Insurance Coverage Transitions After the Medicaid Unwinding

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Companion piece: Appendix Tables

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Medicaid and the Children's Health Insurance Program (CHIP) have both played a key role in the response to the COVID-19 Public Health Emergency, providing a vital source of health coverage for millions of people. The Families First Coronavirus Response Act (FFCRA) implemented a continuous coverage requirement in Medicaid, coupled with an increase in federal payments to states.[1] The requirement prevented states from disenrolling Medicaid enrollees (except in limited circumstances), which allowed people to remain enrolled in Medicaid regardless of changes in circumstances that may make someone ineligible, such as a change in income. In April 2023, the continuous coverage requirement ended; states then resumed Medicaid eligibility redetermination procedures for nearly 95 million Medicaid enrollees, a process commonly known as the Medicaid "unwinding."[2]

Though administrative data have provided an evolving picture of the magnitude of redetermination and reenrollment during the unwinding, less is known about the share of enrollees that transitioned off the Medicaid program, the share of enrollees that transitioned to other sources of health insurance coverage (or uninsurance), and the factors associated with different transition types (e.g., off of Medicaid, to other source of coverage, to uninsurance, etc.).

Methods

Our analysis examined rates of transitions off Medicaid, transitions to other forms of coverage (or uninsurance), and the factors associated with these outcomes. We narrowed our focus on understanding these outcomes during the first year of Medicaid redeterminations (after the April 2023 end of the COVID-19 public health emergency).

For this analysis, we used data from the 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC), a federal survey representative of all states and D.C. that includes respondents of all ages.

There are several definitions that are important for understanding our analysis and methods. Individuals were either noted to have 'Remained in Medicaid' (meaning an individual self-reported Medicaid coverage both in 2023 and at the time of interview in February – April 2024) or to have 'Transitioned off Medicaid'. A transition off Medicaid was defined as self-reporting Medicaid coverage at some point during 2023 *and* self-reporting no Medicaid coverage at the time of interview in February – April 2024.

Among those who transitioned off Medicaid, we examined rates of transition to employer/military coverage, direct purchase health insurance, Medicare coverage, and uninsurance (i.e., no coverage). The analysis includes statistics that describe rates of both transitions off Medicaid and transitions to other forms of coverage by a range of individual, economic, and geographic factors. We also produced multivariate models of these outcomes that isolated the independent associations between each of these factors and our outcomes of interest, all else held equal.

[1] The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) provided states with a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

[2] "Medicaid Enrollment and Unwinding Tracker," November 1, 2024. San Francisco, CA: KFF. Accessed November 12, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.

Summary of Key Findings

- Of those with Medicaid in 2023, 94.2% remained on Medicaid while 5.8% transitioned off Medicaid by the time of the interview period.
- In February – April 2024, 55.8% of those who transitioned off Medicaid transitioned to other coverage. Of those who transitioned off Medicaid, 38.9% transitioned to employer/military coverage, 9.9% to direct purchase health insurance, and 7.7% to Medicare coverage. Still, a large share, 44.2%, transitioned to no coverage, becoming uninsured.
- Children (age 0-18) and older adults (age 45+) were less likely to transition off Medicaid, while young adults (age 19-25) were more likely to transition off Medicaid (compared to all persons, 5.8% of whom transitioned off Medicaid).
- Higher income was associated with higher rates of transition off Medicaid.
- Both full-time workers and the recently unemployed were more likely to transition off Medicaid.
- People who moved between counties or states in the past year were more likely to transition off Medicaid.
- The factors most strongly associated with becoming uninsured after transitioning off Medicaid were having an income below 139% Federal Poverty Guideline (FPG), being a Hispanic/Latino person of any race or a person of some other race or multiple races, having a high school or lower level of education, and not being a U.S. citizen.
- The only factors independently associated with transitioning to direct purchase coverage after transitioning off Medicaid were having an income of 139-250% FPG, 251-400% FPG, or 401%+ FPG (all compared to an income <139% FPG).

Conclusions

Our analysis shows that individuals with characteristics that made them likely to be eligible for Medicaid (such as having a low income or being a child or an older adult) were less likely to transition off Medicaid during the first year of the unwinding, while individuals whose income or employment status may have given them access to private coverage were more likely to transition off Medicaid. However, we also found that regardless of other eligibility factors, individuals who recently moved were more likely to transition off coverage, potentially because Medicaid agencies lacked current address or contact information, pointing to potential administrative issues.

Among those who transitioned off Medicaid during the first year of the unwinding, the majority successfully transitioned to other forms of coverage, with most of these in the form of transitions to private coverage (i.e., employer/military or direct purchase health insurance).

However, it is still important to note that more than 40% of enrollees who transitioned off Medicaid became uninsured, and concerningly, the largest independent associations with this transition were related to former enrollees' poverty level, race and ethnicity, citizenship status, and educational attainment. These associations suggest that those who transitioned to uninsurance from Medicaid were some of those with the fewest political and socioeconomic advantages and who relied the most on Medicaid for coverage.

More positively, among those who transitioned off Medicaid coverage, children were substantially less likely to transition to uninsurance and more likely to transition to other forms of coverage compared to nonelderly adults.

Many states made efforts during the unwinding to smoothly transition those losing Medicaid coverage during redetermination to direct purchase health insurance, particularly subsidized marketplace coverage.[3] Our analysis shows that among those who transitioned off Medicaid, the main driver of successful transitions to direct purchase was having an income that was either eligible for subsidized coverage (i.e., 139%-400% FPG) or that was high enough to (likely) make unsubsidized direct purchase health insurance reasonably affordable (i.e., 401%+ FPG).

[3] Corlette S, Levitis J, Straw T. "Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions," February 24, 2023. Princeton, NJ: State Health & Value Strategies. Accessed February 17, 2025. https://www.shvs.org/secrets-to-a-successful-unwinding-actions-state-based-marketplaces-and-insurance-departments-can-take-to-improve-coverage-transitions.

Notes

The CPS ASEC asks respondents if they had a source of comprehensive health insurance coverage at any point during the previous calendar year. Respondents can report multiple sources of coverage, though these sources of coverage are not necessarily held simultaneously.

This analysis categorizes self-reported insurance coverage as follows:

- Medicaid coverage includes individuals who reported Medicaid, Medical Assistance, CHIP, and Basic Health Program names specific to the respondent's state.
- Employer/Military includes individuals reporting employment-based coverage or coverage associated with military services including Veteran's Administration (VA), CHAMPVA and TRICARE.
- Direct purchase health insurance includes anyone who reported direct purchase health insurance, including coverage purchased through a marketplace (subsidized or unsubsidized).
- Respondents who reported no source of comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service[4]) during the prior calendar year are considered uninsured.

[4] Indian Health Service coverage is not considered comprehensive health insurance coverage by the U.S. Census Bureau. See https://www.census.gov/topics/health/health-insurance/about/glossary.html

INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) have both played a key role in the response to the COVID-19 Public Health Emergency, providing a vital source of health coverage for millions of people. The Families First Coronavirus Response Act (FFCRA) implemented a continuous coverage requirement in Medicaid, coupled with an increase in federal payments to states.[5] The requirement prevented states from disenrolling Medicaid enrollees (except in limited circumstances, such as a request for voluntary disenrollment or change in state residency), effectively eliminating churn during the Public Health Emergency.

In April 2023, with the official end of the continuous coverage requirement, states began redetermining Medicaid eligibility for nearly 95 million Medicaid enrollees, a process commonly known as the Medicaid "unwinding."[6] While administrative records of Medicaid enrollment as of June 2024 show that over 56 million people had their coverage renewed, there were also more than 25 million people who were disenrolled from Medicaid or CHIP coverage.[7]

Though administrative data have provided an evolving picture of the magnitude of redetermination and reenrollment during the unwinding, less is known about:

- The factors associated with either maintenance of coverage or a transition off Medicaid (i.e., going from having Medicaid to not having Medicaid)
- The share of those transitioned off Medicaid who transitioned either to other sources of health insurance coverage or uninsurance, and
- The factors associated with those coverage transitions (or transitions to uninsurance).

To better understand transitions off Medicaid and to other coverage (or uninsurance) during the first year of the Medicaid unwinding, the State Health Access Data Assistance Center (SHADAC) conducted a study using data from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) to produce estimates of both transitions off Medicaid and transitions to other coverage (or uninsurance) from 2023 to February – April 2024, the first year of the Medicaid unwinding period. Alongside these estimates, this work also includes analysis of the individual, family, economic, and geographic factors associated with transitions off Medicaid and subsequent transitions to uninsurance. The analysis includes individuals of all ages enrolled in Medicaid, including those with other sources of coverage.

This report focuses on the statistically significant findings from our analysis, first presenting rates of transitions off Medicaid, then focusing on transitions to other types of coverage or to uninsurance among those who transitioned off the program.

Transitions off Medicaid During the First Year of the Unwinding

Among those with Medicaid in 2023, our analysis found that 5.8% reported having no Medicaid coverage when they were interviewed in February – April 2024, approximately one year into the unwinding (**Figure 1**).

[5] The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) provided states with a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

[6] "Medicaid Enrollment and Unwinding Tracker," November 1, 2024. San Francisco, CA: KFF. Accessed November 12, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.

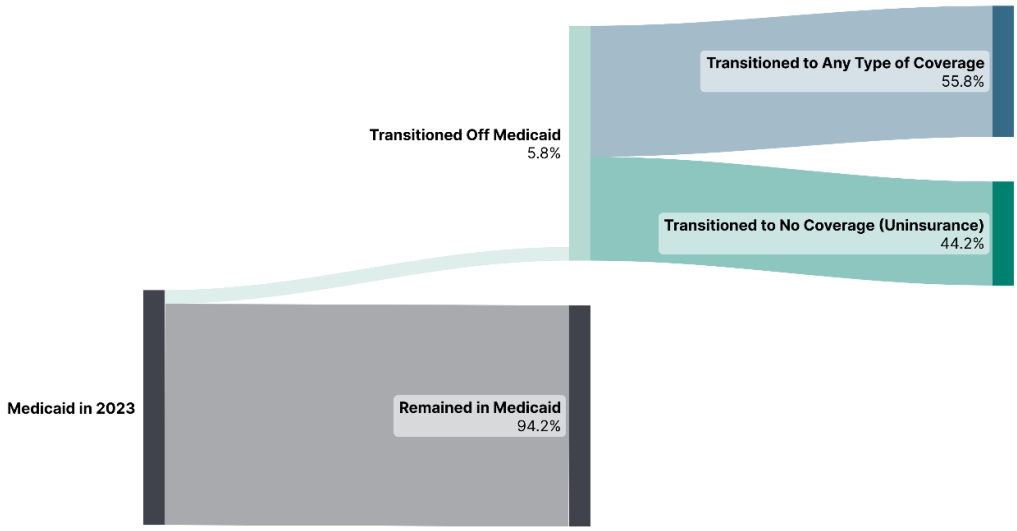
[7] Tolbert J, Corallo B. "An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding," September 18, 2024. San Francisco, CA: KFF. Accessed November 12, 2024. https://www.kff.org/medicaid/issue-brief/an-examination-of-medicaid-renewal-outcomes-and-enrollment-changes-at-the-end-of-the-unwinding/.

This rate of transition off Medicaid is lower than the post-Affordable Care Act and pre-COVID-19 transition off Medicaid estimate produced by the Medicaid and CHIP Payment and Access Commission (MACPAC) in 2018 (21%)[8]; our estimate is also below the projected Medicaid coverage losses predicted by a number of organizations after the conclusion of the unwinding.[9,10,11] Our estimate of transition off Medicaid is likely lower than these cited estimates for three main reasons:

- First, our analysis only includes transitions off the Medicaid program that took place during the first year of the unwinding;
- Second, our analysis cannot distinguish between enrollees who maintained their Medicaid coverage during redetermination from enrollees who lost and then regained Medicaid coverage during redetermination; and
- Third, our analysis of transitions off Medicaid only includes on individuals who affirmatively knew they were covered by Medicaid (a group arguably more likely to retain their coverage) rather than the full Medicaid population.

While it is useful to consider our estimate in context of past analyses, it is important to note that because of differences in data sources, study populations, and timeframes, these previous findings are not directly comparable to our analysis of transitions off Medicaid and to other coverage (or uninsurance). And, for these reasons, our relatively low estimate does not necessarily call into question the validity of previous estimates.

Figure 1. Coverage Transitions between 2023 and February – April 2024 Among Individuals with Medicaid Coverage in 2023



Notes: This represents the coverage transitions of individuals who reported having Medicaid in 2023 who were interviewed again in February – April 2024. The Current Population Survey Annual Social and Economic Supplement (CPS ASEC) asks respondents if they had a source of comprehensive health insurance coverage at the time of interview. This analysis categorizes self-reported insurance coverage as follows: Medicaid coverage includes individuals who reported Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Employer/Military includes individuals reporting employment-based coverage or coverage associated with military services including Veteran's Administration (VA), CHAMPVA, and TRICARE. Direct purchase health insurance includes anyone who reported direct purchase health insurance, including coverage purchased through a marketplace (subsidized or unsubsidized). Respondents who reported no source of comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service) at the time of interview are considered uninsured. Respondents can report multiple sources of coverage.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

[8] "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," October 2021. Washington, D.C.: Advising Congress on Medicaid and CHIP Policy. Accessed February 17, 2025. https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

[9] "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022. Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation. Accessed February 17, 2025. https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf.

[10] Tolbert J, Ammula M. "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," June 9, 2023. San Francisco, CA: KFF. Accessed February 17, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision.

