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Continuous Medicaid coverage during the COVID-19 public health emergency reduced churning, but did not eliminate it

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Abstract

Preserving insurance coverage in the wake of pandemic-related job loss was a priority in early 2020. To this end, the Families First Coronavirus Response Act implemented a continuous coverage policy in Medicaid to shore up access to health insurance. Prior to the pandemic, Medicaid enrollees experienced frequent coverage disruptions, known as “churning.” The effect of the continuous coverage policy on churning during the COVID-19 public health emergency (PHE) is unknown. We performed a difference-in-differences analysis of nonelderly Medicaid enrollees using longitudinal national survey data to compare a 2019–2020 cohort exposed to the policy with a control cohort in 2018–2019. We found that the policy led to reduced transitions to uninsurance among adults, although not among children. The policy prevented over 300 000 transitions to uninsurance each month. However, disenrollment from Medicaid persisted at a low rate, despite the continuous coverage policy. As the PHE unwinds, policymakers should consider long-term continuous coverage policies to minimize churning in Medicaid.

Keywords

Medicaid; insurance coverage; insurance churning; COVID-19 public health emergency

Introduction

The economic consequences of the early COVID-19 pandemic destabilized health insurance coverage for many Americans. Between 1.6 and 3.3 million people lost employer-sponsored

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Conflicts of interest

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Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

health insurance due to job loss in 2020, although initial pre-dictions were even bleaker.[1,2] Many of the newly unemployed became eligible for Medicaid.

The Families First Coronavirus Response Act (FFCRA) was passed by Congress in 2020 to address the state budgetary pressures that occurred with increasing Medicaid enrollment and to shore up insurance coverage at a time of employment volatility. The legislation offered states a 6.2-percentage-point increase in federal Medicaid matching funds if they implemented a continuous coverage policy for Medicaid enrollees. All states chose to participate. The policy required states to allow anyone validly enrolled by March 18, 2020, to remain on Medicaid for the duration of the public health emergency (PHE), despite almost any change in income or family circumstances that would otherwise make them ineligible. The FFCRA specified that only an enrollee's voluntary request or move out of state could trigger a disenrollment.[3]

Health insurance transitions—also known as "churning"—are of particular concern during a pandemic, as both losing and changing coverage lead to delayed and foregone appropriate care.[4-6] These risks are heightened for low-income people, who face difficulty paying for care out of pocket and navigating new provider networks.[4] Prior to the pandemic, it was estimated that 14%–25% of adult Medicaid enrollees experienced a churning event each year,[4,7] with children also likely to have fragmented coverage over time.[8-10] Churning events are more common in states that have not opted to expand Medicaid eligibility under the Affordable Care Act (ACA).[7]

Since the continuous coverage policy was implemented, Medicaid enrollment has grown dramatically after years of stability, increasing from 71 million enrollees in March 2020 to 91 million in September 2022.[11] Evaluations of administrative data from a limited number of states have suggested that much of the early pandemic growth was due to the continuous coverage policy preventing most Medicaid disenrollment.[12,13] This aligns with evidence that enrollment growth has outpaced the growth of new applications.[5] Studies of Medicaid churning prior to the pandemic have found that historically marginalized groups experience both different churning rates and different responses to policies that address churning.[7,9,14,15] However, an analysis of FFCRA's continuous coverage policy on national churning rates and rates of churning in historically marginalized groups has not been performed, which may be important given at least 1 early report suggesting that not all states adhered to the continuous coverage provision.[16] As the PHE draws to a close, several states are implementing measures that would expand continuous coverage in specific populations,[17-19] making an understanding of the effects of such policies timely. We used nationally representative, longitudinal survey data to evaluate the effects of the FFCRA's continuous coverage policy on churning in the Medicaid program in the first year of the COVID-19 pandemic.

Data and methods

Data and study sample

We used publicly available data from the Medical Expenditure Panel Survey—Household Component (MEPS-HC) from the years 2018 to 2020, which captures monthly health

insurance enrollment status along with other important sociodemographic and health care utilization data. We used the MEPS-HC longitudinal data files, which follows respondents for 24 months; our sample is composed of 2 mutually exclusive cohorts: the 2018–2019 cohort, and the 2019–2020 cohort. Our study population was restricted to nondisabled, nonelderly adults with ages 19 to 64 years and non-disabled children ages 18 years and younger. The Department of Population Medicine institutional review board (IRB) reviewed our study protocol and deemed it not human subjects research.

