REPORT 03 OF THE COUNCIL ON MEDICAL SERVICE (A-22)
Preventing Coverage Losses After the Public Health Emergency Ends
(Reference Committee A)

EXECUTIVE SUMMARY

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition for receiving a temporary increase in federal matching funds. Partially as a result, Medicaid/CHIP enrollment has increased by more than 14 million individuals, or 20 percent. Once the PHE ends, states must begin redetermining eligibility for all Medicaid/CHIP enrollees, a massive undertaking that will be operationally challenging for states and may put some Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. Because the mass redeterminations will significantly impact people of color, who make up more than half of Medicaid enrollees, it will be critical for policymakers to address health equity implications of the unwinding and how to prevent exacerbation of existing health care inequities. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy that will help ensure that, as the PHE unwinds, individuals who remain eligible for Medicaid/CHIP retain their coverage and those no longer eligible successfully transition to alternate coverage for which they are eligible, such as subsidized coverage through the Affordable Care Act (ACA) marketplace or employer-sponsored insurance.

At the time this report was written, the PHE remained in effect and states were at various stages of planning for the unwinding. The Council recognizes that the potential for coverage losses and the ability to transition individuals disenrolled from Medicaid/CHIP to other coverage will be highly dependent on how each state performs during the post-PHE period. This report describes the following strategies that are key to state efforts to prevent coverage losses:

- Streamlining enrollment/redetermination/renewal process;
- Investing in outreach and enrollment assistance;
- Adopting continuous eligibility;
- Encouraging auto-enrollment;
- Facilitating coverage transitions, including automatic transitions, to alternate coverage; and
- Monitoring and oversight.

Consistent with these strategies, the Council recommends new AMA policy encouraging states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate coverage for which the individual is eligible, and that auto-transitions meet certain standards. Additionally, the Council recommends supporting coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies that will help facilitate coverage transitions, and monitoring certain enrollment indicators as the PHE unwinds. Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982); adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855); and auto-enrollment in health insurance coverage (Policy H-165.823).

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 03-A-22

Subject: Preventing Coverage Losses After the Public Health Emergency Ends

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to nearly all Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition of receiving a temporary increase in federal matching funds. With disenrollments effectively frozen, churn in and out of the program has temporarily ceased and enrollees have experienced two years of coverage stability. Once the PHE and continuous enrollment requirement expire, states will begin redetermining eligibility for all Medicaid /CHIP enrollees and, ideally, retaining eligible enrollees and transitioning those no longer eligible to other affordable coverage, such as through Affordable Care Act (ACA) marketplaces. The mass of impending eligibility redeterminations will be operationally challenging for states and may put significant numbers of Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy supportive of strategies that will help ensure continuity of coverage after the PHE ends. This report describes strategies to prevent coverage losses as the PHE unwinds, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Although Medicaid enrollment had been declining between 2017 and 2019, the arrival of COVID-19 in early 2020 led to rapid and steady enrollment increases that have continued throughout the PHE. Between February 2020 and September 2021 (the latest month for which enrollment data are available), enrollment in Medicaid/CHIP increased by 14.1 million individuals. Most of this growth was in Medicaid, which increased by nearly 13.8 million individuals or 21.6 percent. Total Medicaid/CHIP enrollment in September 2021 topped 84 million, with Medicaid enrolling more than 77 million people.[1]

Experts agree that the growth in Medicaid enrollment has been driven by two factors. First, pandemic-related job losses, especially during the pandemic's first year, made many people newly eligible for Medicaid based on income. Second, provisions in the Families First Coronavirus Response Act (FFCRA) provided a temporary 6.2 percentage point increase in federal Medicaid matching funds to states that meet certain maintenance of eligibility (MOE) requirements, including maintaining continuous coverage of most enrollees throughout the PHE. Because states have not been able to disenroll anyone enrolled in Medicaid on or after March 18, 2020, enrollment has been increasing month over month for well over two years.