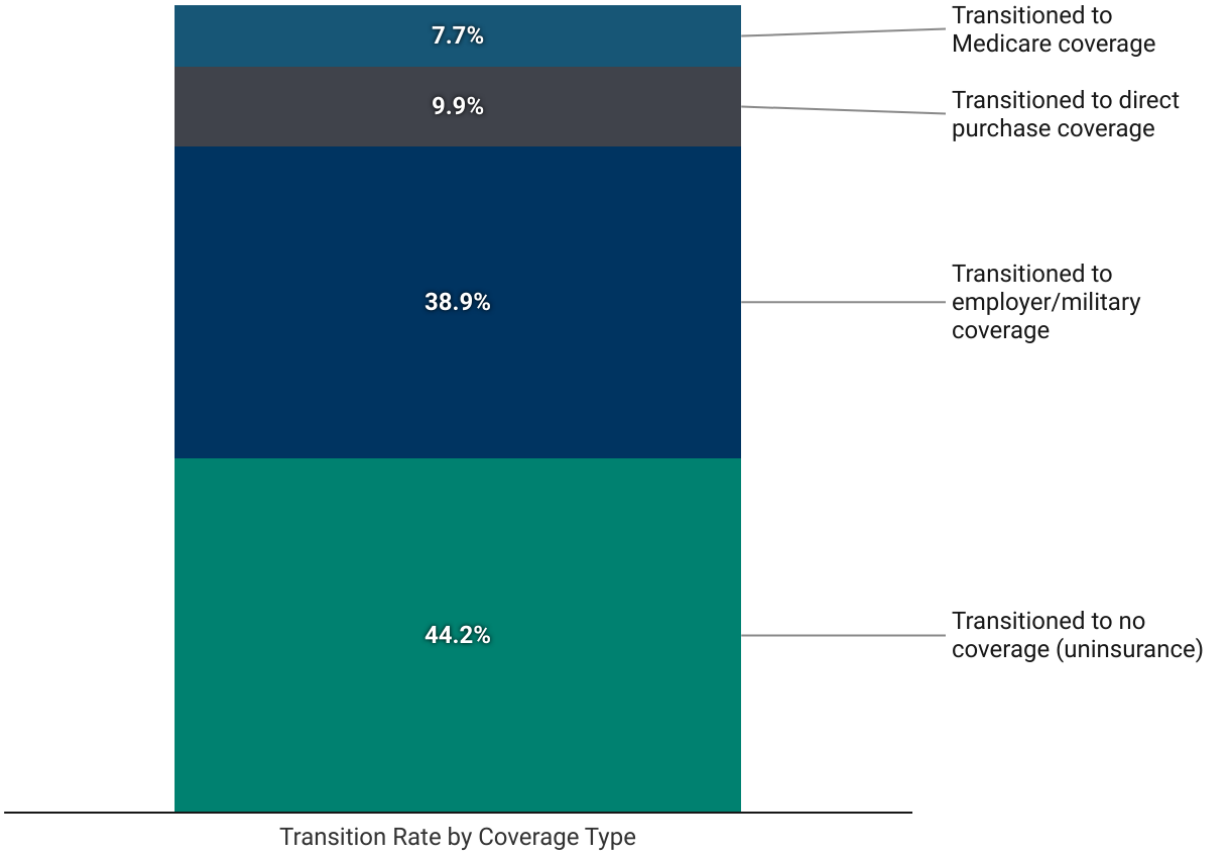
[11] Buettgens M, Green A. "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," December 2022. Washington, D.C.: Urban Institute. Accessed February 17, 2025. https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage_0.pdf.

Transitions off Medicaid to Other Insurance Coverage or Uninsurance During the First Year of the Unwinding

Notably, of those who transitioned off Medicaid, 55.8% reported a transition to another type of coverage. By type, 38.9% reported having employer/military coverage, 9.9% reported direct purchase health insurance, and 7.7% reported Medicare coverage. However, a large share of those who transitioned off Medicaid did not transition to a different form of coverage — 44.2% reported having no coverage (uninsurance) **(Figure 2)**.

Note: The distribution of coverage for those who transitioned off Medicaid by February – April 2024 sums to more than 100% because of individuals who report multiple sources of insurance coverage.

Figure 2. Coverage Distribution Among Individuals Who Transitioned off Medicaid between 2023 and February – April 2024



Notes: Percentages sum to more than 100% because respondents can report multiple sources of coverage.
Coverage categories: The Current Population Survey Annual Social and Economic Supplement (CPS ASEC) asks respondents if they had a source of comprehensive health insurance coverage at the time of interview. This analysis categorizes self-reported insurance coverage as follows: Medicaid coverage includes individuals who reported Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Employer/Military includes individuals reporting employment-based coverage or coverage associated with military services including Veteran's Administration (VA), CHAMPVA, and TRICARE. Direct purchase health insurance includes anyone who reported direct purchase coverage, including coverage purchased through a marketplace (subsidized or unsubsidized). Respondents who reported no source of comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service) at the time of interview are considered uninsured. Respondents can report multiple sources of coverage.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

ANALYSIS OF COVERAGE TRANSITIONS

This section describes the results of our analysis of transitions off Medicaid coverage, including transitions to direct purchase health insurance and transitions to uninsurance (no coverage) among those who transitioned off Medicaid. Analysis of transitions to employer/military coverage and Medicare coverage can be found in the Appendix Tables.

Factors Associated with Transition off Medicaid

In this section, we begin by detailing factors that were found to be significantly associated with transition off Medicaid coverage. We found that the likelihood of transitioning off Medicaid was tied to certain life circumstances along with individual, family, and geographic characteristics.

Key findings:

- Young adults age 19-25 were more likely to transition off Medicaid, whereas older adults age 45-64 and 65+ were less likely to transition off Medicaid (compared to children), all else equal;
- People with incomes at or above 139% FPG were more likely to transition off Medicaid (compared to those with incomes below 139% FPG), all else equal;
- People who moved between counties, states, or from abroad in the past year were more likely to transition off Medicaid (compared to those who did not move in the past year), all else equal;
- People who worked full time in 2023 were more likely to transition off Medicaid (compared to those who did not work full time in 2023), all else equal; and
- Among the factors we evaluated, our analysis did not show significant associations between race and ethnicity, marital status, and citizenship status and the likelihood of transitioning off Medicaid, all else equal.

Descriptive Analysis

This section describes the factors that were significantly associated with higher or lower rates of transitioning off Medicaid between 2023 and February – April 2024. The analysis compares rates of transition off Medicaid for specific groups (e.g., age groups, individuals with disabilities, noncitizens, etc.) compared to everyone who had the potential to transition off Medicaid (everyone with Medicaid in 2023).

Reference group: In most cases, the analysis compares the rate of transition off Medicaid for a specific group to the total transition rate (5.8%). But, in some cases, the analysis uses a more limited reference population because the factor or characteristic only applies to a select group of individuals (e.g., when examining characteristics related to work, the reference population is limited to individuals aged 15 or older).

Individual Characteristics

The likelihood of transition off Medicaid depended on many individual-level characteristics, including many related to eligibility for Medicaid (e.g., age, disability) and to one's ability to access other forms of coverage (e.g., ability to access through a spouse, level of education necessary to obtain coverage-eligible employment, disability that limits or prevents work, etc.).

Compared to the reference group, the rate of transition off Medicaid was **significantly higher** among people who (**Figure 3**):

- Were nonelderly adults (age 19-64),
- Were young adults (age 19-25),
- Were younger-to-middle-aged adults (age 19-44),
- Were non-Hispanic White,
- Were married,
- Had a BA or higher level of education (among those age 25+),
- Had no reported difficulty (i.e., disability; among those age 15+), and
- Had no reported disability that limits or prevents work (among those age 15+).

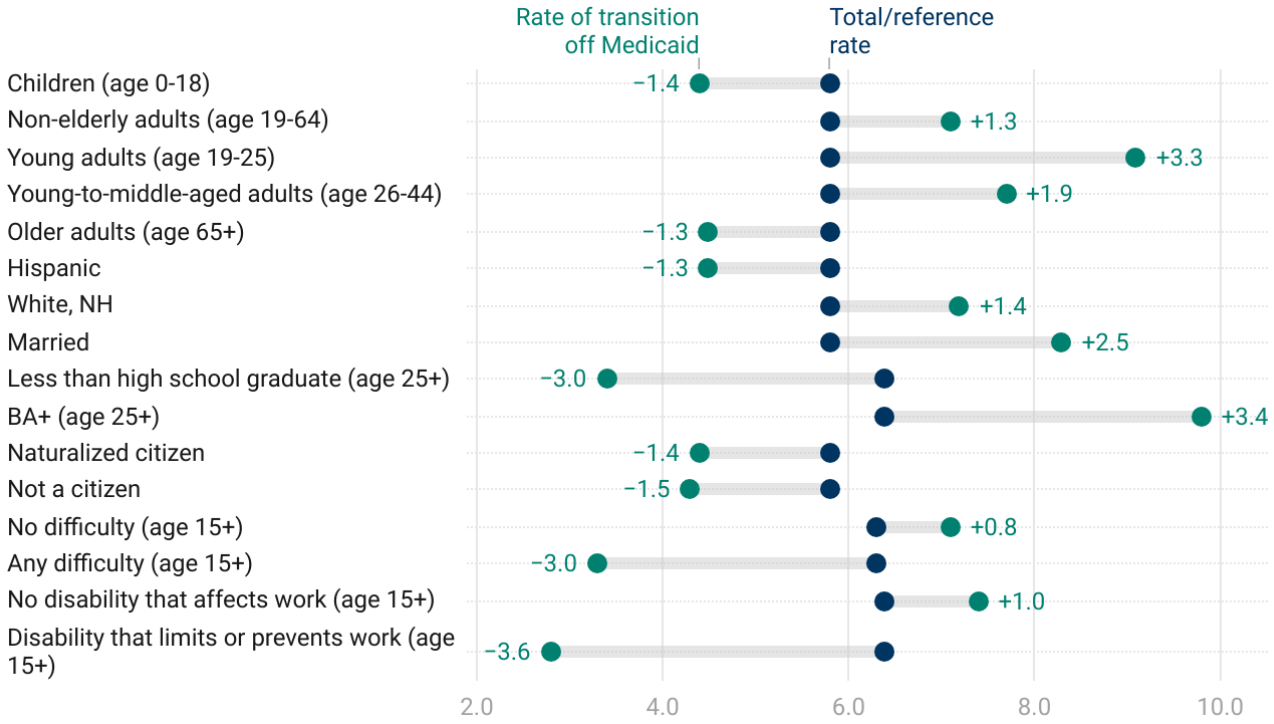
Compared to the reference group, the rate of transition off Medicaid was **significantly lower** among people who (**Figure 3**):

- Were children (age 0-18),
- Were older adults (age 65+),
- Were Hispanic/Latino (of any race),
- Had less than a high school level of education (among those age 25+),
- Were naturalized U.S. citizens,
- Were not U.S. citizens,
- Reported any difficulty (i.e., disability; among those age 15+), and
- Reported having a disability that limits or prevents work (among those age 15+).

We did not observe significant differences by sex, family size, or presence of children in the family.

Note: Rates of transition off Medicaid by individual characteristics are available in greater detail in the Appendix Tables.

Figure 3. Rates of Transition off Medicaid and Significant Percentage Point Difference from Total Transition Rates by Individual Characteristics



Notes: The total reference rate of transition off Medicaid for all civilian noninstitutionalized people is 5.8%. Transition off Medicaid is defined as having self-reported Medicaid coverage at some point in 2023 and no self-reported Medicaid coverage at the time of interview in February – April 2024. Family is defined based on the SHADAC Health Insurance Unit definition. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

Economic, Employment, and Insurance Coverage Circumstances

The likelihood of transition off Medicaid also varied depending on an individual's 2023 economic and employment situation. We also saw variation depending on an individual's insurance coverage circumstances (e.g., whether they reported having Medicaid all year or for part of 2023, whether they reported having Medicaid alone or in combination with another source of insurance coverage in 2023).

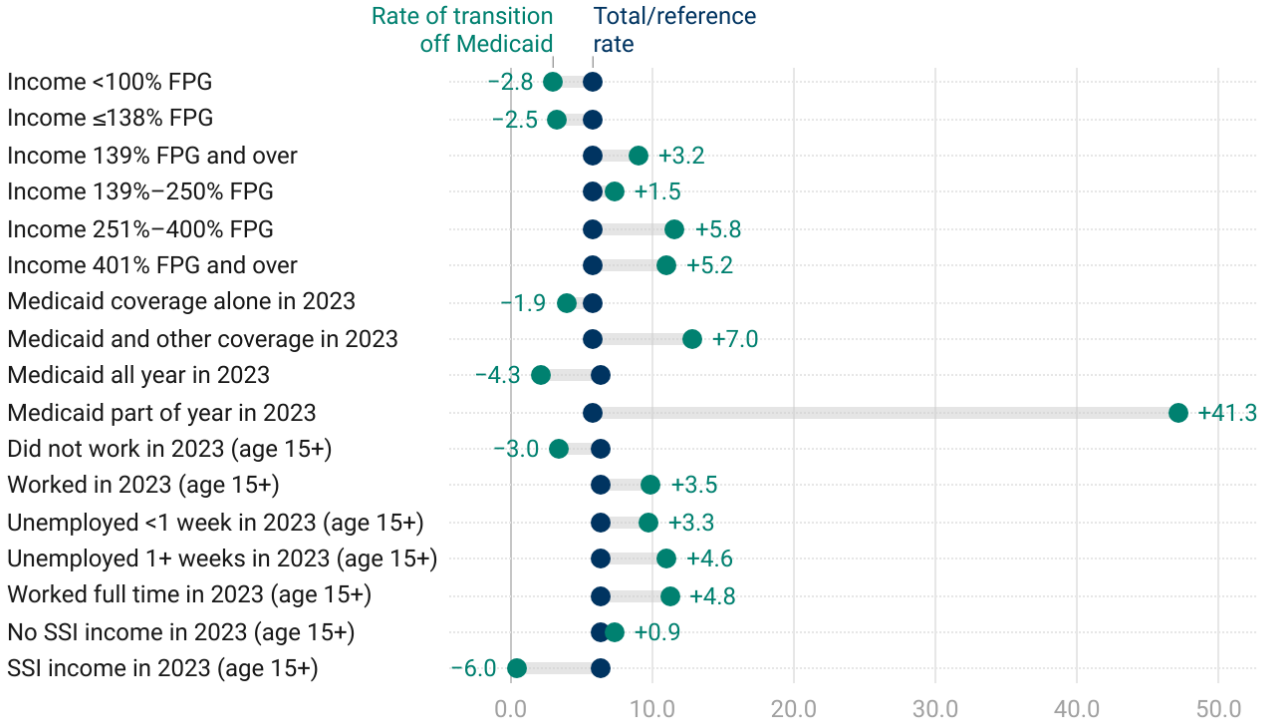
Compared to the reference group, those **significantly more likely** to have transitioned off Medicaid by February - April 2024 were people who (**Figure 4**):

- Had incomes 139% FPG and over (including those in the income ranges 139%-250% FPG, 251%-400% FPG, and 401%+ FPG),
- Had Medicaid and another type of coverage in 2023,
- Had Medicaid for only part of 2023,[12]
- Worked in 2023 (among those age 15+),
- Were unemployed fewer than one week in 2023 (among those age 15+),
- Were unemployed one or more weeks in 2023 (among those age 15+),
- Worked full time in 2023 (among those age 15+), and
- Did not receive Supplemental Security Income (SSI) in 2023 (among those age 15+).

