Tracking Health Reform

Medicaid and the Great Unwinding: The Administrative Presidency Meets Federalism

Michael K. Gusmano
Lehigh University

Frank J. Thompson
Rutgers University

Abstract In the context of America's fragmented health insurance system, federal policy makers frequently turn to Medicaid to temporarily assist the blameless victims of societal crises. In this vein, the COVID pandemic triggered passage of major legislation that led Medicaid enrollments to soar. The end of the public health emergency presented the Biden administration and state Medicaid programs with the daunting task of implementing the "great unwinding"—redetermining eligibility for millions of enrollees. This article describes the core strategies the Biden administration employed to induce state implementing agents to minimize inappropriate Medicaid disenrollments during the unwinding. Preliminary data suggest great variation in state responses to the Biden strategic initiatives. On balance, however, the Biden administrative presidency appears to have made headway in nudging states toward more take-up–friendly renewal processes. The article also discusses the implications of the great unwinding for more general efforts to enhance Medicaid participation rates.

Keywords Medicaid, unwinding, federalism, Biden, Trump

From the early years of the United States, Congress sought to mitigate the impact of disasters by appropriating funds to assist the blameless victims of these events. In the 20th century, these disasters increasingly came to be defined not just as natural (e.g., hurricanes, earthquakes) but also as societally induced calamities such as the Great Depression of the 1930s (Dauber 2013). In the context of America's fragmented health insurance system, federal policy makers have increasingly turned to Medicaid to temporarily assist those suffering from major societal disruptions. Created in 1965, Medicaid provides matching grants to the states to subsidize health care for

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low-income individuals. With some exceptions,[1] the grant covers from 50% to roughly 75% of state spending on the program; states with lower per capita incomes receive proportionately greater federal subsidies.

Before the COVID pandemic, the 21st century witnessed two major federal initiatives to enhance Medicaid coverage during economic downturns: one in 2001 from President George W. Bush and another in 2009 under President Barack Obama (Mitchell 2020). The initiatives featured two standard federal tools to entice states to help meet the challenge of sustaining health insurance coverage during a time of rising unemployment. First, they temporarily increased the federal share of Medicaid costs (the match rate). The 2001 legislation bolstered the federal match by nearly 3 percentage points, and its 2009 counterpart did so by just over 6 percentage points. Second, both initiatives sought to ensure that states maintained their Medicaid coverage effort. Among other things, they required states not to reduce their Medicaid eligibility criteria for the duration of the enhanced match.

The federal legislative response to the COVID pandemic also drew on these two tools but went further. The Families First Coronavirus Response Act of March 2020 authorized a 6.2 percentage point increase in the federal Medicaid match rate as of January 1, 2020. To receive this enhanced subsidy, a state had to refrain from imposing more stringent eligibility criteria. In addition, and particularly importantly, the law called for the continuous enrollment of those who qualified for benefits under state eligibility criteria, thereby barring states from disenrolling most Medicaid beneficiaries. This meant that beneficiaries whose incomes subsequently exceeded the amount that originally entitled them to Medicaid would remain enrolled during the public health emergency. Hence, Medicaid enrollment gains would likely be substantially greater than those resulting from the 2001 and 2009 federal initiatives. The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) promised to fuel this growth. The ACA had given states the option to expand Medicaid coverage to nondisabled, nonelderly adults at a greatly enhanced federal match rate. By 2020, more than 30 states had done so and had seen their Medicaid enrollments swell.

Bolstered by the Coronavirus Response Act's continuous enrollment provision and the emergence of the ACA, Medicaid enrollment grew from 64 million in January 2020 to more than 85 million by the end of 2022, an increase of 33% (Corallo and Moreno 2023). This growth vastly exceeded

1. For instance, the federal government covers at least 90% of the costs for those eligible under the Affordable Care Act's Medicaid expansion. See 42 U.S.C. § 18001.

the increases during the 2001 recession (two million, or 5.6%) and the growth resulting from the stimulus legislation designed to mitigate the Great Recession of 2009 (4.3 million, nearly 10%) (Mitchell 2020: 4).

The greater magnitude of the enrollment increase in the wake of the 2020 pandemic legislation triggered another sharp difference from the 2001 and 2009 forerunners: Federal policy makers were much more concerned about what would happen to health insurance coverage once the emergency legislation ended. At that point, states would face the staggering administrative task of coping with the "great unwinding"—the need to redetermine eligibility for the massively expanded number of Medicaid enrollees. Stakeholders sounded alarm bells as to how the great unwinding might go awry. They warned that many enrollees would have incomes too high to qualify for Medicaid and would fail to transition promptly to alternative coverage on the ACA's Marketplace or from employers. They anticipated that many beneficiaries would continue to meet Medicaid eligibility criteria but would lose coverage for failure to meet burdensome administrative requirements for renewal. Projections by both government and private analysts reinforced these concerns. For instance, KFF estimated that from eight to 24 million enrollees would lose coverage when the public health emergency expired (Burns et al. 2023; see also ASPE 2022; Buettgens and Green 2022).

The great unwinding commenced on April 1, 2023, with states required to complete the redeterminations of their Medicaid enrollees within 14 months. This article explores the Biden administration's efforts to reduce the process's damaging effects on Medicaid enrollments and health insurance coverage. It also considers how the Biden administration attempted to use its response to the unwinding to address a chronic Medicaid problem: the fact that many who are eligible for benefits do not enroll in the program. What strategies did the Biden administration employ to promote Medicaid enrollment and limit coverage losses from the unwinding? What, if any, evidence exists that the administration succeeded in mitigating adverse impacts of the unwinding and laying the groundwork for higher take-up rates in the future? The answers to these questions intersect with two important features of American governance: the administrative presidency and the forces of federalism. We seek to illuminate the interplay between these two governance features during the unwinding.

The initial section of this article elaborates on the governance terrain of the unwinding. Reliance on state implementing agents poses challenges for presidential administrations trying to shape policy outcomes. In this vein, we first explore how Congress and the White House laid the legislative and executive groundwork to ameliorate these challenges. Second, we assess

the strategies the Biden administration pursued to entice states to adopt practices that would preserve health insurance for low-income people. Third, we review preliminary evidence on the enrollment outcomes of the unwinding. While far from definitive, the evidence suggests great state variation in implementing the unwinding. The next section makes the case that the Biden administrative presidency made headway in nudging states toward more take-up–friendly redetermination processes. We conclude by assessing the implications of the unwinding for more general efforts to reduce the administrative burdens and other obstacles that often depress Medicaid participation.

