AMERICAN MEDICAL ASSOCIATION YOUNG PHYSICIANS SECTION

Resolution: 2
(A-25)

Introduced by: YPS Resolution Writing Committee (At large submission)

Subject: Preservation of Medicaid

Referred to: YPS Reference Committee

Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBT individuals [1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–12]; and

Whereas, The Children's Health Insurance Program (CHIP) provides essential health coverage to over 7 million children in low-income families who do not qualify for Medicaid but cannot afford private insurance, ensuring access to critical preventive care, vaccinations, and treatment for chronic conditions[13-14]; and

Whereas, CHIP has been shown to improve health outcomes, reduce disparities, and support early childhood development, while also reducing the financial burden on families and the healthcare system, including physicians[15]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[16]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[17,18]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[19]; and

Whereas, reductions to federal funding of Medicaid and CHIP or changes to Medicaid and CHIP eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, Loss of coverage for patients does not lead to a decrease in need for care or in accessing services, but does result in loss of reimbursement for care provided; and

Whereas, proposed 2025 federal cuts ($2.3 trillion) threaten per capita caps, reduced Affordable Care Act expansion funding, and lower Federal Medical Assistance Percentage rates—policies shown to force coverage reductions[18]; therefore be it

RESOLVED, our AMA will make preservation of federal funding and eligibility for all public health insurance programs, including Medicaid and CHIP, an urgent and top legislative advocacy priority, effective immediately at the conclusion of the Annual 2025 House of Delegates Meeting; and be it further

RESOLVED, our AMA strongly opposes federal and state efforts to restrict eligibility and funding for public health insurance programs, including Medicaid and CHIP.

Fiscal Note: Moderate

Received:

REFERENCES

1. October 2024 Medicaid & CHIP Enrollment Data Highlights | Medicaid. Accessed February 17, 2025. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html?utm_source
2. Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility. doi:10.26099/vad1-s645
3. Miller S, Johnson N, Wherry LR. Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*. *Q J Econ*. 2021;136(3):1783-1829. doi:10.1093/qje/qjab004
4. Chu RC, Peters C, Buchmueller T. Medicaid: The Health and Economic Benefits of Expanding Eligibility. Published online 2024.
5. Medicaid's lasting impressions: Population health and insurance at birth - ScienceDirect. Accessed February 17, 2025. https://www.sciencedirect.com/science/article/abs/pii/S0277953617300503?via%3Dihub
6. East CN, Miller S, Page M, Wherry LR. Multigenerational Impacts of Childhood Access to the Safety Net: Early Life Exposure to Medicaid and the Next Generation's Health. *Am Econ Rev*. 2023;113(1):98-135. doi:10.1257/aer.20210937
7. Goodman-Bacon A. Public Insurance and Mortality: Evidence from Medicaid Implementation. *J Polit Econ*. 2018;126(1):216-262. doi:10.1086/695528
8. Goodman-Bacon A. The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes. *Am Econ Rev*. 2021;111(8):2550-2593. doi:10.1257/aer.20171671
9. Sommers BD, Maylone B, Blendon RJ, Orav EJ, Epstein AM. Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults. *Health Aff (Millwood)*. 2017;36(6):1119-1128. doi:10.1377/hlthaff.2017.0293
10. Fact Sheet: Medicaid | AHA. February 13, 2025. Accessed February 17, 2025. https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid
11. Sep 26 P, 2023. Medicaid Enrollment and Unwinding Tracker - Overview. KFF. Accessed September 26, 2023. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/
12. optimal. Understanding the Biggest Payers in Long-Term Care. Articles | LTC Ally. December 17, 2024. Accessed February 17, 2025. https://ltcally.com/articles/understanding-the-biggest-payers-in-long-term-care/
13. Alker J. CHIP: Serving America's Children for 25 Years. Georgetown University Health Policy Institute. Published July 15, 2022. https://ccf.georgetown.edu/2022/07/15/chip-serving-americas-children-for-25-years/
14. American Academy of Pediatrics Committee on Child Health Financing. Children's Health Insurance Program (CHIP): Accomplishments, Challenges, and Policy Recommendations. Pediatrics. 2014;133(3):e784-e793. doi:10.1542/peds.2013-4081
15. McManus M, White PH, Barfield W, et al. Medicaid and the Children's Health Insurance Program. Pediatrics. 2023;152(5):e2023064088. doi:10.1542/peds.2023-064088
16. Williams E, Mudumala A, Hinton E, Published RR. Medicaid Enrollment & Spending Growth: FY 2024 & 2025. KFF. October 23, 2024. Accessed February 17, 2025. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2024-2025/
17. Sommers BD, Chen L, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Aff (Millwood)*. 2020;39(9):1522-1530. doi:10.1377/hlthaff.2020.00538
18. Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements — Results from the First Year in Arkansas. *N Engl J Med*. 2019;381(11):1073-1082. doi:10.1056/NEJMsr1901772
19. Williams E, Mudumala A, Rudowitz R, Published AB. Medicaid Financing: The Basics. KFF. January 29, 2025. Accessed February 17, 2025. https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/
18. Rudowitz R, Burns A, Hinton E, Published JT. Medicaid: What to Watch in 2025. KFF. January 23, 2025. Accessed February 17, 2025. https://www.kff.org/medicaid/issue-brief/medicaid-what-to-watch-in-2025/

19. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfcmt.zip/2023-7-3-AMA-comments-Medicaid-Access-Rule-FINAL.pdf

RELEVANT AMA POLICY

Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.
    b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

[Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH rep. 1, I-21; Appended: Res. 122, A-22]

Transforming Medicaid and Long-Term Care H-290.982

1. Our American Medical Association urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
2. Our AMA encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
3. Our AMA encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches.
4. Our AMA calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs.
5. Our AMA calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care.
6. Our AMA urges states to administer their Medicaid and SCHIP programs through a single state agency.
7. Our AMA strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs.
8. Our AMA supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers forrecipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children.
9. Our AMA advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services.
10. Our AMA calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care.

11. Our AMA supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income.
12. Our AMA supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care.
13. Our AMA supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs.
14. Our AMA supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance.
15. Our AMA supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living.
16. Our AMA supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments.
17. Our AMA urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form.
18. Our AMA urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
19. To prevent a delay in care, our AMA supports favoring the treating physician’s judgment if the reviewing physician is not available.

[BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep. 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05, Reaffirmation A-05; Reaffirmation: A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Modified: Res. 803, I-23; Appended: Res. 804, I-23]

Medicaid and Efforts to Assure it Maintains its Role as a Safety Net H-290.986

1. Our American Medical Association supports the position that the Medicaid program maintain its role as a safety net for the nation's most vulnerable populations.

[Sub. Res. 204, A-96; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21]

Enhanced CHIP Enrollment, Outreach, and Payment H-290.976

1. It is the policy of our American Medical Association that prior to or concomitant with states’ expansion of Children’s Health Insurance Programs (CHIP) to adult coverage, our AMA urges all states to maximize their efforts at outreach and enrollment of CHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, and the value of the care provided, includes inflation-based updates, and pays no less than 100 percent of RBRVS Medicare allowable.

[Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed:

CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: CMS Rep. 1, I-22; Reaffirmed: Res. 105, A-23; Modified: CMS Rep. 08, A-24]