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Report to Congressional Committees

June 2025

MEDICAID AND CHILDREN'S HEALTH INSURANCE

Disenrollments After COVID-19 Varied Across States and Populations

GAO-25-107413

GAO

Highlights

Highlights of GAO-25-107413, a report to congressional committees

June 2025

MEDICAID AND CHILDREN'S HEALTH INSURANCE

Disenrollments After COVID-19 Varied Across States and Populations

Why GAO Did This Study

Continuous enrollment during the COVID-19 public health emergency, which largely paused disenrollments, contributed to Medicaid and CHIP growing from 71 million enrollees in February 2020 to 94 million enrollees in March 2023—an increase of more than 30 percent.

During unwinding, some people were expected to be disenrolled either because they were no longer eligible or because of procedural reasons, such as not returning information necessary to determine their eligibility. States are required to report data on redetermination outcomes during unwinding to CMS. CMS has used the data to monitor, for example, how many people were disenrolled or had their coverage renewed.

The CARES Act includes a provision for GAO to report on the federal response to the COVID-19 pandemic. This report describes (1) the results of CMS's analyses of unwinding outcomes, and (2) the extent to which selected states identified differences in unwinding outcomes across population characteristics.

GAO reviewed CMS analyses, such as analyses of state-reported data on eligibility redeterminations scheduled for completion from March 2023 through June 2024, some of which were completed through September 2024. GAO also interviewed CMS officials. GAO also reviewed information from five states—Arizona, Maryland, Montana, New York, and Wisconsin—selected to capture a mix of program size and geographic diversity.

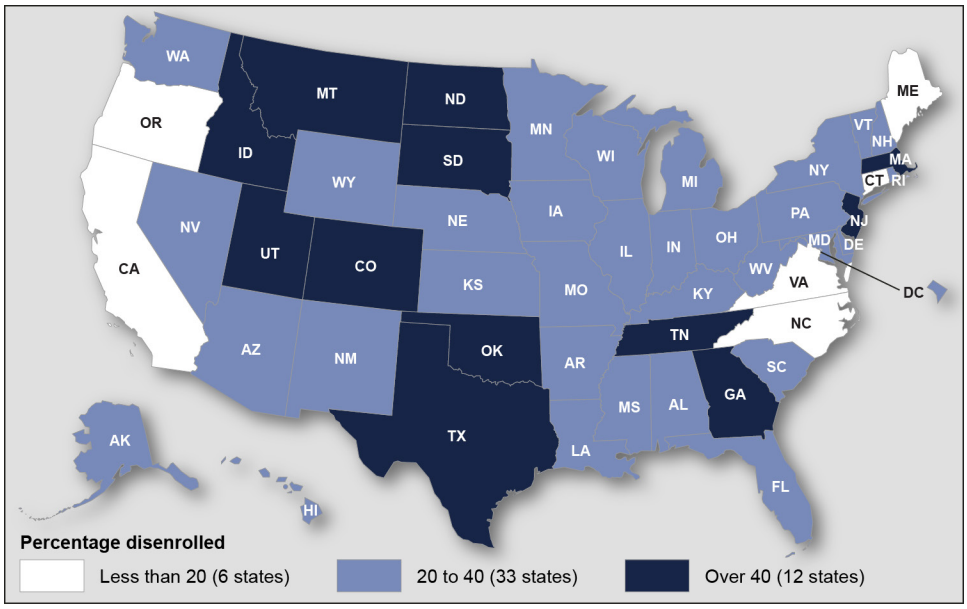
View GAO-25-107413. For more information, contact Michelle B. Rosenberg at RosenbergM@gao.gov

What GAO Found

During the COVID-19 public health emergency, Congress provided temporary additional federal funding to states to keep Medicaid and most Children's Health Insurance Program (CHIP) enrollees continuously enrolled. In April 2023, states began resuming full eligibility redeterminations for the millions of enrollees who had been continuously enrolled, including disenrolling those no longer eligible or who did not submit all required information—a process known as "unwinding." States are to complete unwinding redeterminations by the end of 2025.

The Centers for Medicare & Medicaid Services (CMS) found that, of the 89 million completed redeterminations by states, about 27 million individuals were disenrolled during the first year and a half of unwinding. Enrollment nationwide was around 79 million as of October 2024, about 10 percent higher than prior to the pandemic. CMS also found significant variation across states in the percentage of individuals disenrolled during unwinding, with a number of factors potentially contributing to those differences.

Percentage of Completed Redeterminations That Resulted in Disenrollments, by State, March 2023-September 2024



Source: GAO analysis of Centers for Medicare & Medicaid Services data; Map Resources. | GAO-25-107413

Note: For more details, see fig. 4 in GAO-25-107413.

CMS and selected states identified certain populations that may have been disenrolled more frequently than others. For example, CMS and two states found that certain young adults were the most likely to be disenrolled when compared to other groups. CMS officials said young adults could have become ineligible because they aged out of child-specific eligibility groups, which generally allow for higher income than eligibility groups for adults who are under the age of 65 and who do not have a disability.

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Abbreviations

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
MAGI	Modified adjusted gross income

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Congressional Committees

During the COVID-19 public health emergency, Medicaid and the Children's Health Insurance Program (CHIP) played a key role in providing access to health care services.[1] Medicaid and CHIP are health care programs that are jointly financed by the federal government and states. In fiscal year 2023, total federal and state spending was about $890 billion for Medicaid and about $23 billion for CHIP. Congress temporarily provided additional federal funds to state Medicaid programs so that enrollees could maintain their health care coverage during the public health emergency.[2] This provision also helped maintain enrollment in CHIP in states that operate CHIP as an expansion of Medicaid.[3] To receive the temporarily increased federal funding, states were required to keep enrollees continuously enrolled in Medicaid, including children enrolled in states' Medicaid-expansion CHIP programs.[4] In this report, we refer to this temporary continuous enrollment condition as "continuous enrollment."

Typically, states redetermine enrollees' eligibility annually and disenroll them if no longer eligible or if they do not complete the process. Under continuous enrollment, however, states were to pause disenrollments

[1]Medicaid finances health care for certain low-income and medically needy individuals, and CHIP does so for certain uninsured children whose household incomes are too high for Medicaid eligibility but may be too low to afford private insurance. Both are federal-state programs.

[2]For purposes of our report, "states" includes the District of Columbia.

[3]States can operate CHIP as a separate program, include CHIP-eligible children in an expansion of their Medicaid program, or use a combination of the two approaches. For example, 39 states operate a combination of the two approaches, covering some CHIP-eligible children through their Medicaid program and others through a separate CHIP program, according to the Centers for Medicare & Medicaid Services (CMS).

[4]Pub. L. No. 116-127, div. F, § 6008, 134 Stat. 178, 208 (2020). The Families First Coronavirus Response Act provided a temporary 6.2 percentage-point increase to the Federal Medical Assistance Percentage rates for states that met certain requirements, such as keeping beneficiaries continuously enrolled in the program. The Federal Medical Assistance Percentage is the statutory formula used to determine the federal funding states receive for Medicaid and is one component in the statutory calculation of the CHIP match rate. As a result, when a state's Federal Medical Assistance Percentage rate increased, its federal match rate for CHIP would generally also increase, though not necessarily by the same amount.

except in limited circumstances. This contributed to an increase in Medicaid and CHIP enrollment from a combined 71 million enrollees in February 2020 to 94 million enrollees in March 2023—an increase of more than 30 percent.

The Consolidated Appropriations Act, 2023, ended the continuous enrollment period effective March 31, 2023, and required states to resume full eligibility redeterminations, including disenrollments.[5] This transition from continuous enrollment is known as "unwinding." As part of unwinding, states were redetermining eligibility for, and taking action to renew or disenroll, most of their enrollees. States were given flexibility in completing unwinding redeterminations, including how quickly they completed the process. Some states were continuing to complete unwinding redeterminations as of March 2025, according to officials from the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid and CHIP.[6]

It was expected that some individuals who were continuously enrolled during the public health emergency were no longer eligible and would therefore be disenrolled during unwinding. For example, some individuals could have obtained new employment that increased their income above income thresholds or had another change in circumstance that affected their eligibility. It was also expected that some individuals would be disenrolled for procedural reasons, such as not submitting needed information, despite remaining eligible. Additionally, certain populations may be more likely to be disenrolled, despite remaining eligible, than others. For example, the federal government estimated that about 52 percent of Latino individuals disenrolled during unwinding would still be eligible for Medicaid compared to 40 percent of White non-Latino individuals.[7] Whether individuals who were disenrolled transition to other

[5]Pub. L. No. 117-328, § 5131, 136 Stat. 4459, 5949 (2022) (codified as amended at 42 U.S.C. § 1396a note). The Consolidated Appropriations Act, 2023, separated the end of the continuous enrollment condition from the end of the COVID-19 public health emergency, which ended on May 11, 2023.

[6]CMS initially required states to complete redeterminations for all Medicaid and CHIP enrollees within 14 months of the state beginning unwinding. Later, in August 2024, CMS gave states a deadline of December 31, 2025, to complete all unwinding redeterminations.

[7]We are reporting the race and ethnicity terms used by the Department of Health and Human Services's analysis. For more information on the analysis, see Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches,* Issue Brief HP-2022-20 (Washington, D.C.: Aug. 2022).

health care coverage, churn back to Medicaid or CHIP, or become uninsured could have implications for those individuals' health outcomes and for federal and state spending.[8]

The Consolidated Appropriations Act, 2023, required states to report data on unwinding outcomes, including renewals and disenrollments, to CMS monthly.[9] States began reporting data on unwinding outcomes to CMS beginning with redeterminations completed in March 2023.[10] The agency has used these data to monitor states' redetermination processes and has made the monthly data and related analyses public.[11] States were not required to report outcomes by enrollee population characteristics, but some states opted to analyze and publish such data.

The CARES Act includes a provision for us to report on the federal response to the COVID-19 pandemic.[12] This report describes

1. the results of CMS's analyses of the outcomes of unwinding, and
2. the extent to which selected states have identified differences in unwinding outcomes across population characteristics.

To describe the results of CMS's analyses of the outcomes of unwinding, we reviewed analyses published from July 2023 through January 2025. This included state-reported outcomes data CMS analyzed and published as well as agency calculations based on that data, such as calculations of total disenrollments and percentages of redeterminations that resulted in renewals and disenrollments. We focused our review on CMS data

[8]When eligible people lose coverage, it can result in "churn" when people move out of and back into Medicaid coverage.

[9]See Pub. L. No. 117-328, div. FF, tit. V, subtit. D, § 5131(b), 136 Stat. 4459, 5950 (codified as amended at 42 U.S.C. § 1396a(tt)).

[10]While states reported on redeterminations that were completed as early as March 2023, disenrollments did not take effect until the following month. For example, disenrollments reported for March 2023 did not take effect until April 2023.

[11]The act required CMS to make state unwinding reports for April 2023 through June 2024 publicly available. See Centers for Medicare & Medicaid Services, *Monthly Data Reports*, accessed March 11, 2025, https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/monthly-data-reports/index.html.

[12]Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). All of our reports related to the COVID-19 pandemic are available on our website at https://www.gao.gov/coronavirus.

updated by states and published by CMS in January 2025, the most recent updated data available at the time of our review.[13] These data include unwinding redeterminations completed from March 2023 through September 2024.[14] We used those data to determine the percentage of completed redeterminations that resulted in (1) renewals or (2) disenrollments, removing the pending cases included in CMS's calculations. (See appendix I for more information on these data.)

