

Preventing Coverage Losses as the PHE Unwinds

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 6.2 percentage point increase in federal matching funds. Because of this requirement, states largely maintained Medicaid/CHIP coverage stability and prevented increases in uninsured rates that would otherwise be expected during a once-in-a-lifetime PHE. Additionally, enrollment growth was significant—increasing by nearly 25 percent between February 2020 and May 2022.

Once the PHE expires, the enhanced federal match will cease and states will be charged with processing eligibility redeterminations for all Medicaid/CHIP enrollees, a massive undertaking that will be operationally challenging for states and may put large numbers of enrollees at risk of losing coverage and becoming uninsured. Although it is unclear how many individuals will be disenrolled from Medicaid during the 12-month unwinding period, coverage and continuity of care could be disrupted for potentially millions of Americans. It is anticipated that most people deemed no longer eligible for Medicaid will qualify for either subsidized ACA marketplace coverage or employer-sponsored insurance. Still, in many states, transitioning between Medicaid, marketplace, and employer-sponsored coverage can be difficult to navigate.

Strategies to prevent coverage losses

The potential for coverage losses and the ability to transition individuals disenrolled from Medicaid/CHIP into other affordable coverage is highly dependent on how each state performs during the post-PHE period. The following strategies will help states ensure that Medicaid/CHIP coverage is appropriately retained by individuals who remain eligible while those

determined ineligible are seamlessly transitioned to other affordable coverage for which they are eligible.

- Medicaid/CHIP enrollment, redetermination, and renewal **processes should be streamlined**, and states should maximize use of *ex parte* renewals that use electronic data sources to verify ongoing eligibility.
- States should **invest in outreach and enrollment assistance** and communicate effectively with Medicaid/CHIP enrollees so they are aware of upcoming redeterminations and actions they must take to retain coverage. Targeted outreach may be needed for people with disabilities or limited English proficiency and enrollees experiencing homelessness.
- States should **adopt 12-month continuous eligibility policies**, which reduce the churn that occurs when people lose coverage and then re-enroll in that coverage within a short period of time.
- **Auto-enrollment** in Medicaid, CHIP, and marketplace plans that meet certain standards should be pursued as a means of expanding health insurance coverage.
- States should **facilitate coverage transitions, including automatic transitions** that meet certain standards, from health insurance coverage for which an individual is no longer eligible to affordable health insurance coverage for which an individual is eligible.
- As the PHE unwinds, states should 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.

Health equity implications

The eligibility redeterminations carried out as the PHE unwinds will significantly impact people of color—who make up more than half of Medicaid enrollees—and people with disabilities, for whom Medicaid can at times be the difference between living independently and in a facility. Accordingly, state and federal policymakers must address the health equity implications of actions taken as the PHE expires and how to prevent exacerbation of existing health care inequities. Notably, 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. 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. People who experience housing instability may also be at risk of being disenrolled by Medicaid if the state is unable to reach them because of outdated contact information.

Where the AMA stands

To prevent coverage losses after the PHE expires, the AMA supports:

- Sustaining Medicaid's role as a safety net program.
 - Streamlining application and enrollment processes for Medicaid/CHIP programs.
 - Investing in outreach and enrollment assistance to achieve and maintain coverage gains.
 - Adopting 12-month continuous eligibility across Medicaid, CHIP, and ACA marketplace plans.
 - Supporting state and/or federal government pursuit of auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, consent, opportunity to opt out, and targeted outreach and streamlined enrollment.
- State facilitation of coverage transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which that person is eligible.
 - Coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies to help facilitate health insurance coverage transitions and maximize coverage.
 - Federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.

Automatic coverage transitions should meet the following standards:

- Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage transitions.
- Individuals should only be auto-transitioned into health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
- Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
- Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
- Existing medical home and patient-physician relationships should be preserved, whenever possible.
- 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.

For more information, see [Council on Medical Service Report 3-A-22, Preventing Coverage Losses After the Public Health Emergency Ends and 2022 and Beyond: AMA's Plan to Cover the Uninsured](#).