We restricted our sample to respondents who reported Medicaid coverage in 1 of the first 3 months of the first year of data collection for the cohort (ie, January to March 2018 for the control group and January to March 2019 for the treatment group). This approach helps avoid capturing the population that newly obtained Medicaid coverage during the PHE (ie, through pandemic-related job loss) who, as a group, likely differ from those who had Medicaid coverage before the PHE and may therefore have a different likelihood of churning.

Outcomes

We identified 3 primary outcomes of interest: transitions from Medicaid to uninsurance, any transition from Medicaid enrollment (ie, transition to private coverage, transition to uninsurance, etc), and time until disenrollment from Medicaid. A transition is identified in our dataset by comparing the respondent's insurance source in the index month to the prior month. Prior work [4,7] on insurance churning has generally reported annual rates of churning outcomes; however, given our short follow-up period, we report monthly rates in our main analysis.

We also performed an exploratory analysis of 3 additional outcomes using difference-in-differences (DID): transitions from Medicaid to employer coverage, concurrent Medicaid and employer coverage, and re-enrollment in Medicaid.

Statistical analysis

To evaluate the effects of the Medicaid continuous coverage policy on churning, we performed a DID analysis of monthly rates of Medicaid transitions. Respondents in the 2019–2020 cohort were exposed to the continuous coverage policy and represent the treatment group, while the 2018–2019 cohort, who were not exposed to the continuous coverage policy, represent the control group (see Appendix for the study design diagram). Because the continuous coverage requirement was implemented in late March 2020 (the second year for the treatment group), we modeled the treatment period as extending from April to December of the second survey year (April to December 2019 for the control group, April to December 2020 for the treatment group). We performed separate analyses for adults and children due to pre-existing policies that impacted Medicaid coverage continuity among children.[20]

We performed linear regression adjusting for the complex survey design to estimate changes in our outcomes from the pre- to post-periods across the treatment and control groups, with clustering by primary sampling unit and survey stratum. We then obtained survey-adjusted mean rates of our outcomes in each group in the pre- and post-intervention period. We

controlled for sociodemographic and health factors, including age, gender, race/ethnicity, US birth status, family income, family size, education, marital status, self-reported health, and report of having a chronic health condition. Respondents reporting any of arthritis, cancer, diabetes, hypertension, high cholesterol, emphysema, angina, coronary heart disease, heart attack, stroke, or other heart condition were coded as having a chronic health condition. We report results from unadjusted analyses in Table S1. As a robustness check and to account for autocorrelation in our longitudinal data, we also implemented generalized estimating equation (GEE) models using an identity link function and Gaussian distribution with robust standard errors clustered at the individual level.

To evaluate the parallel assumption in our data, we performed linear regression, using pre-intervention data only, interacting treatment group status with a time trend variable. This interaction was not significant, providing evidence to support the parallel trends assumption (Table S2). We also performed placebo testing in the pre-period where we altered the treatment timing to each pre-intervention month and evaluated for a treatment effect; 2 of the 48 tests were significant, in line with what would be expected due to chance alone (0.05×48 tests = 2.4 tests significant; Table S3).

To assess the effect of the continuous coverage policy on Medicaid enrollment duration before a churning event, we performed Cox regression to evaluate whether respondents had a longer time to Medicaid disenrollment during the PHE compared with the pre-pandemic control group (2018–2019). Survival functions were compared across treatment groups in the pre- and post-intervention periods and were adjusted for health and sociodemographic factors, as above. Pre- and post-intervention hazard ratios (HRs) were directly compared using post-estimation methods. Respondents who were continuously enrolled in Medicaid for the first 6 months of their first interview year were included in the survival analysis.

We also performed subgroup analysis to evaluate whether the effects of the continuous coverage policy differed by demographic and health characteristics. We stratified our DID and survival analyses of adults by gender, race/ethnicity, and chronic disease status among adults. We stratified children by race/ethnicity.

All analyses were performed using StataMP version 14 (StataCorp, College Station, TX).

