What Health Insurers Can Do: Turning Enrollment Volatility into Care Continuity

The Fiscal Viability Question

Medicaid managed care organizations have spent the past decade building business models around predictable assumptions: relatively stable enrollment, utilization patterns that follow member acuity, quality metrics that reward care continuity, and value-based arrangements where 12-18 month care coordination investments pay off through prevented acute care. OB3's work requirements beginning December 2026 upend every one of these assumptions simultaneously.

The fundamental problem isn't just that 18.5 million people will face new administrative requirements. It's that the requirements create enrollment volatility uncorrelated with medical risk. Documentation-capable people stay enrolled regardless of health status while documentation-challenged people cycle out regardless of health need. Historical utilization patterns become nearly useless for predicting future costs. The business model built on actuarial predictability faces systematic unpredictability.

For the 18.5 million adults subject to OB3's work requirements beginning December 2026, managed care organizations face systematic volatility that cascades through every operational aspect. Plans could see 30-40% annual churn rates in expansion populations – far exceeding baseline Medicaid turnover. The actuarial foundations of managed care, long built on relative enrollment stability, face fundamental disruption.

The Cascade of Dysfunction

The operational impacts compound. Consider chronic disease management. Your plan invests in a diabetic member over six months: comprehensive assessment, medication optimization, specialist coordination. The investment pays off as A1C comes under control and emergency visits decline. Then the member loses coverage because she missed a work verification deadline during a family crisis. Three months later, when she navigates appeals and gets reinstated, her A1C has jumped two points, she's developed early neuropathy, and she's been to the emergency department twice. Nine months of care coordination investment is partially erased.

Multiply this across thousands of members and actuarial models predicting next quarter's costs become unreliable. Medical loss ratio targets assumed stable populations with predictable utilization curves. Churn creates sawtooth patterns – members cycling through periods of managed care and unmanaged deterioration. When enrolled, they're in crisis recovery mode with higher acute utilization. When out, they're getting sicker. When they return, they present with advanced disease states.

The care coordination team faces impossible math. If you expect a member to churn within six months, do you invest in comprehensive care management when payback periods typically run 12-18 months? Investing fully in someone who'll be gone in six months is actuarially irrational. Not investing guarantees poor outcomes during enrollment, damaging quality metrics and increasing costs. There's no good answer – only trade-offs.

Quality metrics designed for stable populations distort. HEDIS measures have continuous enrollment requirements. State quality rating systems and contract performance metrics face similar issues. You're competing with plans in states without work requirements whose populations have more stable coverage. Your diabetic population's outcomes look worse not because your diabetes program is inferior but because members cycle through coverage gaps that disrupt medication access and monitoring.

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Value-based payment arrangements assume you can influence member behavior over meaningful periods. Shared savings calculations typically look at 12-month measurement periods with continuous enrollment requirements. Work requirements mean substantial portions of your expansion population don't meet continuous enrollment criteria, removing them from value-based payment success metrics. The members who most need care coordination are least likely to be included in shared savings calculations.

The Stratification Dilemma

The logical response to unpredictable populations is stratification – dividing members into groups managed differently with resources allocated accordingly. But work requirements create two competing logics pointing in opposite directions.

The first logic stratifies by coverage stability. Invest heavily in members likely to maintain continuous enrollment: those with stable employers who help with verification, strong digital literacy, documented exemptions, or sufficient social support. For these members, traditional care coordination works – long-term care plans, intensive chronic disease management, preventive care focus. The payback period justifies investment.

For members at high risk of churning – gig workers, seasonal employees, those with unstable housing, limited English proficiency, episodic health conditions – operate with shorter time horizons. Front-load preventive services at enrollment, provide portable self-management tools, focus on acute intervention rather than long-term coordination. This optimizes care coordination spending.

But the second stratification logic cuts against this entirely. Coverage instability correlates with medical complexity and social vulnerability. The gig worker cycling on and off coverage likely has chronic conditions making traditional employment difficult. The person who can't navigate documentation systems probably struggles with medication management too. The individual with housing instability almost certainly has higher medical needs. Unstable coverage doesn't predict low medical risk – it predicts high medical risk combined with high social complexity.