Compared to the reference group, those **significantly less likely** to have transitioned off Medicaid by February – April 2024 were people who (**Figure 4**):

- Had incomes below 100% FPG,
- Had incomes at or below 138% FPG,
- Had Medicaid coverage alone in 2023,
- Had Medicaid all year in 2023,
- Did not work at any point in in 2023 (among those age 15+), and
- Received SSI in 2023 (among those age 15+).

Figure 4. Rates of Transition off Medicaid Significant Percentage Point Difference from Total Transition Rates by Economic, Employment, and Insurance Coverage Circumstances



Notes: The total reference rate of transition off Medicaid for all civilian noninstitutionalized people is 5.8%. Transition off Medicaid is defined as having self-reported Medicaid coverage at some point in 2023 and no self-reported Medicaid coverage at the time of interview in February – April 2024. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. FPG stands for Federal Poverty Guidelines. SSI stands for Supplemental Security Income.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

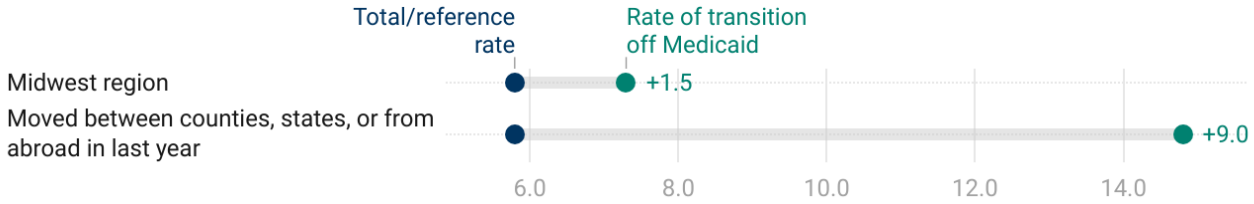
[12] This is a large group, as it includes everyone who transitioned off Medicaid before 2024

Geographic Characteristics

The likelihood of transition off Medicaid also depended on where people lived and if they had moved in the past year.

People living in the Midwest were significantly more likely to have transitioned off Medicaid, as were those who had moved between counties, states, or from abroad in the past year (**Figure 5**). We did not find that rates of transition off Medicaid varied significantly by Medicaid expansion status or by state marketplace type.

Figure 5. Rates of Transition off Medicaid and Significant Percentage Point Difference from Total Transition Rates by Geographic Characteristics



Notes: The total reference rate of transition off Medicaid for all civilian noninstitutionalized people is 5.8%. Transition off Medicaid is defined as having self-reported Medicaid coverage at some point in 2023 and no self-reported Medicaid coverage at the time of interview in February – April 2024. Region is defined using the Census Bureau Region definitions. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

Multivariate Analysis

This section describes the factors that were independently positively or negatively associated with the likelihood of transition off Medicaid when simultaneously considering multiple factors, including individual characteristics, economic and employment circumstances, and other coverage factors.

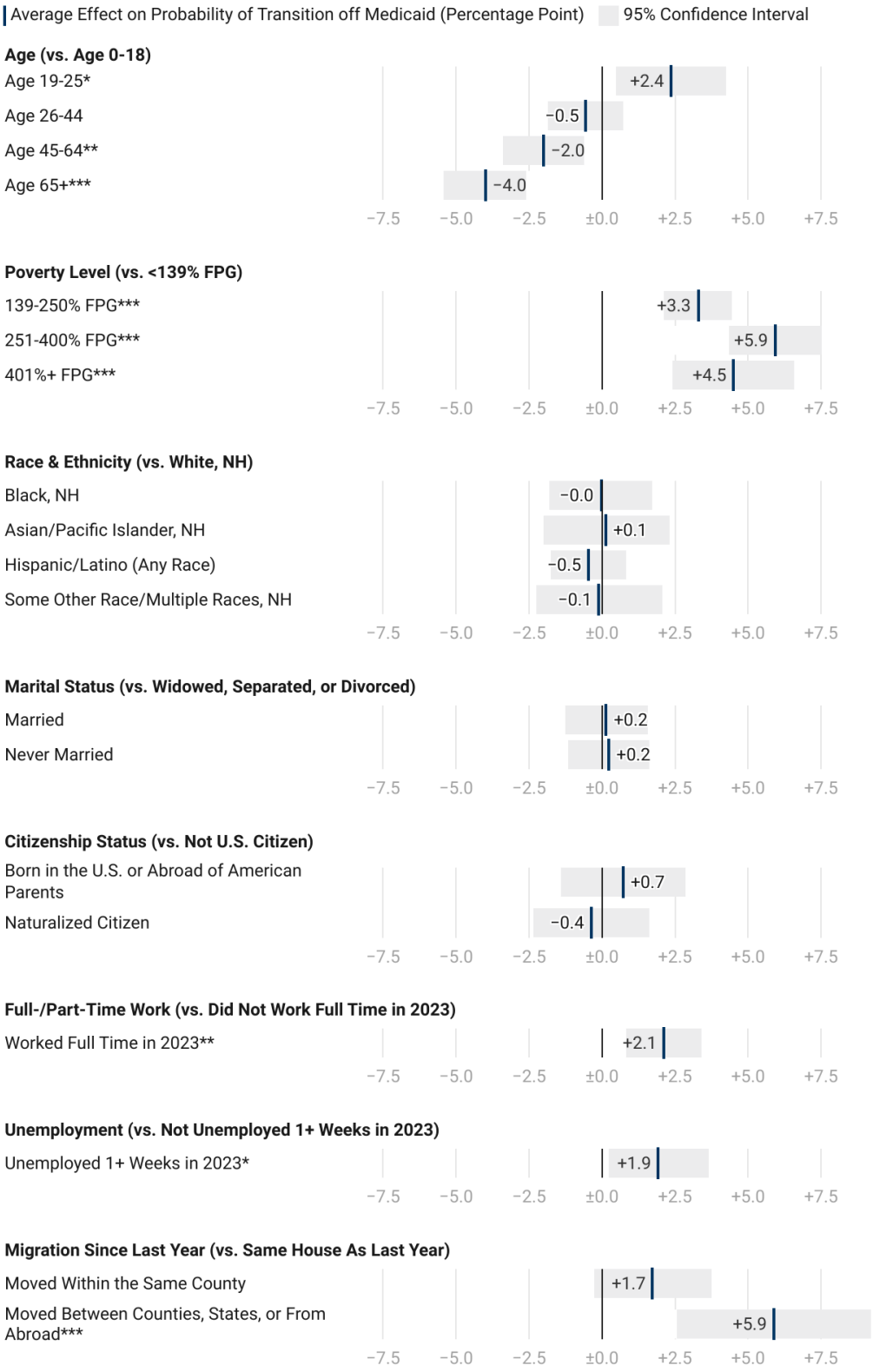
Several factors were associated with being **significantly more likely** to transition off Medicaid (**Figure 6**):

- Being a young adult (age 19-25) (compared to being a child [age 0-18]),
- Having incomes 139% FPG or higher (in the categories 139%-250% FPG, 251%-400% FPG, or 401%+ FPG categories) (compared to having income below 139% FPG),
- Working full time in 2023 (compared to not working full time in 2023 [i.e., working part time or not working]),
- Being unemployed one or more weeks in 2023 (compared to not being unemployed one or more weeks in 2023 [i.e., being unemployed fewer than one weeks or not working and not looking for work]), and
- Moving between counties, states, or from abroad in the past year (compared to living in the same house as last year).

Being middle aged or older (age 45-64 and age 65 or older) were both significantly associated with a lower likelihood of transition off Medicaid (compared to being age 0-18).

Race and ethnicity, marital status, and citizenship status were not significantly associated with either a higher or lower likelihood of transition off Medicaid.

Figure 6. Average Percentage Point Effect on Probability of Transition off Medicaid



Notes: Transition off Medicaid is defined as having self-reported Medicaid coverage at some point in 2023 and no self-reported Medicaid coverage at the time of interview in February – April 2024. FPG stands for Federal Poverty Guidelines. Income is measured at the family level, defined based on the SHADAC Health Insurance Unit definition. NH stands for Not Hispanic.
* = Significant at 95% confidence level, ** = Significant at 99% confidence level, *** = Significant at 99.9% confidence level
Model uses Current Population Survey (CPS) replicate weights to account for Current Population Survey Annual Social and Economic Supplement (CPS ASEC) complex survey design. Model includes state fixed effects.
N = 27,332; Model chi2 = 1655
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

Factors Associated with Transition to No Coverage (Uninsurance)

Looking specifically at those who transitioned off Medicaid, we found that there are groups of people with particular characteristics and/or circumstances that were more likely to transition off Medicaid to no health insurance coverage. In other words, there are factors we found that make it more likely for an individual to become uninsured after losing Medicaid coverage.

In our analysis, a transition to no coverage is defined as having self-reported Medicaid coverage at any point in 2023 and no form of self-reported comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service) at the time of interview in February – April 2024.

Key findings:

- Adults age 26-44 and age 45-64 were more likely to transition to no coverage (compared to children), all else equal;
- People with incomes below 139% FPG and of 139-250% FPG were more likely to transition to no coverage (compared to people with incomes above 400% FPG), all else equal;
- Hispanic/Latino people of any race and non-Hispanic people of some other race or multiple races were more likely to transition to no coverage (compared to non-Hispanic White people), all else equal;
- People with a high school level of education or less were more likely to transition to no coverage (compared to people with a BA or greater level of education), all else equal; and
- People who were not U.S. citizens were more likely to transition to no coverage (compared to people who were U.S. citizens), all else equal.

Descriptive Analysis of Transition to No Coverage (Uninsurance)

This section describes the factors that were significantly associated with higher or lower rates of transition off Medicaid coverage in 2023 to no coverage (uninsurance) at the time of interview in February – April 2024. The analysis compares rates of transition to no coverage for specific groups (e.g., by age groups, by race and ethnicity, etc.) to all of those who transitioned off Medicaid over this time.

In most cases, this means comparing the rate of transition to no coverage of a specific group to the overall rate of transition to no coverage (44.2%), though, in some cases, the reference population is a more specific group where the factor only applies to certain people (e.g., work and employment factors only pertain to people age 15 or older).

Among those who transitioned off Medicaid, the rate of transition to no coverage (uninsurance) was **significantly higher** among people who (**Figure 7**):

- Were Hispanic/Latino of any race,
- Were of some other race or multiple races (not Hispanic),
- Had never married,
- Had less than a high school level of education (among people aged 25+),
- Were not U.S. citizens,
- Had family income below 100% FPG,
- Had family income at or below 138% FPG,
- Had Medicaid coverage alone in 2023,
- Lived in the South region, and
- Lived in a state that had not implemented Medicaid expansion.

The rate of transition to no coverage (uninsurance) was **significantly lower** among people who (**Figure 7**):

- Were White (not Hispanic),
- Were married,
- Were divorced, separated, or widowed,
- Had a BA or higher level of education (among people age 25+),
- Were naturalized U.S. citizens,
- Lived in a family of two people,
- Had family incomes of 139% FPG or greater,
- Had family incomes of 251%-400% FPG,
- Had family incomes of 401% FPG or greater,

- Had Medicaid and some other coverage in 2023,
- Lived in the Northeast region, and
- Lived in a state with a state-based marketplace.

Age, sex, presence and number of children in the family, disability and work-affecting disability status, full-/partial-year Medicaid coverage (in 2023), work and unemployment, receipt of Supplemental Security Income, and migration status were not significantly associated with rates of transition to no coverage in our descriptive analysis.