Limitations

This study's work should be interpreted in the context of several limitations. First, our outcomes are based on self-reported insurance status, which is subject to recall bias and the potential for misclassification in cases when respondents lack accurate information about their enrollment status. Several prior studies of churning in the Medicaid program have relied on these data.[6,7,14,15] Survey response may have differed in the 2018–2019 and 2019–2020 MEPS cohorts due to the pandemic. While MEPS adjusted for pandemic-related nonresponse bias when constructing survey weights,[21] residual bias could remain.

Because we used publicly available MEPS data, our data did not have state identifiers to investigate any variation in the effects of the continuous coverage policy across individual states. We were limited in our ability to infer the cause of Medicaid disenrollment either

prior to or during the PHE. MEPS tracks income annually, making it difficult to track income fluctuations over shorter time durations. MEPS also does not have information on when a pregnancy begins and ends.

This study uses a limited follow-up period. The treatment cohort was from the 2019–2020 MEPS data, which were the most recent data available at the time of conducting this study. Therefore, our study focused on the effect of the continuous coverage policy on churning during the early stage of the PHE.

Following the majority of studies in the churning literature,[7,22-25] we did not adjust for multiple comparisons, which may increase the risk of false positives. Because our inclusion criteria required respondents to have Medicaid coverage in 1 of the first 3 survey months, the population we identified may disproportionately include people in longer Medicaid spells who are therefore less likely to experience churning. Our estimates may reflect a lower bound on the amount of churning in Medicaid beneficiaries overall and may not be fully generalizable to the broader Medicaid population.

Last, our control group is imperfect and not contemporaneous with our treatment group; because the continuous coverage policy was federal in nature and thus implemented nationwide simultaneously, a historical control represents a useful comparator. Other work evaluating federal health insurance policy has used a similar control method.[26] Despite our approach, we are unable to entirely eliminate the possibility that other phenomena led to the observed results due to the absence of a contemporaneous control. Our results could be affected by underlying unobserved secular trends. The validity of our control group relies on the assumption that, absent an intervention, the average outcome in the treatment and control groups would follow similar trends in the treatment period; while many studies evaluate this across chronological time, given our design, parallel trends were evaluated from the beginning of each panel's data-collection period. We did not find evidence against parallel pre-intervention period trends in the control and treatment groups, suggesting that any differential secular effect is likely small relative to the magnitude of the treatment effect.

Results

The study included 2724 respondents in the 2018–2019 control cohort and 1827 in the 2019–2020 treatment cohort. Baseline characteristics were similar across the control and treatment cohorts, except that the 2019–2020 cohort had slightly higher incomes and were more likely to be married (Table S4). In each cohort, just over half of respondents were children.

In DID analyses among adults, adoption of the Medicaid continuous coverage policy was associated with statistically significant reductions in the likelihood of a transition to uninsurance, but not in the likelihood of any transition from Medicaid. The baseline monthly rates of our outcomes in the treatment cohort were 1.28% for transitions to uninsurance and 2.10% for any transition from Medicaid. The continuous coverage policy was associated with a 0.57-percentage-point reduction in the monthly rate of transitions to uninsurance (Table 1; $P = .026$).

Among children and before the PHE, each month, 0.52% of enrollees in the treatment cohort transitioned to uninsurance and 0.87% experienced any transition from Medicaid. There was no statistically significant reduction in transitions to uninsurance or from Medicaid (Table 1).

In adjusted survival analysis evaluating time to Medicaid disenrollment, there was no significant difference in the HRs comparing the treatment and control groups in the pre-intervention period, but they differed in the post-intervention period among adults and not children (Figures 1 and 2). Adults in the treatment cohort had an HR of 0.54 of experiencing Medicaid disenrollment while the continuous coverage policy was in effect relative to the control group ($P = .003$; Figures 1 and 2). In post-estimation testing comparing the HRs derived from before and after the start of the PHE, significant differences were found among adults (HR: 0.58, 95% CI: [0.35, 0.96]; $P = .034$), but not in children.

In DID analysis among subgroups of adults, the continuous coverage policy was not associated with significantly lower rates of churning outcomes, although the associations among female and non-White adults and adults without chronic disease had P values less than .10 (Table 2). In survival analysis, adult males and adults without chronic disease had significantly lower post- vs pre-intervention HRs (HR: 0.45, 95% CI: [0.23, 0.87]; $P = .018$; 0.45, 95% CI: [0.22, 0.90]; $P = .025$; Table S5).

