

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Medicaid Unwinding Update
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the health care system; and a report of actions taken by the AMA and recommendations for further action. This report describes Medicaid enrollment changes since the Medicaid continuous enrollment requirement ended, discusses potential impacts of the unwinding on physicians and hospitals, summarizes relevant AMA policy and advocacy, and presents policy recommendations.

The Medicaid unwinding has been described as the most significant nationwide coverage transition since the Affordable Care Act, with major implications for patients, physicians, and health equity. At the time this report was written, the Medicaid unwinding was still in its early stages; many states had been redetermining enrollee eligibility for only a few months; and information on whether individuals disenrolled from Medicaid/Children's Health Insurance Program (CHIP) had transitioned to other sources of coverage—or become uninsured—was limited. Over the coming months, millions of individuals are expected to be disenrolled from Medicaid/CHIP coverage which may in turn decrease patient volume as well as revenue for physicians, clinics, and hospitals treating large numbers of Medicaid/CHIP patients. The Council will continue to monitor unwinding data as it becomes available and recommend new policy and physician resources as needed. At this time, the Council recommends amending Policy H-290.955, which was adopted at the 2022 Annual Meeting via [Council Report 3-A-22, Preventing Coverage Losses After the PHE Ends](#), by the addition of three new clauses that encourage state implementation of strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons; encourage states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan; and encourage state Medicaid agencies to make coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals.

The Council also recommends reaffirmation of Policy H-165.855, which calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and supports allowing for presumptive eligibility and retroactive coverage to the time at which an eligible person seeks care; and Policy H-165.823, which encourages states to pursue auto-enrollment in health insurance coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-23

Subject: Medicaid Unwinding Update

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

1 At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American
2 Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to
3 provide an update on loss of coverage and uninsurance rates following the return to regular
4 Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the
5 ensuing financial and administrative challenges experienced by physicians, physician practices,
6 hospitals, and the health care system; and a report of actions taken by the AMA and
7 recommendations for further action. The Board of Trustees assigned this item to the Council on
8 Medical Service for a report back to the House of Delegates at the 2023 Interim Meeting.

9
10 This report provides an overview of Medicaid enrollment changes since the Medicaid continuous
11 enrollment requirement ended, highlights federal policy and guidance, discusses challenges for
12 physicians and other providers, summarizes AMA policy and advocacy, and presents policy
13 recommendations.

14 15 BACKGROUND

16
17 At the 2022 Annual Meeting, while the Medicaid continuous enrollment requirement was still in
18 effect and many states were planning for the impending onslaught of eligibility redeterminations,
19 the Council on Medical Service presented [Report 3-A-22, Preventing Coverage Losses After the
20 PHE Ends](#), which established new AMA policy encouraging state and federal actions to prepare for
21 and respond to the Medicaid unwinding (Policy H-290.955). Having recognized the potential for
22 widespread coverage disruptions once the continuous enrollment requirement expired, the Council
23 self-initiated Report 3-A-22 to ensure that the AMA had strong policy supportive of key state
24 strategies for preventing coverage losses, including streamlining enrollment/redetermination
25 processes; investing in outreach and enrollment assistance; adopting continuous eligibility policies;
26 encouraging auto-enrollment in health insurance coverage; facilitating coverage transitions,
27 including automatic transitions, to alternate sources of coverage; and federal and state monitoring
28 and oversight. Taken together, these strategies would help ensure that, as states return to normal
29 redeterminations, individuals who continue to be eligible for Medicaid and the Children's Health
30 Insurance Program (CHIP) retain that coverage and those determined no longer eligible can
31 seamlessly transition to other health insurance, such as subsidized Affordable Care Act (ACA)
32 marketplace plans or employer-sponsored insurance (ESI).

33
34 During the PHE, the Families First Coronavirus Response Act required states to provide
35 continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary
36 federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of
37 the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069

1 in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement
2 was lifted.¹ Most of this growth was in the Medicaid program, which increased by 22,634,781
3 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984
4 individuals (5.4 percent).² The Consolidated Appropriations Act of 2023 (CAA), which was signed
5 into law in December 2022, established March 31, 2023 as the end date for the Medicaid
6 continuous enrollment requirement and phased down the enhanced FMAP amount through
7 December 2023.

