

Medicaid Redetermination Coverage Transitions

Background

During the COVID-19 public health emergency (PHE), Medicaid enrollment increased by [28.5%](#) (20.2 million individuals)¹. Some of these newly enrolled individuals are due to the expansion of Medicaid coverage in three states during the PHE (Nebraska, Missouri, and Oklahoma), while others are due to worsening economic conditions during the pandemic. However, a large amount of the increase in Medicaid enrollment is likely due to the Medicaid Maintenance of Eligibility (MOE) requirement included in the Families First Coronavirus Response Act. This MOE provision required states to provide continuous Medicaid coverage to receive an enhanced 6.2% Federal Medical Assistance Percentage (FMAP). The MOE provision with increased federal funding enabled states to ensure that vulnerable individuals retained their health coverage and were able to access vital medical services, including services for COVID-19 testing, treatment, and vaccination.

The 2023 Consolidated Appropriations Act decoupled the Medicaid MOE provision from the PHE and established the end of the MOE provision as March 31, 2023. Beginning on February 1, 2023, states could begin redetermining eligibility for Medicaid enrollees. On April 1, 2023, states may begin disenrolling people from Medicaid who are no longer eligible without losing enhanced federal funding.

Many Medicaid enrollees will be transitioning to other coverage sources during the redetermination period due to loss of Medicaid coverage. NORC's analysis provides state-level coverage source estimates for those predicted to lose Medicaid coverage during redetermination.

This project was funded by AHIP. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. AHIP is committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Methodology

NORC created state-level estimates for coverage pathways following Medicaid coverage loss based on two key sources:

- 1) The Urban Institute's state-level estimates² of projected Medicaid coverage loss due to the PHE expiration.
- 2) Data on historical coverage transitions from the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC).

While our findings closely match Urban Institute's distribution on national transitions, there are limitations to consider. These include more recent coverage policies that could enhance coverage access during the redetermination process, which include but are not limited to enhanced APTCs starting in 2021 and state-specific actions that could facilitate enrollment in alternative forms of

¹ [10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision.](#)

² [Urban Institute Report: The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage.](#)

coverage, hence our model may overstate the number of uninsured. These limitations are further explained later in this document.

1. Coverage loss by state

NORC relied on state-level estimates from Table B.1 in the appendix section of the [Urban Institute report](#) for estimates of nonelderly people losing Medicaid coverage over the 14 months following the end of the PHE in April 2023.

Overall, the Urban Institute estimates that 18 million nonelderly people would lose Medicaid coverage over the 14 months following the end of the PHE in April 2023.

Urban Institute estimates of Medicaid coverage loss reflect the difference between projections of the number of adults and children who would have enrolled in Medicaid by April 2023, and the pre-pandemic long-term trend.

2. Estimates of historical coverage pathways

The CPS ASEC³ is widely used by social scientists and policy makers as it contains data on widely used measures of income, poverty, and other socioeconomic markers. Among the variables covered by the ASEC are questions related to health insurance coverage status for a representative sample of the U.S. population.

NORC used these coverage questions to analyze the coverage pathways for people losing Medicaid (e.g., transitioning to EPC, becoming uninsured, etc.). Coverage transitions were defined as two-year periods, wherein an individual reported having Medicaid coverage in the first year and no Medicaid coverage in the second year. Since insurance coverage responses lag by a year, NORC used ASEC data from 2019 to 2020 to assess coverage transitions from 2018 to 2019, which is prior to the PHE and hence not affected by the effects of continuous enrollment for the Medicaid population.

NORC conditioned the analysis sample to a panel of respondents that met three conditions:

- Respondents that had coverage responses in the first year and second year of the coverage transition (2018 to 2019)
- Respondents that had Medicaid coverage in year one and no Medicaid coverage in year two
- Respondents younger than 65 (nonelderly population)

