Fact Sheet

Resumption of Medicaid Eligibility Reassessments: Over 1 Million Enrollees Ages 50 to 64 Could Lose Their Benefits

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Before the COVID-19 pandemic, state Medicaid programs typically reassessed enrollees' eligibility at least once a year and would disenroll them if they no longer qualified. The pandemic put that practice on hold, however, with a federal law passed in March 2020 that required state Medicaid programs to keep people enrolled throughout the public health emergency. States received enhanced federal funding for implementing the requirement.[1]

This policy—often referred to as continuous enrollment—has led to a record-high Medicaid enrollment of more than 84 million people as of November 2022.[2] Rates of uninsured Americans have also dropped to record levels, hitting a low of 8 percent in early 2022.[3] Overall, continuous enrollment helped ensure that tens of millions of people did not have to worry about losing health coverage during a time of health and economic uncertainty.

However, major changes are coming soon. A spending bill that passed at the end of 2022 is ending the continuous coverage protection, and state Medicaid programs will once again be able to disenroll people who are no longer eligible starting on April 1, 2023.[4] Previous analyses suggest that 5 to 17.5 percent of Medicaid enrollees could lose coverage during this "unwinding" process.[5]

The AARP Public Policy Institute (PPI) contracted with NORC at the University of Chicago to further examine the implications of the unwinding process for older Americans. NORC analyzed Medicaid enrollment trends for the 50-to-64 population before and during the public health emergency and used these data to model the impact of resuming Medicaid eligibility reassessments, or redeterminations, in this population. This paper discusses these findings as well as their context within the larger health care system. We also provide an overview of federal and state actions taken in advance of the April 1 changeover date and discuss policy options that could help ease the transition.

Impact on the 50-to-64 population

NORC's model predicts that the unwinding process could result in 1 million people ages 50 to 64 being dropped from Medicaid over the next year, from approximately 12.2 million as of March 31, 2023, to an estimated 11.2 million on April 1, 2024. This finding is due to a few factors. Some individuals will be disenrolled because they no longer qualify (e.g., if their income has increased), whereas others who might otherwise still qualify will be disenrolled due to administrative reasons—not receiving necessary information, not understanding material explaining steps they need to take and therefore failing to take those steps, and otherwise falling through the cracks.

Notably, NORC's model is based on disenrollment trends prior to the public health emergency. Because this historical data is not reflective of the unique challenges created by the public health emergency or sudden resumption of eligibility reassessments, our findings could in fact underestimate enrollment changes. Examples of factors associated with this uncharted territory include the following:

- Record-high Medicaid enrollment requires a record-high number of redeterminations.[6] States will have a limited time until June 1, 2024 to complete all eligibility redeterminations and disenrollments, and state Medicaid officials report that agencies are understaffed and have lost institutional knowledge on conducting the redetermination process.[7]
- Newer Medicaid enrollees are likely not as familiar with the redetermination process and how to complete it because many have not gone through it previously.
- Enrollees may have moved and not updated their address with their state Medicaid agency and therefore may not receive their redetermination notice. A Kaiser Family Foundation analysis found that about 10 percent of Medicaid enrollees moved in 2020 alone.[8]

Despite the anticipated drop in enrollment due to the unwinding process, NORC's model estimates that the overall number of Medicaid enrollees ages 50 to 64 will be 24 percent larger in June 2024 than it was just before the start of the pandemic (i.e., February 2020). The number of people ages 50 to 64 who are enrolled in Medicaid is expected to increase by just over 1 million between February 2020 and June 2024. Predictions for growth rates and disenrollment rates vary significantly by state, as detailed in the appendix.

Other coverage options, and connecting consumers to them

In considering the end of continuous coverage protections for Medicaid beneficiaries, it is worthwhile to consider other health care coverage options that individuals may be able to access. Some people who no longer qualify for Medicaid may have access to health insurance coverage through their job or employer. Also, people who lose Medicaid eligibility due to higher income may be eligible for financial assistance to defray the cost of a private health insurance plan on the Health Insurance Marketplace (Marketplace), created by the Affordable Care Act.

