

RESEARCH REPORT

# The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage

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# Executive Summary

An unprecedented number of people has enrolled in Medicaid since the COVID-19 pandemic began; the most recent data show enrollment jumped by more than 18 million people from February 2020 to June 2022. This increased enrollment largely owes to the continuous coverage requirement of the Families First Coronavirus Response Act, which has prevented state Medicaid agencies from disenrolling people during the public health emergency (PHE) unless they specifically request it. An increasingly urgent question is what will happen to health coverage after the PHE expires and states resume normal eligibility determinations. Using the latest available administrative data on Medicaid enrollment, recent household survey data on health coverage, and the Urban Institute's Health Insurance Policy Simulation Model, we estimate health coverage at the expiration of the PHE (when Medicaid enrollment will be at its peak) and after the major coverage transitions that will follow.

We estimate that if the PHE expires in April 2023, 18.0 million people will lose Medicaid coverage in the following 14 months. Of those 18.0 million people,

- about 3.2 million children are estimated to transition from Medicaid to separate Children's Health Insurance Programs, so total Medicaid and Children's Health Insurance Program enrollment will decline by 14.8 million people;
- about 3.8 million people will become uninsured;
- about 9.5 million people will either newly enroll in employer-sponsored insurance after losing Medicaid or transition to employer-sponsored insurance as their only source of coverage after being enrolled in both employer-sponsored insurance and Medicaid sometime during the PHE;
- and more than 1 million people will enroll in the nongroup market, most of whom will be eligible for premium tax credits in the Marketplace.

Further extensions of the PHE are possible. If it is extended for an additional 90 days, we estimate that the number of people losing Medicaid will rise to nearly 19 million.



# The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage

## Background

Facing an unprecedented public health crisis, Congress passed the Families First Coronavirus Response Act in 2020. This act contained two important provisions for Medicaid coverage while the public health emergency (PHE) is in place. First, the share of Medicaid costs paid for by the federal government, rather than the state, increased. This provision is called enhanced federal medical assistance percentage (FMAP). Second, state Medicaid agencies are not allowed to disenroll people unless they specifically request it. This continuous coverage requirement was intended to minimize the number of people losing health coverage during the pandemic. An unprecedented number of people have enrolled in Medicaid since the pandemic began; the most recent data at the time of this writing show enrollment jumped by more than 18 million people from February 2020 to June 2022.<sup>1</sup> Many were concerned in 2020 that the number of uninsured people would spike. However, the National Health Interview Survey found that about 4.5 million fewer people were uninsured in the first quarter of 2022 compared with the first quarter of 2020. This increase in coverage owes to the continuous coverage requirement and the enhanced Marketplace premium tax credits (PTCs) that have been in place since 2021 (Buettgens, Banthin, and Green 2022).

## Health Coverage after the Public Health Emergency Expires

An increasingly urgent question is what will happen to health coverage after the PHE expires. On October 13, 2022, the secretary of health and human services extended the PHE for 90 more days.<sup>2</sup> The Biden administration has said states will be given at least 60 days' notice before the PHE is terminated.<sup>3</sup> No notice of termination was given before November 13, so we assume the PHE will be extended for another 90 days, until April 2023. The future of the pandemic and related federal policies is still uncertain, so even further extension is possible. Current guidance from the US Department of Health and Human Services gives states up to 14 months after the PHE ends to return to normal Medicaid eligibility processing.<sup>4</sup> We estimate that if the PHE expires in April 2023, 18.0 million people will lose

Medicaid coverage in the following 14 months. If the PHE were extended for an additional quarter, the number would rise to nearly 19 million.

This paper updates our earlier estimates of how the PHE and its expiration will affect Medicaid enrollment (Buettgens and Green 2021, 2022). In this report, we go further to show what would happen to people disenrolling from Medicaid and whether they take up other types of coverage. We estimate that if the PHE expires in April 2023, of the 18.0 million people who will lose Medicaid coverage, about 3.2 million children will transition from Medicaid to separate Children’s Health Insurance Program (CHIP) programs. Total Medicaid and CHIP enrollment will decline by 14.8 million. Based on recent survey data, we estimate that of the 18.0 million people losing Medicaid coverage, 3.8 million will become uninsured following the expiration of the PHE. We project that the remainder of those losing Medicaid will be enrolled in nongroup coverage or employer-sponsored insurance (ESI). Indeed, an unknown number of those enrolled in Medicaid during the PHE has also been enrolled in ESI.

## State Policy Issues

We also consider several state policy issues and provide sensitivity analyses that illustrate how the transition from the end of the PHE to the end of the 14-month redetermination period after the PHE depends on state decisions. First, some states could process enrollment more rapidly than others. The loss of the enhanced FMAP in the quarter following the PHE expiration provides a financial incentive to do so. This could result in millions more people losing coverage in the first months after the PHE expires than if states gradually process program eligibility over 14 months.

Second, many people losing Medicaid will be eligible for Marketplace coverage with PTCs, so coordination between Marketplaces and state Medicaid agencies will be essential to minimizing losses of health coverage after the PHE expires. This may be easier for state-based Marketplaces—especially those that integrate Medicaid eligibility functions—than for federally facilitated Marketplaces. The Biden administration recommends states share with the Marketplaces the contact and eligibility information of people losing Medicaid (CMS 2022), but the extent to which that will occur in individual states is unknown.

Third, some are concerned that the unprecedented volume of income redeterminations that states must process may result in the inappropriate disenrollment of people still eligible for Medicaid. This could lead to lower Medicaid enrollment and higher numbers of uninsured people.



Fourth, Medicaid take-up could be somewhat higher in the long term after the PHE than it was before the pandemic. Recent focus on Medicaid administrative processes may make state governments and the public more aware of issues related to Medicaid disenrollment and churn in health coverage—whereby people enroll and disenroll during the course of a year. Also, record-high Medicaid enrollment may lessen any stigma associated with the program, and more people may now be familiar with the application process.

Fifth, though the national unemployment rate is close to its prepandemic value, some areas' unemployment rates are still higher than they were before the pandemic. Lingering economic impacts could lead to more people retaining Medicaid eligibility than before the pandemic until employment fully recovers. Conversely, some states have lower unemployment rates than before the pandemic, which would have the opposite effect.

### **About US Health Reform—Monitoring and Impact**

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## Methods

Our methods for projecting Medicaid enrollment are the same as in our earlier papers on Medicaid enrollment during the PHE (Buettgens and Green 2021, 2022). We use the latest available administrative data from each state to compute monthly enrollment increases relative to prepandemic enrollment. We then use each state's average enrollment growth rate in the most recent six months of data available to project enrollment for all remaining months through the end of the PHE.

