What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?

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Contents

Acknowledgments

What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?

Medicaid enrollment has risen substantially since the start of the COVID-19 pandemic. Recent data show enrollment jumped by more than 9 million people from February 2020 to January 2021.[1] The higher enrollment is driven by two main causes: the unprecedented pandemic-related job losses concentrated in March to June of 2020 and the continuous coverage requirement of the Families First Coronavirus Response Act, which prohibits state Medicaid agencies from disenrolling beneficiaries during the public health emergency (PHE). Even as the economy improves, however, the continuous coverage provision is likely to contribute to even higher Medicaid enrollment through 2021.

We analyze state enrollment patterns to determine their main drivers and to project enrollment growth for 2021. We then project two possible disenrollment scenarios for 2022. Our key findings are as follows:

- We estimate that by the end of 2021, 17 million more nonelderly people will be enrolled in Medicaid than before the pandemic, reaching a total of 76.3 million Medicaid enrollees younger than 65. Our estimate assumes the PHE will expire at the end of 2021.

- We find that the continuous coverage provision significantly contributes to ongoing Medicaid enrollment growth. In a typical month before the pandemic, many people would lose Medicaid eligibility and fall off the rolls, while other people would gain eligibility and sign up because of changes in income or family composition. Over 21 months, eliminating the disenrollment caused by loss of eligibility translates into a substantial cumulative enrollment increase.

- A recent change in guidance from the Centers for Medicare & Medicaid Services (CMS) gives states up to 12 months to restore normal income eligibility redeterminations for Medicaid enrollees once the PHE expires, instead of just 6 months under previous rules (CMS 2021). More gradual processing of enrollment over 12 months could reduce unnecessary losses of coverage by allowing more time for planning and outreach. However, the expected loss of the

enhanced federal medical assistance percentage (FMAP) in March 2022 gives states a financial incentive to process enrollment more quickly.

- We estimate that the number of Medicaid enrollees could decline by about 15 million people during 2022. This includes 8.7 million adults and 5.9 million children. We estimate that one-third of adults losing Medicaid coverage after the PHE could qualify for subsidized private health coverage in the Marketplaces. Nearly all of the remainder would likely have access to an offer of employer coverage in their family deemed affordable under the Affordable Care Act (ACA).

- Many of those losing Medicaid coverage would be eligible for other sources of subsidized coverage. Of the adults who would lose Medicaid, we estimate about a third would be eligible for Marketplace premium tax credits (PTCs) if the enhanced tax credits in the American Rescue Plan Act (ARPA) were made permanent. Of the children losing Medicaid, 57 percent would be eligible for the Children's Health Insurance Program (CHIP), and an additional 9 percent would be eligible for Marketplace coverage with tax credits. Thus, good coordination between state Marketplaces and Medicaid agencies is essential to reduce unnecessary losses of health coverage.

Decisions made during the remainder of this year can substantially improve continuity of care for Medicaid enrollees and the stability of state finances during 2022. In recently-issued guidance, CMS helped states minimize disruptions in health coverage and reduce unnecessary disenrollment by allowing states up to 12 months to complete the transition (CMS 2021). CMS could further assist states by encouraging them to extend changes to their programs made during the pandemic. Congress could maximize the number of people gaining eligibility for Marketplace PTCs by making the ARPA enhanced PTCs permanent. Congress could also extend the enhanced FMAP throughout 2022 to remove the financial pressure on states to rapidly disenroll large numbers of beneficiaries before the FMAP is expected to expire in March 2022.

Introduction

The COVID-19 pandemic and federal laws enacted to mitigate its effects have produced unprecedented Medicaid enrollment. Beginning in March 2020, millions of people lost jobs in a few months as social and economic activity were severely restricted to slow the spread of COVID-19. In April 2021, just over a year later, 8.4 million fewer people were employed than before the pandemic.[2] Most Americans get their health coverage through employers, so people who lost jobs likely lost health coverage.[3] In addition, income losses made more people eligible for Medicaid.

The Families First Coronavirus Response Act contained several provisions related to Medicaid. Two of them are important for this work. First, the act increased FMAPs by 6.2 percentage points, and these additional payments to states will continue through the quarter after the PHE expires. In other words, the federal government has paid a higher share of Medicaid costs for all populations except those enrolled through the ACA's Medicaid expansion since the beginning of the pandemic, and the government is expected to continue to pay that higher share through March 2022. Second, in return for accepting this enhanced FMAP (which all states did), states were prohibited from disenrolling beneficiaries during the COVID-19 public health emergency except at the beneficiary's own request. This prohibition on disenrollment is referred to as the continuous coverage requirement.

A substantial share of enrollees have always gained and lost Medicaid coverage from month to month. These transitions are called churn and occur for several reasons, such as gaining or losing a job. States regularly verify eligibility for the program, sometimes as often as every 3 or 6 months, though the ACA limited it to 12 months for some eligibility types. The redetermination process can sometimes disenroll people who are still eligible but fail to file the required paperwork. Policymakers are

concerned about enrollment churn because it can undermine continuity of health care (Sugar et al. 2021).

But the requirement that states stop disenrolling beneficiaries temporarily eliminates losses of Medicaid coverage because of typical income verification requirements. The continuous coverage provision ensures that enrollment will rise each month during the PHE simply because existing beneficiaries are not being disenrolled, while others newly gain eligibility and enroll each month. We expect the PHE to last through the end of 2021.[4]

We do not know what will happen to Medicaid enrollment after the PHE ends. Many enrollees could be tested for eligibility within a few months, but others may not be retested until 12 months after their latest renewal during the PHE. Thus, even though a recent change in CMS guidance allows states to return to normal income eligibility testing within 12 months of the PHE expiring (CMS 2021), rather than 6 months under previous guidance (CMS 2020), states may decide to process enrollment more quickly. In this report, we use the latest available monthly Medicaid enrollment data in each state to document the enrollment growth that has already taken place. We compare growth rates across states and project enrollment in each state up to the end of the PHE, which we assume will be the end of 2021, and through the end of 2022. We also examine associated state and federal Medicaid costs.

Methods

We begin with pre-COVID-19 estimates of Medicaid enrollment from the Health Insurance Policy Simulation Model's (HIPSM's) pre-COVID-19 2020 baseline (Buettgens and Banthin 2020). As part of our process for annually updating HIPSM, we bring in the latest data and validate the enrollment counts in the same manner across all states. This gives us a measure of enrollment that is consistent across all states. Different sources for state data can count enrollment differently, so starting with consistent data strengthens our analysis.

Second, we use the latest available data from each state to compute monthly enrollment increases relative to pre-COVID-19 enrollment. We collected Medicaid enrollment data from CMS and individual state Medicaid websites for all available months in 2020 and 2021. If a state's Medicaid agency publishes more recent data than those available from CMS, we use the data from the state's Medicaid website; otherwise, we use CMS data. We calculate enrollment growth in each month relative to enrollment levels in February 2020 for all available months. September 2020 was the latest

month for which data were available at the time of analysis for the 14 states for which we rely on CMS data. For the other 36 states and the District of Columbia, the latest month for which data were available at the time of analysis ranges from October 2020 to February 2021.

Third, we develop projected monthly growth rates for all remaining months through the end of 2021, when the PHE is expected to end. To do so, we use an average of each state's monthly enrollment growth rates in recent months. Thus, we are assuming enrollment will continue to grow steadily at these rates through the end of 2021. For the states where we rely on data from the state's Medicaid agency, we generally take an average of monthly enrollment growth rates over the most recent six-month period at the time of analysis (September 2020 to February 2021). For the states where we rely on CMS data, we generally take an average of monthly enrollment growth rates over all available months (March 2020 to September 2020). The specific methodology we used for each state is listed in appendix table A.5.

For each state, we then apply the cumulative monthly growth rate in a given month to pre-COVID-19 enrollment levels to determine total enrollment through the end of 2021.[5]

We expect that Medicaid eligibility determination will return to normal by the end of 2022, one year after the PHE is expected to end. We used HIPSM to project Medicaid enrollment in 2022, after the effects of the continuous coverage requirement are worked out (Blumberg et al. 2020). Consistent with Congressional Budget Office (CBO) projections,[6] we assume the pandemic will still have some residual impact on employment. We include the additional Medicaid eligibility that would result from this.

The trajectory of Medicaid enrollment between its height at the expiration of the PHE and the end of 2022 is much more uncertain. We define two scenarios for projecting Medicaid enrollment during this transition period. Under current CMS guidance, states have up to 12 months to return to normal eligibility processing, though states could do so more rapidly. First, we assume all states completely process continuous coverage enrollment within the first 6 months of 2022. This gives an upper bound of the pace of Medicaid disenrollment. Next, we define a second alternative that gives a lower bound by assuming states would gradually test all enrollees 12 months after enrollees' latest coverage renewals during the PHE. Under this scenario, enrollment would phase down linearly over 12 months. State disenrollment rates are likely to fall between these two scenarios. Also, disenrollment may vary by state in ways we cannot predict based on publicly available data.

An important consideration is the types of health coverage for which enrollees losing Medicaid would be eligible. We estimated this by imputing such people on our American Community Survey–

based HIPSM dataset for 2022 who are not currently eligible for Medicaid but who would have been eligible at some point during the previous year. As we show later, the large majority of the increased Medicaid enrollment is because of the continuous coverage requirement eliminating churn out of Medicaid, rather than pandemic-related job losses, so we used detailed pre-COVID-19 data on income volatility. We took data from the Survey of Income and Program Participation up to 2014. We inflated dollar amounts to 2022 and reweighted the survey to match the HIPSM data. We determined eligibility for Medicaid, CHIP, and Marketplace PTCs at several points during each year of Survey of Income and Program Participation data and used the result to impute HIPSM observations previously eligible for Medicaid. From these, we selected the number of Medicaid expansion adults, Medicaid nonexpansion adults, and Medicaid children who would lose coverage according to our projections and looked at their current eligibility for Marketplace PTCs, CHIP, and employer-sponsored coverage.

Our projections have important limitations because of the limitations on publicly available data. The number of months of enrollment data available for each state varies considerably. When state data were available from multiple sources—usually CMS and state Medicaid websites—they rarely matched exactly. But we find that the differences in resulting growth rates were minor. Also, different states report enrollment differently, particularly for groups such as limited-benefit enrollees. We minimize the impact of this inconsistency by computing enrollment growth using a single, internally consistent data source for each state and applying the growth to a previously validated pre-COVID-19 enrollment estimate from HIPSM.

Results

We begin by examining average monthly Medicaid enrollment rates for two time periods characterized by the amount of COVID-19-related job loss, distinguishing between enrollment growth in the first few months of the pandemic (April through June 2020), when job losses were very high, and enrollment growth in subsequent months, when employment stabilized and began to slowly recover. We also examine differences in those enrollment growth rates by time period across states. We then present projections of Medicaid enrollment and costs by state through the end of 2022.

State Medicaid Enrollment Growth Rates during the Pandemic

We find that in the first three months of major pandemic impact in the US, the second quarter of 2020 (Q2 2020), the median state Medicaid enrollment growth rate was 1.7 percent a month (figure 1, table

1). Not counting growth caused by new Medicaid expansions, historical enrollment growth in a normal year is generally around 1 percent a *year* nationally.[7] Median enrollment growth rates varied considerably between states, with the interquartile range running from 1.4 to 2.4 percent a month. The quarter saw unprecedented levels of employment loss, and many people gained Medicaid eligibility because they lost their jobs or lost income because of reduced work hours.

