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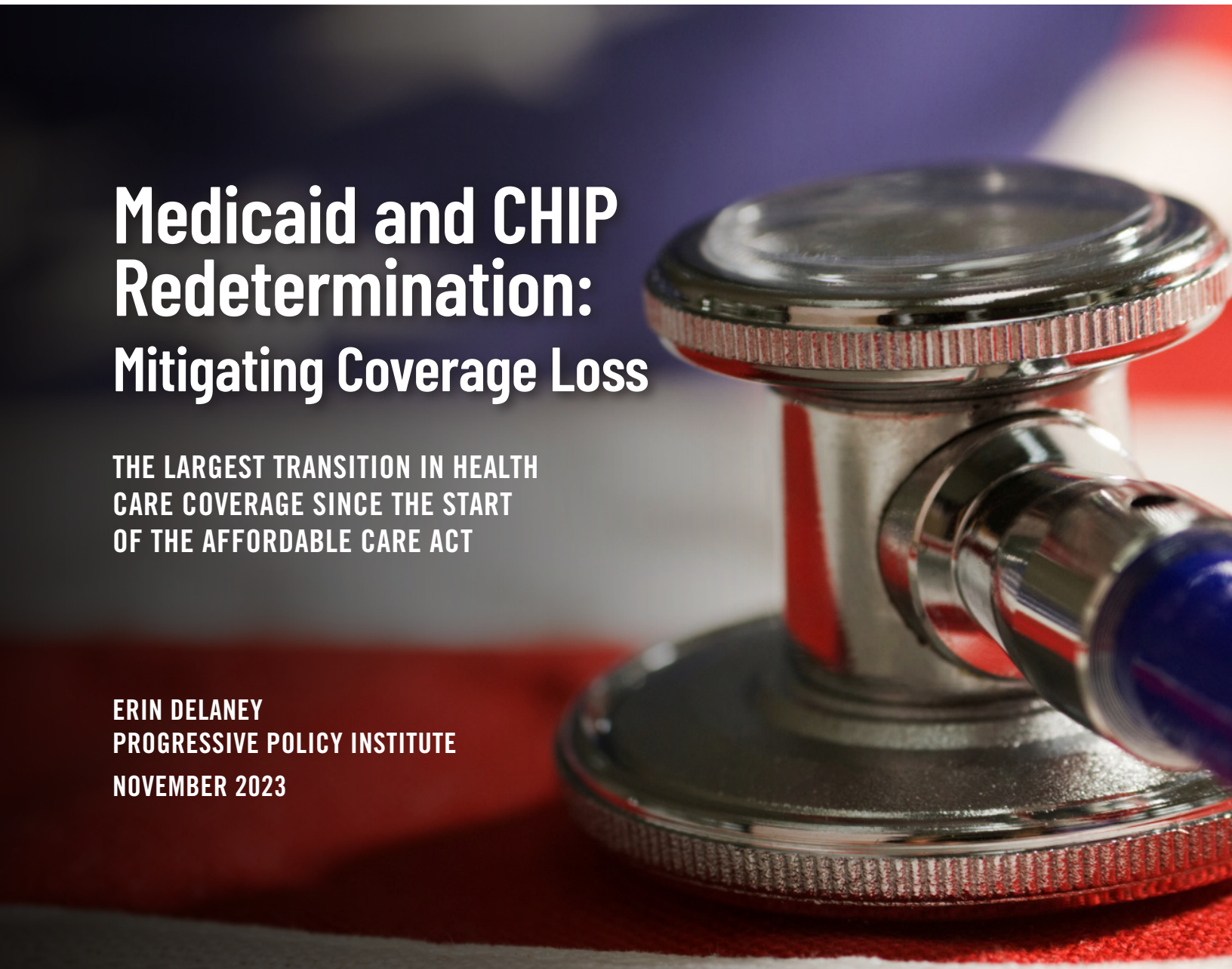

Medicaid and CHIP Redetermination:
Mitigating Coverage Loss

THE LARGEST TRANSITION IN HEALTH CARE COVERAGE SINCE THE START OF THE AFFORDABLE CARE ACT

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NOVEMBER 2023

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I. INTRODUCTION

America's health insurance system is undergoing a massive disruption in coverage, specifically for adults enrolled in Medicaid and for children enrolled in the Children's Health Insurance Program (CHIP). On April 1, 2023, four months after the COVID-19 public health emergency declaration ended, states resumed their Medicaid and CHIP redetermination process, which had been suspended during the pandemic. Troubling data is emerging from the states about what is happening to the 93 million Americans — nearly one in four — who gained Medicaid or CHIP coverage during the health care emergency.

