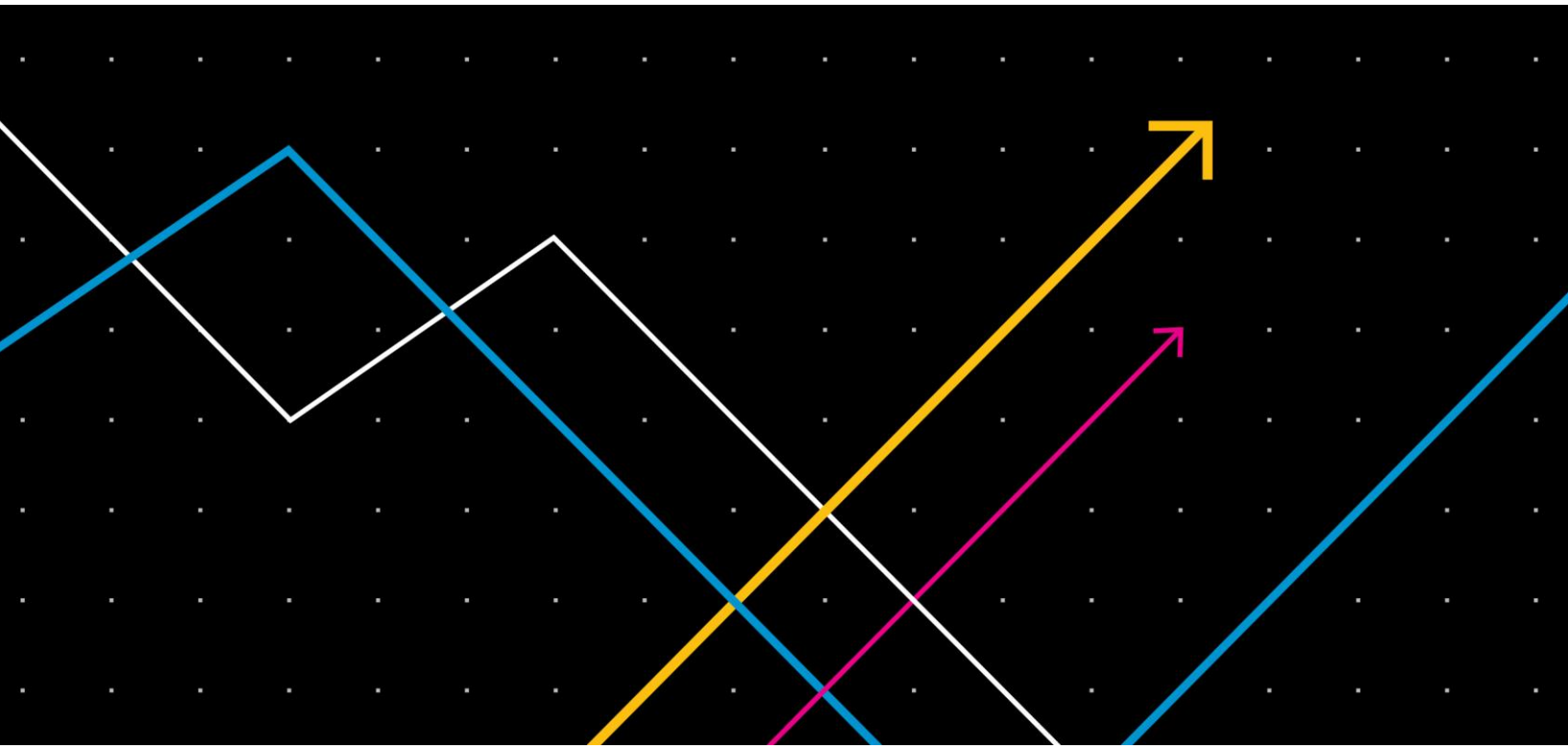

RESEARCH REPORT

State Variation in Medicaid and CHIP Unwinding for Children and Adults as of November 2023

Analyses of Enrollment Relative to Earlier Projections and Key Policy Choices

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Executive Summary

In 2020, Congress passed the Families First Coronavirus Relief Act, which barred states from disenrolling people from Medicaid or child Medicaid coverage funded through the Children's Health Insurance Program (M-CHIP) during the pandemic unless they requested it. This led to record-high Medicaid enrollment growth of over 20 million more Medicaid enrollees than before the requirement (Buettgens and Green 2022). Three years later, Congress passed legislation to end this continuous coverage requirement effective March 31, 2023, and allowed states to resume the Medicaid eligibility redetermination process, also known as Medicaid "unwinding." Using monthly enrollment reports, we find that enrollment in Medicaid and CHIP declined by about 9 million people from April through November 2023.[1] Many observers are concerned that states are moving too fast and that many enrollees could lose coverage for procedural reasons even though they remain eligible.[2] Other observers argue that slowing down the unwinding leaves ineligible people on the rolls at an unnecessary cost to both state and federal budgets (Gonshorowski, Blase, and Kleinworth 2023).

Concern has been particularly high for children, given the potential consequences of coverage gaps and early problems during automatic redetermination processes in 29 state systems that disproportionately impacted children.[3] In December 2023, the Centers for Medicare & Medicaid Services called for greater efforts to improve the process for children and identified nine states with disproportionately large disenrollment among children.[4]

A December 2022 Urban Institute report estimated that 14.8 million people on net would lose Medicaid or CHIP coverage after all eligibility redeterminations were completed (Buettgens and Green 2022). The estimate assumed that Medicaid enrollment patterns would return to the historical trend observed prior to the continuous coverage requirement after accounting for changes in policy. While actual enrollment trends may diverge from this historical trend, the historical trend provides a useful benchmark against which to measure state unwinding activity. In this report, we compare net disenrollment (total disenrollment less new enrollment or reenrollment) through November 2023 for 47 states and the District of Columbia with our estimated total disenrollment to assess the extent of the unwinding and its correspondence with several policy choices. Our main findings are:

- Nationwide, aggregate net disenrollment as of November 2023 was at 60.5 percent of projected total disenrollment throughout the unwinding for our sample of nearly all states.

- Behind the national total, we find tremendous diversity among states: 19 states had net disenrollment of 50 percent or less of our projected total net disenrollment, while eight states had already disenrolled more people than 100 percent of our projected total net disenrollment.
- The net disenrollment rate was much higher for children than adults nationwide, largely because of exceptionally high child net disenrollment in some states. Total net disenrollment among children was 84.2 percent of the expected total, while total net disenrollment among adults was 50.7 percent of our estimates. Seven states had adult net disenrollment greater than 100 percent of expected disenrollment, while 12 states had child net disenrollments that exceeded that threshold. This means current Medicaid enrollment levels in these states are below the historical trend.
- States that publicized their intention to complete the unwinding in less than 12 months, states that obtained few federal waivers to streamline renewal, and states that prioritized the renewal of those likely to be ineligible all had notably higher overall net disenrollment rates relative to other states. States with any of these three characteristics had net child disenrollment over 120 percent of our projections on average.

The results from this analysis are likely to change when more recent data become available, particularly as more states complete the unwinding process, originally scheduled to end in June 2024. As noted below, these results reflect the information that was available on Medicaid/CHIP enrollment as of November 2023 relative to our projections for enrollment when unwinding is complete. Some variation we find between states may be because of their different start dates.

Our projections of Medicaid/CHIP enrollment include a degree of uncertainty; future state enrollment trends may be higher or lower than our projections because of several factors. For example, states may enact policies to reduce enrollment churn by keeping eligible children and adults enrolled at higher rates than the historical trend, thus increasing future enrollment. As another example, states that experience increased economic growth with higher employment may see lower Medicaid enrollment or vice versa.

