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What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?

Updated Projections of Medicaid Coverage and Costs

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Introduction

Medicaid enrollment has risen to unprecedented levels since the start of the COVID-19 pandemic. The most recent data at the time of this writing show enrollment jumped by nearly 13 million people from February 2020 to July 2021.¹ In an earlier analysis (Buettgens and Green 2021), we showed that most of this new Medicaid enrollment was from the continuous coverage requirement of the Families First Coronavirus Response Act, which prohibits state Medicaid agencies from disenrolling beneficiaries during the public health emergency (PHE). Determining what will happen to the health coverage of these millions of new enrollees and how to avoid a large increase in the number of people uninsured after the PHE ends are urgent issues for policymakers this year.

Many of the people who disenroll from Medicaid at the end of the PHE are estimated to be eligible for Marketplace subsidies, but not all of them will enroll. The enhanced premium tax credits (PTCs) enacted by the American Rescue Plan and currently in place through 2022 increase the likelihood of take-up of Marketplace coverage by those leaving Medicaid. Under current law, however, these enhanced PTCs will expire unless Congress acts this year to extend them into or beyond 2023. Fewer people leaving Medicaid will enroll in Marketplace coverage if the enhanced PTCs expire.

The legislation that enacted the continuous coverage requirement also increased the share of Medicaid costs paid for by the federal government, rather than the state. This enhanced federal medical assistance percentage (FMAP) will expire in the quarter following the end of the PHE, creating financial pressure for states to redetermine eligibility for current enrollees soon after the PHE ends. Current guidance from the US Department of Health and Human Services (HHS) gives states up to 14 months after the PHE to return to normal eligibility processing to spread the administrative burden of

processing redeterminations for large numbers of enrollees over time, but states may choose to process them more quickly.²

On January 14, 2022, the HHS secretary extended the PHE for 90 more days.³ The PHE will likely be extended through the second quarter of 2022, though this has not been officially confirmed at the time of this writing. The future of the pandemic is still uncertain, so even further extension is possible. In this brief, we update our earlier estimates of Medicaid enrollment and costs, which assumed the PHE would not be extended into 2022, consistent with HHS guidance at the time.⁴ We also improve the accuracy of our projections, particularly at the state level, by incorporating the latest Medicaid enrollment data.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation’s and Urban Institute Health Policy Center’s websites.

We project Medicaid enrollment for the population under age 65 and federal and state Medicaid spending for 2022 and 2023, assuming the PHE is extended through the first, second, or third quarters of 2022. We find the following:

- The Medicaid continuous coverage requirement has provided stable health coverage to millions of people during the pandemic and has helped prevent the number of uninsured people from increasing in the wake of pandemic job losses.
- The longer the PHE lasts, the greater the potential number of people losing Medicaid coverage over the 14 months after the PHE ends and normal eligibility processing resumes: 12.9 million if it expires after the first quarter of 2022, 14.4 million if it expires after the second quarter, and 15.8 million if it expires after the third quarter. Our earlier analysis found that 15 million people could lose Medicaid coverage after the PHE (Buettgens and Green 2021). Our new estimates based on more recent data are a little lower, given a similar PHE end date, but that does not make the issue any less urgent.
- People losing Medicaid coverage risk becoming uninsured. We estimate many of them would be eligible for other subsidized health insurance coverage through the Children’s Health Insurance Program (CHIP) or the Marketplace, but not all eligible people would enroll in these coverage sources because they may cost the affected families more than Medicaid. However, if Congress does not extend the enhanced PTCs from the American Rescue Plan Act, many of these people

will face higher premiums and decline to enroll, and others may lose eligibility for subsidized Marketplace coverage in 2023.

- The unprecedented volume of eligibility determinations that states will have to process raises concerns that eligible people could be unnecessarily disenrolled from Medicaid and become uninsured. Further, some stakeholders worry the rate at which enrollees are inappropriately disenrolled will be higher after the PHE than was typical before the pandemic. If this happens, the number of people losing coverage could be higher than we project.
- Compared with PHE expiration after the first quarter of 2022, federal government spending on Medicaid in 2022 and 2023 would be \$34.0 billion higher if the PHE were extended for one additional quarter and \$70.5 billion higher if the PHE were extended for two quarters. State government spending in 2022 and 2023 would be \$5.0 billion higher if the PHE were extended for one additional quarter and \$10.9 billion higher if the PHE were extended for two quarters.

Many people losing Medicaid after the PHE expires will be eligible for other coverage. Of the adults who would lose Medicaid at the end of the PHE, we estimated in previous work that about a third would be eligible for Marketplace PTCs in 2022 (Buettgens and Green 2021). However, unless Congress extends the enhanced tax credits in the American Rescue Plan Act of 2021, many of these people will face higher premiums or lose eligibility in 2023. Of the children losing Medicaid, 57 percent would be eligible for the Children's Health Insurance Program (CHIP), and an additional 9 percent would be eligible for Marketplace coverage with tax credits. Thus, good coordination between Marketplaces and Medicaid agencies is essential to reduce inappropriate losses of health coverage.

As noted, states will have to process an unprecedented number of eligibility determinations after the PHE expires. This has led to concern that state policies, administrative issues, and other circumstances could increase the inappropriate disenrollment of people still eligible for Medicaid. The financial incentive for states to process eligibility quickly because of the expiration of the enhanced federal Medicaid funding may compound the potential for inappropriate disenrollment. If the rate of inappropriate disenrollment in a state is higher than it was before the pandemic, losses of Medicaid coverage will be larger than we forecast. On the other hand, some states could choose to prioritize continuity of coverage more than in the past, which could lower inappropriate disenrollment. We have little evidence for predicting what will happen in individual states, so the most conservative assumption for this analysis is that enrollment will return to each state's prepandemic trend.

Methods

Our methods are the same as in our earlier brief on Medicaid enrollment under the PHE (Buettgens and Green 2021). As before, we focus on the noninstitutionalized Medicaid population under age 65. However, we use the latest available data from each state to compute monthly enrollment increases relative to prepandemic enrollment. We collected Medicaid enrollment data from the Centers for Medicare & Medicaid Services (CMS) and individual state Medicaid websites for all available months in 2020 and 2021. If a state's Medicaid agency publishes more recent data than those available from CMS,

we use the data from the state’s Medicaid website; otherwise, we use CMS data. We calculate enrollment growth in each month relative to enrollment levels in February 2020 for all available months. For the 18 states for which we rely on CMS data, June 2021 was the latest month for which data were available at the time of analysis.⁵ For the other 32 states and the District of Columbia, the latest month for which data were available at the time of analysis ranged from September to December of 2021.