8
9 Though challenging to quantify the impact on Medicaid enrollment once continuous enrollment
10 was no longer required, the AMA and other interested parties understood that the number of people
11 covered by Medicaid was likely to decrease substantially. The Robert Wood Johnson Foundation
12 estimated that 18 million people would lose coverage during the 14-month unwinding period,
13 including about 3.2 million children expected to transition from Medicaid to CHIP coverage, 9.5
14 million people who would turn to ESI, 3.8 million who would become uninsured, and one million
15 who would be eligible for subsidized marketplace plans.³ Estimates from the Kaiser Family
16 Foundation (KFF) ranged from between eight and 24 million people who would be disenrolled
17 from Medicaid during the unwinding period,⁴ while the U.S. Department of Health and Human
18 Services (HHS) projected that approximately 15 million Medicaid/CHIP enrollees would lose
19 coverage.⁵ According to the HHS analysis, an estimated 2.7 million people disenrolled from
20 Medicaid would qualify for subsidized marketplace plans and 383,000 people would fall into the
21 coverage gap (i.e., below poverty with income too low for ACA marketplace coverage and too high
22 for the state's eligibility limit) in the 10 states that have not expanded Medicaid. HHS also
23 predicted that 8.2 million disenrollments would be due to loss of eligibility while 6.8 million
24 people would lose coverage for procedural reasons, such as the state Medicaid agency being unable
25 to contact an enrollee or not receiving required documentation in time. Children and young adults
26 as well as minoritized groups would be disproportionately impacted by the unwinding, according to
27 the HHS analysis, including those who are African American or Latino.⁶ A more recent analysis by
28 the Congressional Budget Office projected that the unwinding would lead to gradual declines in
29 Medicaid enrollment throughout 2023 and 2024, with an estimated 9.3 million people under age 65
30 transitioning from Medicaid to other sources of coverage, namely ESI and marketplace plans, while
31 approximately 6.2 million people no longer enrolled in Medicaid would become uninsured.⁷

32 33 EARLY DATA ON MEDICAID/CHIP RENEWALS AND DISENROLLMENTS

34
35 According to the early data that was available at the time this report was written, renewal,
36 disenrollment, and procedural termination rates vary substantially across states. However, a rapid
37 rate of disenrollments in some states, coupled with high proportions of terminations for procedural
38 reasons, is cause for potential concern. Centers for Medicare & Medicaid Services (CMS) data
39 released on July 28, 2023 indicated that more than two million Medicaid/CHIP enrollees went
40 through the renewal process in 18 states that completed renewals during the first month of the
41 unwinding—April 2023.⁸ Just over one million (45.5 percent) of these enrollees had their coverage
42 renewed while more than 700,000 (32.2 percent) had their coverage terminated and the status of
43 another 22 percent of enrollees was still pending.⁹ Notably, procedural reasons were behind nearly
44 four in five (79 percent) of those whose Medicaid/CHIP coverage was terminated. CMS also
45 reported that 54,000 people previously covered by Medicaid or CHIP had enrolled in a marketplace
46 plan in April 2023 while noting that more complete information on transitions to marketplace
47 coverage is not expected for several months.¹⁰

48
49 Because Medicaid/CHIP enrollment data released from CMS are usually at least three months old,
50 the Council also reviewed data from the KFF, which updates national Medicaid disenrollment
51 numbers based on the most current data from at least 48 states publicly sharing those numbers and

1 the District of Columbia. According to KFF, as of September 12, 2023—just six months into the
2 unwinding—over six million (6,428,000) Medicaid enrollees had been disenrolled from the
3 program, almost three quarters (72 percent) for procedural reasons and just over a quarter due to an
4 actual determination of ineligibility.¹¹ Texas had the highest rate of disenrollments, at 69 percent,
5 over 70 percent of which were procedural, while only 9 percent of Michigan’s completed renewals
6 led to disenrollments. In the 16 states reporting the ages of those disenrolled from Medicaid,
7 children made up approximately 42 percent of those disenrolled.¹²