At the time this report was written, the PHE had been extended through mid-July 2022. Although it is impossible to know exactly what will happen to Medicaid enrollment after the PHE expires, the number of people covered by Medicaid could decrease substantially. Prior to the pandemic, it was not uncommon for people to lose Medicaid coverage for procedural reasons (e.g., because they did

not respond to requests for information needed by the Medicaid agency to complete eligibility renewals or because they missed a paperwork submission deadline).[2] According to *Kaiser Health News*, Colorado officials anticipate that, of the 500,000 people whose eligibility will need to be reviewed post-PHE, 40 percent may lose Medicaid due to income while 30 percent will be at risk of losing coverage because of outstanding requests for information.[3]

Workforce challenges across many state Medicaid agencies, and fiscal pressures that may drive some states to complete their redeterminations in an abbreviated timeframe, add to concerns that, post-PHE, Medicaid/CHIP coverage and continuity of care could be disrupted for potentially millions of Americans. Urban Institute has projected that Medicaid enrollment could decline by 13 to 16 million people, depending on the PHE's end date.[4] Additionally, a report from the Georgetown University Health Policy Institute estimated that more than 6 million of the 39.6 million children enrolled in Medicaid/CHIP could lose coverage.[5] Urban Institute projects that one-third of adults losing Medicaid coverage post-PHE could be eligible for premium tax credits for marketplace plans (the American Rescue Plan Act's [ARPA's] enhanced tax credits and elimination of the "subsidy cliff" are currently scheduled to expire after 2022), and an additional 65 percent could have an offer of employer-sponsored coverage in their family. Additionally, Urban Institute estimates that more than half (57 percent) of children losing Medicaid coverage could qualify for CHIP coverage, while an additional 9 percent would be eligible for subsidized marketplace coverage.[6] According to these estimates, most people leaving Medicaid should be eligible for alternate coverage through the marketplace, CHIP, or an employer-sponsored plan. However, without proper notice and assistance, not all will enroll in alternate coverage.

Throughout the pandemic, the Centers for Medicare & Medicaid Services (CMS) has provided periodic guidance to states to support their planning for the eventual end of the PHE in a manner that mitigates coverage disruptions and bolsters consumer protections. CMS guidance[7] includes the following directives:

- States must initiate all Medicaid/CHIP renewals and outstanding eligibility and enrollment actions within 12 months after the month in which the PHE ends and will have two additional months (14 months total) to complete all actions.
- States can begin their unwinding periods up to two months prior to the end of the month in which the PHE ends but cannot terminate enrollees' Medicaid/CHIP coverage before the first day of the month following the end of the PHE. States that begin disenrolling before then can no longer claim the temporary Federal Medical Assistance Percentages (FMAP) increase.
- States must develop an "unwinding operational plan" and determine how they will prioritize and carry out their eligibility redeterminations.
- States should initiate no more than 1/9 of their total Medicaid/CHIP renewals in a given month during the unwinding period.
- States are required to take steps to transition enrollees who are determined ineligible for Medicaid to other insurance affordability programs, such as through ACA marketplaces. As such, states must promptly assess an individual's potential eligibility for marketplace coverage and transfer that individual's electronic account to the marketplace.
- To minimize coverage disruptions among Medicaid enrollees who became eligible for, but did not enroll in, Medicare coverage during the PHE, states are encouraged to reach out and encourage these people to enroll in Medicare.[8]

Policy changes relevant to the end of the PHE were also included in the US House of Representatives-passed Build Back Better Act, although the Senate had not acted by the time this

report was written and it is unclear whether any of the House-passed provisions will be considered in a separate bill. In addition to closing the Medicaid coverage gap—by allowing people with incomes below 138 percent of the federal poverty level to obtain zero-premium marketplace coverage through 2025—the House-passed provisions would extend premium tax credit generosity, cost-sharing assistance and elimination of the subsidy cliff provided under ARPA to the end of 2025 and require 12 months of continuous eligibility for children under Medicaid/CHIP.