Even with these limitations, our analysis highlights a few areas of concern. As of November 2023, some states had disenrolled more people than we had projected for the entire unwinding, suggesting that overall disenrollment could be even greater than anticipated. Children are being disenrolled at particularly high rates in several states. It is impossible to know whether some disenrolled children and adults were still eligible for Medicaid/CHIP and were disenrolled erroneously. They may eventually reenroll in the program after being uninsured for a spell. However, a lack of insurance coverage, even for a few months, can disrupt care and lead to negative consequences for many people, such as those with chronic conditions. In particular, we know that children, because of their rapid development at

young ages, are at higher risk relative to adults of negative health consequences when there are disruptions in care because of spells without coverage.

We find smaller declines in enrollment in states that have adopted more administrative flexibility through waivers and in states that did not announce an intention to complete the process in less than 12 months. Available data do not allow us to assess whether these states have been more effective than others in preventing the erroneous disenrollment of eligible people. As the unwinding continues, states should consider maximizing access to enrollment assistance supports for disenrolled people. Assistance in reenrolling in Medicaid if, as may be the case, they are still eligible for the program would be especially important, as would ensuring they are connected with other coverage, such as through separate CHIP programs or the Marketplace.

State Variation in Medicaid and CHIP Unwinding for Children and Adults as of November 2023

Background

An unprecedented number of people, 94.2 million, were enrolled in Medicaid and the Children's Health Insurance Program (CHIP) by April 2023, more than 21 million higher than enrollment in April 2020.[5] This increase was almost entirely because of the continuous coverage requirement of the Families First Coronavirus Response Act of 2020. To help states pay for higher enrollment during the pandemic and ensure access to medical care during a health crisis, the federal government boosted its share of Medicaid costs, increasing the federal medical assistance percentage for the duration of the public health emergency (PHE). In exchange, the law prevented state Medicaid agencies from disenrolling people during the PHE to minimize the number of people losing health coverage during the pandemic. The Consolidated Appropriations Act (CAA) of 2023 delinked the continuous coverage requirement from the PHE and allowed states to resume normal eligibility processing as early as April 2023. The law generally gave states up to 14 months to complete the process of redetermining eligibility for all Medicaid enrollees, often called the "unwinding" of the continuous coverage requirement. The CAA also phased out the enhanced federal medical assistance percentage over the remainder of 2023. According to monthly enrollment data, we find that Medicaid and CHIP enrollment declined by about 9 million people from March 2023 through November 2023.

As of November 2023, states reported that they had completed redeterminations for about 30 percent of Medicaid enrollees, according to data collected and reported under the CAA.[6] However, 17 states reported that they prioritized processing people who were most likely to be ineligible for Medicaid and therefore more likely to be disenrolled. Thus, the estimate of 30 percent probably understates the share of total net disenrollment nationwide as of November 2023. Also, given the numerous temporary pauses and other changes in unwinding, the number of redeterminations reported as completed in the CAA data may not be entirely accurate.

While separate CHIP programs were not bound by the continuous coverage requirement during the PHE, like Medicaid and M-CHIP, some states also made changes to separate CHIP policies during

the continuous coverage period, such as pausing premiums and enrollment fees (Brooks et al. 2023). While some states are eliminating CHIP premiums, and a recent federal rule eliminates CHIP waiting periods and lockout periods for nonpayment of premiums by 2025, reinstatement of these policies during the unwinding period could also contribute to disenrollment of children from separate CHIP programs.[7] So far, though many children losing Medicaid have been expected to transition to separate CHIP coverage, low growth in separate CHIP enrollment indicates that transitions from Medicaid to separate CHIP are not offsetting Medicaid losses, raising the need to improve transitions.[8]

Many observers are concerned that the Medicaid unwinding will leave many people uninsured, including people who are still eligible for Medicaid but fall through the cracks during the renewal process or who have become ineligible but are not connected to other coverage. Nationwide, about seven in 10 people who have gone through the redetermination process thus far have been disenrolled for "procedural" reasons, such as not receiving or completing required paperwork, rather than being found no longer eligible, though this share varies widely across states.[9] Some are concerned that a more rapid unwinding may lead to more erroneous disenrollment of eligible people;[10] observers are particularly concerned that children may be disenrolled erroneously even though they are much more likely to remain eligible for either Medicaid or CHIP given more generous eligibility thresholds than for adults. Not only are there many immediate benefits for children and adults to having health coverage—including decreased morbidity and mortality and increased family financial security—but it has also been documented that having health coverage as a child leads to improved health and well-being through adulthood (see the discussion below). Thus, large-scale disruptions in children's coverage because of the unwinding could have adverse consequences for decades.

To facilitate state efforts on the unwinding process, the Centers for Medicare and Medicaid Services (CMS) made available many waiver authorities for states to use temporarily under Section 1902€(14)(A) of the Social Security Act (referred to hereafter as "e-14 waivers").[11] The new waiver authorities included policies such as using Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families data or evidence of lack of any income that facilitates states' use of ex parte renewal processes (automatic renewals that do not require action on the part of enrollees). Another waiver authority gives managed care organizations more latitude in helping enrollees through the renewal process. Stakeholders are eager to learn how well these waivers have worked to date.[12] We include exploratory analyses of waiver authorities by showing the correspondence between the use of waivers and the changes in net disenrollment.

Data and Methods

In previous research, we used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to project health coverage after the redetermination process that would unwind the effects of the continuous coverage requirement and after the major coverage transitions that would follow (Buettgens and Green 2022). We estimated that by the end of the unwinding, total Medicaid and CHIP enrollment would decline by about 14.8 million people. As explained below, we use a modified version of these projections to assess the current unwinding process in this new study.

We use monthly reports from state Medicaid agencies and CMS showing total enrollment, consistent with the data we used for our projections (see below). Some analysts refer to newly created state data that tracks renewal activities as required by the CAA, including a number called "disenrollment." However, this measure is a different concept that should not be compared with our projections. The CAA measure does not capture changes in overall Medicaid and CHIP caseload because it does not count new enrollment, and, in many states, it does not reflect the final disposition of people going through the renewal process or account for people who reenrolled after being disenrolled. For example, the CAA data through November 2023 show that 12.4 million have lost Medicaid versus 9 million based on available enrollment reports.

Data

For this analysis, we used the most recently available monthly CMS Medicaid enrollment reports through November 2023 to assess states' unwinding activity.[13] We restricted our sample of states to those that were actively engaged in the unwinding process. We dropped three states that implemented major "pauses" in the process or announced broad reinstatements of Medicaid enrollment. Specifically, we excluded Hawaii because the state paused disenrollments in September because of catastrophic wildfires.[14] We also excluded Kansas and Rhode Island because of temporary policy decisions such as broad Medicaid/CHIP reinstatements, which do not reflect the eventual trajectory of unwinding.[15] Additionally, Arizona separately reports the child share of the Medicaid population every quarter, so we treat October 2023 as the state's most recent data.[16]

Monthly reports from CMS showing total enrollment incorporate the net result of disenrollment and new enrollment and are regularly updated to be consistent with program administrative systems. The outcome of interest for our analysis is net disenrollment, the change in covered lives since the unwinding started.

To assess the state of unwinding during the first several months of the process in each state, we compare reported net disenrollment as of November 2023 to our projections of net disenrollment over the full unwinding period from HIPSM. The approach of comparing to HIPSM projections rather than simply assessing changes in net disenrollment accounts for variation in the rate of enrollment growth in each state during the continuous coverage period, so states with larger gains between 2020 and 2023 are anticipated to have larger declines in enrollment during unwinding.

We adjust and update our estimates of projected changes in Medicaid enrollment at the end of the unwinding from those reported in Buettgens and Green (2022). First, we updated projections to include separate CHIP enrollment for consistency with data available on enrollment through November 2023. The projections of net Medicaid disenrollment published in table B.1 in Buettgens and Green (2022) were for Medicaid only. To estimate net disenrollment in Medicaid and CHIP, we adjusted them in states with separate CHIP programs consistent with our estimate of a 14.8 million decline in Medicaid and CHIP published in that paper. We also modified our December 2022 projections for South Dakota to include Medicaid expansion, which started in July 2023.