We produce our estimates for health coverage after the unwinding of the PHE using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy

options (Buettgens and Banthin 2020). We assume the PHE will not permanently alter Medicaid enrollment; because the economy has recovered and employment has mostly returned to prepandemic trends, we expect Medicaid enrollment will also return to its long-term, prepandemic trend, as estimated by HIPSIM. We then determine the number of adults and children in each state who would have been enrolled in Medicaid in April 2023, according to our projections, and compare those estimates with estimated post-PHE Medicaid enrollment. The difference is the number of people expected to lose Medicaid after the PHE expires.

We then identify people in HIPSIM who, although not currently eligible for Medicaid, were most likely to have been eligible within the last two years. The people most likely to churn in and out of Medicaid eligibility include young adults, workers with part-time jobs, and people with incomes close to eligibility cutoffs. We draw from these people imputed to have been formerly eligible to match peak Medicaid enrollment in each state when the PHE expires. This gives us health coverage distributions for when the PHE expires and after the unwinding of the PHE 14 months later. Finally, we phase out PHE Medicaid enrollment between these two points to get monthly estimates of health coverage.

We expect that losses of coverage due to unwinding the PHE will be like the gains in coverage between 2020 and 2022, as measured in surveys. We rely mostly on the National Health Interview Survey, which recorded about 4.5 million fewer uninsured people from the beginning of 2020 to the beginning of 2022. Extending that trend to another year in which the PHE will be in effect would result in about 6.4 million fewer people being uninsured. We then subtract from this number the reduction in the number of uninsured people that we attribute to enhanced Marketplace PTCs, which were introduced in 2021 and were recently extended for three years (Buettgens, Banthin, and Green 2022).<sup>5</sup> The net result is 3.8 million people, so we impute Medicaid enrollment at the peak of the PHE such that there will be 3.8 million more uninsured people 14 months later as coverage transitions settle.

We discuss our methods further in appendix A.

## Results

We begin by discussing the coverage transitions we project to occur after the end of the PHE. Then, we discuss how the coverage impacts may differ by state. Next, we discuss several factors that may affect the trajectory of coverage transitions. Finally, we show how our estimates of changes in Medicaid enrollment and the number of uninsured people would differ if the PHE were extended for an additional 90 days.

## Health Coverage Transitions after the Public Health Emergency

We estimate that by April 2023, the currently expected end of the PHE, 85.6 million nonelderly people will be enrolled in Medicaid or CHIP, 30.7 percent of the population (table 1). This is a historical high. Around 7.9 percent of the population will be uninsured, a historical low, because of the Medicaid continuous coverage requirement and enhanced Marketplace PTCs.

**TABLE 1**

**Distribution of Health Insurance Coverage among the Nonelderly Population during and after the Public Health Emergency**

Coverage	April 2023, assumed end of the PHE (thousands of people)	June 2024, end of transition (thousands of people)	Difference, thousands of people	Percent difference
Medicaid/CHIP	85,571	70,775	-14,796	-17.3
Other public	8,436	8,684	247	2.9
Employer sponsored	142,266	151,725	9,459	6.6
Nongroup	17,870	18,895	1,024	5.7
Uninsured	22,052	25,875	3,823	17.3
Non-ACA compliant	2,237	2,479	242	10.8

Source: Health Insurance Policy Simulation Model.

Notes: PHE = public health emergency. CHIP = Children’s Health Insurance Program. ACA = Affordable Care Act.

Slightly more than half of the nonelderly population will be covered only by ESI when the PHE expires. An unknown number of new Medicaid enrollees during the PHE is also enrolled in ESI. Employment has largely recovered from the economic shutdowns of 2020 (see the Health Insurance Coverage by State section below). If a Medicaid enrollee gets a new job with health benefits during the PHE, they will not be disenrolled from Medicaid unless they specifically contact the agency and request it, which has been rare.

We estimate that about 6.4 percent of the nonelderly population will be enrolled in nongroup coverage when the PHE ends in April 2023. The American Rescue Plan Act enhanced Marketplace PTCs, resulting in the highest-ever Marketplace enrollment figures (Buettgens, Banthin, and Green 2022). The remaining nonelderly population will have either other public coverage or non-Affordable Care Act-compliant plans.

If the PHE expires in April 2023, Medicaid enrollment will peak in that month. We estimate that 18.0 million people will then be disenrolled from Medicaid over the following 14 months. This includes about 10.6 million adults and 7.3 million children (appendix table B.1). We estimate that 3.2 million

children will transfer from Medicaid to separate CHIP programs (figure 1), so combined Medicaid and CHIP enrollment will decline by 14.8 million people, or 17.3 percent.

We estimate that 3.8 million more people will be uninsured after the coverage transitions following the expiration of the PHE have settled, an increase of 17.3 percent. About 1.5 million people, or 40 percent of the newly uninsured, would be eligible for Marketplace PTCs. Those eligible may not enroll either because Marketplace premiums are higher than Medicaid for less comprehensive coverage or because limited coordination between state Medicaid agencies and the Marketplaces creates barriers to enrollment. Some may not know that they are eligible for PTCs.

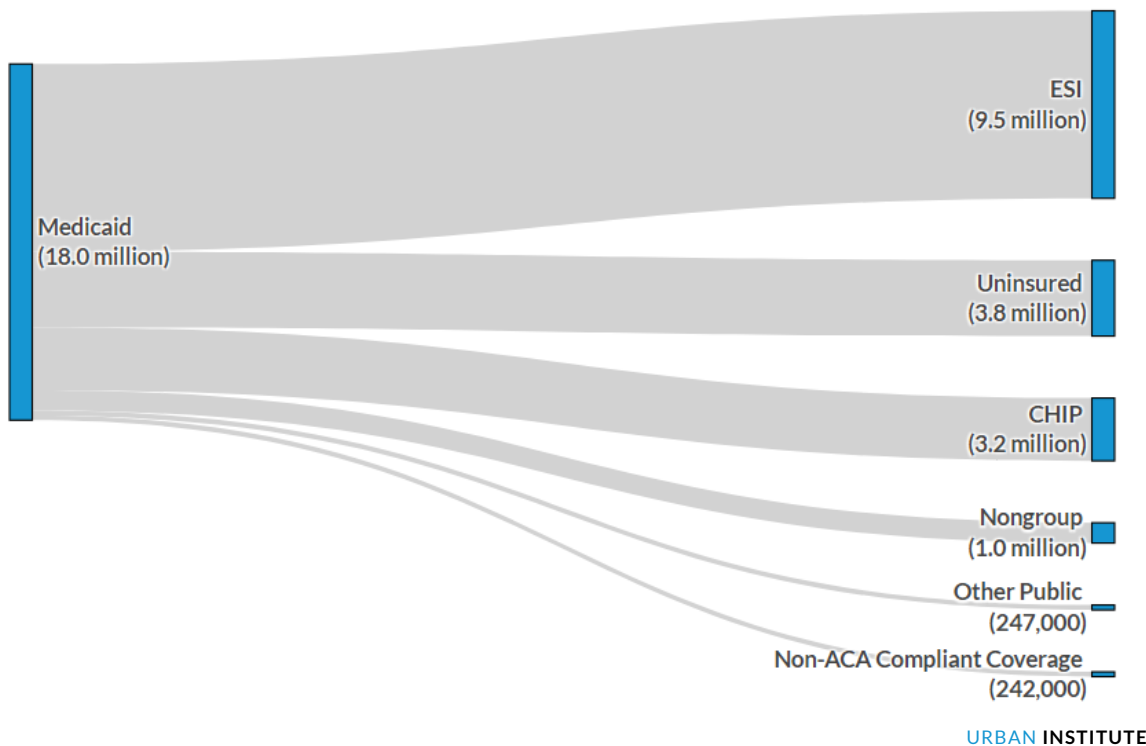
Our projected reduction in the uninsured population during the PHE is smaller than that reported in the National Health Interview Survey because that survey captures gains in coverage due to both the Medicaid continuous coverage requirement and the enhanced Marketplace PTCs. The latter will remain in place through 2025, so those coverage gains will not be lost (see appendix A for more details). State actions could potentially lead to a larger number of people becoming uninsured after the PHE, as we discuss in the State-Specific Factors That Could Alter the Trajectory of Health Coverage section.