HEALTH EQUITY CONCERNS

Before the pandemic, available state Medicaid data showed that more than 60 percent of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that children of color experienced coverage disruptions at higher rates[9] and enrollees of color experienced poorer outcomes and more barriers to care than whites.[10] It will be critical for state and federal policymakers to address the health equity implications of the PHE unwinding and how to prevent exacerbation of existing health care inequities.

As noted in Council on Medical Service Report 5-Nov-20, Medicaid Reform, the pandemic disproportionately impacted Black, Latino/a and Native American communities and highlighted longstanding health inequities that disproportionately affect minoritized communities. Social drivers including racism contribute to higher rates of chronic diseases, lower access to health care, and lack of or inadequate health insurance, which help propel disparate health outcomes. Black and Latino/a people also experienced the pandemic's economic impacts that contributed to higher unemployment and housing instability, especially among groups that struggle against economic marginalization.[11] Frequent changes in employment may put people at risk of losing Medicaid coverage as the PHE unwinds because income volatility can lead to procedural hurdles and multiple requests for income verification and notices from the state Medicaid agency. People who experience housing instability may also be at risk of being disenrolled by Medicaid if the state is not able to reach them because of outdated contact information.[12] Importantly, disenrollment may also have a particularly damaging impact on people with disabilities, for whom Medicaid can at times be the difference between living independently and in a facility.

STRATEGIES FOR PREVENTING COVERAGE LOSSES AFTER THE PHE ENDS

Because Medicaid is a joint federal-state program, eligibility and enrollment rules, and the processes for implementing these rules, can vary significantly by state. Accordingly, the potential for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable coverage will be highly dependent on how each state performs during the post-PHE period. The following strategies may help ensure that, after the PHE ends, people still eligible for Medicaid/CHIP are appropriately retained while those found ineligible are seamlessly transitioned to subsidized ACA marketplace plans or other affordable coverage for which they are eligible.

Streamline Enrollment/Redetermination/Renewal Processes

Since Medicaid enrollees can lose coverage because they did not receive a renewal form or return information on time, it is important that states improve redetermination processes by maximizing the use of automatic renewals based on available data sources such as Internal Revenue Service and quarterly wage data, unemployment claims, or information from the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families (TANF). The use of data sources to verify continued eligibility is known as *ex parte* renewal and it minimizes churn because it reduces administrative errors and does not require action by the enrollee. Medicaid rules generally require states to attempt to confirm eligibility *ex parte* before sending out renewal documents and

requiring enrollees to respond.[13] However, if an *ex parte* renewal cannot be completed, state Medicaid agencies must contact enrollees directly to request information needed to verify eligibility. Completing renewals by traditional means (e.g., forms transmitted through the mail) can be problematic when enrollees are not aware of the steps they need to take to retain coverage or if they have moved or have outdated contact information on file with the state.

Notably, state implementation of Medicaid rules intended to streamline renewal processes vary significantly across states, as does the percentage of completed *ex parte* renewals, with some states completing under a quarter of renewals *ex parte* and others renewing 75-90 percent using existing data sources.[14] While states will always have enrollees with complex situations or who otherwise must be renewed using traditional formats—either online, in-person or by phone—states should be encouraged to streamline renewals and improve *ex parte* renewal rates.

Invest in Outreach and Enrollment Assistance

Effective communications between states and Medicaid/CHIP enrollees, physicians and other providers, health plans, and community organizations will be important to ensuring that everyone is aware of and engaged in state preparations for the mass eligibility redeterminations. CMS has encouraged states to conduct outreach to remind enrollees to update contact information on file with the state Medicaid agency.[15] Without such information, enrollees who have moved during the pandemic may not receive renewal notices and could be disenrolled from Medicaid while still actually eligible. States that effectively communicate with Medicaid enrollees may prevent coverage losses by making people aware of upcoming redeterminations and actions they must take to retain coverage.