In DID analysis of racial and ethnic child subgroups, White and non-White children did not have statistically significant changes from prior to the continuous coverage policy (Table 2). In the survival analysis among child subgroups, non-White children in the treatment group during the PHE had an adjusted HR for disenrollment of 0.40 compared to the control group ($P = .025$), although the pre- to post-comparison of HRs was not significant (Table S5). The survival analysis showed no differences in disenrollment among White children between treatment and control groups.

Our DID results using GEE yielded similar effect sizes across outcomes and subgroups, with smaller standard errors (Table S6). None of our exploratory outcomes in DID analysis (transitions from Medicaid to employer coverage, concurrent Medicaid and employer coverage, or re-enrollment in Medicaid) were significantly different between the treatment and control groups (Table S7).

Discussion

In this analysis of nationally representative survey data, we found that the Medicaid continuous coverage policy during the COVID-19 PHE led to significant reductions in coverage loss among adult Medicaid enrollees. Adults were also more likely to have a longer time to disenrollment from Medicaid during the PHE. In the treatment cohort from April 2019 to March 2020, the yearly rate of insurance transitions was 14.5%. Although the analysis of change in the monthly rate of insurance transitions did not reach statistical significance, we project that the annual rate of transitions from Medicaid declined to 7.6% after the start of the PHE (Figure S1). Using average monthly enrollment estimates during our study period,[11] the point estimates from our DID analysis suggest that approximately

326 000 transitions to uninsurance were avoided every month as a result of the PHE continuous coverage policy.

We did not find significant reductions in the overall likelihood of any transition from Medicaid among adults, nor did we find any significant reduction in churning among children. Our study may have been underpowered to detect differences in the monthly rates of churning, especially given our short follow-up period and small sample size. In addition, we selected our sample from a population with Medicaid coverage in early 2019, some of whom were long-term Medicaid enrollees; this likely skewed our sample toward a group with less frequent baseline rates of churning. This would also imply that the significant estimates we present are a lower bound on the effects of the PHE. It is also possible that some of the reductions in transitions to uninsurance were offset by gains in employer coverage as unemployment fell in the latter half of 2020.[27]

Children and adults had different baseline rates of churning and were impacted differentially by the continuous coverage policy. We observed that, prior to the pandemic, children experienced lower overall rates of transitions out of Medicaid. Medicaid and the Child's Health Insurance Program (CHIP) have long provided states the ability to provide continuous coverage to children; 23 and 25 states had adopted 12-month continuous coverage policies for children prior to March 2020 in Medicaid and CHIP, respectively, while only 2 states (New York and Montana) had a similar policy in place for adults.[5,20] Differences in the risk of churning between adults and children predate the ACA; a survival analysis in 2009 found that adults had 1.75 times the risk of disenrollment relative to children in a 2-year follow-up period.[15] Pre-existing continuous coverage policies may also explain why we found no effect of the PHE policy on churning among children, despite finding an effect among adults.

Our findings provide early evidence that part of the increase in Medicaid enrollment since the start of the PHE has been due to reduced coverage loss and are consistent with existing evidence on the effect of the PHE's continuous coverage policy, at least among adults. Prior work using administrative data from Wisconsin simulated 2020 Medicaid enrollment trends in the state with and without the continuous coverage policy, and concluded that a large proportion of the difference between expected and observed enrollment could be attributed to the continuous coverage policy, with the remainder due to pandemic-related job loss.[12] Similarly, a descriptive analysis of Medicaid enrollment data from 6 states found that reduced disenrollment accounted for 75% of the enrollment growth in 2020.[13] A paper using MEPS data showed that adult and child enrollees with Medicaid coverage in 2019 were less likely to be uninsured at the end of 2020 compared with the likelihood of those with Medicaid in 2018 reporting uninsurance at the end of 2019.[28] Our quasi-experimental approach complements this descriptive study and also permits analysis of dynamic, within-year changes in coverage while adjusting for observable year-to-year changes in the composition of the Medicaid population. Reduced churning is likely responsible for proportionally more of Medicaid enrollment growth during the latter stages of the PHE, given that economic conditions have stabilized and unemployment is nearing pre-pandemic levels.