Medicaid and CHIP enrollment grew substantially throughout the emergency due to the combination of the pandemic recession, new "continuous coverage" requirements and money from the federal government, and belated decisions in Nebraska, Montana, and Oklahoma to expand Medicaid under the Affordable Care Act (ACA). As a result, an additional 20.2 million Americans gained health care coverage.

Spiking unemployment rates caused millions of Americans to lose their employer-sponsored health insurance along with their jobs. Unemployment peaked at 14.7% in April 2020.[1] By May, an estimated 27 million workers and their dependents had lost their health plans.[2] Not surprisingly, the biggest increases in uninsured people were seen in states that had declined to expand Medicaid under the ACA.

Hit hardest by loss of coverage were mostly men, people aged 27-50, Hispanics, and low-income families.[3] In response, Congress passed the 2020 Families First Coronavirus Response Act (FFCRA), which expanded enrollment in state Medicaid and CHIP programs from 71 to 94 million.[4] In addition, more Americans purchased private health plans in the ACA's individual insurance Marketplace.[5] As a result, during the emergency the U.S. uninsured rate actually dropped to a historic low of 8.6% in 2021.[6]

Now that the continuous enrollment has ended, an estimated 17.4% of Medicaid and CHIP enrollees (15 million) are projected to lose coverage. Some experts have estimated that disenrollments could range from 8 to 24 million.[7] The Department of Health and Human Services (HHS) predicts that nearly 7 million eligible people could lose coverage for "procedural" reasons.[8] This refers to situations in which states have outdated contact information due to misunderstanding or confusion the enrollee has on the paperwork, or they did not complete the renewal packets within the deadline.

The Congressional Budget Office (CBO) estimates that 6.2 million Americans will lose coverage in the redetermination process and will fully become uninsured, and an estimated 5.3 million children are anticipated to lose their coverage as well. HHS estimates that a third of those who will be at risk for losing Medicaid coverage are Hispanic, and 15% are Black.[9] Unfortunately, the current data coming out of most states does not include a breakout of demographic groups. CBO estimates that this will swell the ranks of the uninsured by over 10% by 2033.[10]

As of November 1, 2023, at least 10,046,000 Medicaid enrollees have been disenrolled based on the data from 50 states and the District of Columbia.[11] Because there are varying lags of when states report data, this is likely an undercount of the actual number of disenrollments. There is also substantial variation in the disenrollment rates among these reporting states as each state has different approaches to managing its redetermination process. "Most concerning among recently reported redetermination data is that 71% of people have been disenrolled due to procedural glitches.[12] Examples include states that have outdated contact information, enrollees confused by the paperwork, or missing deadlines for completing renewal packets. Confusion abounds, as adults and children may or may not still be eligible for Medicaid and CHIP, may have other coverage options, or may remain eligible for Medicaid or CHIP but don't know it.

Throughout the redetermination process, people will lose Medicaid coverage because their income has increased as the economy has recovered. Disenrollment rates will vary according to differences in how the states approach redetermination. Those who are no longer eligible for Medicaid may be able to find coverage through the ACA Marketplace. They'll be eligible for premium tax credits if they don't have employer-sponsored health insurance that is considered affordable, meaning the employee share of premiums doesn't exceed 9.12% of income in 2023.[13] HHS estimates that nearly 3 million people could get ACA plans, while 5 million people who are disenrolled from Medicaid will gain coverage through their employers.[14] While it will be critically important for those who are deemed ineligible for Medicaid to gain coverage through the exchanges or their employer, copays and out-of-pocket costs may be higher than Medicaid, making those coverage alternatives less affordable for some. Additionally, a KFF analysis shows that very few adults and/or children who lose their Medicaid and CHIP coverage will seamlessly transition to the ACA's individual insurance exchanges. The most recent coverage transition data shows that roughly two-thirds (65%) of those who were disenrolled from Medicaid in 2018 had a period of uninsurance in the year following disenrollment and only 26% enrolled in another source of coverage for the full year following disenrollment.[15]