It will also be important for states to target specific outreach to people with disabilities or limited English proficiency and enrollees experiencing homelessness. Many states have planned outreach campaigns to encourage people to make sure their contact information in the state health care database is accurate and up to date. CMS has encouraged states to partner with health plans to update contact information and communicate with Medicaid enrollees, using multiple modalities—mail, email, and text— to reach people. Equally as important, states will need to communicate with enrollees no longer deemed eligible for Medicaid that they may be eligible for no- or low-cost marketplace plans and inform them how to enroll. Navigators embedded across community-based organizations and health plans may be utilized to help conduct outreach and empower people to enroll in marketplace plans.

Adopt Continuous Eligibility

Continuous eligibility policies, which allow enrollees in Medicaid, CHIP and marketplace plans to maintain coverage for 12 months, have long been supported by the AMA as a strategy to reduce churn that occurs when people lose coverage and then re-enroll within a short period of time. Churn-induced coverage disruptions are most pronounced in Medicaid, both because income fluctuations are common and because Medicaid enrollees can lose coverage for procedural reasons.[16]

Once the PHE and FFCRA continuous enrollment requirements expire, continuous eligibility will remain an option for states through Section 1115 waivers. While more states may be looking into this option, at the time this report was written only New York and Montana had continuous eligibility policies in place for adult enrollees. States have had the option to adopt continuous eligibility for children with Medicaid and CHIP coverage since 1997 and many—but not all—

states have done so. At the time this report was written, 27 states had implemented continuous eligibility for children enrolled in CHIP while 25 states had it for children enrolled in Medicaid.[17]

Providing continuous eligibility to individuals who remain eligible after post-PHE redeterminations would ensure continuity of Medicaid/CHIP coverage for large numbers of people. Importantly, without continuous enrollment policies in place, states will return to normal procedures that base Medicaid eligibility on a family's current monthly income. Typically, states check data sources and require enrollees to report even small income fluctuations that may put them just above the Medicaid income threshold in some months. An important example of continuous eligibility for a subsection of Medicaid enrollees is the option for states—made available under ARPA—to extend postpartum coverage to 12 months. Consistent with AMA policy, this option is intended to improve maternal health and coverage stability and to help address racial disparities in maternal health.[18]

Encourage Auto-Enrollment

Auto-enrollment in marketplace coverage, Medicaid/CHIP, and employer-sponsored coverage was addressed by the Council in Council on Medical Service Report 1-Nov-20 as a means of expanding coverage. Maryland's Easy Enrollment Health Insurance Program is an auto-enrollment initiative that facilitates health coverage through tax filing by allowing filers to share insurance status and income on tax forms and authorize the state to determine whether they are eligible for Medicaid or subsidized marketplace plans.[19] During the first year of implementation in 2020, over 60,000 Marylanders shared their information via Easy Enrollment. Most were found eligible for Medicaid or marketplace coverage and over 4,000 people were auto-enrolled in coverage.[20] Other states considering similar "easy enrollment" programs include Colorado and New Jersey.[21]

State departments of motor vehicles and unemployment insurance systems have also been identified as potential avenues for leveraging auto-enrollment in health coverage. Legislation adopted in Maryland and under consideration in New Jersey would allow individuals applying for unemployment to share information and permit the state to offer Medicaid or marketplace coverage to eligible individuals.[22] While several states have expressed interest in various approaches to auto-enrollment, income verification and citizenship attestation have been identified as barriers to implementation.[23]

Facilitate Coverage Transitions, Including Automatic Transitions

As states undertake redeterminations of all Medicaid and CHIP enrollees once the PHE expires, many people disenrolled because their incomes have risen will be eligible for subsidized coverage through state or federally facilitated marketplaces or through a Basic Health Program (BHP) in states that operate a BHP (Minnesota and New York). However, in most states transitioning people to marketplace coverage from Medicaid is not automatic and may be difficult for people to navigate. Additionally, some people disenrolled from Medicaid may not know that they are eligible for subsidized marketplace coverage or may think the plans are unaffordable.[24] Although ARPA increased subsidies for all those eligible, including newly eligible over 400 percent of the federal poverty level, these provisions will expire at the end of 2022 unless Congress extends them. If the ARPA subsidies expire, people enrolled in subsidized marketplace plans this year may be at risk of coverage lapses next year once eligibility and premiums are reset for their marketplace plans.