An analysis by the Office of the Assistant Secretary for Planning and Evaluation found that almost one-third of individuals who lose Medicaid coverage will qualify for Marketplace premium assistance. Most of these individuals (60 percent) may be eligible to have their premiums fully covered.[9] However, research has shown that among those individuals who lose Medicaid coverage but are eligible to move to subsidized Marketplace plans, few actually enroll. A recent study by the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) found that only about 3 percent of people who disenrolled from Medicaid enrolled in a Marketplace plan within a year.[10]

The federal government has put in place several policies to help ease the transition from Medicaid to Marketplace coverage, including financial assistance, enrollment windows, and connections between the Medicaid and Marketplace eligibility processes. Federal financial assistance in the form of premium tax credits and cost-sharing reduction subsidies are available to help people afford Marketplace coverage. The availability of premium tax credits, which the federal government has significantly expanded through 2025, make these plans more affordable to individuals transitioning from Medicaid.[11] Recent PPI analyses estimate that these tax credit expansions are critical to making health coverage affordable and can save older adults up to $4,700 in premiums and ensure that 1 million fewer older adults ages 50 to 64 are uninsured.[12]

In addition to providing this financial assistance, to help people enroll in Marketplace coverage, the federal government created a temporary "unwinding" special enrollment period (SEP) for people losing Medicaid or CHIP coverage between March 31, 2023 and July 31, 2024.[13] People may also be eligible for other SEPs,[14] and people in most states with income levels under 150 percent of the federal poverty level and who are also eligible for premium tax credits may be eligible to enroll year-round.[15]

Meanwhile, in anticipation of the unwinding, state Medicaid officials have been working closely with their Marketplace counterparts, and both states and the federal government have been developing communication strategies to help ensure that people who lose Medicaid are aware of Marketplace coverage options and the availability of financial assistance. If a state determines an individual's income to be too high for Medicaid, it sends the applicant's information to the Marketplace, helping connect the two programs for the user. The Marketplace eligibility system then sends a letter to the person with information and instructions on enrolling in a Marketplace plan.

Other federal and state efforts to mitigate impact of unwinding process

Federal- and state-level agencies have been actively working to prepare for the unwinding in other areas as well. The Centers for Medicare and Medicaid Services (CMS) has been encouraging enrollees to update their contact information with Medicaid agencies and to be on the lookout for communications about redeterminations. Federal and state officials have also been working to improve coordination between Medicaid and Marketplace enrollment processes and make improvements to the redetermination process to cut down on disenrollments due to administrative reasons.

An enrollee's redetermination experience will in part depend on their state. For example, many states use available data to reduce the amount of information enrollees need to submit, and some states have focused on improving data use and implementing other system upgrades in the past few years. However, the extent of data use and burden on enrollees vary widely.[16] States have also employed varying approaches to education and outreach and making information public.[17] (For specific examples of steps some states are taking, see box "Notes From a MACPAC Meeting: What States Are Doing on the Ground.") Amid these varying efforts and even despite the more proactive ones, many people may remain unaware of the upcoming changes. As of December 2022, more than 64 percent of adults who are enrolled in Medicaid, or who have a family member who is enrolled, were unaware of the upcoming redetermination process.[18]

Additional efforts needed

People who lose health insurance coverage completely, even for short periods (sometimes referred to as "churn"), are likely to experience both financial and medical adverse impacts. Loss of health care coverage leads people to skip needed care and incur high costs to pay for the care they do get.[19] These stakes are also higher for those ages 50 to 64 than for younger groups:

- Twenty percent of 50- to 64-year-olds report being in fair to poor health, compared with 11 percent of those ages 18 to 49. For those who make less than 25,000 a year, this number rises to 48 percent.[20]
- People ages 54 to 64 also report higher rates of multiple common chronic health conditions compared with younger cohorts.[21]

Given the implications for millions of people, as well as the increased reliance on Medicaid among the 50-to-64 population, policymakers should ensure that the unwinding/Medicaid redetermination process goes as smoothly as possible. Priorities should include the following:

Ensuring sufficient state staffing. For a redetermination effort to be successful, states will need to ensure adequate staff in

Notes From a MACPAC Meeting: What States Are Doing on the Ground

During a January 2022 public meeting of the Medicaid and CHIP Payment and Access Commission, several state representatives discussed planning and process updates that they hope will help the redetermination process go more efficiently and effectively.[25] Highlights of such updates taking place included improvements to the reassessment process and ways to engage enrollees more effectively:

Process

- **Improved performance management and monitoring tools**, including new dashboards
- **Additional external support** in coordinating enrollment between Medicaid and Marketplace plans and referrals to other safety net services
- **Better use of data** to streamline the process and minimize the amount of information that enrollees must provide

Engaging enrollees

- **Media campaigns** to alert enrollees to the upcoming process
- **Updating and improving enrollee communication materials** and sharing sample language and clear messaging strategies with community partners for consistent messaging to enrollees
- **Creation of a return-mail center** to standardize processes for undeliverable mail and take further steps to reach enrollees

several pivotal roles, including eligibility case workers, call center staff, eligibility systems support, and determination appeals staff. This is an area of risk for states because many current staff members have expressed concern about adequate staffing. CMS has gathered some best practices for states to address these challenges, such as cross-training state and county staff from other agencies to help fill roles on a temporary basis and creating specialized units to handle more complex tasks.[22]

Opportunities for enrollee feedback. So that officials can address systemic issues as quickly as possible, states should ensure they have robust channels in place to gather reports of enrollee concerns and problems experienced in the redetermination process. Addressing issues quickly will help ensure that enrollees stay covered or transition smoothly to other available coverage options.