We project that nongroup coverage will increase by 1.0 million people after the PHE expires. Many of those losing Medicaid will become eligible for PTCs in the Marketplaces. It is thus critical that these people know they are eligible for financial assistance and can enroll without much difficulty. Otherwise, fewer of these people will enroll in the Marketplaces and more will become uninsured. We discuss this in more detail later.

We estimate that roughly 9.5 million more people will have ESI coverage only after the PHE expires. An unknown number of these people has already enrolled in ESI during the PHE as employment has recovered from pandemic-related shutdowns. The number of new ESI enrollees after the PHE expires will likely be smaller than this number.

FIGURE 1

Coverage Transitions of Medicaid Enrollees after the Public Health Emergency Expires



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Source: Health Insurance Policy Simulation Model.

Notes: ESI = employer-sponsored insurance. CHIP = Children’s Health Insurance Program. ACA = Affordable Care Act.

Health Insurance Coverage by State

As of February 2022, the national unemployment rate had nearly recovered to its prepandemic level (appendix table B.2). However, the economic recovery has not been even across all states. Twenty-nine states and the District of Columbia still had a higher unemployment rate in February 2022 than in February 2020. Eleven of those states and the District of Columbia had unemployment rates at least 1 percentage point higher than their prepandemic unemployment rates: California, Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Nevada, New York, and Texas. New York City is estimated to have recovered fewer than 71 percent of the jobs lost in the early months of the pandemic, whereas the US has recovered 95 percent of jobs lost, illustrating how the employment recovery has been uneven (Office of the New York State Comptroller 2022). For example, unemployment rates for Black workers and young adult workers in New York City continued to rise in 2021. With lower employment, more people will retain eligibility for Medicaid, so Medicaid enrollment could remain higher in these localities for several years until full recovery.

On the other hand, 19 states had lower unemployment rates in February 2022 than in February 2020: Arizona, Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Mississippi, Montana, Nebraska, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, West Virginia, Wisconsin, and Wyoming. The number of people eligible for Medicaid in these states could be lower now than before the pandemic.

In appendix table B.3, we show how Medicaid and CHIP enrollment would change in each state between April 2023, when we assume the PHE will expire, and the end of the transition period 14 months later. We estimate that Medicaid and CHIP enrollment reductions will range from 10 to 33 percent. The 14 states projected to have the highest Medicaid enrollment reductions, of 20 percent or more, are Arizona, Colorado, Florida, Idaho, Indiana, Maine, Minnesota, Nevada, New Hampshire, North Dakota, Utah, Virginia, Wisconsin, and Wyoming. These state differences are primarily the result of enrollment increases reported in administrative data, though differences in unemployment during the pandemic also have an effect, as discussed above.

In appendix table B.4, we show the estimated number of uninsured people in each state at the end of the PHE and the end of the transition period. The 19 states projected to have the highest increases in uninsurance, of 20 percent or more, are Arizona, Arkansas, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, and West Virginia. Naturally, states with larger reductions in Medicaid enrollment will tend to have larger increases in the number of uninsured people, but much also depends on the characteristics of people in each state who were eligible for Medicaid during the PHE. States differ substantially in income distribution, the availability of ESI, and eligibility for Marketplace PTCs. In particular, some adults losing Medicaid in states that have not expanded Medicaid under the Affordable Care Act may not be eligible for PTCs because their incomes are below 100 percent of the federal poverty level. Changes in unemployment during the pandemic also influence changes in the uninsured population.

## **State-Specific Factors That Could Alter the Trajectory of Health Coverage**

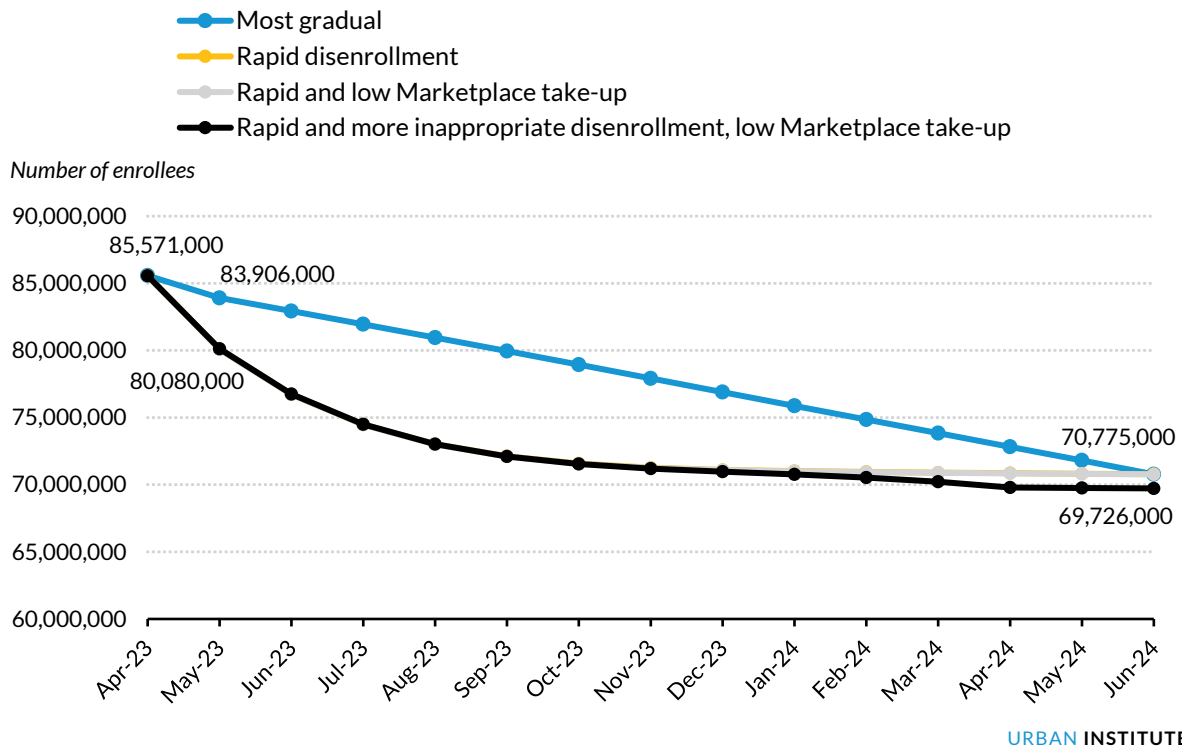
In this section, we discuss several other factors in individual states that could affect coverage transitions after the PHE ends.