For this report, we do not, however, include other policy adjustments that will likely increase projected enrollment by the end of unwinding:

- North Carolina's Medicaid expansion started in December 2023. However, our data series ends in November, so we did not adjust our projections. For the size of this adjustment, see Buettgens and Ramchandani (2023).
- The 12-month Medicaid and CHIP continuous eligibility for children became mandatory for all states beginning in 2024. All the data included in this report is for 2023, so we did not adjust projections for states that did not already have continuous eligibility for children. For more on this adjustment, see Buettgens (2023).
- We did not include multiyear continuous coverage expansions, such as those implemented for children through age 6 in Oregon and Washington, and two-year continuous coverage expansion for 6- to 65-year-olds in Oregon.
- We did not include post-partum extensions of 12 months of coverage adopted in most states by November 2023.[17]

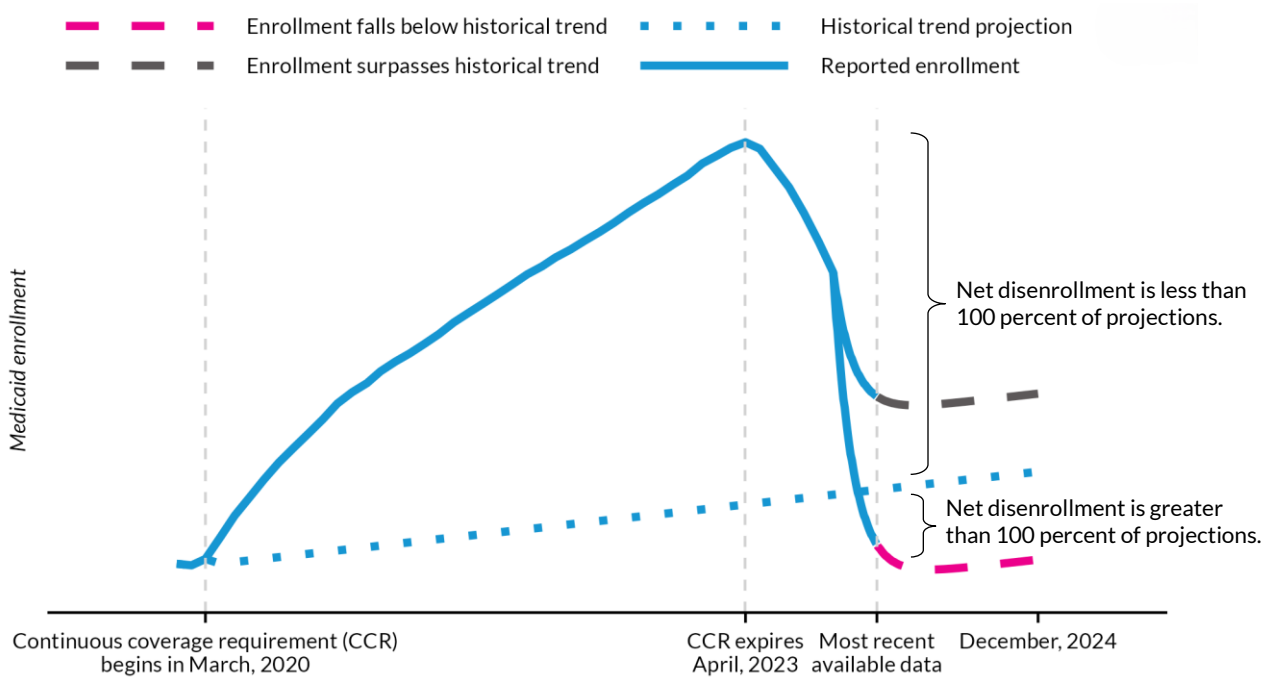
We compare state policy decisions related to the unwinding using data reported to CMS: length of the unwinding,[18] state e-14 waivers,[19] and state reports of ex parte system issues.[20]

Net Disenrollment

Figure 1 illustrates how we calculate net disenrollment as a share of total projected disenrollment for each state. The figure presents reported and projected Medicaid and CHIP enrollment in two hypothetical states from the pandemic's start through the end of the unwinding. The dotted line represents our projection of the long-term historical enrollment trend based on data before the continuous coverage requirement was in effect. We assume that enrollment will eventually return to the historical trend unless the state has taken actions or adopted policies that would permanently affect enrollment levels. Such actions include expanding Medicaid eligibility (Buettgens and Ramchandani 2023) and expanding continuous eligibility for Medicaid and CHIP (Buettgens 2023).

FIGURE 1

Calculating the Percent of Projected Disenrollment



Source: Urban Institute analysis of synthetic data, 2024.
Notes: This graph represents two potential unwinding scenarios to illustrate the calculation of the projected disenrollment metric. A state's enrollment could stabilize above or below what would be implied by the historical trend as the unwinding progresses. This stabilization is displayed by the lines that start to match the slope of the historical trend as states resume regular operations.

The solid blue line represents the two states' reported enrollment, which begins rising in March 2020 under the continuous coverage requirement, peaks just before a state resumes disenrollment, and falls during the unwinding. Net disenrollment is computed as the difference between peak enrollment at

the start of the unwinding and current enrollment. Net disenrollment is less than 100 percent of the total projected net disenrollment when a state exceeds the long-term historical trend. Net disenrollment is more than 100 percent of the total projected net disenrollment when a state is below the long-term historical trend. If a state has made changes that permanently increase enrollment, enrollment could stabilize after the unwinding at a level higher than the historical trend, shown where the upper solid blue line transitions into a dashed line. The lower dashed line shows a state stabilizing below the historical trend.

Limitations

Several limitations are acknowledged. This analysis is preliminary, and results will likely change as the unwinding continues. We plan to update our work when more data become available.

Our state projections of net disenrollment during the unwinding are based on HIPSM estimates of historical enrollment trends prior to the continuous coverage requirement and projected into the future. There is inherent uncertainty in HIPSM estimates and its future projections, with greater uncertainty for smaller states. States may have taken actions since 2020 or are considering actions that will permanently affect enrollment levels. For example, some states may implement changes to reduce enrollment churn and the administrative burden of renewals that could permanently increase enrollment by eliminating spells of uninsurance among eligible enrollees. In addition, state-specific economic factors and employment rates can cause Medicaid enrollment to deviate from historical trends. Increased economic growth in a state may reduce its Medicaid enrollment.

It is also important to note that reported net disenrollment as of November 2023 can be affected by two distinct sets of factors: the speed with which a state conducts redeterminations (i.e., the fraction of enrollees redetermined each month) and the effectiveness of the state's redetermination systems to successfully keep eligible people enrolled (i.e., because of better computer systems or using available waiver flexibilities). At this time, we cannot assess how successful states are in keeping eligible people enrolled. We know that nine states received letters from CMS raising concerns about the disenrollment of large numbers of children. Those states were Texas, Florida, Georgia, Ohio, Arkansas, South Dakota, New Hampshire, Idaho, and Montana.[21]

The effectiveness of state redetermination systems includes fixes to problems identified in many states' ex parte renewal systems and reported data that we discuss below on the share of people renewed ex parte and the share procedurally disenrolled. Thus, a state that appears to be unwinding slowly may be, in fact, on a path to a new higher steady state (illustrated by the upper dotted line in

figure 1). In our analysis of the association between states' decisions to apply for multiple waivers and disenrollment, we cannot disentangle the effect of states' intentions from the effect of waivers on the disenrollment process.