We use these administrative data to compute each state’s average enrollment growth rate in the most recent six months of data available, which we then use to project enrollment for all remaining months through the end of the PHE.⁶ In addition to the current extension of the PHE through the first quarter of 2022, we made projections assuming the PHE is extended through the second and third quarters of the year. As noted, states have 12 months after the PHE to resume normal eligibility processing. We assume the resulting disenrollment would occur evenly throughout that time. States could choose to process enrollment more quickly, but we lack evidence that would allow us to predict what each state would do.

Our projections assume Medicaid enrollment in each state will eventually return to its long-term, prepandemic trend based on historical administrative data. These trends include the net result of all forms of enrollment “churn,” whereby people enroll and disenroll during the course of a year, including churn based on inappropriate terminations. Thus, our results reflect enrollment changes if states return to their prepandemic churn rates. Actual disenrollment depends largely on how each state handles the unprecedented volume of eligibility determinations that they must process after the PHE. We have little basis for predicting what will happen in individual states, so we assume a return to historical trends in this analysis.

Results

We first present updated projections of Medicaid enrollment through the end of 2023 for three possible PHE expiration dates. We then project the impact on state and federal Medicaid costs.

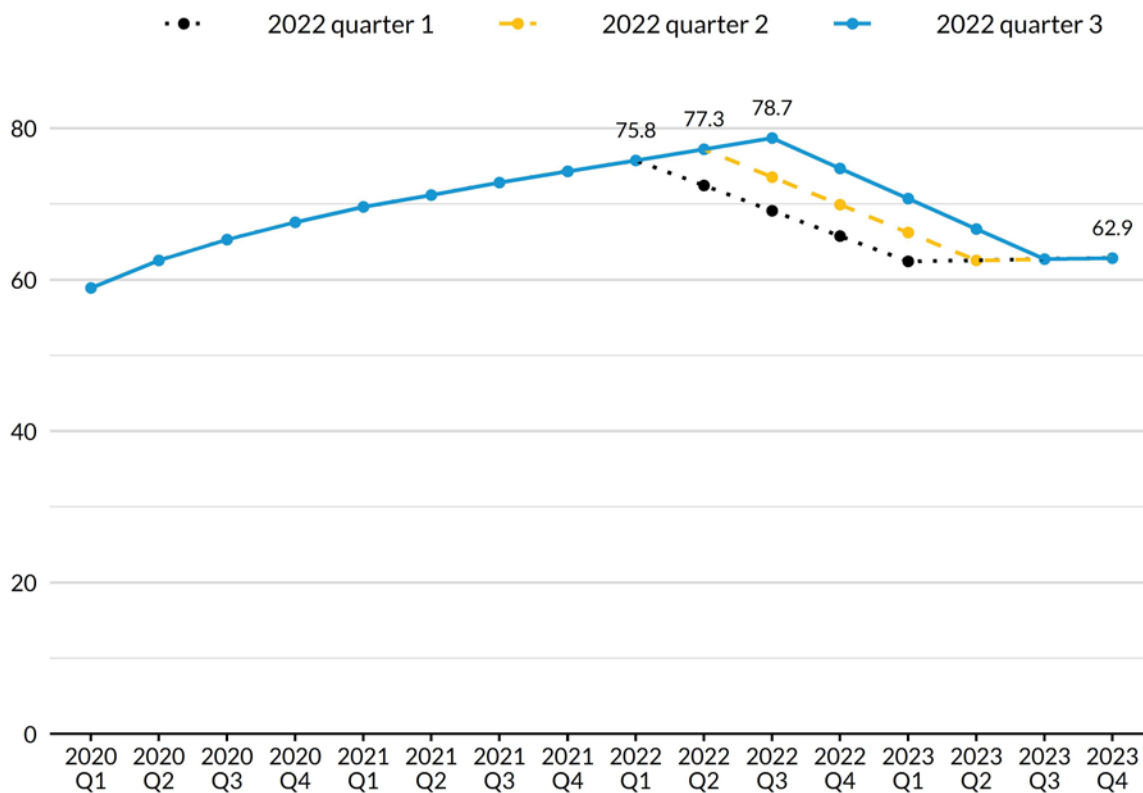
Changes in Medicaid Enrollment

If the PHE continues through the first quarter of 2022, we project that the number of nonelderly people enrolled in Medicaid will rise to a peak of 75.8 million in the first quarter of 2022 before falling to 62.9 million by the end of 2023, a difference of 12.9 million people (figure 1). Our new projections for the loss of enrollment are lower than what we published in September 2021 given a similar PHE end date (Buettgens and Green 2021), because enrollment growth rates in the administrative data were somewhat lower beginning in the second quarter of 2021. This is visible in the slight bend in the curve of figure 1. As noted above, however, the number of people who lose Medicaid coverage by the end of 2023 could be higher if the unprecedented number of eligibility determinations to be processed leads to more inappropriate disenrollment in some states than was typical before the pandemic.

If the PHE is extended through the second quarter of 2022, we project that enrollment will peak at 77.3 million nonelderly people in the second quarter of 2022, and 14.4 million people will lose Medicaid coverage by the end of 2023. Finally, if the PHE is extended through the third quarter of 2022, additional enrollment will peak at 78.7 million, and 15.8 million people will lose Medicaid coverage over the next year.

While the paper was in production, CMS issued new guidance giving states up to 14 months to fully process enrollment. Our estimates follow the previous guidance giving states 12 months. States can choose to process their enrollment more quickly. The difference between 12 and 14 months does not affect the enrollment peak or estimates of the number of people eventually losing Medicaid. It simply makes the phase-out of enrollment after the peak slightly less steep.

FIGURE 1
Past and Projected Medicaid Enrollment among the Nonelderly Population, by Potential Public Health Emergency End Date in 2022, 2020–23
Millions of people



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Source: Urban Institute analysis.

Notes: We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency.