After Q2 2020, a different pattern emerged: monthly enrollment growth settled to a median rate of 1.1 percent per month, with the interquartile range running from 0.9 to 1.5 percent. This steady monthly growth—continuing up to the time of writing—is consistent with the ongoing impact of the continuous coverage requirement, so we refer to this as the continuous coverage period, covering Q3 2020 to 2021. This terminology is convenient but not exact. Job losses, including income losses caused by reduced hours, and the continuous coverage requirement are not mutually exclusive, and both likely contribute to ongoing enrollment increases. The continuous coverage requirement was also in effect for Q2 2020, so it likely contributed to enrollment growth. Also, some people losing jobs early in the pandemic may have waited until after July to enroll in Medicaid. And because of churn in employment, some people have experienced pandemic-related job losses since July 2020, leading to subsequent Medicaid enrollment, even though the employment rate has slowly risen since then. Finally, the continuous coverage requirement has been in effect for more than a year, so those who enrolled because of pandemic-related job losses in 2020 will have their coverage automatically renewed under the continuous coverage requirement.

FIGURE 1

Average Monthly State Medicaid Enrollment Growth Rates among the Nonelderly Population, Q2 2020 and Continuous Coverage Period (2020–21)
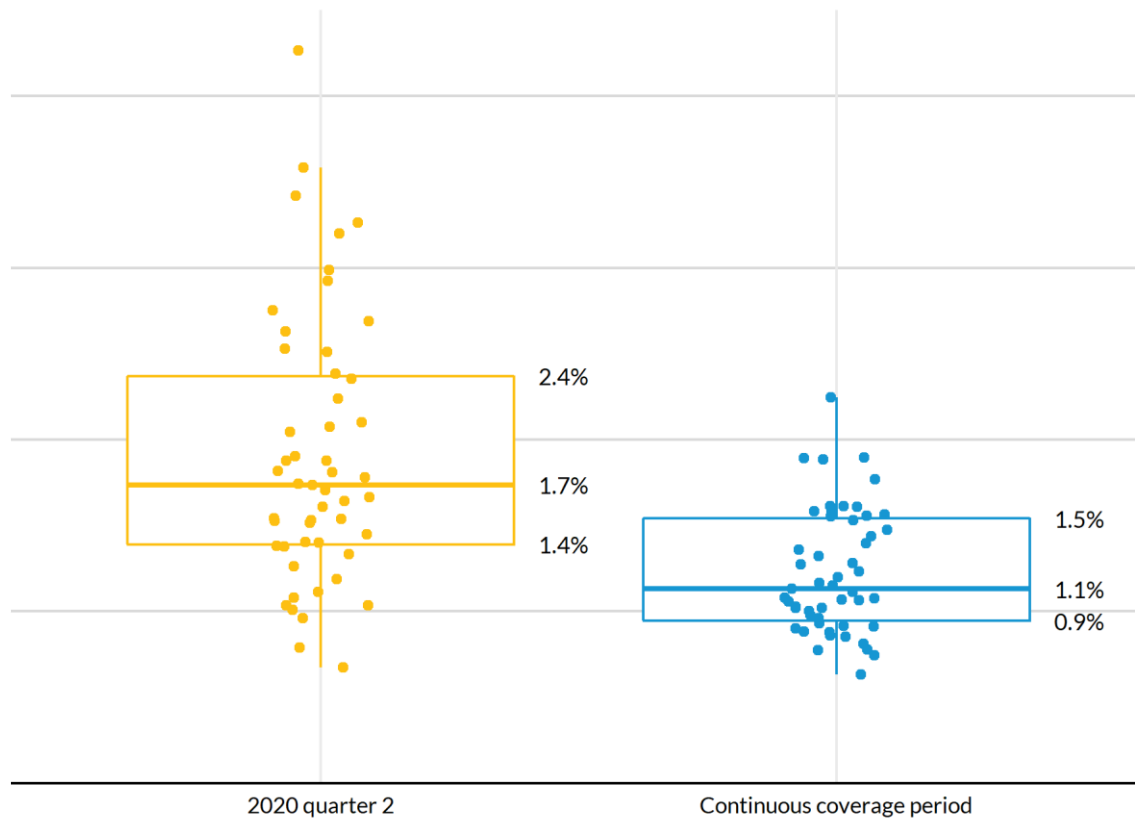
Source: Urban Institute analysis of enrollment growth rates from the Centers for Medicare & Medicaid Services and state websites.

Notes: The three numbers beside each plot represent, from lowest to highest, the 25th percentile, the median, and the 75th percentile. Growth rates in the continuous coverage period reflect an average of a state's growth rates in recent months. For most states, we take an average of monthly enrollment growth rates over the most recent six-month period for each state at the time of analysis (September 2020 to February 2021). For states where recent data are not available, we take an average over all available months, which includes months in Q2 2020.

TABLE 1

Distribution of Average Monthly State Medicaid Enrollment Growth Rates, Q2 2020 and Continuous Coverage Period (2020–21)

Percent

Percentile	Q2 2020	Continuous coverage period
10th	1.0	0.9
25th	1.4	0.9
50th	1.7	1.1
75th	2.4	1.5
90th	3.0	1.6

Source: Urban Institute analysis of enrollment growth rates from the Centers for Medicare & Medicaid Services and state websites.

Notes: Growth rates in the continuous coverage period reflect an average of a state's growth rates in recent months. For most states, we take an average of monthly enrollment growth rates over the most recent six-month period for each state at the time of analysis (September 2020 to February 2021). For states where recent data are not available, we take an average over all available months, which includes months in Q2 2020.

In figures 2 and 3, we show monthly Medicaid growth rates for each state, separately for Q2 2020 (figure 2) and for the most recent six months of state data available, or the continuous coverage period (figure 3). The consistency in growth rates during the continuous coverage period is notable, as measured by the narrow interquartile range. This lack of variation by state suggests a common force behind the growth rates. Because job losses in 2020 have varied by state, we infer that the continuous coverage provision, common to all states, is a major driver of the enrollment patterns from Q3 2020 to 2021.

The two time periods we have defined show very different growth rates. The Q2 2020 and continuous coverage period growth rates differ in their median levels and the breadth of their interquartile ranges. Some states saw very different growth rates in the two periods. The five states with the highest growth rates in Q2 2020 are different from the five states with the highest growth rates during the continuous coverage period, except for Utah. Utah had the third-highest growth rate in Q2 2020 but has seen by far the highest relative growth of any state since then. Much of this is likely because of the way Utah phased in its Medicaid expansion; adults with incomes between 100 percent and 138 percent of the federal poverty level (FPL) were able to enroll for the first time starting in January 2020.[8] New enrollment caused by that change likely took months to fully materialize. States with the lowest growth rates were more consistent between the two time periods. California, the District of Columbia, and Tennessee were among the five states with the lowest growth rates in both Q2 2020 and the continuous coverage period.

Earlier research on Medicaid churning has found much lower disenrollment rates among adults in Medicaid expansion states than in nonexpansion states (Goldman and Sommers 2020). We find that Medicaid growth rates in expansion states during the continuous coverage period tend to be slightly lower than in nonexpansion states, but the difference is not dramatic. The median growth rate among expansion states is only 0.1 percentage points lower than the median among nonexpansion states (data not shown). Our growth rates are for all enrollees, not just nondisabled adults. Nondisabled adults make up a minority of total enrollment in nonexpansion states, but they tend to experience greater churning than others, such as disabled adults and children.

FIGURE 2

Monthly State Medicaid Enrollment Growth Rates among the Nonelderly Adult Population in the First Months of the Pandemic (Q2 2020), by State Medicaid Expansion Status
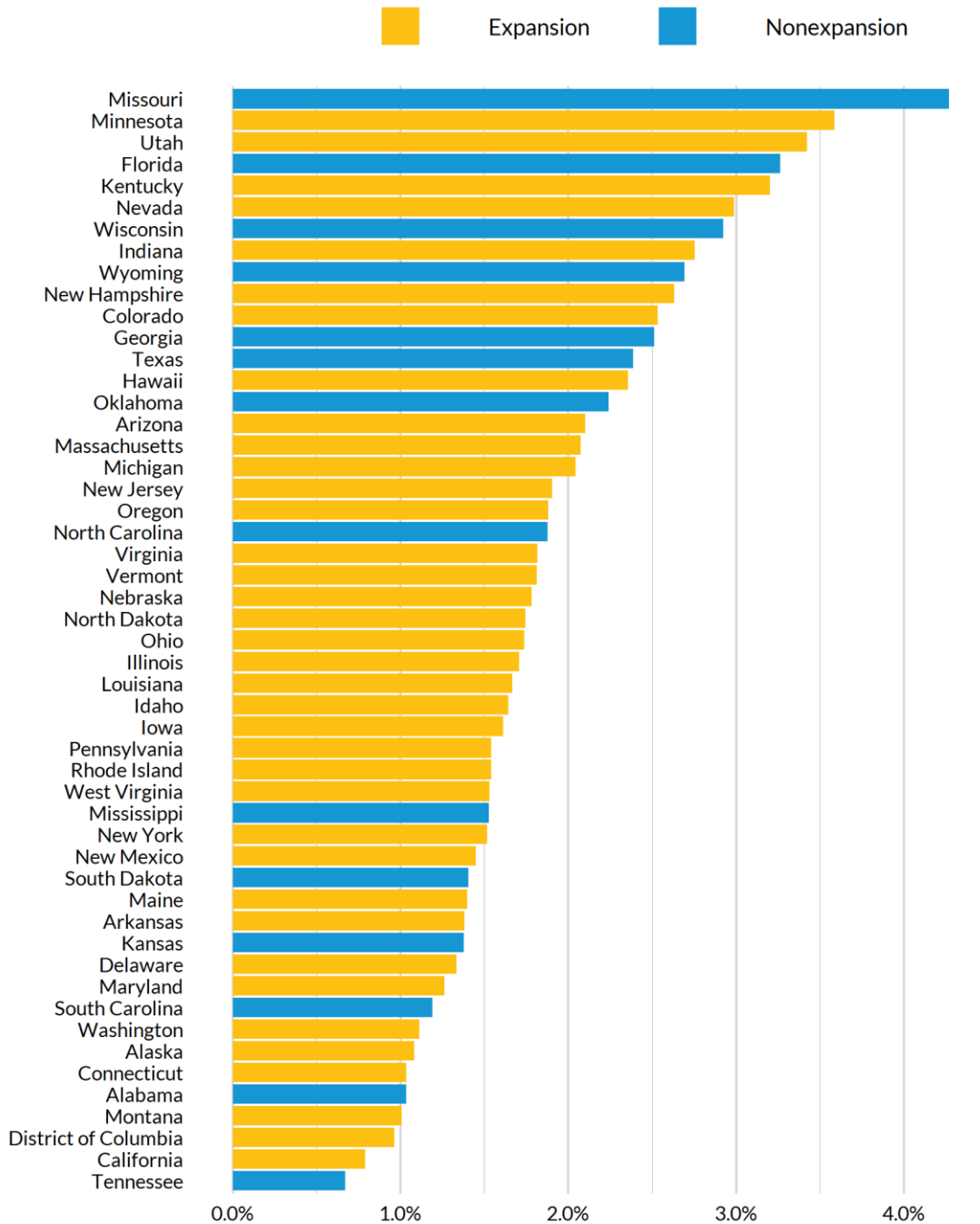
Source: Urban Institute analysis of enrollment growth rates from the Centers for Medicare & Medicaid Services and state websites.