We also reviewed published analyses for which CMS used other data sources, including analyses of changes in net enrollment, redetermination outcomes by eligibility and age groups, and transitions to other health care coverage after disenrollment. In addition to reviewing published analyses, we reviewed some non-public CMS analyses. These analyses were limited by available data, and as a result, reflect different time periods during unwinding. We also interviewed agency officials about factors driving variation in outcomes across states and different populations and the agency's plans for any additional analysis.

To describe the extent to which selected states have identified differences in unwinding outcomes across population characteristics, we reviewed documents and data and interviewed Medicaid officials from five states: Arizona, Maryland, Montana, New York, and Wisconsin. We selected these states to capture a mix of program size, geographic diversity, progress in completing unwinding eligibility redeterminations, and public reporting of unwinding outcomes by population characteristics. We reviewed publicly available state data and analyses of unwinding outcomes by age, geography, race and ethnicity, and other population characteristics, when available, as well as additional data states provided

[13]CMS has publicly shared preliminary data reported by states as well as updated data, which has generally lagged the preliminary data by five or more months. The updated data includes the outcomes of millions of cases that were pending in the preliminary data. Pending redeterminations are those that were initiated but were not completed in the month due. The agency has analyzed both the preliminary and updated data but has indicated that the latter are the more complete.

[14]CMS reports data based on cohorts of enrollees that have their redeterminations scheduled to be completed in a given month, referred to as "due" in the state reporting. We reviewed CMS data published in January 2025 for the monthly cohorts of redeterminations scheduled to be completed from March 2023 through June 2024, which is the time period when most states originally expected to complete all unwinding redeterminations. For each monthly cohort, these data generally include the redetermination outcomes as of 3 months after the redetermination was scheduled to be completed. Thus, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023, and the data for the June 2024 cohort includes outcomes for redeterminations completed as of September 2024.

to us on redeterminations, renewals, and disenrollments, when available. We used the data to determine the percentage of completed redeterminations, by population characteristics, that resulted in (1) renewals or (2) disenrollments. When reporting on state-identified differences in unwinding outcomes by population characteristics, we used the categories the states used in their data and analyses.[15]

We assessed the reliability of CMS data on unwinding outcomes by reviewing agency documentation, interviewing CMS officials, and reviewing the data for internal consistency. We assessed the reliability of outcomes data from selected states by reviewing state documentation, interviewing state officials, and reviewing the data for internal consistency. We determined that the federal and state data included in this report were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from February 2024 to June 2025 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid and CHIP are health care programs jointly financed by the federal government and states. States receive matching funds from the federal government for their Medicaid and CHIP programs.

Medicaid and CHIP Eligibility and COVID-19

The federal government sets minimum eligibility criteria for Medicaid and CHIP, and states have flexibility to expand eligibility to cover additional individuals. As a result, eligibility criteria vary across states.

To qualify for Medicaid coverage, individuals generally must fall within certain categories or groups of individuals such as children, pregnant women, or individuals with disabilities, and meet the eligibility criteria applicable within their state. Those criteria include, for example, having

[15]States were not required to analyze unwinding outcomes by population characteristics. For example, CMS did not require states to analyze outcomes by categories related to race and ethnicity that are in line with the Office of Management and Budget's Statistical Policy Directive No. 15: *Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.*

income below specified levels or having significant health care needs.[16] For certain groups, such as those needing long-term services and supports, states consider both income and an individual's assets in assessing eligibility.[17] Some individuals are eligible for full Medicaid benefits and others for limited benefits. For example, benefits for certain individuals may be limited to certain services, such as family planning, or care provided for a specific condition like tuberculosis.

To qualify for CHIP, individuals must also fall into certain groups such as children under 19 or pregnant women and meet eligibility criteria applicable to the state. This includes having income below a specified level and, for certain CHIP programs, not having other health insurance coverage. In contrast to Medicaid, which has both full and limited benefit coverage, there is no limited benefit coverage in CHIP.

Typically, states must redetermine eligibility for Medicaid enrollees on an annual basis and disenroll those who are no longer eligible. During the COVID-19 public health emergency, however, states were generally required to keep individuals continuously enrolled in Medicaid to receive a temporary increase in federal matching funds. States that operated CHIP as an expansion of Medicaid were also required to keep individuals continuously enrolled.[18] During the continuous enrollment condition, states could continue redetermining eligibility, but they could not disenroll Medicaid enrollees, including those enrolled in states' Medicaid-expansion CHIP programs, except in limited circumstances. These limited circumstances included if the individual asked to be disenrolled, moved

[16]Individuals must also meet nonfinancial criteria such as citizenship and residency requirements. Individuals may meet the criteria for more than one group but are generally only enrolled under one basis of eligibility. For example, a child who has a disability could meet the eligibility criteria for children as well as an individual with a disability. States must assess eligibility on all bases before terminating enrollment.

[17]For the purposes of this report, we use the term assets to refer to resources, which include anything owned, such as bank accounts or property, that can be converted to cash. See Centers for Medicare & Medicaid Services, State Medicaid Manual § 3250 (definition of resource).

[18]In fiscal year 2023, Medicaid-expansion CHIP programs accounted for about two-thirds of all children enrolled in CHIP. See Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, (Washington, D.C.: Dec. 2024). The continuous enrollment condition did not apply to separate CHIP programs. However, most states sought, and CMS granted, authority to delay renewal processing, extend renewal deadlines, or maintain continuous enrollment for separate CHIP program enrollees through a state plan option or waiver, according to CMS officials.

out of state, or died. While most states continued redetermining eligibility during the public health emergency, other states paused those activities.

Medicaid and CHIP Eligibility Redeterminations During Unwinding

During unwinding, states were generally required to redetermine the eligibility of all individuals who had been continuously enrolled during the COVID-19 public health emergency, including both those with full and limited benefit coverage. According to CMS data published in January 2025, states had completed 89 million eligibility redeterminations as part of unwinding.[19]

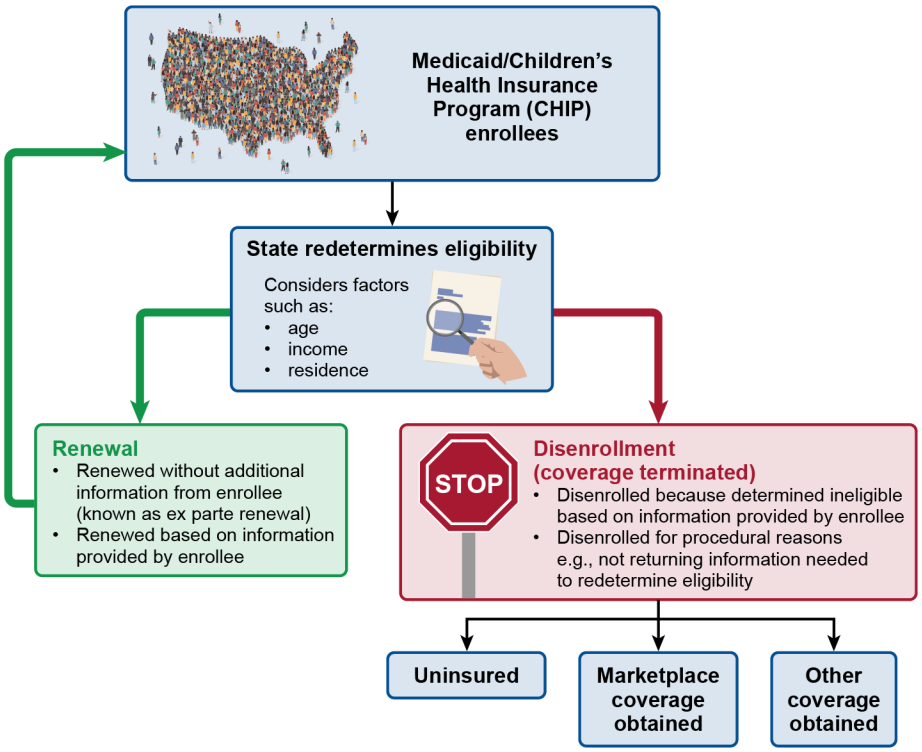
The redetermination process results in one of two outcomes: renewal or disenrollment, the latter of which terminates coverage (see fig. 1). States must first attempt to use available reliable information to redetermine eligibility, a process called “ex parte.” For example, this could include using income information from the state’s Supplemental Nutrition Assistance Program. If there is sufficient information for the state to renew eligibility, the state must do so. If not, the state must seek additional information from the enrollee.[20] If the person does not respond within required time frames or is otherwise determined ineligible, the state must disenroll them, which terminates coverage.[21] Disenrollment due to lack of response is referred to as a procedural disenrollment. These disenrollments could include both individuals who may still be eligible for Medicaid and CHIP as well as those who were not.

[19]The data may reflect the outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, generally 12 months later. Data reflect redeterminations that were due for completion from March 2023 through June 2024.

[20]When the state is not able to complete a redetermination on an ex parte basis, it must provide the enrollee with a renewal form and request any additional information needed to complete the redetermination.

[21]States must take several steps before disenrolling individuals, including considering all potential bases of eligibility. See 42 C.F.R. § 435.916(d) (2024).

Figure 1: Potential Outcomes of the Medicaid and CHIP Eligibility Redetermination Process



Source: GAO analysis of Centers for Medicare & Medicaid Services information; Siberian Art/stock.adobe.com (population illustration); GAO (other illustrations). | GAO-25-107413

Note: Marketplaces are state and federal health insurance exchanges established through the Patient Protection and Affordable Care Act. Some individuals who purchase health insurance coverage through a marketplace may be eligible for federal premium tax credits. "Other coverage" can include, for example, employer-sponsored insurance or, if eligible, Medicare.

After disenrollment, an individual could transition to another form of health care coverage or become uninsured. For example, they could enroll in employer-sponsored coverage; get coverage through a state or federal health insurance exchange (referred to as a marketplace); or churn back to Medicaid or CHIP (if eligible) after a temporary gap in coverage.[22] Prior to disenrollment, states are required to take certain steps to assess eligibility for and transfer information on certain individuals no longer

[22]Marketplaces were established through the Patient Protection and Affordable Care Act. See Pub. L. No. 111-148, 124 Stat. 119 (2010). That act also established premium tax credits and cost-sharing reductions that are available to certain individuals to help them afford coverage.

eligible for Medicaid and CHIP to certain other health programs. For example, states may transfer information to marketplaces—which allow individuals to shop for and enroll in private health coverage—to determine individuals' eligibility for federal premium tax credits.

Redetermining Medicaid and CHIP eligibility is complex for states to administer due to the different criteria that apply for different eligibility groups and the federal requirements that the eligibility determination process must meet. To protect enrollees from erroneous termination and reduce state administrative burden when redetermining Medicaid and CHIP eligibility, CMS provided states with temporary flexibilities during unwinding. For example, upon state request, CMS provided temporary waivers authorized under section 1902(e)(14) of the Social Security Act—also referred to as e(14) waivers—of certain eligibility verification and redetermination requirements.[23] CMS approved one or more flexibilities in nearly all states. Some of the most common flexibilities related to how states verify income and asset information and update enrollees' contact information. However, the flexibilities sought varied across states.