In our analyses, we focus on the declines in total overall Medicaid enrollment, but it is important to consider the effect of the unwinding on smaller Medicaid populations whose eligibility is not based solely on income, such as people with disabilities and those with breast and cervical cancer. These groups may not have seen the same levels of enrollment growth during the continuous coverage requirement because their eligibility is based on factors besides income, such as specific diagnoses, which are not as volatile over time. However, their contact and employment information was up to three years old when the unwinding started, potentially exposing them to higher rates of procedural termination. Any disruption in coverage could be particularly harmful to these people. Unfortunately, there are almost no publicly available data about the net disenrollment of these populations during the unwinding, though several recent legal cases have claimed that state Medicaid agencies have violated the Americans with Disabilities Act.[22]

Results

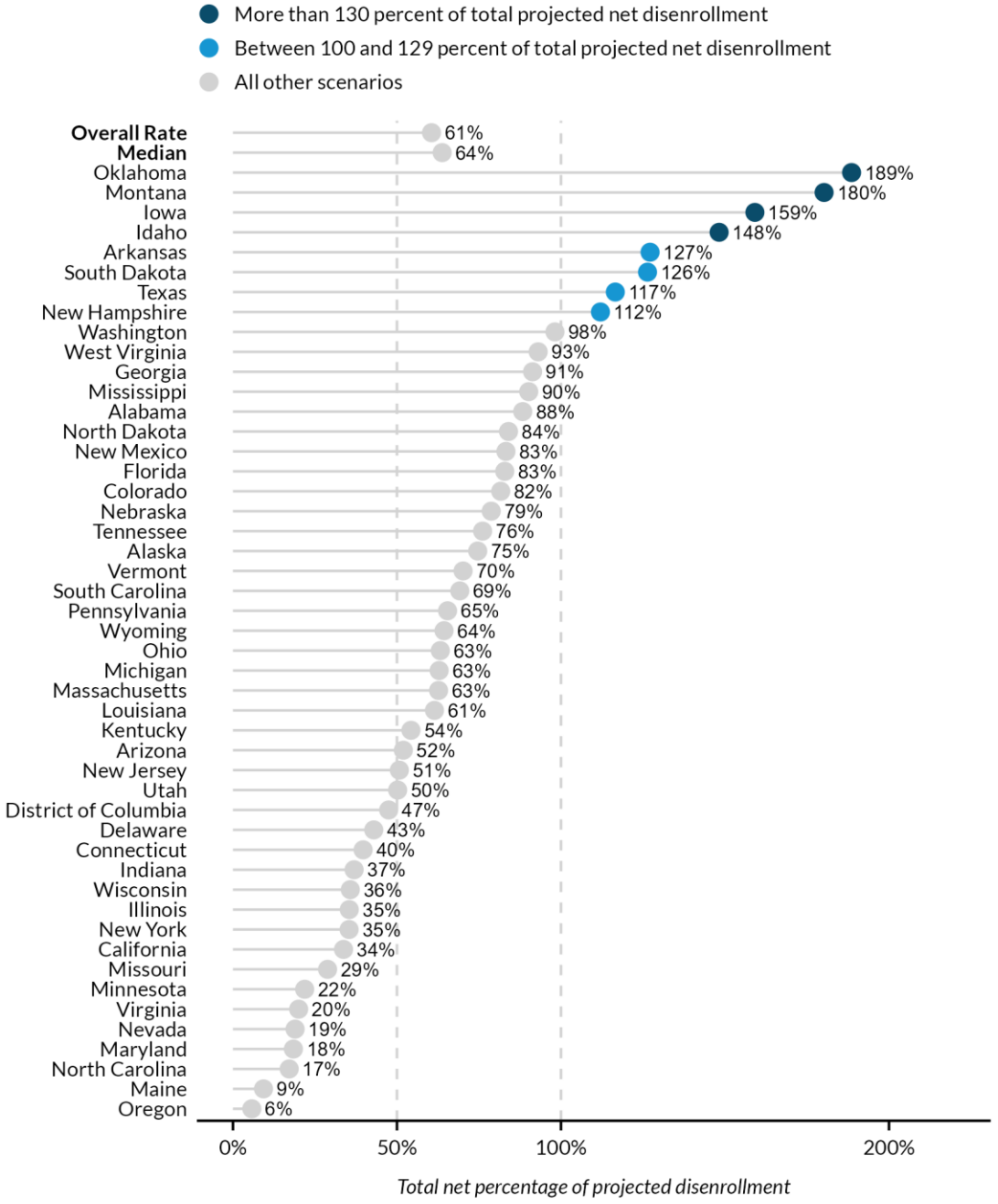
We first compare reported net disenrollment as a share of projected total net disenrollment across states and then separately for adults and children. Second, we identify some state policy decisions that appear to be associated with notable differences in net disenrollment.

Eight States Have Disenrolled More than 100 Percent of Total Projected Disenrollment

In figure 2, we show reported Medicaid and CHIP net disenrollment through November 2023 as a percentage of our total projected net disenrollment by state. In our sample of 47 states plus the District of Columbia, total net disenrollment was 60.5 percent of projections, while the median among states was 63.2 percent. Twenty-one states have disenrolled roughly half of our projected total or less. On the other hand, eight states have disenrolled more than 100 percent of our projected total net disenrollment for the entire unwinding: South Dakota, New Hampshire, Texas, Arkansas, Iowa, Idaho, Montana, and Oklahoma.

FIGURE 2

Reported Medicaid/CHIP Net Disenrollment as A Percentage of Total Projected Net Disenrollment, by State



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Source: Health Insurance Policy Simulation Model, 2023. State administrative data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. Reported net disenrollment is based on data through November 2023. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. Kansas, Rhode Island, and Hawaii were removed from this analysis because of broad reinstatements or pauses in

disenrollment, which do not reflect the eventual trajectory of unwinding. We use October 2023 reports for Arizona because the data are updated quarterly.

Four states—Idaho, Iowa, Montana, and Oklahoma—have disenrolled roughly 150 percent of our projections or more. The unwinding is not yet over, and these numbers may change. Other states may eventually exceed 100 percent of our projected total net disenrollment. Five states have already disenrolled between 90 percent and 100 percent of our projections: Mississippi, Georgia, West Virginia, New Mexico, and Washington. However, it is also possible that some states with high disenrollment rates as of November 2023 may eventually settle at a lower disenrollment rate if erroneously disenrolled people reenroll.