While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

Changes in Medicaid Costs

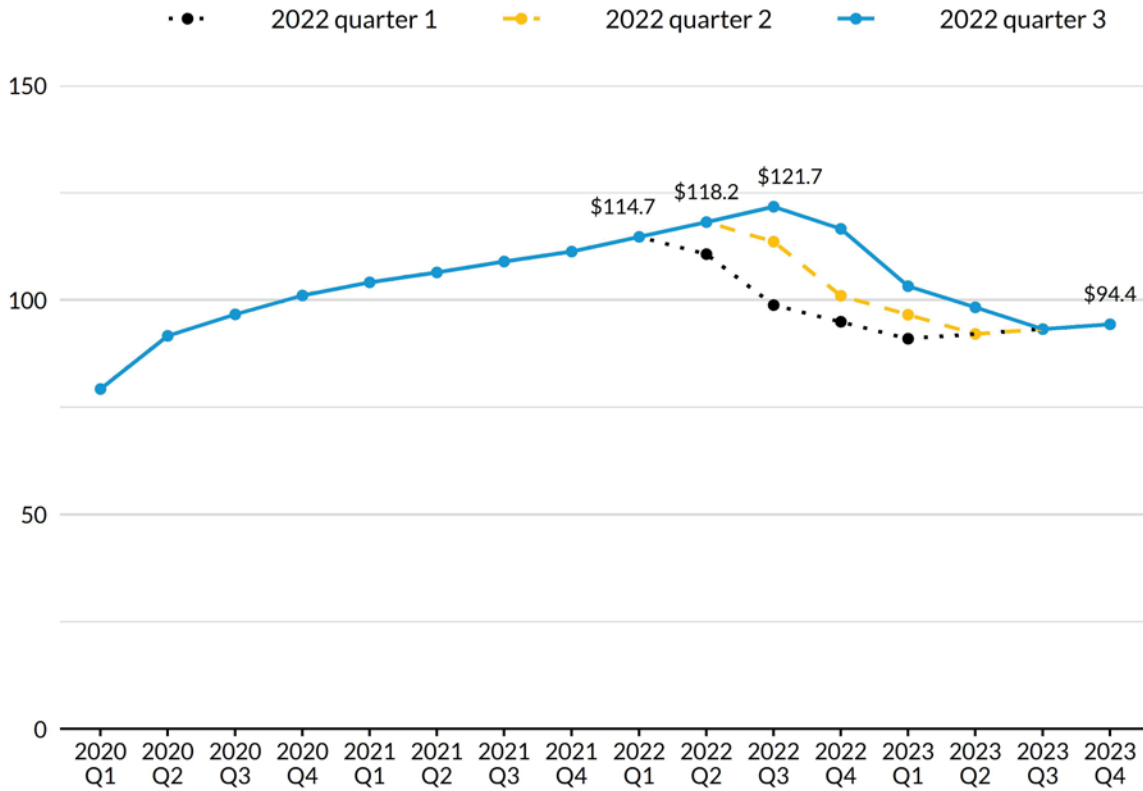
If the PHE is not extended beyond the first quarter of 2022, we project that quarterly federal Medicaid costs for acute care for the nonelderly will peak at \$114.7 billion in the first quarter of 2022 before falling to \$94.4 billion by the end of 2023 (figure 2). If the PHE is extended one additional quarter, the peak quarterly federal spending will be an estimated \$118.2 billion in the second quarter of 2022. If the PHE is extended for two additional quarters, the peak quarterly federal spending will be \$121.7 billion in the third quarter of 2022.

If the PHE is not extended beyond the first quarter of 2022, we project that the federal government will spend \$419.1 billion in 2022 and \$370.6 billion in 2023 on acute care for nonelderly Medicaid recipients, a total of \$789.8 billion (table 1). If the PHE is extended for one additional quarter, the federal government will spend an estimated \$823.8 billion in 2022 and 2023, an increase of \$34.0 billion, or 4.3 percent. Extending the PHE for two additional quarters would increase federal spending by \$70.5 billion, or 8.9 percent.

FIGURE 2

Past and Projected Federal Medicaid Spending on Acute Care for the Nonelderly, by Potential Public Health Emergency End Date in 2022, 2020–23

Billions of dollars



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Source: Urban Institute analysis.

Notes: Estimates exclude spending on long-term care and the elderly. We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

TABLE 1

Summary of Projected Costs for Medicaid Acute Care for the Nonelderly Population in 2022 and 2023, by Public Health Emergency End Date

2022 PHE end date	2022		2023		Total	
	Federal	State	Federal	State	Federal	State
	Total Medicaid spending (\$billions)					
First quarter	419.1	205.0	370.6	203.9	789.8	408.9
Second quarter	447.5	206.9	376.3	207.0	823.8	413.9
Third quarter	471.2	205.8	389.1	214.0	860.3	419.8
	Difference from PHE ending in the first quarter (\$billions)					
Second quarter	28.4	1.9	5.6	3.1	34.0	5.0
Third quarter	52.1	0.7	18.5	10.1	70.5	10.9
	Percent difference from PHE ending in the first quarter					
Second quarter	6.8	0.9	1.5	1.5	4.3	1.2
Third quarter	12.4	0.4	5.0	5.0	8.9	2.7

Source: Urban Institute analysis.

Notes: PHE is public health emergency. Estimates exclude spending on long-term care and the elderly. We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

Though federal Medicaid costs will peak with the highest enrollment levels before falling steadily over the year after the PHE expires, state Medicaid costs show a more complicated pattern. Two factors affect state costs in opposite ways. On the one hand, spending will decrease as the number of enrollees declines after the PHE. On the other hand, the loss of the enhanced FMAP will increase the share of Medicaid costs paid by the state. Consequently, state Medicaid costs would decline slightly in the quarter after the PHE expiration and reach their peak in the following quarter (figure 3).