Figure 7. Rates of Transition to No Coverage (Uninsurance) and Significant Percentage Point Difference from Total Transition Rates

Notes: The total reference rate of transition to no coverage (uninsurance) for all civilian noninstitutionalized people who transitioned off Medicaid is 44.2%. Transition to no coverage (uninsurance) is defined as having self-reported Medicaid coverage at some point in 2023 and no source of comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service) at the time of interview in February – April 2024. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Family is defined based on the SHADAC Health Insurance Unit definition, and income and poverty level are determined at the family level. FPG stands for Federal Poverty Guidelines. Region is defined using the Census Bureau Region definitions. Medicaid expansion status is defined based on a state's implementation of Medicaid expansion as of June 1, 2023.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

Multivariate Analysis of Transition to No Coverage (Uninsurance)

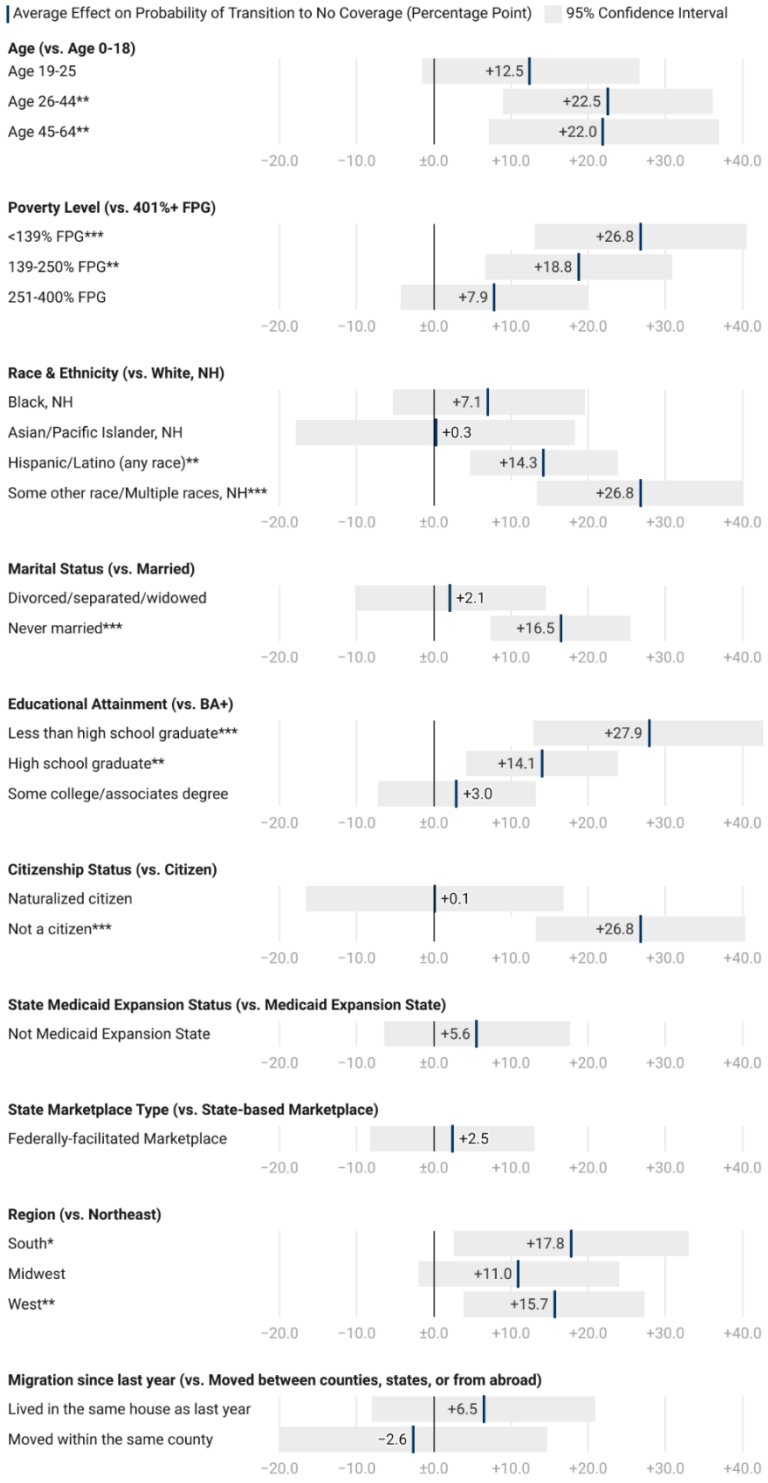
This section describes the factors that were independently positively or negatively associated with the likelihood of transition to no coverage (uninsurance) when simultaneously considering multiple factors, including individual characteristics, economic and employment circumstances, and other coverage factors.

Note: Because in our sample no respondents age 65 or older who transitioned off Medicaid transitioned to no coverage (all transitioned to Medicare), the model is limited to individuals younger than 65.

Several factors were associated with being **significantly more likely** to transition to no coverage (uninsurance), many of them quite substantially (**Figure 8**):

- Being age 26-44 (compared to being age 0-18),
- Being age 45-64 (compared to being age 0-18),
- Having a family income below 139% FPG (compared to 401%+ FPG),
- Having a family income of 139-250% FPG (compared to 401%+ FPG),
- Being a Hispanic/Latino person of any race (compared to being White, non-Hispanic),
- Being a non-Hispanic person of some other race or multiple races (compared to being White, non-Hispanic),
- Having never married (compared to being married),
- Having a less than high school level of education (compared to having a BA or higher level of education),
- Having a high school level of education (compared to having a BA or higher level of education),
- Not being a U.S. citizen (compared to being a U.S. citizen), and
- Living in the South or West region (compared to living in the Northeast region).

Figure 8. Average Percentage Point Effect on Probability of Transition to No Coverage (Uninsurance), Age 0-64



Notes: Transition to no coverage (uninsurance) is defined as having self-reported Medicaid coverage at some point in 2023 and no source of comprehensive health insurance coverage (this includes a report of coverage through the Indian Health Service) at the time of interview in February – April 2024. FPG stands for Federal Poverty Guidelines. Income is measured at the family level, defined based on the SHADAC Health Insurance Unit definition. NH stands for Not Hispanic.
* = Significant at 95% confidence level, ** = Significant at 99% confidence level, *** = Significant at 99.9% confidence level
Model uses Current Population Survey (CPS) replicate weights to account for Current Population Survey Annual Social and Economic Supplement (CPS ASEC) complex survey design.
N = 1,502; Model chi2 = 134.6
Universe: Civilian noninstitutionalized individuals aged 0-64 who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024. No age 65+ respondents in our sample transitioned to no coverage (all transitioned to Medicare), so this model was limited to people younger than 65.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

Factors Associated with Transitioning to Employer/Military Coverage

We found that there are groups of people with particular characteristics and/or circumstances that were more likely to transition off Medicaid to coverage obtained through an employer or connected to military service including Veteran's Administration (VA), CHAMPVA, and TRICARE.

In our analysis, transition to employer/military coverage is defined as having self-reported Medicaid at any point in 2023 and self-reported employer/military coverage (and no Medicaid coverage) at the time of interview in February – April 2024, either alone or in combination with other coverage.

Key findings:

- People who worked full time in 2023 were more likely to transition to employer/military coverage (compared to those who did not work full time), all else equal;
- People living in a state that expanded Medicaid were more likely to transition to employer/military coverage (compared to those living in a non-expansion state), all else equal;
- Adults ages 26-44, 45-64, and 65+ were less likely to transition to employer/military coverage (compared to children), all else equal;
- Hispanic/Latino people of any race and non-Hispanic people of some other race or multiple races were less likely to transition to employer/military coverage (compared to non-Hispanic, White people), all else equal;
- People with a high school graduate or lower level of education were less likely to transition to employer/military coverage (compared to people with a BA or greater), all else equal; and
- People who were not U.S. citizens were less likely to transition to employer/military coverage (compared to people who were U.S. citizens), all else equal.

Descriptive Analysis of Transition to Employer/Military Coverage

This section describes the factors that were significantly associated with higher or lower rates of transitioning off Medicaid coverage in 2023 to employer/military coverage at the time of interview in February – April 2024. The analysis compares rates of transition to employer/military coverage for specific groups (e.g., by age, by race and ethnicity, etc.) to all of those who transitioned off Medicaid over this time.

In most cases, this means comparing the rate of transition to employer/military coverage of a specific group to the overall rate of transition to employer/military coverage (38.9%), though, in some cases, the reference population is a more specific group where the factor only applies to a specific group of people (e.g., work and employment factors only pertain to people age 15 or older).

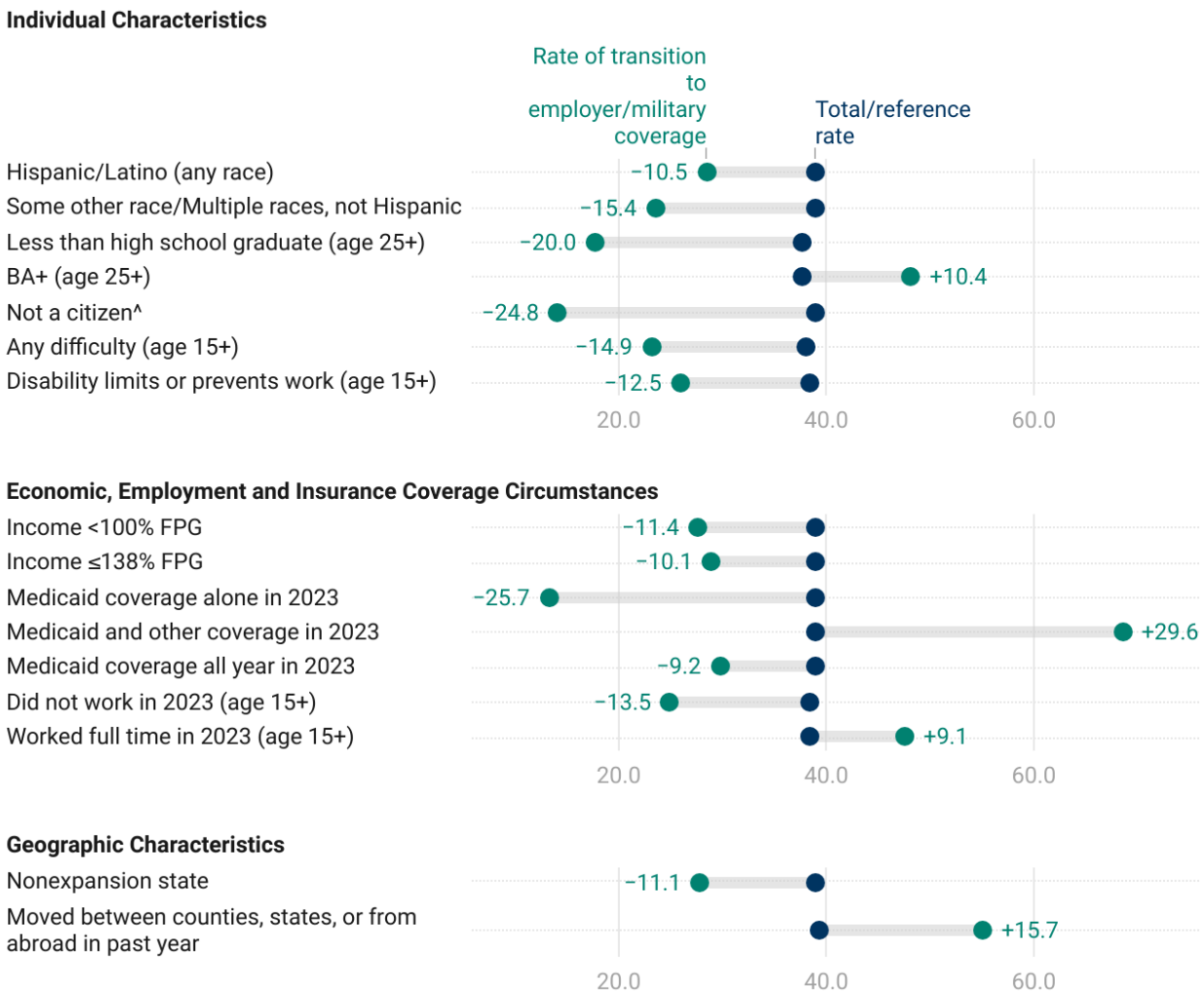
Among those who transitioned off Medicaid, the rate of transition to employer/military coverage was **significantly higher** among people who (**Figure 9**):

- Had a BA or higher level of education (among those age 25 or older),
- Had Medicaid coverage and other coverage in 2023,
- Worked full time in 2023 (among those age 25 or older), and
- Moved between counties, states, or from abroad in the past year.

Among those who transitioned off Medicaid, the rate of transition to employer/military coverage was **significantly lower** among people who (**Figure 9**):

- Were Hispanic/Latino of any race,
- Were of some other race or multiple races and not Hispanic,
- Had less than a high school level of education (among those age 25 or older),
- Were not a U.S. citizen,
- Had reported any difficulty (i.e., disability) (among those age 15 or older),
- Had reported any work-limiting disability (among those age 15 or older),
- Had family incomes below 100% FPG,
- Had family incomes at or below 138% FPG,
- Had Medicaid coverage alone in 2023,
- Had Medicaid coverage for all of 2023, and
- Lived in a Medicaid non-expansion state.

Figure 9: Rates of Transition to Employer/Military Coverage and Significant Percentage Point Difference from Total Transition Rates



^ Subgroup estimate is statistically unreliable (RSE>30%) and should be treated with caution

Notes: The total reference rate of transition to employer/military coverage for all civilian noninstitutionalized people who transitioned off Medicaid is 38.9%. Transition to employer/military coverage is defined as having self-reported Medicaid coverage at some point in 2023 and employer/military coverage at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Employer/Military coverage is defined as coverage obtained through an employer or connected to military service including Veteran's Administration (VA), CHAMPVA, and TRICARE. Family is defined based on the SHADAC Health Insurance Unit definition, and income and poverty level are determined at the family level. FPG stands for Federal Poverty Guidelines. State Medicaid expansion status (i.e., non-expansion state) is defined based on state implementation of Medicaid expansion as of June 1, 2023.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

In our descriptive analysis, the following factors were not significantly associated with rates of transition to employer/military coverage: age, sex, marital status, family size, presence of children in the family, receipt of Supplemental Security Income, region of residence, and state marketplace type.