The Administrative Presidency and State Implementing Agents

The rise of the administrative state has afforded the executive branch vast discretion to shape federal programs. This development has in turn spawned the emergence of the "administrative" or "unilateral" presidency (Howell 2003; Howell and Moe 2023; Jacobs and Milkis 2022; Nathan 1983; Thompson, Wong, and Rabe 2020). Presidents have myriad tools (e.g., executive orders, administrative rulemaking, political appointments) to influence the direction of federal programs. Over the last half century presidents have aggressively deployed these tools to realize their policy preferences. In seeking to achieve their objectives through executive action, presidents often confront implementation challenges (Howell 2003). This is especially true when federal officials rely on states as implementing agents. In this circumstance, presidents cannot generally rely on hierarchical authority embedded in descriptions of bureaucracy and principal-agent models to get their preferences implemented. As Ingram (1977: 501) has observed about federal grants: "Instead of a federal master dangling a carrot in front of a state donkey, the more apt image reveals a rich merchant haggling on equal terms with a sly bargain-hunting consumer." In essence, federal-state relationships in the implementation process for grants reflect power symmetry between the two parties. Differences between the two levels tend to be resolved by negotiation and bargaining rather than more coercive exercises of federal authority.

Given this backdrop, the Biden administration faced formidable obstacles in shaping the great unwinding. Potential problems sprang from two primary sources: state capacity and commitment. A KFF survey of state Medicaid officials in late 2022 raised serious questions about states' administrative capacity to conduct the unwinding effectively (Brooks

et al. 2023). More than half the states reported personnel shortages among eligibility and call center staffs, respectively. And this figure did not include potential staffing deficits at the county level. In 15 states (including California and New York, with their large Medicaid populations), county governments play an important role in renewal processes. State Medicaid officials also confronted a training challenge, since many of their employees had never done a redetermination. While some states indicated they would turn to private contractors to assist with renewals, uncertainty shrouded the efficacy of this approach.

Capacity issues also emanated from the limits to state information systems. These limits increased the administrative burdens of the renewal process for both eligibility workers and beneficiaries. Advocates for Medicaid enrollees have touted the importance of "ex parte renewal," whereby states use data already in their possession to determine eligibility. This approach obviates the need for officials to track down enrollees (who have frequently moved to unknown addresses) to obtain pertinent information on income and other eligibility criteria. It reduces the administrative burdens on beneficiaries to supply such information. Instead, eligibility workers obtain the needed information from such sources as the state's wage and unemployment compensation files or records concerning the applicant's participation in the Supplemental Nutrition Assistance Program. Since 2012, federal regulations had required states to initiate the renewal process by assessing whether they had sufficient eligibility data to obviate the need to seek it from enrollees (MACPAC 2023). Ex parte renewal had not, however, been firmly institutionalized in state practices. Nearly half the states, including several populous ones, performed less than 25% of their renewals via ex parte processes (Brooks et al. 2023).

The Biden administration additionally faced the challenge of state commitment to its unwinding goal of maximizing health insurance take-up. Would state officials make take-up in their Medicaid programs a priority? Or would they be more concerned about removing those no longer eligible from the rolls? The fact that states would gradually lose the enhanced federal match for keeping people enrolled might well incline them to prune the Medicaid rolls. For instance, 25 Republican governors sent a letter to President Joe Biden in late 2022 complaining that the continuous enrollment provisions in the Coronavirus Response Act were "negatively affecting states" by "artificially growing" the Medicaid population and "costing states hundreds of millions of dollars" (Sununu et al. 2022). Questions also loomed as to how hard states would try to assist those disenrolled from Medicaid with signing up for coverage on the ACA's marketplaces.

Groundwork: Executive and Congressional Action

The Medicaid unwinding commenced in April 2023. Before then, the Biden administration had taken two notable executive steps to mitigate the unwinding's potential adverse effects. First, it rescinded a Trump administration directive that states conduct all redeterminations within six months of the end of the public health emergency. The Biden administration worried that this time frame would compel states to conduct redeterminations rapidly, thereby heightening the risks of procedural disenrollments and false negative errors (i.e., denying renewal to applicants who meet eligibility criteria). To counter this possibility, the Biden administration lengthened the period states had to do the Medicaid eligibility redeterminations to 14 months.[2] Second, the Biden administration extended the public health emergency into 2023, despite Republican pressure to end it sooner. This delay prolonged insurance coverage for millions while giving states more time to prepare for the unwinding.

In addition to these executive initiatives, Biden worked with congressional Democrats to fortify the federal government's leverage in dealing with the states through passage of the Consolidated Appropriations Act (CAA) in December 2022. CAA imposed certain process requirements on states as they handled redeterminations. For instance, it required them to ensure they had up-to-date contact information for beneficiaries by using the US Postal Service National Change of Address Database or some other valid source. It mandated that states not disenroll any beneficiary based on return-to-sender mail without first attempting to contact the individual by telephone, email, or some other means.

CAA also established transparent reporting requirements for the states to combat the information asymmetry that often bedevils efforts by political principals to hold implementing agents accountable (Moe 1985). Among other things, CAA required states to report the number of redeterminations initiated, the number of enrollees renewed (including those redetermined via ex parte processes), and the number terminated for procedural reasons (i.e., where states lacked the information to determine eligibility). States also had to report total call center volume as well as average wait times and abandonment rates. CAA additionally focused on the transition of disenrolled Medicaid beneficiaries to the ACA's insurance exchanges. In this vein, states had to report on the number of disenrolled beneficiaries deemed eligible for an exchange plan who signed up. It further required the federal

2. Several states began the renewal process just before April. The Biden administration subsequently extended the redetermination period for several states.

bureaucracy to publicly post state monthly reports. This would, in theory, enable the media and advocacy groups to monitor states and prod them toward preserving Medicaid enrollments.