We previously reported that the first year of unwinding revealed a number of issues with state redetermination processes, including areas where states were not complying with federal redetermination requirements, which sometimes resulted in erroneous disenrollments.[24] At times during unwinding, states have opted to delay procedural disenrollments or been required by CMS to pause procedural disenrollments while working to come into compliance with requirements.[25]

[23]See 42 U.S.C. § 1396a(e)(14)(A). According to CMS guidance issued in November 2024, some of the flexibilities CMS granted to states during unwinding may continue long term at state option under Medicaid or CHIP state plan authority, some will become required under a final rule CMS issued in April 2024, and others will sunset after June 30, 2025.

[24]We recommended CMS document and implement the oversight practices the agency learned during unwinding were needed to prevent and detect state compliance issues with redetermination requirements. As of April 2025, the recommendation had been partially implemented with additional steps planned by CMS to evaluate unwinding efforts and incorporate lessons learned. See GAO, *Medicaid: Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned After COVID-19*, GAO-24-106883 (Washington, D.C.: July 18, 2024).

[25]At least 23 states paused some or all procedural disenrollments during unwinding. See GAO-24-106883.

CMS Monitoring of Outcomes

Examples of Unwinding Monthly Data Reporting Requirements for States

- Total number of renewals
- Number of renewals made without additional information from the enrollee (i.e., ex parte renewals)
- Total number of enrollees disenrolled
- Number of enrollees disenrolled for procedural reasons, such as not providing information requested by the state

Source: GAO summary of Centers for Medicare & Medicaid Services information. | GAO-25-107413

The Consolidated Appropriations Act, 2023, required states to report certain eligibility redetermination outcomes to CMS starting on April 1, 2023.[26] These outcomes included, for example, the number and type of renewals and disenrollments as well as transitions to marketplace coverage. While states had previously reported data on Medicaid and CHIP applications and enrollment, they began reporting new data on redetermination outcomes. During unwinding, CMS used the newly reported outcomes data to monitor states' redetermination efforts. In addition to using the data to inform technical assistance to states, CMS used them to perform national analyses.

CMS began posting the unwinding outcomes data publicly in July 2023. During unwinding, the agency also posted a number of national snapshots and other analyses leveraging the data reported by states. Although the act's reporting requirements ended on June 30, 2024, CMS issued guidance in May 2024, extending certain reporting requirements indefinitely and notifying states that the agency intended to continue monitoring and publicly sharing eligibility redetermination outcome data.[27] CMS has also published several analyses using those data and other data states report to CMS, such as eligibility and enrollment data reported through its Transformed Medicaid Statistical Information System.

State Monitoring of Outcomes

States generally have discretion in how they monitor unwinding outcomes. While states must report summary data on outcomes to CMS, such as the total number of renewals, CMS did not require states to analyze or report data on outcomes by age, race and ethnicity, geographic location or other population characteristics. However, some states have opted to do so and have made such outcomes data public.

[26]See 42 U.S.C. § 1396a(tt). Some of the required reporting outcomes—such as certain enrollment data and call center wait times—were captured by existing CMS data collection efforts. For example, CMS collects detailed Medicaid and CHIP enrollment data in the agency's Transformed Medicaid Statistical Information System.

[27]CMS extended reporting requirements due to their usefulness in monitoring compliance with federal redetermination requirements and to enhance transparency on Medicaid and CHIP redetermination outcomes. See Centers for Medicare & Medicaid Services, *State Health Official Letter #24-002: Continuation of Certain Medicaid and CHIP Eligibility Processing Data Reporting*, (Baltimore, Md.: May 30, 2024).

CMS Analyses Showed Enrollment Nationwide Declined During Unwinding but Remained Higher than Pre-Pandemic Levels

Although about 27 million individuals were disenrolled during the first year and a half of unwinding, enrollment nationwide remained higher than before the COVID-19 pandemic, according to analyses conducted by CMS. In addition, the percentage of individuals disenrolled varied significantly across states from 8 percent to 53 percent of those for whom redeterminations were completed. CMS's analyses also provided some insight into how unwinding outcomes varied by age and eligibility group.

CMS Data Indicate About 27 Million Individuals Were Disenrolled During Unwinding

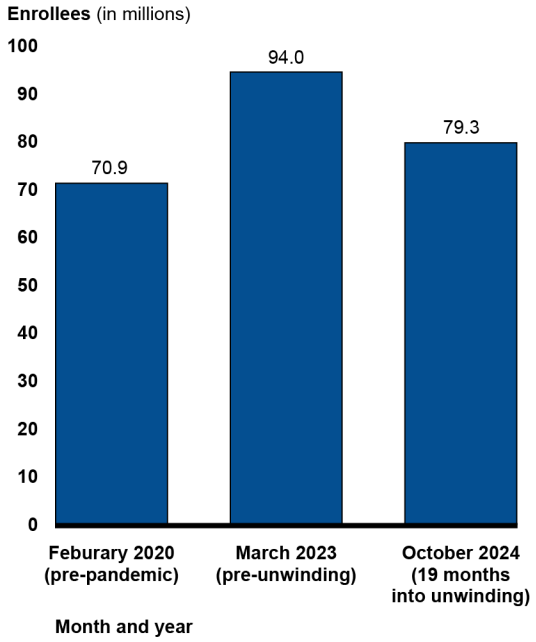
CMS data indicate that of the 89.0 million redeterminations completed during unwinding, 26.8 million individuals (30 percent) were disenrolled from Medicaid or CHIP from March 2023 through September 2024.[28] About 62 million individuals (70 percent of those with completed redeterminations) had their coverage renewed. The 26.8 million disenrollments represent a significant increase from the preliminary data on disenrollments reported by CMS in September 2024. At that time, the total number of disenrollments reported was 20.8 million. The difference was due, at least in part, to a larger number of pending redeterminations in the preliminary data.

Although 26.8 million individuals were disenrolled during unwinding from March 2023 through September 2024, enrollment nationwide across Medicaid and CHIP declined by only 14.7 million, from 94.0 million to 79.3 million. In addition, enrollment nationwide remained higher than pre-pandemic levels as of October 2024.[29] (See fig. 2.)

[28]Completed redeterminations are those that ended in a renewal or disenrollment. We calculated the percentage of individuals with a completed redetermination that were disenrolled for redeterminations due for completion from March 2023 through June 2024. As noted earlier, for each monthly cohort of redeterminations, the data generally include the redetermination outcomes as of 3 months after the redetermination was scheduled to be completed. Redeterminations completed more than 3 months after the month they were due are generally not included in the data. Thus, for example, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort includes outcomes for redeterminations that were completed as of September 2024.

[29]Medicaid and CHIP disenrollments take effect in the month after they are determined (e.g., September disenrollments take effect in October). As a result, the net decline in enrollment from March 2023 through October 2024 reflects disenrollments through September 2024.

Figure 2: Comparison of Medicaid and Children's Health Insurance Program Enrollment Nationwide—Pre-Pandemic, Pre-Unwinding, and as of October 2024



Source: GAO summary of Centers for Medicare & Medicaid Services data. | GAO-25-107413

Note: Medicaid enrollment only includes enrollees with full benefit coverage. It does not include those with limited benefit coverage. Pre-unwinding refers to the month prior to when disenrollments after the continuous enrollment period could begin taking effect. Disenrollments take effect in the month after they are determined (e.g., September disenrollments take effect in October). As a result, October 2024 enrollment reflects disenrollments through September 2024.

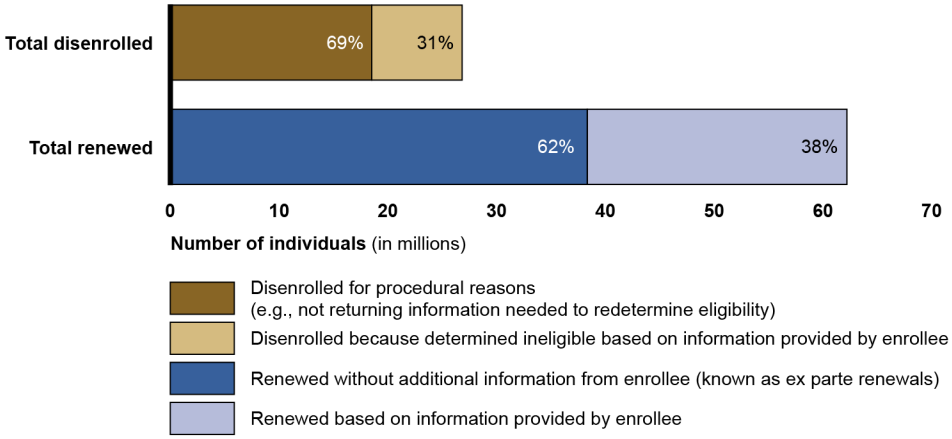
CMS attributed the difference between total disenrollments and the decline in enrollment nationwide to several different factors. For example, officials noted that enrollment nationwide reflects new enrollees, churn back into Medicaid or CHIP, and reinstatements for individuals erroneously disenrolled during unwinding.[30] In addition, certain policy changes may have also increased enrollment during this time period. For example, North Carolina expanded Medicaid eligibility to certain low-income adults in 2023, and its enrollment increased during unwinding. The difference between total disenrollments and the decline in enrollment

[30]At least 35 states have reinstated coverage for enrollees who were disenrolled erroneously during unwinding, according to CMS. For example, CMS data indicate that in 28 of the 29 states that did not always conduct ex parte reviews for each individual in a household as required, roughly 420,000 children and adults lost Medicaid coverage, as of January 2024. All of these individuals had been reinstated, according to CMS officials.

nationwide is also due, in part, to data differences. Specifically, unwinding disenrollment data include enrollees with limited benefit coverage, while the enrollment data do not.[31]

CMS analysis indicates that the majority of disenrollments were for procedural reasons and the majority of renewals were done via ex parte where enrollees do not need to provide any new information.[32] CMS data indicate that about 70 percent of the disenrollments during unwinding were for procedural reasons while over 60 percent of the renewals resulted from the ex parte process (see fig. 3). Because CMS was not monitoring data on redeterminations prior to unwinding, CMS officials could not speak to how these percentages compared to outcomes prior to the COVID-19 public health emergency.

Figure 3: Prevalence of Procedural Disenrollments and Ex Parte Renewals During Unwinding, March 2023-September 2024



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-25-107413

Notes: Data are for Medicaid and the Children's Health Insurance Program. These data reflect the initial outcomes (renewal or disenrollment) of unwinding redeterminations for the monthly cohorts of redeterminations that were due to be completed from March 2023 through June 2024. For each monthly cohort, the data reflect redeterminations completed in the month due or any of the 3 subsequent months. Redeterminations completed more than 3 months after the month they were due are generally not included in the data. Thus, for example, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort

[31]CMS publishes data on enrollees by benefit package for Medicaid and CHIP enrollees by year. According to these data, about 8.1 million enrollees had limited benefits in 2022.

[32]In certain circumstances, states may disenroll enrollees for procedural reasons, such as when enrollees do not timely submit all the information required to have their eligibility redetermined and coverage renewed. In addition, states can renew enrollees through an ex parte process, which allows states to renew enrollees based on available reliable data, without contacting enrollees for additional information.

includes outcomes for redeterminations that were completed as of September 2024. This analysis is focused on completed redeterminations and excluded those reflected as pending in the data.