8
9 Only limited data regarding the ability of individuals disenrolled from Medicaid/CHIP to re-enroll
10 in Medicaid, if eligible, or obtain new coverage through ESI or marketplace plans were available at
11 the time this report was written. Such data are expected to change over time and were not sufficient
12 for the Council to draw meaningful conclusions regarding the impact of the unwinding on loss of
13 coverage, transitions to new coverage, and uninsured rates, beyond the concerns expressed herein
14 and in Council Report 3-A-22. In our review of the data, the Council was mindful that the early
15 numbers are likely impacted by differences between state renewal plans and, most notably, the
16 prioritization by some states to disenroll people already known to be ineligible for Medicaid/CHIP
17 or have other health coverage (some of whom may be categorized as procedural terminations if
18 they did not respond to inquiries from the state Medicaid agency or submit required paperwork).
19 Still, concerns about improper or inappropriate procedural disenrollments are widespread and have
20 led CMS to work with some states to temporarily pause these terminations and address potential
21 problems with their renewal processes.¹³

22
23 In its 2022 report, the Council emphasized that the potential for coverage losses and the ability to
24 transition those disenrolled from Medicaid to other affordable coverage would be highly dependent
25 on each state’s Medicaid policies and unwinding plans, and whether the state has expanded
26 Medicaid. Though permitted to begin terminating coverage of Medicaid/CHIP enrollees in April
27 2023, only a handful of states did so, while others began disenrolling individuals in May or June
28 and a dozen states waited until July to do so.¹⁴ Therefore, the data available at the time this report
29 was written were still very much evolving.

30 31 FEDERAL POLICY, GUIDANCE, AND RESOURCES

32
33 The CAA established new requirements that states must meet to receive the phased-down FMAP
34 increase and gave CMS authority to require states to submit monthly unwinding data, such as the
35 number of people whose coverage was terminated, the number of those terminated based on
36 eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA
37 also authorized several enforcement mechanisms including corrective action plans, financial
38 penalties, and requiring states to temporarily pause terminations.¹⁵

39
40 Leading up to the April 1, 2023 unwinding start date, CMS issued numerous [fact sheets, guidance,](#)
41 [policy and operational resources, best practices and strategies to support specific populations, and](#)
42 [Medicaid/Marketplace coordination resources](#) and began offering monthly “all state calls” to
43 support states and territories as well as monthly partner education webinars. CMS also worked with
44 states to assess compliance with Medicaid renewal requirements and adopt mitigation strategies to
45 address areas of non-compliance, summaries of which can be found [here](#). An assortment of
46 [outreach resources](#) have been made available, including flyers that physicians can use to inform
47 patients how to [prepare for their renewal](#) and direct patients deemed ineligible for Medicaid
48 coverage to [explore other coverage options](#). Notably, many state Medicaid agencies, state medical
49 associations, and national medical specialty societies have also created resources to help physicians
50 help patients retain coverage as the continuous enrollment requirement unwinds (e.g., American
51 Academy of Pediatrics [flyer](#), Michigan State Medical Society [media release](#), and Illinois State

1 Medical Society [event](#)). Such resources are critical since, despite national and state campaigns to
2 inform Medicaid enrollees about steps to take to retain Medicaid/CHIP coverage, consumer
3 awareness and understanding of the unwinding and what it means for one’s health coverage has
4 been limited.¹⁶

5
6 In response to early data indicating high rates of procedural disenrollments, in June 2023, CMS
7 announced an “all hands on deck” strategy to address the unwinding along with new [flexibilities](#) to
8 help mitigate mass disenrollments. Specifically, the new flexibilities included allowing:

9 1) managed care plans to assist with completing renewal forms; 2) states to delay termination for
10 one month while additional targeted outreach is performed; and 3) certain frontline entities such as
11 pharmacies and community-based organizations to facilitate reinstatement of coverage based on
12 presumptive eligibility criteria, among other flexibilities. HHS also encouraged states to maximize
13 the use of alternative data sources, such as U.S. Postal Service data, to update enrollee contact
14 information, increase *ex parte* renewal rates (which is when eligibility is confirmed
15 administratively with third-party data), and facilitate reenrollment of people disenrolled for
16 procedural reasons. In an accompanying letter to U.S. governors, the HHS Secretary urged state
17 Medicaid agencies not to rush renewals and to instead take the full 12 months to initiate them, take
18 full advantage of available federal flexibilities and waivers, and get creative in partnering with
19 schools, faith-based organizations, and other community-based groups to perform targeted
20 outreach.¹⁷

21
22 Other relevant federal policies impacting coverage transitions during the unwinding period include:

23
24 *Mandatory Requirement for Medicaid/CHIP 12-Months Continuous Eligibility for Children:*

25 Continuous eligibility policies, which allow enrollees to maintain Medicaid/CHIP coverage for 12
26 months, have long been supported by the AMA as a strategy to reduce the churn that occurs when
27 people lose coverage and then re-enroll within a short period of time. Although 24 states had
28 adopted continuous Medicaid/CHIP eligibility for children by 2022, the CAA requires all states to
29 implement continuous eligibility in Medicaid/CHIP for all children up to age 19, by January 1,
30 2024.