FIGURE 1

Monthly State Medicaid Enrollment Growth Rates among the Nonelderly Population in the Continuous Coverage Period (2020–21), by State Medicaid Expansion Status

Expansion   Nonexpansion
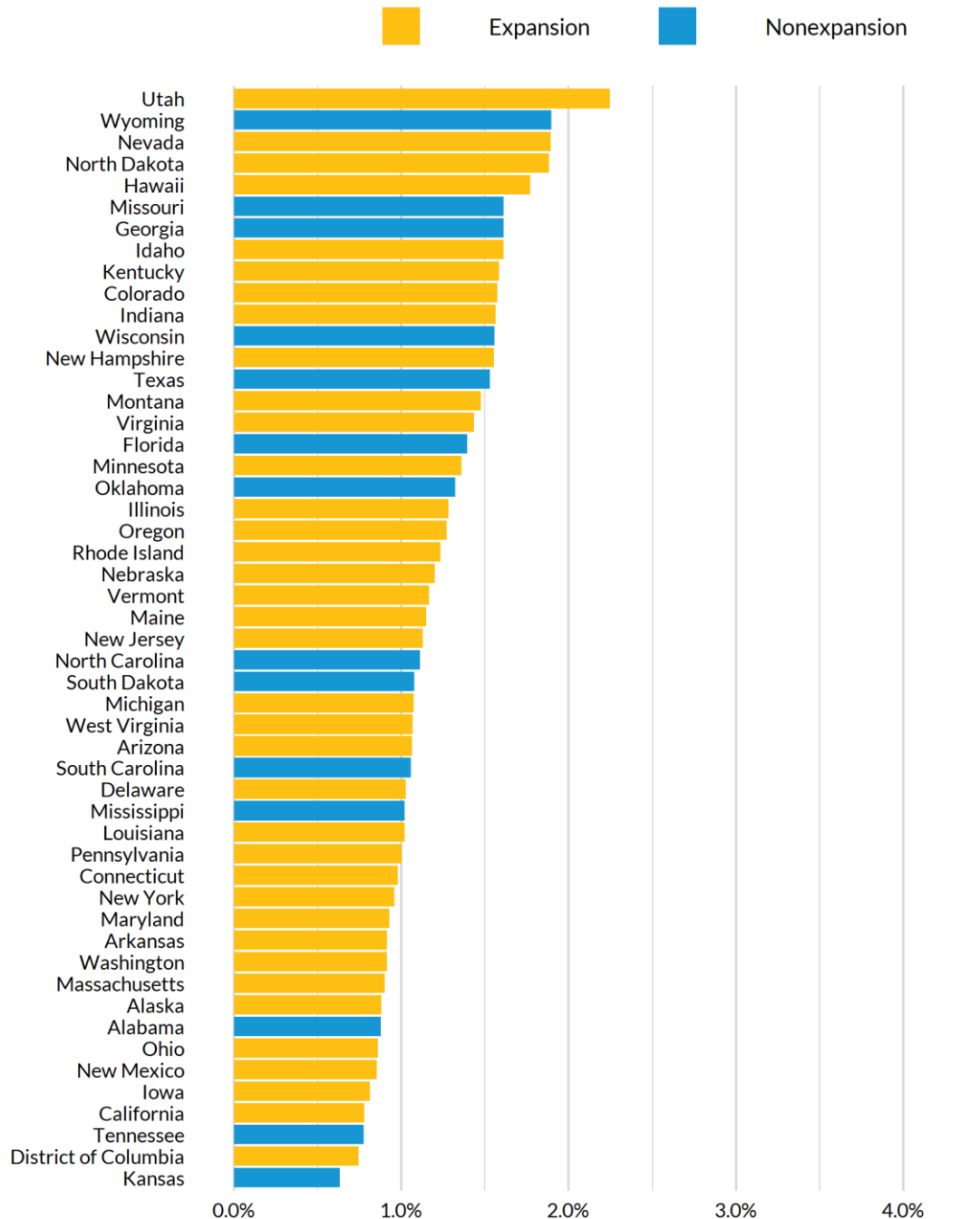
Source: Urban Institute analysis of enrollment growth rates from the Centers for Medicare & Medicaid Services and state websites.

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Notes: Growth rates in the continuous coverage period reflect an average of a state's growth rates in recent months. For most states, we take an average of monthly enrollment growth rates over the most recent six-month period for each state at time of analysis (September 2020 to February 2021). For states where recent data are not available, we take an average over all available months, which includes months in Q2 2020.

Medicaid Growth and Pandemic-Related Job Losses

We find no correlation between Medicaid growth rates and the percentage of employment losses by state for Q2 2020. Given the earlier evidence that showed the highest monthly growth rates occurring during the pandemic's early months when job losses were highest, this may seem surprising. But earlier research by Frenier, Nikpay, and Golberstein (2020) came to the same conclusion. We can think of several possible reasons for this apparent paradox. First, the continuous coverage requirement took effect in Q2 2020. We have provided evidence that it has likely driven substantial enrollment growth since then, so the provision likely caused similar growth in Q2 2020. Moreover, we would not expect continuous coverage enrollment growth to be correlated with employment losses in Q2 2020 because it would apply across all states and to all Medicaid enrollees who were enrolled before the job losses began.

Second, the rates of employer health coverage loss may have been much less than the overall rate of employment loss and may have varied significantly between states. The National Health Interview Survey showed no statistically significant change in the number of uninsured people between January to June 2019 and the same months in 2020 (Cohen et al. 2021). But the survey response rate was sharply lower in 2020. If those affected by the pandemic and related job losses were less likely to respond, the number of people uninsured might have been understated in 2020. Nonetheless, the survey results suggest that loss of health coverage was notably lower in 2020 than in past recessions, particularly the Great Recession of 2008–10 (Garrett and Gangopadhyaya 2020). Job losses may have been disproportionately among jobs that did not offer coverage to begin with. As of April 2020, 18.1 million people reported being on temporary layoff.[9] We do not know how many of those people continued to receive health benefits while they were laid off. Finally, we do not know what share of those losing jobs could get coverage through a spouse's employer-sponsored insurance offer. Given the limited amount of data available on the characteristics of lost jobs, HIPSM-based estimates that tried to account for these unknown factors produced much lower estimates of employer coverage loss and increases in the number of people uninsured than those based on the experience of the Great Recession (Banthin et al. 2020).

Additional evidence that much of the increase in Medicaid enrollment during the pandemic was caused by the continuous coverage requirement, rather than by pandemic-related job losses, is

presented in figure 4. Job losses peaked in April 2020. Employment has steadily increased since then, though as of April 2021, it was still roughly 8 million workers below pre-COVID-19 employment.[10] In contrast, Medicaid enrollment has grown steadily from month to month. Normally, we would expect employment and Medicaid enrollment to move in opposite directions, but the continuous coverage requirement during the PHE prevents Medicaid enrollment from decreasing as employment increases.

FIGURE 4

Employment and Projected Medicaid Enrollment for the Nonelderly Population, by Month, 2020–21
Millions of people
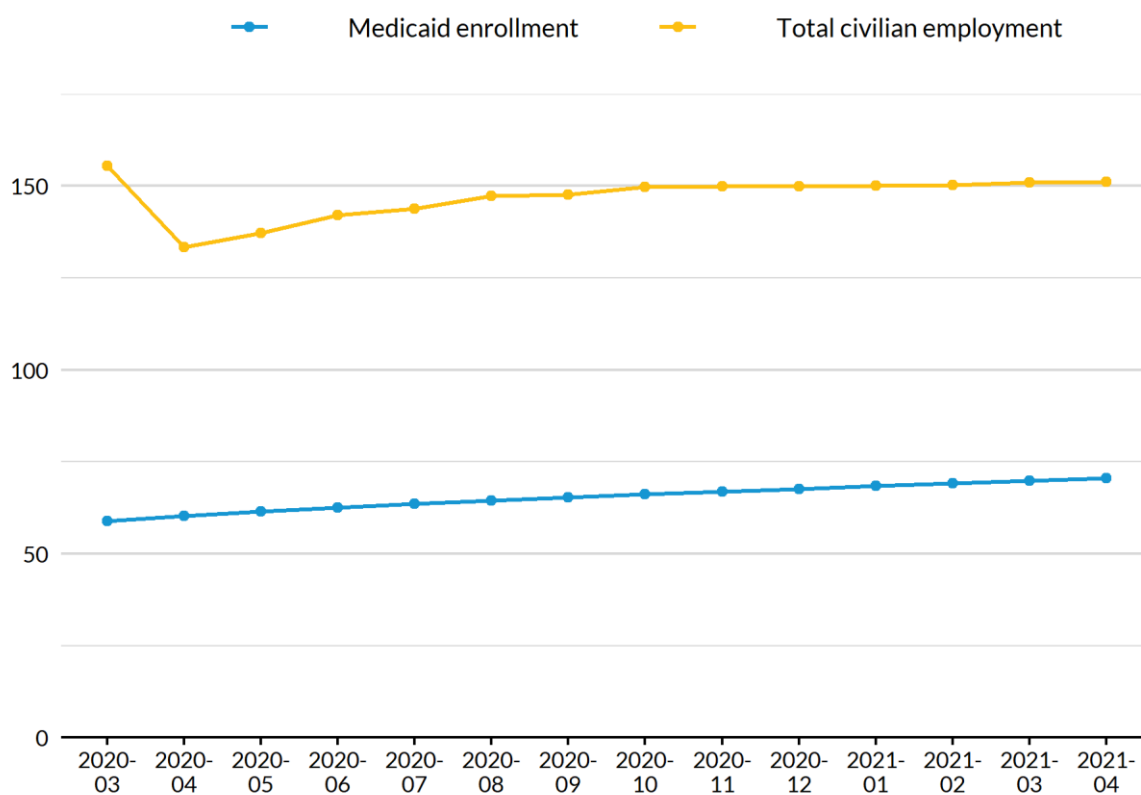
Source: Urban Institute analysis of seasonally adjusted civilian employment data from the Bureau of Labor Statistics.

The attribution of most Medicaid growth after Q2 2020 to the continuous coverage requirement is further supported by data on the number of new Medicaid applications received each month during 2020 (CMS, n.d.). CMS data show that the number of new applications in March and April 2020 was far higher than in previous years, with a peak of around 3.2 million new applications in April. But new applications then dropped to 2.1 million in May 2020 and continued at or below levels for previous

years through the rest of the year. Thus, enrollment growth since May appears to be largely driven by enrollees staying on the rolls. Finally, CMS attributes the majority of new enrollment to the continuous coverage requirement (CMS 2021).

While the PHE lasts, the continuous coverage requirement prevents those enrolled in Medicaid from becoming uninsured. Those gaining eligibility because of changed circumstances can still enroll, but churn in the opposite direction is suspended. Thus, the continuous coverage requirement will continually reduce the number of uninsured people over time. Several provisions of the ARPA will have the same effect.[11] The number of uninsured people at the end of 2021 might be notably lower than it was before the pandemic.

Projections of Medicaid Enrollment through 2022

Shortly before the pandemic, about 58.9 million nonelderly people were enrolled in Medicaid. If the pandemic had never happened and enrollment had followed its historic pattern, we estimate that enrollment would have risen gradually to just over 60.6 million people by the end of 2022 (figure 5). By the end of Q2 2020, when the pandemic had severely affected the US for three months, nonelderly Medicaid enrollment had risen to about 62.5 million people. After that, enrollment has increased by just over 1 percent each month (figure 1). We project this will continue as long as the continuous coverage requirement for the PHE is in place. Consequently, we estimate that nearly 72 million nonelderly people will be enrolled in Medicaid by Q2 2021. That represents an increase of roughly 13 million people since the start of the pandemic. We estimate that nearly 76.3 million nonelderly people will be enrolled in Medicaid by the end of 2021, an increase of about 17 million people since the start of the pandemic. Enrollment will continue to increase from month to month under the continuous coverage requirement, because in any given month people become eligible as their incomes change. People are also losing eligibility, of course, but they are not disenrolled while the continuous coverage requirement is in effect.