Education and outreach efforts. CMS and states should stay engaged with communities to provide resources, such as those that help explain the redetermination process or direct people to local legal or advocacy entities that can help them navigate the process.

Improved monitoring. States must submit reports to CMS on the redetermination and disenrollment processes, and CMS must make the reports publicly available.[23] CMS has not yet provided information on how or where it will publish these reports but will likely provide updates on its website dedicated to guidance and information on this process.[24] These reports can provide important information for policymakers and reveal insights that warrant further investigation.

Appendix

State	50- to 64-year old enrollment 2/1/20 [observed]	50- to 64-year old enrollment 4/1/23 [projected]	50- to 64-year old enrollment 4/1/24 [projected]	Enrollment change from start of pandemic (February 2020) to 4/1/23 [projected]	Enrollment change from start of pandemic (February 2020) to 4/1/24 [projected]
AK	28,233	34,936	32,492	23.7%	15.1%
AL	89,940	106,915	106,440	18.9%	18.3%
AR	113,650	148,644	134,946	30.8%	18.7%
AZ	221,059	317,039	286,770	43.4%	29.7%
CA	1,600,331	2,068,897	1,783,519	29.3%	11.4%
CO	167,181	253,356	222,479	51.5%	33.1%
CT	127,597	159,324	150,234	24.9%	17.7%
DC	40,495	48,133	46,680	18.9%	15.3%
DE	33,643	45,031	39,302	33.9%	16.8%
FL	289,744	411,185	414,120	41.9%	42.9%
GA	145,638	178,673	175,908	22.7%	20.8%
HI	45,667	70,529	60,565	54.4%	32.6%
IA	86,552	110,578	105,155	27.8%	21.5%
ID	35,618	56,261	49,940	58.0%	40.2%
IL	377,313	575,520	525,682	52.5%	39.3%
IN	200,617	309,433	298,495	54.2%	48.8%
KS	34,603	40,169	40,246	16.1%	16.3%
KY	195,730	251,609	224,542	28.5%	14.7%
LA	198,285	267,793	247,840	35.1%	25.0%
MA	255,890	351,230	346,109	37.3%	35.3%
MD	170,787	230,496	205,108	35.0%	20.1%
ME	42,238	66,555	68,121	57.6%	61.3%
MI	335,405	449,437	376,027	34.0%	12.1%
MN	127,040	174,225	164,100	37.1%	29.2%
MO	99,412	172,342	161,962	73.4%	62.9%
MS	74,650	84,886	86,248	13.7%	15.5%
MT	35,515	47,151	48,406	32.8%	36.3%
NC	181,312	248,121	240,327	36.8%	32.5%
ND	10,679	14,876	13,265	39.3%	24.2%
NE	18,130	33,813	30,744	86.5%	69.6%
NH	23,715	36,710	32,216	54.8%	35.8%
NJ	239,905	322,211	301,808	34.3%	25.8%
NM	95,788	122,210	113,288	27.6%	18.3%
NV	84,400	126,588	123,176	50.0%	45.9%

State	50- to 64-year old enrollment 2/1/20 [observed]	50- to 64-year old enrollment 4/1/23 [projected]	50- to 64-year old enrollment 4/1/24 [projected]	Enrollment change from start of pandemic (February 2020) to 4/1/23 [projected]	Enrollment change from start of pandemic (February 2020) to 4/1/24 [projected]
NY	942,988	1,260,072	1,180,737	33.6%	25.2%
OH	368,107	480,415	445,755	30.5%	21.1%
OK	69,823	104,841	95,114	50.2%	36.2%
OR	157,096	233,041	189,287	48.3%	20.5%
PA	440,763	583,754	506,244	32.4%	14.9%
RI	50,534	68,932	67,081	36.4%	32.7%
SC	99,960	124,788	120,923	24.8%	21.0%
SD	8,313	10,243	10,085	23.2%	21.3%
TN	148,804	173,753	167,076	16.8%	12.3%
TX	254,215	312,116	302,061	2.8%	18.8%
UT	28,817	48,854	45,261	69.5%	57.1%
VA	191,858	291,198	300,732	51.8%	56.7%
VT	23,174	32,178	29,805	38.9%	28.6%
WA	225,712	306,796	276,211	35.9%	22.4%
WI	131,680	186,196	167,933	41.4%	27.5%
WV	86,331	107,038	94,269	24.0%	9.2%
WY	4,656	6,466	6,619	38.9%	42.2%

Endnotes

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