

OBBBA's Six-Month Redetermination Could Reduce Medicaid Expansion Enrollment by 2.0 to 3.1 Million in 2028

Minimizing Procedural Disenrollment Will Be Critical to Reducing Coverage Losses

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March 2026

Summary

The Budget Reconciliation Act of 2025 made major changes to both Medicaid and the health insurance Marketplaces. In this paper, we focus on one of the Medicaid provisions: by December 31, 2026, states must start redetermining eligibility for Affordable Care Act (ACA) Medicaid expansion enrollees every six months. This eliminates a provision of the ACA under which eligibility for Medicaid expansion enrollees is redetermined once every 12 months. We used the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the impact of this change in 2028, when the six-month redetermination process will be fully in effect.

- Medicaid expansion enrollment in an average month of 2028 would be 18.2 million if 12-month eligibility redetermination remained in place. We estimate that 77 percent of Medicaid

expansion enrollees facing their six-month redetermination would keep their coverage, 13 percent would be found no longer eligible because of higher earnings that month, and the remaining 11 percent would be procedurally disenrolled if procedural disenrollment rates in 2028 remain consistent with evidence from 2025. However, some of those people who are disenrolled may regain eligibility and re-enroll. Under this scenario, average monthly Medicaid expansion enrollment will be reduced by 3.1 million, or 17.2 percent.

- If all states matched the procedural disenrollment performance of the states with best practices, we estimate that 81 percent of enrollees facing their six-month redetermination would maintain their coverage, 12 percent would be found no longer eligible, and the remaining 7 percent would be procedurally disenrolled. Again, some of those disenrolled would re-enroll later in the year. Under this best-case scenario, average monthly enrollment would be reduced by 2.0 million, or 10.7 percent.
- The difference between these two scenarios reflects uncertainty about (1) how much states can limit procedural disenrollment—cases where people lose Medicaid because of administrative issues without their actual eligibility ever having been determined—during the shortened redetermination period; and (2) the rates at which people disenrolled would later re-enroll in Medicaid. The change in average monthly enrollment is the net result of disenrollment because of the shortened redetermination period and the subsequent re-enrollment of some people who were either procedurally disenrolled or regained eligibility after their income changed.
- Between 1.3 and 2.3 million people would become uninsured in an average month because of the six-month redetermination, depending on procedural disenrollment rates and rates of re-enrollment among those disenrolled.

Disruptions in coverage for Medicaid expansion enrollees because of six-month redetermination can result in worse health, delays in obtaining health care, unmet health needs, financial insecurity, and increased barriers to employment. Many of those disenrolled would be procedurally disenrolled, rather than being found no longer eligible. The single biggest way that states can minimize coverage disruptions under this policy is to reduce procedural disenrollment, such as by increasing the effectiveness of ex parte redeterminations (using available data to automatically redetermine eligibility without requiring paperwork) and improving outreach and assistance to those who must take action to renew their coverage. Such efforts could also reduce disenrollment because of the OBBBA's work requirements for Medicaid expansion enrollees (Buettgens et al. 2026; Karpman, Haley, and Kenney 2025).

As a result of the income volatility common among low-income workers, more frequent Medicaid redetermination will necessarily cause repeated disruptions in health coverage for many working people whose monthly income fluctuates around the Medicaid eligibility threshold. A six-month redetermination will also increase the Medicaid program's administrative costs by doubling the number of full redeterminations required each year and requiring changes to administrative systems. We were unable to estimate these costs because of the lack of state-level administrative data on renewal costs for Medicaid expansion enrollees.

Background

On July 4, 2025, President Trump signed the Budget Reconciliation Act of 2025, also known as the One Big Beautiful Bill Act (OBBBA), into law.¹ This law makes major changes to both Medicaid and the health insurance Marketplaces (State Health & Value Strategies 2025). In this paper, we examine one of the Medicaid provisions: by December 31, 2026, states must redetermine eligibility for Medicaid expansion enrollees every six months. Under the ACA, eligibility for Medicaid expansion enrollees and other recipients whose eligibility is determined by modified adjusted gross income is not determined more often than once every 12 months.

With both six- and 12-month Medicaid redeterminations, most enrollees are found to still be eligible, but some are found to be ineligible, while others are procedurally disenrolled without a determination of eligibility. Although six-month redetermination will identify more people who are ineligible at the time of redetermination, income volatility is high among low-wage workers, and according to our analysis, many who are found ineligible at six-month redetermination will become eligible again within the year.

Requiring states to conduct six-month redeterminations will also increase the likelihood of procedural disenrollments relative to 12-month redeterminations.² Procedural disenrollment occurs when enrollees don't receive renewal notices, have difficulty completing the paperwork, or have their paperwork caught up in administrative backlogs. It can also happen when enrollees do not respond to renewal notices in the required time, which can be as short as 10 days in some states. Many enrollees who lose Medicaid, particularly those procedurally disenrolled, re-enroll after a gap in coverage (Swartz et al. 2015).

Loss of health coverage, even if temporary, can be a problem for beneficiaries. Research has shown that health coverage reduces mortality (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2019) and improves financial stability (Caswell and Waidmann 2017; Hu et al. 2016). Conversely, disruptions in health coverage have been shown to reduce continuity of health care, resulting in worse health (Sommers et al. 2016), delays in obtaining health care, and unmet health needs (Ku and Brantley 2020). Those who re-enroll in Medicaid after losing Medicaid have more emergency department visits and higher hospitalization rates (Banerjee, Ziegenfuss, and Shah 2010).

Mandatory six-month redetermination will also increase program administrative costs for both federal and state governments. States will have to conduct twice as many redeterminations each year, increase staffing and other resources, and make important changes to their administrative systems. Moreover, studies have shown that churn among enrollees in and out of Medicaid results in higher Medicaid costs (Swartz et al. 2015).

The impact of mandatory six-month redetermination will vary between states for several reasons. First, although redetermination for Medicaid expansion enrollees is only once every 12 months, most states perform data matches during the year that can identify enrollees who may no longer be eligible and require them to document their eligibility.³ States that perform the most extensive data checks and

give enrollees the shortest time to respond will see less impact from mandatory six-month redetermination because they are already disenrolling some of those no longer eligible after six months.