In addition to establishing a transparent performance scorecard for states, CAA signaled that lapses in state performance would trigger federal intervention and possible financial penalties. The law established a detailed procedure for federal administrators to require corrective action plans from errant states. Once notified, the state had to submit the corrective plan within 14 days. If a state failed to submit an acceptable plan, the secretary of Health and Human Services (HHS) could require it to suspend all or some of its procedural terminations. CAA also authorized financial penalties to encourage state compliance. A state that did not meet its monthly reporting requirement could lose up to 1 percentage point off its federal match rate. A state that failed to submit or implement an acceptable corrective action plan could face penalties of up to $100,000 per day.

Core Unwinding Strategies of the Biden Administration

To what degree did the Biden administration use the CAA tools as well as other resources to shape state approaches to the great unwinding? To address this question fully would require detailed knowledge of the interactions (especially negotiations and bargaining) between federal Medicaid administrators and their counterparts in all 50 states. Such an approach exceeds our research capacity. Instead, we mine public records, published articles, and media reports to distill certain broad unwinding strategies the Biden administration employed.[3] These strategies centered on preserving data integrity in promulgating a performance scorecard, relying on negotiation and more informal pressures rather than CAA's punitive sanctions in dealing with errant states, and approving numerous take-up–friendly waivers.

Transparent Scorecards: Data Integrity and Mobilized Advocates

Advocacy groups and certain members of Congress urged the prompt establishment of CAA's state-specific unwinding scorecard. They wanted access to state data from the onset of the unwinding so they could identify

3. We especially draw on a proprietary news service, *InsideHealthReports*, updated daily with an array of articles describing legislative, administrative, and court actions shaping federal health policy.

problems and pressure states to avoid sharp drops in enrollments. The Biden administration sympathized with these stakeholders, but it also placed a premium on data integrity. This proved to be a source of tension between the Centers for Medicare and Medicaid Services (CMS) and these stakeholders.

From the outset, CMS emphasized that promulgating the state scorecards would take time. In March 2023, just before the unwinding, a CMS administrator warned that the agency would need to work with the states to bring them up to speed on submitting the required information. He underscored that once states submitted the required monthly reports, CMS staff would have to clean the data to assure its accuracy. Given these circumstances, he anticipated that state performance data would not be publicly available for two or three months after the unwinding began on April 1 (Mills-Gregg 2023a).

Nonetheless, pressures persisted on CMS to release state data more rapidly. In early June, two key congressional actors in the health policy arena, Representative Frank Pallone (D) and Senator Ron Wyden (D), wrote a letter to the CMS administrator and the HHS secretary claiming that "unfortunately" CMS had yet to publicly release the state data and "has not yet committed to a timeline" for doing so (Lotven 2023). Similarly, an advocacy group representative asserted that "CMS should address data quality problems by attaching warning labels, not by delaying release of state reports for months." He warned that delay means that "millions of people can lose their Medicaid, suffering irreparable harm, before the public knows what's going on" (Mills-Gregg 2023b). Despite these and other pressures, the CMS staff worked methodically to clean the data before posting it. Speaking at a conference in early June, a CMS official went out of her way to justify the agency's approach: "A state sent us renewal data. It was missing a zero, and we were able to catch that before it was posted publicly and prevent the panic" (Mills-Gregg 2023c).

In late July, nearly four months after the unwinding commenced, CMS released April data on 18 states. (Most states delayed the unwinding until later in the spring.) Of the 2.2 million redeterminations,[4] more than one million enrollees sustained their coverage, while roughly 700,000 lost it, with the remaining redeterminations in process. Fueling the concerns of advocacy groups, 80% of the disenrollments were procedural. This suggested that many enrollees had not surmounted the administrative burdens

4. This figure includes those enrolled in the Children's Health Insurance Program, which covers individuals aged 18 and younger from families with incomes too high to qualify for Medicaid.

associated with applying for renewal. While advocacy groups praised the release of the first monthly report, they also pressed the Biden administration to "address the unprecedented coverage losses" through aggressive enforcement of CAA's penalties. Instead, the HHS secretary sent a letter to the states indicating he was "deeply concerned about high rates of procedural terminations due to 'red tape' and other paperwork issues" (Mills-Gregg 2023d).

The CMS scorecard was a valuable resource for think tanks and advocacy groups throughout the unwinding. For instance, KFF used the CMS data to set up its own renewal tracking system and periodically issued reports derived from the unwinding data (e.g., Rudowitz et al. 2023). Advocacy groups also released reports. In early November 2023, 10 such groups (e.g., the NAACP, Protect Our Care, Southern Poverty Law Center Action Fund) issued an assessment based on unwinding data that called for CMS to suspend procedural disenrollments in certain states until they addressed renewal problems. Chairs of the Black, Hispanic, and Asian Pacific American caucuses in Congress endorsed the report's findings (Mills-Gregg 2023e). Another coalition of advocacy groups sought to prod states by issuing report cards on their performance. It gave 15 states a failing grade on their management of the renewal process, including several with large Medicaid populations, such as Florida, Georgia, and Texas (Mills-Gregg 2023f). A letter sent to CMS in December 2023 from the Connecting to Coverage Coalition testifies to the value that stakeholders had come to place on the unwinding scorecard in promoting Medicaid take-up (American Academy of Pediatrics et al. 2023). More than 20 coalition members representing providers (e.g., the American Medical Association), insurance companies (e.g., America's Health Insurance Plans), and others strongly urged CMS to continue the transparent scorecard after the unwinding ended in mid-2024.

The Quest for State Compliance: Keep the Hammer in the Closet

In addition to establishing a transparent scorecard, the Biden administration faced strategic questions concerning how to encourage states to adopt take-up–friendly renewal practices. In particular, it had to weigh whether to adopt CAA's hierarchical punitive approach in dealing with underperforming states. CAA had authorized the federal bureaucracy to demand corrective action plans and impose financial penalties on errant states. An advocacy group representative from UnidosUS, a Latino civil rights

organization, referred to these resources as the "hammer" in the federal implementation arsenal (Mills-Gregg 2023g).