Children Were Disenrolled at a Higher Rate than Adults Overall

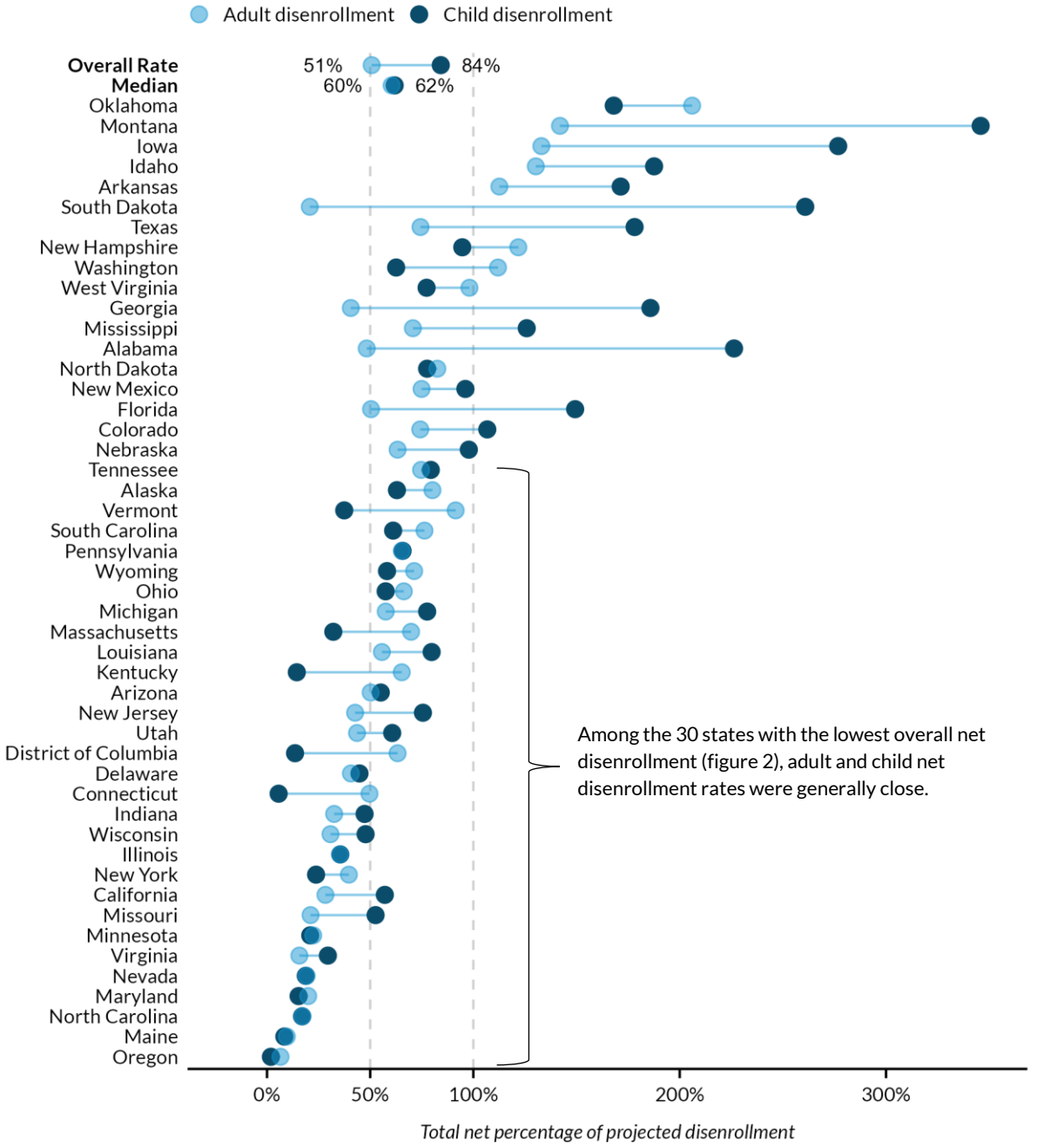
We find that adults and children have seen very different rates of net disenrollment during the unwinding in aggregate and in some states (figure 3 and table 1). As of November 2023, total net disenrollment of adults was at 50.7 percent of projections, while the net disenrollment of children was 84.2 percent of projections on average in our sample of states.

We ordered the states in figure 3 by the overall rates of net disenrollment in figure 2 to reveal that there were greater differences between adults and children among states with higher overall net disenrollment rates. Only seven states (OK, MT, IA, ID, NH, AR, and WA) have disenrolled more than 100 percent of our projections for adults, while 12 states (MT, IA, SD, AL, ID, GA, TX, AR, OK, FL, MS, and CO) have disenrolled more than 100 percent of our projections for children. The group of states with the highest disenrollment rates for children overlaps considerably with the nine states identified by CMS as having the largest percentage or absolute losses of children through September 2023 (TX, FL, GA, OH, AR, SD, NH, ID, and MT).[23] Some of these states also have relatively large separate CHIP programs, suggesting that missed transitions to CHIP may be contributing to their higher Medicaid/CHIP disenrollment for children.[24]

States with lower overall rates of net disenrollment also tended to have smaller differences between adults and children. The 30 states with the lowest net disenrollment as a percent of projections in figure 2 generally showed fairly small differences between adults and children, with some states reporting lower child net disenrollment. In 23 states, adult net disenrollment was about 50 percent or less of our projections. In 18 states, net disenrollment for children was about 50 percent or less of our projections.

FIGURE 3

Reported Medicaid/CHIP Net Disenrollment as A Percentage of Total Projected Net Disenrollment Among Nonelderly Adults and Children, by State



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Source: Health Insurance Policy Simulation Model, 2023. State administrative data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. State numbers for adults and children are available in table 1. Reported net disenrollment is based on data through November 2023. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. Kansas, Rhode Island, and Hawaii were removed from this

analysis because of broad reinstatements or pauses in disenrollment, which do not reflect the eventual trajectory of unwinding. We use October 2023 reports for Arizona because the data are updated quarterly.

Net Disenrollment and State Policies

Next, we look at how net disenrollment varies according to three state policy choices related to the unwinding. The CAA gave states 14 months to complete the unwinding, but some states reported to CMS that they planned to complete it more quickly. The six states intending to take less than 12 months for the unwinding reported net disenrollment, an average of 127.2 percent of our projections, compared with 61.7 percent in the remaining states that planned to complete the unwinding in 12 to 14 months (figure 4). This difference is even more dramatic for children's coverage; states intending to take less than 12 months for the unwinding disenrolled children at an average of 182.2 percent above our projections, compared with 72.7 percent for other states.

CMS gave states many optional flexibilities to streamline the redetermination process during the unwinding.[25] The new waiver authorities included policies that facilitate states' use of ex parte renewal processes (automatic renewals that do not require action on the part of enrollees), such as using data from other public programs, including Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families and data providing evidence of lack of any income. Another waiver authority gives managed care organizations more latitude in helping enrollees through the renewal process. Expanded use of ex parte renewal processes using a wider range of data might improve the accuracy of state redeterminations, but we cannot measure that.

We find that states taking fewer waivers disenrolled at higher rates than states taking more waivers. The 12 states that took four or fewer of these e-14 waivers had an average net disenrollment of 115.6 percent of our projected total net disenrollment (figure 5). By contrast, 19 states that took five to nine waivers had an average net disenrollment of 63.4 percent of projections, and the 17 states that took 10 to 15 waivers had an average net disenrollment of 44.9 percent of projections.

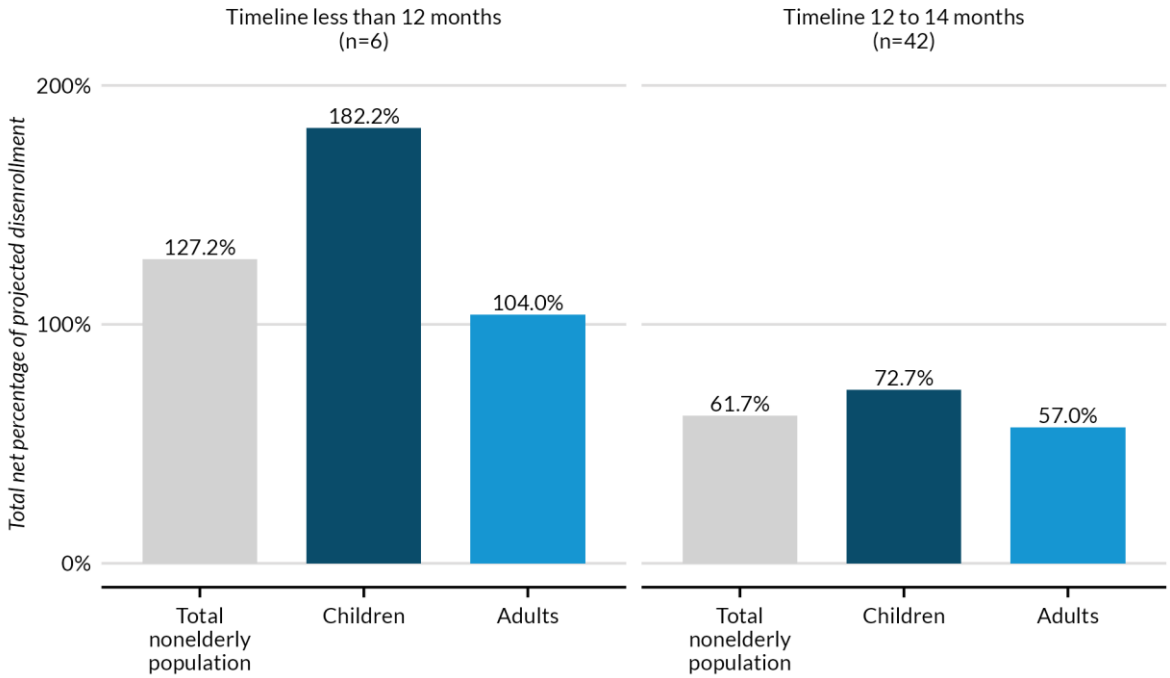
The number of e-14 waivers had a particularly striking association with children's disenrollment. The 12 states with zero to four waivers disenrolled children at an average rate of 162.5 percent of our projections, compared with 77.7 percent for the 19 states with five to nine waivers and 42.4 percent for the 17 states with 10 to 15 waivers. Thus, states with at least 10 waivers saw little difference in disenrollment between adults and children. Child net disenrollment was slightly lower than adult net disenrollment among states with 10 or more waivers.