Before the ACA, Massachusetts implemented its own subsidized health insurance exchange (Commonwealth Care) along with a policy that automatically switched premium lapsers into a free plan, if one was available, rather than disenrolling them. Researchers found that this policy prevented coverage losses among 14 percent of enrollees eligible for zero premium plans and that

those retained were younger, healthier, and less costly to insure.[25] Another Massachusetts policy temporarily associated with its pre-ACA exchange auto-enrolled people who were found eligible for Commonwealth Care—through either an application for the exchange or a Medicaid redetermination—but who did not actively choose a plan. This policy, which applied only to people with incomes below 100 percent of the federal poverty level, was found to significantly increase enrollment.[26]

Some state Medicaid agencies already partner with their state's marketplace to identify strategies for improving transitions from Medicaid to marketplace coverage and identifying barriers to seamless transitions. Information technology (IT) challenges can present barriers to smooth coverage transitions, especially in states that have not updated and/or integrated their IT systems so they are able to share eligibility information between Medicaid/CHIP and the marketplace.[27] Those states that already have integrated IT systems in place may have an easier time auto-transitioning people from Medicaid to the marketplace, or from marketplace plans to Medicaid. However, at the time this report was written, most states had not integrated their Medicaid and marketplace eligibility systems, which could make it more difficult to switch people from one source of coverage to another. The degree to which state Medicaid and marketplace agencies work together matters greatly but varies across states and may be more challenging in states that do not run their own marketplaces.

Provide Monitoring and Oversight

It will be critical that states monitor the effectiveness of their policies and plans as the PHE unwinds so they become aware of concerning indicators signaling a need for the state to intervene or change course. In particular, states should monitor Medicaid/CHIP enrollment and disenrollment data and whether individuals are being disenrolled appropriately due to income or because of procedural or paperwork issues. States experiencing unusually high levels of churn may need to take steps to ensure that enrollees still eligible for Medicaid/CHIP are being appropriately retained. Similarly, increases in the numbers of newly uninsured individuals should suggest to states that new policy or action may be needed to address avoidable churn and/or whether new procedures are needed to facilitate transitions between coverage programs. CMS has indicated that the agency will monitor a state's progress in completing its redeterminations and that states will need to submit baseline and then monthly data during the unwinding period.[28] At a minimum, states should be encouraged to track and make available key enrollment data to ensure appropriate monitoring and oversight of Medicaid/CHIP retention and disenrollment, successful transitions to new coverage, and numbers and rates of uninsured.

EXAMPLES OF STATE PLANS FOR THE UNWINDING OF THE PHE

At the time this report was written, the PHE remained in effect and states were in various stages of planning for the unwinding. In a January 2022 survey conducted by the Kaiser Family Foundation and Georgetown University Center for Children and Families, 27 states indicated that they had developed plans for resuming redeterminations once the continuous coverage requirement is lifted.[29] This survey also found that 39 states intend to take up to a full year to process redeterminations (9 states plan to do so more quickly); 46 states are planning to update enrollee mailing addresses before the PHE expires; and 30 states are taking steps to increase agency staffing in order to process the renewals. Among states that were able to project anticipated disenrollments as the PHE unwinds, estimates varied widely across states and ranged from 8 percent to 30 percent of total enrollees potentially losing Medicaid coverage.[30]

Washington State plans to use most of the time allotted by CMS after the PHE ends to complete its redeterminations. The State of Washington Health Care Authority has been keeping up with renewals throughout the PHE (without disenrolling anyone) and, once it expires, will attempt to auto-renew enrollees using the state's Healthplanfinder system.[31] Because Healthplanfinder is an integrated system, it can help facilitate transitions of enrollees who are no longer Medicaid-eligible to marketplace plans for which they are eligible. Additionally, the State of Washington has over 900 navigators located at clinics and community support organizations around the state and over 1600 state-certified brokers available to help people stay covered.[32]