Notably, more than half of children in the U.S. receive health care coverage through CHIP or Medicaid. CHIP covers children whose family earns too high of an income to qualify for Medicaid but do not earn enough to afford private health insurance. Unfortunately, parents who are getting notified that they've lost their Medicaid coverage don't always know that their child still qualifies, resulting in further confusion on coverage options. Parents then try to enroll their children in a Marketplace plan that doesn't always have the correct benefits for children, when they should be receiving coverage through CHIP. Both Medicaid and CHIP benefits are better designed to meet the needs of children, provide more comprehensive benefits, and are more affordable than private plans.[16] There are certain limits on costs for care in CHIP and CHIP has been shown to be a more affordable option than employer-sponsored and Marketplace coverage. It's clear that moving from Medicaid and CHIP to other forms of coverage demonstrates how important it is for a strong, coordinated response from the federal and state governments to mitigate disenrollments, especially for those who are disenrolled due to procedural reasons.

This significant gain in health coverage for millions of Americans saved countless lives, reduced suffering, and highlighted the importance of sound policies to make coverage more affordable and accessible, while incorporating coverage for telehealth services and for COVID-19 testing and vaccination. This period of continuous coverage is likely the closest the U.S. has gotten to universal coverage, making a smooth transition out of the PHE and mitigating coverage losses throughout the Medicaid redetermination process that much more critical. Despite the loss of the emergency expansion of coverage and the anticipated ineligibility of those who had this access, it is crucial to ensure that those who are deemed ineligible for Medicaid and CHIP are able to find alternative coverage options.

Given the enormity of this challenge and the impact that it will have on millions of Americans, this redetermination process has been deemed the largest transition in health care coverage since the first open enrollment period of the Affordable Care Act (ACA).[17] PPI believes that both state and federal lawmakers should focus on improving data collection and state utilization of available CMS waivers and flexibilities, maximizing coordination with various stakeholders, and continued intervention in states with high procedural termination rates.

This policy brief examines what actions have been taken at the federal level to mitigate coverage loss, the trends of current redetermination data, and policy changes that states and the federal government can embrace to ensure that millions of Americans don't fully lose their access to health coverage as the country transitions out of continuous coverage.

II. THE END OF THE PUBLIC HEALTH EMERGENCY

In 2020, Congress enacted the $192 billion Families First Coronavirus Response Act (FFCRA). It offered states a temporary 6.2% increase in Medicaid funding on the condition that they maintain "maintenance of effort" requirements including keeping Medicaid and CHIP beneficiaries enrolled throughout the emergency.[18] In December 2022, Congress delinked the Medicaid continuous coverage requirement from the COVID-19 Public Health Emergency (PHE) through March 31, 2023. States began redetermining eligibility for Medicaid and the Children's Health Insurance Program (CHIP) on April 1, 2023.

During negotiations, lawmakers tried to find a way to pay for a set of pandemic health-related programs, including those that would provide Medicaid coverage for a full year for new mothers, a year of continuous coverage provisions for children, and others. The Congressional Budget Office (CBO) estimated at the time that delinking the PHE from Medicaid continuous coverage would save the federal government $22.1 billion over ten years when the PHE was initially expected to end in July 2023.[19] The substantial savings demonstrated in the CBO scoring of this provision; the pressure from state legislatures to set an end-date for COVID provisions; and the Biden administration's hope to end the emergency and pass its Build Back Better Act, were all cumulatively part of how a set of health-related policies were included in the final omnibus bill, resulting in the end of the COVID Medicaid continuous coverage.[20]

States have not immediately lost their access to the enhanced federal funding provided by the 2023 Consolidated Appropriations Act (CAA), but will be phased out from April to December 31, 2023, with pre-pandemic levels of federal funds to return at the start of 2024. This was intended to encourage states to take deliberate action for outreach to ensure enrollment among eligible individuals and mitigate administrative-related coverage loss. Washington sent extra federal funding to states during the pandemic on five conditions:

- They could not increase premiums;
- They could not restrict eligibility standards that were higher or more restrictive than those that went into effect on January 1, 2020;
- They must cover COVID testing and treatment without cost-sharing;
- They had to provide continuous eligibility through the end of the month in which the PHE ended; [21]
- States had to continue to provide coverage regardless of those aging out of an eligibility group, facing income changes, address changes, or if they failed to pay premiums.[22]