31
32 *Extension of Enhanced Premium Tax Credit Subsidies for ACA Marketplace Plans:* The Inflation
33 Reduction Act, signed into law in August 2022, extended through 2025 the enhanced premium tax
34 credits that were made available to eligible consumers under the American Rescue Plan Act of
35 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium
36 contribution for families with incomes between 100 and 150 percent of the federal poverty level
37 (FPL) to zero and provides subsidies to 90 percent of people selecting marketplace plans.

38
39 *Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage:* CMS
40 established an SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the
41 continuous enrollment requirement. This SEP, which runs between March 31, 2023 and July 31,
42 2024, allows individuals and families to enroll in federally facilitated marketplace
43 (HealthCare.gov) plans, if eligible, outside of the annual open enrollment period.¹⁸ CMS, along
44 with the Departments of Labor and Treasury, also sent a letter to employers, plan sponsors, and
45 insurers encouraging them to match the steps taken by HealthCare.gov by allowing employees and
46 their dependents who lose Medicaid/CHIP coverage to enroll anytime through July 31, 2024.

47
48 *Fixing the “Family Glitch:”* The AMA has long supported fixing the “family glitch” which was
49 accomplished this year by regulations allowing family members of workers offered affordable self-
50 only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it is
51 anticipated that nearly one million Americans will gain access to more affordable coverage.¹⁹

1 CHALLENGES FOR PHYSICIANS, PRACTICES, HOSPITALS AND HEALTH SYSTEMS

2
3 Since this report was written only a few months after the continuous enrollment requirement
4 expired, meaningful data regarding the impact of Medicaid/CHIP coverage terminations on
5 physicians, physician practices, hospitals and health systems is limited and still emerging.
6 However, it is generally assumed that the unwinding will increase uninsured rates. The CBO
7 estimates that the number of uninsured will increase from 23 million (uninsured rate of 8.3 percent)
8 in 2023 to 28 million (10.1 percent) in 2027 and remain at that level, which is below the 12 percent
9 uninsured rate in 2019, through 2033.²⁰

10
11 In turn, physician practices, hospitals and health systems serving large numbers of Medicaid/CHIP
12 patients or located in underserved communities—including rural areas—could disproportionately
13 experience decreased patient volume and revenue losses in the coming months. Such effects may
14 then impact the ability of some practices and facilities to employ staff and continue serving
15 patients, particularly those covered by Medicaid or CHIP, which tend to pay physicians and other
16 providers at rates lower than Medicare and commercial insurance, thus further exacerbating
17 existing access inequities. For example, a January 2023 predictive analysis of the potential effects
18 of the Medicaid unwinding on community health centers, which rely greatly on Medicaid revenue,
19 estimated that the unwinding would decrease health center revenue by \$1.5 to \$2.5 billion, or four
20 to seven percent, overall. As a result, the analysis posits that between 1.2 and 2.1 million fewer
21 patients will be served and between 10.7 and 18.5 thousand fewer people will be employed by
22 health centers.²¹ Kaufman Hall summaries of data from more than 900 hospitals in the first months
23 of the unwinding similarly found increases in both charity care and bad debt, as well as declines in
24 volume, that are attributed by the authors to unwinding-related coverage losses.²²

25
26 Additionally, physicians, hospitals, and other providers will likely see more and more patients who
27 may not realize that they are no longer covered by Medicaid/CHIP, and are therefore uninsured,
28 until they seek care. Most states do not provide renewal information to physicians and other
29 providers or allow them to access such data via the Medicaid agency portal; however, Kentucky is
30 an exception and even [explains](#) how providers can find patients' renewal dates online. Having such
31 information in hand before an enrollee is at the practice for an appointment would be helpful to
32 physicians who could then make sure a patient is aware of their Medicaid/CHIP renewal and
33 coverage status.