Multivariate Analysis of Transition to Employer/Military Coverage

This section describes the factors that were independently positively or negatively associated with the likelihood of transition to employer/military coverage when simultaneously considering multiple factors, including individual characteristics, economic and employment circumstances, and other coverage factors.

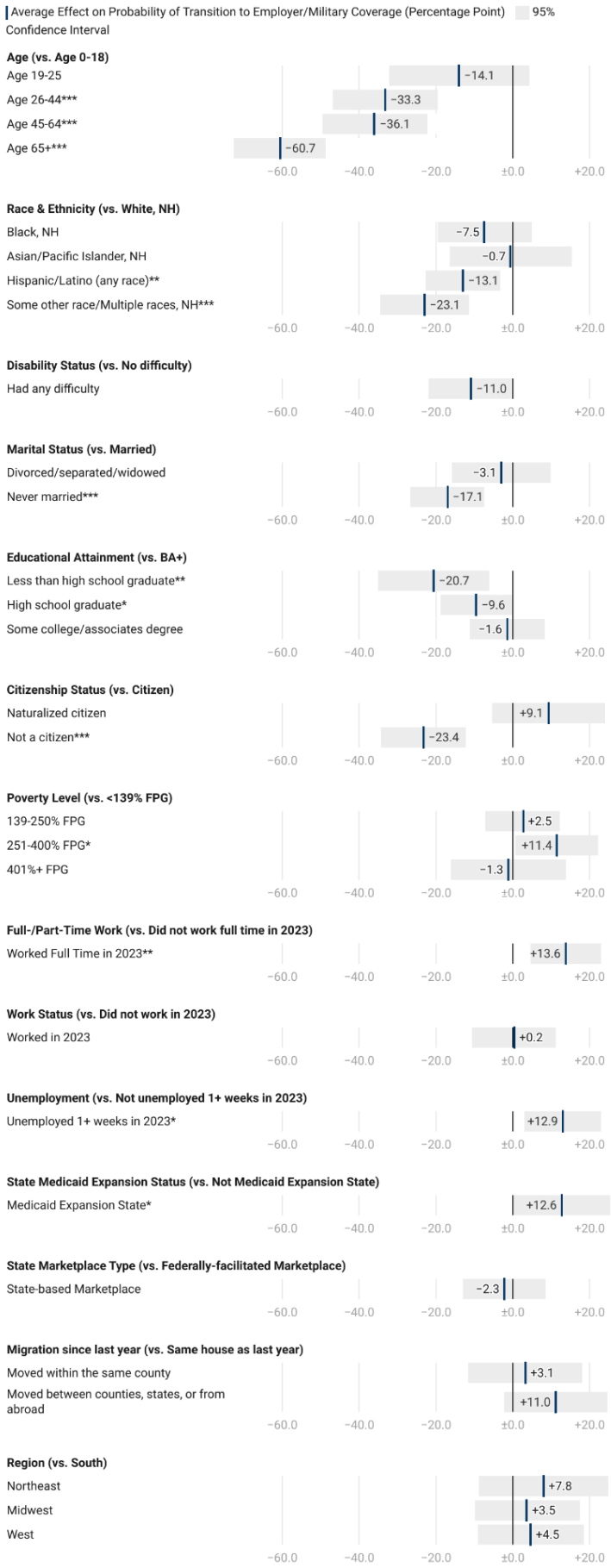
Several factors were significantly associated with being significantly **more likely** to transition to employer/military coverage (**Figure 10**):

- Having a family income of 241-400% FPG (compared to below 139% FPG),
- Working full time in 2023 (compared to not working full time in 2023),
- Being unemployed one or more weeks in 2023 (compared to not being unemployed one or more weeks in 2023), and
- Living in a state that expanded Medicaid (compared to living in a non-expansion state).

Several factors were significantly associated with being significantly **less likely** to transition to employer/military coverage, some quite substantially (**Figure 10**):

- Being age 26-44, 45-64, and 65 or older (compared to being age 0-18),
- Being Hispanic/Latino of any race (compared to being non-Hispanic White),
- Being of some other race or multiple races (compared to being non-Hispanic White),
- Having never married (compared to being married),
- Having a less than high school level of education or high school level of education (compared to having a BA or greater level of education), and
- Not being a U.S. citizen (compared to being a citizen born in the U.S. or abroad of American parents).

Figure 10. Average Percentage Point Effect on Probability of Transition to Employer/Military Coverage



Notes: Transition to employer/military coverage is defined as having self-reported Medicaid coverage at some point in 2023 and employer/military coverage at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. FPG stands for Federal Poverty Guidelines. Income is measured at the family level, defined based on the SHADAC Health Insurance Unit definition.
NH stands for Not Hispanic.
* = Significant at 95% confidence level, ** = Significant at 99% confidence level, *** = Significant at 99.9% confidence level
Model uses Current Population Survey (CPS) replicate weights to account for Current Population Survey Annual Social and Economic Supplement (CPS ASEC) complex survey design.
N = 1,589; Model chi2 = 123.6
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

Factors Associated with Transition to Direct Purchase Health Insurance

Looking specifically at those who transitioned off Medicaid, we found that there are groups of people with particular characteristics and/or circumstances that were more likely to transition off Medicaid to direct purchase health insurance (sometimes called non-group or individual coverage). This type of coverage is purchased from a private health insurance company directly (i.e., not from an employer, union, state government, or other organization), either through a state health insurance marketplace (subsidized or unsubsidized) or off-marketplace (through a broker or directly from the health insurer).

In our analysis, transition to direct purchase health insurance is defined as having self-reported Medicaid coverage at any point in 2023 and self-reported direct purchase health insurance (and no Medicaid coverage) at the time of interview in February– April 2024, either alone or in combination with other coverage.

Key findings:

- People with family incomes of 139-250% FPG, 251-400% FPG, and 401%+ FPG were more likely to transition to direct purchase health insurance (compared to people with family incomes below 139% FPG), all else equal; and
- People who were naturalized U.S. citizens or not U.S. citizens were less likely to transition to direct purchase health insurance (compared to people who were U.S. citizens), all else equal.

Descriptive Analysis of Transition to Direct Purchase Coverage

This section describes the factors that were significantly associated with higher or lower rates of transition off Medicaid coverage in 2023 to direct purchase health insurance at the time of interview in February – April 2024. The analysis compares rates of transition to direct purchase health insurance for specific groups (e.g., by age, by race and ethnicity, income, geographic regions, etc.) to all of those who transitioned off Medicaid over this time.

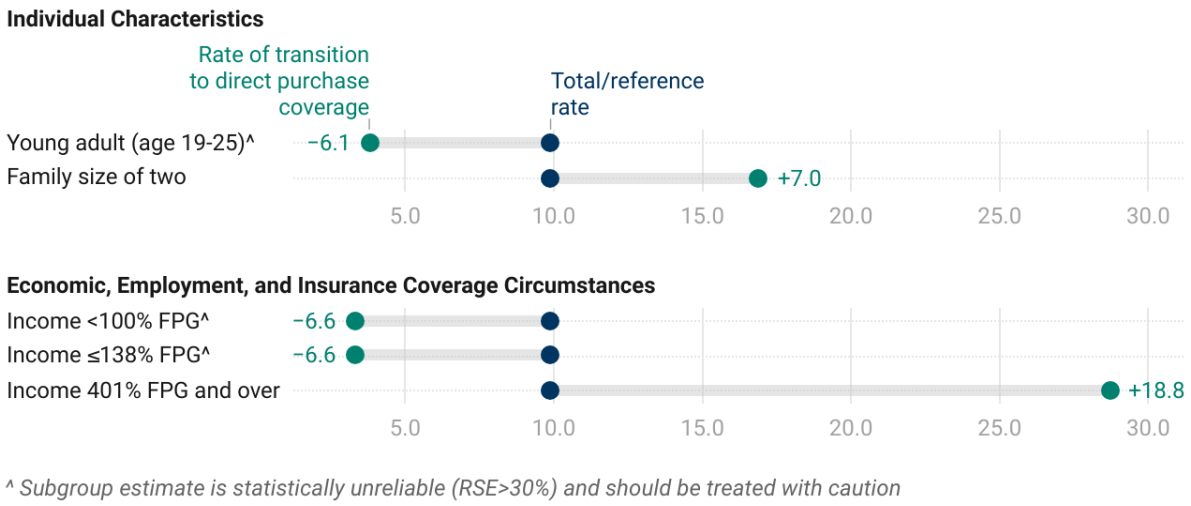
In most cases, this means comparing the rate of transition to direct purchase of a specific group to the overall rate of transition to direct purchase health insurance (9.9%), though, in some cases, the reference population is a more specific group where the factor only applies to a specific group of people (e.g., work and employment factors only pertain to people age 15 or older).

Among those who transitioned off Medicaid, the rate of transition to direct purchase health insurance was **significantly higher** among those (**Figure 11**):

- In a family size of two, and
- With family incomes of 401% FPG or greater.

The rate of transition to direct purchase insurance was significantly lower among young adults (age 19-25), and those with family incomes below 100% FPG or at or below 138% FPG (**Figure 9**).

Figure 11. Rates of Transition to Direct Purchase Health Insurance and Significant Percentage Point Difference from Total Transition Rates



^ Subgroup estimate is statistically unreliable (RSE>30%) and should be treated with caution

Notes: The total reference rate of transition to direct purchase health insurance for all civilian noninstitutionalized people who transitioned off Medicaid is 9.9%. Transition to direct purchase insurance is defined as having self-reported Medicaid coverage at some point in 2023 and direct purchase insurance at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Family is defined based on the SHADAC Health Insurance Unit definition, and income and poverty level are determined at the family level. FPG stands for Federal Poverty Guidelines.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

Our analysis did not find significant differences in rates of transition to direct purchase health insurance by the following factors: sex, race and ethnicity, marital status, educational attainment, citizenship status, presence and number of children in the family, disability and work-affecting disability statuses, 2023 Medicaid coverage alone/in-combination, 2023 Medicaid full-/partial-year coverage, work and employment, receipt of Supplemental Security Income, region, state Medicaid expansion status, state health insurance marketplace type, and migration status.

It is possible that there were true relationships between these factors and rates of transition to direct purchase coverage, but we did not observe them in our data, potentially because we lacked enough sample cases to statistically detect small differences. Our analysis does not say definitively that there were no relationships between these measured factors and transition to direct purchase coverage.

Multivariate Analysis of Transition to Direct Purchase Coverage

This section describes the factors that were independently positively or negatively associated with the likelihood of transition to direct purchase health insurance when simultaneously considering multiple factors, including individual characteristics, economic and employment circumstances, and other coverage factors. The model includes people of all ages.

In our multivariate models, the only factors consistently and significantly associated with being more likely to transition to direct purchase health insurance were income-related (**Figure 12**):

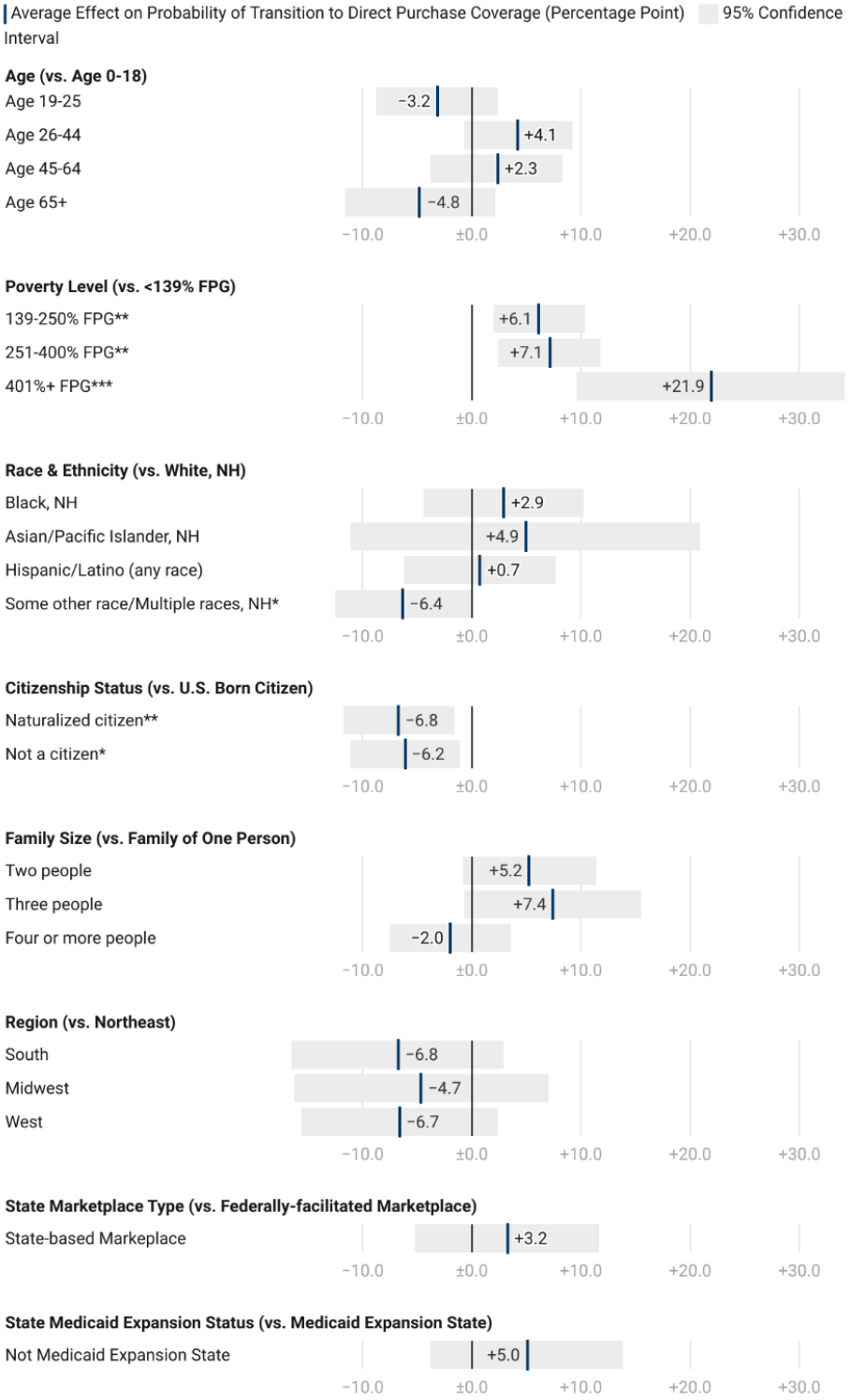
- Having income in the measured poverty level categories at or above 139% FPG (income eligible for direct purchase on the marketplace) compared to income below 139% FPG, and
- Specifically having a family income of 139%-250% FPG, of 251%-400% FPG, or family income greater than 400% FPG compared to below 139% FPG.