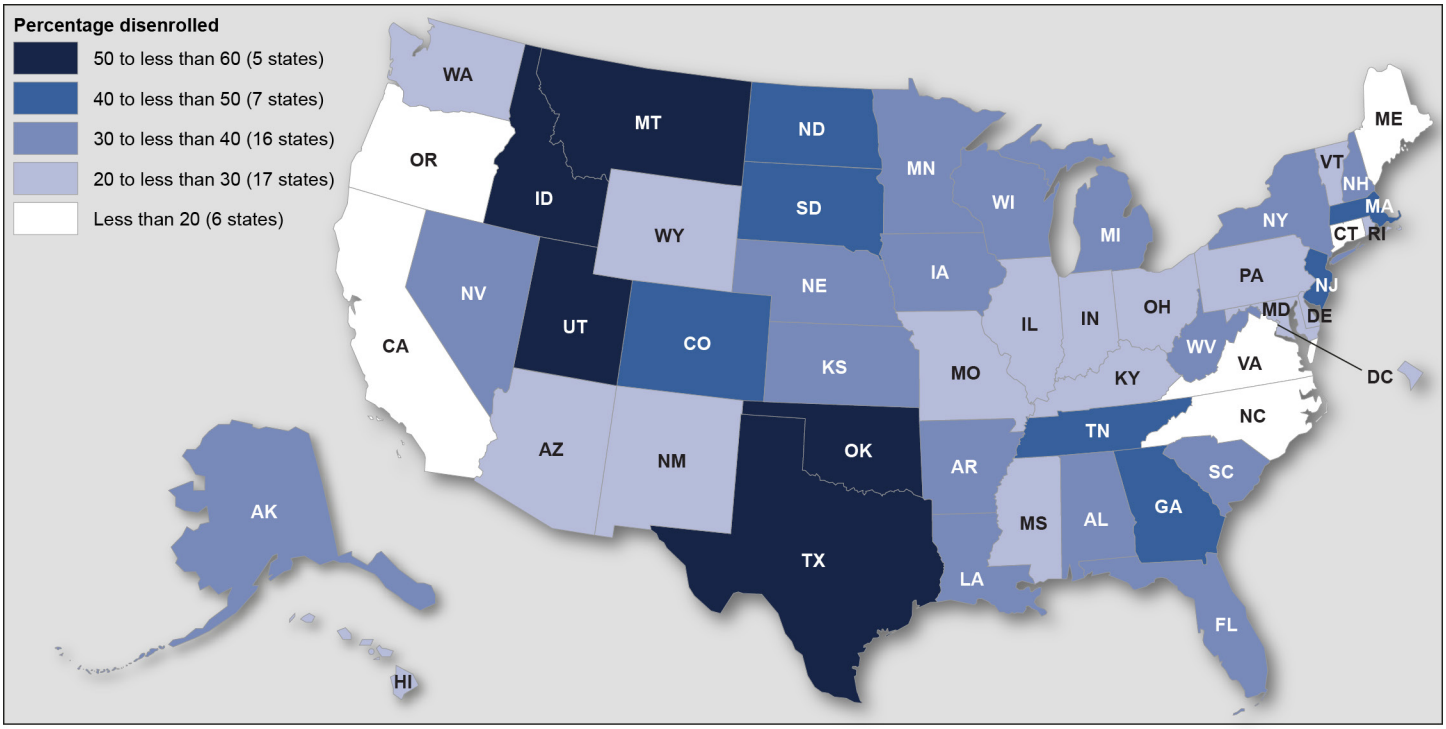
The data generally do not reflect changes to an outcome after a redetermination was completed, such as state decisions to reinstate coverage for those initially disenrolled. The data may reflect outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, which is generally 12 months later.

Most unwinding redeterminations had been completed as of March 2025, but the exact number remaining and in which states is unknown, according to CMS officials. CMS officials said they did not know what the outcomes were for 5.7 million redeterminations that were pending in the data at the time of our review and said it was likely that at least some unwinding-related redeterminations had not yet been initiated by states as of March 2025. States have until the end of December 2025 to complete all unwinding redeterminations.

Percentage of Individuals Disenrolled Varied Significantly Across States, Ranging from 8 Percent to 53 Percent of Completed Redeterminations

CMS data indicate that the percentage of completed unwinding redeterminations that resulted in a disenrollment from March 2023 through September 2024 ranged from 8 percent in Maine to 53 percent in Montana (see fig. 4). Five states disenrolled more than 50 percent of individuals from Medicaid or CHIP during this period. Six states disenrolled less than 20 percent of individuals from Medicaid or CHIP. (See appendix I for disenrollments, renewals, and pending redeterminations by state.)

Figure 4: Percentage of Completed Redeterminations That Resulted in Disenrollments During Unwinding, by State, March 2023-September 2024



Source: GAO analysis of Centers for Medicare & Medicaid Services data; Map Resources. | GAO-25-107413

Notes: Data are for Medicaid and the Children's Health Insurance Program. They reflect the initial outcomes (renewal or disenrollment) of unwinding redeterminations for the monthly cohorts of redeterminations that were due to be completed from March 2023 through June 2024. For each monthly cohort, the data reflect redeterminations completed in the month due or any of the 3 subsequent months. Redeterminations completed more than 3 months after the month they were due are generally not included in the data. Thus, for example, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort includes outcomes for redeterminations that were completed as of September 2024. This analysis is focused on completed redeterminations and excluded those reflected as pending in the data.

The data generally do not reflect changes to an outcome after a redetermination was completed, such as state decisions to reinstate coverage for those initially disenrolled. However, Arkansas, California, Oklahoma, Pennsylvania, Rhode Island, Wyoming, and South Carolina included data for some months on eligibility decisions that occurred after the initial redetermination, such as reinstatements of coverage for individuals that were initially disenrolled. The data may reflect outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, which is generally 12 months later.

CMS officials and early CMS analyses indicated several factors may have contributed to the wide variation in the percentage disenrolled across states during unwinding. For example,

Flexibilities and mitigation measures. CMS officials said that state implementation of temporary flexibilities and mitigation measures that aimed to prevent erroneous disenrollments may have contributed to the variation in the percentage of individuals disenrolled across states. States adopted flexibilities during unwinding that made it easier to renew individuals and may have led to fewer disenrollments, according to CMS.[33] For example, 38 states requested and received approval to use older income information that demonstrated low or no income to renew a Medicaid or CHIP enrollee's eligibility, when no other income information was listed on relevant data sources.[34] This streamlined the redetermination process for these states and enrollees and may have led to fewer disenrollments. In addition, some states implemented mitigation measures to help them address areas of non-compliance with federal redetermination requirements, which may have led to fewer disenrollments, according to CMS officials. For example, Maine paused procedural disenrollments from August 2023 through August 2024. As a result, Maine's results for this time period mostly reflect individuals who were determined eligible or were determined ineligible. The results do not reflect most individuals whose eligibility could not be determined because, for example, they did not return required information. This may partially explain why Maine had the lowest overall percentage of disenrolled (8 percent), according to CMS officials.

Ex parte renewals. CMS officials indicated that the extent to which states used ex parte renewals may have contributed to some of the state variation in overall disenrollments. Because ex parte renewals require no action from the enrollee to retain coverage, states with relatively higher ex parte renewals may have fewer disenrollments, according to CMS officials. States varied in their percentage of unwinding renewals that were completed through the ex parte process, from 7 percent to almost 100 percent from March 2023 through September 2024. CMS data show that states with the lowest percentage of enrollees disenrolled often had relatively higher percentages of renewals completed through the ex parte process. For example, out of the six states with the lowest percentage of

[33]See 42 U.S.C. § 1396a(e)(14)(A). According to CMS guidance issued in November 2024, some of the flexibilities CMS granted to states during unwinding will continue long-term.

[34]This e(14) waiver permits a state to complete ex parte renewals when no income data is returned from data sources for individuals who were previously enrolled or whose coverage was renewed based on a verified attestation of zero dollar income or income at or below 100 percent of the federal poverty level.

disenrollments, five had ex parte renewals exceeding 65 percent of their total renewals.[35]

Differences in eligibility criteria. Early CMS analysis indicated that states that did not expand Medicaid eligibility to certain low-income individuals—referred to as non-expansion states—generally had a higher percentage of disenrollments than states that did. Our analysis of disenrollments found similar results. For example, during unwinding, the percentage of individuals disenrolled from Medicaid or CHIP averaged 36 percent in non-expansion states (10 states) compared to 30 percent in expansion states (41 states), from March 2023 through September 2024.[36] States that did not expand Medicaid also had a disproportionate share of total disenrollments. These states accounted for 22 percent of completed unwinding redeterminations but almost 30 percent of all disenrollments during this time period.

Although states frequently used procedural disenrollments, CMS officials said they did not know how they were associated with variation among states in the overall percentage of individuals disenrolled from Medicaid or CHIP during unwinding. The percentage of unwinding disenrollments that were procedural exceeded 50 percent in 46 states from March 2023 through September 2024. In addition, more than 75 percent of disenrollments were procedural in 19 states, including in several states with relatively lower percentages of disenrollments overall. For example, North Carolina disenrolled 13 percent of individuals with a completed redetermination, but the percentage of disenrollments that were procedural was 85 percent.

CMS officials told us they used the data on renewals and disenrollments to monitor state compliance with redetermination requirements and to provide technical assistance to states on their redetermination processes. For example, CMS officials told us they reviewed data on renewals and disenrollments weekly to identify state outliers and determine if CMS needed additional information from the state before escalating an issue internally. In some cases, this data monitoring enabled CMS to find and address problems with states' redetermination processes. CMS officials plan to continue collecting renewals and disenrollment data from states

[35]The remaining state, Maine, completed 27 percent of renewals through the ex parte process. According to CMS officials, Maine may have had the lowest percentage of disenrolled due to its pause on procedural disenrollments.

[36]North Carolina and South Dakota are considered expansion states in this analysis.

after unwinding is complete, due to the data's importance in helping the agency monitor and oversee states' redetermination processes, which they outlined in May 2024 guidance. This is consistent with our July 2024 recommendation to CMS on documenting and implementing oversight practices the agency learned during unwinding were needed to help ensure states' compliance issues with redetermination requirements.[37]

CMS Analyses Provide Some Insight into Unwinding Outcomes by Age and Eligibility Group and Transitions to Other Health Care Coverage

CMS analyses of unwinding outcomes by age and eligibility group suggest that certain populations were more likely to be disenrolled. CMS indicated that these analyses were limited by what data were available and the time period reviewed.

- **Adult and child.** CMS analyzed differences in the percentage decline in Medicaid and CHIP enrollment from March 2023 through May 2024 for adults compared to children. CMS found that the decline in enrollment was about 4 percentage points more for adults during this time period.[38] CMS officials said this may partly be a result of the higher eligibility income limits for children compared to adults.[39]
- **Eligibility group.** CMS analyzed the percentage of individuals who were disenrolled from Medicaid or CHIP or transitioned to limited benefit coverage for different eligibility groups from April 2023 through December 2023.[40] This analysis suggests that young adults aged 19 to 23 in a child-eligibility group were the most likely to be disenrolled

[37]For more information on how CMS used data during unwinding as part of its oversight, including to identify and address states' lack of compliance with federal redetermination requirements, see GAO-24-106883.