Throughout the unwinding, various stakeholders urged CMs to employ the CAA hammer in dealing with problematic state performance. By early June 2023, it had become apparent to stakeholders that great numbers of enrollees in several states had lost Medicaid coverage primarily on procedural grounds. For instance, Arkansas officials reported that nearly 73,000 enrollees had lost coverage in one month, more than 70% of them for procedural reasons (Weiland 2023). This development prompted an array of Medicaid beneficiary advocates to urge that the Biden administration use CAA's enforcement tools to address the problem (Mills-Gregg 2023g). For instance, 26 organizations (e.g., the American Lung Association, the Epilepsy Foundation) sent a letter to top Biden administration officials urging them to impose corrective action plans and suspend procedural terminations in several states (Alpha-1 Foundation et al. 2023). By September 2023, Texas had disenrolled 69% of Medicaid beneficiaries who had experienced redetermination, more than 70% for procedural reasons, so all Democratic members of the Texas congressional delegation urged CMS to halt procedural terminations in the state until its eligibility processes had been "thoroughly investigated and corrected to comply with federal law" (Lotven and Mills-Gregg 2023). Some news media also issued calls for federal assertiveness. In late December 2023, for instance, an opinion piece on the unwinding in *The New York Times* concluded that the Biden "administration has begun to bark; now it needs to bite. At some point it must by cracking down on states that are recklessly pushing so many people off the rolls" (Covert 2023).

Resistance to Coercive Strategies

Despite these pressures, the Biden administration kept the CAA hammer in the closet as it dealt with problematic state performance. To be sure, federal officials did not rule out using CAA's penalties as a last resort. In one instance, they did apply them.[5] But in general these penalties remained in the backdrop as the Biden administration negotiated and bargained with states to address renewal problems. CMS set the tone for this approach in March 2023, before the unwinding. At this point a top CMS official cautioned: "I think it'd be easy for us to sit here from a federal standpoint and

5. CMS applied CAA's penalties to Nevada for noncompliance with unwinding data reporting requirements (GAO 2024).

say 'We are going to watch you all do it. Fail or succeed. We're going to look at some numbers and get really mad at you and send you a letter and ask for money back.'" But in his view this hierarchical, punitive approach would represent a "giant missed opportunity" for working "collaboratively" with the states to assure a successful unwinding (Mills-Gregg 2023a). Reinforcing this view, the HHS secretary stressed that "Medicaid is really a state-run program," and the "levers" the Biden administration had to compel state behavior were not that "big" (Mills-Gregg 2023h).

Rather than pursue CAA's more hierarchical approach, the Biden administration emphasized exhortation, guidance on best practices, and technical assistance in its efforts to enhance state performance. When state performance lagged, it attempted to resolve issues more informally through negotiation and bargaining with state Medicaid officials. This is not to suggest that CMS abstained from all formal efforts to remedy deficient redetermination practices. Of particular note, the Biden administration negotiated more informal mitigation plans to address unwinding problems. Unlike CAA's corrective action plans, the mitigation documents were not necessarily public. Advocacy groups complained that this lack of transparency undercut their ability to pressure states for inadequate performance. But CMS claimed it was faster and more effective to use mitigation, rather than the corrective action plans (Mills-Grigg 2023i). By mid-July, the Biden administration had negotiated mitigation plans with 34 states and the District of Columbia. These plans targeted a range of renewal practices. For instance, more than 70% of the plans cited state failures to adequately incorporate ex parte practices into their renewal processes. To counter complaints about the lack of transparency, CMS released brief summaries of each state's mitigation strategies. Moreover, nine states agreed to suspend procedural disenrollments until they addressed potential violations of renewal requirements (Mills-Gregg 2023j).

In addition to mitigation plans, the Biden administration relied on well-publicized letters to the states to promote take-up–friendly renewal processes. In early August 2023, for instance, CMS sent letters to seven states—all but one of which, Washington, had Republican governors—expressing concern that at least 40% of their disenrollments had been for procedural reasons (Mills-Gregg 2023k). A similar pattern emerged in December 2023. At that point, the HHS secretary sent letters to the governors of nine states that had either dropped the most children from Medicaid and the Children's Health Insurance Program (CHIP), or where children accounted for the highest percentage of disenrollments. All nine states with these concerning enrollment patterns—Arkansas, Florida,

Georgia, Idaho, Montana, New Hampshire, Ohio, South Dakota, and Texas—had Republican governors. The letters uniformly endorsed a panoply of measures designed to promote take-up, such as greater reliance on ex parte renewals, targeted outreach through schools and community organizations, enhancement of call center capacity, and the adoption of waiver "flexibilities" in renewal processes (discussed below). It urged Florida, Georgia, and Texas, which had not joined the ACA's Medicaid expansion, to do so. None of the letters, however, required the states to submit a mitigation or corrective action plan, or threatened to penalize them financially (HHS 2023).

Although the Biden administration generally refrained from an aggressive hierarchical approach in dealing with the states, it did move assertively to address a computer programming problem that was sapping enrollments. Many states had not programmed their ex parte renewal systems to take into account that Medicaid income eligibility thresholds for children tended to be higher than for adults in the same family. Hence, children in a family could continue to qualify for renewal while their parents did not. By ignoring this differential, ex parte systems in many states had erroneously disenrolled children when adults in the family no longer qualified for Medicaid. Recognizing this problem, CMS sent letters to the states requiring them to fix it. They agency simultaneously demanded that the states reinstate children who had been adversely affected and to suspend procedural enrollments until the problem was addressed (CMS 2023b). This led to a pause in terminations of children in 29 states.

Sources of Coercive Reticence

The Biden administration's reluctance to impose CAA penalties on errant states reaffirms what federalism scholars have already underscored: that "severe federal sanctions against noncompliant state implementers are rare" (Nugent 2009: 177). But this raises questions about the more specific forces driving the administration's preference for intergovernmental negotiation and bargaining rather than brandishing CAA's enforcement hammer. Insights gleaned from the policy implementation literature and our documents review suggest that three primary factors underpinned the Biden administration's preference for less punitive intergovernmental approaches.

First, federal officials understood that financial penalties might harm Medicaid enrollees. States possess enormous discretion to shape who gets what from Medicaid (Michener 2018). Withdrawing federal funds might

have undermined state administrative capacity and triggered actions that curtailed enrollee access to high-quality services (e.g., by reducing the number of providers willing to serve Medicaid enrollees).