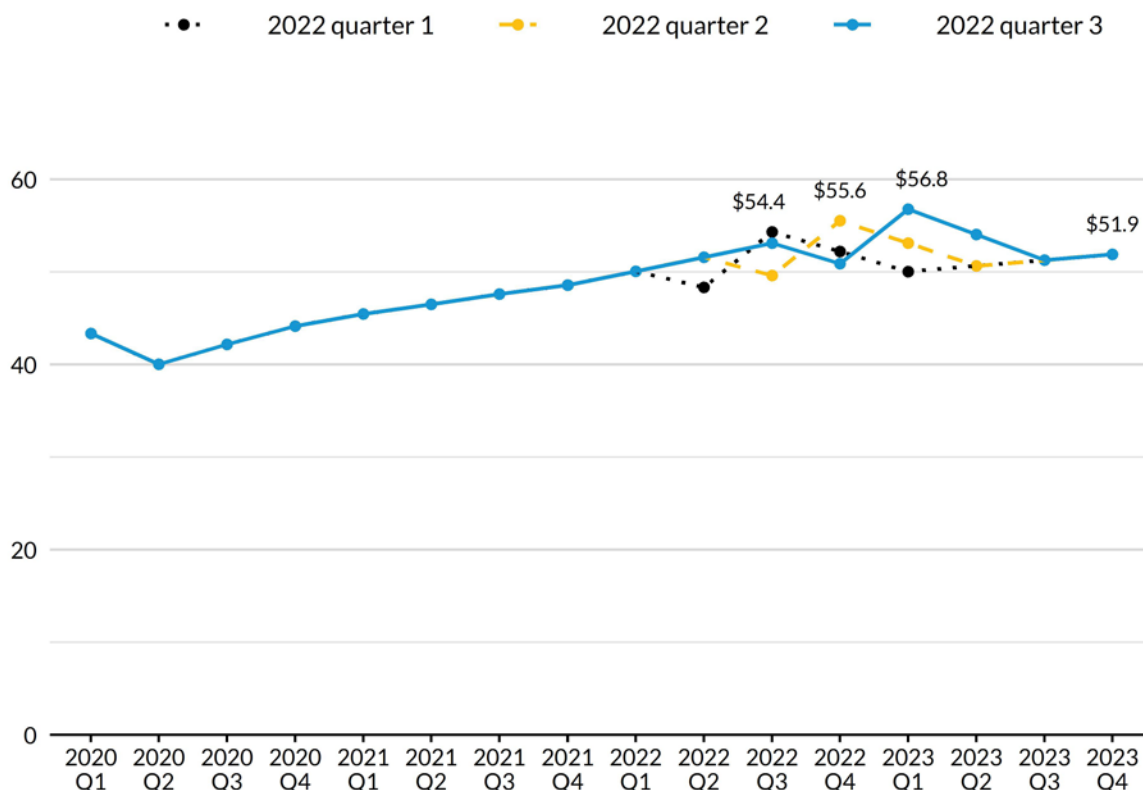
If the PHE is not extended beyond the first quarter of 2022, we estimate state governments will spend \$205.0 billion in 2022 and \$203.9 billion in 2023 on acute care for nonelderly Medicaid recipients, a total of \$408.9 billion (table 1). If the PHE is extended for one additional quarter, state governments will spend an estimated \$413.9 billion in 2022 and 2023, an increase of \$5.0 billion, or 1.2 percent. Extending the PHE for two additional quarters would increase state spending by \$10.9 billion, or 2.7 percent.

In the State-Level Data section, we provide estimates of Medicaid enrollment and costs for each state assuming the PHE is extended through the first quarter of 2022.

FIGURE 3

Past and Projected State Medicaid Spending on Acute Care for the Nonelderly, by Potential Public Health Emergency End Date in 2022, 2020–23

Billions of dollars



URBAN INSTITUTE

Source: Urban Institute analysis.

Notes: Estimates exclude spending on long-term care and the elderly. We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

Conclusion

In January, the HHS secretary renewed the PHE for 90 days, and he will likely extend it through the second quarter of 2022. As of the time of this writing, the pandemic is clearly not over, and its trajectory is still uncertain (Corlette et al. 2022). So, further extensions of the PHE are possible. A growing body of evidence finds that Medicaid coverage saves lives and increases families’ financial stability (Caswell and Waidmann 2019; Goldin, Lurie, and McCubbin 2019; Hu et al. 2016; Miller, Johnson, and Wherry 2021). Large-scale, rapid Medicaid disenrollment during a time when families will still be trying to deal with the pandemic’s health and economic consequences could have serious effects on the health and financial well-being of millions of people.

Many people losing Medicaid after the PHE expires will be eligible for other coverage (Buettgens and Green 2021). Nearly 60 percent of children losing Medicaid coverage will be eligible for CHIP. States are responsible for administering both programs, so disenrollment for reasons other than eligibility can realistically be minimized. However, some families with children moving to CHIP coverage may have to pay premiums for such coverage.

We estimate that one-third of adults and nearly one-tenth of children who will lose Medicaid are eligible for Marketplace tax credits in 2022. Coordination between state Medicaid agencies and the Marketplaces is essential to minimize the number of people who become uninsured after losing Medicaid coverage. Coordination will be much easier for the District of Columbia and the 17 states with their own Marketplaces.⁷ States that use HealthCare.gov have limited abilities to coordinate the two programs, so they will have to rely on outreach and enrollment assistance efforts.

New CMS guidance clarifies state options to help ensure that more people losing Medicaid coverage end up enrolling in the Marketplaces.⁸ States may now assume that anyone no longer eligible for Medicaid or CHIP is eligible for Marketplace coverage and may transfer electronic records and contact information for processing. States are encouraged to notify people losing Medicaid that their information is being forwarded and to coordinate outreach with community-based groups and similar organizations. These options are not entirely new, and we do not know how many states will adopt them.

The enhanced PTCs established by the American Rescue Plan Act are currently set to expire after 2022, so more people will lose health coverage if Congress does not extend the PTCs. In that case, only 28 percent of adults and 5 percent of children projected to lose Medicaid coverage would be eligible for Marketplace PTCs.

Most people losing Medicaid but not gaining eligibility for PTCs or CHIP would have access to health coverage through a family member's employer. But these alternative coverage sources, particularly employer coverage, would likely cost the affected families much more than Medicaid.

Extending the PHE gives states more chances to plan and prepare, though continuing uncertainty about the PHE's duration makes this difficult. Extending the PHE and giving more than 60 days' notice before its expiration would give states more time to improve administrative systems' readiness to handle the coming surge in eligibility determinations. The extra time could also be used to prepare outreach and application assistance programs for people who will no longer be eligible for Medicaid but may be eligible for CHIP or Marketplace PTCs.

However, extending the PHE also raises the stakes after the PHE expires. The enrollment that must be processed will increase with each quarter the PHE is renewed; the number of nonelderly enrollees to be processed is 75.8 million if the PHE expires after the first quarter of 2022, 77.3 million if it is extended through the second quarter, and 78.7 million if it is extended through the third quarter. Greater enrollment at the end of the PHE also means the loss of the enhanced FMAP in the quarter after the PHE ends will give states an even larger incentive to process enrollment quickly. Extending the PHE through the second quarter of 2022 would increase state government spending by \$5.0 billion in

2022 and 2023. Extending it through the third quarter would increase state spending by \$10.9 billion. Rushing enrollment processing could lead to more inappropriate losses of health coverage.

The PHE has been in place for nearly two years. Rising COVID-19 cases and uncertainty about the future of the pandemic make further extension of the PHE possible. The Medicaid continuous coverage requirement has provided stable health coverage to millions of people during the pandemic, but the longer it lasts, the more people will be affected after it ends. Each extension would make it even more important for states to prepare now to minimize inappropriate disenrollment and losses of health coverage.