## THE RAPIDITY OF MEDICAID ELIGIBILITY PROCESSING AND DISENROLLMENT

Current Biden administration guidance gives states up to 14 months following the end of the PHE to fully resume normal income eligibility redeterminations for Medicaid. However, states could choose to do so more rapidly. The enhanced FMAP ends in the quarter following the expiration of the PHE, so states have a financial incentive to process enrollment quickly before the extra federal money is discontinued. Figure 2 illustrates the difference between gradual disenrollment over the 14 transition months and more rapid disenrollment in the first months after the PHE expires. With gradual disenrollment, the number of Medicaid enrollees would decline by about 1 million each month. However, if all states choose rapid processing and disenrollment, the number of people losing Medicaid in the first month after eligibility redeterminations resume could be closer to 5 million. The number of uninsured people and people enrolled in private coverage would also increase faster with more rapid Medicaid disenrollment.

**FIGURE 2**

**Changes in Medicaid/CHIP Coverage during the Transition Period after the Public Health Emergency Expires, by Rapidity of Eligibility Processing and Disenrollment and Marketplace Coverage Take-Up**



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**Source:** Health Insurance Policy Simulation Model.

**Notes:** CHIP = Children’s Health Insurance Program. The rapid disenrollment line largely overlaps with the rapid disenrollment and low Marketplace take-up line.

## MARKETPLACE TAKE-UP AMONG PEOPLE LOSING MEDICAID

We estimate that about 1 million people losing Medicaid will enroll in the nongroup market. Of the 3.8 million people who we estimate will become uninsured after the PHE expires, about 1.5 million would be eligible for Marketplace PTCs. Enrolling former Medicaid beneficiaries who are newly eligible for PTCs will be crucial for minimizing the number of people who become uninsured after the PHE expires. This may be easier for the 18 state-based Marketplaces—especially those with integrated eligibility systems—but will be more difficult for other states because it will require coordination between the federal government and state Medicaid agencies.<sup>6</sup> Current administration guidance recommends states share with the Marketplace the contact and eligibility information of people losing Medicaid. However, the extent to which this will happen in specific states is unclear. By default, we assume Marketplace take-up rates among people losing Medicaid will be a little higher than current take-up rates for state-based Marketplaces and lower for other states. If take-up rates are lower than this assumption, nongroup enrollment will be lower than we project and the number of uninsured people will be higher, by about 673,000 people (data not shown).

More rapid Medicaid disenrollment could make it more difficult for outreach and assistance efforts to reach people who are newly eligible for Marketplace PTCs.

## THE POSSIBILITY OF GREATER INAPPROPRIATE DISENROLLMENT FROM MEDICAID

Some are concerned that the unprecedented volume of eligibility redeterminations that states must process and the loss of the enhanced FMAP could result in more inappropriate disenrollment from Medicaid among people still eligible for the program than has occurred in the past. For example, if inappropriate disenrollment affects 1.5 percent of Medicaid enrollees, fewer people would be enrolled in Medicaid than we project, and about 1.7 million more people would end up uninsured (data not shown).

More rapid processing of enrollment redeterminations could lead to more inappropriate disenrollment. Even if significant inappropriate disenrollment occurs during the transition, it may not continue after eligibility processing has settled, meaning the resulting loss of Medicaid enrollment may not be long term.

## THE POSSIBILITY OF HIGHER LONG-TERM MEDICAID TAKE-UP

Medicaid take-up behavior could change in the long term in other ways as a result of the PHE. Growing media coverage has raised awareness of disenrollment and churn in health coverage both at state Medicaid agencies and among the public. States may decide to continue temporary waivers



implemented during the PHE that streamlined eligibility determination. More widespread Medicaid enrollment may help reduce any stigma attached to the program. Currently, no evidence exists that these factors could have a large impact on enrollment, but a modest impact is plausible.

## Further Extensions of the Public Health Emergency

If the PHE is extended an additional quarter, to July 2023, we estimate that 19.0 million people will be disenrolled from Medicaid over the next 14 months, up from 18.0 million if the PHE ends in the previous quarter. With a July 2023 end date, we estimate that more than 3.3 million children will enroll in separate CHIP programs, so net enrollment in Medicaid and CHIP will decline by 15.6 million (table 2). Thus, 826,000 more people will lose Medicaid and CHIP coverage than if the PHE ended in April 2023. Additionally, we estimate that 3.9 million more people will be uninsured after the unwinding of the PHE, 84,000 more people than if the PHE ends in April 2023.

TABLE 2

### Changes in Medicaid/CHIP Enrollment and Uninsurance among the Nonelderly Population after the Public Health Emergency Expires, April 2023 Expiration versus July 2023 Expiration

	April 2023 (thousands of people)	July 2023 (thousands of people)	Difference, thousands of people	Percent difference
Medicaid/CHIP	-14,796	-15,622	-826	5.6
Uninsured	3,823	3,907	84	2.2

Source: Health Insurance Policy Simulation Model.

Note: CHIP = Children's Health Insurance Program.

Thus, further extensions of the PHE will increase the number of people losing Medicaid after the PHE by about 1 million each quarter, notably increasing the number of redeterminations that each state would have to process. Regardless of the PHE's end date, states will still get 60 days' notice before the PHE expires, so further extension may not help them plan better.

## Discussion

If the COVID-19 PHE expires in April 2023, as currently expected, we estimate that 18.0 million people will lose Medicaid coverage over the next 14 months. Of these, 3.2 million children will transition from Medicaid to a separate CHIP program. The state government administers both programs, so transitions

may be smooth, though some enrollees may have to pay premiums for CHIP coverage that they did not have to pay for Medicaid coverage.