Second, states also vary considerably in the share of people procedurally disenrolled during redetermination and renewal because of paperwork issues. Based on performance indicator data reported to the Centers for Medicare and Medicaid Services (CMS) in early 2025,⁴ procedural disenrollment was at or below 10 percent of enrollees being redetermined in 20 states⁵ and above 25 percent of enrollees being redetermined in five states.⁶ Nationwide, procedural disenrollment rates have risen since June 2025, following the elimination of some federal and state efforts to increase ex parte enrollment during the Medicaid unwinding (CMS 2025). Doubling the number of redeterminations in one year will result in additional procedural disenrollment, with higher rates in states with higher current procedural disenrollment rates.

Third, American Indians and Alaska Natives (AI/AN) are exempt from the six-month redetermination requirement; their eligibility will continue to be redetermined once every 12 months. This will reduce the impact of six-month redetermination in states with large AI/AN populations.

Fourth, the demographic and employment characteristics of Medicaid expansion enrollees vary across states in ways that are correlated with changes in income over the course of a year, which will affect within-year eligibility.

In this brief, we estimate the average monthly Medicaid expansion enrollment each state would have in 2028 without six-month redetermination and the effect of adding mandatory six-month redetermination. Along with disenrollment because of the shorter redetermination period, we account for re-enrollment by some of those who lose Medicaid. Although the six-month redetermination takes effect in 2027, we simulate the impact in 2028 because the impact on average monthly enrollment will be lower during the first year as implementation rolls out. Depending on state decisions, it could be up to six months before the first enrollees are subject to new redeterminations. Finally, we estimate the increase in the number of people who would be uninsured in an average month because of this provision.

Methods

We used HIPSM to produce our analysis of the effects of mandatory six-month redetermination in 2028.⁷ HIPSM is a microsimulation model of the US health care system, focused on the nonelderly population, designed to estimate the cost and coverage effects of proposed policy changes. The model's baseline is regularly updated to reflect changes in law, state policies such as Medicaid expansion, premium increases, population growth, general inflation, and the most recent published Medicaid and Marketplace enrollment and costs in each state. We project the model's baseline to 2028.

We updated our estimates of state Medicaid enrollment for this analysis, incorporating 2025 administrative data from CMS monthly enrollment reports⁸ and several state websites.⁹ After calibrating our model, total Medicaid expansion enrollment for 2028 was about 18.2 million people.

To simulate the impact of a mandatory six-month redetermination, we estimate the share of Medicaid expansion enrollees who would ever lose Medicaid coverage under this policy change. Two groups of people could lose Medicaid: Those found to no longer be eligible and those procedurally disenrolled. For the former, we analyzed data from the Survey of Income and Program Participation (SIPP), which follows people's circumstances over time, to estimate the share of likely Medicaid expansion enrollees who would no longer be eligible six months later, as well as the share who would regain eligibility within the year. We imputed these conditions for Medicaid expansion enrollees in HIPSM using the most relevant characteristics, which our analysis identified as income and age. The resulting shares of people no longer eligible vary by state according to differences in the demographic and employment characteristics of each state's enrollees.

As mentioned above, many states conduct automated data checks during the year and require people who may no longer be eligible to provide documentation or lose their coverage. Thus, some people who are no longer eligible after six months of enrollment would already have been disenrolled even without a six-month redetermination. States that conduct these automated checks will likely see a smaller impact of six-month redeterminations on enrollment. To understand how to model state approaches to using automated data, we examined the types of automated data checks that states perform and the length of time in which enrollees must respond. We defined four state groups, ranging from states that did not perform such checks to the states that performed checks using TANF, SNAP, and electronic income data, and gave enrollees only 10 days to respond. Since these state policies are less comprehensive than a full six-month redetermination, we assumed that even the largest effect would be modest, ranging from a reduction in disenrollment of a third of people found ineligible at the six-month check for the states with the most comprehensive checks and limited response times to no effect in the states that do not perform such checks.

Along with modeling the number of people who are found to be ineligible, we need to model the impact of adding another redetermination process during the year on the number of people being procedurally disenrolled. We estimate a scenario with low automatic renewal rates that reflects 2025 procedural disenrollment rates, and a scenario with high automatic renewal rates that could be achieved if all states reduce their procedural disenrollment rates to 10 percent or less, a level already attained by about half of Medicaid expansion states.