The only factors consistently and significantly associated with being less likely to transition to direct purchase health insurance were being (**Figure 12**):

- A naturalized U.S. citizen, or
- Not being a U.S. citizen,

both compared to being a U.S.-born citizen or citizen born abroad of American parents.

Figure 12. Average Percentage Point Effect on Probability of Transition to Direct Purchase Health Insurance



Notes: Transition to direct purchase health insurance is defined as having self-reported Medicaid coverage at some point in 2023 and direct purchase health insurance at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. FPG stands for Federal Poverty Guidelines. Income is measured at the family level, defined based on the SHADAC Health Insurance Unit definition.
NH stands for Not Hispanic.
* = Significant at 95% confidence level, ** = Significant at 99% confidence level, *** = Significant at 99.9% confidence level
Model uses Current Population Survey (CPS) replicate weights to account for Current Population Survey Annual Social and Economic Supplement (CPS ASEC) complex survey design.
N = 1,589; Model chi2 = 60.76
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

Factors Associated with Transition to Medicare Coverage

We found that there are groups of people with particular characteristics and/or circumstances that were more likely to transition off Medicaid to Medicare coverage. In our analysis, transition to Medicare coverage is defined as having self-reported Medicaid at any point in 2023 and self-reported Medicare coverage (and no Medicaid coverage) at the time of interview in February – April 2024, either alone or in combination with other coverage.

Key, significant findings from this section were:

- People who did not work in 2023 were more likely to transition to Medicare (compared to people who worked in 2023), all else equal; and
- Hispanic/Latino people of any race were less likely to transition to Medicare (compared to non-Hispanic White people), all else equal.

Descriptive Analysis of Transition to Medicare Coverage

This section describes the factors that were significantly associated with higher or lower rates of transition off Medicaid coverage in 2023 to Medicare coverage at the time of interview in February – April 2024. The analysis compares rates of transition to Medicare coverage for specific groups (e.g., by age, by race and ethnicity, etc.) to all of those who transitioned off Medicaid over this time.

In most cases, this means comparing the rate of transition to Medicare coverage of a specific group to the overall rate of transition to employer/military coverage (7.7%), though, in some cases, the reference population is a more specific group where the factor only applies to a specific group of people (e.g., work and employment factors only pertain to people age 15 or older).

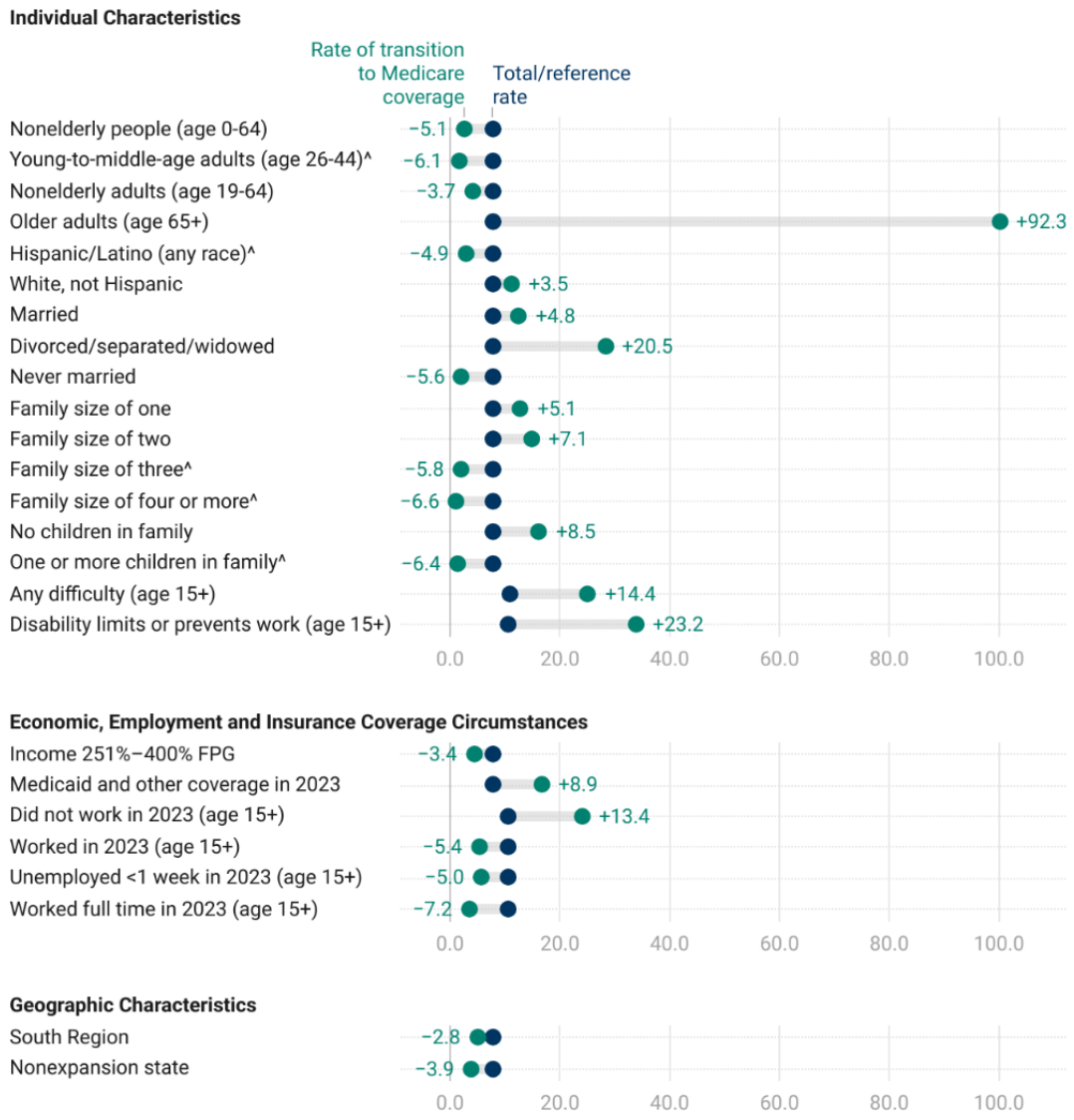
Among those who transitioned off Medicaid, the rate of transition to Medicare coverage was **significantly higher** among people who (**Figure 15**):

- Were older adults (age 65+),
- Were White and non-Hispanic,
- Were married,
- Were divorced, separated, or widowed,
- Lived in a family of one,
- Lived in a family of two,
- Had no children in their family (within the household),
- Had any difficulty (i.e., disability) (among those age 15 or older),
- Had a disability that limited or prevented work (among those age 15 or older),
- Had Medicaid in combination with other coverage in 2023, and
- Did not work in 2023 (among those age 15 or older).

Among those who transitioned off Medicaid, the rate of transition to Medicare coverage was **significantly lower** among people who (**Figure 15**):

- Were younger than age 65,
- Were younger-to-middle-aged adults (age 26-44),
- Were nonelderly adults (age 19-64),
- Were Hispanic/Latino of any race,
- Had never married,
- Lived in a family of three people,
- Lived in a family of four or more people,
- Had one or more children in their family (within the household),
- Had family incomes of 251%-400% FPG,
- Worked in 2023 (among those age 15 or older),
- Were unemployed for less than one week in 2023 (among those age 15 or older),
- Worked full time in 2023 (among those age 15 or older),
- Lived in the South region, and
- Lived in a state that had not implemented Medicaid expansion.

Figure 15: Rates of Transition to Medicare Coverage and Significant Percentage Point Difference from Total Transition Rates



^ Subgroup estimate is statistically unreliable (RSE>30%) and should be treated with caution

Notes: The total reference rate of transition to Medicare coverage for all civilian noninstitutionalized people who transitioned off Medicaid is 7.7%. Transition Medicare coverage is defined as having self-reported Medicaid coverage at some point in 2023 and Medicare coverage at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. Medicaid coverage is based on respondents' self-report of coverage in Medicaid, Medical Assistance, Children's Health Insurance Program (CHIP), and Basic Health Program names specific to the respondent's state. Family is defined based on the SHADAC Health Insurance Unit definition, and income and poverty level are determined at the family level. FPG stands for Federal Poverty Guidelines. State Medicaid expansion status (i.e., non-expansion state) is defined based on state implementation of Medicaid expansion as of June 1, 2023.

All differences are significant at the 95% level or more.
Universe: Civilian noninstitutionalized individuals who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) microdata via IPUMS CPS.

In our descriptive analysis, the following factors were not significantly associated with rates of transition to Medicare coverage: sex, educational attainment, full-/partial-year 2023 Medicaid coverage, and receipt of Supplemental Security Income in 2023.

Multivariate Analysis of Transition to Medicare Coverage

This section describes the factors that were independently positively or negatively associated with the likelihood of transition to Medicare coverage when simultaneously considering multiple factors, including individual characteristics, economic and employment circumstances, and other coverage factors.

Note: our multivariate analysis of is limited to those age 19-64. Among those who transitioned off Medicaid, no children (age 0-18) transitioned to Medicare and all older adults (age 65+) transitioned to Medicare. This lack of variation in our outcome of interest in these age groups prevents us from including these individuals in the model.

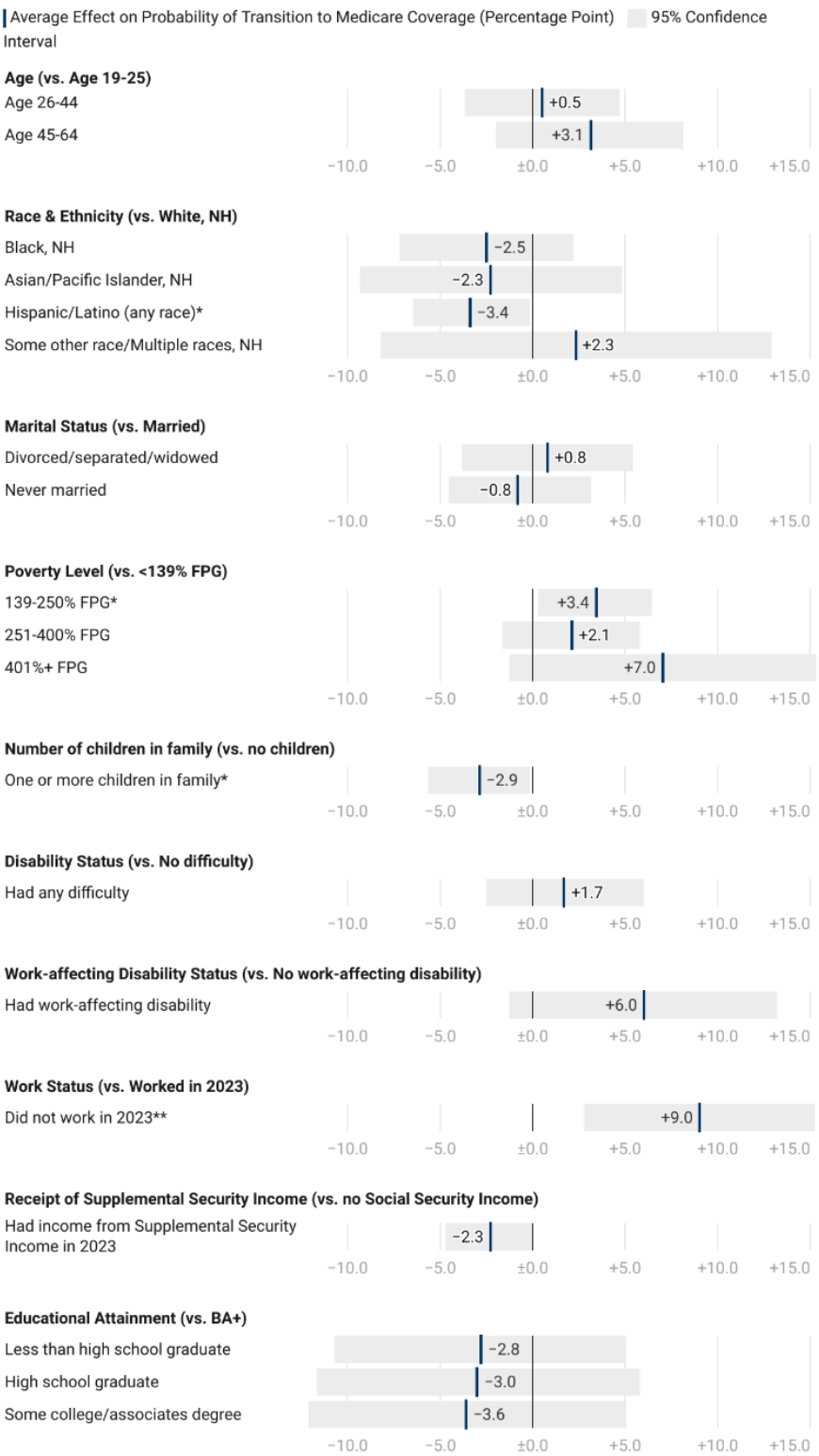
Two factors were significantly associated with being **more likely** to transition to Medicare coverage (**Figure 16**):

- Having a family income of 139%-250% FPG (compared to income below 139% FPG), and
- Not working in 2023 (compared to working in 2023).