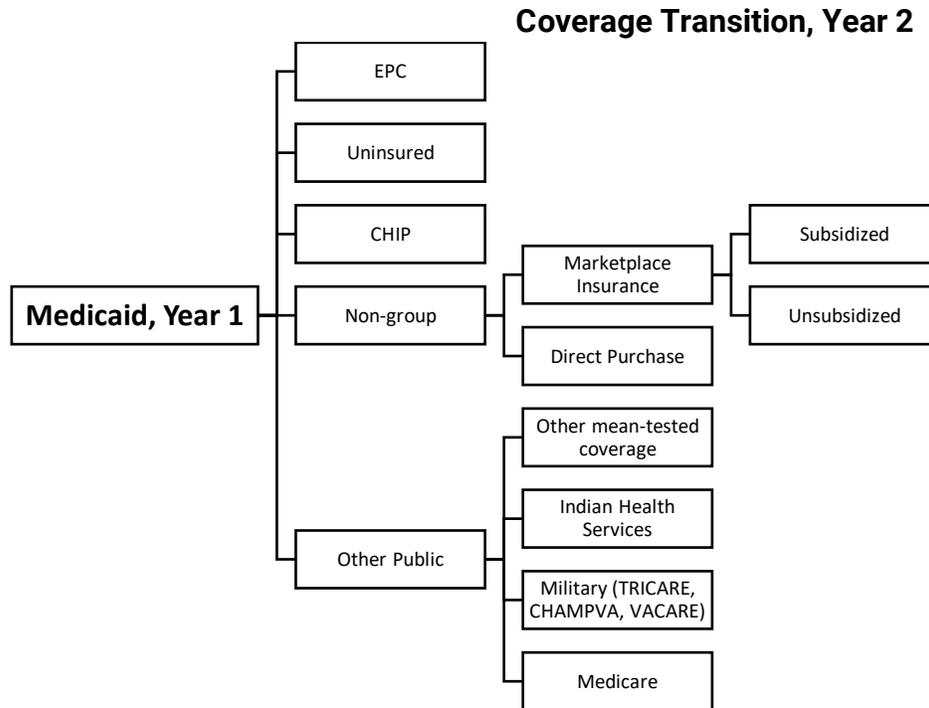
Implementing these conditions yielded a sample of **about 3,500 survey respondents** (out of a total of approximately 180,000 respondents), which NORC further analyzed by state and categorized into several types of coverage transitions in year two (e.g., some may become uninsured, others may enroll in non-group coverage, or EPC etc.).

As a result, sample size was a concern, particularly for smaller states. To enhance the analysis sample, NORC added two additional historical two-year periods for coverage transitions, for a total of three historical two-year periods for coverage transitions: 2016 to 2017, 2017 to 2018, and 2018 to 2019. In total, NORC analyzed **11,199 unique survey respondents** across the three transition periods.

³ For more information on ASEC supplements, refer to <https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html>

Figure 1 (below) illustrates the potential coverage transitions for Medicaid beneficiaries:

Figure 1 - Coverage Transitions for Medicaid beneficiaries



Because approximately 14% of respondents indicated more than one type of coverage, NORC used a hierarchy to determine mutually exclusive coverage transitions.

- In year 1 of the transition, respondents that indicated they had Medicaid coverage were determined to have Medicaid coverage regardless of any other type of additional coverage indicated.
- In year 2 of the transition, when respondents indicated more than one type of coverage, NORC used the following prioritization system: 1) EPC, 2) uninsured, 3) CHIP, 4) nongroup, and 5) other public coverage. This means, for example, if a respondent indicated having EPC and non-group at any point of the year, NORC first prioritized EPC. This hierarchy is based on the ranking order of Urban Institute’s projected distribution of coverage transitions at the national level as shown in the table below.

Table 1 - Urban Institute National Coverage Transitions for people losing Medicaid ending the PHE

Coverage Transition	Number of People	Percent
EPC	9,500,000	52.8%
Uninsured	3,800,000	21.1%
CHIP	3,200,000	17.8%
Nongroup	1,000,000	5.6%
Other Public	247,000	1.4%

Non-ACA compliant	242,000	1.3%
Total	17,989,000	100%

3. Weighted Blend of Urban and ASEC Results

After applying the hierarchy, NORC produced state-specific coverage distributions across the different health insurance types shown in Figure 1. We then compared these proportions on a national level to Urban Institute, which we believe to be the best publicly available benchmark.⁴

From these preliminary distributions, NORC identified discrepancies in our estimates of the distribution of former Medicaid enrollees going to CHIP, Medicare, and the nongroup market as shown in the table below (“Other Public Coverage” in the Urban analysis includes Medicare).