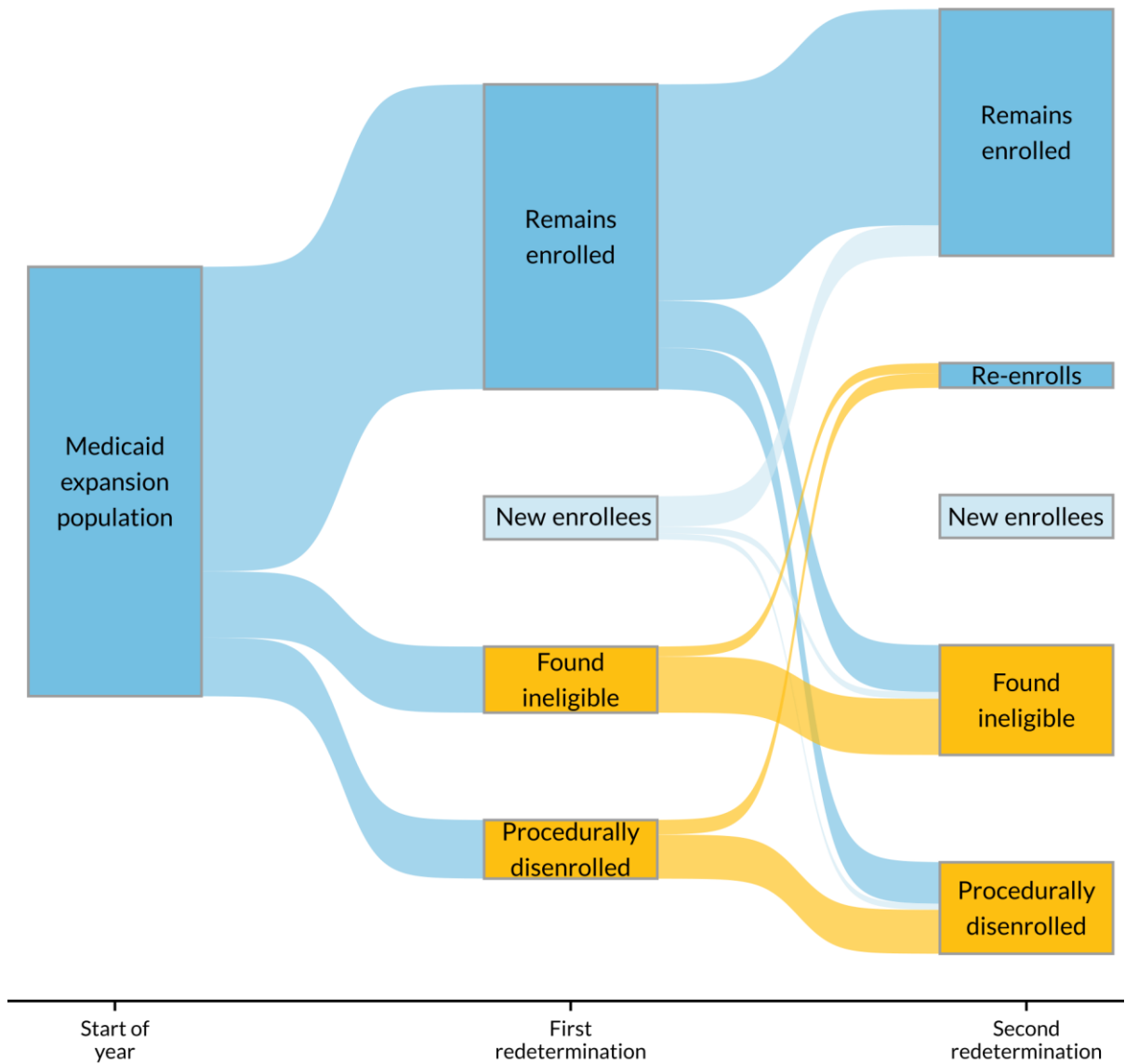
Our low mitigation scenario is based on state procedural disenrollment rates reported in the CMS Performance Indicator data in early 2025, after the Medicaid unwinding.¹⁰ As noted above, this share of people who were redetermined and procedurally disenrolled was at or below 10 percent in 20 states and above 25 percent in five states. We assume that four states with missing data on procedural enrollment¹¹ have the national average procedural disenrollment rate of 13 percent. Swartz et al. (2015) reviewed older literature and estimated a similar rate of about 15 percent. We average together clusters of states reporting similar procedural disenrollment rates in 2025 to estimate their approximate procedural disenrollment rates in 2028: states reporting up to 10 percent, up to 15 percent, up to 20 percent, and over 20 percent. The reported rates vary over time, so the smaller differences between states in each cluster may not be valid in 2028. This allows us to correct for

apparent state-level measurement error and smooth some dramatic and potentially inaccurate differences across states. For example, the states with the highest rates will likely continue to have the highest rates over time (the low automatic renewal scenario assumes no state efforts to reduce procedural disenrollment), but may not have exactly the same rates as in 2025. We assign each state in a group a rate several percentage points higher than the reported group average because procedural termination rates have risen since June 2025, due to the elimination of some temporary waivers introduced during the Medicaid unwinding that will continue to have an effect through early 2026 (CMS 2025). Also, states will have to update their administrative systems to accommodate the new change, which could lead to additional disruption. For the high automatic renewal scenario, we assume that all states can reduce procedural disenrollment rates to 10 percent or less. The procedural disenrollment rate is assumed to be 7 percent in states currently reporting rates below 10 percent (the average of their reported rates) and 10 percent in all other states.

Building on our analysis of enrollees who would ever be disenrolled because of six-month redetermination, we then estimated the impact on average monthly health coverage using a Markov chain model simulating the flows into and out of Medicaid (figure 1). We simulate Medicaid enrollees never disenrolled because of six-month redetermination, enrollees found ineligible, the share of those enrollees who re-enroll later in the year after regaining eligibility, enrollees procedurally disenrolled because of six-month redetermination, the share of procedurally disenrolled people who later re-enroll, and new Medicaid enrollees entering the system.

We estimated re-enrollment of people found ineligible based on our SIPP analysis of the share who would regain eligibility. We find that approximately 30 percent would regain eligibility, but both this share and the share of those who regain eligibility and re-enroll are uncertain. We assume that 30 percent of those found ineligible would re-enroll in the high mitigation scenario and 20 percent in the low mitigation scenario. The re-enrollment rates among those procedurally disenrolled are based on the review of the literature by Swartz et al. (2015). Unlike the OBBBA's work requirements, a six-month redetermination would not affect the flow of new enrollment, except for the re-enrollment of those losing Medicaid under the policy. Finally, we estimated changes in the average monthly levels of the uninsured, nongroup coverage, and employer coverage, given changes in average monthly Medicaid expansion enrollment, using HIPSM.

FIGURE 1
Schematic Diagram of Coverage Transitions After Six-Month Continuous Eligibility



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2025.

Limitations

Several uncertainties and limitations affect these estimates:

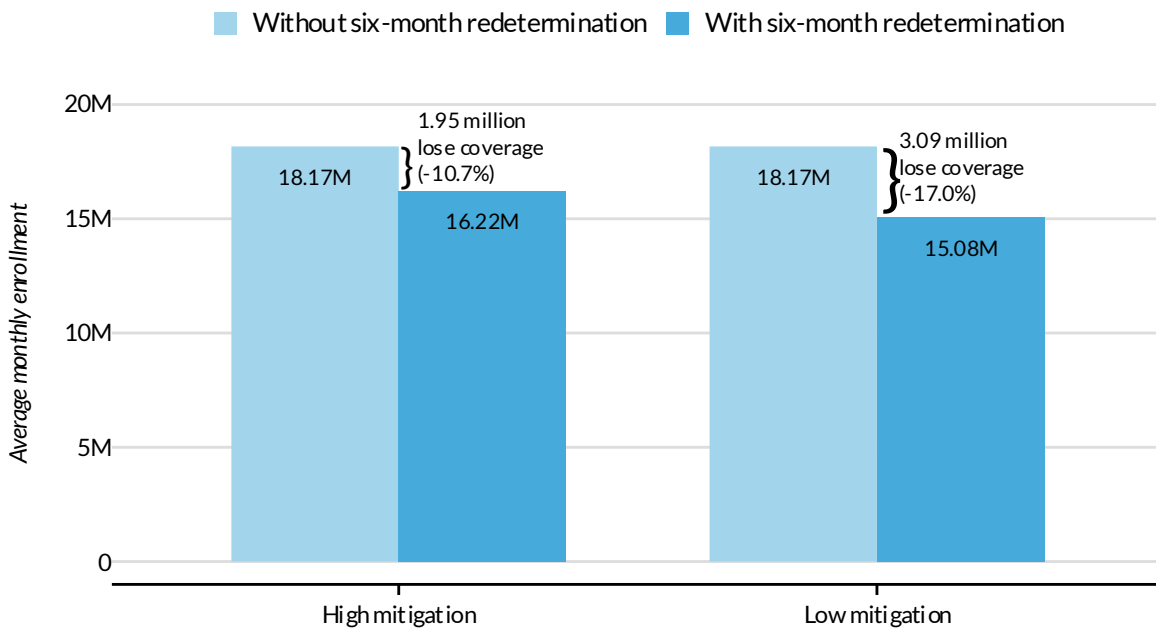
- As discussed, procedural termination rates are based on 2025 data and could change by 2028 as states prepare to implement provisions such as six-month redetermination and work requirements (Buettgens et al. 2026).

- The share of Medicaid expansion enrollees whose incomes rise above the eligibility threshold after six months depends on the economy and labor market. In an economic downturn, the share could be smaller, and vice versa.
- The SIPP data are not state-representative. Our estimates of people ineligible after six months and subsequently regaining eligibility reflect differences in the employment characteristics of Medicaid expansion enrollees across states in the much larger HIPS M population based on the American Community Survey, but may not reflect other state differences.
- No public data are available on how many Medicaid expansion enrollees in each state are currently disenrolled after less than 12 months because of the results of data matches. We estimated this based on published information on the extent of data checks conducted in each state and the length of time enrollees have to respond. If more people are disenrolled during the year than we estimated, the impact of six-month redetermination could be smaller.
- There is some uncertainty about which individuals enrolled in modified adjusted gross income-based eligibility groups other than the ACA Medicaid expansion group, generally through a Section 1115 demonstration waiver, would be subject to work requirements. CMS recently released a letter to state Medicaid directors,¹² but the letter does not specify how the eligibility criteria apply in individual states. Our estimates are based on our understanding of the relevant state waivers.
- We assume that enhanced Marketplace premium tax credits (PTCs) will not be renewed by Congress (Buettgens et al. 2025). If they are extended, more people who are becoming ineligible for Medicaid would enroll in Marketplace coverage, and the increase in uninsurance would be somewhat lower. However, the majority would still become uninsured.

Results

We estimate that there would be 18.2 million expansion enrollees in 2028 without six-month redetermination (figure 2). Under the low mitigation scenario, which assumes procedural disenrollment rates consistent with 2025 trends, we estimate that Medicaid expansion enrollment would be 3.1 million lower, a decline of 17.0 percent. Under our high mitigation scenario, which assumes that all states can reduce procedural disenrollment to 10 percent or less (a level already achieved by 20 expansion states), average monthly Medicaid expansion enrollment would be lower by 2.0 million people because of six-month redetermination, a decline of 10.7 percent. Along with differences in procedural disenrollment, the high mitigation scenario also assumes higher Medicaid re-enrollment rates among those disenrolled because of the six-month redetermination.

FIGURE 2
Average Monthly Medicaid Expansion Enrollment Under Six-Month Redetermination, 2028



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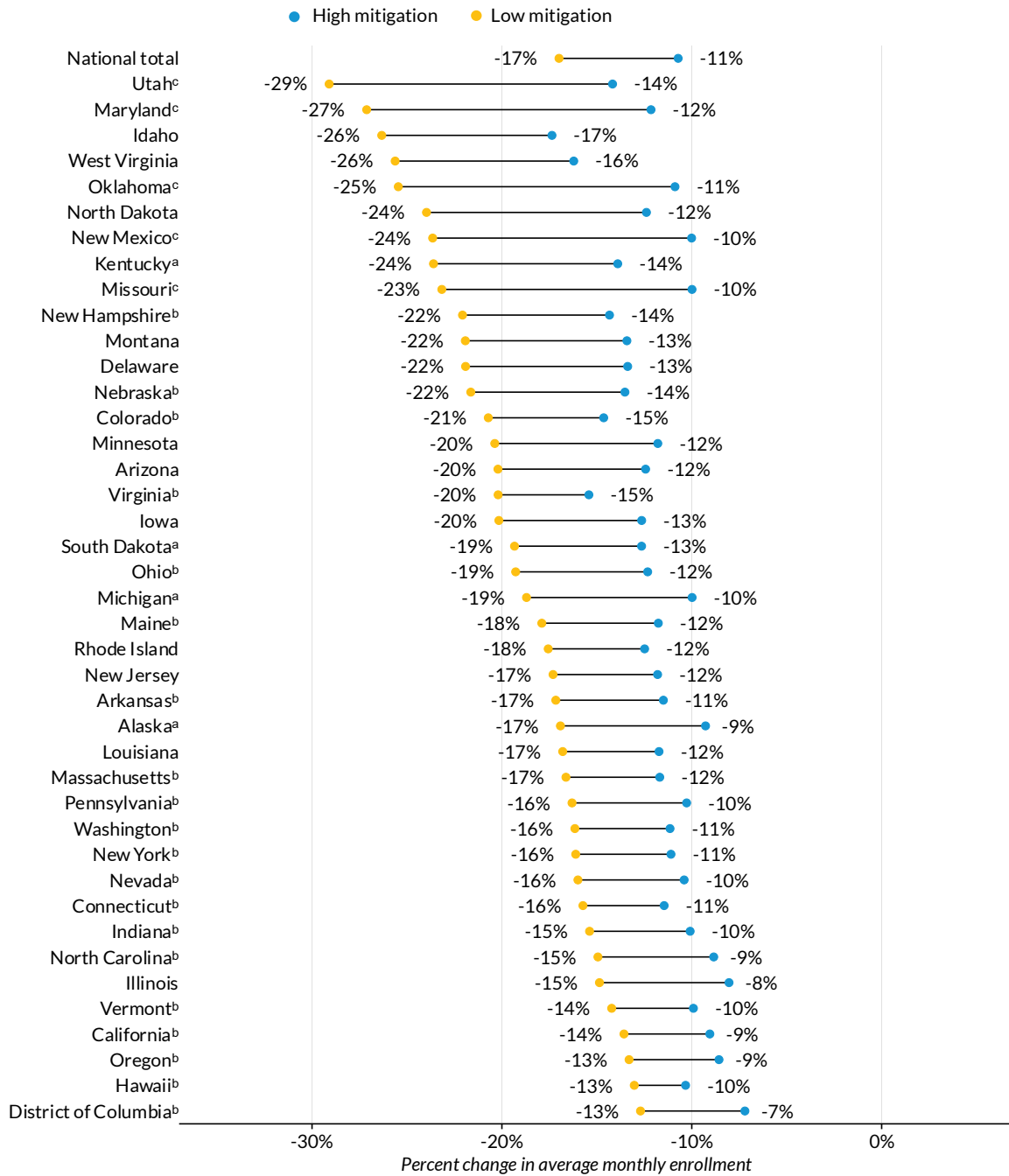
Source: The Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: High mitigation assumes that all states can bring procedural disenrollment down to 10 percent or less. Low mitigation procedural disenrollment rates are set to 2025 trends (see methods).