Nineteen states reported that they planned to identify people more likely than others to be ineligible for Medicaid before the unwinding and prioritized processing their renewals early in the unwinding. These had higher net disenrollment on average: 96.2 percent of our projections versus 52.7 percent of the 29 states that did not prioritize (figure 6). Prioritizing states disenrolled children at an average rate of 122.6 percent of our projections versus 62.7 percent for other states.

FIGURE 4

Average Reported Medicaid/CHIP Net Disenrollment as A Percentage of Projected Net Disenrollment by States' Intended Unwinding Timeline

Among the total nonelderly population, children, and adults



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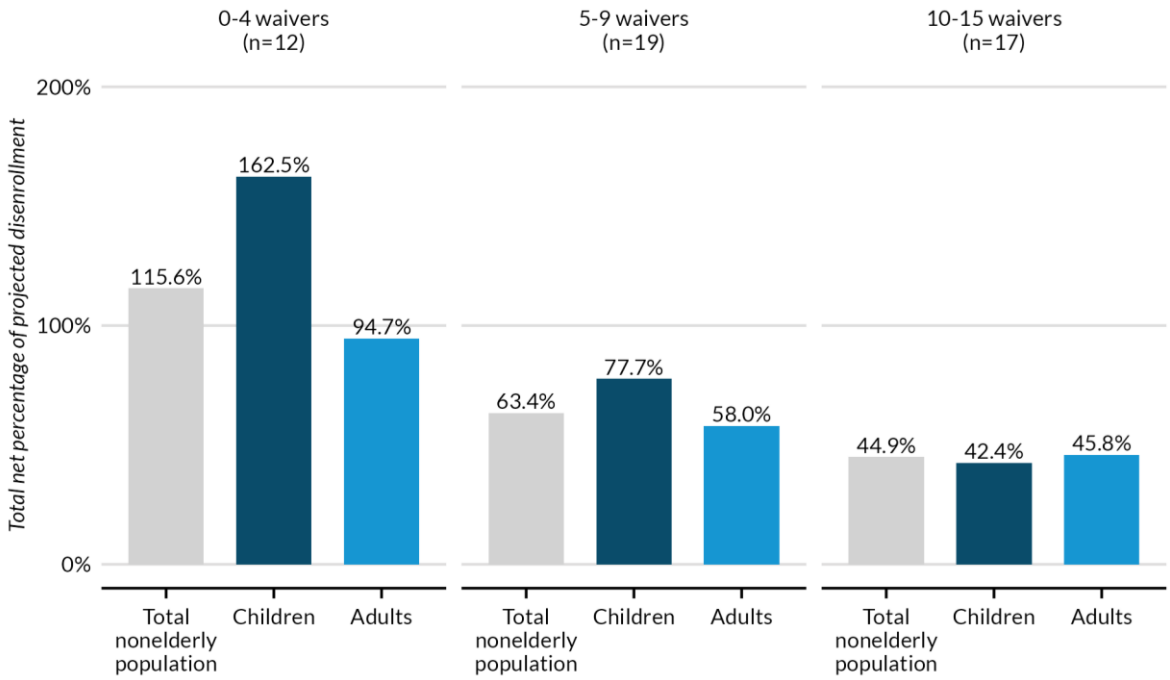
Source: Health Insurance Policy Simulation Model, 2023. State administrative data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. Reported net disenrollment is based on publicly available data through November 2023. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. Kansas, Rhode Island, and Hawaii were removed from this analysis because of broad reinstatements or pauses in disenrollment, which do not reflect the eventual trajectory of unwinding. We use October 2023 reports for Arizona because the data are updated quarterly.

FIGURE 5

Average Reported Medicaid/CHIP Net Disenrollment as A Percentage of Projected Net Disenrollment by Number of State Waivers

Among the total nonelderly population, children, and adults



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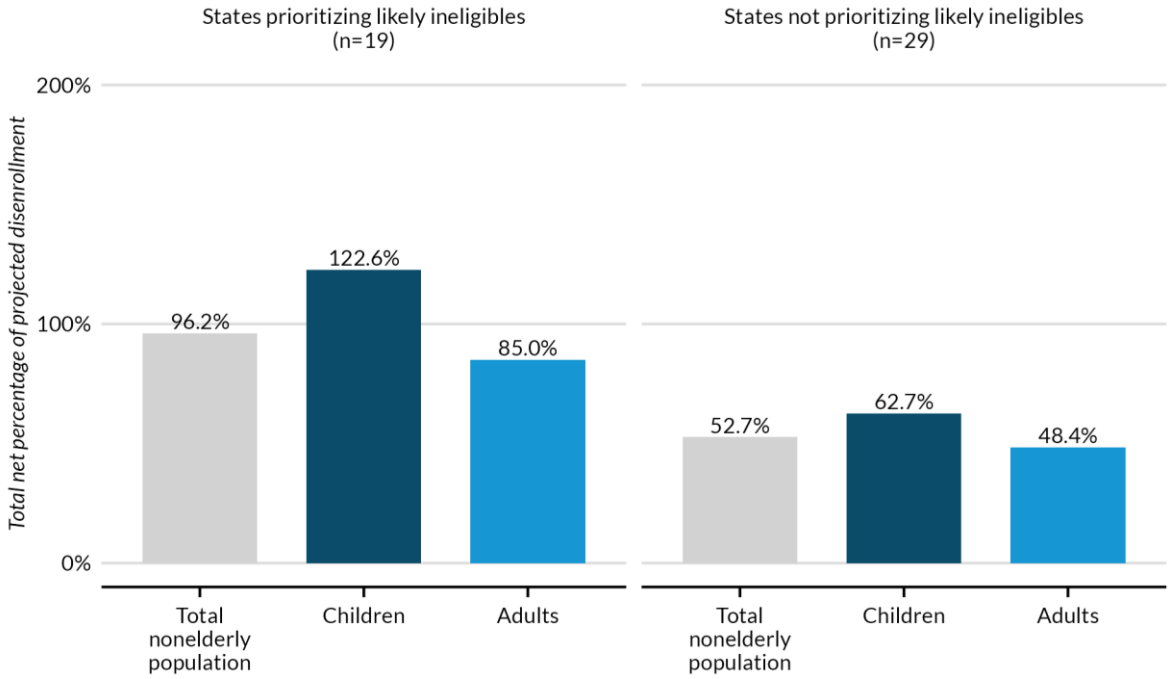
Source: Health Insurance Policy Simulation Model, 2023. State administrative data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. Reported net disenrollment is based on publicly available data through November 2023. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. Kansas, Rhode Island, and Hawaii were removed from this analysis because of broad reinstatements or pauses in disenrollment, which do not reflect the eventual trajectory of unwinding. We use October reports for Arizona because the data are updated quarterly.

FIGURE 6

Average Reported Medicaid/CHIP Net Disenrollment as A Percentage of Projected Net Disenrollment, by State Decisions to Prioritize People Likely to be Ineligible

Among the total nonelderly population, children, and adults



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Source: Health Insurance Policy Simulation Model, 2023. State administrative data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. Reported net disenrollment is based on publicly available data through November 2023. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. Kansas, Rhode Island, and Hawaii were removed from this analysis because of broad reinstatements or pauses in disenrollment, which do not reflect the eventual trajectory of unwinding. We use October reports for Arizona because the data are updated quarterly.