III. COVERAGE DURING THE EMERGENCY

Under the continuous enrollment provision, Medicaid and CHIP enrollment grew substantially throughout the emergency with an estimated 71.7 million people gaining coverage through Medicaid from February 2020 to the end of March 2023, when the continuous enrollment provision expired.[23] Recent data from CMS shows that more than 91.3 million individuals were enrolled in Medicaid or CHIP as of October 2022.[24] Specifically, the continuous coverage resulted in 655,000 additional children enrolled in Medicaid in 26 states.[25] Prior to the pandemic, 24 states had adopted a 12-month continuous coverage requirement for children, which is slated to begin in January 2024, and was included in the omnibus package Congress passed last year.

As a result of the FFCRA continuous enrollment provision for Medicaid and CHIP, the American Rescue Plan (ARP)'s enhanced ACA subsidies extended through 2025, as well as the state option for postpartum coverage, the national uninsured rate reached an all-time low of 8% in early 2022.[26] Notably, the changes in this uninsured rate were most significant for individuals with incomes below 100% of the FPL and incomes between 200% and 400% FPL.

IV. IMPACT OF REDETERMINATIONS

States now have 12 months to initiate renewals for 93 million Americans who are enrolled in Medicaid and CHIP and have 14

months to complete them. Typically, Medicaid redeterminations must be conducted once every 12 months or if the state Medicaid agency receives new information about an enrollee's circumstances, and gives them the chance to report those changes within 10 to 30 days.[27] Many states were able to continue their regular Medicaid redetermination process throughout the pandemic, but were not able to disenroll people who were deemed ineligible and/or who didn't respond to renewal requests. Instead, states were permitted to move enrollees from the same coverage tier to one with more robust coverage.[28] Every enrollee will be evaluated by state Medicaid agencies to determine their eligibility status because of this long delay of routine Medicaid redeterminations. States will have until June 2024 to complete the job.

State Medicaid agencies initially believed those most likely to be booted out of the program would include those who are relatively healthier and have a higher income than their lower income counterparts, and who are eligible for coverage through the exchange, Marketplace, or employer-sponsored health insurance.[29] However, health officials and analysts feared that some people who are eligible for coverage will lose it due to administrative errors, while others may not be aware that they have lost coverage until they seek care.

Furthermore, an estimated 1.9 million people in the 10 states that have not expanded Medicaid could fall into what is known as the coverage gap, meaning they aren't eligible for Medicaid or ACA subsidies in the private insurance market.[30] Meanwhile, children account for the majority of pandemic-related Medicaid enrollment in these Republican-controlled states.[31] Because these states cover fewer adults, the reduction in Medicaid and CHIP rolls will mostly affect children, new mothers, and low-income parents. The uninsured rate for children actually declined by more than 5% since 2019.[32] An estimated 5.3 million children are anticipated to lose their coverage, with nearly 3.8 million children estimated to lose coverage due to churn.[33] It's important to note that when children lose this coverage, it's not because of their ineligibility in the long term, it's because their parents might have picked up an extra shift at work, or they might have missed a phone call or piece of mail from the state Medicaid agency for re-enrollment.

Many Medicaid enrollees are also unaware and unprepared for the Medicaid redetermination process. A May 2023 survey by the Kaiser Family Foundation (KFF) found that a staggering two-thirds (65%) of all Medicaid enrollees are unsure if states are even allowed to remove people from Medicaid if they don't meet eligibility requirements, or don't complete the renewal process.[34] Worse, nearly half (about 47%) said they have not been through the renewal process before, including two-thirds of enrollees who are 65 and older.[35]

V. WHAT WE KNOW ABOUT REDETERMINATION

Current redetermination data shows that as of November 1, over 10 million people have been disenrolled from Medicaid since redeterminations began. The most concerning among recently reported redetermination data is that 71% of people have been disenrolled for procedural reason.[36]

While states are required to submit certain data to CMS, they are not required to publicly release that information. Each state has its own anticipated timeline for initiating unwinding for disenrollments and most publicly available data

from less than half of states represent a range of time from under a month to up to four months of data. This variation and inconsistent publicly reported data makes it hard to get a clear picture of who is impacted the most by terminations.