FIGURE 5

Projected Medicaid Enrollment among the Nonelderly Population at the Pre-COVID-19 Baseline, under 6-Month and 12-Month Disenrollment, by Quarter, 2020–22
Millions of people
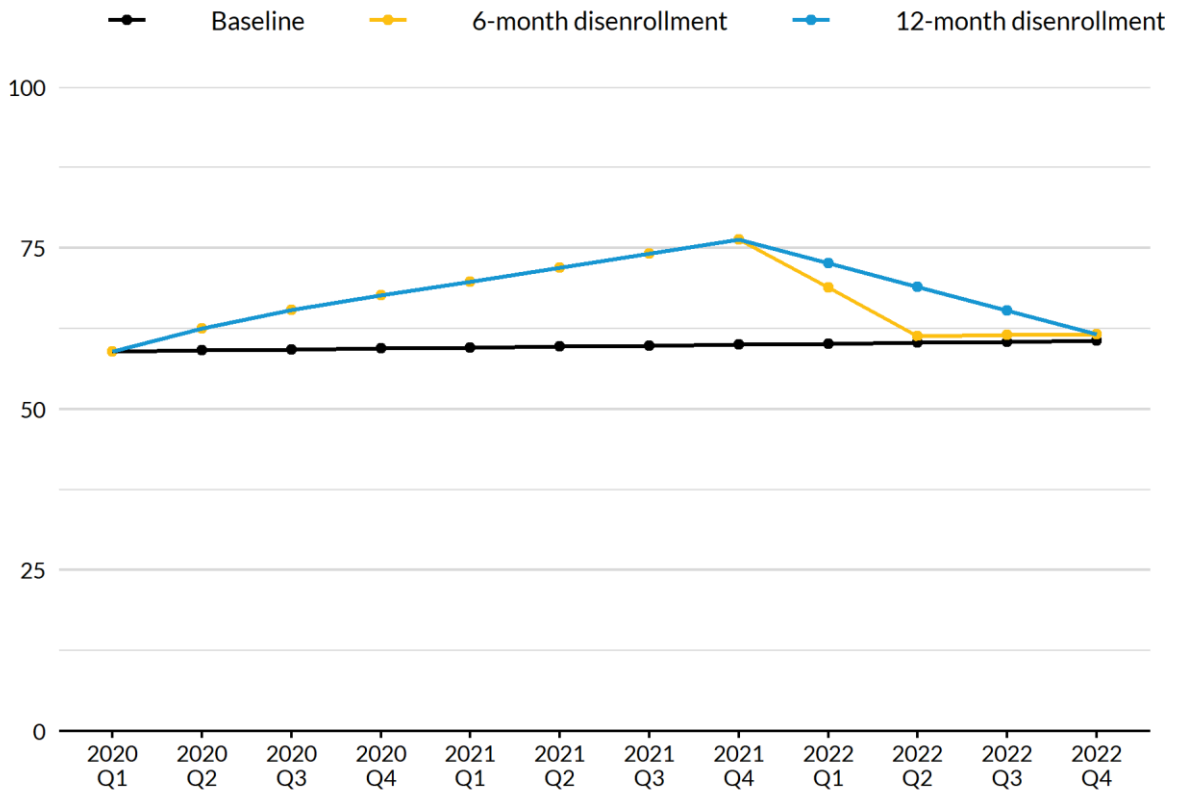
Source: Urban Institute analysis.
Notes: Current CMS guidance allows a return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could choose to do so more quickly. These scenarios bracket the possible changes in Medicaid enrollment after the expiration of the public health emergency.

The rate at which enrollment in individual states will change after the PHE expires is highly uncertain, so we have modeled two scenarios of Medicaid enrollment patterns for 2022. Recent CMS guidance allows states 12 months after the PHE expires to return to normal income eligibility, though states could choose to act more quickly. If we assume all states process redeterminations within 6 months, we estimate that 15 million people would be disenrolled from Medicaid in the first half of 2022 (figure 5, table 2). Nearly one-fifth of all nonelderly people on Medicaid would be disenrolled in six months (table 2). After that, enrollment would be close to what we would expect if the pandemic had never happened.

We also estimated another disenrollment scenario that minimizes the disenrollment rate after the PHE, assuming that all states take the full 12 months to return to normal eligibility processing. We estimate that about 7 million people would be disenrolled from Medicaid in the first half of 2022, and an additional 7 million would be disenrolled during the following six months (figure 5). We cannot predict the speed at which individual states would choose to act, so the most likely result is between these two projections.

Our projections impose the same assumptions on all states because of the considerable uncertainty involved in trying to predict what will happen in individual states. A recent Kaiser Family Foundation survey recorded three relevant state policy decisions: whether a state is processing *ex parte* renewals, whether a state is sending renewal forms, and whether a state plans a comprehensive update of addresses before the end of the PHE (Brooks et al. 2021). These actions would potentially produce more rapid disenrollment, but that does not necessarily mean a state would use them in that way. Processing *ex parte* renewals can identify some enrollees who are still eligible and do not need further processing. On the other hand, it could allow more specific targeting of those who may not still be eligible. This is particularly true if a state is also sending out renewal forms during the PHE. Enrollees not responding to the forms could be targeted for disenrollment without further requests for information. However, CMS guidance also requires redetermination to occur after the expiration of the PHE (CMS 2021). For example, enrollees cannot be terminated for failing to submit documentation requested during the PHE. Systematically updating addresses before the PHE expires would facilitate eligibility processing, but whether that would lead to more or less rapid disenrollment would depend on other state decisions.

TABLE 2

Projected Medicaid Disenrollment among the Nonelderly Population in the Two Quarters after the Public Health Emergency Ends under 6-Month versus 12-Month Disenrollment

Millions of people

Metric	6-month disenrollment	12-month disenrollment
Q4 2021 enrollment (millions of people)	76.30	76.30
Q2 2022 enrollment (millions of people)	61.36	68.98
Difference (millions of people)	−14.94	−7.32
Percent difference	−19.58	−9.60

Source: Urban Institute analysis.

Notes: CMS = Centers for Medicare & Medicaid Services. Current CMS guidance allows a return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could choose to do so more quickly. These scenarios bracket the possible changes in Medicaid enrollment after the public health emergency expires.

Notable economic growth occurred in early 2021 through the time of writing, and many predict even stronger growth in the latter half of 2021. We assume, consistent with CBO projections,[12] that the economy will have partly recovered from the pandemic by the end of 2021. A faster economic recovery through 2021 and 2022 may result in increased employment and wages. Consequently, enrollment in 2022 could decline somewhat more than we project. Or stronger economic growth in the latter half of 2021 could slow Medicaid enrollment growth more than we project. But just over three-quarters of our projected total Medicaid enrollment growth would happen by Q2 2021, so even substantial growth that decreased enrollment noticeably during the second half of the year would have little impact on our overall total. Moreover, the economic growth that has happened so far in 2021 may have little impact on Medicaid enrollment. Real-time estimates of poverty show that so far in 2021, despite strong economic growth, the poverty rate has grown consistently and is now at its highest point since January 2020 (Han, Meyer, and Sullivan 2021). Similarly, we did not see a noticeable decline in Medicaid enrollment growth in the 2021 months, despite economic growth. Finally, at the time of writing, COVID-19 cases had started rising rapidly in all states as vaccinations stalled. We may not necessarily be done with the pandemic and its economic effects.

Projected Medicaid Costs through 2022

We project that quarterly federal Medicaid spending on acute care for the nonelderly would rise from $79.3 billion in Q1 2020 to a peak of $114.2 billion in Q4 2021 (figure 6). Federal costs would then decline after the continuous coverage requirement and enhanced FMAP both expire. If all enrollees were processed for eligibility within six months, as CMS previously recommended, federal spending would fall to $86.5 billion in Q2 2022 and to $88.7 billion in Q4 2022 because of normal enrollment growth. In contrast, if all states gradually resumed normal eligibility over 12 months, federal spending would fall from the same peak of $114.2 billion in Q4 2021 to $97.4 billion in Q2 2022 and would reach the same spending levels as under CMS guidance by the end of 2022. Barring major changes from current expectations, the actual situation is likely to be between these two.

Over the course of 2022, gradual 12-month enrollment processing in all states would cost the federal government $22.3 billion more in Medicaid spending on acute care for the nonelderly than would 6-month enrollment processing, a 6.1 percent increase (table 3).

Quarterly state Medicaid spending on acute care for the nonelderly would rise from $43.4 billion in Q1 2020 to $49.8 billion in Q4 2021. If all enrollees were processed for eligibility within 6 months, state spending would fall to $47.6 billion in Q2 2022, before rising slightly to $48.8 billion in Q4 2022

because of normal enrollment growth. If all states gradually resumed normal eligibility over 12 months, state spending would rise to $53.6 billion in Q2 2022 before falling to virtually the same level by the end of the year. The peak in state spending at the middle of the year is caused by the enhanced FMAP running out while most continuous-coverage-period beneficiaries are still enrolled.

Over the course of 2022, gradual resumption of normal income eligibility over 12 months would cost states $11.5 billion more than doing so over 6 months. That represents a 6.1 percent increase in spending on acute care for the nonelderly. Costs will likely fall between these two extremes.

Our cost estimates are based on HIPSM projections of the per capita costs for major groups of nonelderly Medicaid enrollees—the disabled, nondisabled adults, and children—in each state (Buettgens and Banthin 2020). We assume they do not change during the period of our projections, except for expected health care cost growth. Recent Medicaid cost data are not publicly available, but service use and costs might be lower than projected. More Medicaid enrollees will likely have other sources of health coverage as the economy recovers. Beneficiaries remain enrolled in Medicaid unless they contact their state Medicaid agency and request disenrollment. In such circumstances, Medicaid should be the payer of last resort, so their costs should be lower. But the Government Accountability Office (2015) has found that the Medicaid costs for those with other sources of coverage are not negligible. Conversations we have had with state Medicaid officials have led to the same conclusion. For those enrolled in Medicaid managed care, lower-than-expected service use—if it is happening—will translate to state savings only to the extent that managed care rates are retroactively renegotiated to reflect them.

FIGURE 6

Projected Federal, State, and Total Costs for Medicaid Acute Care for the Nonelderly Population at the Baseline, under 6-Month and 12-Month Disenrollment, by Quarter, 2020–22

Billions of dollars

Legend: Federal, State, Total, Baseline, 6-month disenrollment, 12-month disenrollment

Y-axis: $0, $50, $100, $150

X-axis: 2020 Q1, 2020 Q2, 2020 Q3, 2020 Q4, 2021 Q1, 2021 Q2, 2021 Q3, 2021 Q4, 2022 Q1, 2022 Q2, 2022 Q3, 2022 Q4
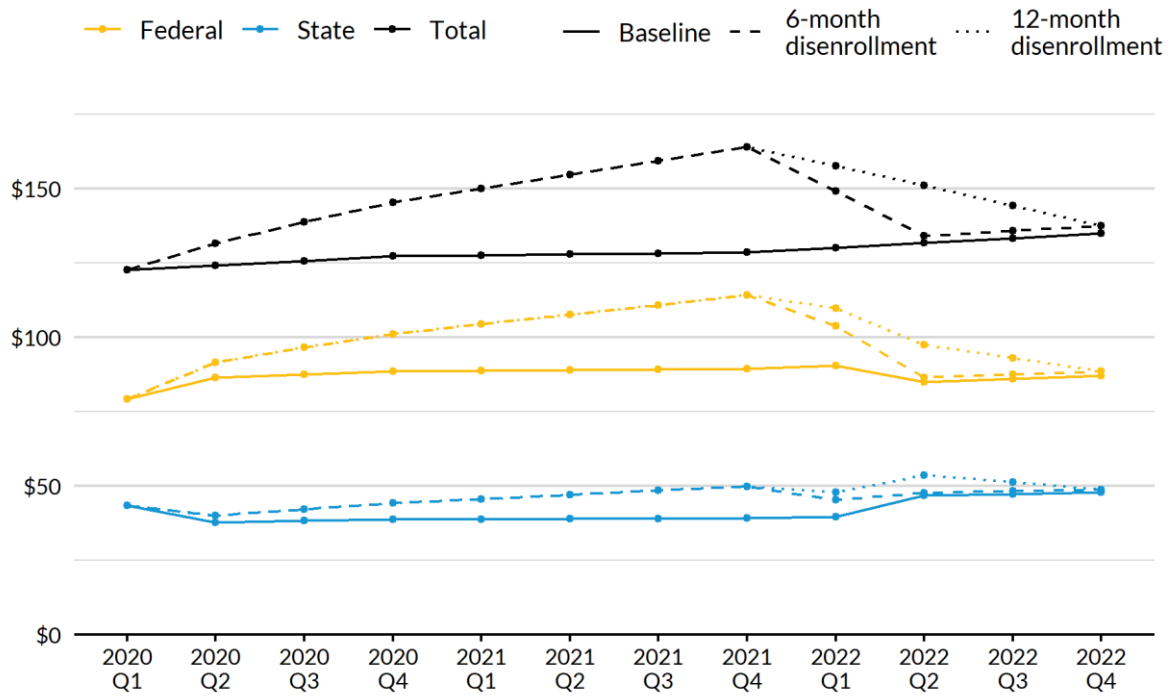
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Source: Urban Institute analysis.