[38]For this analysis, CMS defined child as it was defined by the state for Medicaid or CHIP. The age limit for a "child" varied from state to state, and child enrollment likely included "children" up to age 24 whose coverage was maintained as a requirement of the Medicaid continuous enrollment condition.

[39]Under Medicaid and CHIP, income eligibility limits vary by state, but childless adults in states that have expanded Medicaid are generally eligible if their income is below 133 percent of the federal poverty level, whereas the income limit for CHIP can generally range from 170 percent to 400 percent of the federal poverty level.

[40]This CMS analysis focuses on individuals who were disenrolled from full benefit Medicaid or CHIP or transitioned to limited benefit coverage from March 31, 2023, through December 31, 2023. Some individuals in Medicaid are eligible for full Medicaid benefits and others for limited benefits. For example, benefits may be limited to certain services, such as family planning, or care provided for a specific condition like tuberculosis.

or transition to limited benefit coverage.[41] Specifically, over 50 percent of these young adults were disenrolled from full benefit Medicaid or CHIP or moved to a program with limited benefits.[42] Enrollees in a pregnancy-related eligibility group were the second most likely to be disenrolled or transition to limited benefit coverage (39 percent). In contrast, enrollees in a disability-specific eligibility group were the least likely (7 percent) to be disenrolled or transition to limited benefit coverage.

According to CMS, populations with relatively higher disenrollments may have moved into eligibility categories with lower income limits and as a result, likely were no longer eligible for Medicaid or CHIP coverage. For example, CMS officials said that young adults aged 19 to 23 may have aged out of child-specific eligibility groups, and the income limits for certain adult eligibility groups generally are lower than for children.[43] In addition, in states that did not expand eligibility to certain low-income adults, these individuals may no longer fall into a category that is eligible for Medicaid, according to CMS officials.

- **Home- and community-based services enrollees.** CMS also analyzed the percentage of individuals who had been receiving home- and community-based services who were disenrolled from Medicaid or CHIP or transitioned to limited benefit coverage.[44] Specifically, CMS compared disenrollments and transitions to limited benefit coverage for those who had been receiving home- and community-based services to the general Medicaid and CHIP population for 36

[41]For additional information, see Centers for Medicare & Medicaid Services, *Medicaid & CHIP Leavers and Coverage Transitions: By Eligibility Category and Home & Community-Based Services (HCBS) 1915(c) Waiver Enrollment, March 31-December 31, 2023*, (November 2024).

[42]The percentages of individuals disenrolled or transitioned to limited benefit coverage exclude enrollees who died or moved to another state's Medicaid program.

[43]Children generally have higher income limits than adults under the age of 65 and who do not have a disability.

[44]All state Medicaid programs finance coverage of long-term services and supports, which help beneficiaries with physical, cognitive, or other limitations performing routine daily activities, such as eating, dressing, and making meals. When these services are provided in beneficiaries' homes or other community settings, the services are known as home and community-based services.

states from April 2023 through December 2023.[45] This analysis suggests that individuals who had been receiving home- and community-based services may have had relatively fewer disenrollments when compared to other individuals. Specifically, 3 percent of individuals who had been receiving home- and community-based services were disenrolled from full benefit Medicaid or CHIP coverage or moved to limited benefit coverage.[46] This is significantly lower than the 18 percent who experienced those outcomes for the general Medicaid and CHIP population.

CMS officials said several factors may affect the relatively fewer disenrollments for home- and community-based services enrollees. For example, the eligibility factors for these individuals, such as their disability status, are less likely to change than the eligibility factors for other groups of enrollees. Individuals receiving home- and community-based services are also more likely to need and have help with renewal forms, which may reduce their likelihood of being disenrolled, according to officials.

CMS analyses of the extent to which those disenrolled during unwinding obtained other health care coverage found that certain populations may be more likely to transition to other coverage or return to Medicaid or CHIP. CMS officials said these analyses only give a partial picture on what happened to individuals after they were disenrolled from Medicaid or CHIP due to gaps in the data on transitions to other coverage.[47]

- **Transitions to marketplace coverage.** From April 2023 through June 2024, CMS found that at least 2.7 million individuals disenrolled from Medicaid or CHIP during unwinding obtained health care coverage in states using the federal marketplace platform.[48] In

[45]This analysis focused on individuals receiving home- and community-based services under waiver programs authorized under section 1915(c) of the Social Security Act. 42 U.S.C. § 1396n(c). In addition, it focused on individuals who were disenrolled from full benefit Medicaid or CHIP or transitioned to limited benefit coverage from March 31, 2023, through December 31, 2023. See Centers for Medicare & Medicaid Services, *Medicaid & CHIP Leavers and Coverage Transitions.*

[46]The percentage of individuals disenrolled or transitioned to limited benefit coverage excludes individuals who died or moved to another state's Medicaid program.

[47]CMS has some national and state-specific data on individuals who transitioned to employer-sponsored coverage by age and eligibility group. Officials told us they do not plan to make the data or analyses publicly available due to the amount of missing data.

[48]States can either use the federal marketplace platform (Healthcare.gov) or run their own state-based marketplace using their own platform.

addition, at least 830,000 individuals obtained health care coverage through state-based marketplaces using their own platforms.[49] CMS also analyzed enrollees who were disenrolled from April 2023 through December 2023 who transitioned to marketplace coverage by certain eligibility groups in states using the federal marketplace platform.[50] CMS found that certain groups were more likely to transition to marketplace coverage than others after disenrollment in these states. Specifically, among enrollees who were disenrolled from full benefit Medicaid or CHIP coverage, adults aged 19 to 64 and not in a disability-specific eligibility group were the most likely to obtain marketplace coverage (at least 14 percent). In contrast, enrollees over 65 and not in a disability-specific eligibility group were the least likely to obtain such coverage (1 percent).

CMS officials told us these differences may be related to who may be eligible for premium tax credits for marketplace coverage. For example. according to CMS analysis, enrollees over 65 and those in a disability-specific eligibility group often qualify for Medicare. As a result, CMS officials said they would often not be eligible for premium tax credits and may be less likely to transition to marketplace coverage compared to other groups.

- **Churn back into Medicaid or CHIP.** CMS found that about 14 percent of individuals who were disenrolled from full benefit coverage from April 2023 through December 2023, churned back into Medicaid or CHIP by March 2024.[51] CMS also analyzed the level of churn by different eligibility groups and found children and those in a pregnancy-related eligibility group were the most likely to experience

[49]CMS officials said that at least 460,000 individuals also obtained health care coverage in states with a state-based marketplace that operate a Basic Health Program or related program, which provides coverage to certain low-income individuals who are not eligible for Medicaid or CHIP and otherwise would be eligible for marketplace coverage.

[50]This CMS analysis focuses on individuals who were disenrolled from full benefit Medicaid or CHIP coverage from March 31, 2023, through December 31, 2023. Thirty-two states used the federal marketplace platform for the 2024 coverage period. CMS did not include data on enrollees moving to other states and those with state-based marketplaces using their own platform due to data limitations. See Centers for Medicare & Medicaid Services, *Medicaid & CHIP Leavers and Coverage Transitions*.

[51]This CMS analysis focuses on individuals who were disenrolled from full benefit Medicaid or CHIP coverage from March 31, 2023, through December 31, 2023, and returned to Medicaid or CHIP in the same state from which they were disenrolled. See Centers for Medicare & Medicaid Services, *Medicaid & CHIP Leavers and Coverage Transitions*.

churn.[52] Specifically, over 15 percent of children under 19 and those enrolled in a pregnancy-related eligibility group who were disenrolled from March 2023 through December 2023 churned back into full benefit Medicaid or CHIP by March 2024. In contrast, enrollees over 65 and not in a disability-specific eligibility group were the least likely to churn back into full benefit Medicaid or CHIP (1 percent).

CMS officials noted that children may have been more likely to churn back into Medicaid or CHIP due to generally higher income limits for eligibility, which is also consistent with a past CMS analysis. Enrollees in a pregnancy-related eligibility group may have been more likely to churn back into Medicaid or CHIP due to states reinstating or reenrolling these individuals as a result of implementation of the 12-month postpartum coverage option, according to CMS.[53]

As of March 2025, CMS officials noted they are interested in doing more analysis on how unwinding outcomes are distributed across different age and Medicaid eligibility groups.

Selected States Found Relatively Higher Disenrollments for Certain Age, Race, and Other Population Groups, Though Findings Varied by State

Our five selected states found relatively higher Medicaid and CHIP disenrollments for certain population groups, though findings varied by state. States were not required to analyze unwinding outcomes, including disenrollments, by population characteristics—and the five states varied in the extent to which they did so (see table 1). (See appendix II for additional information on disenrollments by population characteristics for the five selected states.)

[52]For this analysis, CMS defined children as individuals aged 0 to 18 who were not in a disability- or pregnancy-related eligibility group.

[53]Federal law generally requires states to provide continuous coverage to pregnant women enrolled in Medicaid or CHIP through approximately 60 days postpartum. See 42 C.F.R. § 435.170 (2024). The American Rescue Plan Act of 2021 gave states the option to extend Medicaid and CHIP postpartum coverage to 12 months, but the authority was set to expire on April 1, 2022. See Pub. L. No. 117-2, §§ 9812, 9822, 135 Stat. 4, 212, 220. Under the Consolidated Appropriations Act, 2023, this option was made permanent. See Pub. L. No. 117-328, div. FF, tit. V, subtit. B, § 5113, 136 Stat. 4459, 5940 (2022). In March 2023, 31 states had extended Medicaid postpartum coverage beyond the 60 days. That number increased to 47 states as of May 2024.

Table 1: Whether Selected States Analyzed Medicaid and CHIP Disenrollments by Certain Population Characteristics

State	Age	Geographic location	Race and ethnicity	Language	Tribal affiliation
Arizona	✓	✓	✓	—	—
Maryland	✓	✓	✓	—	—
Montana	✓	✓	—	—	✓
New York	✓	✓	✓	✓	—
Wisconsin	✓	✓	✓	✓	—

Legend:

CHIP: Children's Health Insurance Program

✓: State analyzed disenrollments by characteristic

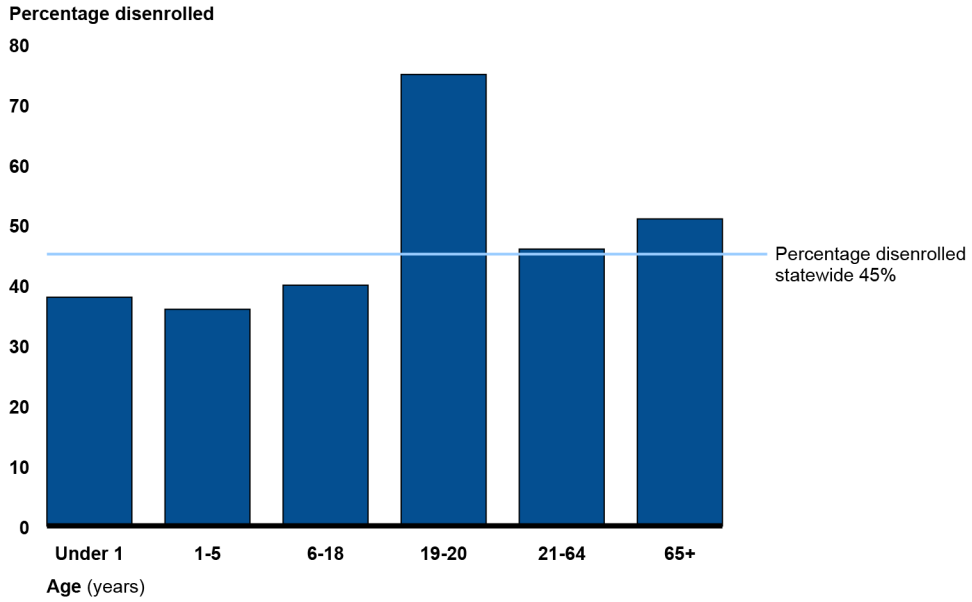
Source: GAO analysis of state information. | GAO-25-107413

Differences in Disenrollments by Age

Information from all five selected states indicated relatively higher disenrollments among enrollees of certain ages. For example, in the two states that analyzed disenrollments for young adults aged 19 to 20 (Maryland and Montana), state data indicated that a higher percentage of enrollees were disenrolled in this age group than in all other age groups. Figure 5 shows disenrollments by age group in one of the states. Officials from this state said they expected young adults to experience higher disenrollments than children because of the different eligibility requirements for these groups in the state.[54]

[54]To be eligible for coverage in Montana, individuals aged 19 and older generally must have a lower income than children aged 18 and under.