Second, the application of sanctions risked eroding the ongoing working relationships between federal and state Medicaid administrators on multiple fronts. CMS depends on state Medicaid agencies to implement the program. In their efforts to reconcile their differences with state counterparts, federal administrators have strong incentives to avoid open conflict with them. They generally avoid embarrassing them publicly or undermining their status with the governors and legislatures to whom they report (Derthick 1970; Ingram 1977). Rather, they prefer the quiet politics of negotiated consent with state Medicaid professionals (Beland, Rocco, and Waddan 2016). In this context, the imposition of CAA's penalties could well interject resentment into the relationship between federal and state officials. Such resentment would have threatened to undermine the norms and networks of trust and reciprocity (i.e., social capital) that facilitate federal-state relationships. It might have impeded progress with the unwinding and spilled over to impair cooperation on other matters of Medicaid implementation at that time and in the future. The Biden administration also understood that keeping the hammer in the closet did not consign them to be shrinking violets in the bargaining process. In a process less formal and transparent than the CAA prescribed, federal officials negotiated mitigation plans with most states. These negotiations often prompted states to suspend procedural disenrollments at least temporarily and adopt more take-up–friendly processes. On a few occasions, the Biden administration did send letters to certain states that publicly chastised them for their unwinding performance; but in general, federal officials preferred to work collaboratively and out of the limelight with state officials.

Third, an aggressive deployment of CAA protocols and penalties would have risked expanding the scope of conflict in ways detrimental to the aims of federal officials. Such action would have heightened the probability that governors and legislators would become players in the implementation process. These officials might denounce the federal bureaucracy and appeal for assistance to their senators and representatives in Congress. The risk of congressional retaliation on multiple fronts would increase along with negative publicity. In essence, the unwinding might shift from a politics of negotiated consent within federalism's professional bureaucratic complex to a politics of dissent featuring elected policy makers (Beland, Rocco, and Waddan 2016). The expanded scope of conflict might also

extend to the courts. While statutory authorization for the unwinding penalties seems clear, one should not underestimate the capacity of state attorneys general to produce creative legal arguments opposing their imposition (Nollette 2015). The skill of state attorneys general in forum shopping—filing suit in a federal district court where they believe judges will be sympathetic to their arguments—boosts their prospects for success.

Given these intergovernmental dynamics, it becomes easier to understand the HHS secretary's claim that CAA's enforcement levers were not that "big." This does not mean that CAA played no role in federal negotiations with the states. State awareness of CAA's sanctions might well have increased their willingness to make unwinding concessions to CMS. Nor can we rule out the possibility that greater Biden administration willingness to deploy CAA's penalties might have sparked a more take-up–friendly unwinding. But the possibility that a more penalty-driven approach could backfire and yield less positive take-up results and other negative outcomes also deserves emphasis.

Take-Up–Friendly Flexibility Waivers

Flexibility waivers also figured prominently in the Biden administration's unwinding strategy. Waivers are congressional delegations of authority to the federal executive branch to permit selective deviations from the law. Medicaid waivers come in various guises, reflecting their authorization by different provisions of the Social Security Act. Medicaid waivers have in the past figured prominently in response to disasters. In this regard, the George W. Bush administration encouraged states to apply for waivers to cover evacuees from Hurricane Katrina. Eventually, 30 states obtained these waivers and provided temporary coverage to 100,000 people (Thompson 2012: 146).

Following in this tradition, the Biden administration aggressively deployed "flexibility" waivers to encourage take-up–friendly renewal processes. These waivers had their provenance in section 1902(e) of the Social Security Act, which authorizes time-limited waivers "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries" (Boozang et al. 2023). The Biden administration persistently implored states to apply for these waivers. When negotiating mitigation plans with underperforming states, CMS often persuaded them to deploy 1902 waivers to help remedy their renewal deficiencies. As of December 2024, the District of Columbia and all states except Florida had obtained 400 flexibility waivers (CMS 2025). The

numbers of flexibility waivers held by the 49 participating states ranged from 15 in both Indiana and Tennessee to one in South Dakota. Except for Florida, the five most populous states with large Medicaid enrollments employed waivers (California—14, Texas—4, New York—10, and Illinois—5).

Substantively, the flexibility waivers fell into several categories (Mudumala, Rudowitz, and Tolbert 2023). About half sought to galvanize greater use of ex parte renewal processes, with nearly all states having at least one such waiver. For instance, several states received permission to use less immediate income data in state files, going back as far as March 2019, in assessing the current eligibility of an enrollee. Use of such "old" data freed states from the need to collect recent income information from the applicant or some other source to determine renewal. This practice heightened the risk that the state would make false-positive eligibility errors (i.e., renewing someone with too much income to qualify), but it reduced the risk of procedural terminations.

Flexibility waivers targeted other areas as well. More than 20% focused on improving enrollee contact information. The fact that Medicaid enrollees frequently moved and that states lacked current addresses for them fueled procedural terminations. To ameliorate this problem, many states received waivers to work closely with Medicaid managed care organizations to track enrollees' locations. Other kinds of waivers sought to help individuals re-enroll if they had been denied eligibility for procedural reasons. In this vein, some states received waivers to authorize community organizations, pharmacies, and providers to declare certain individuals among the disenrolled to be presumptively qualified for Medicaid benefits. This allowed these individuals to receive Medicaid services until a state agency had determined their eligibility. Yet another type of waiver sought to assist enrollees in completing renewal forms, such as by authorizing Medicaid managed care organizations to perform this task. These organizations were paid on a capitated basis for serving Medicaid beneficiaries, so they had considerable incentive to help eligible individuals secure renewals. In these and myriad other ways, flexibility waivers sought to promote take-up–friendly renewal processes.

Preliminary Evidence on Redetermination Outcomes

A calibrated assessment of the degree to which Biden administration strategies yielded a successful unwinding lies beyond the reach of this article. Above all, such an assessment would need to track the extent to

which all enrollees in April 2023 received uninterrupted Medicaid coverage if they continued to meet the program's eligibility criteria. It would need to consider whether those who no longer qualified for Medicaid transitioned smoothly to the ACA exchanges or other sources of health insurance. We can, however, provide a preliminary perspective on the unwinding by examining two pertinent statistical patterns: those related to Medicaid enrollments and procedural terminations.