Additionally, CMS and HHS do not require states to do a breakout report for terminations for children in Medicaid/CHIP. Only 20 states voluntarily report this data, and at least 1,881,000 children have been disenrolled out of 4,841,000 total disenrollments in these states. There is a substantial range in disenrollments, with a 68% rate in Texas to 16% in Massachusetts.[37]

At the end of July, CMS released its first unwinding coverage report that only showed data for 18 states for March and April. Approximately 715,000 were disenrolled in April and only about 54,000 of them selected a Marketplace plan that month, which is less than 8%.[38] There is currently a four-month lag in data reporting from CMS, which is rather long when considering that states are required to report new data on the 8th of every month. The states with the highest rates of procedural termination at this point of the process are Nevada, New Mexico, Washington, D.C., Georgia, South Carolina, Utah, and Washington with termination rates above 90%.[39]

To put these numbers into perspective, in August 2022, the Assistant Secretary for Planning and Evaluation (ASPE) gave a range of potential trajectories of administrative churning based on 2015-2016 redetermination data. They predicted that a "high churning" scenario would result in a total of 18.4 million individuals disenrolled from the program, with monthly disenrollment of 1.5 million individuals over 12 months.[40] Based on the current redetermination data presented, we can see that the U.S. is well on its way to actualizing a high churn scenario in which most individuals predicted to lose coverage will do so because of administrative-related churn, especially for children.

VI. ACTIONS TAKEN TO MITIGATE COVERAGE LOSS

CMS is tasked with providing technical assistance and oversight with Medicaid regulations for states, while HHS is working with states to minimize administrative-related churning and to help facilitate enrollment in other sources of health coverage for those who are disenrolled. States are responsible for eligibility redeterminations, including how they invest in their staffing capacity and preparedness in the end of the PHE, which varies greatly across states.[41]

The CAA included a number of beneficiary protections that states are required to comply with in order to receive the enhanced federal funding, including: maintaining current eligibility standards through 2023, adhering to federal requirements for conducting Medicaid eligibility redeterminations, ensuring that they have current contact information for beneficiaries prior to redetermining their eligibility, and using multiple modalities for contacting beneficiaries prior to terminating their enrollment on the basis of returned email.[42] HHS has been tasked with determining if states are completing these Medicaid redeterminations in accordance with CMS requirements.[43]

Both HHS and CMS have responded to various challenges that states have faced throughout the start of the redetermination process. CMS launched a special ACA enrollment period that will run through July 31, 2024, for those who lose Medicaid and CHIP coverage during the redetermination period.[44] CMS has also announced new waivers in the last several months to mitigate coverage loss, including extending re-enrollment deadlines, partnering with

various stakeholders, including managed care plans, and expanding enrollment and ex parte renewal qualifications.[45] HHS has provided additional assistance and flexibilities to states, including engaging Medicaid managed care plans to help Medicaid enrollees with completing their renewal forms, permitting states to delay a procedural disenrollment for one month for the state to conduct additional outreach to the enrollee, and allowing pharmacies and community-based organization to help reinstate coverage to those who were disenrolled for procedural reasons.[46] This method allows states to renew their coverage using existing available data sources on an individual's eligibility rather than having them submit a renewal form.

Following data showing the high rate of procedural disenrollments, HHS Secretary Xavier Becerra asked U.S. governors last June to take action. He announced new flexibility for states to spread renewals over a 12-month period, using data from the U.S. Postal Service to update enrollee contact information. Becerra also warned that HHS would not hesitate to assert its Congressionally granted compliance authority, including requesting states to pause their procedural terminations.[47]

In response to bureaucratic confusion and violations of due process protections, CMS paused around a half-dozen states' procedural terminations and reinstated Medicaid coverage to individuals who were terminated. CMS has not named those states and says it is working with them to correct errors in their redetermination process. The most common mistake is not matching enrollees with the correct data to automatically re-enroll them.[48]

Last June, House Education and Commerce Ranking Member Frank Pallone (D-N.J.) and Senate Finance Committee Chairman Ron Wyden (D-Ore.) sent a letter to CMS questioning the high rate of procedural terminations, and especially the high rate of children losing coverage. They urged CMS to use the tools given by Congress through the CAA to "ensure states are held accountable for complying with federal law" and to step in to protect enrollees from improper termination, pointing specifically to Florida and Arkansas.