34 35 AMA ACTIVITY

36
37 The AMA has consistently worked at both the state and federal levels to improve Medicaid and
38 CHIP programs, expand Medicaid and CHIP coverage options, and generally make it easier for
39 physicians to see Medicaid and CHIP patients. Since the ACA was enacted, AMA advocacy on
40 Medicaid and CHIP has been guided by AMA policy, highlighted in the [AMA's Plan to Cover the](#)
41 [Uninsured](#), which seeks to extend the reach of coverage to the remaining uninsured, including
42 individuals eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with
43 AMA policy, the AMA continues to advocate for Medicaid expansion and three years of 100
44 percent federal funding for states that newly expand.

45
46 The AMA regularly comments on federal and state Medicaid proposals related to patient access to
47 care and adequate physician payment, defined in AMA policy as a minimum of 100 percent of
48 Medicare rates. The AMA has advocated that CMS ensure that states are maintaining Medicaid rate
49 structures at levels that ensure sufficient physician participation, so that Medicaid patients can
50 access appropriate, necessary care, including specialty and behavioral health services, in a timely

1 manner and within a reasonable distance to where they live. Specifically in response to the
2 unwinding of the continuous enrollment requirement, the AMA also:

- 3
- 4 • Participates in the [Connecting to Coverage Coalition](#), which represents a diverse collection of
5 industry voices partnering to minimize coverage disruptions associated with the resumption of
6 state Medicaid renewals;
- 7 • Meets with senior Administration officials to discuss the status of the unwinding and on-the-
8 ground implications, AMA’s role in educating physicians on CMS’ new guidance and
9 resources, and potential areas for future collaboration;
- 10 • Facilitates educational opportunities for the Federation, including a session in August 2023 at
11 the AMA’s State Advocacy Roundtable in which resources were shared and unwinding
12 strategies were discussed;
- 13 • Shares CMS resources with the Federation and encourages members to participate in CMS’
14 monthly webinars that are part of the agency’s “all hands-on deck” strategy;
- 15 • Regularly distributes new unwinding information and guidance announcements from CMS and
16 other sources through various AMA platforms and channels, including *AMA Today* and the
17 AMA’s biweekly Advocacy Update;
- 18 • Creates unwinding-specific resources for physicians, such as AMA issue briefs on [Preventing](#)
19 [Coverage Losses as the PHE Unwinds](#) and [COVID-19 flexibilities that ended when the PHE](#)
20 [expired](#); and
- 21 • Submits comments to CMS on relevant notices of proposed rulemaking, such as proposals this
22 year on [special enrollment periods and standards for navigators and other consumer assisters](#);
23 [ensuring access to Medicaid services](#); and [managed care access, finance, and quality](#).
- 24

25 RELEVANT AMA POLICY

26

27 Policies H-165.832 and H-165.855 support the adoption of 12-month continuous eligibility across
28 Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and
29 coordination of patient care. Policy H-165.855 also supports allowing for the presumptive
30 assessment of eligibility and retroactive coverage to the time at which an eligible person seeks
31 medical care. AMA policy also supports investments in outreach and enrollment assistance
32 activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). The role of community
33 health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines
34 for patient navigator programs. Policy D-290.979 directs the AMA to work with state and specialty
35 medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974
36 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of
37 pregnancy. Policy H-290.958 supports increases in FMAP or other funding during significant
38 economic downturns to allow state Medicaid programs to continue serving Medicaid patients and
39 cover rising enrollment.

40

41 Policy H-290.955 encourages states to facilitate transitions, including automatic transitions, from
42 health insurance coverage for which an individual is no longer eligible to alternate health insurance
43 coverage for which the individual is eligible; supports coordination between state agencies
44 overseeing Medicaid, ACA marketplaces, and workforce agencies to help facilitate health
45 insurance coverage transitions and maximize coverage; and supports federal and state monitoring
46 of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and
47 uninsured rates. Policy H-165.839 advocates that health insurance exchanges address patient
48 churning between health plans by developing systems that allow for real-time patient eligibility
49 information. Support for fixing the ACA’s “family glitch” is addressed by Policy H-165.828,
50 which also supports efforts to ensure clear and meaningful differences between plans offered on

1 health insurance exchanges. Policy H-165.824 supports increasing the generosity of premium tax
 2 credits as well as eliminating ACA’s subsidy “cliff.” Under Policy H-285.952, patients in an active
 3 course of treatment who switch to a new health plan should be able to receive continued
 4 transitional care from their treating out-of-network physicians and hospitals at in-network cost-
 5 sharing levels.