State-Level Data

TABLE 2

Past and Projected State Medicaid Enrollment among the Nonelderly Population Assuming the Public Health Emergency Ends after the First Quarter of 2022, by Quarter and State

Millions of people

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AL	0.80	0.82	0.85	0.87	0.89	0.91	0.93	0.95	0.91	0.88	0.84	0.81	0.81	0.81	0.82
AK	0.18	0.19	0.19	0.20	0.20	0.21	0.21	0.21	0.21	0.20	0.19	0.19	0.19	0.19	0.19
AZ	1.77	1.84	1.89	1.96	2.01	2.06	2.07	2.10	2.01	1.92	1.82	1.73	1.74	1.74	1.74
AR	0.77	0.79	0.82	0.83	0.85	0.86	0.88	0.89	0.86	0.83	0.80	0.77	0.78	0.78	0.78
CA	9.33	9.59	9.82	10.04	10.22	10.40	10.59	10.78	10.44	10.10	9.76	9.42	9.44	9.46	9.49
CO	1.02	1.07	1.12	1.17	1.20	1.23	1.26	1.28	1.21	1.13	1.06	0.99	0.99	0.99	1.00
CT	0.74	0.76	0.79	0.81	0.82	0.82	0.83	0.84	0.82	0.79	0.77	0.75	0.75	0.75	0.75
DE	0.17	0.18	0.18	0.19	0.19	0.20	0.20	0.21	0.20	0.19	0.18	0.17	0.17	0.18	0.18
DC	0.15	0.16	0.16	0.16	0.17	0.17	0.17	0.17	0.17	0.16	0.16	0.15	0.16	0.16	0.16
FL	3.21	3.37	3.52	3.67	3.78	3.88	3.97	4.05	3.79	3.54	3.29	3.04	3.04	3.05	3.06
GA	1.70	1.77	1.84	1.89	1.94	1.98	2.03	2.07	1.96	1.86	1.75	1.65	1.65	1.66	1.66
HI	0.23	0.24	0.26	0.27	0.27	0.28	0.29	0.30	0.28	0.26	0.24	0.23	0.23	0.23	0.23
ID	0.34	0.36	0.38	0.39	0.40	0.41	0.42	0.43	0.40	0.38	0.36	0.34	0.34	0.34	0.34
IL	2.17	2.40	2.48	2.55	2.59	2.64	2.68	2.71	2.58	2.44	2.31	2.17	2.17	2.18	2.18
IN	1.29	1.36	1.43	1.50	1.54	1.58	1.63	1.66	1.56	1.45	1.34	1.24	1.24	1.24	1.24
IA	0.55	0.57	0.59	0.60	0.61	0.62	0.62	0.63	0.61	0.59	0.57	0.55	0.55	0.55	0.56
KS	0.31	0.32	0.33	0.33	0.34	0.34	0.35	0.35	0.34	0.33	0.32	0.31	0.31	0.31	0.31
KY	1.26	1.36	1.36	1.42	1.43	1.46	1.49	1.51	1.43	1.35	1.27	1.19	1.19	1.20	1.20
LA	1.30	1.36	1.40	1.43	1.46	1.48	1.51	1.53	1.47	1.40	1.34	1.28	1.29	1.29	1.29
ME	0.30	0.31	0.33	0.33	0.34	0.35	0.35	0.36	0.34	0.33	0.31	0.29	0.29	0.29	0.29
MD	1.04	1.07	1.11	1.14	1.16	1.18	1.20	1.22	1.17	1.13	1.08	1.03	1.04	1.04	1.04
MA	1.43	1.47	1.52	1.57	1.59	1.62	1.66	1.69	1.62	1.55	1.48	1.42	1.42	1.42	1.43
MI	2.10	2.21	2.29	2.36	2.41	2.45	2.49	2.52	2.40	2.29	2.17	2.06	2.06	2.07	2.07
MN	1.06	1.11	1.15	1.20	1.23	1.26	1.28	1.30	1.22	1.15	1.07	1.00	1.00	1.00	1.00
MS	0.57	0.59	0.61	0.62	0.64	0.65	0.65	0.66	0.64	0.61	0.59	0.57	0.57	0.57	0.57
MO	0.85	0.94	0.99	1.02	1.06	1.09	1.18	1.32	1.27	1.23	1.19	1.15	1.15	1.15	1.16
MT	0.21	0.22	0.23	0.24	0.24	0.25	0.25	0.25	0.24	0.23	0.22	0.21	0.21	0.21	0.21
NE	0.20	0.21	0.23	0.24	0.26	0.27	0.27	0.28	0.28	0.27	0.27	0.26	0.26	0.26	0.26

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NV	0.62	0.65	0.68	0.71	0.72	0.74	0.76	0.78	0.73	0.69	0.64	0.60	0.60	0.60	0.60
NH	0.20	0.21	0.22	0.23	0.23	0.24	0.24	0.25	0.24	0.22	0.21	0.19	0.19	0.20	0.20
NJ	1.36	1.43	1.48	1.53	1.56	1.60	1.62	1.65	1.58	1.50	1.43	1.35	1.36	1.36	1.36
NM	0.69	0.72	0.74	0.75	0.76	0.78	0.79	0.80	0.77	0.75	0.72	0.69	0.69	0.70	0.70
NY	5.54	5.75	5.96	6.10	6.22	6.34	6.44	6.54	6.29	6.03	5.78	5.52	5.54	5.55	5.56
NC	1.75	1.82	1.89	1.95	2.00	2.03	2.08	2.11	2.01	1.91	1.82	1.72	1.72	1.73	1.73
ND	0.08	0.08	0.08	0.09	0.09	0.09	0.09	0.10	0.09	0.09	0.08	0.07	0.07	0.07	0.07
OH	2.30	2.38	2.45	2.50	2.55	2.60	2.65	2.69	2.59	2.49	2.38	2.28	2.29	2.29	2.30
OK	0.61	0.64	0.66	0.68	0.69	0.83	0.88	0.93	0.90	0.88	0.86	0.83	0.83	0.84	0.84
OR	0.85	0.88	0.92	0.95	0.97	1.00	1.02	1.04	0.99	0.94	0.89	0.83	0.84	0.84	0.84
PA	2.28	2.36	2.43	2.50	2.54	2.60	2.65	2.69	2.59	2.49	2.39	2.29	2.29	2.30	2.30
RI	0.25	0.26	0.27	0.27	0.28	0.28	0.29	0.29	0.28	0.27	0.26	0.25	0.25	0.25	0.25
SC	0.83	0.86	0.89	0.91	0.93	0.95	0.97	0.99	0.95	0.91	0.87	0.83	0.83	0.84	0.84
SD	0.10	0.11	0.11	0.11	0.12	0.12	0.12	0.12	0.12	0.11	0.11	0.10	0.10	0.10	0.10
TN	1.16	1.20	1.23	1.26	1.29	1.31	1.34	1.36	1.31	1.27	1.23	1.18	1.19	1.19	1.19
TX	4.16	4.37	4.59	4.77	4.93	5.09	5.23	5.36	5.03	4.70	4.36	4.03	4.04	4.05	4.06
UT	0.43	0.48	0.51	0.53	0.55	0.57	0.58	0.59	0.55	0.51	0.46	0.42	0.42	0.42	0.42
VT	0.14	0.15	0.15	0.15	0.16	0.16	0.16	0.17	0.16	0.15	0.15	0.14	0.14	0.14	0.14
VA	1.27	1.33	1.39	1.44	1.48	1.51	1.55	1.59	1.50	1.42	1.34	1.26	1.26	1.27	1.27
WA	1.52	1.57	1.62	1.65	1.68	1.71	1.74	1.77	1.71	1.65	1.59	1.53	1.53	1.53	1.54
WV	0.45	0.46	0.48	0.50	0.51	0.52	0.53	0.54	0.52	0.49	0.47	0.45	0.45	0.45	0.45
WI	0.88	0.93	0.97	1.01	1.04	1.06	1.08	1.10	1.04	0.98	0.91	0.85	0.85	0.85	0.85
WY	0.05	0.05	0.05	0.05	0.06	0.06	0.06	0.06	0.06	0.06	0.05	0.05	0.05	0.05	0.05