If the 2025 procedural disenrollment rates remain unchanged across states (low automatic renewal), Medicaid expansion enrollment would decline between 13 and 29 percent (figure 3). If all states can reduce procedural disenrollment because of the six-month redetermination to 10 percent or less (high mitigation), Medicaid expansion enrollment would decline across states by between 7 and 17 percent (figure 3). Along with procedural disenrollment rates, factors affecting declines in average monthly Medicaid enrollment in individual states include (1) differences in current midyear data checks and resulting disenrollment, (2) differences in demographic and employment characteristics of Medicaid expansion enrollees, and (3) differences in the share of AI/AN among Medicaid expansion enrollees.

In appendix table A.1, we summarize state estimates of changes in average monthly Medicaid expansion enrollment.

FIGURE 3
Percent Declines in Average Monthly Medicaid Expansion Enrollment Under Six-Month Redetermination by State, 2028



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: *High mitigation* assumes that all states can bring procedural disenrollment down to 10 percent or less. *Low mitigation* procedural disenrollment rates are set to 2025 trends (See methods). (a) State data not reported, national average assumed. (b) Rates at 10 percent or less. (c) Rates above 25 percent.

Coverage Losses at Redetermination

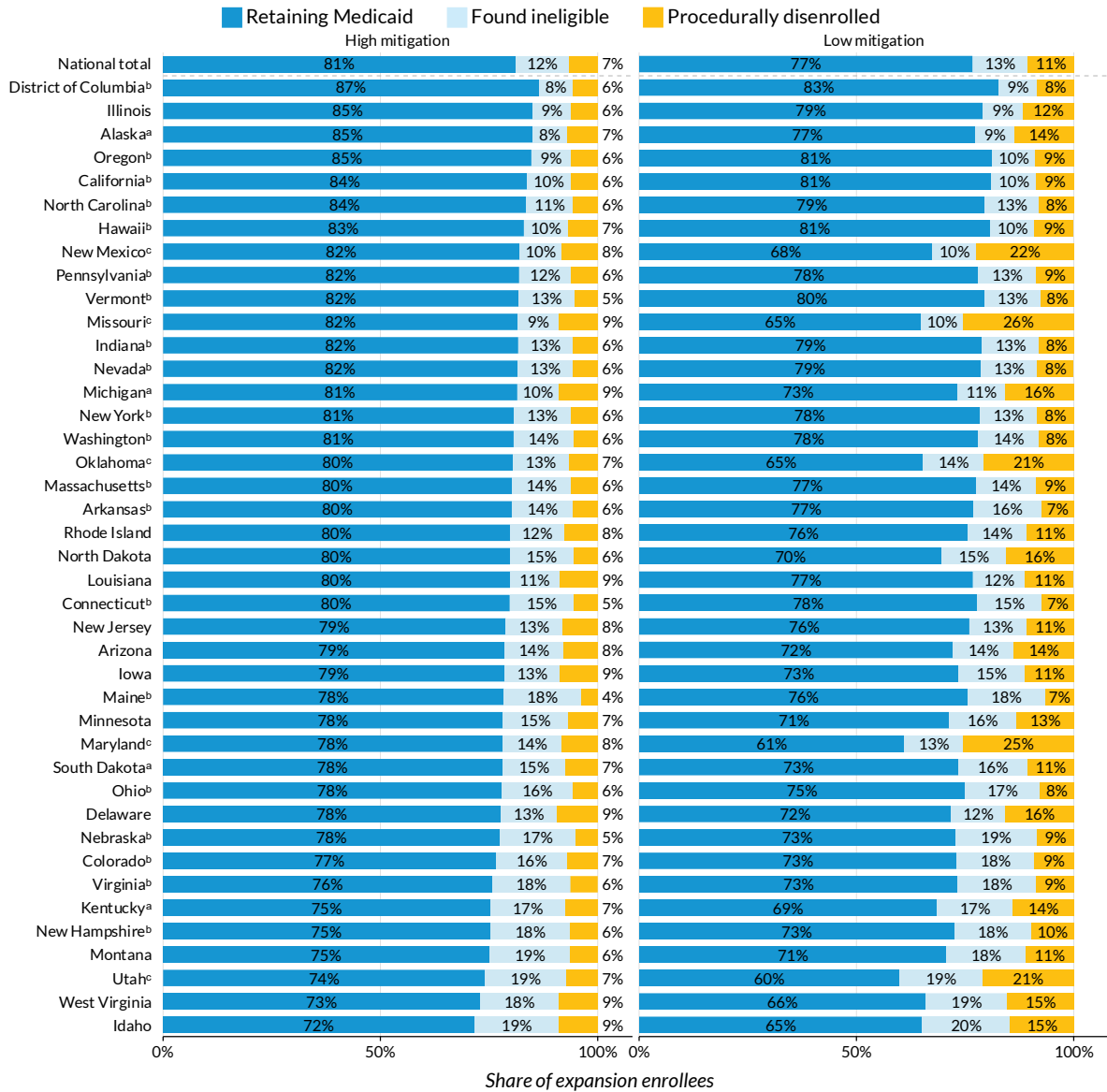
In figure 4, we summarize the effects of the new six-month redetermination requirement at the point at which redetermination is occurring. Under the low mitigation scenario, we estimate that 77 percent of Medicaid expansion enrollees would maintain their eligibility and stay enrolled after the six-month redetermination, 13 percent would be found ineligible, and 11 percent would be procedurally disenrolled. The share disenrolled immediately after redetermination is higher than the percent decline in average monthly enrollment in figure 2 because many of those disenrolled would later re-enroll after a disruption in coverage. Under the high mitigation scenario, 81 percent of Medicaid expansion enrollees would stay enrolled, 12 percent would be found ineligible, and 7 percent would be procedurally disenrolled.