Non-White children and adults may have disproportionally benefited from the continuous coverage policy, although in our analysis, these associations did not reach statistical significance. Prior research has shown that non-White children more likely to experience disruptions in Medicaid coverage, suggesting that non-White children would benefit disproportionately from a policy aimed at reducing coverage disruptions.[9] An analysis of churning rates following the ACA's Medicaid expansion similarly found that non-White adults had disproportionally reduced rates of churning.[7]

Although we found that some measures of churning decreased at the implementation of the continuous coverage policy, churning was not eliminated. This was despite a policy that was intended to prevent Medicaid disenrollment for all of the most common reasons, including changes in income or family circumstances (ie, the end of a pregnancy), or failure to successfully renew eligibility. Some of this is due to enrollees gaining other insurance coverage. However, transitions to uninsurance persisted. Ongoing disenrollment should have occurred only due to enrollees who died, moved out of state, or voluntarily disenrolled. No respondents in the sample died during the study period; estimates for the frequency of Medicaid disenrollment due to voluntary disenrollment are not available, and we do not assess between-state migration. Other work has also found ongoing disenrollment during the PHE.[13] Our findings raise the possibility that some states disenrolled residents from Medicaid despite policy explicitly prohibiting it, or at least led residents to believe they were in danger of losing coverage. A recent report showed that Idaho processed disenrollments during the pandemic despite the continuous coverage policy [16]; other states may have done the same. In addition, although there was no requirement to do so, many states continued to process Medicaid renewals—including sending renewal forms to enrollees—during the PHE,[29] which could cause some people to misunderstand their enrollment status and report that they lost coverage. Further work should investigate the reasons for Medicaid coverage loss during the PHE.

As the PHE unwinds—and with it, the continuous coverage policy—many states are making efforts to preserve continuity in Medicaid and prevent coverage loss. The omnibus spending bill passed at the end of 2022 requires states to provide 12-month continuous coverage for children in Medicaid and CHIP and makes permanent a state option to extend continuous coverage to pregnant women for 12 months after delivery. Several states are taking further steps to ensure continuous coverage after the conclusion of the PHE, especially for children. Oregon will now offer continuous coverage for Medicaid-enrolled children from the ages of 0 to 6 years, a 24-month continuous coverage policy for all other children, and a 12-month policy for adults; other states are seeking approval for similar policies.[17,18] Massachusetts is adopting a continuous coverage policy for 12 months for justice-involved individuals and 24 months for enrollees experiencing homelessness.[19] We provide evidence that continuous coverage policies offer 1 tool to reduce coverage loss and provides support for efforts to expand continuous coverage in other states. However, given that our analysis raises the possibility that some Medicaid beneficiaries do not know they are enrolled, states designing policies to extend continuous coverage need to ensure that the people who benefit from the policy understand their enrollment status.

Other approaches to reducing the effects of churning currently in place include automated (also called facilitated, or ex parte) renewals and prepopulated eligibility renewal forms, which seek to reduce the administrative burden placed on enrollees to successfully navigate the eligibility redetermination process.[7,30] In many states, the same insurers that operate Medicaid managed care plans also offer insurance plans on the exchange; evidence suggests that an enrollee transitioning between insurance products from the same insurer will experience less of a disruption in provider networks.[31] This approach is taken to its limit in Arkansas and Iowa, where Medicaid-eligible people may purchase marketplace plans using Medicaid funds rather than shifting between separate insurance products.[32] However, our findings suggest that any of these policies—which differ from the PHE's continuous coverage policy in extent, approach, and duration—may not eliminate transitions to uninsurance entirely.