Source: Urban Institute analysis.

Notes: We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

TABLE 3

Past and Projected Federal Medicaid Spending on Acute Care for the Nonelderly Population Assuming the Public Health Emergency Ends after the First Quarter of 2022, by Quarter and State

Billions of dollars

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AL	1.08	1.12	1.16	1.19	1.22	1.24	1.27	1.31	1.27	1.14	1.11	1.07	1.09	1.10	1.11
AK	0.25	0.26	0.27	0.27	0.28	0.29	0.29	0.30	0.30	0.26	0.26	0.25	0.25	0.26	0.26
AZ	2.95	3.12	3.23	3.34	3.43	3.51	3.54	3.62	3.50	3.18	3.05	2.93	2.96	3.00	3.04
AR	1.24	1.29	1.34	1.36	1.38	1.41	1.44	1.47	1.44	1.32	1.29	1.25	1.27	1.29	1.30
CA	10.96	11.38	11.76	12.03	12.25	12.47	12.69	13.04	12.75	11.61	11.33	11.05	11.18	11.32	11.46
CO	1.28	1.36	1.44	1.50	1.54	1.58	1.61	1.66	1.58	1.40	1.32	1.24	1.26	1.27	1.29
CT	1.19	1.24	1.30	1.32	1.35	1.35	1.36	1.39	1.37	1.24	1.21	1.19	1.20	1.22	1.23
DE	0.34	0.35	0.37	0.38	0.39	0.40	0.41	0.42	0.41	0.37	0.35	0.34	0.34	0.35	0.35
DC	0.39	0.40	0.42	0.43	0.43	0.44	0.44	0.45	0.44	0.41	0.40	0.39	0.40	0.40	0.41
FL	4.15	4.40	4.64	4.83	4.98	5.10	5.23	5.38	5.09	4.36	4.09	3.81	3.86	3.91	3.96
GA	2.23	2.35	2.45	2.53	2.59	2.65	2.71	2.79	2.68	2.34	2.23	2.12	2.14	2.17	2.20
HI	0.28	0.29	0.31	0.32	0.33	0.34	0.35	0.36	0.34	0.30	0.29	0.27	0.27	0.28	0.28
ID	0.56	0.60	0.63	0.66	0.67	0.69	0.70	0.72	0.69	0.62	0.59	0.56	0.57	0.58	0.58
IL	2.06	2.30	2.40	2.47	2.51	2.56	2.59	2.65	2.55	2.23	2.13	2.02	2.05	2.07	2.10
IN	2.21	2.35	2.50	2.61	2.69	2.76	2.84	2.93	2.77	2.45	2.29	2.13	2.16	2.19	2.21
IA	0.82	0.86	0.89	0.91	0.92	0.93	0.95	0.97	0.95	0.86	0.84	0.82	0.83	0.84	0.85
KS	0.40	0.41	0.43	0.44	0.44	0.45	0.45	0.46	0.45	0.40	0.40	0.39	0.39	0.40	0.40
KY	2.24	2.44	2.48	2.57	2.60	2.65	2.70	2.78	2.66	2.41	2.29	2.16	2.19	2.22	2.24
LA	2.04	2.15	2.24	2.29	2.33	2.37	2.41	2.47	2.39	2.20	2.12	2.04	2.07	2.09	2.12
ME	0.47	0.50	0.53	0.54	0.55	0.56	0.57	0.59	0.57	0.50	0.48	0.46	0.46	0.47	0.47
MD	1.65	1.72	1.79	1.84	1.88	1.92	1.95	2.00	1.94	1.74	1.68	1.63	1.65	1.67	1.69
MA	1.94	2.02	2.11	2.18	2.21	2.25	2.30	2.36	2.29	2.02	1.95	1.88	1.90	1.93	1.95
MI	3.54	3.75	3.93	4.05	4.14	4.21	4.27	4.37	4.21	3.81	3.65	3.49	3.53	3.58	3.62
MN	1.91	2.02	2.11	2.20	2.26	2.32	2.35	2.41	2.29	1.98	1.87	1.76	1.78	1.80	1.82
MS	1.08	1.13	1.18	1.21	1.24	1.26	1.27	1.30	1.27	1.14	1.10	1.07	1.08	1.10	1.11
MO	1.92	2.13	2.27	2.35	2.43	2.50	2.70	3.05	2.98	2.66	2.60	2.54	2.56	2.59	2.62
MT	0.44	0.47	0.50	0.51	0.52	0.53	0.54	0.56	0.54	0.50	0.48	0.46	0.47	0.47	0.48
NE	0.27	0.28	0.32	0.34	0.36	0.37	0.38	0.40	0.39	0.35	0.35	0.35	0.35	0.35	0.36
NV	0.78	0.84	0.88	0.91	0.93	0.96	0.98	1.01	0.96	0.85	0.81	0.76	0.77	0.77	0.78
NH	0.24	0.25	0.27	0.28	0.29	0.29	0.30	0.31	0.30	0.26	0.25	0.23	0.23	0.24	0.24
NJ	1.60	1.70	1.77	1.83	1.87	1.91	1.94	2.00	1.93	1.72	1.65	1.58	1.60	1.62	1.64
NM	1.34	1.40	1.45	1.48	1.50	1.53	1.55	1.59	1.55	1.45	1.41	1.37	1.39	1.40	1.42
NY	7.35	7.71	8.07	8.26	8.42	8.59	8.73	8.95	8.69	7.85	7.59	7.33	7.42	7.51	7.60