We estimate that 1.0 million people losing Medicaid coverage will enroll in nongroup coverage, mainly Marketplace coverage with PTCs. In addition, we estimate that 1.5 million former Medicaid beneficiaries will be eligible for PTCs but will not enroll. It will require more effort to ensure those eligible for Marketplace PTCs know they are eligible for assistance and to minimize barriers to their enrollment than it will be for CHIP, particularly for states with federally facilitated Marketplaces and with state-based Marketplaces that are siloed from the Medicaid program. Also, people transitioning to Marketplace coverage will pay more for premiums and cost sharing than they did under Medicaid, though presumably their incomes will be higher than they were when they qualified for Medicaid.

The largest share of people losing Medicaid, 9.5 million, will end up with ESI. Nationally, unemployment has nearly returned to prepandemic levels, and many people will lose Medicaid eligibility precisely because they gained new employment during the PHE. An unknown number of those transitioning from Medicaid to ESI only was enrolled in both types of coverage during the PHE; the number of people newly enrolling in ESI after the PHE will likely be considerably lower than 9.5 million.

Gains in employment since the economic shutdowns at the start of the pandemic have been uneven. All states have lower unemployment rates now than at the height of the pandemic, but some states' rates still lag behind prepandemic rates, whereas other states' rates are lower than they were before the pandemic. Evidence shows variation in substate regions, such as New York City, as discussed earlier. These differences could affect Medicaid enrollment in both directions for the next few years. Also, some believe the US could face a recession in the next few years, and if that happens, Medicaid enrollment will likely be higher than we project.

The end of the PHE is still uncertain. If it is extended for 90 more days, about 1 million more people will lose Medicaid after its expiration. The Biden administration has promised to give 60 days' notice before the end of the PHE but has resisted requests by many states for more notice.

The Medicaid continuous coverage requirement and enhanced Marketplace PTCs have resulted in record-high Medicaid and Marketplace enrollment and record-low numbers of uninsured people. Though the enhanced PTCs have been extended through 2025, we project that Medicaid enrollment will likely fall by 18.0 million if the PHE expires in April 2023, or more if the PHE is extended beyond then. We expect that the large majority of people losing Medicaid (more than 14 million) will find other sources of coverage, though we project that about 3.8 million more people will be uninsured. However,

people transitioning from Medicaid to private coverage will pay more in premiums and out-of-pocket health costs. It is possible that more people losing Medicaid, particularly those without access to ESI, may experience a temporary interruption in health coverage before enrolling in alternative coverage. State policy decisions during the transition following the PHE expiration will affect how many people lose coverage, how rapidly they lose coverage, and how many people will enroll in other coverage. Medicaid enrollment during the PHE may have other lasting effects, such as raising awareness of churning in health insurance coverage and possibly changing perceptions of Medicaid. The experience may also inform the debate around other issues related to churn and continuity of coverage, such as 12-month continuous eligibility in Medicaid and better coordination between Medicaid and the Marketplaces.

# Appendix A. Methodology

Our methods for projecting Medicaid enrollment are the same as in our earlier papers on Medicaid enrollment during the PHE (Buettgens and Green 2021, 2022). We again focus on the noninstitutionalized Medicaid population under age 65.

## Administrative Data

We use the latest available data from each state to compute monthly Medicaid 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, 2021, and 2022. 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. Appendix table B.5 shows the data source for each state. We calculate enrollment growth in each month relative to enrollment levels in February 2020 for all available months. For the 20 states and the District of Columbia for which we rely on CMS data, May 2022 was the latest month for which data were available at the time of analysis. For the other 30 states, the latest month for which data were available ranged from June to September of 2022.

We use these administrative data to compute each state’s average Medicaid 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. In addition to the extension of the PHE into April 2023, we made projections assuming the PHE is extended into July 2023. As noted, states have 14 months after the PHE end date to resume normal Medicaid eligibility processing.

## The Health Insurance Policy Simulation Model

We produce our estimates for health coverage after the unwinding of the PHE using HIPSM, a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several

years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

We assume the PHE will not permanently alter Medicaid enrollment; because the economy has recovered and employment has mostly returned to prepandemic trends, we expect Medicaid enrollment will also return to its long-term, prepandemic trend, as estimated by HIPSM. These estimates of post-PHE Medicaid enrollment are almost identical to those we published earlier this year (Buettgens, Banthin, and Green 2022), except for updates to the District of Columbia and West Virginia. The details of our methodology are published in a separate report (Buettgens and Banthin 2022). We determine the number of adults and children in each state who would have been enrolled in Medicaid in April 2023 (or July 2023) if the PHE were still in place, according to our projections, and compare those estimates with post-PHE Medicaid enrollment. The difference is the number of people expected to lose Medicaid after the PHE expires.

We then identify people in HIPSM who, although not currently eligible for Medicaid, were most likely to have been eligible within the last two years. The people most likely to churn in and out of Medicaid eligibility include young adults, workers with part-time jobs, and people with incomes close to eligibility cutoffs. People who were enrolled in Medicaid during the PHE but later became ineligible are in this group. We identify this population based on a separate analysis of data from the Survey of Income and Program Participation (SIPP). We use the 2008 panel of the SIPP, which collected data into 2014, and reweight it to 2023. The survey was redesigned after this panel, making it less useful for our purposes. We use monthly data on income and household composition to determine people's eligibility for Medicaid at various points over two years. Then we use machine learning techniques to predict whether people in the SIPP who are not currently eligible for Medicaid would have been eligible at some point in the past two years. Finally, we use the models that we fit on the SIPP data to predict past eligibility in HIPSM. A paper with detailed methodology and results is forthcoming.

We draw from this population imputed to have been formerly eligible for Medicaid to match peak Medicaid enrollment in each state when the PHE expires. This gives us health coverage distributions for when the PHE expires and after the unwinding of the PHE 14 months later. Finally, we phase out PHE Medicaid enrollment between these two points to get monthly estimates of health coverage.

We expect that the losses of coverage due to unwinding the PHE will be similar to the gains in coverage between 2020 and 2022, as measured in surveys. We rely mostly on the National Health Interview Survey, which recorded that the number of uninsured people declined by about 4.5 million from the beginning of 2020 to the beginning of 2022. Extending that trend to another year in which the

PHE will be in effect would result in about 6.4 million fewer uninsured people. However, the PHE was not the only policy change that affected health coverage during the pandemic. Marketplace PTCs were also enhanced beginning in 2021 and were recently extended for three years (Banthin, Buettgens, and Green 2022). We forecast that, after the PHE unwinding, enhanced PTCs alone will reduce the number of uninsured people by about 3.1 million. We estimate that roughly 500,000 of those 3.1 million would have been enrolled in Medicaid during the PHE (Buettgens and Banthin 2022). If we take the 6.4 million uninsured people and subtract those not enrolled in Medicaid during the PHE who would gain Marketplace coverage with PTCs after the PHE expiration, the result is about 3.8 million uninsured people. Thus, we impute Medicaid enrollment at the peak of the PHE so that there will be 3.8 million more uninsured people 14 months later, when coverage transitions have settled.