Stakeholders and think tanks repeatedly expressed concern that the unwinding would precipitate a sharp drop in Medicaid enrollments. And, in fact, the unwinding witnessed an enrollment decline of about 15%, dropping to 72.4 million as of July 2024 (CMS 2024a). A significant minority of the disenrolled may have become uninsured at least over the short run.[6] The overall decline in Medicaid enrollments masks great variation among states. As table 1 indicates, Medicaid enrollment changes from March through January 2024 ranged from an increase of 11% in North Carolina (which commenced a Medicaid expansion on December 1, 2023) to a decline of 33% in Texas. Four states experienced Medicaid enrollment gains, while 11 states and the District of Columbia had modest declines of less than 10%. Half the states saw heftier enrollment decreases of 10%–20%, while 10 states experienced dramatic declines of greater than 20%. Data in table 1 leave open the question of whether variation in state adoption of the take-up–friendly renewal practices promoted by the Biden administration help explain enrollment trends. Other potential causal factors (e.g., economic conditions, demographic changes, policy modifications) may have also contributed. But table 1 certainly suggests a continuing need to examine the potential significance of state redetermination practices in seeking to explain enrollment outcomes.

Partisan factors may also drive state variation. In an era of fractious, polarized federalism, partisan control of state government often shapes the level of state commitment to implementing federal policies. The party out of power in Washington often drags its feet at the state level in implementing federal policy (Bulman-Pozen 2014; Thompson, Wong, and Rabe 2020). Moreover, Republican policy makers have often exhibited less support for redistributive policies, evinced more concern about such policies' budget implications, and expressed distaste for "fraud, waste, and abuse" in social programs. Given its potential relevance for the unwinding, table

6. Estimates of the coverage impact vary. A KFF survey found that, as of early 2024, about 25% of those who lost coverage remained uninsured (Galewitz 2024). Another study concludes that as of late 2023, the unwinding had little impact on health insurance coverage among working-age adults (Gupta et al. 2024).

Table 1 Percentage Decline in Medicaid Enrollment by State (March 2023–January 2024)

State*	March 2023 Medicaid enrollment	January 2024 Medicaid enrollment	Percentage change
States with no decline			
North Carolina**	2,015,206	2,241,223	11%
Oregon	1,215,714	1,262,394	4%
Maine	358,879	356,554	0.6%
Hawaii	441,293	442,471	0.3%
States with a decline of less than 10%			
California	12,987,086	12,456,744	–4%
Nevada	840,149	803,677	–4%
Virginia	1,844,629	1,758,414	–5%
Connecticut	1,006,400	956,801	–5%
Maryland	1,541,682	1,453,369	–6%
Illinois	3,479,696	3,273,517	–6%
Minnesota	1,398,501	1,313,425	–6%
Rhode Island	333,040	311,100	–7%
New York	6,988,923	6,478,756	–7%
Wisconsin	1,363,102	1,249,151	–8%
District of Columbia	280,143	255,483	–9%
Kentucky	1,496,500	1,362,961	–9%
States with a decline of 10%–20%			
Alaska	254,947	228,769	–10%
Nebraska	354,594	321,065	–10%
Delaware	300,281	269,299	–10%
New Jersey	1,983,857	1,778,471	–10%
Louisiana	1,727,474	1,545,535	–11%
New Mexico	836,594	740,937	–11%
South Carolina	1,211,431	1,073,593	–11%
Indiana	1,911,455	1,690,668	–12%
Ohio	3,167,340	2,798,776	–12%
Alabama	999,839	881,409	–12%
Missouri	64,197	1,288,100	–12%
Washington	2,112,292	1,852,947	–12%
Tennessee	1,653,118	1,447,319	–12%
Vermont	189,355	165,744	–13%
Massachusetts	1,812,393	1,583,961	–13%
Pennsylvania	3,479,427	3,041,919	–13%
Arizona	2,184,898	1,908,284	–13%
Michigan	2,939,330	2,546,503	–13%
Mississippi	709,170	610,448	–14%

(*continued*)

Table 1 Percentage Decline in Medicaid Enrollment by State (March 2023–January 2024) (*continued*)

State*	March 2023 Medicaid enrollment	January 2024 Medicaid enrollment	Percentage change
Wyoming	79,699	68,129	–15%
South Dakota	127,505	107,906	–15%
Georgia	2,183,410	1,790,170	–18%
North Dakota	130,551	107,035	–18%
Kansas	442,442	361,859	–18%
Florida	4,890,203	3,946,249	–19%
States with a decline greater than 20%			
West Virginia	617,974	489,769	–21%
Oklahoma	1,183,657	932,841	–21%
Iowa	792,716	618,205	–22%
Colorado	1,603,310	1,238,439	–23%
Idaho	420,638	312,599	–26%
Arkansas	1,012,818	740,318	–27%
New Hampshire	229,437	165,122	–28%
Montana	300,888	214,906	–29%
Utah	448,327	320,006	–29%
Texas	5,612,475	3,767,028	–33%

***** Boldface represents a state where the Republican Party controlled the governor's office and both houses of the legislature.

** On December 1, 2023, North Carolina became the 40th state to adopt the ACA Medicaid expansion.

Source: CMS (n.d.).

1 displays in bold type the 22 states where Republicans control the governor's office and both houses of the legislature. Republican-dominated states tended to experience greater Medicaid enrollment declines, at a statistically significant level.[7] All of them witnessed decreases of at least 10%. Republican policy makers controlled 9 of the 10 states with the greatest decreases (20% or more).

Compared to Medicaid enrollment, data on procedural terminations provide more direct insight into the efficacy of the unwinding. These removals, which occur when eligibility workers lack the requisite information to assess whether an enrollee should be renewed, may occur for multiple reasons. For instance, beneficiaries may have moved and may not have received the

7. Statistical significance at the .05 level applies to the difference between Democratic- and Republican-controlled states. Divided-government states did not differ at statistically significant levels from either of these two partisan cohorts.

request to file a renewal application. Others who have received the notifications may fail to overcome the administrative burdens associated with reapplying. A procedural termination does not automatically mean that a qualified enrollee has been denied renewal. Some would fail to meet eligibility criteria even if they reapplied, but many would likely continue to qualify for Medicaid coverage. Procedural terminations need not be permanent; enrollees receiving notices that their Medicaid coverage has ended may successfully reapply. But such churning of the Medicaid rolls heightens transaction costs for both eligibility workers and enrollees, and it leads to discontinuities in health care. For these reasons, procedural terminations became an important indicator of state performance for the Biden administration, which constantly exhorted and otherwise pressured states to reduce their incidence.