6
 7 Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health
 8 insurance coverage that meets certain standards related to cost of coverage, individual consent,
 9 opportunity to opt-out after being auto-enrolled, and targeted outreach and streamlined enrollment.
 10 Under this policy, individuals should only be auto-enrolled in health insurance coverage if they are
 11 eligible for coverage options that would be of no cost to them after the application of any subsidies.
 12 Candidates for auto-enrollment would therefore include individuals eligible for Medicaid/CHIP or
 13 zero-premium marketplace coverage. Policy H-165.823 also outlines standards that any public
 14 option to expand health insurance coverage, as well any approach to cover individuals in the
 15 coverage gap, must meet.

16
 17 Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach
 18 efforts to increase public awareness of advance premium tax credits and encourages state
 19 innovation, including considering state-level individual mandates, auto-enrollment and/or
 20 reinsurance, to maximize the number of individuals covered and stabilize health insurance
 21 premiums without undercutting any existing patient protections. Policy H-165.824 further supports:
 22 (a) eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond
 23 400 percent of the FPL; (b) increasing the generosity of premium tax credits; (c) expanding
 24 eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

25
 26 Policy H-165.822 encourages new and continued partnerships to address non-medical, yet critical
 27 health needs and the underlying social determinants of health and supports continued efforts by
 28 public and private health plans to address social determinants of health. Policy H-180.944 states
 29 that health equity, defined as optimal health for all, is a goal toward which our AMA will work by
 30 advocating for health care access, research and data collection; promoting equity in care; increasing
 31 health workforce diversity; influencing determinants of health; and voicing and modeling
 32 commitment to health equity.

33
 34 **DISCUSSION**

35
 36 The Medicaid unwinding has been described as the most significant nationwide coverage transition
 37 since the ACA, with major implications for patients, physicians, and health equity. As noted by the
 38 Council in Report 3-A-22, eligibility redeterminations and resulting coverage losses may have a
 39 disproportionate impact on individuals of color and those with disabilities, and it is critical that
 40 states consider how best to avoid exacerbating existing health care inequities. Even if states adopt
 41 many of the strategies outlined in Council Report 3-A-22 to help prevent coverage losses (e.g.,
 42 streamlining redeterminations, adopting continuous eligibility policies, encouraging auto-
 43 enrollment, and facilitating coverage transitions, etc.), the unwinding will be painful for many
 44 people who have relied on Medicaid/CHIP for their health coverage and may decrease patient
 45 volume and revenue for physicians, clinics, and hospitals who regularly provide care to large
 46 populations of Medicaid and CHIP patients.

47
 48 At the time this report was written, the Medicaid unwinding was in its early stages; many states had
 49 been conducting renewals for only a few months; and information on transitions from
 50 Medicaid/CHIP to other coverage was limited. While state renewal approaches vary and may
 51 evolve over time, early data suggesting high rates of procedural terminations in some states are

1 concerning since an unknown—but potentially substantial—number of individuals (including
2 children) still eligible for Medicaid/CHIP coverage may have been improperly disenrolled. The
3 Council will continue to monitor unwinding data as it becomes available and recommend new
4 AMA policy and physician resources as needed. At this time, the Council has identified three
5 priority areas for new AMA policy development and advocacy: encouraging states to reduce
6 inappropriate terminations from Medicaid/CHIP for procedural reasons; expand continuity of care
7 protections for disenrolled individuals; and enable provider access to Medicaid/CHIP coverage and
8 renewal information.

9
10 As the PHE continuous enrollment unwinds over the coming months, disenrollments from
11 Medicaid/CHIP will continue, some based on eligibility and others for procedural reasons, and
12 physicians and hospitals may encounter more patients who do not realize that they have lost
13 Medicaid/CHIP coverage and are therefore uninsured. It is widely understood that even brief gaps
14 in coverage can be costly in terms of interrupting continuity of care and necessary treatments,
15 especially for patients with acute or chronic health conditions. To address concerns regarding
16 procedural terminations of coverage for individuals still eligible for Medicaid, the Council
17 recommends amending Policy H-290.955 to encourage state Medicaid agencies to implement
18 strategies to reduce inappropriate procedural terminations, including automating renewal processes
19 and following up with enrollees who have not responded to a renewal request before terminating
20 coverage.