## Sensitivity Analysis

We use several important parameters when phasing out PHE Medicaid coverage:

- **The speed of disenrollment.** We present two scenarios, one with gradual phase-out over 14 months and another with more rapid phase-out in the early months after PHE expiration.
- **The rate at which people becoming eligible for Marketplace PTCs after losing Medicaid enroll in Marketplace coverage.** We present results for one option with expected take-up and another with lower take-up. The latter leads to more uninsured people after the coverage impacts of the PHE settle.
- **The rate of inappropriate disenrollment of people still eligible for Medicaid.** We initially assume that 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, 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 Medicaid eligibility determinations that they must process after the PHE. With this in mind, we also produce estimates in which higher inappropriate disenrollment affects 1.5 percent of Medicaid enrollees nationally. In practice, inappropriate disenrollment may vary significantly by state, but we have little evidence for predicting what will happen in individual states.
- **The impact of changes in employment since the beginning of the pandemic.** Some states still have notably higher unemployment than before the pandemic, so more Medicaid enrollees will

retain eligibility and coverage until the economy has fully recovered. Other states, however, have lower unemployment than before the pandemic, which will result in fewer people retaining Medicaid eligibility.

## Other Estimates of Disenrollment

A recent report from the Office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services estimates that 15 million people will be disenrolled from Medicaid after the PHE expires (ASPE 2022). The analysis uses data from the SIPP for 2015 and 2016 to estimate disenrollment due to loss of eligibility (8.2 million) and administrative churn (6.8 million). The report estimates that total Medicaid enrollment will decline by 9.3 million people, implying new enrollment of about 5.7 million people, partially offsetting the 15 million people who are disenrolled. Though we account for some enrollment growth relative to prepandemic enrollment, we do not see any underlying change in the economy or state enrollment practices that would result in permanently higher Medicaid enrollment on this scale. Additionally, the report assumes the PHE ended in December 2021, which means the enrollment growth that has occurred in 2022 and will continue until the expiration of the PHE is excluded from their estimate of the population facing disenrollment after the PHE ends.

# Appendix B. State-Level Tables

TABLE B.1

Projected Incremental Medicaid Enrollment among the Nonelderly Population, by State, April 2023

Thousands of people

State	Total	Adults	Children
Alabama	196	100	96
Alaska	32	18	15
Arizona	504	302	202
Arkansas	234	148	86
California	2,044	1,369	675
Colorado	394	266	127
Connecticut	116	77	39
Delaware	44	29	15
District of Columbia	44	30	14
Florida	1,414	717	697
Georgia	564	248	316
Hawaii	68	47	21
Idaho	109	67	42
Illinois	616	400	217
Indiana	565	368	197
Iowa	127	82	46
Kansas	48	22	26
Kentucky	269	186	83
Louisiana	303	194	109
Maine	99	70	29
Maryland	251	172	78
Massachusetts	349	254	94
Michigan	538	354	184
Minnesota	383	221	162
Mississippi	124	59	64
Missouri	378	202	175
Montana	56	38	19
Nebraska	40	19	21
Nevada	221	132	89
New Hampshire	64	41	23
New Jersey	403	275	128
New Mexico	120	73	47
New York	1,318	829	488
North Carolina	515	262	252
North Dakota	26	18	9
Ohio	534	347	187
Oklahoma	176	84	91
Oregon	264	176	88
Pennsylvania	546	368	178
Rhode Island	52	37	15
South Carolina	214	109	106
South Dakota	30	13	17
Tennessee	242	133	110
Texas	1,786	738	1,048
Utah	226	138	88
Vermont	33	20	13



State	Total	Adults	Children
Virginia	479	303	175
Washington	340	188	152
West Virginia	117	82	35
Wisconsin	333	216	116
Wyoming	17	8	9
<b>Total</b>	<b>17,962</b>	<b>10,647</b>	<b>7,315</b>

Source: Health Insurance Policy Simulation Model.

TABLE B.2

Unemployment Rate (Seasonally Adjusted), by State, February 2020 and February 2022

State	February 2020 (%)	February 2022 (%)	Percentage-point difference
<b>United States</b>	<b>3.5</b>	<b>3.8</b>	<b>0.3</b>
Alabama	2.6	3.0	0.4
Alaska	5.1	5.3	0.2
Arizona	4.9	3.6	-1.3
Arkansas	3.8	3.1	-0.7
California	4.3	5.3	1.0
Colorado	2.8	4.0	1.2
Connecticut	3.7	4.9	1.2
Delaware	4.5	4.6	0.1
District of Columbia	5.0	6.1	1.1
Florida	3.3	3.3	0.0
Georgia	3.5	3.2	-0.3
Hawaii	2.1	4.2	2.1
Idaho	2.6	2.8	0.2
Illinois	3.6	4.8	1.2
Indiana	3.2	2.3	-0.9
Iowa	2.9	3.5	0.6
Kansas	3.2	2.5	-0.7
Kentucky	4.2	4.2	0.0
Louisiana	5.2	4.3	-0.9
Maine	3.1	4.0	0.9
Maryland	3.5	5.0	1.5
Massachusetts	2.8	4.7	1.9
Michigan	3.7	4.7	1.0
Minnesota	3.3	2.7	-0.6
Mississippi	5.8	4.5	-1.3
Missouri	3.6	3.7	0.1
Montana	3.7	2.6	-1.1
Nebraska	3.0	2.1	-0.9
Nevada	3.7	5.1	1.4
New Hampshire	2.6	2.7	0.1
New Jersey	3.7	4.6	0.9
New Mexico	5.3	5.6	0.3
New York	3.9	4.9	1.0
North Carolina	3.6	3.7	0.1
North Dakota	2.3	2.9	0.6
Ohio	4.7	4.2	-0.5
Oklahoma	3.1	2.6	-0.5
Oregon	3.5	4.0	0.5
Pennsylvania	5.0	5.1	0.1

State	February 2020 (%)	February 2022 (%)	Percentage-point difference
Rhode Island	4.0	3.9	-0.1
South Carolina	2.8	3.5	0.7
South Dakota	2.9	2.6	-0.3
Tennessee	3.9	3.4	-0.5
Texas	3.7	4.7	1.0
Utah	2.5	2.1	-0.4
Vermont	2.5	2.9	0.4
Virginia	2.5	3.2	0.7
Washington	4.1	4.3	0.2
West Virginia	5.1	3.9	-1.2
Wisconsin	3.3	2.9	-0.4
Wyoming	4.8	3.6	-1.2