If you stratify by coverage stability and reduce investment in volatile populations, you're reducing investment in people whose health will deteriorate most rapidly without intervention. When they cycle back, they return sicker and more expensive. The emergency visits, hospitalizations, and complications you didn't prevent during first enrollment hit your medical loss ratio when they return. Short-term savings from reduced care coordination gets overwhelmed by increased acute care costs.

The timing mismatch compounds the problem. Your costs for unmanaged deterioration often appear after re-enrollment. You saved on care coordination during first enrollment. But the expensive hospitalization from uncontrolled hypertension happens during second enrollment. Your actuarial attribution model sees high costs in the second period without connecting them to under-investment in the first period.

The question becomes: optimize for short-term operational efficiency by matching investment to expected enrollment duration, or optimize for total population health and long-term cost control by investing most heavily in people most likely to get expensive when care breaks down? The two optimization problems point in opposite directions.

The Rate Negotiation Paradox

The textbook response to increased costs and risk is negotiating higher capitation rates. Work requirements create new administrative burden, care coordination complexity, and utilization uncertainty. Document these costs and request rate adjustments reflecting the new reality.

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But this negotiation happens in a political economy where states implemented work requirements partly to reduce Medicaid spending. The Congressional Budget Office scored OB3's work requirements as saving $344 billion through reduced enrollment. States expect savings, not increased per-member costs. When managed care plans request rate increases because work requirements make populations harder to manage, states hear: "The policy we implemented to save money is costing more money."

The dynamics are complex because plans and states have asymmetric information. Plans have detailed utilization data showing increased costs. States have enrollment data showing reduced coverage. From the state's perspective, if enrollment drops 15% but total spending only drops 10%, retained members appear more expensive, suggesting rate reductions. From the plan's perspective, members who left were relatively healthy (documentation-capable, not documentation-challenged), so the remaining pool is higher acuity, justifying rate increases.

Neither side has complete information about the counterfactual. Are increased per-member costs due to work requirement churn or underlying medical trend? Is risk pool composition actually changing or are plans managing less effectively? Without randomized trials, these questions are empirically unresolvable.

Political optics compound the challenge. Managed care plans requesting rate increases while people lose healthcare coverage creates terrible optics, even if actuarially justified. States might accept that volatile populations cost more and adjust rates accordingly, but this creates new problems. If rates include premiums for work requirement administration, plans have financial incentive for requirements to continue. If rates are risk-adjusted for coverage instability, plans might not invest optimally in preventing that instability.

More likely, rates won't fully adjust to cover increased costs, at least initially. States will allow some adjustment but less than plans request. Plans will absorb some volatility through operational efficiency. This creates pressure to manage expansion populations at lower cost per member, bringing back the stratification dilemma with sharper trade-offs.

What Actually Works: Three Operational Approaches

Given these constraints, three operational approaches show promise for maintaining care continuity despite enrollment volatility.

The first approach integrates work requirement support into existing care coordination. Rather than creating separate work requirement navigation teams, train care coordinators to handle verification assistance, exemption documentation, and employment service referrals alongside health management. The care coordinator who knows a diabetic member's medication regimen should also know their verification status and upcoming deadlines. When verification problems arise, the same person addressing them already understands the member's health needs and social circumstances. This integration recognizes that for many members, benefits navigation IS health management – losing coverage destroys health outcomes regardless of how good your diabetes program is.

Implementation requires several components. Care coordinators need real-time access to state verification systems showing member compliance status. They need simple templates for documenting medical exemptions that providers can complete in minutes rather than hours. They need direct lines to employment services, adult education programs, and volunteer coordinators who can help members find qualifying activities when hours fall short. They need authority to initiate exemption applications on members' behalf rather than waiting for members to navigate bureaucracy themselves.

The cost structure works because you're enhancing existing infrastructure rather than building parallel systems. A plan serving 100,000 expansion members might have 80-100 care coordinators already. Training them on work requirements, giving them tools and system access, and expanding their role costs

substantially less than hiring separate navigation staff. The marginal cost per member is modest – perhaps $3-5 PMPM – but the impact on coverage retention can be substantial.