As of March 2024, 60% of Medicaid and CHIP enrollees had been renewed during the unwinding, and 27% had lost coverage (with the other renewals in process). Of those disenrolled, 70% lost coverage for procedural reasons (KFF n.d.). As with Medicaid enrollment trends, states varied considerably in the percentage of all beneficiaries up for redetermination who were procedurally terminated. Table 2 captures this variation through March 2024. It indicates that total procedural terminations ranged from a low of 1% in Minnesota to 50% in Utah. Seven states kept procedural disenrollments below 10%, while 18 (plus the District of Columbia) had procedural termination rates of 10%–19%. The remaining 25 states had procedural termination rates greater than 20%, with 10 of them at 30% or higher. Again, a partisan pattern emerges, with Republican-controlled states (listed in bold in table 2) tending to feature higher procedural termination rates at statistically significant levels.[8] Seventeen of the 22 Republican states had procedural termination rates greater than 20%; 7 of the 10 states with the highest rates of procedural terminations (30% or greater) had Republican governors and legislatures.

The preliminary nature of the patterns embedded in table 2 deserves emphasis. The table focuses on the first nine months of the unwinding, and different findings could emerge when the process finally ends. So, too, our observations about the link between partisan control and procedural terminations might no longer hold true if subjected to statistical analysis with controls for other potentially significant causal variables.

8. Statistical significance at the .01 level applies to the difference between Republican- and Democratic-controlled states. Divided-government states also differed from each of these two partisan cohorts at this statistical level.

Table 2 Percentage of Enrollees Terminated for Procedural Reasons by State, Cumulative Through March 2024

State*	Percentage terminated for procedural reasons
Less than 10%	
Maine	1%
Oregon	5%
Virginia	6%
Illinois	8%
Delaware	9%
Kentucky	9%
North Carolina	9%
10%–19%	
Wyoming	10%
Nebraska	12%
Pennsylvania	12%
California	13%
Connecticut	13%
New York	13%
Arizona	14%
Kansas	15%
Michigan	15%
Mississippi	15%
New Jersey	15%
Vermont	15%
Alaska	16%
Maryland	16%
Hawaii	17%
Ohio	17%
District of Columbia	18%
Missouri	18%
Iowa	19%
20%–29%	
Indiana	20%
Minnesota	21%
Rhode Island	21%
New Mexico	22%
South Carolina	23%
Wisconsin	23%
Florida	24%
South Dakota	24%
Washington	24%
Louisiana	25%
New Hampshire	27%

Table 2 (*continued*)

State*	Percentage terminated for procedural reasons
Tennessee	27%
Alabama	28%
Arkansas	29%
Montana	29%
30% and above	
Massachusetts	30%
West Virginia	30%
Colorado	31%
North Dakota	31%
Texas	31%
Nevada	34%
Georgia	35%
Idaho	39%
Oklahoma	43%
Utah	50%

* Boldface represents a state where the Republican Party controlled the governor's office and both houses of the legislature.

Source: KFF (n.d.).

Unwinding and the Administrative Presidency

The preliminary findings of the previous section leave open this question: To what degree did the Biden administration's executive actions galvanize more positive unwinding outcomes than would have otherwise occurred? In the absence of a counterfactual, we cannot definitively provide an answer. Clearly, the Biden initiatives were no elixir. During the unwinding, states disenrolled 25 million Medicaid and CHIP beneficiaries, nearly 70% of them for procedural reasons (Tolbert and Corallo 2024). Nor was the Biden administration able to eradicate the great variation among states in their propensity to establish take-up–friendly redetermination processes. In an era of polarized, partisan federalism, the Biden administration could typically count on Democratic-dominated states to be committed to its renewal objectives and receptive to its initiatives. In contrast, the task of persuading many Republican-controlled states to implement take-up–friendly renewal practices was more challenging. At least initially, these states tended to exhibit greater rates of Medicaid enrollment declines and procedural terminations. The substantial state variation reinforces a well-established finding about Medicaid: Where beneficiaries live markedly shapes their respective experiences with the program (Michener 2018).

Despite these limitations, a credible case exists that the Biden administration's unwinding strategies nudged many states toward better renewal performance. Its strategies were almost certainly more take-up–friendly than the Trump administration's policies would have been, had Trump remained in office. Trump administration efforts to sabotage the ACA and undercut Medicaid through executive action have been well documented (e.g., Noll 2022; Thompson, Wong, and Rabe 2020). Trump's proposal to cram the unwinding into a six-month period—which Biden reversed—would likely have fueled more procedural terminations and false-negative eligibility errors as states rushed to comply.

KFF reports indicate that state renewal practices became more take-up–friendly as the unwinding unfolded (Brooks et al. 2024; Corallo and Tolbert 2024). State progress in conducting ex parte renewals stands out in this regard. Among enrollees retaining coverage, the share renewed through ex parte processes increased from 51% at the outset to 70% 10 months later. All states took at least one step to boost ex parte rates. Although procedural terminations remained stubbornly high, the percentage of all redetermination decisions leading to procedural denials trended downward during the first nine months of the unwinding, from 26% in April and 29% in May to 13% in December (CMS 2024b). During the first 10 months of the unwinding, the proportion of those disenrolled for procedural reasons decreased from 74% to 67% (Corallo and Tolbert 2024).

In addition to promoting ex parte renewal, the Biden administration's flexibility waivers permitted states to adopt an array of innovative renewal practices. Along the same lines, the Biden administration's persistent communications with lagging states and insistence that many of them adopt remedial action plans probably increased take-up. More than two thirds of the mitigation plans called for states to advance their use of ex parte renewals. CMS's insistence on regularly promulgating a transparent scorecard targeting renewal practices and outcomes may also have improved state unwinding performance. This exercise in performance measurement and management helped galvanize advocacy groups and may well have caused many state officials to prioritize efforts to enhance renewal processes. The scorecards may have facilitated policy and administrative learning concerning more effective renewal practice. In general, the case of the unwinding suggests that, despite federalism's implementation challenges, an administrative presidency can make headway in shaping the performance of state implementing agents.