Source: "Unemployment Rate (Seasonally Adjusted)," Kaiser Family Foundation, accessed November 18, 2022, <https://www.kff.org/other/state-indicator/unemployment-rate/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

TABLE B.3

**Medicaid and CHIP Enrollment among the Nonelderly Population during and after the Public Health Emergency**

State	April 2023, assumed end of the PHE (thousands of people)	June 2024, end of transition (thousands of people)	Difference, thousands of people	Percent difference
Alabama	1,104	976	-129	-11.7
Alaska	234	206	-28	-12.0
Arizona	2,252	1,751	-500	-22.2
Arkansas	1,082	879	-202	-18.7
California	12,866	11,236	-1,629	-12.7
Colorado	1,569	1,238	-331	-21.1
Connecticut	898	801	-97	-10.8
Delaware	233	193	-40	-17.4
District of Columbia	265	225	-40	-15.0
Florida	4,515	3,438	-1,076	-23.8
Georgia	2,353	1,958	-395	-16.8
Hawaii	329	268	-61	-18.5
Idaho	479	380	-99	-20.6
Illinois	3,032	2,507	-526	-17.3
Indiana	1,897	1,364	-534	-28.1
Iowa	785	685	-99	-12.6
Kansas	417	372	-45	-10.9
Kentucky	1,577	1,333	-243	-15.4
Louisiana	1,669	1,401	-268	-16.1
Maine	395	306	-89	-22.5
Maryland	1,526	1,325	-201	-13.2
Massachusetts	1,934	1,648	-285	-14.8
Michigan	2,646	2,176	-471	-17.8
Minnesota	1,296	943	-353	-27.2
Mississippi	709	607	-102	-14.4
Missouri	1,591	1,318	-274	-17.2

State	April 2023, assumed end of the PHE (thousands of people)	June 2024, end of transition (thousands of people)	Difference, thousands of people	Percent difference
Montana	309	261	-48	-15.5
Nebraska	354	316	-38	-10.7
Nevada	856	670	-186	-21.7
New Hampshire	261	204	-57	-21.7
New Jersey	1,939	1,588	-352	-18.1
New Mexico	825	726	-99	-12.1
New York	6,854	5,779	-1,075	-15.7
North Carolina	2,489	2,114	-375	-15.1
North Dakota	102	75	-27	-26.5
Ohio	2,906	2,393	-513	-17.6
Oklahoma	1,093	933	-160	-14.6
Oregon	1,212	1,005	-206	-17.0
Pennsylvania	2,996	2,502	-494	-16.5
Rhode Island	306	261	-45	-14.6
South Carolina	1,118	952	-166	-14.8
South Dakota	139	114	-25	-18.0
Tennessee	1,562	1,361	-201	-12.9
Texas	6,069	4,860	-1,208	-19.9
Utah	701	473	-228	-32.5
Vermont	154	125	-29	-19.0
Virginia	1,840	1,399	-441	-24.0
Washington	1,887	1,622	-265	-14.0
West Virginia	596	481	-115	-19.3
Wisconsin	1,278	970	-309	-24.1
Wyoming	70	54	-16	-23.1
<b>Total</b>	<b>85,571</b>	<b>70,775</b>	<b>-14,796</b>	<b>-17.3</b>

Sources: Health Insurance Policy Simulation Model.

Notes: CHIP = Children's Health Insurance Program. PHE = public health emergency.

TABLE B.4

Uninsurance among the Nonelderly Population during and after the Public Health Emergency

State	April 2023, assumed end of the PHE (thousands of people)	June 2024, end of transition (thousands of people)	Difference, thousands of people	Percent difference
Alabama	371	432	61	16.6
Alaska	71	82	11	15.2
Arizona	608	733	125	20.6
Arkansas	168	207	39	23.5
California	2,921	3,327	407	13.9
Colorado	370	444	74	19.9
Connecticut	163	183	21	12.8
Delaware	46	54	8	17.1
District of Columbia	26	29	3	12.0
Florida	1,727	2,069	342	19.8
Georgia	971	1,138	167	17.1
Hawaii	91	103	11	12.6

State	April 2023, assumed end of the PHE (thousands of people)	June 2024, end of transition (thousands of people)	Difference, thousands of people	Percent difference
Idaho	129	160	31	23.8
Illinois	840	971	131	15.6
Indiana	363	445	82	22.6
Iowa	102	129	28	27.1
Kansas	286	301	16	5.5
Kentucky	170	225	54	32.0
Louisiana	297	362	65	22.0
Maine	32	41	9	28.7
Maryland	325	369	44	13.4
Massachusetts	205	230	25	12.3
Michigan	366	441	75	20.5
Minnesota	194	241	47	24.0
Mississippi	260	303	43	16.5
Missouri	284	370	86	30.4
Montana	60	73	14	22.7
Nebraska	92	106	14	15.0
Nevada	324	369	45	14.0
New Hampshire	46	58	12	25.2
New Jersey	544	613	69	12.6
New Mexico	172	203	31	17.9
New York	830	988	158	19.0
North Carolina	800	955	155	19.4
North Dakota	54	65	11	20.7
Ohio	488	611	123	25.2
Oklahoma	273	324	51	18.6
Oregon	273	329	56	20.4
Pennsylvania	477	581	104	21.9
Rhode Island	40	51	10	25.8
South Carolina	373	445	72	19.3
South Dakota	71	80	10	13.5
Tennessee	542	631	90	16.5
Texas	3,558	4,071	514	14.4
Utah	195	228	33	16.8
Vermont	36	43	7	19.4
Virginia	525	618	94	17.8
Washington	498	566	68	13.6
West Virginia	79	103	24	30.5
Wisconsin	248	298	49	19.9
Wyoming	71	78	7	10.3
<b>Total</b>	<b>22,052</b>	<b>25,875</b>	<b>3,823</b>	<b>17.3</b>

Sources: Health Insurance Policy Simulation Model.

Note: PHE = public health emergency.