Two factors were significantly associated with being **less likely** to transition to Medicare coverage (**Figure 16**):

- Being a Hispanic/Latino person of any race, and
- Having one or more children in the family (within the household).

Figure 16. Average Percentage Point Effect on Probability of Transition to Medicare Coverage, Age 19-64



Notes: Transition to Medicare coverage is defined as having self-reported Medicaid coverage at some point in 2023 and Medicare coverage at the time of interview in February – April 2024 along with no self-reported Medicaid coverage. FPG stands for Federal Poverty Guidelines. Income is measured at the family level, defined based on the SHADAC Health Insurance Unit definition. NH stands for Not Hispanic.
* = Significant at 95% confidence level, ** = Significant at 99% confidence level, *** = Significant at 99.9% confidence level
Model uses Current Population Survey (CPS) replicate weights to account for Current Population Survey Annual Social and Economic Supplement (CPS ASEC) complex survey design.
N = 930; Model chi2 = 80.05
Universe: Civilian noninstitutionalized individuals age 19-64 who reported having Medicaid coverage at any point in 2023 and no Medicaid coverage at the time of interview in February – April 2024.
Source: SHADAC analysis of 2024 CPS ASEC microdata via IPUMS CPS.

DISCUSSION

Transitions off Medicaid Coverage

While there is evidence from other studies to suggest that some eligible individuals lost Medicaid coverage,[13] our analysis shows that, with the exception of individuals who had recently moved, individuals with characteristics that made them likely to be eligible for Medicaid, were more likely to retain their coverage.

Our analysis suggests that people whose age and income characteristics made them more likely to be eligible for Medicaid were more likely to retain (or, if lost, to regain) their Medicaid coverage during the unwinding's first year. For example, our analysis shows that children (age 0-18) and adults age 65 and older were less likely to transition off Medicaid compared to people in other age groups, as were people with family incomes below 139% FPG compared to those with incomes above this level.

The factors associated with a higher likelihood of transition off Medicaid were tied either to greater ability to access other forms of health insurance coverage or to changes in age- or income-related eligibility. For example, people who worked full time in 2023 (and who, therefore, were more likely to have access to employer-sponsored coverage) were more likely to transition off Medicaid coverage. This was also the case for those unemployed but actively looking for work in 2023. These individuals could have been receiving Medicaid coverage while looking for work in 2023 and subsequently found employment (and employer-sponsored coverage) by the time of interview in spring 2024.

Similarly, people whose incomes made them likely ineligible for Medicaid coverage but potentially eligible for subsidized marketplace coverage (i.e., 139%-250% FPG and 251%-400% FPG) were also more likely to transition off Medicaid coverage, as were young adults (age 19-25) who may have aged out of Medicaid eligibility since first enrolling as children.

One potential point of concern was that inter-county/inter-state migration was one of the largest predictors of transition off Medicaid coverage. All else equal, Medicaid-covered people should have been able to retain their coverage (or reenroll in Medicaid coverage) after moving; this could suggest that recent migrants were more likely to be disenrolled from coverage because Medicaid agencies lacked current address or contact information, regardless of their eligibility, pointing to an administrative issue.

Transitions to Other Health Insurance Coverage

Our analysis shows that a majority of Medicaid enrollees who transitioned off Medicaid during the first year of the unwinding successfully transitioned to other forms of coverage, with most of these in the form of transitions to private coverage (i.e., employer/military or direct purchase health insurance). This is encouraging for those concerned about access to coverage for those who transitioned off Medicaid during the beginning of redeterminations.

However, it is still important to note that more than 40% of enrollees who transitioned off Medicaid became uninsured, and concerningly, the largest independent associations with this transition were related to former enrollees' poverty level, race and ethnicity, citizenship status, and educational attainment. These associations suggest that those who transitioned to uninsurance from Medicaid were some of those with the fewest political and socioeconomic advantages and who relied the most on Medicaid for coverage.

More positively, among those who transitioned off Medicaid coverage, children were substantially less likely to transition to uninsurance and more likely to transition to other forms of coverage compared to nonelderly adults.

Many states made efforts during the unwinding to smoothly transition those losing Medicaid coverage during redetermination to direct purchase health insurance, particularly subsidized marketplace coverage.[14] Our analysis shows that among those who transitioned off Medicaid, the main driver of successful transitions to direct purchase was having an income that was either eligible for subsidized coverage (i.e., 139%-400% FPG) or that was high enough to (likely) make unsubsidized direct purchase health insurance reasonably affordable (i.e., 401%+ FPG).

[13] Corallo B, Diana A, Tolbert J, Mudumala A, Rudowitz R. "Unwinding of Medicaid Continuous Enrollment: Key Themes from the Field," January 10, 2024. San Francisco, CA: KFF. Accessed February 17, 2025. https://www.kff.org/report-section/unwinding-of-medicaid-continuous-enrollment-key-themes-from-the-field-issue-brief.

[14] Corlette S, Levitis J, Straw T. "Secrets to a Successful Unwinding: Actions State-Based Marketplaces and Insurance Departments Can Take to Improve Coverage Transitions," February 24, 2023. Princeton, NJ: State Health & Value Strategies. Accessed February 17, 2025. https://www.shvs.org/secrets-to-a-successful-unwinding-actions-state-based-marketplaces-and-insurance-departments-can-take-to-improve-coverage-transitions.

DATA SOURCES AND METHODS

Data Source

This analysis relies on microdata from the U.S. Census Bureau and Bureau of Labor Statistics' Current Population Survey Annual Social and Economic Supplement (CPS ASEC) via IPUMS CPS.[15] The CPS is a household survey conducted each month by the U.S. Census Bureau for the Bureau of Labor Statistics to collect data on employment status, income, and health insurance, among other topics. The CPS collects health insurance coverage data through its ASEC survey in February, March, and April of each year. The CPS is representative of the U.S. civilian noninstitutionalized population nationally and of all states and D.C. The survey is conducted in person and over the phone.

More specifically, our analysis uses data from the 2024 CPS ASEC. The CPS asks respondents about their coverage in the previous calendar year (i.e., 2023) and about their coverage at the time of interview (i.e., February – April 2024). This allows us to observe individuals' coverage at two points in time. It also allows us to determine who had Medicaid coverage in 2023 and no Medicaid coverage at the time of interview in 2024 along with any other coverage they held (or did not hold) at the time of interview.

As shown in Table 1, there were 144,265 respondents in our 2024 CPS ASEC dataset. Of those, 27,507 had Medicaid coverage in 2023, and of those, 1,591 transitioned off Medicaid by the time of interview in 2024.

Table 1. Sample and Subsample Sizes in Analytic Dataset

Sample / Subsample	Sample Size
2024 CPS ASEC	144,265
2023 Medicaid Coverage	27,507
No Medicaid Coverage at Time of 2024 Interview	1,591

Notes: Sample size counts represent persons. Indented sample/subsample descriptions indicate a subsample within the sample described in the line above.
Source: SHADAC analysis of 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) via IPUMS CPS.

Methods

We used Stata v18 for this analysis. We used Stata's SVY package to account for the CPS' complex survey design. We produced weighted descriptive and multivariate estimates of transitions off Medicaid and transitions to other coverage using the 2024 person-level ASEC survey weights and CPS' replicate weights, which produce more accurate estimated standard errors than other weighting approaches while still accounting for the CPS' complex survey design.

Levels of statistical significance are indicated using one asterisk (*) for a 95% confidence level, two asterisks (**) for a 99% confidence level, and three asterisks (***) for a 99.9% confidence level. Changes and differences discussed in this report are statistically significant at the 95% confidence level or greater level of significance.

Descriptive Analysis

We conducted two-sided t-tests to assess statistical significance when evaluating differences between populations. In cases where comparisons were made between two non-independent populations (e.g., between a population subgroup and the total population), we used a modified t-test that accounts for the variation in the total population contributed by the subgroup.

Multivariate Analysis

We conducted multivariate analysis using logistic regression models within Stata's SVY package and using 2024 person-level ASEC survey weights and CPS replicate weights. Average marginal effects were computed using Stata's MARGINS command and CPS replicate weights.

[15] Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Megan Schouweiler, and Michael Westberry. IPUMS CPS: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2024. doi:10.18128/D030.V12.0

We ran multiple models including different combinations of theoretically relevant independent variables. We chose final model specifications iteratively, striking a balance between including the largest number of theoretically important independent variables and only including variables that improved overall model fit and did not introduce problems with multiple collinearity. This represented a pragmatic approach in balancing methodological ideals with the limitations of our relatively small sample size.

A plausible impact of this approach on our analysis is that our results may show that our outcomes of interest are significantly associated with a smaller number of discrete, independent variables, when in truth, there may be a larger, more complex set of interrelated factors that are significantly associated with our outcomes of interest. With our relatively limited sample size, we simply lack the statistical power to disentangle these more complicated associations. Thus, we chose an approach that may be a more simplified representation of the true dynamics at play.

LIMITATIONS

Though we made every effort in this analysis to create reliable, credible estimates, it is important to consider the known limitations described below when interpreting the results we present.

Nonresponse Bias

Beginning with the 2020 CPS ASEC, the first ASEC survey collected during the COVID-19 pandemic, the CPS ASEC has had notably low and declining response rates (67.2% in March 2024 compared to 81.5% in March 2019) and measurable levels of nonresponse bias.

Though a Census blog post on response rates points out that low response rates in and of themselves are not inherently problematic,[16] issues can arise when certain types of respondents are overrepresented in the data as compared to nonrespondents in a manner that cannot be adjusted for using their observable characteristics (for example, by weighting the data). This can lead survey estimates to be less than representative of the target population. For example, starting in 2020, the CPS began to see more respondents with reported higher earnings than in years prior, and Census researchers have found that differences in median earnings between respondents and nonrespondents were statistically significant in each year since 2019 (2020–2024).

Self-Reported Data

Our analysis relies on the information that survey respondents report, which makes these data subject to a number of unavoidable biases inherent to all survey data, including:

- Recall bias (respondents' ability to accurately recall information about the past),
- Social desirability bias (respondents' tendency to answer questions in a way that will be viewed favorably), and
- Respondents' understanding (or lack thereof) of the subjects about which they are being asked.

For this reason, survey data typically portray a less accurate representation of true reality than measures based on administrative data. However, survey data can still accurately represent perceived realities at the population level and are often the best source of information about measures unavailable through administrative sources (e.g., uninsurance).

We considered a variety of ways to define the target population and their unwinding transitions, with some options including longer look-back periods or more refined reference periods. Ultimately, we chose a definition that gave us confidence in individuals' ability to self-report and less concerned about how respondent biases might impact the results. We defined people who transitioned off Medicaid as those people who reported having Medicaid coverage at any point in the 2023 calendar year and no Medicaid coverage when they were interviewed in February – April 2024. This definition includes in the denominator all people who knew they had Medicaid coverage before the beginning of the unwinding and then observes their transition outcomes approximately one year after the first redeterminations began. Importantly, our definition's use of respondents' report of their coverage at the time of interview in February – April 2024 eliminates the potential recall bias that would have resulted from using a post unwinding coverage estimate based a report of insurance coverage in the respondent's past (e.g., Medicaid coverage in the last year).

[16] Bee A, Rothbaum J. "Using Administrative Data to Evaluate Nonresponse Bias in the 2024 Current Population Survey Annual Social and Economic Supplement," September 10, 2024. Suitland, MD: U.S. Census Bureau. Accessed February 17, 2025. https://www.census.gov/newsroom/blogs/research-matters/2024/09/administrative-data-nonresponse-bias-cps-asec.html.

The Medicaid Undercount

The most significant limitation related to self-reported data for this analysis is the Medicaid undercount, which refers to the long-running tendency for survey data to undercount the number of people with Medicaid coverage compared to counts from administrative data.

Studies of the Medicaid undercount often either (1) link administrative coverage records to survey responses to observe if respondents who were enrolled in Medicaid according to administrative data reported having Medicaid when surveyed, or (2) administer survey instruments to respondents whose coverage type is known from administrative records. Across different population surveys, studies of the undercount have found it to be caused primarily by measurement error, which is to say, by those with Medicaid coverage incorrectly reporting their coverage when surveyed, either misstating that they have a different form of coverage or that they are uninsured ("under-reporting") and by non-enrollees incorrectly reporting that they have Medicaid ("over-reporting").

The magnitude of misreporting and the undercount vary by state, which is likely linked to differing characteristics of enrollees, state residents, and state program characteristics such as Medicaid expansion status and presence of a Basic Health Program (BHP).[17,18,19] Evidence shows that, among Medicaid enrollees, children, those outside the labor force, and those with lower incomes generally have lower levels of under-reporting, while adults, those currently employed, non-citizens, and those with higher incomes tend to have higher levels of under-reporting.