Notes: Spending on long-term care and the elderly population is not included. Current Centers for Medicare & Medicaid Services guidance allows a return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could choose to do so more quickly. These scenarios bracket the possible changes in Medicaid enrollment after the expiration of the public health emergency.

TABLE 3

Summary of Projected Costs for Medicaid Acute Care for the Nonelderly Population in 2022

Comparing 6-month and 12-month disenrollment scenarios

	Total	Federal	State
6-month disenrollment ($billions)	556.62	366.59	190.03
12-month disenrollment ($billions)	590.40	388.87	201.53
Difference ($billions)	33.79	22.29	11.50
Percent difference	6.1	6.1	6.1

Source: Urban Institute analysis.

Notes: Current Centers for Medicare & Medicaid Services guidance allows a return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could choose to do so more quickly. These scenarios bracket the possible changes in Medicaid enrollment after the public health emergency expires.

Eligibility for Assistance among Those Losing Medicaid after the PHE Expires

Between the peak of enrollment at the end of the PHE and the point at which eligibility determination fully returns to normal, by the end of 2022, we estimate that Medicaid enrollment will decline by 15 million people. This includes nearly 9 million adults and nearly 6 million children. Among adults losing eligibility, we estimate that 27.5 percent would be eligible for Marketplace PTCs and have incomes up to 400 percent of FPL (figure 7). An additional 5.9 percent would have incomes above 400 percent of FPL but would be eligible for enhanced Marketplace PTCs under the ARPA. These are scheduled to expire after 2022, but the president's budget calls for their permanent extension (Banthin et al. 2021). Thus, one-third of adults losing Medicaid coverage after the PHE could qualify for subsidized private health coverage in the Marketplaces. Nearly all of the remainder would have an offer of employer coverage in their family deemed affordable under the ACA. Single coverage could cost up to 10 percent of family income and still be deemed affordable, and the cost of family coverage could be higher (Buettgens and Banthin 2021). Thus, nearly all adults losing Medicaid after the PHE expires have a coverage option, though nearly all would have to pay more in premiums and out-of-pocket costs, particularly if the ARPA enhanced PTCs expire.

Children losing Medicaid have more assistance available than adults. Of the 5.9 million children losing Medicaid after the PHE expires, 57 percent will be eligible for CHIP (figure 7). Just over 5 percent will be eligible for Marketplace coverage with PTCs, and an additional 3.9 percent will be eligible for PTCs if PTCs in the ARPA are made permanent. Virtually all of the remaining children have coverage available through the employer of a working parent.

FIGURE 7

Eligibility for Various Health Insurance Coverage Options among Nonelderly Adults and Children Projected to Lose Medicaid Coverage from 2021 to 2022

Among 8.7 million adults

PTCs over 400% of FPL
(ARPA only)
516,000 people or 5.9%

None
140,000 people,
or 1.6%

PTCs up to 400% of FPL
2,390,000 people, or
27.5%

Employer coverage offer
5,645,000 people,
or 65.0%

Among 5.9 million children

PTCS over 400% FPL (ARPA only)
234,000 people, or 3.9%

PTCs up to 400% of FPL
323,000 people,
or 5.4%

None
200 children, or 0.0%

Employer coverage
offer
1,988,000 people,
or 33.6%
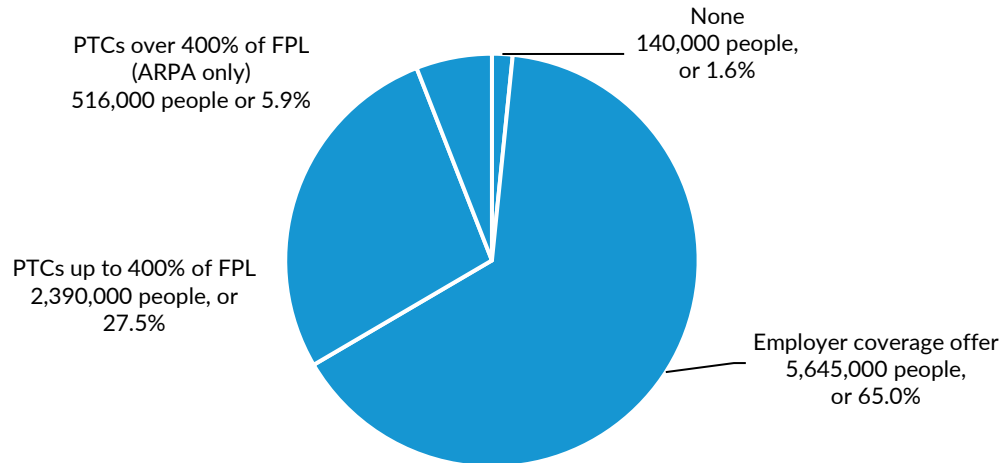
CHIP
3,379,000 people,
or 57.0%
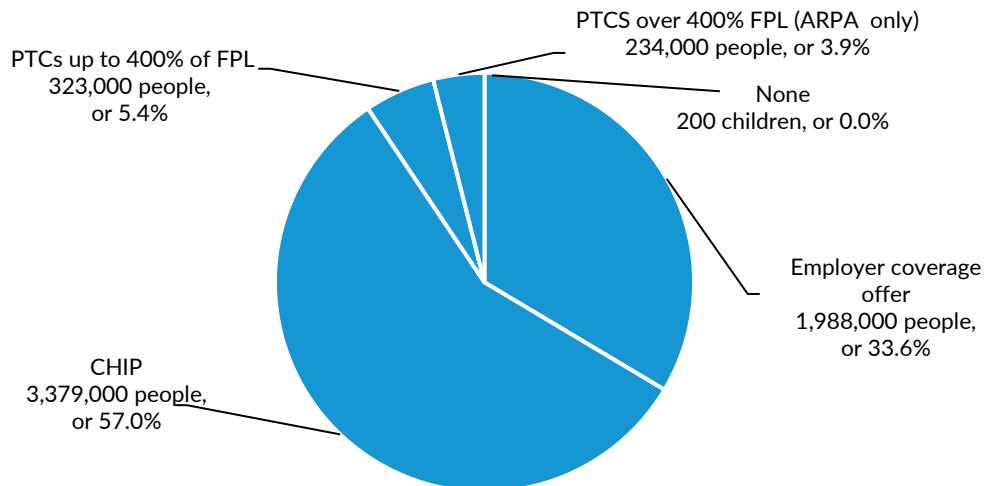
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Source: Urban Institute analysis using the Health Insurance Policy Simulation Model.
Notes: PTC = premium tax credit. FPL = federal poverty level. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program.

Discussion

Medicaid growth rates since March 2020 have been remarkably similar across states; the median growth rate was 1.7 percent per month in Q2 2020, and enrollment grew steadily at a median of 1.1 percent per month after that. That translates into a median of 24 percent growth over 12 months for Q2 2020 rates and a median growth of about 14 percent over 12 months for the continuous coverage period. It is instructive to compare these with results from the Medicaid churn literature. Goldman and Sommers (2020) estimated that annual Medicaid coverage disruption rates in expansion states declined from 17.9 percent before the ACA to 13.7 percent during the first years of the ACA. Medicaid growth rates under the continuous coverage requirement are not the same as pre-COVID-19 disenrollment rates, but Goldman and Sommers's estimated disenrollment rate is close to our estimates of Medicaid growth after the first few months of the pandemic. The higher rates during Q2 2020 are most likely because of an influx of new enrollees in response to the unprecedented rapid loss of employment during that time.

Goldman and Sommers (2020) also found a much higher Medicaid disenrollment rate for nondisabled adults in nonexpansion states, 23.8 percent. We found much smaller differences in Medicaid growth between expansion and nonexpansion states during the pandemic. A large part of this difference may be that we measure the growth for all nonelderly enrollees, not just nondisabled adults. Much of the Medicaid enrollment in nonexpansion states consists of children, who may have lower disenrollment rates.

The rise in Medicaid enrollment in the first three months of the pandemic followed by a year and a half of just over 1 percent enrollment growth per month may add up to about 17 million more Medicaid enrollees by the time the PHE expires at the end of 2021. *Kaiser Health News* recently reported that Medicaid enrollment had risen by 9 million from February 2020 to January 2021.[13] *Kaiser*'s total enrollment of just over 80 million differs from ours mainly because it includes elderly Medicaid enrollees, whereas our estimates include only those younger than 65.

CMS guidance gives states 12 months after PHE expiration to return to normal income eligibility, though states could do so more rapidly. If all states process their redeterminations within 6 months, 15 million people could lose coverage in during that period. The end of the enhanced FMAP provides a strong financial incentive for states to trim their Medicaid rolls, but some states will be concerned about rapid disenrollment, and others may face capacity constraints because their administrative systems were not designed for this situation.[14] Consequently, actual enrollment changes may not be as rapid and are likely to vary considerably between states. We project that the most gradual possible

disenrollment—assuming all states take 12 months to return to normal program eligibility—would lead to just over 7 million people losing coverage within six months and 7 million more losing coverage within another six months.

We believe that policymakers have time before the PHE expires to consider how best to address both Medicaid beneficiaries' needs for maintaining health coverage and the financial and administrative pressures on state and local governments. A growing body of evidence finds that Medicaid coverage saves lives and increases families' financial stability (Caswell and Waidmann 2019; Goldin, Lurie, and McCubbin 2019; Hu et al. 2016; Miller, Johnson, and Wherry 2021). Large-scale, rapid Medicaid disenrollment during a time when families will still be trying to deal with the pandemic's health and economic consequences could have serious effects on the health and financial well-being of millions of people.

We find that virtually all of those projected to lose Medicaid after the PHE expires would have a health coverage option, but they would generally pay more for that coverage and may need assistance finding the most affordable option.

- **CHIP.** We find that almost 60 percent of children losing Medicaid would become eligible for CHIP. In some states, these programs have somewhat higher premiums and cost sharing than Medicaid, but these are generally far lower than with private health insurance. State governments run both Medicaid and CHIP, so they can facilitate these coverage transitions more easily than transitions to the Marketplaces, as discussed below.

- **Marketplaces.** We find that a third of adults losing Medicaid and just under 10 percent of children losing Medicaid would be eligible for PTCs for Marketplace coverage in 2022. If enhanced PTCs under the ARPA expire after 2022, many of these people would lose eligibility beginning in 2023, leaving 28 percent of adults and 5 percent of children eligible. The degree of coordination between state Medicaid agencies and the state Marketplaces varies considerably between states, particularly in states that chose to have the federal government run their Marketplace. Effective coordination between the programs and outreach efforts to help enroll those newly eligible for PTCs are essential for preventing unnecessary coverage losses.