In early August, CMS sent letters to every state expressing concern about the Medicaid redetermination process, particularly for procedural disenrollment rates.[49] Calling out 28 states with especially high rates, CMS highlighted three problem areas: long call center wait times, the concerning number of procedural disenrollments, and delays in verifying applicants' incomes. CMS said it would review these areas to see if a corrective action plan from the agency to these states is warranted.

Most recently, CMS required states to report on why so many people — 500,000, mostly children — have been disenrolled from Medicaid or CHIP. It has ordered 30 states to pause disenrollment as a result of ex parte renewals.[50] These renewals allow for states to renew coverage using existing available data sources on an individual's eligibility rather than having them submit a renewal form. Following this, CMS released guidance earlier this month to states on implementing 12-month continuous eligibility for all children in Medicaid and CHIP under the age of 19 per the enactment of the CAA. States will not have to postpone implementation until state legislation is enacted and they must adopt this 12-month continuous eligibility for all children in Medicaid and/or CHIP effective January 1, 2024.[51] For children enrolled prior to January 1, the date of their most recent application will

be considered the beginning of their 12-month continuous eligibility period. This doesn't count for children who didn't have their coverage renewed in 2023 and won't benefit from this policy until their eligibility is confirmed during their renewal.[52]

VII. PPI RECOMMENDATIONS

Now that we are over seven months into the redetermination process, there is still time to address the myriad of challenges that continue to impact redetermination outcomes and to prevent a swelling of the ranks of the uninsured. The goal should be to ensure that those who are losing coverage because they are determined ineligible find new sources of coverage, and especially to ensure that those who may still be eligible for Medicaid and CHIP maintain that coverage. PPI believes that both state and federal lawmakers should focus on improving data collection and state utilization of available CMS waivers and flexibilities, maximizing coordination with various stakeholders, and continued intervention in states with high procedural termination rates. Specifically, we propose seven key policy recommendations:

HHS should take immediate action to require all states to report how many children have been disenrolled from coverage.

Approximately 7.3 million children gained Medicaid/CHIP coverage throughout the continuous coverage period and data has shown that they are at a particularly higher risk of losing that coverage. The CBO estimates that 5.3 million children could lose access to health insurance coverage throughout this redetermination process. The Consolidated Appropriations Act included a provision that permits CMS to request extra data on terminations, including for children. CMS has yet to require termination data for children from states and it should use its authority under the CAA to request this data. Not having a clear understanding of how many children are losing coverage will make any mitigation strategy to prevent children from losing coverage or to re-enroll them that much harder.

Only 15 states are voluntarily reporting this data to CMS and HHS. Confoundingly, the lack of data on children's health coverage is not even necessarily related to the unwinding period, but has been a problem for decades. Every state should be required to report this data, particularly for non-expansion states where children are expected to lose the most coverage for procedural reasons. States can and should use existing monthly reports with the data that they already have, and provide all of the renewal outcomes for how many children are there.

CMS should direct states to submit evaluations for retroactive coverage waivers.

CMS is able to grant 1115 waivers to states for federal Medicaid requirements to conduct a demonstration or project to further the goals of the program. In return, states must show how they are improving Medicaid coverage. States are required to do an evaluation every five years when they seek to re-up those waivers and provide information about what they have found to CMS. However, CMS has never enforced the retroactive coverage piece of the evaluation. As part of a long-standing feature of Medicaid, retroactive coverage covers health care expenses for three months prior to the Medicaid application date if the beneficiary would've been eligible during that period.[53]

States are not required to provide 90-day retroactive coverage and of the 14 states that provide this coverage, only two have submitted

evaluations to CMS.[54] Unfortunately, this means that CMS has been granting these waivers for Medicaid's 90-day retroactive coverage requirement for over two decades because they claim they have insufficient data. This administration alone has approved at least six retroactive coverage waivers, because they claim that there is not enough data to show that the retroactive coverage waivers were harmful.

Retroactive coverage has been important for people to receive coverage in the three months prior to submitting their Medicaid application. This coverage is critical for those who are uninsured and who apply for Medicaid typically after a major health event. They could be hospitalized or incapacitated for long periods of time and unable to go through the full application process for Medicaid. Retroactive coverage helps to cover otherwise insurmountable medical bills for both the provider and the patient. CMS directing states to submit these evaluations would help inform the agency how critically important this coverage is, likely leading to fewer waivers being approved that prohibit this coverage, especially throughout the redetermination process.