By the fall of 2021, California's Department of Health Care Services was already preparing for redeterminations of nine to ten million Medi-Cal recipients by, among other strategies, working with health navigators, advocates, managed care plans and community-based organizations to communicate the need for enrollees to update their contact information.[33] Under state legislation (S.B. 260) passed in 2019, the state's health insurance exchange—Covered California—is required to automatically enroll individuals no longer eligible for Medicaid (Medi-Cal) into the lowest cost silver plan before they are terminated.[34] As the PHE unwinds, California's Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)—an integrated system supporting eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families—will be used to auto-transition individuals no longer eligible for Medi-Cal into subsidized Covered California plans.[35]

In Ohio, the state legislature included language in its biennial budget bill that set parameters around the state's post-COVID Medicaid redeterminations. As passed by the General Assembly, H.B. 110 requires the Ohio Department of Medicaid to conduct eligibility redeterminations of all Ohio Medicaid recipients within 90 days after the PHE expires. The legislation further requires expedited eligibility reviews of enrollees identified as likely ineligible for Medicaid within 90 days and—to the extent permitted under federal law—disenroll those people who are no longer eligible.[36] Multiple media outlets have reported that $35 million was appropriated by the state to contract with an outside vendor (Boston-based Public Consulting Group) to automate its eligibility redeterminations in exchange for a share of the savings.[37,38]

RELEVANT AMA POLICY

The AMA's long-standing goals to cover the uninsured and improve health insurance affordability are reflected in a plethora of AMA policies and the AMA proposal for reform. Among the most relevant policies are those that support the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care (Policies H-165.832 and H-165.855). AMA policy also supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-290.982 calls for states to streamline enrollment in Medicaid/CHIP by, for example, developing shorter applications, coordinating Medicaid and TANF application processes, and placing eligibility workers where potential enrollees work, go to school, and receive medical care, and urges CMS to ensure that outreach efforts are culturally sensitive. This policy also urges states to undertake, and state medical associations to take part in, educational and outreach activities aimed at Medicaid and CHIP-eligible children. The role of community health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines for patient navigator programs.

Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958

supports increases in states' FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. Medicaid and incarcerated individuals addressed by Policy H-430.986. Policy H-290.961 opposes work requirements as a criterion for Medicaid eligibility.

Policy H-165.839 advocates that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt out after being auto-enrolled, and targeted outreach and streamlined enrollment. Under this policy, 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/CHIP or zero-premium marketplace coverage. Individuals eligible for zero-premium marketplace coverage would be randomly assigned among the zero-premium plans with the highest actuarial values. Policy H-165.823 also outlines standards that any public option to expand health insurance coverage, as well any approach to cover individuals in the coverage gap, must meet. Principles for the establishment and operation of state Basic Health Programs are outlined in Policy H-165.832.

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

Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

Medicaid is the largest health insurance program in the US; the leading payer of medical costs associated with births, mental health services and long-term care; and an indispensable safety net for people exposed to poverty. Throughout the PHE, Medicaid and CHIP have provided health coverage and care to more than 80 million people, including individuals affected by COVID-19 and those who experienced pandemic-related job losses. Because of the Medicaid continuous enrollment requirement and enhanced FMAP provided under the FFCRA, states have largely maintained Medicaid/CHIP coverage stability and prevented increases in uninsured rates that would otherwise be expected during a once-in-a-lifetime PHE. The loss of enhanced federal matching funds once the PHE expires will compound the many pressures already facing states and their Medicaid agencies, including budgetary concerns, the duration of time that has passed since

the state has had contact with many enrollees, and an ongoing shortage of human services workers trained to complete eligibility redeterminations.