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NC	3.08	3.24	3.39	3.50	3.58	3.65	3.72	3.82	3.68	3.24	3.10	2.96	3.00	3.04	3.07
ND	0.13	0.13	0.14	0.15	0.15	0.16	0.16	0.17	0.16	0.14	0.13	0.12	0.12	0.13	0.13
OH	3.74	3.91	4.07	4.15	4.23	4.31	4.39	4.51	4.38	3.96	3.83	3.70	3.75	3.80	3.84
OK	1.03	1.09	1.15	1.17	1.19	1.43	1.52	1.62	1.59	1.43	1.41	1.38	1.40	1.41	1.43
OR	1.40	1.48	1.55	1.60	1.65	1.69	1.72	1.77	1.70	1.53	1.47	1.40	1.41	1.43	1.45
PA	3.55	3.71	3.87	3.98	4.05	4.14	4.21	4.32	4.20	3.76	3.64	3.52	3.56	3.61	3.65
RI	0.31	0.33	0.34	0.35	0.35	0.36	0.36	0.37	0.36	0.33	0.31	0.30	0.31	0.31	0.32
SC	1.12	1.18	1.22	1.26	1.29	1.31	1.34	1.38	1.34	1.19	1.15	1.11	1.12	1.14	1.15
SD	0.16	0.17	0.18	0.19	0.19	0.19	0.20	0.20	0.20	0.17	0.16	0.16	0.16	0.16	0.16
TN	1.84	1.92	1.99	2.04	2.09	2.12	2.16	2.22	2.17	1.93	1.88	1.84	1.86	1.88	1.90
TX	7.02	7.44	7.89	8.20	8.47	8.76	8.99	9.31	8.82	7.55	7.08	6.61	6.69	6.78	6.86
UT	0.83	0.92	0.99	1.04	1.07	1.11	1.14	1.17	1.10	0.95	0.88	0.80	0.81	0.82	0.83
VT	0.33	0.34	0.36	0.37	0.37	0.38	0.39	0.40	0.39	0.34	0.33	0.32	0.32	0.32	0.33
VA	2.01	2.12	2.24	2.31	2.38	2.44	2.49	2.58	2.47	2.21	2.11	2.00	2.02	2.05	2.07
WA	1.93	2.02	2.10	2.15	2.19	2.23	2.26	2.33	2.27	2.07	2.01	1.95	1.97	2.00	2.02
WV	0.74	0.77	0.81	0.84	0.86	0.87	0.89	0.92	0.89	0.81	0.78	0.75	0.76	0.77	0.78
WI	1.10	1.17	1.24	1.29	1.33	1.36	1.39	1.43	1.36	1.17	1.10	1.03	1.05	1.06	1.07
WY	0.09	0.09	0.10	0.10	0.10	0.11	0.11	0.11	0.11	0.09	0.09	0.08	0.08	0.08	0.08

Source: Urban Institute analysis.

Notes: We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

TABLE 4

Past and Projected State Medicaid Spending on Acute Care for the Nonelderly Population Assuming the Public Health Emergency Ends after the First Quarter of 2022, by Quarter and State

Billions of dollars

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AL	0.30	0.31	0.32	0.33	0.34	0.35	0.35	0.37	0.36	0.44	0.43	0.42	0.42	0.43	0.43
AK	0.16	0.16	0.17	0.17	0.17	0.18	0.18	0.19	0.18	0.20	0.20	0.19	0.19	0.20	0.20
AZ	0.74	0.78	0.81	0.84	0.86	0.88	0.89	0.91	0.87	1.03	0.99	0.95	0.96	0.97	0.99
AR	0.29	0.30	0.32	0.32	0.33	0.33	0.34	0.35	0.34	0.41	0.40	0.39	0.40	0.40	0.41
CA	5.74	5.96	6.16	6.31	6.42	6.53	6.65	6.83	6.68	7.38	7.20	7.02	7.11	7.19	7.28
CO	0.65	0.70	0.74	0.77	0.79	0.81	0.83	0.85	0.81	0.87	0.82	0.77	0.78	0.79	0.80
CT	0.69	0.72	0.75	0.77	0.78	0.79	0.79	0.81	0.80	0.89	0.87	0.85	0.86	0.87	0.88
DE	0.15	0.16	0.17	0.17	0.18	0.18	0.18	0.19	0.18	0.21	0.20	0.19	0.19	0.20	0.20
DC	0.11	0.11	0.12	0.12	0.12	0.12	0.12	0.13	0.13	0.15	0.15	0.15	0.15	0.15	0.16
FL	1.98	2.10	2.22	2.31	2.38	2.44	2.50	2.57	2.43	2.73	2.56	2.39	2.42	2.45	2.48
GA	0.80	0.85	0.88	0.91	0.93	0.96	0.98	1.01	0.97	1.14	1.08	1.03	1.04	1.05	1.07
HI	0.13	0.14	0.15	0.15	0.16	0.16	0.16	0.17	0.16	0.17	0.16	0.15	0.16	0.16	0.16
ID	0.14	0.14	0.15	0.16	0.16	0.17	0.17	0.17	0.17	0.19	0.18	0.17	0.18	0.18	0.18
IL	1.27	1.41	1.47	1.51	1.54	1.57	1.59	1.63	1.56	1.70	1.62	1.54	1.56	1.57	1.59
IN	0.66	0.70	0.74	0.77	0.80	0.82	0.84	0.87	0.82	0.92	0.86	0.80	0.81	0.82	0.83
IA	0.32	0.34	0.35	0.36	0.36	0.37	0.37	0.38	0.37	0.43	0.42	0.41	0.41	0.42	0.42
KS	0.21	0.22	0.23	0.23	0.23	0.24	0.24	0.24	0.24	0.28	0.27	0.27	0.27	0.27	0.28
KY	0.48	0.52	0.53	0.55	0.55	0.56	0.57	0.59	0.56	0.66	0.62	0.59	0.60	0.60	0.61
LA	0.54	0.57	0.60	0.61	0.62	0.63	0.64	0.66	0.64	0.74	0.71	0.68	0.69	0.70	0.71
ME	0.18	0.19	0.20	0.21	0.21	0.22	0.22	0.23	0.22	0.25	0.24	0.23	0.23	0.23	0.24
MD	0.93	0.97	1.01	1.04	1.06	1.08	1.10	1.13	1.10	1.20	1.16	1.12	1.14	1.15	1.17
MA	1.24	1.29	1.35	1.39	1.41	1.44	1.47	1.51	1.46	1.61	1.55	1.50	1.52	1.53	1.55
MI	1.13	1.20	1.26	1.30	1.32	1.35	1.37	1.40	1.35	1.53	1.47	1.40	1.42	1.44	1.46
MN	1.21	1.29	1.34	1.40	1.44	1.47	1.50	1.53	1.46	1.57	1.48	1.39	1.41	1.43	1.44
MS	0.22	0.23	0.24	0.25	0.25	0.25	0.26	0.26	0.26	0.34	0.33	0.32	0.32	0.33	0.33
MO	0.75	0.83	0.89	0.92	0.95	0.98	1.06	1.19	1.17	1.39	1.36	1.33	1.34	1.36	1.37
MT	0.12	0.13	0.14	0.14	0.14	0.15	0.15	0.15	0.15	0.17	0.16	0.16	0.16	0.16	0.16
NE	0.17	0.18	0.20	0.22	0.23	0.24	0.24	0.25	0.25	0.29	0.29	0.29	0.29	0.29	0.30
NV	0.26	0.28	0.30	0.31	0.32	0.32	0.33	0.34	0.33	0.37	0.35	0.32	0.33	0.33	0.34
NH	0.14	0.15	0.16	0.17	0.17	0.17	0.18	0.18	0.18	0.19	0.18	0.17	0.17	0.17	0.18
NJ	0.87	0.93	0.96	1.00	1.02	1.04	1.06	1.09	1.05	1.14	1.10	1.05	1.06	1.08	1.09
NM	0.27	0.28	0.29	0.30	0.30	0.31	0.31	0.32	0.31	0.37	0.36	0.35	0.36	0.36	0.36
NY	3.81	3.99	4.18	4.28	4.36	4.45	4.52	4.64	4.50	4.93	4.76	4.60	4.66	4.71	4.77