Increases in Uninsurance

Finally, we estimate the impact on the number of people uninsured in an average month. Among those losing Medicaid, HIPSM simulates whether they find alternative coverage. Those no longer eligible for Medicaid generally lose eligibility because their incomes have risen above 138 percent of the federal poverty level. They may become eligible for Marketplace coverage with PTCs or health coverage through an employer. Under the low mitigation scenario, we estimate that there would be 2.3 million more uninsured people in an average month. If all states reduced procedural disenrollment because of six-month redetermination (the high mitigation scenario), we estimate that there would be 1.3 million more uninsured people (figure 5). The high mitigation scenario assumes higher Marketplace take-up rates than the low mitigation scenario, but both reflect lower take-up rates than those seen in 2025 because of the expiration of enhanced PTCs and provisions of the OBBBA affecting the Marketplaces (see discussion).

FIGURE 4

Shares of Medicaid Expansion Enrollees Retaining Coverage or Disenrolled as a Result of the Six-Month Redetermination, 2028

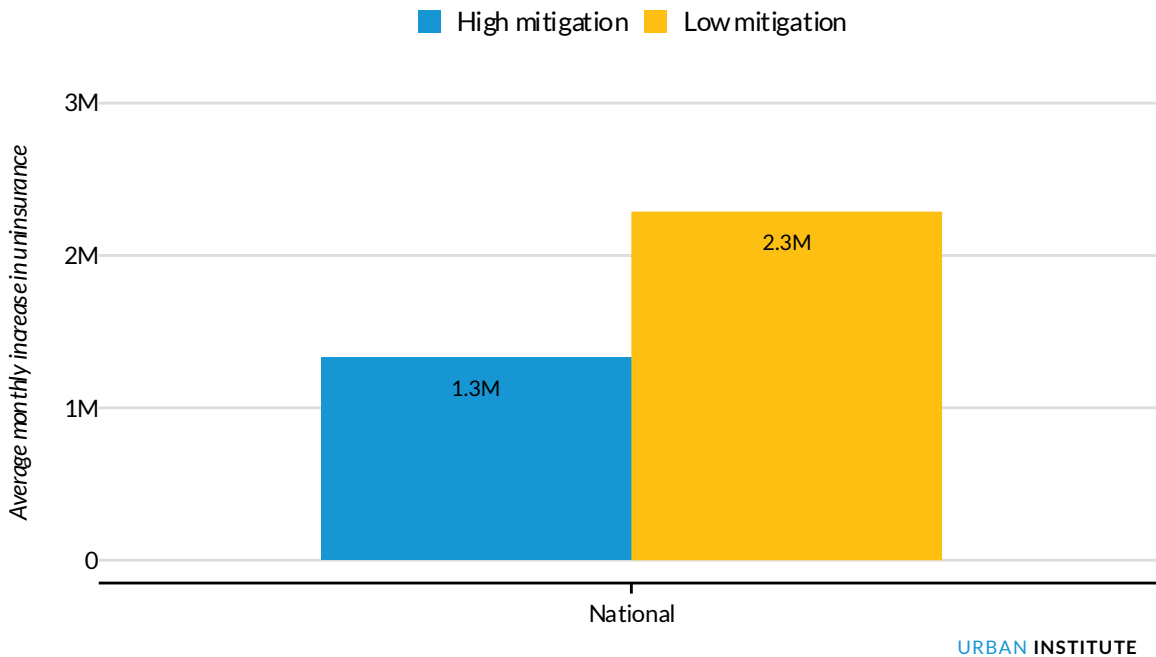


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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: High mitigation assumes that all states can bring procedural disenrollment down to 10 percent or less. Low mitigation procedural disenrollment rates are set to 2025 trends (See methods). (a) State data not reported, national average assumed. (b) Rates at 10 percent or less. (c) Rates above 25 percent.

FIGURE 5
Increases in Average Monthly Uninsurance Under Six-Month Redetermination, 2028



Source: The Urban Institute, Health Insurance Policy Simulation Model, 2025.

Notes: High mitigation assumes that all states can bring procedural disenrollment down to 10 percent or less. Low mitigation procedural disenrollment rates are set to 2025 trends (see methods).

Discussion

This study shows that six-month redetermination would reduce average monthly Medicaid expansion enrollment by 3.1 million people if states had procedural disenrollment rates comparable to 2025, and by 2.0 million if all states achieved the lowest rates observed. Some of this drop would be due to people being found ineligible because of higher incomes, while others would be procedurally disenrolled without having their eligibility determined. Some of the efforts states are making to improve data matching for work requirements could reduce procedural disenrollment more generally (Buettgens et al. 2026). These reductions in average monthly enrollment are the net result over time of people being disenrolled because of more frequent redetermination and the subsequent re-enrollment of some of those disenrolled (figure 1 and methods). The literature shows that many procedurally disenrolled people re-enroll soon afterwards (Swartz et al. 2015). Our analysis of SIPP data shows that a sizeable share of those found ineligible after six months would regain eligibility within the year, and many would re-enroll (see methods). Although the biggest difference between the automatic renewal scenarios is in procedural disenrollment rates, they also differ in the rates at which those disenrolled would re-enroll in Medicaid later.