The Council recognizes that states and state Medicaid programs have been operating under considerable financial and administrative strain during the pandemic and that state Medicaid spending may increase when the enhanced federal match dries up at the end of the quarter in which the PHE expires. Most states have experienced substantial enrollment increases over the last two years and many individuals, whose incomes have risen above Medicaid eligibility thresholds, will appropriately be disenrolled as states right-size their programs. The Council maintains that people should be properly enrolled in quality affordable coverage for which they are eligible. At the same time, the Council is concerned that the impending eligibility redeterminations will trigger excessive churn and coverage losses in some states at a time when many enrollees, and state and local governments, are still struggling with the aftereffects of COVID-19. As the PHE unwinds, physicians and other providers may see more patients who do not realize that they are uninsured because they are no longer covered by Medicaid/CHIP. Because even brief gaps in coverage can be costly in terms of interrupting continuity of care and necessary treatments, the Council hopes that states will employ strategies that help them retain Medicaid/CHIP-eligible enrollees and transition those no longer eligible into other affordable health plans.

The appended policy crosswalk outlines the strategies described in this report along with AMA policy that supports adoption of these strategies. As noted, it is anticipated that most people who lose Medicaid/CHIP coverage as the PHE unwinds will qualify for subsidized coverage through the marketplace or for employer-sponsored insurance. Although the ACA expanded the availability of coverage options, transitioning between Medicaid, marketplace and employer-sponsored coverage remains challenging to navigate. Accordingly, the Council recommends encouraging states to facilitate coverage transitions, including automatic transitions, to alternate coverage for which individuals are eligible. If adopted, this new policy would support more seamless coverage transitions among individuals found ineligible for Medicaid/CHIP into other affordable plans. Notably, the recommended policy would also support other coverage transitions, such as: newly unemployed individuals transitioning into Medicaid or marketplace coverage; young adults aging out of CHIP or family coverage securing other affordable coverage for which they may be eligible; and individuals whose marketplace coverage has lapsed because of premium increases moving into a more affordable marketplace plan or Medicaid, if they are eligible. In all circumstances, the Council emphasizes that individuals should be transitioned into the best affordable plans for which they are eligible.

The Council understands that states vary in terms of their ability to facilitate transitions from one source of coverage to another, and that few states are currently prepared to auto-transition people from Medicaid to marketplace coverage. However, we hope that states continue to pursue more seamless coverage transitions in the future. To that end, the Council believes that coordination among state agencies overseeing Medicaid, marketplace plans, and workforce/unemployment offices is integral to helping individuals maintain continuity of care across coverage programs. Accordingly, the Council recommends supporting coordination among state Medicaid, marketplace and workforce agencies that will help facilitate health coverage transitions. The Council also believes strongly that monitoring and oversight will be critical to preventing unnecessary coverage losses and recommends supporting federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.

Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982) and adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855) to

minimize churn and ensure that states are appropriately retaining Medicaid/CHIP enrollees. The Council also recommends reaffirming AMA policy that encourages states to pursue auto-enrollment in health insurance coverage (Policy H-165.823) as a means of expanding coverage.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) encourage 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. (New HOD Policy)

2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage. (New HOD Policy)

3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (New HOD Policy)

4. That our AMA reaffirm Policy H-285.952, which supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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Appendix
AMA Policy and
Strategies to Prevent Coverage Losses After the Public Health Emergency Ends

Strategy	AMA Policy
Streamline redetermination/renewal processes	Policy H-290.982 calls for states to streamline enrollment processes within Medicaid/CHIP and use simplified application forms.
Invest in outreach and enrollment assistance	Policy H-290.982 urges states to undertake educational and outreach activities and ensure that Medicaid/CHIP outreach efforts are appropriately sensitive to cultural and language diversities.
Adopt continuous eligibility	Policy H-165.855 states that in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans.
Encourage auto-enrollment	Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt-out, and targeted outreach and streamlined enrollment.
Facilitate coverage transitions, including automatic transitions to alternate coverage	No relevant AMA policy. New policy recommended (see Recommendations 4 and 5)
Provide monitoring and oversight	No relevant AMA policy. New policy recommended (see Recommendation 6)