Discussion

We find that nationwide, net disenrollment as of November 2023 was 60.5 percent of our projected total net disenrollment when unwinding is complete, with net disenrollment above 100 percent of our projections in eight states. Children saw notably higher net disenrollment rates than adults nationwide and in several states. Total child net disenrollment was 84.2 percent of projections versus 50.7 percent for adults. The difference in the two rates was largely driven by a small number of states with particularly high disenrollment for children. Twelve states had child net disenrollment over 100 percent of projections, compared with seven states with adult net disenrollment at those levels. Four states had child net disenrollment over 200 percent of our projected net disenrollment for the entire unwinding.

Three of these states have separate CHIP programs, so coordination between Medicaid and CHIP could be a contributing factor. These results may change as more states approach or exceed 100 percent of projected disenrollment. It is also possible that some states that have exceeded disenrollment projections will end up settling at a lower rate if eligible disenrolled people successfully reenroll after a spell of uninsurance.

It nonetheless raises some concern that certain states appear to have disenrolled more people from Medicaid as of November 2023 than we project would be disenrolled over the full course of the unwinding. This suggests that many eligible people may be among those losing Medicaid and CHIP and raises the possibility that this problem may increase as the unwinding continues. We show that states intending to rapidly complete unwinding have much higher net disenrollment rates than other states, but other factors, such as limits on the capacity of administrative systems, could also explain higher-than-expected disenrollment rates. Further research is needed, yet it will be difficult for researchers to learn how many of those disenrolled were still eligible for Medicaid or CHIP. A spell of uninsurance can be harmful. The importance of Medicaid coverage for improving the health of both adults and children has been documented by several studies and includes reducing mortality and improving mental health (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2021; McMorrow et al. 2017), increasing the financial security of those gaining health coverage (Caswell and Waidmann 2017; Hu et al. 2016), reducing unwanted pregnancies (Grindlay and Grossman 2016), and increasing access to effective contraception for some subgroups (Kavanaugh and Pliskin 2020; Johnston and McMorrow 2020).

Special attention must be paid to children's enrollment status. Our results suggest children are being disenrolled at disproportionate rates compared with adults. The states we identify as disenrolling children at higher-than-expected rates are many of the same states that CMS sent letters to last year, reinforcing our results. A recent study finds that about 8 percent of pediatric patients at a large sample of community health centers who had been Medicaid-insured during the unwinding were uninsured for at least one visit between March and December 2023 (Bensken 2024).[26] Children may suffer adverse consequences from even short spells of being uninsured, so it is especially important to avoid disenrolling children who are still eligible for Medicaid or CHIP coverage. Moreover, several studies have found that interventions in childhood—such as health coverage—have important benefits throughout adult life (Cunha, Heckman, and Schennach 2010). The authors found that such interventions were particularly important in early childhood. Goodman-Bacon (2016) found that the increased availability of child health coverage because of the introduction of Medicaid reduced later-life mortality (particularly among nonwhites), reduced adult disability measures, increased adult labor

market participation, and reduced adult receipt of public benefits. Thus, large-scale disruptions in children's health coverage can have adverse consequences for decades.

We also find that certain state policy decisions appear to be associated with large differences in net disenrollment during the first several months of unwinding. States that planned to complete unwinding in less than a year, states obtaining four or fewer e-14 waivers, and states prioritizing the renewal of those likely ineligible all had notably higher net disenrollment rates than other states. For children, the average net disenrollment in states falling into any of these three groups was over 120 percent of our projections. In contrast, we find that child net disenrollment is slightly lower than adult net disenrollment in states with 10 or more waivers. These findings are confirmed by CMS findings on variation in child disenrollment, indicating that the use of available flexibilities and ex parte renewals is associated with lower disenrollment among children.[27]

It is too early to comprehensively assess what types of health coverage those losing Medicaid end up with, but there is evidence that the unwinding and expansions in subsidies for Marketplace plans have led to increases in Marketplace coverage. The 2024 Marketplace open enrollment period saw record increases in Marketplace enrollment, a 28 percent increase in plan selections from 15.9 million to 20.4 million. Together, the enhanced premium tax credits (PTCs), available since the middle of 2021, and the unwinding contributed to this year's increases being far larger than any seen in the 2022 and 2023 open enrollment periods. Similarly, the unwinding affected mid-year 2023 enrollments into the Marketplace since people disenrolled from Medicaid qualify for a special enrollment period to allow them to enroll in the Marketplace at any time during the unwinding. CMS reported that there were 1.6 million new Marketplace enrollees between March and September 2023, compared with only about 100,000 people for the same period in the previous year, and 90 percent of new enrollees in healthcare.gov states had incomes below 150 percent of FPL.[28] The federal "unwinding special enrollment period " was recently extended until November 30, 2024.[29]

However, reliable data on how the unwinding has affected employer-sponsored health insurance and the uninsured are still largely unavailable. A survey prepared for the Utah Department of Health and Human Services in December 2023 and obtained by Kaiser Health News asked questions about these types of coverage, but without a survey response rate, the representativeness and accuracy of the responses are impossible to assess (Lighthouse Research & Development, Inc. 2023). They reported that 57 percent of former Medicaid enrollees who responded to the survey did not attempt to renew their coverage. It is unclear that those enrollees were aware of the need to renew, though 84 percent reported having other health coverage, mostly through an employer. Fewer than half of all respondents

said they did not need or want Medicaid, and about one in five said they did not receive renewal paperwork.[30]

Other states have also provided partial views of coverage transitions. Kentucky reported that, according to data from Medicaid managed care organizations, roughly 40 percent of those disenrolled already had other types of coverage, and another 13 percent had enrolled in the state's Marketplace.[31] Idaho and Massachusetts reported much higher shares enrolling in the Marketplaces.

Household survey data are the only sources of information on changes in the number of people who are uninsured. However, results are published after a time lag, so these sources only provided limited information at the time of writing. Data from the Household Pulse Survey, sponsored by the US Census Bureau, is released monthly and shows a small but statistically insignificant increase in the share of uninsured nonelderly adults between March 2023 and November 2023.[32] The data also show a small statistically significant decrease in the share with Medicaid. Data from the National Health Interview Survey, sponsored by the National Center of Health Statistics, is released quarterly.[33] Data for the third quarter of 2023 (July through September 2023) show that the share of nonelderly people with public health insurance had fallen, and the share who were uninsured had risen relative to the second quarter of 2023, but these changes were not statistically significant.[34] The full impact of the unwinding on uninsurance will only become apparent when later quarters of data are available.

The unwinding of the continuous coverage requirement is a complex administrative process, and our results show that states are approaching it in various ways. Some states have extended their timelines.[35] North Carolina and Kentucky have paused unwinding for an additional year for children. To minimize adverse consequences for children, adults, and their families, states should consider ways to maximize disenrolled people's access to supports to assist them in finding coverage. This may involve helping them reenroll in Medicaid if they remain eligible or ensuring they are connected with other coverage, such as separate CHIP programs or the Marketplace.

Conclusion

This analysis of enrollment data through November 2023 is the first in a series of planned reports as the unwinding continues. Our initial conclusions are that while net disenrollment in many states is much lower than our projections, some have already exceeded the total net disenrollment expected for the entire unwinding, and others are close to doing so. High net disenrollment is a particular issue for children in some states, with 12 states already having disenrolled over 100 percent of our projected amount. Important state policy decisions related to the unwinding, such as the number of e-14 waivers

obtained by a state, are also associated with dramatic differences in net disenrollment, though we cannot determine how much of this is because of state intentions about the unwinding and how much is because of the policies themselves reducing disenrollment.