21
22 While many states require insurers to cover services for patients in an active course of treatment at
23 in-network cost-sharing if their provider is terminated from an insurer network, fewer states require
24 similar continuity of care protections for people switching health plans. Because Medicaid patients
25 have higher rates of chronic disease and complex health conditions, the Council recommends
26 encouraging states to provide continuity of care protections for Medicaid/CHIP enrollees
27 transitioning to new health coverage and to recognize prior authorizations completed by the prior
28 Medicaid/CHIP plan. The Council also recommends encouraging states to make Medicaid
29 coverage status, including expiration of current coverage and information on pending renewals,
30 accessible to physicians, clinics, and hospitals through the state Medicaid agency’s portal or by
31 other readily accessible means, so that providers can inform patients of upcoming renewals when
32 they come in for appointments.

33
34 The Council further recommends reaffirmation of two AMA policies: 1) Policy H-165.855, which
35 calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange
36 plans and supports allowing for presumptive eligibility and retroactive coverage to the time at
37 which an eligible person seeks care; and 2) Policy H-165.823, which encourages states to pursue
38 auto-enrollment in health insurance coverage as a means of expanding coverage among individuals
39 who may not know that they are eligible for a state’s Medicaid or marketplace coverage or what
40 steps to take to enroll.

41 42 RECOMMENDATIONS

43
44 The Council on Medical Service recommends that the following be adopted and the remainder of
45 the report be filed:

- 46
47 1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to
48 read:
49 4. Our AMA encourages state Medicaid agencies to implement strategies to reduce
50 inappropriate terminations from Medicaid/CHIP for procedural reasons, including

- 1 automating renewal processes and following up with enrollees who have not responded to
2 a renewal request, using multiple modalities, before terminating coverage.
3 5. Our AMA encourages states to provide continuity of care protections to patients
4 transitioning from Medicaid or CHIP to a new health plan that does not include their
5 treating physicians and other providers in network, and to recognize prior authorizations
6 completed under the prior Medicaid/CHIP plan.
7 6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status,
8 including expiration of current coverage and information on pending renewals, accessible
9 to physicians, clinics, and hospitals through the state’s portal or by other readily accessible
10 means.
11 7. Our AMA supports additional strategies that respond to improper Medicaid
12 disenrollments, such as requiring states to reinstate Medicaid coverage for individuals
13 improperly terminated and encouraging states to pause disenrollments until the cause of the
14 improper terminations has been mitigated.
15 8. Our AMA supports the establishment of special enrollment periods that allow those
16 disenrolled from Medicaid to enroll in Affordable Care Act marketplace plans outside of
17 annual open enrollment dates, and increased funding for health insurance navigators, when
18 significant Medicaid/CHIP disenrollments occur.
19 9. Our AMA supports strategies to prevent states from improperly disenrolling physicians
20 from Medicaid/CHIP. (Modify HOD Policy)
21
22 2. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month
23 continuous eligibility across Medicaid, Children’s Health Insurance Program, and
24 exchange plans and supports allowing for the presumptive assessment of eligibility and
25 retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm
26 HOD Policy)
27
28 3. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal
29 government pursuing auto-enrollment in health insurance coverage that meets certain
30 standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD
31 Policy)

Fiscal Note: Less than \$500.

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APPENDIX

Policies Recommended for Amendment and Reaffirmation

Preventing Coverage Losses After the Public Health Emergency Ends H-290.955

1. AMA encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations. b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned. d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible. h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.

2. Our AMA supports coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.

3. Our AMA supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (CMS Rep. 3, A-22)

Medical Care for Patients with Low Incomes H-165.855

It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled

populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12; Reaffirmed in lieu of Res. 101, A-13; Reaffirmed: CMS Rep. 02, A-16; Reaffirmation: A-18; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Reaffirmed: CMS Rep. 3, A-22)

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
 - a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
 - b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
 - c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - e. The public option is financially self-sustaining and has uniform solvency requirements.
 - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
 - g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
 - h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the

availability of premium tax credits and cost-sharing reductions and establishing a special enrollment period.

4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (CMS Rep. 1, I-20Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22)