Congress should create a permanent solution to the ACA subsidy cliff that existed prior to COVID.
The Inflation Reduction Act (IRA) ensures that the American Rescue Plan Act (ARPA) subsidies continue without interruption for an additional three years, through 2025. Those subsidies helped to increase private insurance coverage by 20%. Because states must complete the redetermination process by June 30, 2024, the ACA subsidies will expire at roughly the same time millions of Americans and their children are losing coverage. Congress should consider a permanent solution to the subsidy cliff from returning and it should be better targeted than making the ARP tax credit permanent.

States should boost coordination between state Medicaid agencies, the ACA Marketplaces, and workforce agencies.
Successful transitions of those who are disenrolled from Medicaid to quality and affordable health coverage either through the ACA Marketplace or through their employer will be critical. Key stakeholders, including Medicaid providers, MCOs, and other community-based organizations to engage with providing targeted outreach to Medicaid enrollees, particularly those who have been disenrolled for procedural reasons, is especially important. States should prioritize connecting Medicaid enrollees with Navigators and assisters, who are provided through states that use the federally run exchange and are funded by the federal government to assist people with enrollment through the Marketplace and refer or assist with Medicaid enrollment. These Navigators can assist with the renewal process and help those who are deemed ineligible to find coverage on the Marketplace or through their employer. States should also establish a public-facing data dashboard and should include displaying who is the most impacted to better target who needs assistance.

States should improve and maximize the use of ex parte redetermination.
Under the ACA, states are required to complete ex parte renewals for Medicaid by verifying eligibility through existing electronic data matches with reliable sources of data prior to requiring enrollees to submit a renewal form.[55] This method allows for states to renew their coverage using existing available data sources on an individual's eligibility rather than having them submit a renewal form and greatly reduces the administrative burden on state Medicaid agencies. During the continuous

coverage period, states were encouraged but not required to continue processing ex parte renewals.[56] To date, 38 states have reported increased utilization of ex parte renewals, but unfortunately, completion rates are low: only 18 of the 43 states that process ex parte renewals successfully completed 50% or more of renewals.[57] States should maximize all available data sources as well as reassess their respective data system hierarchies and adjust those as new data sources become available to improve the process. States should prioritize increasing ex parte renewals and completing more than just 50% of renewals using this process to prioritize continuity of care for eligible enrollees, decrease state workload and backlog, and create efficient use of caseworker time.

States should create provider portals specifically for Medicaid renewal information
As providers interact with Medicaid enrollees, they should be able to ascertain quickly whether or not their patients need to renew their coverage. All states should create a specific portal for Medicaid renewal information for providers in their state for Medicaid patients. There should be a designated list for renewal, particularly to share with community health centers that traditionally treat most Medicaid patients.

States should maximize the use of their CHIP outreach dollars to ensure children have coverage.
All state CHIP programs are required to conduct outreach to families of children who are likely to be eligible for CHIP or Medicaid and offer enrollment assistance.[58] However, the 2020 CHIP Annual Financial Management Report found that less than 13 states reported their direct expenditures for outreach.[59] States should maximize the use of their CHIP outreach dollars to help children who have lost coverage regain it.

VIII. LOOKING AHEAD

Millions of Americans are losing access to health care coverage, which means they can't see doctors to get treated for chronic conditions or for preventative care. Ensuring enrollment for those who qualify for Medicaid and CHIP while easing the transition for others to employer-sponsored health insurance, the ACA Marketplace, or an alternative form of affordable coverage will be critical to the millions of Americans and their families whose coverage and access to care is now in question. We are just halfway through the redetermination process, and it's clear further steps are necessary to help Medicaid and CHIP enrollees, many of whom are undergoing renewal for the first time.

The COVID-19 pandemic required an unprecedented response from states and the federal government to address the challenges that the country faced to ensure that Americans had access to health care. This unwinding period should be treated no differently. Should the U.S. face another public health crisis that demands a proportionate response to ensure health coverage and access, it will be critical to address Medicaid and CHIP coverage in a way that prevents this type of massive and disruptive coverage transition from happening again.

ABOUT THE AUTHOR

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