Table 2: Calibration of Urban and ASEC Distributions

Coverage Transition	Urban Institute National Distribution	Initial ASEC Distribution
EPC	52.8%	54%
Uninsured	21.1%	20%
CHIP	17.8%	5%
Nongroup*	5.6%	12%
Other Public*	1.4%	9%, (6% from Medicare)
Non-ACA Compliant	1.3%	NA
Total	100%	100%

*For coverage types making up these categories refer to Figure 1

The discrepancies seen above may stem from differences between the Medicaid population makeup in historical ASEC transition patterns and the population subject to continuous enrollment during the PHE. The population likely to lose coverage following the end of the MOE requirement likely have higher incomes at the time of redetermination than upon initial enrollment in Medicaid during the PHE. As a result, we anticipate that more children will transition to CHIP than seen in past transitions. This is reflected in the Urban Institute national estimates, but not in the ASEC historic data.

To address the differences between historical coverage transitions based on ASEC data and Urban’s national coverage transition distribution, NORC estimated coverage transitions based on a weighted blend consisting of weighing Urban’s national coverage distribution by 75% and the state-specific historical coverage transitions from ASEC by 25%. This weighing was done to balance the under-estimation of CHIP and overestimation of Medicare and nongroup coverage transitions based on ASEC

⁴ NORC also consulted a ASPE issue brief which provides high-level estimates of coverage transitions based on the Survey for Income and Program Participation (SIPP) March 2015 to November 2016 data. ASPE estimates that only 8.2 million people will lose Medicaid coverage, and that 44% will transition to EPC, 33% will become eligible for APTCs, 17% will change to non-marketplace coverage, 5% will fall into the Medicaid coverage gap, and 3% will have an offer of affordable EPC but not enroll. https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

data while maintaining the ability to preserve historical patterns of coverage transitions at the state level.

NORC’s final estimates of national coverage transitions compared to the Urban Institute’s national numbers are shown in Table 3 below.

Table 3: Final Estimates of Coverage Transitions

Coverage Transition	Urban Percent	NORC Weighted Blend
EPC	54%	54%
Uninsured	21%	21%
CHIP	18%	15%
Nongroup	6%	7%
Other Public	1%	3%
Total*	100%	100%

*Urban’s distribution was adjusted to exclude non-ACA compliant coverage since ASEC data does not allow to specify this type of coverage.

The above coverage types are shown to compare results to Urban; state-specific coverage distributions include sub-categories, e.g., subsidized versus unsubsidized marketplace coverage (refer to Figure 1), which are applied to state-level estimates of Medicaid coverage loss generated by the Urban Institute.

Results

All results, including the proportion and number of people estimated to move to new coverage sources following the redetermination, can be found in the “Coverage Transition Modeling Dashboard.”

Overall, our modeling finds that in nearly all states, the majority of individuals will transition to employer-provided coverage (EPC). Variation across states ranges from the lowest proportion (48.9%) in Georgia, to the highest proportion (57.1%) in Delaware, enrolling in EPC.

Notably, approximately 3.8 million (or 21.2%) of people who lose Medicaid coverage during redetermination are estimated to become uninsured. Variation ranges from 17.7% in Massachusetts to 26.2% in South Dakota.

Limitations

A blended approach allowed NORC to produce state-specific estimates on coverage transitions by balancing state historical transition patterns and Urban’s simulation on coverage pathways at the end of the PHE. However, there are other factors that are not considered in the model that could influence coverage pathways for individuals.

Among these factors are state specific policies that may facilitate enrollment in other forms of coverage and changes influencing population income in industry-specific markets because of the PHE. The model only reflects coverage transitions at the end of the redetermination process, 14 months following the end of the PHE. The model does not estimate nor represents coverage churning during this process, which would be reflective of more near-term effects on coverage following the end of the PHE. This analysis also does not take into account disruptions in coverage when children transition between Medicaid and CHIP due to specific state circumstances.⁵

Finally, the American Rescue Plan Act (ARPA) of 2021 expanded both eligibility for, and the level of, Marketplace subsidies. These changes were recently extended through 2025 under the Inflation Reduction Act. These changes to subsidies will likely increase enrollment in subsidized Marketplace plans among those losing Medicaid coverage during redeterminations. However, because this policy was enacted in 2021, it is not reflected in the ASEC historical data, and we do not believe it is reflected in Urban's national-level coverage estimates either, given that NORC's unweighted ASEC analysis returned similar proportions of uninsured to Urban. It is possible therefore that NORC's model overstates the proportion of people becoming uninsured, but we are unable to estimate the magnitude of this impact.

⁵ For more information on state-specific circumstances that might cause disruptions in coverage when enrollees transfer from Medicaid to CHIP, please refer to <https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/>.