Conclusion

The COVID-19 PHE's Medicaid continuous coverage policy led to a significant reduction in coverage transitions to uninsurance among adult Medicaid enrollees, contributing substantially to the increase in Medicaid enrollment. Nevertheless, some Medicaid disenrollment continued. As the PHE unwinds, policymakers should implement continuous coverage policies in Medicaid to prevent disruptions in insurance coverage and avoid a regression to pre-pandemic levels of insurance churning.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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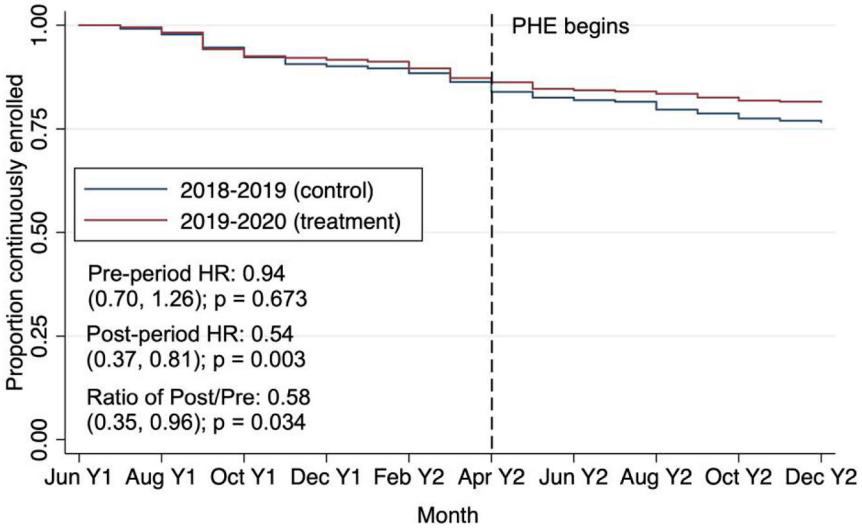

Figure 1.

Kaplan-Meier curves for Medicaid disenrollment, adults ages 19–64 years. Source: Authors' analysis of data from MEPS-HC longitudinal cohorts from 2018 to 2020. The population was restricted to adults ages 19–64 years. The control group was taken from the 2018–2019 cohort; the treatment group was taken from the 2019–2020 cohort. The index group is the control cohort. Analyses were adjusted for respondent age, gender, race/ethnicity, US birth status, family income, family size, education, marital status, self-reported health, and report of having a chronic health condition. Abbreviations: MEPS-HC, Medical Expenditure Panel Survey—Household Component; PHE, public health emergency; Y, year.

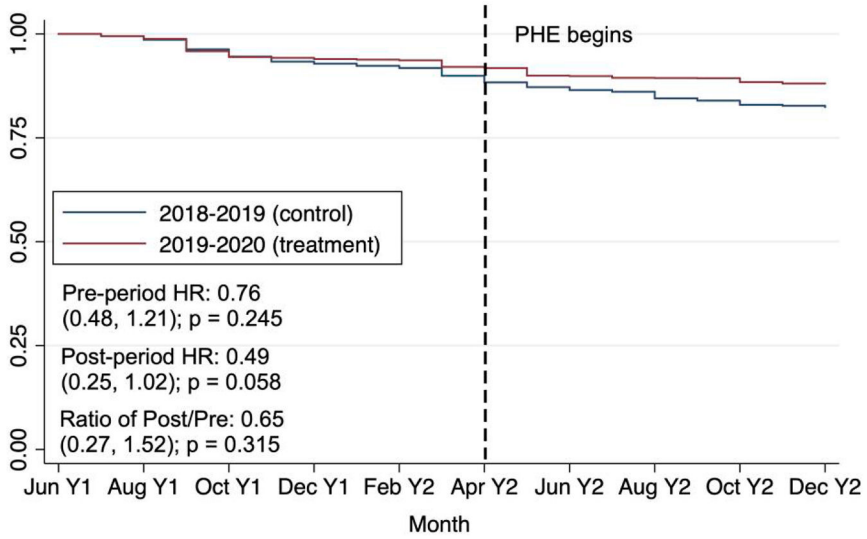

Figure 2.

Kaplan-Meier curves for Medicaid disenrollment, children ages 0–18 years. Source: Authors' analysis of data from MEPS-HC longitudinal cohorts from 2018 to 2020. The population was restricted to children ages 0–18 years. The control group was taken from the 2018–2019 cohort; the treatment group was taken from the 2019–2020 cohort. The index group is the control cohort. Abbreviations: MEPS-HC, Medical Expenditure Panel Survey—Household Component; PHE, public health emergency; Y, year.

Table 1.

Adjusted probabilities of churning outcomes, pre- and postadoption of continuous coverage policy.