Figure 5: Percentage of Completed Redeterminations That Resulted in Disenrollments During Unwinding in Montana, by Age, May 2023-June 2024



Source: GAO analysis of state data. | GAO-25-107413

Notes: "Percentage disenrolled" is the percentage of Medicaid and Children's Health Insurance Program enrollees with completed redeterminations that resulted in disenrollment as of June 2024. At that time, the state had not completed about 8 percent of redeterminations due, including redeterminations for 13 percent of enrollees under age 1, 19 percent of those aged 65 or older, and 5 to 8 percent of enrollees in other age groups. The state data used to calculate percentages reflect the initial redetermination decisions made during unwinding and do not reflect changes in outcomes that may have occurred during the state's 90-day reconsideration period after a procedural disenrollment. The data include enrollees who went through the state's standard eligibility redetermination process; other enrollees, such as those Medicaid-eligible due to foster care status, are not included.

Similarly, data from three states (Arizona, Maryland, and Montana) indicated that older age groups (adults) had relatively higher disenrollments than children aged 18 and under. For example, in Maryland, 26 percent of enrollees aged 21 to 44 with completed redeterminations were disenrolled as compared to 19 percent of children aged 5 and under.[55] Similarly, in Arizona, adults aged 19 and older were a larger share of disenrollments when compared to their overall share of the enrollee population. Specifically, adults accounted for 66 percent of

[55]Maryland data reflect redeterminations completed from May 2023 through April 2024. State date also showed, for procedural disenrollments by age, that among individuals who were disenrolled, children aged 18 and under had a larger percentage of procedural disenrollments than most other age groups.

disenrollments during unwinding but were 58 percent of the state's total Medicaid and CHIP population in May 2024.[56] Arizona and Montana officials said they expected relatively higher disenrollments among adults than among children aged 18 and under because of generally lower income eligibility limits for adults in these states.

In one selected state, officials told us that age differences in disenrollments had informed their outreach efforts. Specifically, after Wisconsin found that a relatively high percentage of adults aged 19 to 35 were disenrolled, they prioritized new outreach efforts to help young adults retain coverage, according to state officials.

Differences in Disenrollments by Geographic Location

Information from all five selected states indicated relatively higher disenrollments in certain zip codes, counties, or regions. For example,

- **Maryland.** State data indicated that the suburban Washington, D.C. and western Maryland regions had the highest percentage of completed redeterminations that resulted in disenrollments (25 percent and 24 percent, respectively), while Baltimore City had the lowest percentage of disenrollments (19 percent).[57]

  Geographic differences in disenrollments during unwinding led the state to increase outreach in certain areas, officials said. To better understand local disenrollment differences, officials analyzed demographic data for the 60 zip codes with the highest percentage of redeterminations that resulted in procedural disenrollment. In doing so, officials said they analyzed procedural disenrollments by race and ethnicity in those zip codes, which allowed the state to identify communities with relatively higher procedural disenrollments and provide targeted outreach. For example, after identifying relatively higher procedural disenrollments in parts of suburban Washington, D.C., particularly among Hispanic or Latino individuals, state officials increased outreach in those areas via Spanish language radio.

- **New York.** Available data indicated that New York City and two other regions had the highest percentage of completed redeterminations

[56]Arizona data reflect redeterminations completed from April 2023 through March 2024.

[57]Maryland data reflect redeterminations completed from May 2023 through April 2024.

that resulted in disenrollment (30 percent).[58] Officials said they had seen higher-than-expected percentages of procedural disenrollments in New York City, and the state targeted outreach in that area to help individuals renew their coverage.

Differences in Disenrollments by Race and Ethnicity

Of the four selected states that analyzed outcomes by race and ethnicity, data from Maryland and Wisconsin indicated relatively higher disenrollments for certain racial and ethnic groups. Data limitations in the two other states—Arizona and New York—made comparisons challenging.

- **Maryland.** State data across 10 categories related to race and ethnicity indicated that individuals who were Pacific Islander, White, or of "other" or unknown race and ethnicity had the highest percentage of completed redeterminations that resulted in disenrollment (about 25 percent or more). In comparison, individuals who were American Indian or Alaska Native, both Black and White, or two or more other races had the lowest percentages of completed redeterminations that resulted in disenrollment (less than 20 percent).[59]

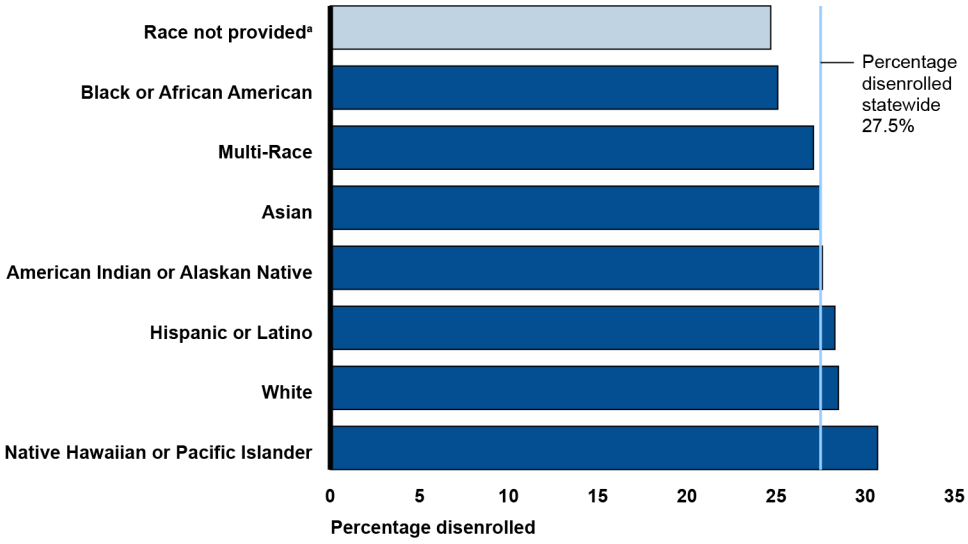
  State data also indicated that individuals who were Black or African American; both Black and White; or of unknown race and ethnicity had the largest percentage of disenrollments that were procedural. Specifically, for each of these groups, more than 64 percent of disenrollments were procedural. In comparison, individuals who were Asian, Pacific Islander, White, or of "other" race and ethnicity had the lowest percentage of procedural disenrollments (less than 58 percent of disenrollments).

[58]New York data reflect redeterminations completed from June 2023 through May 2024 for the 5.1 million Medicaid and CHIP enrollees whose eligibility was redetermined centrally though a state eligibility system. Data do not include redeterminations for the 1.3 million enrollees whose eligibility was redetermined by local departments of social services because disenrollments by region were not available for those enrollees, state officials said.

[59]Maryland data reflect redeterminations completed from May 2023 through April 2024. Data are based on enrollees' self-reported race and ethnicity and reflect the categories the state used in its analysis. "Black and White" includes individuals who identified as both Black and White; "two or more other races" includes all other individuals who identified as two or more races; and "other" includes individuals whose only reported race or ethnicity was "other," Maryland officials said. Enrollees can choose not to report their race and ethnicity. Individuals of unknown race and ethnicity accounted for less than 1 percent of unwinding redeterminations in Maryland.

- **Wisconsin.** State data across eight categories related to race and ethnicity indicated that Native Hawaiian or Pacific Islander, White, and Hispanic or Latino individuals had the highest percentages of completed redeterminations that resulted in disenrollment.[60] (See fig. 6.) State data also indicated that American Indian or Alaskan Native, Hispanic or Latino, and Native Hawaiian or Pacific Islander individuals had the largest percentage of disenrollments that were procedural (about 67 percent).

Figure 6: Percentage of Completed Redeterminations That Resulted in Disenrollments During Unwinding in Wisconsin, by Race and Ethnicity, June 2023-June 2024



Source: GAO analysis of state data. | GAO-25-107413

Notes: "Percentage disenrolled" is the percentage of Medicaid and Children's Health Insurance Program enrollees with completed redeterminations that resulted in disenrollment. Data are based on enrollees' self-reported race and ethnicity and reflect the categories the state used in its analysis. Data reflect redeterminations completed from June 2023 through June 2024, which account for all redeterminations due during unwinding. Data also reflect changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment. The state data used to calculate percentages include enrollees who went through the state's standard eligibility redetermination process; other enrollees, such as those Medicaid eligible due to foster care status, are not included.

[a]Enrollees could choose not to report their race. Enrollees who did not report their race accounted for 12 percent of unwinding redeterminations.

[60]Wisconsin data reflect redeterminations completed from June 2023 through June 2024. Data are based on enrollees' self-reported race and ethnicity and reflect the categories the state used in its analysis. Enrollees could choose not to report their race. Enrollees who did not report their race accounted for 12 percent of unwinding redeterminations in Wisconsin.

Wisconsin officials told us they created an unwinding outreach dashboard to share outcomes data by race, primary language, and other population characteristics with partner organizations, such as provider groups. Feedback on the data from those organizations helped the state adapt outreach to certain populations.

Differences in Disenrollments by Other Population Characteristics

State data also indicated relatively higher disenrollments by other population characteristics. For example,

- **Language.** Two selected states (New York and Wisconsin) analyzed disenrollments by enrollees' language. For example, in New York, available data across 28 written language categories, including English, indicated that enrollees who selected French Creole, Nepali, or Japanese as their preferred written language had the highest percentage of completed redeterminations that resulted in disenrollment (more than 33 percent). In comparison, enrollees who selected Arabic, Swahili, or Somali as their preferred written language were among those with the lowest percentage of redeterminations that resulted in disenrollment (16 to 18 percent).[61] Individuals must select their preferred written language when applying for coverage through the eligibility system that manages most of the states' Medicaid and CHIP enrollees.[62]
- **Tribal affiliation.** One of our selected states—Montana—analyzed disenrollments by tribal affiliation. State data indicated relatively more disenrollments among enrollees who did not report being tribally affiliated than those who did. Forty-six percent of non-tribally affiliated enrollees with a completed redetermination had been disenrolled as of June 2024, as compared to 36 percent of tribally affiliated enrollees

[61]New York data reflect redeterminations completed from June 2023 through May 2024 for the 5.1 million Medicaid and CHIP enrollees whose eligibility was redetermined centrally though a state eligibility system. Data do not include redeterminations for the 1.3 million enrollees whose eligibility was redetermined by local departments of social services because disenrollments by language were not available for those enrollees, state officials said.