Unwinding and the Future of Medicaid Participation

The case of the great unwinding also intersects with broader issues of take-up rates, that is, the percentage of those eligible for program benefits who become enrolled. Researchers have long noted that many who meet the eligibility criteria for Medicaid and CHIP fail to participate in the program (e.g., Decker, Abdus, and Lipton 2022; Sommers et al. 2012). Various administrative burdens imposed on potential enrollees help account for this pattern (Herd and Moynihan 2018). These burdens generally tend to be greater in means-tested programs like Medicaid. The reliance on states as implementing agents further complicates the challenges of ameliorating them.

Recent decades have witnessed reductions in these administrative burdens (Fox et al. 2020; Rauscher and Burns 2023). The Biden administration's unwinding efforts and related policy developments reinforced this trend. Under CMS pressure, state capacity to perform ex parte renewals increased during the unwinding (CMS 2024b). Information system challenges associated with implementing this initiative persist,[9] but most states seem likely to surmount these technical obstacles over time (MACPAC 2023). Flexibility waivers also fostered innovative take-up strategies. As the unwinding moved forward, CMS indicated that it was assessing which flexibilities could be made permanent through formal rulemaking and other executive actions (CMS 2024b). In May 2024, CMS extended the life of the flexibility waivers through June 2025. Meanwhile, Congress intervened legislatively to reduce administrative burdens on children. CAA required states to provide 1-year coverage of children enrolled in Medicaid or CHIP starting in 2024. The Biden administration also reminded states that they could extend coverage for children beyond a year through a demonstration waiver. It issued a new administrative rule in April 2024 aimed at further streamlining Medicaid and CHIP application and renewal processes (HHS 2024). CMS additionally required states to continue to report renewal data that had initially been mandated for the unwinding's transparent scorecards (Lotven 2024).

Promising as these developments appear, the return of a Trump presidency in 2025 seems likely to reverse take-up progress. Above all, the Republican commitment to work requirements for certain adult Medicaid enrollees looms large. Survey research indicates substantial public support for such requirements, especially among Republicans (Haeder and

9. In many states, Deloitte Consulting has come under criticism for failure to install effective ex parte renewal systems (Mills-Gregg 2024b; Rosenbaum 2024).

Moynihan 2023; Haeder, Sylvester, and Callaghan 2021). During its first term, the Trump administration endorsed work requirement waivers, and more than half the states controlled by Republicans applied for waivers to impose them. Subsequently, private litigants succeeded in persuading federal district and appellate courts to void these waivers. The Trump administration responded by appealing these rulings to the Supreme Court. However, Biden withdrew the appeal before the high court could hear the case. It remains an open question whether the Supreme Court would approve work requirements if the case again came before it. Studies suggest that only a small percentage of otherwise eligible individuals fail to meet work or community engagement requirements. Instead, substantial disenrollment occurs because beneficiaries do not overcome the burdens associated with reporting work and related activities to eligibility workers.[10]

The return of Trump may also usher in state waivers and other initiatives that foster a market-oriented approach to Medicaid and CHIP. This approach aims to make Medicaid more like private health insurance, where enrollees "have skin in the game" and demonstrate "personal responsibility" in their health care decisions. Among other things, this approach typically imposes premiums and cost sharing on Medicaid enrollees—measures that significantly undercut take-up rates (e.g., Sommers et al. 2012). State commitment to the market-based approach may also spring from budget concerns. For instance, Florida officials voiced these concerns when it sued the federal government over its congressionally mandated 1-year continuous eligibility requirement for CHIP enrollees, on grounds that it would prevent the state from disenrolling kids whose families failed to pay a monthly premium. While the case was pending, Florida disenrolled 22,000 children for failure to remit premiums (Mills-Gregg 2024a).

Conclusion

In the federal response to domestic crises, Medicaid has become the go-to program in the US health insurance regime. The COVID epidemic ignited policy maker concerns about a lethal threat to the populace of unknown proportions and, more conventionally, about prospects for a severe economic downturn. In early 2020, federal policy makers approved the Families First Coronavirus Response Act to ameliorate the crisis. This legislation

10. In their study of Arkansas, Sommers and colleagues (2020) estimated that only 5% of enrollees did not meet the work or community engagement requirements. Soni and colleagues (2020) used a more general survey to come up with a higher proportion: 22%.

promoted the most ambitious use of Medicaid to alleviate a major societal disruption in the program's history. While Medicaid enrollments soared, policy makers also realized that the end of the public health emergency could trigger an unwinding that would greatly increase the ranks of the uninsured.

The election of Joe Biden and a Democratic-controlled Congress in 2020 meant that managing the unwinding to preserve health insurance coverage became a federal priority. With legislative support from Congress, the Biden administration strove to assure an enrollee-friendly unwinding over the short term and to institutionalize practices that would enhance future Medicaid participation rates. At its core, the unwinding became an important test for the Biden administrative presidency as it dealt with the forces of federalism. Would state implementing agents have the capacity, commitment, and skills to achieve federal policy goals? Enticing states to implement federal take-up goals posed formidable challenges. In confronting these challenges, the Biden administration made headway in nudging many states to pursue more take-up–friendly redetermination practices. But there were also strict limits on its accomplishments. The Biden administration was not able to surmount partisan opposition and other forces that precipitated great variation in state performance. Some 25 million enrollees at least temporarily lost Medicaid coverage, mainly for procedural reasons. Nor could it assure that the emergence of a Republican administrative presidency would not undo its efforts to enhance Medicaid participation rates.

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Michael K. Gusmano is the Iacocca endowed chair; professor and associate dean for academic programs with the College of Health; codirector of the Health, Medicine, and Society Program; and director of the Center for Ethics, all at Lehigh University. His research investigates the consequences of health and social policy for poor and other vulnerable populations.
mig321@lehigh.edu

Frank J. Thompson is the Distinguished Professor of Public Affairs and Administration Emeritus at Rutgers-Newark and the Rutgers Center for State Health Policy in New Brunswick, New Jersey. He publishes on issues of health policy and implementation with a particular focus on health policy and federalism. His more recent publications have focused on how the Obama, Trump, and Biden administrations have sought to shape the Affordable Care Act.

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