting applications through this process in January 2017. Kaiser Family Foundation, *supra* note 42.
- 37 Kaiser Family Foundation, The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (Jan. 25, 2016), [kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/](https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/).
- 38 Kaiser Family Foundation, The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act (Jan. 2019), [kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-who-remains-uninsured-after-the-aca-and-why-do-they/](https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-who-remains-uninsured-after-the-aca-and-why-do-they/).
- 39 Erin Spain, *Northwestern Now*, High Debt Could Be Hazardous to Your Health (2013), [news.northwestern.edu/stories/2013/08/high-debt-could-be-hazardous-to-your-health](https://www.news.northwestern.edu/stories/2013/08/high-debt-could-be-hazardous-to-your-health).
- 40 Zurlo et.al, Unsecured Consumer Debt and Mental Health Outcomes in Middle-Aged and Older Americans, *The Journals of Gerontology*, Series B, Vol. 69, Issue 3, pp. 461–469 (Mar. 17, 2014), doi.org/10.1093/geronb/gbu020.
- 41 See Olga Khazan, *The Atlantic*, Americans Are Going Bankrupt From Getting Sick (Mar. 15, 2019), [theatlantic.com/health/archive/2019/03/hospital-bills-medical-debt-bankruptcy/584998/](https://www.theatlantic.com/health/archive/2019/03/hospital-bills-medical-debt-bankruptcy/584998/).
- 42 Kaiser Family Foundation, The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act (Jan. 2019), [kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-who-remains-uninsured-after-the-aca-and-why-do-they/](https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-who-remains-uninsured-after-the-aca-and-why-do-they/).
- 43 U.S. Census Bureau, The Supplemental Poverty Measure: 2015 (Sept. 2016), [census.gov/content/dam/Census/library/publications/2016/demo/p60-258.pdf](https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-258.pdf).
- 44 AFL-CIO, Nat’l Nurses United, Coalition for a Humane Hopkins, Taking Neighbors To Court: Johns Hopkins Hospital Medical Debt Lawsuits (May 2019), act.nationalnursesunited.org/page/-/files/graphics/Johns-Hopkins-Medical-Debt-report.pdf.
- 45 Kaiser Family Foundation, The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (Jan. 5, 2016), [kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/](https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/) (31% of blacks and 32% of Hispanics compared to 24% of whites report having problems paying medical bills; 47% of people with a disability report having problems paying medical bills, as do 29% of women compared to 23% of men); Wiltshire et.al, J. Health Care Poor Underserved, Gender Differences in Financial Hardships of Medical Debt (Feb. 2011), [ncbi.nlm.nih.gov/pubmed/21317529](https://pubmed.ncbi.nlm.nih.gov/pubmed/21317529) (“Women are more likely than men to forgo, delay, and ration medical care because of medical debt.”).
- 46 *Schott v. Olszewski*, 401 F.3d 682, 685 (6th Cir. 2005) (more than \$40,000 in unpaid bills, and more than \$8,000 in reimbursement due to patient for bills she had paid herself).
- 47 Harris Meyer, *supra* note 9. (John is not the patient’s real name.)

- 48 For example, “After Iowa asked for the 1115 waiver, the chief financial officer of an Iowa-based nursing home company wrote to CMS stating, “with the state requesting elimination of (retroactive payment), our nursing homes will no longer admit any prospective resident who is Medicaid-pending, or will become Medicaid-pending shortly after admission.” Ctr.on Budget & Policy Priorities, Ending Medicaid’s Retroactive Coverage Harms Iowa’s Medicaid Beneficiaries and Providers (Nov. 9, 2017), cbpp.org/blog/ending-medicoids-retroactive-coverage-harms-iowas-medicoid-beneficiaries-and-providers.
- 49 Note that under federal law, retroactive coverage does not apply to Qualified Medicare Beneficiaries who have income below 100% of FPL. 42 U.S.C. § 1396d(a).
- 50 MACPAC, Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled (Aug. 2017), macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf.
- 51 Harris Meyer, New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients, Modern Healthcare (Feb. 9, 2019), modernhealthcare.com/article/20190209/NEWS/190209936/new-medicoid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.
- 52 This is based on actuarial analyses showing that about 5% of Medicaid payments occur retrospectively, which is consistent with what safety-net hospital officers have estimated. The Commonwealth Fund, The Financial Impact of the American Health Care Act’s Medicaid Provisions on Safety-Net Hospitals (Jun. 28, 2017), commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-american-health-care-acts-medicoid-provisions.
- 53 *Id.*
- 54 One in five rural hospitals nationwide is at risk of closing. Navigant Consulting, Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents (Feb. 2019), navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf%20.