TABLE B.5

## Data Sources, by State

State	Data source	URL
Alabama	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Alaska	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Arizona	State Medicaid agency	<a href="https://www.azdhs.gov/health-care-cost-containment-system">Arizona Health Care Cost Containment System</a>
Arkansas	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
California	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Colorado	State Medicaid agency	<a href="https://www.colorado.gov/health-care-policy-and-financing">Colorado Department of Health Care Policy and Financing</a>
Connecticut	State Medicaid agency	<a href="https://www.ct.gov/open-data">Connecticut Open Data</a>
Delaware	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
District of Columbia	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Florida	State Medicaid agency	<a href="https://www.fda.gov/health-care-administration">Florida Agency for Health Care Administration</a>
Georgia	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Hawaii	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Idaho	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Illinois	State Medicaid agency	<a href="https://www.illinois.gov/healthcare-and-family-services">Illinois Department of Healthcare and Family Services</a>
Indiana	State Medicaid agency	<a href="https://www.in.gov/family-and-social-services-administration">Indiana Family and Social Services Administration</a>
Iowa	State Medicaid agency	<a href="https://www.iowa.gov/human-services">Iowa Department of Human Services</a>
Kansas	State Medicaid agency	<a href="https://www.kansas.gov/health-and-environment">Kansas Department of Health and Environment</a>
Kentucky	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Louisiana	State Medicaid agency	<a href="https://www.louisiana.gov/department-of-health">Louisiana Department of Health</a>
Maine	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Maryland	State Medicaid agency	<a href="https://www.maryland.gov/medicaid-ehealth-statistics">Maryland Medicaid eHealth Statistics</a>
Massachusetts	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Michigan	State Medicaid agency	<a href="https://www.michigan.gov/department-of-health-and-human-services">Michigan Department of Health and Human Services</a>
Minnesota	State Medicaid agency	<a href="https://www.minnesota.gov/human-services">Minnesota Department of Human Services</a>
Mississippi	State Medicaid agency	<a href="https://www.mississippi.gov/division-of-medicaid">Mississippi Division of Medicaid</a>
Missouri	State Medicaid agency	<a href="https://www.missouri.gov/department-of-social-services">Missouri Department of Social Services</a>
Montana	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Nebraska	State Medicaid agency	<a href="https://www.nebraska.gov/department-of-health-and-human-services">Nebraska Department of Health and Human Services</a>
Nevada	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
New Hampshire	State Medicaid agency	<a href="https://www.newhampshire.gov/department-of-health-and-human-services">New Hampshire Department of Health and Human Services</a>
New Jersey	State Medicaid agency	<a href="https://www.newjersey.gov/department-of-human-services">New Jersey Department of Human Services</a>
New Mexico	State Medicaid agency	<a href="https://www.newmexico.gov/human-services-department">New Mexico Human Services Department</a>
New York	State Medicaid agency	<a href="https://www.newyork.gov/state-department-of-health">New York State Department of Health</a>
North Carolina	State Medicaid agency	<a href="https://www.northcarolina.gov/department-of-health-and-human-services">North Carolina Department of Health and Human Services</a>
North Dakota	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Ohio	State Medicaid agency	<a href="https://www.ohio.gov/department-of-medicaid">Ohio Department of Medicaid</a>
Oklahoma	State Medicaid agency	<a href="https://www.oklahoma.gov/health-care-authority">Oklahoma Health Care Authority</a>
Oregon	State Medicaid agency	<a href="https://www.oregon.gov/health-authority">Oregon Health Authority</a>
Pennsylvania	State Medicaid agency	<a href="https://www.pennsylvania.gov/department-of-human-services">Pennsylvania Department of Human Services</a>
Rhode Island	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
South Carolina	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
South Dakota	State Medicaid agency	<a href="https://www.southdakota.gov/department-of-social-services">South Dakota Department of Social Services</a>
Tennessee	State Medicaid agency	<a href="https://www.tennessee.gov/division-of-tenncare">Tennessee Division of TennCare</a>
Texas	State Medicaid agency	<a href="https://www.texas.gov/health-and-human-services">Texas Health and Human Services</a>
Utah	State Medicaid agency	<a href="https://www.utah.gov/department-of-health-and-human-services">Utah Department of Health and Human Services</a>
Vermont	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Virginia	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
Washington	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>
West Virginia	State Medicaid agency	<a href="https://www.westvirginia.gov/department-of-health-and-human-resources">West Virginia Department of Health and Human Resources</a>
Wisconsin	State Medicaid agency	<a href="https://www.wisconsin.gov/department-of-health-services">Wisconsin Department of Health Services</a>
Wyoming	CMS	<a href="https://www.medicaid.gov">Medicaid.gov</a>

Note: CMS = Centers for Medicare & Medicaid Services.

# Notes

- <sup>1</sup> CMS reported total Medicaid enrollment of 82.3 million in June 2022; enrollment was 64.0 million in February 2020. See “June 2022 Medicaid and CHIP Enrollment Trends Snapshot,” Medicaid.gov, accessed October 4, 2022, <https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>.
- <sup>2</sup> US Department of Health and Human Services, Administration for Strategic Preparedness and Response, “Renewal of Determination That a Public Health Emergency Exists,” news release, October 13, 2022, <https://aspr.hhs.gov/legal/PHE/Pages/covid19-13Oct2022.aspx>.
- <sup>3</sup> Centers for Medicare & Medicaid Services, letter 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>.
- <sup>4</sup> Centers for Medicare & Medicaid Services, letter 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.”
- <sup>5</sup> The American Rescue Plan Act enhanced Marketplace PTCs for 2021 and 2022, and the Inflation Reduction Act extended the enhanced PTCs for an additional three years, to 2025.
- <sup>6</sup> “State Health Insurance Marketplace Types, 2023,” Kaiser Family Foundation, accessed November 15, 2022, <https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?activeTab=map&currentTimeframe=0&selectedDistributions=marketplace-type&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

# References

- ASPE (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation). 2022. “Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches.” Washington, DC: ASPE.
- Buettgens, Matthew, and Jessica Banthin. 2020. *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology*. Washington, DC: Urban Institute.
- . 2022. “Estimating Health Coverage in 2023: An Update to the Health Insurance Policy Simulation Model Methodology.” Washington, DC: Urban Institute.
- Buettgens, Matthew, Jessica Banthin, and Andrew Green. 2022. “What If the American Rescue Plan Act’s Premium Tax Credits Expire? Coverage and Cost Projections for 2023.” Washington, DC: Urban Institute.
- Buettgens, Matthew, and Andrew Green. 2021. *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?* Washington, DC: Urban Institute.
- . 2022. “What Will Happen to Medicaid Enrollees’ Health Coverage after the Public Health Emergency? Updated Projections of Medicaid Coverage and Costs.” Washington, DC: Urban Institute.
- Glied, Sherry A., Anupama Arora, and Claudia Solís-Román. 2015. “The CBO’s Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?” New York: Commonwealth Fund.
- Office of the New York State Comptroller. 2022. “New York City’s Uneven Recovery: An Analysis of Labor Force Trends.” Albany, NY: Office of the New York State Comptroller.

# 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.

**Andrew Green** is a research analyst in the Health Policy Center. His work focuses on developing and using Urban's Health Insurance Policy Simulation Model to evaluate the coverage and cost effects of health insurance reform proposals. Green holds a bachelor's degree in business administration from the University of Michigan and a master's degree in data science and public policy from Georgetown University.



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