Appendix

Sensitivity Analysis Excluding Separate CHIP Programs

As noted in this paper, analyses of enrollment presented here are based on combined enrollment in Medicaid and CHIP (Medicaid expansion and separate programs), and the continuous coverage requirement did not affect separate CHIP enrollment. Some states do not have separate CHIP programs, and many states cover only a small number of children in separate CHIP (Brooks et al. 2023). In FY 2022, according to MACPAC, more than 10 percent of child Medicaid/CHIP enrollment was in separate CHIP programs in Alabama, Georgia, Idaho, Iowa, Kansas, Massachusetts, Montana, New Jersey, New York, Oregon, and Wisconsin.[36] If states' reporting of separate CHIP caseloads differ in a way that significantly affects disenrollment metrics, it would be problematic to combine separate CHIP enrollees with children enrolled in Medicaid (or Medicaid expansion CHIP) for this analysis. We therefore conducted a sensitivity analysis to ensure that we are not erroneously combining the two populations. We removed the separate CHIP caseload from the total child enrollment counts, recomputed peak enrollment accordingly, and compared net disenrollment to 2022 projections for the Medicaid-only population (Buettgens and Green 2022). While there was some fluctuation in state-by-state numbers, the order of states remained largely the same, and the 12 states with child disenrollment rates exceeding 100 percent of projected disenrollment remained the same. Results for each policy detail examined in this report (unwinding timelines, waiver take up, and prioritization of likely ineligible members) also remained unaffected by this change.

State Disenrollment Percentages and Policy Details

TABLE 1

Reported Medicaid/CHIP Net Disenrollment as A Percentage of Projected Net Disenrollment

	Percentage of Projected Disenrollment			Policy Details		
State	Overall	Children	Nonelderly adults	Unwinding timeline	Prioritizing ineligibles?	Waivers taken
Alabama	88%	226%	48%	12-14 months	No	6
Alaska	75%	63%	80%	12-14 months	No	10
Arizona	52%	55%	50%	12-14 months	Yes	9
Arkansas	127%	171%	113%	<12 months	Yes	6
California	34%	57%	28%	12-14 months	No	14
Colorado	82%	107%	74%	12-14 months	No	5
Connecticut	40%	6%	50%	12-14 months	No	5
Delaware	43%	45%	41%	12-14 months	No	8
District of Columbia	47%	14%	63%	12-14 months	No	11
Florida	83%	149%	50%	12-14 months	Yes	0
Georgia	91%	186%	41%	12-14 months	No	7
Hawaii	-	-	-	12-14 months	No	13
Idaho	148%	188%	130%	12-14 months	Yes	3
Illinois	35%	36%	35%	12-14 months	No	5
Indiana	37%	47%	33%	12-14 months	No	15
Iowa	159%	277%	133%	12-14 months	Yes	2
Kansas	-	-	-	12-14 months	No	8
Kentucky	54%	14%	65%	12-14 months	No	14
Louisiana	61%	80%	56%	12-14 months	No	9
Maine	9%	8%	10%	12-14 months	No	10
Maryland	18%	15%	20%	12-14 months	Yes	11
Massachusetts	63%	32%	70%	12-14 months	Yes	9
Michigan	63%	78%	58%	12-14 months	No	12
Minnesota	22%	21%	22%	12-14 months	No	14
Mississippi	90%	126%	71%	12-14 months	No	6
Missouri	29%	53%	21%	<12 months	No	7
Montana	180%	346%	142%	<12 months	Yes	3
Nebraska	79%	98%	63%	12-14 months	No	3
Nevada	19%	19%	19%	12-14 months	Yes	13
New Hampshire	112%	95%	122%	<12 months	Yes	4
New Jersey	51%	76%	43%	12-14 months	No	8
New Mexico	83%	96%	75%	12-14 months	Yes	12
New York	35%	24%	40%	12-14 months	No	10
North Carolina	17%	17%	17%	12-14 months	No	11
North Dakota	84%	78%	83%	12-14 months	No	10
Ohio	63%	57%	66%	12-14 months	Yes	7
Oklahoma	189%	168%	206%	<12 months	Yes	3
Oregon	6%	2%	7%	12-14 months	No	5
Pennsylvania	65%	66%	65%	12-14 months	No	3
Rhode Island	-	-	-	12-14 months	No	4
South Carolina	69%	61%	76%	12-14 months	Yes	13
South Dakota	126%	261%	21%	<12 months	Yes	1
Tennessee	76%	79%	75%	12-14 months	No	15
Texas	117%	178%	74%	12-14 months	Yes	4
Utah	50%	61%	44%	12-14 months	Yes	8

	Percentage of Projected Disenrollment			Policy Details		
State	Overall	Children	Nonelderly adults	Unwinding timeline	Prioritizing ineligibles?	Waivers taken
Vermont	70%	37%	91%	12-14 months	Yes	9
Virginia	20%	30%	16%	12-14 months	No	10
Washington	98%	63%	112%	12-14 months	Yes	5
West Virginia	93%	77%	98%	12-14 months	No	4
Wisconsin	36%	48%	31%	12-14 months	No	2
Wyoming	64%	58%	71%	12-14 months	No	6

Source: Health Insurance Policy Simulation Model, 2023. CMS data tracking Medicaid enrollment, 2024.
Notes: CHIP = Children's Health Insurance Program. Reported net disenrollment is based on publicly available data through February 2023 and will increase as the unwinding progresses. If reported net disenrollment is higher than our projected total, that means that a state's enrollment is below the long-term historical trend. These percentages can be negative if enrollment in a population is higher than the peak enrollment value observed before the unwinding began. State definitions of children vary from state to state and are defined in their Medicaid/CHIP state plan for reporting data to CMS. Kansas, Rhode Island, and Hawaii were removed from this analysis because of broad reinstatements or pauses in disenrollment, which do not reflect the eventual trajectory of unwinding. We use October 2023 reports for Arizona because the data are updated quarterly. State policy decisions related to the unwinding used data reported to CMS for the length of the unwinding,[37] state e-14 waivers,[38] and state reports of ex parte system issues.[39]

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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 several 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, which was used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Jameson Carter is a senior data scientist in the Health Policy Center, where he develops and applies Urban's Health Insurance Policy Simulation Model. Before joining Urban, Carter produced microsimulation analyses of antipoverty programs at the Congressional Research Service using Urban's Transfer Income Model. His work at the Congressional Research Service included comprehensive estimations of federal transfers' impacts on poverty, evaluations of stimulus checks, and research informing the temporary expansion of the child tax credit. Additionally, in 2022, he helped the Internal Revenue Service's Office of Research, Applied Analytics, and Statistics research best practices for trustworthy artificial intelligence.

Carter received a BA in economics from Carleton College and an MS in public policy, management, and data analysis from Carnegie Mellon University's Heinz College, with coursework in causal inference, machine learning, and database management.

Jessica Banthin is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage, costs, and households' financial burdens. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy director for health at the Congressional Budget Office. During her eight-year term at the Congressional

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Banthin has also conducted significant research on a wide range of topics, such as the burdens of health care premiums and out-of-pocket costs on families, prescription drug spending, and employer and nongroup market premiums. She has special expertise in the design of microsimulation models for analyzing health insurance coverage and an extensive background in the design and use of household and employer survey data. Banthin served on the President's Task Force on National Health Care Reform in 1993 and participated in an interagency work group on improving the measurement of income and poverty in 1998 that led to the Census Bureau's Supplemental Poverty Measure. Banthin earned her AB cum laude from Harvard University and her PhD in economics from the University of Maryland, College Park. Jessica Banthin has served on the advisory board for the Cancer Policy Institute since 2020.

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Levitis served at the US Treasury Department from 2009 to 2017. He represented the Treasury on the interagency team that helped craft the ACA and later led the Treasury's ACA implementation as counselor to the assistant secretary for tax policy. He also cochaired the interagency working group that stood up the Section 1332 waiver program.

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