State	2020			2021				2022				2023			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NC	1.12	1.18	1.24	1.28	1.31	1.33	1.36	1.39	1.34	1.59	1.52	1.45	1.47	1.49	1.51
ND	0.07	0.08	0.08	0.08	0.09	0.09	0.09	0.10	0.09	0.10	0.09	0.09	0.09	0.09	0.09
OH	1.35	1.41	1.47	1.50	1.53	1.56	1.59	1.63	1.58	1.82	1.76	1.70	1.72	1.74	1.76
OK	0.40	0.42	0.44	0.45	0.46	0.55	0.58	0.62	0.61	0.74	0.72	0.71	0.72	0.73	0.74
OR	0.49	0.51	0.54	0.56	0.57	0.59	0.60	0.62	0.59	0.66	0.63	0.60	0.61	0.62	0.62
PA	1.99	2.08	2.17	2.22	2.26	2.31	2.36	2.42	2.35	2.61	2.53	2.44	2.47	2.50	2.53
RI	0.16	0.17	0.18	0.18	0.19	0.19	0.19	0.20	0.19	0.21	0.20	0.20	0.20	0.20	0.21
SC	0.34	0.35	0.37	0.38	0.39	0.39	0.40	0.42	0.40	0.49	0.48	0.46	0.47	0.47	0.48
SD	0.09	0.10	0.10	0.11	0.11	0.11	0.11	0.12	0.11	0.13	0.12	0.12	0.12	0.12	0.12
TN	0.74	0.77	0.80	0.82	0.84	0.85	0.87	0.89	0.87	1.03	1.01	0.98	0.99	1.00	1.02
TX	3.44	3.65	3.87	4.02	4.16	4.30	4.41	4.56	4.32	4.85	4.55	4.25	4.30	4.35	4.41
UT	0.24	0.26	0.28	0.29	0.30	0.31	0.32	0.33	0.31	0.35	0.32	0.29	0.30	0.30	0.30
VT	0.18	0.19	0.20	0.21	0.21	0.21	0.22	0.22	0.22	0.24	0.23	0.22	0.23	0.23	0.23
VA	0.99	1.04	1.10	1.13	1.17	1.19	1.22	1.26	1.21	1.30	1.24	1.18	1.19	1.21	1.22
WA	0.96	1.00	1.04	1.06	1.08	1.10	1.12	1.15	1.12	1.23	1.20	1.16	1.18	1.19	1.21
WV	0.15	0.15	0.16	0.17	0.17	0.17	0.18	0.18	0.18	0.22	0.21	0.20	0.21	0.21	0.21
WI	0.58	0.62	0.65	0.68	0.70	0.71	0.73	0.75	0.71	0.80	0.75	0.71	0.72	0.72	0.73
WY	0.07	0.07	0.07	0.08	0.08	0.08	0.09	0.09	0.08	0.09	0.09	0.08	0.08	0.08	0.08

Source: Urban Institute analysis.

Notes: We assume a complete return to normal eligibility processing within 12 months of the end of the public health emergency. While the paper was in production, CMS extended the maximum time to 14 months. However, states could process their enrollment more quickly.

Notes

- ¹ CMS reported total Medicaid and CHIP enrollment of 83.6 million in July 2021; enrollment was 70.7 million in February 2020. See “July 2021 Medicaid & CHIP Enrollment Data Highlights,” Medicaid.gov, accessed January 31, 2022, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.
- ² Centers for Medicare & Medicaid Services, guidance to state health officials regarding, “Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) upon Conclusion of the COVID-19 Public Health Emergency,” March 3, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.
- ³ US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, “HHS Secretary Becerra Renews COVID-19 Pandemic Public Health Emergency Declaration, Marking Two Years of Global Pandemic,” news release, January 14, 2022, <https://aspr.hhs.gov/newsroom/Pages/NewsDetailView.aspx?ItemID=690>.
- ⁴ Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.
- ⁵ “State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data,” Medicaid.gov, accessed February 1, 2022, <https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360>.
- ⁶ We follow a modified projection process for Missouri, Nebraska, and Oklahoma, because these states expanded Medicaid during the analysis window. For these states, we rely on Health Insurance Policy Simulation Model projections to estimate the effects of Medicaid expansion on enrollment growth. We then combine these estimates with our estimates of enrollment growth attributable to the pandemic and the continuous coverage requirement to arrive at the final growth rates used to calculate projections for these states.
- ⁷ The 17 states in which enrollment is not currently handled by HealthCare.gov are California, Colorado, Connecticut, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. See Centers for Medicare & Medicaid Services, “Marketplace 2022 Open Enrollment Period Report: National Snapshot,” news release, December 9, 2021, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-national-snapshot>.
- ⁸ CMS, guidance to state health officials, regarding, “Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP, and BHP upon Conclusion of the Public Health Emergency.”

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About the Authors

Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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