- **Employer-sponsored coverage.** We estimate that virtually all of those projected to lose Medicaid who are not eligible for CHIP or Marketplace PTCs would be able to obtain health coverage through an employer—either their own or that of a spouse. But single coverage could cost up to nearly 10 percent of family income, and covering an entire family could be

more expensive (Buettgens and Banthin 2021). States can do much less outreach and enrollment assistance for employer-sponsored health coverage.

Many people whose enrollment was maintained during the PHE may no longer be eligible for Medicaid, but it is important to minimize any unnecessary disenrollment of those who are still eligible. CMS has extended the deadline for processing PHE enrollment from 6 to 12 months (CMS 2021). Taking extra time would reduce the strain on state administrative systems and allow more time for resolving individual renewal issues, such as providing documentation. It would also better allow states to provide outreach and enrollment assistance to those who now qualify for other types of health coverage.

Many states made temporary changes to their programs to streamline eligibility determination or to improve continuity of coverage during the PHE.[15] States could reduce unnecessary disenrollment by extending these after the PHE expires. For example, changes made under disaster relief state plan amendments could be maintained by filing regular state plan amendments. CMS could encourage, or at least facilitate, such measures.

We also recognize the financial strain that state and local governments have been operating under during the pandemic. Although the enhanced FMAP has substantially boosted federal assistance to state Medicaid programs since March 2020, that additional funding was intended to assist state Medicaid programs during the pandemic and has already been used by states. Additional costs in 2022 caused by the loss of the enhanced FMAP and high enrollment caused by the continuous coverage requirement and the pandemic's continued economic impact are legitimate concerns for state governments. Giving states up to 12 months to restore normal Medicaid eligibility would give states more time to prepare for and evaluate their restoration of income eligibility processing to minimize unnecessary disenrollment. States would also be better able to conduct appropriate outreach and assistance for those losing Medicaid coverage but gaining eligibility for Marketplace PTCs and CHIP. But such an extension would raise Medicaid spending in 2022. If every state were to take 12 months (rather than 6) to return to normal eligibility processes, Medicaid spending would increase by a maximum of 6.1 percent, with $22.3 billion in new federal costs and $11.5 billion in new state costs.

Extending the enhanced FMAP through 2022 would more than cover additional state costs because it immediately affects spending on all enrollees, except for the Medicaid expansion group. State Medicaid spending is projected to peak in Q2 2022. An extension of the enhanced FMAP through 2022 or a gradual phasedown could be combined with guidance encouraging states to take

the full 12 months to restore normal Medicaid eligibility. Legislation would be required to change the expiration of the enhanced FMAP.

Conclusion

All states have seen unprecedented and steady growth in Medicaid enrollment since March 2020. This growth will continue until the PHE expires, which is expected in December 2021. By then, we estimate that 17 million more nonelderly people will be enrolled in Medicaid than before the pandemic. Medicaid enrollment is expected to return to normal within a year of PHE expiration, but the resumption of eligibility testing could disenroll up to 15 million people in the first six months after the PHE expires. The discontinuation of the enhanced FMAP after March 2022 gives states a financial incentive to process pending renewals quickly. However, many states will likely be concerned about continuity of coverage, and many will likely face capacity constraints in their administrative systems.

Many of those losing Medicaid after the PHE expires would be eligible for other programs. Nearly 60 percent of children losing Medicaid coverage would be eligible for CHIP. One-third of adults and nearly one-tenth of children losing Medicaid would be eligible for Marketplace tax credits if ARPA enhanced PTCs are made permanent. Otherwise, 28 percent of adults and 5 percent of children would be eligible for Marketplace PTCs. Nearly all of the remainder would have access to health coverage through a family member's employer. But these alternative sources of coverage—particularly employer coverage—would likely cost the affected families much more than Medicaid.

Federal and state governments have time to prepare before the expected PHE expiration. CMS recently changed its guidance, allowing states 12 months to fully return to normal Medicaid eligibility, rather than six months as under earlier guidance (CMS 2020, 2021). States can minimize unnecessary disruptions in health coverage by taking advantage of that extra time; doing so would have the following effects:

- Medicaid disenrollment would be more gradual during a period when the country will still be recovering from the pandemic's effects.

- States would have more opportunity to minimize unnecessary disenrollment.

- States would be able to better provide outreach and assistance to those losing Medicaid eligibility, particularly those who would be eligible for Marketplace PTCs or CHIP.

- An unprecedented burden on state Medicaid administrative systems in the first half of 2022 would be avoided. Because most Medicaid enrollees are on a 12-month renewal cycle, this would also mean that these systems would face a spike in volume every year at this time for many years to come.

CMS could also improve this transition by encouraging states to continue measures taken during the pandemic to streamline eligibility processing and enhance continuity of coverage. Congress also has a role. Extending the enhanced FMAP through the transition period to normal eligibility would remove a major incentive for states to cut enrollment quickly and would facilitate a smoother transition both for beneficiaries and state governments. Also, making enhanced Marketplace PTCs in the ARPA permanent would make many of those losing Medicaid coverage after the PHE eligible for assistance. Decisions made during the remainder of this year can improve continuity of care for Medicaid enrollees and the stability of state finances during 2022.

Appendix

Monthly Medicaid Growth Rates in Q2 2020 and the Continuous Coverage Period (2020–21), by State

Percent

State	Q2 2020	Continuous coverage period (2020–21)
Alabama	1.0	0.9
Alaska	1.1	0.9
Arizona	2.1	1.1
Arkansas	1.4	0.9
California	0.8	0.8
Colorado	2.5	1.6
Connecticut	1.0	1.0
Delaware	1.3	1.0
District of Columbia	1.0	0.7
Florida	3.3	1.4
Georgia	2.5	1.6
Hawaii	2.4	1.8
Idaho	1.6	1.6
Illinois	1.7	1.3
Indiana	2.8	1.6
Iowa	1.6	0.8
Kansas	1.4	0.6
Kentucky	3.2	1.6
Louisiana	1.7	1.0
Maine	1.4	1.1
Maryland	1.3	0.9
Massachusetts	2.1	0.9
Michigan	2.0	1.1
Minnesota	3.6	1.4
Mississippi	1.5	1.0
Missouri	4.3	1.6
Montana	1.0	1.5
Nebraska	1.8	1.2
Nevada	3.0	1.9
New Hampshire	2.6	1.6
New Jersey	1.9	1.1
New Mexico	1.4	0.9
New York	1.5	1.0
North Carolina	1.9	1.1
North Dakota	1.7	1.9
Ohio	1.7	0.9
Oklahoma	2.2	1.3
Oregon	1.9	1.3
Pennsylvania	1.5	1.0
Rhode Island	1.5	1.2
South Carolina	1.2	1.1
South Dakota	1.4	1.1
Tennessee	0.7	0.8
Texas	2.4	1.5
Utah	3.4	2.2

State	Q2 2020	Continuous coverage period (2020–21)
Vermont	1.8	1.2
Virginia	1.8	1.4
Washington	1.1	0.9
West Virginia	1.5	1.1
Wisconsin	2.9	1.6
Wyoming	2.7	1.9

Source: Urban Institute analysis of data available at state websites listed in appendix table A.5.

Notes: Growth rates in the continuous coverage period reflect an average of a state's growth rates in recent months. For most states, we take an average of monthly enrollment growth rates over the most recent six-month period available for each state at the time of analysis (September 2020 to February 2021). For states where recent data are not available, we take an average over all available months, which includes months in Q2 2020.

Projections of State Medicaid Enrollment for the Nonelderly Population, by Quarter and State, under the 6-Month Disenrollment Scenario, 2020–22

Millions of people

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4[a]	Q1	Q2	Q3	Q4
Alabama	0.81	0.83	0.85	0.88	0.90	0.92	0.94	0.87	0.80	0.81	0.81
Alaska	0.18	0.19	0.19	0.20	0.20	0.21	0.21	0.20	0.18	0.18	0.18
Arizona	1.77	1.84	1.89	1.96	2.01	2.07	2.13	1.92	1.72	1.72	1.73
Arkansas	0.77	0.79	0.81	0.84	0.86	0.88	0.90	0.84	0.77	0.77	0.77
California	9.24	9.57	9.80	10.04	10.27	10.50	10.74	10.04	9.35	9.37	9.40
Colorado	1.02	1.07	1.12	1.17	1.22	1.27	1.31	1.15	0.98	0.98	0.99
Connecticut	0.74	0.76	0.79	0.81	0.84	0.86	0.88	0.81	0.74	0.74	0.75
Delaware	0.17	0.18	0.18	0.19	0.19	0.20	0.21	0.19	0.17	0.17	0.17
District of Columbia	0.15	0.16	0.16	0.16	0.17	0.17	0.17	0.16	0.15	0.15	0.15
Florida	3.21	3.37	3.52	3.66	3.79	3.92	4.05	3.53	3.01	3.02	3.03
Georgia	1.70	1.77	1.85	1.93	2.01	2.09	2.17	1.90	1.64	1.64	1.64
Hawaii	0.23	0.24	0.26	0.27	0.28	0.29	0.30	0.27	0.23	0.23	0.23
Idaho	0.34	0.36	0.38	0.39	0.41	0.42	0.44	0.39	0.33	0.33	0.33
Illinois	2.17	2.40	2.48	2.56	2.65	2.73	2.82	2.48	2.15	2.16	2.16
Indiana	1.29	1.36	1.43	1.49	1.55	1.61	1.67	1.45	1.23	1.23	1.23
Iowa	0.55	0.57	0.59	0.60	0.61	0.63	0.64	0.60	0.55	0.55	0.55
Kansas	0.31	0.32	0.33	0.33	0.34	0.35	0.35	0.33	0.31	0.31	0.31
Kentucky	1.26	1.38	1.39	1.44	1.50	1.56	1.61	1.40	1.18	1.18	1.19
Louisiana	1.30	1.36	1.40	1.44	1.48	1.52	1.56	1.42	1.27	1.28	1.28
Maine	0.29	0.30	0.31	0.32	0.33	0.34	0.35	0.32	0.29	0.29	0.29
Maryland	1.04	1.07	1.11	1.13	1.16	1.19	1.22	1.12	1.03	1.03	1.03
Massachusetts	1.44	1.49	1.53	1.57	1.61	1.65	1.69	1.55	1.40	1.41	1.41
Michigan	2.10	2.21	2.29	2.36	2.43	2.50	2.56	2.30	2.04	2.05	2.05
Minnesota	1.07	1.12	1.16	1.20	1.24	1.28	1.33	1.16	0.99	0.99	0.99
Mississippi	0.57	0.59	0.61	0.63	0.64	0.66	0.68	0.62	0.56	0.56	0.57
Missouri	0.85	0.94	0.99	1.03	1.06	1.10	1.14	0.96	0.78	0.78	0.78
Montana	0.21	0.22	0.23	0.24	0.25	0.26	0.27	0.24	0.21	0.21	0.21
Nebraska	0.20	0.21	0.23	0.25	0.29	0.30	0.32	0.29	0.26	0.26	0.26
Nevada	0.62	0.65	0.69	0.72	0.75	0.79	0.82	0.71	0.59	0.59	0.59
New Hampshire	0.20	0.21	0.22	0.23	0.24	0.25	0.26	0.22	0.19	0.19	0.19
New Jersey	1.36	1.43	1.48	1.52	1.57	1.62	1.66	1.50	1.34	1.35	1.35
New Mexico	0.69	0.72	0.74	0.75	0.77	0.79	0.81	0.75	0.69	0.69	0.69