	Control cohort		Treatment cohort			
	Pre-period	**Post-period**	**Pre-period**	**Post-period**	**DID estimate (95% CI), percentage points**	***P***
Children 0 to 18 y						
Any transition from Medicaid	0.97%	0.97%	0.87%	0.45%	−0.42 (−0.95, 0.11)	.121
Transition to uninsurance	0.55%	0.73%	0.52%	0.35%	−0.35 (−0.78, 0.08)	.111
Adults 19 to 64 y						
Any transition from Medicaid	2.46%	1.77%	2.10%	0.91%	−0.53 (−1.22, 0.17)	.135
Transition to uninsurance	1.41%	1.08%	1.28%	0.41%	−0.57 (−1.07, −0.07)	.026

Source: Authors' analysis of data from MEPS-HC longitudinal cohorts from 2018 to 2020. The control group was taken from the 2018–2019 cohort; the treatment group was taken from the 2019–2020 cohort. DID analyses were adjusted for respondent age, gender, race/ethnicity, US birth status, family income, family size, self-reported health, and report of having a chronic health condition; adult analyses also adjusted for education and marital status. Pre- and post-period means are survey-adjusted estimates.

Abbreviations: DID, difference-in-differences; MEPS-HC, Medical Expenditure Panel Survey—Household Component.

Table 2.

Subgroup analysis: adjusted probabilities of churning outcomes, pre- and post-adoption of continuous coverage policy.

	Control cohort		Treatment cohort			
	Pre-period	**Post-period**	**Pre-period**	**Post-period**	**DID estimate (95% CI); percentage points**	***P***
Children, 0–18 y						
Race/ethnicity						
Any transition from Medicaid						
White	0.97%	0.54%	0.97%	0.44%	−0.12 (−1.04, 0.79)	.787
Non-White	0.97%	1.19%	0.82%	0.45%	−0.57 (−1.21, 0.06)	.074
Transition to uninsurance						
White	0.40%	0.39%	0.57%	0.41%	−0.15 (−0.99, 0.69)	.730
Non-White	0.63%	0.90%	0.49%	0.32%	−0.45 (−0.97, 0.06)	.084
Adults, 19–64 y						
Gender						
Any transition from Medicaid						
Female	2.37%	1.77%	2.11%	1.02%	−0.54 (−1.39, 0.30)	.206
Male	2.60%	1.77%	2.07%	0.71%	−0.51 (−1.48, 0.46)	.302
Transition to uninsurance						
Female	1.39%	1.07%	1.35%	0.49%	−0.59 (−1.20, 0.02)	.060
Male	1.46%	1.09%	1.16%	0.25%	−0.54 (−1.36, 0.28)	.193
Race/ethnicity						
Any transition from Medicaid						
White	2.60%	1.54%	2.04%	0.98%	−0.02 (−1.05, 1.01)	.967
Non-White	2.34%	1.94%	2.15%	0.86%	−0.93 (−1.91, 0.06)	.066
Transition to uninsurance						
White	1.39%	0.99%	1.16%	0.29%	−0.49 (−1.30, 0.31)	.225
Non-White	1.43%	1.14%	1.38%	0.50%	−0.64 (−1.31, 0.03)	.062
Self-reported health status						
Any transition from Medicaid						
Chronic disease	2.16%	1.46%	1.98%	0.66%	−0.61 (−1.44, 0.23)	.154
No chronic disease	2.69%	1.99%	2.19%	1.08%	−0.46 (−1.44, 0.51)	.348

	Control cohort		Treatment cohort			
	Pre-period	Post-period	Pre-period	Post-period	DID estimate (95% CI); percentage points	*P*
Transition to uninsurance						
Chronic disease	1.07%	0.93%	0.93%	0.32%	−0.48 (−1.12, 0.16)	.138
No chronic disease	1.69%	1.18%	1.54%	0.47%	−0.63 (−1.35, 0.10)	.090

Source: Authors' analysis of data from MEPS-HC longitudinal cohorts from 2018 to 2020. The control group was taken from the 2018–2019 cohort; the treatment group was taken from the 2019–2020 cohort. DID analyses were adjusted for respondent age, gender, race/ethnicity, US birth status, family income, family size, self-reported health, and report of having a chronic health condition; adult analyses also adjusted for education and marital status. The subgroup variable is omitted as a covariate (ie, the female subgroup analysis does not control for gender). Pre- and post-period means are survey-adjusted estimates. Abbreviations: DID, difference-in-differences; MEPS-HC, Medical Expenditure Panel Survey—Household Component.