[62]State officials noted that the state has programs in which partner organizations with staff who speak more than 60 languages can help enrollees renew coverage. During unwinding, the state sent monthly reports to these partners about which enrollees had been procedurally disenrolled, to facilitate outreach and reenrollment for eligible individuals.

with a completed redetermination.[63] State officials said the relatively lower disenrollments among tribally affiliated enrollees could reflect many of these enrollees tending to live in areas with fewer economic opportunities. In addition, state officials worked with the federal Indian Health Service and tribal groups to help tribally affiliated enrollees retain coverage, if eligible. They did so by identifying which enrollees were at risk of disenrollment due to not returning renewal forms and then sharing that information with those external groups to facilitate outreach, state officials said.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The agency provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at RosenbergM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

//SIGNED//

Michelle B. Rosenberg
Director, Health Care

[63]Montana data reflect redeterminations completed from May 2023 through June 2024. As of June 2024, the state had not completed about 8 percent of redeterminations due.

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Appendix I: Nationwide Data on Disenrollments, Renewals, and Pending Redeterminations, by State, March 2023 Through September 2024

States reported certain unwinding outcomes—such as the number and type of renewals and disenrollments—for Medicaid and Children's Health Insurance Program (CHIP) enrollees to the Centers for Medicare & Medicaid Services (CMS) beginning with redeterminations completed in March 2023. CMS has publicly shared preliminary data reported by states as well as updated data, which has generally lagged the preliminary data by five or more months. The preliminary data include millions more pending redeterminations—redeterminations that were incomplete and still being processed—compared to the updated data. We are reporting on numbers and percentages using the updated data that were published in January 2025.

These data reflect the outcomes for monthly cohorts of redeterminations due for completion from March 2023 through June 2024. For each monthly cohort, the updated data generally include redeterminations completed in the month due or any of the 3 subsequent months. Thus, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort includes outcomes for redeterminations that were completed as of September 2024. Redeterminations completed more than 3 months after the month they were due are generally reflected as pending in the data and not included in our calculations of the percentage of disenrollments or renewals. In addition, the data generally do not reflect changes to an outcome after a redetermination was completed, such as state decisions to reinstate coverage for those initially disenrolled. Finally, the data may reflect outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, which is generally 12 months later.

CMS data published in January 2025 included the number of completed redeterminations as well as how many enrollees were renewed and disenrolled from March 2023 through September 2024 (see table 2).

Table 2: Medicaid and Children's Health Insurance Program (CHIP) Renewals and Disenrollments, by State, March 2023-September 2024

	Number of Medicaid and CHIP enrollees			Percentage of all completed redeterminations	
State	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Alabama	1,324,475	886,970	437,505	67.0%	33.0%
Alaska	145,461	95,930	49,531	65.9%	34.1%
Arizona	2,912,469	2,318,188	594,281	79.6%	20.4%

	Number of Medicaid and CHIP enrollees			Percentage of all completed redeterminations	
State	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Arkansas	1,036,666	661,734	374,932	63.8%	36.2%
California	11,660,941	9,539,870	2,121,071	81.8%	18.2%
Colorado	1,773,941	964,368	809,573	54.4%	45.6%
Connecticut	1,389,391	1,141,133	248,258	82.1%	17.9%
Delaware	284,628	200,884	83,744	70.6%	29.4%
District of Columbia	310,421	237,222	73,199	76.4%	23.6%
Florida	5,474,605	3,433,559	2,041,046	62.7%	37.3%
Georgia	2,258,892	1,310,900	947,992	58.0%	42.0%
Hawaii	454,399	357,597	96,802	78.7%	21.3%
Idaho	445,744	221,774	223,970	49.8%	50.2%
Illinois	3,481,913	2,609,772	872,141	75.0%	25.0%
Indiana	1,970,524	1,438,297	532,227	73.0%	27.0%
Iowa	992,736	690,750	301,986	69.6%	30.4%
Kansas	481,856	312,537	169,319	64.9%	35.1%
Kentucky	966,082	725,384	240,698	75.1%	24.9%
Louisiana	1,973,454	1,298,656	674,798	65.8%	34.2%
Maine	408,443	375,230	33,213	91.9%	8.1%
Maryland	1,702,861	1,277,379	425,482	75.0%	25.0%
Massachusetts	1,699,566	1,010,933	688,633	59.5%	40.5%
Michigan	3,091,089	1,970,952	1,120,137	63.8%	36.2%
Minnesota	1,438,010	983,378	454,632	68.4%	31.6%
Mississippi	684,397	524,124	160,273	76.6%	23.4%
Missouri	1,221,511	860,231	361,280	70.4%	29.6%
Montana	274,759	128,222	146,537	46.7%	53.3%
Nebraska	393,078	274,577	118,501	69.9%	30.1%
Nevada	1,107,978	718,230	389,748	64.8%	35.2%
New Hampshire	227,042	156,195	70,847	68.8%	31.2%
New Jersey	1,735,638	960,401	775,237	55.3%	44.7%
New Mexico	865,705	631,925	233,780	73.0%	27.0%
New York	6,744,956	4,716,821	2,028,135	69.9%	30.1%
North Carolina	2,560,336	2,229,624	330,712	87.1%	12.9%
North Dakota	157,682	90,795	66,887	57.6%	42.4%
Ohio	4,126,025	3,154,553	971,472	76.5%	23.5%
Oklahoma	1,490,558	724,683	765,875	48.6%	51.4%
Oregon	1,345,402	1,149,623	195,779	85.4%	14.6%

	Number of Medicaid and CHIP enrollees			Percentage of all completed redeterminations	
State	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Pennsylvania	3,771,362	2,733,324	1,038,038	72.5%	27.5%
Rhode Island	317,371	225,032	92,339	70.9%	29.1%
South Carolina	1,195,123	760,613	434,510	63.6%	36.4%
South Dakota	125,106	62,828	62,278	50.2%	49.8%
Tennessee	1,510,063	899,112	610,951	59.5%	40.5%
Texas	4,891,717	2,322,485	2,569,232	47.5%	52.5%
Utah	471,555	221,327	250,228	46.9%	53.1%
Vermont	168,969	124,137	44,832	73.5%	26.5%
Virginia	2,083,864	1,808,974	274,890	86.8%	13.2%
Washington	1,946,119	1,445,212	500,907	74.3%	25.7%
West Virginia	575,604	346,508	229,096	60.2%	39.8%
Wisconsin	1,291,994	815,987	476,007	63.2%	36.8%
Wyoming	71,739	55,044	16,695	76.7%	23.3%
Total	**89,034,220**	**62,203,984**	**26,830,236**	**69.9%**	**30.1%**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-25-107413

Notes: Data are for Medicaid and the Children's Health Insurance Program. They reflect the initial outcomes (renewal or disenrollment) of unwinding redeterminations for the monthly cohorts of redeterminations that were due to be completed from March 2023 through June 2024. For each monthly cohort, the data reflect redeterminations completed in the month due or any of the 3 subsequent months. Redeterminations completed more than 3 months after the month they were due are generally not included in the data. Thus, for example, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort includes outcomes for redeterminations that were completed as of September 2024. This analysis is focused on completed redeterminations and excluded those reflected as pending in the data.

The data generally do not reflect changes to an outcome after a redetermination was completed, such as state decisions to reinstate coverage for those initially disenrolled. However, Arkansas, California, Oklahoma, Pennsylvania, Rhode Island, Wyoming, and South Carolina included data for some months on eligibility decisions that occurred after the initial redetermination, such as reinstatements of coverage for individuals that were initially disenrolled. The data may reflect outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, which is generally 12 months later.

CMS also published state data on the number of renewals completed without the state requesting additional information from the enrollee, i.e., through the "ex parte" process, and the number of disenrollments that were based on procedural reasons, such as enrollees not providing requested information to state Medicaid agencies (see table 3).

Table 3: Medicaid and Children's Health Insurance Program (CHIP) Prevalence of Ex Parte Renewals and Procedural Disenrollments, by State, March 2023-September 2024

	Percentage of all renewals		Percentage of all disenrollments	
State	Renewed based on new information from enrollee	Renewed via ex parte[a]	Determined ineligible	Disenrolled for procedural reasons[b]
Alabama	44.6%	55.4%	14.9%	85.1%
Alaska	38.3%	61.7%	50.5%	49.5%
Arizona	10.8%	89.2%	32.2%	67.8%
Arkansas	27.5%	72.5%	24.1%	75.9%
California	26.2%	73.8%	25.9%	74.1%
Colorado	51.6%	48.4%	35.0%	65.0%
Connecticut	18.8%	81.2%	30.8%	69.2%
Delaware	53.7%	46.3%	38.1%	61.9%
District of Columbia	20.3%	79.7%	10.3%	89.7%
Florida	66.1%	33.9%	36.2%	63.8%
Georgia	31.0%	69.0%	30.7%	69.3%
Hawaii	28.7%	71.3%	21.1%	78.9%
Idaho	48.9%	51.1%	24.7%	75.3%
Illinois	24.8%	75.2%	28.3%	71.7%
Indiana	28.1%	71.9%	23.8%	76.2%
Iowa	48.7%	51.3%	27.7%	72.3%
Kansas	56.6%	43.4%	40.0%	60.0%
Kentucky	14.9%	85.1%	44.5%	55.5%
Louisiana	20.3%	79.7%	29.0%	71.0%
Maine	72.6%	27.4%	81.3%	18.7%
Maryland	25.9%	74.1%	25.0%	75.0%
Massachusetts	34.4%	65.6%	33.3%	66.7%
Michigan	41.8%	58.2%	19.6%	80.4%
Minnesota	43.4%	56.6%	21.7%	78.3%
Mississippi	70.1%	29.9%	26.2%	73.8%
Missouri	20.9%	79.1%	19.7%	80.3%
Montana	50.4%	49.6%	31.9%	68.1%
Nebraska	46.8%	53.2%	45.7%	54.3%
Nevada	26.1%	73.9%	7.7%	92.3%
New Hampshire	24.1%	75.9%	19.8%	80.2%
New Jersey	56.9%	43.1%	26.4%	73.6%
New Mexico	39.2%	60.8%	17.0%	83.0%

	Percentage of all renewals		Percentage of all disenrollments	
State	Renewed based on new information from enrollee	Renewed via ex parte[a]	Determined ineligible	Disenrolled for procedural reasons[b]
New York	48.1%	51.9%	53.6%	46.4%
North Carolina	0.5%	99.5%	15.3%	84.7%
North Dakota	52.8%	47.2%	30.9%	69.1%
Ohio	31.8%	68.2%	30.1%	69.9%
Oklahoma	66.4%	33.6%	18.3%	81.7%
Oregon	19.6%	80.4%	54.5%	45.5%
Pennsylvania	92.5%	7.5%	47.0%	53.0%
Rhode Island	9.0%	91.0%	24.7%	75.3%
South Carolina	33.8%	66.2%	34.6%	65.4%
South Dakota	73.9%	26.1%	51.5%	48.5%
Tennessee	29.5%	70.5%	24.4%	75.6%
Texas	88.6%	11.4%	32.1%	67.9%
Utah	50.9%	49.1%	10.0%	90.0%
Vermont	25.2%	74.8%	28.7%	71.3%
Virginia	33.3%	66.7%	45.9%	54.1%
Washington	11.2%	88.8%	15.4%	84.6%
West Virginia	63.2%	36.8%	24.3%	75.7%
Wisconsin	61.1%	38.9%	42.9%	57.1%
Wyoming	46.8%	53.2%	25.7%	74.3%
Total	**38.4%**	**61.6%**	**31.0%**	**69.0%**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-25-107413

Notes: Data are for Medicaid and the Children's Health Insurance Program. They reflect the initial outcomes (renewal or disenrollment) of unwinding redeterminations for the monthly cohorts of redeterminations that were due to be completed from March 2023 through June 2024. For each monthly cohort, the data reflect redeterminations completed in the month due or any of the 3 subsequent months. Redeterminations completed more than 3 months after the month they were due are generally not included in the data. Thus, for example, data for the March 2023 cohort includes outcomes for redeterminations completed as of June 2023 and data for the June 2024 cohort includes outcomes for redeterminations that were completed as of September 2024. This analysis is focused on completed redeterminations and excluded those reflected as pending in the data.