Reducing procedural disenrollment rates seems to be the most important tool that states have for reducing disruptions in coverage because of the six-month redetermination. Increased use of automatic (ex parte) renewal is a crucial way to achieve this. However, after June 2025, nationwide ex parte rates declined from 57 to 50 percent, and procedural termination rates rose from 11 to 14 percent (CMS 2025). Much of this was from the elimination of some temporary state flexibilities that CMS gave states during the Medicaid unwinding. It will take about a year for these changes to have their full impact, so further increases in procedural disenrollment are likely through early 2026.

CMS has emphasized that states are expected to take a “data-first”¹³ approach to implementing work requirements, and states are currently assessing ways to improve data matches. Some of these changes are specific to work requirements, but others, particularly improved income verification, could also increase ex parte renewal rates more generally. As a result, procedural termination rates in 2028 may be lower than those reported in 2025. If they are not, then the higher disenrollment shown in our low automatic renewal scenario will be more likely.

The OBBBA and the decision by Congress not to renew enhanced PTCs would also make Marketplace coverage with PTCs less affordable and more difficult to obtain. This would be the only affordable health coverage option for working adults whose incomes rise above Medicaid eligibility at the time of redetermination and who do not have an affordable coverage option through an employer. The effect of the loss of enhanced PTCs received considerable attention this past fall (Buettgens et al. 2025), but an OBBBA provision that eliminates provisional PTC eligibility while the verification process is pending is less well known.¹⁴ People recently made eligible for PTCs because their incomes rose above the Medicaid threshold would be particularly vulnerable to being flagged by matches based on outdated data, and would have to pay the full premium for up to three months until their eligibility is fully verified. Former Medicaid enrollees would very likely be unable to do this.

OBBBA provisions for six-month redetermination and Marketplace coverage could be particularly disruptive for many working adults. Many studies have shown that low-income working families often have fluctuating incomes (Andersen et al. 2015; Ben-Ishai 2015). Our analysis shows that a sizable proportion (roughly 30 percent) of Medicaid expansion adults found ineligible during the six-month redetermination would become eligible again within the year because of a decline in monthly income. We estimate that because of such income volatility, mandatory six-month redetermination will repeatedly disrupt the health coverage of several million working adults whose income fluctuates around the eligibility threshold.

Disruptions in health coverage can harm both people’s health and economic well-being. Multiple studies have found that health coverage under the ACA *decreased mortality* (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2019). Other studies have found that Medicaid expansion *improved financial security* measures, such as credit scores, while reducing financial insecurity measures, such as medical debt collection balances (Caswell and Waidmann 2019; Hu et al. 2016). Several studies found that Medicaid expansion *reduced barriers to employment* (Gehr and Wikle 2017).

The Impact of 12-Month Redetermination Under the ACA

Three states redetermined eligibility every six months before the ACA and had to change to 12-month redetermination after 2014: Georgia, North Carolina, and Texas (Heberlein et al. 2013). None of these states expanded Medicaid eligibility in the first years of the ACA, so the extension of redetermination was likely the biggest change affecting enrollment in those years. By 2015, with 12-month redetermination starting in 2014, these states saw enrollment increases of 15 percent, 16 percent, and 12 percent, respectively, according to CMS monthly enrollment reports. These increases in total enrollment include categories such as the aged and disabled, whose eligibility is generally less volatile than for Medicaid expansion adults, so the impact on nondisabled, nonelderly adults may have been larger. On the other hand, ex parte renewal rates are now generally higher and procedural disenrollment rates lower than in 2014. Thus, although this historical change is not the same as changing the redetermination frequency of current Medicaid expansion enrollees, it is a reasonable approximation of the difference that it could make. The experience of these three states falls within our estimated enrollment decline range of 11.9 to 21.1 percent.

Comparison with Other Estimates

The Congressional Budget Office (CBO) has released limited details about their simulation of a six-month redetermination: About 10 percent of those subject to the provision would no longer have coverage, 70 percent of these would be procedurally disenrolled, and 700,000 more people would be uninsured at a point in time.¹⁵ Their 10 percent statistic should be compared with our estimated average monthly changes in Medicaid expansion enrollment, which are 11.9 percent under a mitigation scenario (best practices) and 21.1 percent under a low mitigation scenario (reflecting 2025 rates across states)

Beyond those overall numbers, we know little about CBO's methodology, so what we can say about potential sources of difference is limited. CBO notes that they used administrative data from the unwinding to estimate procedural disenrollment. Procedural disenrollment rates varied considerably during the unwinding across states and often in the same state at different times during unwinding, so it is unclear from their description exactly what data they used. We used state procedural termination rates reported to CMS after the bulk of the unwinding and considered modest recent increases reported after June 2025 in our high scenario (see methods). CBO did not give any details of how they estimated the number of people who would be found ineligible in the new redeterminations. As described in the methods above, we analyzed survey data showing how the incomes and other circumstances of adults eligible for the Medicaid expansion at a point in time change six months later.

Rao et al. (2026) also estimate the impact of six-month redeterminations, estimating that Medicaid enrollment would decline by just over 900,000 people by 2034. They state that these do not include interactions with other OBBBA provisions. Their estimate of people no longer eligible for Medicaid during the new redeterminations is based on data reported to CMS on the number of people found to be ineligible under current redeterminations. They estimated increased procedural disenrollment based on these data as well, but discounted them by 50 percent. They state that procedural disenrollment due to

the additional redeterminations is uncertain and assume that they would be half of what they are for current redeterminations.

Conclusion

Although the mandatory six-month redetermination has received less attention than other OBBBA provisions, particularly work requirements, we find that it will lead to notable reductions in Medicaid expansion enrollment on its own. We estimate that, in 2028, between 2.0 million and 3.1 million fewer people would be enrolled in Medicaid expansion in an average month, a decline of between 10.7 and 17.0 percent. Disenrollment would vary considerably by state. Although several reasons explain this variation, by far the single most important factor within the control of state governments is the rate of procedural termination. States can reduce disenrollment by improving data matches used for automatic (ex parte) redetermination and using outreach and assistance efforts to improve the response rate among those who cannot be renewed automatically. Such efforts could also reduce disenrollment because of the OBBBA’s work requirements for Medicaid expansion enrollees (Buettgens et al. 2026; Karpman, Haley, and Kenney 2025).