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4[a]	Q1	Q2	Q3	Q4
New York	5.54	5.75	5.96	6.09	6.26	6.42	6.59	6.04	5.48	5.49	5.51
North Carolina	1.75	1.82	1.89	1.95	2.01	2.07	2.13	1.92	1.71	1.71	1.71
North Dakota	0.08	0.08	0.08	0.09	0.09	0.10	0.10	0.09	0.07	0.07	0.07
Ohio	2.30	2.38	2.45	2.51	2.57	2.64	2.70	2.48	2.26	2.27	2.28
Oklahoma	0.61	0.64	0.66	0.68	0.71	0.73	0.75	0.67	0.58	0.58	0.58
Oregon	0.85	0.88	0.92	0.95	0.98	1.02	1.05	0.94	0.83	0.83	0.83
Pennsylvania	2.28	2.36	2.43	2.50	2.57	2.64	2.71	2.49	2.27	2.28	2.28
Rhode Island	0.25	0.26	0.27	0.28	0.29	0.30	0.30	0.27	0.24	0.24	0.25
South Carolina	0.83	0.86	0.89	0.92	0.94	0.97	1.00	0.91	0.83	0.83	0.83
South Dakota	0.10	0.11	0.11	0.11	0.12	0.12	0.12	0.11	0.10	0.10	0.10
Tennessee	1.16	1.20	1.23	1.26	1.29	1.32	1.35	1.26	1.17	1.18	1.18
Texas	4.16	4.37	4.59	4.77	4.96	5.15	5.33	4.67	4.00	4.01	4.02
Utah	0.43	0.48	0.51	0.53	0.56	0.59	0.62	0.51	0.41	0.41	0.42
Vermont	0.14	0.15	0.15	0.16	0.16	0.17	0.17	0.15	0.14	0.14	0.14
Virginia	1.27	1.33	1.38	1.44	1.49	1.55	1.60	1.43	1.25	1.25	1.26
Washington	1.52	1.57	1.63	1.66	1.71	1.75	1.80	1.66	1.52	1.52	1.52
West Virginia	0.45	0.46	0.48	0.50	0.51	0.52	0.54	0.49	0.45	0.45	0.45
Wisconsin	0.88	0.93	0.97	1.01	1.05	1.09	1.13	0.99	0.84	0.84	0.85
Wyoming	0.05	0.05	0.05	0.06	0.06	0.06	0.06	0.06	0.05	0.05	0.05

Source: Urban Institute analysis.

Notes Current Centers for Medicare & Medicaid Services guidance allows a complete return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could do so more quickly.

[a] Q4 2021 is the expected end of the public health emergency.

Projections of Federal Medicaid Spending on Acute Care for the Nonelderly Population, by Quarter and State, under the Six-Month Disenrollment Scenario, 2020–22

Billions of dollars

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4[a]	Q1	Q2	Q3	Q4
Alabama	1.08	1.13	1.17	1.20	1.23	1.26	1.29	1.21	1.03	1.05	1.06
Alaska	0.25	0.26	0.27	0.28	0.28	0.29	0.30	0.28	0.24	0.24	0.25
Arizona	2.95	3.12	3.23	3.34	3.43	3.53	3.63	3.31	2.82	2.86	2.89
Arkansas	1.24	1.29	1.33	1.37	1.41	1.44	1.48	1.38	1.21	1.22	1.24
California	10.86	11.36	11.75	12.03	12.31	12.59	12.87	12.15	10.65	10.78	10.91
Colorado	1.28	1.36	1.44	1.50	1.57	1.63	1.69	1.49	1.20	1.21	1.23
Connecticut	1.19	1.24	1.30	1.33	1.37	1.41	1.44	1.34	1.14	1.16	1.17
Delaware	0.34	0.35	0.37	0.38	0.39	0.40	0.41	0.38	0.33	0.33	0.34
District of Columbia	0.39	0.40	0.42	0.43	0.44	0.45	0.46	0.43	0.38	0.39	0.39
Florida	4.15	4.40	4.64	4.82	4.99	5.16	5.34	4.70	3.68	3.72	3.77
Georgia	2.23	2.35	2.48	2.59	2.69	2.80	2.91	2.57	2.04	2.07	2.09
Hawaii	0.28	0.29	0.31	0.32	0.34	0.35	0.37	0.32	0.26	0.26	0.27
Idaho	0.56	0.60	0.63	0.66	0.69	0.71	0.74	0.66	0.54	0.55	0.55
Illinois	2.06	2.30	2.40	2.48	2.56	2.65	2.73	2.43	1.95	1.97	2.00
Indiana	2.21	2.35	2.50	2.60	2.70	2.81	2.91	2.55	2.06	2.08	2.11
Iowa	0.82	0.86	0.89	0.91	0.93	0.95	0.98	0.91	0.79	0.80	0.81
Kansas	0.40	0.41	0.43	0.43	0.44	0.45	0.46	0.44	0.37	0.38	0.38
Kentucky	2.25	2.48	2.52	2.62	2.73	2.83	2.93	2.56	2.08	2.11	2.14
Louisiana	2.04	2.15	2.24	2.30	2.37	2.43	2.50	2.29	1.97	1.99	2.02
Maine	0.46	0.48	0.51	0.52	0.54	0.55	0.57	0.52	0.44	0.44	0.45
Maryland	1.65	1.72	1.79	1.84	1.89	1.93	1.98	1.84	1.57	1.59	1.61
Massachusetts	1.96	2.04	2.13	2.18	2.23	2.29	2.34	2.17	1.81	1.84	1.86
Michigan	3.54	3.75	3.93	4.05	4.17	4.28	4.40	3.99	3.36	3.40	3.45
Minnesota	1.92	2.04	2.13	2.21	2.28	2.36	2.43	2.15	1.69	1.71	1.73
Mississippi	1.08	1.13	1.18	1.22	1.25	1.29	1.32	1.22	1.03	1.04	1.06
Missouri	1.92	2.13	2.27	2.35	2.44	2.53	2.62	2.22	1.67	1.69	1.71
Montana	0.44	0.47	0.50	0.52	0.54	0.56	0.58	0.52	0.44	0.45	0.46
Nebraska	0.27	0.28	0.32	0.34	0.40	0.42	0.44	0.41	0.33	0.34	0.34
Nevada	0.78	0.84	0.89	0.93	0.97	1.02	1.06	0.92	0.73	0.74	0.75
New Hampshire	0.24	0.25	0.27	0.28	0.29	0.30	0.31	0.28	0.22	0.23	0.23
New Jersey	1.60	1.70	1.77	1.83	1.88	1.94	1.99	1.82	1.52	1.54	1.56
New Mexico	1.34	1.40	1.45	1.49	1.52	1.56	1.60	1.49	1.32	1.34	1.35

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4ᵃ	Q1	Q2	Q3	Q4
New York	7.35	7.71	8.07	8.25	8.48	8.70	8.93	8.26	7.06	7.15	7.24
North Carolina	3.08	3.24	3.39	3.50	3.61	3.72	3.82	3.48	2.86	2.89	2.93
North Dakota	0.13	0.13	0.14	0.15	0.16	0.16	0.17	0.15	0.12	0.12	0.12
Ohio	3.74	3.91	4.07	4.16	4.27	4.37	4.47	4.15	3.57	3.61	3.66
Oklahoma	1.03	1.09	1.15	1.18	1.22	1.26	1.30	1.16	0.93	0.94	0.96
Oregon	1.40	1.48	1.55	1.61	1.66	1.72	1.77	1.60	1.35	1.36	1.38
Pennsylvania	3.55	3.71	3.87	3.98	4.09	4.21	4.32	4.01	3.39	3.44	3.48
Rhode Island	0.31	0.33	0.34	0.35	0.36	0.38	0.39	0.35	0.29	0.30	0.30
South Carolina	1.12	1.18	1.22	1.26	1.30	1.34	1.38	1.27	1.07	1.08	1.10
South Dakota	0.16	0.17	0.18	0.19	0.19	0.20	0.20	0.19	0.15	0.15	0.16
Tennessee	1.84	1.92	1.99	2.04	2.09	2.14	2.18	2.06	1.77	1.79	1.81
Texas	7.02	7.44	7.89	8.21	8.53	8.85	9.17	8.11	6.37	6.45	6.53
Utah	0.83	0.92	0.99	1.04	1.09	1.15	1.20	1.01	0.77	0.78	0.79
Vermont	0.33	0.34	0.36	0.37	0.38	0.39	0.40	0.37	0.30	0.31	0.31
Virginia	2.01	2.12	2.23	2.32	2.40	2.49	2.58	2.32	1.93	1.95	1.97
Washington	1.93	2.02	2.11	2.16	2.22	2.28	2.33	2.17	1.88	1.90	1.93
West Virginia	0.74	0.77	0.81	0.83	0.86	0.88	0.91	0.84	0.72	0.73	0.74
Wisconsin	1.10	1.17	1.24	1.30	1.35	1.40	1.45	1.28	1.00	1.01	1.02
Wyoming	0.09	0.09	0.10	0.10	0.11	0.11	0.12	0.10	0.08	0.08	0.08

Source: Urban Institute analysis.

Notes: Estimates exclude spending on long-term care and the elderly. Current Centers for Medicare & Medicaid Services guidance allows a complete return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could do so more quickly.

ᵃ Q4 2021 is the expected end of the public health emergency.

Projections of State Medicaid Spending on Acute Care for the Nonelderly Population, by Quarter and State, under the Six-Month Disenrollment Scenario, 2020–22

Billions of dollars

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4[a]	Q1	Q2	Q3	Q4
Alabama	0.30	0.31	0.33	0.33	0.34	0.35	0.36	0.34	0.40	0.41	0.41
Alaska	0.16	0.16	0.17	0.17	0.18	0.18	0.19	0.17	0.19	0.19	0.19
Arizona	0.74	0.78	0.81	0.84	0.86	0.88	0.91	0.83	0.92	0.93	0.94
Arkansas	0.29	0.30	0.32	0.32	0.33	0.34	0.35	0.33	0.38	0.38	0.39
California	5.69	5.95	6.16	6.30	6.45	6.60	6.74	6.37	6.77	6.85	6.93
Colorado	0.65	0.70	0.74	0.77	0.80	0.83	0.86	0.76	0.74	0.75	0.76
Connecticut	0.69	0.72	0.75	0.78	0.80	0.82	0.84	0.78	0.82	0.83	0.84
Delaware	0.15	0.16	0.17	0.17	0.18	0.18	0.19	0.17	0.19	0.19	0.19
District of Columbia	0.11	0.11	0.12	0.12	0.12	0.13	0.13	0.12	0.14	0.15	0.15
Florida	1.98	2.10	2.22	2.30	2.39	2.47	2.55	2.24	2.30	2.33	2.36
Georgia	0.80	0.85	0.89	0.93	0.97	1.01	1.05	0.93	0.99	1.00	1.02
Hawaii	0.13	0.14	0.15	0.15	0.16	0.17	0.17	0.15	0.15	0.15	0.15
Idaho	0.14	0.14	0.15	0.16	0.17	0.17	0.18	0.16	0.17	0.17	0.17
Illinois	1.27	1.41	1.47	1.52	1.57	1.62	1.67	1.49	1.48	1.50	1.52
Indiana	0.66	0.70	0.74	0.77	0.80	0.83	0.86	0.75	0.77	0.78	0.79
Iowa	0.32	0.34	0.35	0.36	0.37	0.37	0.38	0.36	0.39	0.40	0.40
Kansas	0.21	0.22	0.23	0.23	0.23	0.24	0.24	0.23	0.26	0.26	0.26
Kentucky	0.48	0.53	0.54	0.56	0.58	0.60	0.62	0.55	0.57	0.58	0.58
Louisiana	0.54	0.57	0.60	0.61	0.63	0.65	0.67	0.61	0.66	0.67	0.68
Maine	0.18	0.19	0.20	0.20	0.21	0.21	0.22	0.20	0.22	0.22	0.23
Maryland	0.93	0.97	1.01	1.04	1.06	1.09	1.12	1.04	1.08	1.10	1.11
Massachusetts	1.25	1.30	1.36	1.39	1.43	1.46	1.50	1.38	1.44	1.46	1.48
Michigan	1.13	1.20	1.26	1.30	1.33	1.37	1.41	1.28	1.35	1.37	1.39
Minnesota	1.22	1.30	1.36	1.40	1.45	1.50	1.55	1.37	1.34	1.36	1.37
Mississippi	0.22	0.23	0.24	0.25	0.25	0.26	0.27	0.25	0.31	0.31	0.32
Missouri	0.75	0.83	0.89	0.92	0.96	0.99	1.03	0.87	0.87	0.88	0.89
Montana	0.12	0.13	0.14	0.14	0.15	0.16	0.16	0.15	0.15	0.15	0.16
Nebraska	0.17	0.18	0.20	0.22	0.26	0.27	0.28	0.26	0.28	0.28	0.28
Nevada	0.26	0.28	0.30	0.31	0.33	0.34	0.36	0.31	0.31	0.32	0.32
New Hampshire	0.14	0.15	0.16	0.17	0.17	0.18	0.19	0.17	0.16	0.16	0.17
New Jersey	0.87	0.93	0.96	1.00	1.03	1.06	1.09	0.99	1.01	1.03	1.04
New Mexico	0.27	0.28	0.29	0.30	0.30	0.31	0.32	0.30	0.34	0.34	0.35