The second approach extends social determinants of health platforms to include work requirement support. Many plans have invested in SDOH screening, referral coordination, and community resource linkage over the past several years. These platforms can be configured to track verification deadlines, document qualifying activities, manage exemption workflows, and connect members to employment and training opportunities. The advantage is leveraging existing technology, existing staff familiarity, and existing community partner relationships.

The SDOH extension recognizes that work requirements are fundamentally a social need like housing, food security, or transportation. A member struggling to meet work hours may need job placement assistance, childcare support to attend training, or transportation to get to volunteer opportunities. The SDOH coordinator who helps secure stable housing can also help navigate work verification. The community health worker who connects people to food banks can connect them to job training programs.

The measurement challenge here is isolating the impact of work requirement support from other SDOH interventions. Members receiving comprehensive social needs support likely have better coverage retention for multiple reasons. But if the platform captures data on work requirement assistance specifically – exemption applications filed, verification help provided, employment referrals made – you can track which interventions correlate with maintained coverage.

The third approach maintains connection through coverage gaps. Some members will lose coverage despite navigation support. The question is what happens during those gaps. Most plans disengage completely once coverage ends – the member disappears from care coordination workflows, no contact occurs, and re-enrollment is entirely member-initiated.

The alternative is light-touch engagement maintaining relationship and facilitating return. Automated text messaging can provide condition-specific self-management tips, remind about medication management, and check in periodically. Community health workers can continue phone contact even when home visits pause. The messaging can include information about re-enrollment processes, updates about changing exemption rules, and reminders about community resources available regardless of coverage status.

The value proposition is that members who maintain some connection return faster and return healthier. The member who loses coverage but receives weekly diabetes management texts for three months may avoid the acute decompensation that otherwise occurs. The text messages cost pennies. The prevented hospitalization saves thousands. Even small differences in re-enrollment timing or health status at return can justify modest gap engagement investment.

Legal and regulatory considerations matter here. Members who lose coverage aren't plan members anymore. Can the plan ethically maintain contact? The answer depends on opt-in consent obtained while enrolled, clear communication that services are voluntary and focus on health information rather than sales. The line between helpful engagement and inappropriate marketing requires careful navigation. But plans providing gap support as community benefit rather than member service can usually find compliant approaches.

The Strategic Choice

Medicaid managed care organizations face a genuine strategic choice. One path is optimizing narrowly – stratify by coverage stability, reduce investment in volatile populations, negotiate for higher rates or accept lower margins, and focus on managing stable populations well. This path minimizes short-term costs and protects financial sustainability in a challenging environment.

The other path is building infrastructure maintaining care continuity despite volatility – invest in navigation and exemption support, integrate work requirement assistance into existing SDOH coordination, maintain light-touch engagement through coverage gaps, document impacts, and work with states to improve the policy environment over time. This path requires upfront investment and accepts near-term financial pressure in exchange for long-term competitive advantage and population health outcomes.

Most plans will land somewhere in the middle. But the direction matters. Plans that view work requirements as operational burden to be minimized will make different decisions than plans viewing them as a new domain where managed care value proposition can be demonstrated. Plans that see volatile populations as unprofitable will manage them differently than plans seeing them as opportunities to prove care coordination works even in the hardest cases.

The coming years will reveal which approach succeeds. Or perhaps more accurately, they'll reveal both approaches are correct for different types of organizations in different markets with different risk appetites and competitive positions. The Medicaid managed care industry has always been heterogeneous – plans pursue different strategies, emphasize different capabilities, and succeed through different paths.

What seems certain is that OB3's work requirements will separate plans that can manage complexity from plans that struggle with it. The winners will be organizations building operational excellence in navigating volatility, integrating work requirement support seamlessly into existing care models, maintaining relationships and health status despite enrollment churn, and documenting impacts rigorously enough to shape future policy.

The question isn't whether work requirements are good policy. The question is what operationally competent managed care organizations do when policy creates volatility that threatens both business models and population health. The answer is adapting – not just to survive but to demonstrate that managed care can deliver value even in the most challenging circumstances.

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