Appendix

APPENDIX TABLE A.1

Changes in Average Monthly Enrollment Among Current Medicaid Expansion Enrollees Under Six-Month Redetermination by State, 2028

(Thousands of people)

	Total expansion enrollees	Low Impact Scenario		High Impact Scenario	
		Reduction in average monthly Medicaid enrollment	Percent reduction in enrollment	Reduction in average monthly Medicaid enrollment	Percent reduction in enrollment
Total	18,165	1,947	10.7%	3,087	17.0%
Alaska	63	6	9.3%	11	16.9%
Arizona	450	56	12.4%	91	20.2%
Arkansas	216	25	11.5%	37	17.2%
California	4,325	391	9.0%	587	13.6%
Colorado	380	56	14.6%	79	20.7%
Connecticut	300	34	11.5%	47	15.7%
Delaware	62	8	13.4%	14	21.9%
District of Columbia	110	8	7.2%	14	12.7%
Hawaii	131	14	10.3%	17	13.0%
Idaho	78	14	17.4%	21	26.3%
Illinois	735	59	8.0%	109	14.9%
Indiana	562	57	10.1%	87	15.4%
Iowa	181	23	12.6%	37	20.2%
Kentucky	405	56	13.9%	96	23.6%
Louisiana	485	57	11.7%	81	16.8%
Maine	68	8	11.8%	12	17.9%

	Low Impact Scenario			High Impact Scenario	
	Total expansion enrollees	Reduction in average monthly Medicaid enrollment	Percent reduction in enrollment	Reduction in average monthly Medicaid enrollment	Percent reduction in enrollment
Maryland	334	41	12.1%	91	27.1%
Massachusetts	297	35	11.7%	49	16.6%
Michigan	711	71	10.0%	133	18.7%
Minnesota	186	22	11.8%	38	20.4%
Missouri	351	35	10.0%	81	23.2%
Montana	77	10	13.4%	17	21.9%
Nebraska	71	10	13.5%	15	21.6%
Nevada	292	30	10.4%	47	16.0%
New Hampshire	52	7	14.3%	12	22.1%
New Jersey	540	64	11.8%	94	17.3%
New Mexico	240	24	10.0%	57	23.6%
New York	1,980	220	11.1%	319	16.1%
North Carolina	671	59	8.8%	100	14.9%
North Dakota	25	3	12.4%	6	24.0%
Ohio	715	88	12.3%	138	19.3%
Oklahoma	233	25	10.9%	59	25.5%
Oregon	536	46	8.6%	71	13.3%
Pennsylvania	746	77	10.3%	122	16.3%
Rhode Island	79	10	12.5%	14	17.6%
South Dakota	32	4	12.6%	6	19.3%
Utah	82	12	14.2%	24	29.1%
Vermont	40	4	9.9%	6	14.2%
Virginia	568	88	15.4%	115	20.2%
Washington	609	68	11.1%	98	16.2%
West Virginia	144	23	16.2%	37	25.6%

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2026.

Notes: High mitigation assumes that all states can bring procedural disenrollment down to 10 percent or less. Low mitigation procedural disenrollment rates are set to 2025 trends (see methods). (a) State data not reported, national average assumed. (b) Rates at 10 percent or less. (c) Rates above 25 percent.

Notes

¹ One Big Beautiful Bill Act, Pub. L. No. 119–21, 139 Stat. 72 (2025).

² Tricia Brooks, Jennifer Tolbert, Anna Mudumala, et al., “Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations: Appendix Tables,” KFF, April 1, 2025, <https://www.kff.org/medicaid/understanding-medicaid-procedural-disenrollment-rates/>.

³ Jennifer Tolbert, Robin Rudowitz, and Patrick Drake, “Understanding Medicaid Procedural Disenrollment Rates,” KFF, September 7, 2023, <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-appendix-tables/#table-27>.

⁴ See methods for details.

⁵ This includes Arkansas, California, Connecticut, Colorado, the District of Columbia, Hawaii, Indiana, Maine, Massachusetts, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, Vermont, Virginia, and Washington.

⁶ This includes Maryland, Missouri, New Mexico, Oklahoma, and Utah.

- ⁷ Urban Institute, “The Health Insurance Policy Simulation Model,” in “Quantitative Data Analysis,” accessed March 2, 2026, <https://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm>.
- ⁸ “Monthly Medicaid & CHIP Application, Eligibility Determination, & Enrollment Reports & Data,” Medicaid.gov, accessed March 2, 2026, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data>.
- ⁹ This includes Alaska, Arizona, Arkansas, California (though these included people enrolled regardless of immigration status), Colorado, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Virginia, and Washington.
- ¹⁰ We used the average of September 2024 through January 2025.
- ¹¹ This includes Alaska, Kentucky, Michigan, and South Dakota.
- ¹² Dan Brillman, “[SMD #26-001 RE: Implementation of “Eligibility Redeterminations.” Section 71107 of the “Working Families Tax Cut.](#),” Legislation (Public Law 119-21),” Section 71107 of the “Working Families Tax Cut” Legislation (Public Law 119-21),” CMS, accessed March 6, 2026.
- ¹³ Heather Landi, “JPM26: Dr. Oz, CMS Leaders Make Their Pitch to Hospitals, Payers on Trump Admin Healthcare Policies,” Fierce Healthcare, January 13, 2026, <https://www.fiercehealthcare.com/regulatory/jpm26-dr-oz-cms-leaders-make-their-pitch-hospitals-payers-trump-admin-policies>.
- ¹⁴ Jason Levitis and Christen Linke-Young, “The Sleeper Provision in the Reconciliation Bill That Could Hobble the ACA Marketplaces,” Georgetown University Center on Health Insurance Reforms, May 19, 2025, <https://chir.georgetown.edu/the-sleeper-provision-in-the-reconciliation-bill-that-could-hobble-the-aca-marketplaces/>.
- ¹⁵ “[Supplemental Cost Estimate.](#)” Congressional Budget Office, October 28, 2025.

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Acknowledgments

This brief was funded by the Commonwealth Fund. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The authors wish to thank the following for their very useful feedback: Sara Collins, Lisa Dubay, John Holahan, Genevieve Kenney, and Stephen Zuckerman, and Sarah LaCorte for copyediting.



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