State	2020			2021				2022			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4[a]	Q1	Q2	Q3	Q4
New York	3.81	3.99	4.18	4.28	4.39	4.51	4.63	4.28	4.43	4.49	4.54
North Carolina	1.12	1.18	1.24	1.28	1.32	1.36	1.39	1.27	1.40	1.42	1.44
North Dakota	0.07	0.08	0.08	0.09	0.09	0.09	0.10	0.09	0.08	0.08	0.09
Ohio	1.35	1.41	1.47	1.50	1.54	1.58	1.61	1.50	1.64	1.66	1.68
Oklahoma	0.40	0.42	0.44	0.45	0.47	0.49	0.50	0.45	0.48	0.49	0.49
Oregon	0.49	0.51	0.54	0.56	0.58	0.60	0.62	0.56	0.58	0.59	0.59
Pennsylvania	1.99	2.08	2.17	2.23	2.29	2.35	2.42	2.24	2.35	2.38	2.41
Rhode Island	0.16	0.17	0.18	0.19	0.19	0.20	0.20	0.19	0.19	0.19	0.20
South Carolina	0.34	0.35	0.37	0.38	0.39	0.40	0.41	0.38	0.44	0.45	0.45
South Dakota	0.09	0.10	0.10	0.11	0.11	0.11	0.12	0.11	0.11	0.11	0.11
Tennessee	0.74	0.77	0.80	0.82	0.84	0.86	0.87	0.83	0.94	0.96	0.97
Texas	3.44	3.65	3.87	4.03	4.19	4.34	4.50	3.98	4.09	4.14	4.19
Utah	0.24	0.26	0.28	0.29	0.31	0.32	0.34	0.29	0.28	0.29	0.29
Vermont	0.18	0.19	0.20	0.21	0.21	0.22	0.23	0.21	0.22	0.22	0.22
Virginia	0.99	1.04	1.09	1.14	1.18	1.22	1.26	1.14	1.14	1.15	1.16
Washington	0.96	1.00	1.05	1.07	1.10	1.13	1.15	1.07	1.12	1.13	1.15
West Virginia	0.15	0.15	0.16	0.17	0.17	0.18	0.18	0.17	0.20	0.20	0.20
Wisconsin	0.58	0.62	0.65	0.68	0.71	0.74	0.76	0.67	0.68	0.69	0.70
Wyoming	0.07	0.07	0.08	0.08	0.08	0.09	0.09	0.08	0.08	0.08	0.08

Source: Urban Institute analysis.

Notes: Estimates exclude spending on long-term care and the elderly. Current Centers for Medicare & Medicaid Services guidance allows a complete return to normal eligibility processing within 12 months of the end of the public health emergency. However, states could do so more quickly.

[a] Q4 2021 is the expected end of the public health emergency.

TABLE A.5

Data Sources, by State

State	Data source	Continuous coverage period average monthly growth rate	URL
Alabama	CMS	All available months	Medicaid.gov
Alaska	CMS	All available months	Medicaid.gov
Arizona	State Medicaid agency	Most recent six months	Arizona Health Care Cost Containment System
Arkansas	State Medicaid agency	All available months	Arkansas Department of Human Services
California	State Medicaid agency	All available months	California Health & Human Services Agency
Colorado	State Medicaid agency	Most recent six months	Colorado Department of Health Care Policy & Financing
Connecticut	State Medicaid agency	Most recent six months	Connecticut Open Data
Delaware	CMS	All available months	Medicaid.gov
District of Columbia	State Medicaid agency	Most recent six months	DC Department of Health Care Finance
Florida	State Medicaid agency	Most recent six months	Florida Agency for Health Care Administration
Georgia	CMS	All available months	Medicaid.gov
Hawaii	CMS	All available months	Medicaid.gov
Idaho	CMS	All available months	Medicaid.gov
Illinois	State Medicaid agency	Most recent six months	Illinois Department of Healthcare and Family Services
Indiana	State Medicaid agency	Most recent six months	Indiana Family and Social Services Administration
Iowa	State Medicaid agency	Most recent six months	Iowa Department of Human Services
Kansas	State Medicaid agency	Most recent six months	Kansas Department of Health and Environment
Kentucky	State Medicaid agency	Most recent six months	Kentucky Cabinet for Health and Family Services
Louisiana	State Medicaid agency	Most recent six months	Louisiana Department of Health
Maine	CMS	All available months	Medicaid.gov
Maryland	State Medicaid agency	Most recent six months	Maryland Medicaid eHealth Statistics
Massachusetts	State Medicaid agency	Most recent six months	MassHealth Monthly Enrollment Snapshots
Michigan	State Medicaid agency	Most recent six months	Michigan Department of Health and Human Services
Minnesota	State Medicaid agency	Most recent six months	Minnesota Department of Human Services
Mississippi	State Medicaid agency	Most recent six months	Mississippi Division of Medicaid
Missouri	State Medicaid agency	Most recent six months	Missouri Department of Social Services
Montana	State Medicaid agency	Most recent six months	Montana Department of Public Health and Human Services
Nebraska	State Medicaid agency	Average of all states	Nebraska Department of Health and Human Services
Nevada	CMS	All available months	Medicaid.gov
New Hampshire	State Medicaid agency	Most recent six months	New Hampshire Department of Health and Human Services
New Jersey	State Medicaid agency	Most recent six months	New Jersey Department of Human Services
New Mexico	State Medicaid agency	Most recent six months	New Mexico Human Services Department
New York	State Medicaid agency	Most recent six months	New York State Department of Health
North Carolina	State Medicaid agency	Most recent six months	North Carolina Department of Health and Human Services
North Dakota	CMS	All available months	Medicaid.gov

State	Data source	Continuous coverage period average monthly growth rate	URL
Ohio	State Medicaid agency	Most recent six months	Ohio Department of Medicaid
Oklahoma	State Medicaid agency	Most recent six months	Oklahoma Health Care Authority
Oregon	State Medicaid agency	Most recent six months	Oregon Health Authority
Pennsylvania	State Medicaid agency	Most recent six months	Pennsylvania Department of Human Services
Rhode Island	CMS	All available months	Medicaid.gov
South Carolina	CMS	All available months	Medicaid.gov
South Dakota	State Medicaid agency	Most recent six months	South Dakota Department of Social Services
Tennessee	State Medicaid agency	Most recent six months	Tennessee Division of TennCare
Texas	State Medicaid agency	Most recent six months	Texas Health and Human Services
Utah	State Medicaid agency	Most recent six months	Utah Department of Health
Vermont	CMS	Most recent six months	Medicaid.gov
Virginia	CMS	All available months	Medicaid.gov
Washington	State Medicaid agency	Most recent six months	Washington State Health Care Authority
West Virginia	State Medicaid agency	Most recent six months	West Virginia Department of Health & Human Resources
Wisconsin	State Medicaid agency	Most recent six months	Wisconsin Department of Health Services
Wyoming	CMS	All available months	Medicaid.gov

Notes: CMS = Centers for Medicare & Medicaid Services. All available months includes months in Q2 2020. We use the average of all states' growth rates for Nebraska, because the state's enrollment numbers were affected by the state's implementation of Medicaid expansion during this time frame.

Notes

1   "Medicaid Enrollment Rises to Historic Mark of 80 Million during Pandemic," *Kaiser Health News*, June 22, 2021, https://khn.org/morning-breakout/medicaid-enrollment-rises-to-historic-mark-of-80-million-during-pandemic/.

2   Bureau of Labor Statistics, "The Employment Situation—April 2020," news release, May 8, 2020, https://www.bls.gov/news.release/archives/empsit_05082020.pdf.

3   How many people lost coverage remains uncertain. Early estimates from the National Health Interview Survey reported relatively little change in coverage, but survey response rates were much lower after the pandemic began (Cohen et al. 2021). If those affected by the pandemic were less likely to respond, that could have biased the results. In July 2020, we predicted an increase in Medicaid enrollment nearly identical to the actual enrollment data for Q2 2020 that we present in this report, along with an increase in the number of people uninsured of about 3 million (Banthin et al. 2020). Other estimates predicted much larger coverage losses.

4   Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

5   We follow a modified projection process for Nebraska because the state recently expanded Medicaid, and expansion took effect in October 2020 (see Louise Norris, "Nebraska and the ACA's Medicaid Expansion," HealthInsurance.org, October 20, 2020, https://www.healthinsurance.org/medicaid/nebraska/). For Nebraska, we rely on HIPSM projections to estimate the effects of Medicaid expansion on enrollment growth, and then use the average of all states' monthly growth rates during recent months to determine the additional enrollment growth attributable to the pandemic and the continuous coverage provision. We combine these two factors to arrive at the growth rates we use in calculating projected enrollment for Nebraska.

6   We calculate job losses as the difference in 2022 employment rates between the pre- and postpandemic economic forecasts from CBO. Prepandemic forecasts are from Blom and coauthors (2020). Postpandemic forecasts are from Shackleton (2020).

7   This rate is as measured in successive HIPSM baselines (Buettgens and Banthin 2020).

8   "Medicaid Expansion," Utah Department of Health, accessed July 28, 2021, http://medicaid.utah.gov/expansion/.

9   Bureau of Labor Statistics, "The Employment Situation—April 2020."

10 Bureau of Labor Statistics, "The Employment Situation—June 2021," news release, July 2, 2021, https://www.bls.gov/news.release/pdf/empsit.pdf.

11 Specifically, the act temporarily (1) extends COBRA (Consolidated Omnibus Budget Reconciliation Act) eligibility and eliminates COBRA premiums, (2) eliminates Marketplace premiums for those receiving unemployment insurance in 2021, and (3) enhances Marketplace PTCs, extending eligibility to those with incomes above 400 percent of FPL.

12 We calculate job losses as the difference in 2022 employment rates between the pre- and postpandemic economic forecasts from CBO. Prepandemic forecasts are from Blom and coauthors (2020). Postpandemic forecasts are from Shackleton (2020).

13 "Medicaid Enrollment Rises to Historic Mark," *Kaiser Health News*.

14 To review concerns some state officials expressed, see Johnston, Haley, and Thomas (forthcoming).

15 "Disaster Relief State Plan Amendments," Medicaid and CHIP Payment and Access Commission, accessed July 28, 2021, https://www.macpac.gov/subtopic/disaster-relief-state-plan-amendments/.

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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). Officials in Massachusetts, Missouri, New York, Virginia, and Washington, as well as the federal government, are using the model provide technical assistance for health reform implementation. His recent work includes research papers analyzing various aspects of national health insurance reform, both nationally and by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments, small firm self-insurance under the Affordable Care Act and its effect on the fully insured market, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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