There is relatively little research on rates of misreporting of Medicaid coverage that has been conducted after implementation of the Affordable Care Act and that specifically evaluates the CPS ASEC health insurance coverage module implemented in the 2014 survey (that has been in use ever since). The most recent study conducted with the updated CPS coverage module showed that, as of 2015:

- Rates of under-reporting of public coverage (i.e., Medicaid, CHIP, and BHP [not Medicare]) ranged from 16.8%–19.2% (higher when respondents with BHP coverage were included),
- Rates of over-reporting ranged from 1.8%–2.1% (lower when including BHP-covered respondents), and that the total CPS Medicaid undercount ranged from 4.3%–5.7% (higher when including BHP-covered respondents).[20]

The same study compared rates of misreporting of public coverage in the CPS to those in the American Community Survey (ACS), another widely used federal survey that asks respondents about their health insurance coverage. The study found that rates of under-reporting were similar between the ACS and CPS when excluding BHP respondents, and lower in the CPS when BHP respondents were included (19.2% vs. 22.0%). Rates of over-reporting were lower in the CPS compared to the ACS both when BHP respondents were excluded (2.1% vs. 8.6%) and when they were included (1.8% vs. 7.0%). Additionally, the total undercount was higher in the CPS than in the ACS both when BHP respondents were excluded (4.3% vs. 2.9%) and when they were included (5.7% vs. 5.6%). However, the ACS' undercount was smaller not because of lower total rates of public coverage misreporting, but rather because higher rates of over-reporting of public coverage more completely offset similar levels of under-reporting.

[17] Boudreaux MH, Call KT, Turner J, Fried B, O'Hara B. Measurement error in public health insurance reporting in the American Community Survey: evidence from record linkage. Health Services Research. 2015 Dec;50(6):1973-95. doi:10.1111/1475-6773.12308

[18] Boudreaux M, Noon JM, Fried B, Pascale J. Medicaid expansion and the Medicaid undercount in the American Community Survey. Health Services Research. 2019 Dec;54(6):1263-72. doi:10.1111/1475-6773.13213

[19] Call KT, Fertig AR, Pascale J. Factors associated with accurate reporting of public and private health insurance type. Health Services Research. 2022 Aug;57(4):930-43. doi:10.1111/1475-6773.13874

[20] Pascale J, Fertig A, Call K. Validation of two federal health insurance survey modules after Affordable Care Act implementation. Journal of Official Statistics. 2019 Jun 1;35(2):409-60. doi:10.2478/jos-2019-0019

Importantly, the Medicaid undercount grew considerably during the Medicaid continuous coverage period, likely in large part because of increased under-reporting of coverage. This increase in under-reporting may have been caused by Medicaid enrollees not understanding that they remained covered despite not going through any regular process to redetermine their eligibility.[21,22,23,24]

This problem of Medicaid enrollees' lack of accurate knowledge of their coverage during the pre-unwinding continuous coverage period creates a meaningful challenge to the external validity of this analysis. More specifically, this is because the group of CPS ASEC respondents who reported having Medicaid coverage in 2023 most likely do not adequately represent the total population of people with Medicaid coverage in 2023 according to administrative records. Rather, the group of CPS ASEC respondents who reported having Medicaid coverage in 2023 are representative of the population of people who *affirmatively knew they had Medicaid coverage in 2023*.

It follows that our analysis of transitions off Medicaid and transitions to other coverage is most likely only representative of this specific group rather than the total population of Medicaid enrollees observed in administrative data. For this reason, our analysis likely presents an underestimate of the true share of 2023 enrollees who transitioned off Medicaid as of February - April 2024. In some respects, this may not be wholly undesirable, as the group of people actively engaged with their Medicaid coverage enough to affirmatively recognize their coverage status may also be more significantly impacted by coverage disruptions than those not actively using or otherwise engaged with their coverage.

Availability of Relevant Data in the CPS ASEC

Compared to analyses of Medicaid churn and coverage transitions that use other data sources, our analysis has some notable limitations, particularly related to how our data source allows us to observe individuals and their coverage across time and its lack of information about the impacts of coverage transitions on use of services, affordability, and health outcomes.

In our analysis using the CPS ASEC, we observe individuals' characteristics at only two points in time, and we can only observe coverage at the level of the full calendar year in 2023, seeing if individuals reported having a specific type of coverage for a full calendar year, part of a calendar year, or none of a calendar year. This limitation prevents us from observing, for example, if individuals had a gap in coverage, and, if so, how long that gap was; if they transitioned between coverage types during the year; if they lost Medicaid and subsequently regained Medicaid coverage and, if so, if they had other coverage during that gap. It also prevents us from understanding if the sub-annual sequence of certain life events (e.g., change in employment, change in income, birth of a child, change in family size) is related to transitions off Medicaid or transitions to other coverage.

Further, our data source lacks important information that could help us understand how transitions off Medicaid and transitions to other coverage may influence important outcomes, including use of health care services, health care affordability or financial hardship, and relevant health outcomes. Observing rates of transitions off Medicaid and transitions to other coverage and the factors affecting those outcomes is just a first step in our understanding of how these processes ultimately impact health and wellbeing.

[21] McIntyre A, Smith RB, Sommers BD. Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility. JAMA Health Forum 2024 Apr 5 (Vol. 5, No. 4, pp. e240430-e240430). American Medical Association. doi:10.1001/jamahealthforum.2024.0430

[22] Hest R. "Tracking the Medicaid Undercount in the 2021 ACS Coverage Data," January 2023. Minneapolis, MN: State Health Access Data Assistance Center. Accessed October 31, 2024. https://www.shadac.org/publications/medicaid-undercount-2021-ACS.

[23] Hest R, Lukanen E, Blewett L. "Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage," December 2022. Minneapolis, MN: State Health Access Data Assistance Center. Accessed October 31, 2024. https://www.shadac.org/publications/medicaid-undercount-doubles-20-21.

[24] Ding D, Sommers BD, Glied SA. Unwinding And The Medicaid Undercount: Millions Enrolled In Medicaid During The Pandemic Thought They Were Uninsured: Study examines the expiration of the Medicaid continuous coverage provision and improving the accuracy of Medicaid enrollment assessments. Health Affairs. 2024 May 1;43(5):725-31. doi:10.1377/hlthaff.2023.01069

Sample Size

In addition, the 2024 CPS ASEC sample has a relatively small sample size. As shown in Table 1, there were only 27,507 persons in our sample who reported Medicaid coverage in 2023 (our effective sample for analysis of transitions off Medicaid) and only 1,591 who reported to have transitioned off Medicaid in 2024 (our effective sample for analysis of transitions to other types of coverage and uninsurance).

In our descriptive analysis, this small sample size creates challenges in producing estimates for smaller subpopulations and effectively limits our analysis to being able to statistically detect only large changes or differences.

In our multivariate analysis, this small sample size limits our flexibility to include the full scope of theoretically important variables in our models, particularly when those variables are highly correlated with other model variables.

For example, level of education and age are correlated, both for the mechanical reason that each additional year of schooling requires an additional year of age and because CPS' question about education attainment is only asked of those respondents at least 15 years of age, making nonresponse to that question directly correlated with being a child. Similar problems exist for age and marital status and for correlated variables related to disability and work and employment.

With our relatively small sample size, we simply do not observe enough variation in transitions off Medicaid and other coverage transitions across these correlated independent variables. This means that our multivariate models of transitions off Medicaid and coverage transitions are most likely incomplete representations of the real-world processes that generate these outcomes and implies some degree of bias in our model outputs (e.g., marginal effects, levels of statistical significance).

APPENDIX: VARIABLE DEFINITIONS

This section provides definitions of variables used in the analysis.

Health Insurance Coverage

The CPS ASEC asks respondents if they had a source of comprehensive health insurance coverage at any point during the previous calendar year and if they had this type of coverage at the time of interview. Respondents can report multiple sources of coverage, though these sources of coverage are not necessarily held simultaneously (except if held at the time of interview).

Medicaid Coverage

In its questions to survey respondents, the CPS ASEC defines Medicaid coverage as "government assistance that pays for health care" and uses both the federal Medicaid program name along with names specific to the respondent's state Medicaid, CHIP, and BHP programs. We use the term "Medicaid" in our analysis to refer to the types of coverage included in this definition.

Employer/Military Coverage

Employer/Military coverage includes individuals reporting employment-based coverage or coverage associated with military services including Veteran's Administration (VA), CHAMPVA, and TRICARE.

Direct Purchase Coverage

Direct purchase health insurance includes anyone who reported direct purchase coverage, including coverage purchased through a marketplace (subsidized or unsubsidized). Direct purchase coverage is also referred to as non-group or individual coverage.

Uninsurance / No Coverage

Respondents who reported no source of comprehensive health insurance coverage are considered uninsured. This includes a report of coverage through the Indian Health Service.

Coverage Transitions

In this report, we use the phrase "transition off Medicaid" to describe the act of leaving Medicaid or CHIP coverage for any other source of coverage or for uninsurance between 2023 and the time of the 2024 interview. In our dataset, those who self-reported having Medicaid or CHIP coverage at any point during 2023 and then self-reported having no Medicaid or CHIP coverage at the time of 2024 interview (conducted February – April 2024) are classified as having transitioned off Medicaid.

Transitions to other forms of coverage in 2024 were measured among those who reported having Medicaid coverage at any point in 2023 and having no Medicaid at the time of 2024 interview.

Poverty Level and Family

Poverty level is defined as a ratio of respondent's previous-year, family income to their individual federal poverty guideline (FPG) based on the U.S. Department of Health and Human Services FPG for their state of residence, family size, and year of interview.[25] The FPGs are used to determine eligibility for health coverage programs such as Medicaid, CHIP, and marketplace tax credits.

Family is defined using SHADAC's Health Insurance Unit (HIU), which defines family in federal survey data in a manner that generally aligns with the way a "family" is defined by private and public insurance coverage programs.[26] This family definition is used to determine family size in the data and to count family income by summing person-level, pre-tax income within each HIU-defined family.

[25] "Poverty Guidelines," January 2024. Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation. Accessed October 14, 2024. https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

[26] Lukanen E, Hest R, Turner K. "Defining Family for Studies of Health Insurance Coverage," July 2023. Minneapolis, MN: State Health Access Data Assistance Center. Accessed October 31, 2024. https://www.shadac.org/sites/default/files/publications/2023%20Defining%20families%20brief.pdf.

Disability Status

A respondent is considered to have a disability if they answered affirmatively to one or more of the CPS' six physical or cognitive difficulty questions, which are only asked of respondents aged 15 or older at the time of interview.[27] Respondents are asked whether or not they are or have:

- "Deaf or has serious difficulty hearing,"
- "Blind or has serious difficulty seeing even with corrective lenses,"
- "Cognitive difficulties (such as remembering, concentrating, or making decisions) because of a physical, mental, or emotional condition,"
- "Serious difficulty walking or climbing stairs,"
- "Any physical, mental, or emotional condition that makes it difficult or impossible to perform basic activities outside the home alone," and
- "Any physical or mental health condition that makes it difficult for them to take care of their own personal needs, such as bathing, dressing, or getting around inside the home."

Disability That Affects Work

Respondents age 15 and older are asked if they have "a health problem or a disability which prevents him/her from working or which limits the kind or amount of work" they can do. Respondents who responded affirmatively to this question were considered to have a disability that affects their ability to work.

Receipt of Supplemental Security Income

Respondents age 15 and older are asked how much pre-tax income they received from Supplemental Security Income (SSI) in the previous calendar year, if any. Respondents who reported receipt of any income from SSI are classified as having received SSI.

Work and Employment

Respondents age 15 and older were asked how many weeks they worked for profit, pay, or as an unpaid family worker during the previous calendar year, if any. Respondents who reported working at least one week were considered to have worked, and vice versa.

Respondents age 15 and older who worked in the previous calendar year were asked how many weeks they looked for work or were on layoff during the previous calendar year. Respondents who were unemployed one or more weeks were considered to have any unemployment in the previous calendar year, and those who were unemployed fewer than one week were considered to have no unemployment.

Respondents age 15 and older were asked whether they worked full time or part time when they were employed, with full-time work defined as thirty-five hours a week or more when working.

Family Size

Family size is calculated by counting the number of people in SHADAC's HIU-defined family within the household, as discussed previously.

Children in Family

The number of children in the family is calculated by counting the number of people younger than age 19 in the HIU family within the household. The number of young children in the household is calculated by counting the number of people younger than age three in the HIU family within the household.

[27] "DIFFANY: Any Difficulty." Minneapolis, MN: IPUMS CPS. Accessed October 31, 2024. https://cps.ipums.org/cps-action/variables/DIFFANY.

Region

Region is defined based on the Census region where the respondent's housing unit was located (as of 2024):

- **Northeast Region:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Pennsylvania
- **Midwest Region:** Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
- **South Region:** Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, Texas
- **West Region:** Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, Alaska, California, Hawaii, Oregon, Washington

State Medicaid Expansion Status

Medicaid expansion state status is defined based on which state the respondent's housing unit was in (as of 2024) and the status of that state's implementation of Medicaid expansion as of June 1, 2023:

- **Non-Expansion States:** Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Wyoming
- **Expansion States:** Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia

State Marketplace Type

State marketplace type is defined based on which state the respondent's housing unit was in (as of 2024) and that state's marketplace type as of 2023[28]:

- **State-Based Marketplace States:** California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, Washington
- **Federally-Facilitated Marketplace States:** Alaska, Alabama, Arkansas, Arizona, Delaware, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Louisiana, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming

Migration Status

Migration status is defined using respondents' 2024 responses to the ASEC's question about migration during the previous year, whether the respondent was living in the same house, or if in a different house, if they had moved within the county, within the state, between states, or from abroad.

[28] "Marketplace 2023 Open Enrollment Period Report: National Snapshot #3," January 11, 2023. Washington, D.C.: Centers for Medicare and Medicaid Services. Accessed October 31, 2024. https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-national-snapshot-3.