The data generally do not reflect changes to an outcome after a redetermination was completed, such as state decisions to reinstate coverage for those initially disenrolled. However, Arkansas, California, Oklahoma, Pennsylvania, Rhode Island, Wyoming, and South Carolina included data for some months on eligibility decisions that occurred after the initial redetermination, such as reinstatements of coverage for individuals that were initially disenrolled. The data may reflect outcomes from two redeterminations for some enrollees—the unwinding redetermination and the routine redetermination completed later in the period, which is generally 12 months later.

[a]Ex parte renewals are renewals that are done without additional information from the enrollee.

[b]Procedural reasons for being disenrolled include, for example, not providing all information needed to redetermine eligibility.

Most states still had pending redeterminations for those due from March 2023 through June 2024 (see table 4). These states had initiated these redeterminations but had not completed them in the month they were due or generally in any of the subsequent 3 months, according to updated data that CMS published in January 2025.

Table 4: Medicaid and Children's Health Insurance Program (CHIP) Pending Redeterminations, by State, for Redeterminations Scheduled for Completion March 2023-June 2024

	Number of Medicaid and CHIP enrollees		
State	Redeterminations due through June 2024[a]	Pending redeterminations[b]	Percentage of pending redeterminations out of all due
Alabama	1,325,451	976	0.1%
Alaska	199,929	54,468	27.2%
Arizona	2,913,465	996	0.0%
Arkansas	1,049,432	12,766	1.2%
California	13,796,970	2,136,029	15.5%
Colorado	1,786,893	12,952	0.7%
Connecticut	1,426,741	37,350	2.6%
Delaware	298,799	14,171	4.7%
District of Columbia	330,549	20,128	6.1%
Florida	5,476,033	1,428	0.0%
Georgia	2,337,840	78,948	3.4%
Hawaii	474,041	19,642	4.1%
Idaho	445,744	0	0.0%
Illinois	3,660,815	178,902	4.9%
Indiana	2,141,471	170,947	8.0%
Iowa	1,036,955	44,219	4.3%
Kansas	609,614	127,758	21.0%
Kentucky	1,168,102	202,020	17.3%
Louisiana	1,976,376	2,922	0.1%
Maine	466,494	58,051	12.4%
Maryland	1,743,727	40,866	2.3%
Massachusetts	1,701,833	2,267	0.1%
Michigan	3,099,634	8,545	0.3%
Minnesota	1,441,999	3,989	0.3%
Mississippi	748,715	64,318	8.6%
Missouri	1,455,929	234,418	16.1%
Montana	336,470	61,711	18.3%

State	Number of Medicaid and CHIP enrollees		Percentage of pending redeterminations out of all due
	Redeterminations due through June 2024[a]	Pending redeterminations[b]	
Nebraska	445,700	52,622	11.8%
Nevada	1,107,978	0	0.0%
New Hampshire	227,072	30	0.0%
New Jersey	2,153,190	417,552	19.4%
New Mexico	919,411	53,706	5.8%
New York	6,856,535	111,579	1.6%
North Carolina	2,973,021	412,685	13.9%
North Dakota	158,065	383	0.2%
Ohio	4,229,596	103,571	2.4%
Oklahoma	1,504,474	13,916	0.9%
Oregon	1,352,565	7,163	0.5%
Pennsylvania	3,787,211	15,849	0.4%
Rhode Island	325,826	8,455	2.6%
South Carolina	1,318,036	122,913	9.3%
South Dakota	125,106	0	0.0%
Tennessee	1,585,807	75,744	4.8%
Texas	5,280,084	388,367	7.4%
Utah	471,555	0	0.0%
Vermont	176,335	7,366	4.2%
Virginia	2,396,673	312,809	13.1%
Washington	1,946,558	439	0.0%
West Virginia	599,989	24,385	4.1%
Wisconsin	1,291,994	0	0.0%
Wyoming	79,423	7,684	9.7%
Total	**94,762,225**	**5,728,005**	**6.0%**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-25-107413

Note: Data were published in January 2025.

[a]The number of redeterminations due includes those that were scheduled for completion from March 2023 through June 2024.

[b]The number of pending redeterminations are those that were due from March 2023 through June 2024 but were not completed in the month they were due or generally in any of the subsequent 3 months. These pending redeterminations may include cases where a state is pausing procedural disenrollments temporarily. Alaska, Colorado, District of Columbia, Delaware, Kansas, Kentucky, Maine, Michigan, New Hampshire, New Mexico, and New York had paused at least some disenrollments that were due to procedural reasons, such as enrollees not returning required information, as of June 2024.

Appendix II: Selected States' Data on Unwinding Outcomes by Population Characteristics

The five selected states included in our review (Arizona, Maryland, Montana, New York, and Wisconsin) varied in the extent to which they analyzed unwinding outcomes for Medicaid and Children's Health Insurance Program (CHIP) enrollees, including disenrollments and renewals, by population characteristics.[1] In addition, the time frames of outcomes analyzed varied by state. The following tables provide information on unwinding outcomes by characteristics states analyzed.

Arizona

Table 5 provides information on disenrollments during unwinding in Arizona by age and county; the state did not similarly track renewals by age and county.[2]

Table 5: Medicaid and Children's Health Insurance Program Unwinding Disenrollments in Arizona, by Age and County, April 2023-March 2024

		Percentage of all disenrollments	
Characteristic	**Number of enrollees disenrolled**	**Determined ineligible**	**Disenrolled for procedural reasons[a]**
Age group (years)			
Under 19	209,507	—	—
19-64	381,346	—	—
65 or older	29,218	—	—
County			
Apache	8,283	38.8%	61.2%
Coconino	11,694	38.1	61.9
Cochise	9,959	44.2	55.8
Maricopa	350,507	39.2	60.8
Mohave	20,082	46.6	53.4

[1]States were not required to analyze unwinding outcomes by population characteristics. For example, CMS did not require states to analyze outcomes by categories related to race and ethnicity that are in line with the Office of Management and Budget's Statistical Policy Directive No. 15: *Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.*

[2]State officials noted that adults aged 19 and older were a larger share of disenrollments when compared to their overall share of the enrollee population. Adults accounted for 66 percent of disenrollments during unwinding and were 58 percent of the state's total Medicaid and CHIP population in May 2024. Officials told us they were not able to separately report enrollment for children and adults before May 2024. However, they estimated that as of January 1, 2023, prior to unwinding, adults aged 19 and older were about 61 percent of total enrollees. (January 2023 data exclude enrollees with Medicare Savings Programs-only Medicaid coverage.) The state also published a zip code-level map that identified areas where people were at high risk of losing coverage due to not completing renewal paperwork.

Characteristic	Number of enrollees disenrolled	Percentage of all disenrollments	
		Determined ineligible	Disenrolled for procedural reasons[a]
Navajo	13,019	41.7	58.3
Pima	86,448	41.9	58.1
Pinal	43,571	42.6	57.4
Santa Cruz	6,258	42.9	57.1
Yavapai	16,332	41.7	58.3
Yuma	24,388	47.9	52.1
Other county in state	10,871	38.2	61.8
Other county out of state	18,659	91.0	9.0
Total	**620,071**	**42.1%**	**57.9%**

Legend: — = Not available.

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from April 2023 through March 2024. Data include changes in outcomes during the state's 90-day reconsideration period after a procedural disenrollment when those changes took place by May 6, 2024, according to Arizona officials. The state did not track the number of renewals by age and county, and as a result, we could not calculate the percentage of individuals disenrolled by age or county.

[a]Procedural reasons for being disenrolled include, for example, not providing all information needed to redetermine eligibility.

Table 6 provides information on disenrollments and renewals during unwinding in Arizona for the subset of enrollees for whom the state analyzed outcomes by race and ethnicity. Specifically, of the roughly 2.6 million enrollees whose eligibility was redetermined during unwinding, there were about 630,000 enrollees (about one-fourth) for whom the state had received information during the COVID-19 public health emergency that indicated they no longer met eligibility criteria or would likely be procedurally ineligible, and for whom the state completed a redetermination during unwinding. The state analyzed outcomes by race and ethnicity for the share of those individuals who provided information on race or ethnicity.[3]

[3]Arizona officials told us that this analysis was completed at the request of stakeholders.

Table 6: Medicaid and Children's Health Insurance Program Unwinding Outcomes in Arizona (subset of enrollees), by Race and Ethnicity, April 2023-December 2023

	Number of enrollees		
Characteristic	**Completed redeterminations**	**Renewed**	**Disenrolled**
Race[a]			
Asian Indian	3,344	1,845	1,499
Asian Unknown	648	355	293
Black	60,621	33,340	27,281
Caucasian or White	387,757	206,580	181,177
Chinese	1,459	710	749
Filipino	2,763	1,314	1,449
Guam or Chamorro	367	132	235
Japanese	628	299	329
Korean	956	482	474
Native American	51,109	29,267	21,842
Native Hawaiian	758	379	379
Native Hawaiian or Other Pacific Islander Unknown	120	48	72
Other Asian	2,805	1,463	1,342
Other Pacific Islander	1,277	659	618
Samoan	395	164	231
Unknown	4,934	2,722	2,212
Unspecified	6,067	3,318	2,749
Vietnamese	3,316	1,796	1,520
Ethnicity[a]			
Another Hispanic, Latino/a or Spanish Origin	11,042	5,975	5,067
Cuban	1,758	786	972
Ethnicity Unknown	7,506	4,092	3,414
Ethnicity Unspecified	29	7	22
Hispanic or Latino/a Unknown	81,879	46,835	35,044
Mexican, Mexican American, or Chicano/a	203,797	113,110	90,687
Not of Hispanic or Latino or Spanish Origin	189,090	99,591	89,499
Puerto Rican	3,443	1,700	1,743

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from April 2023 through December 2023 for a subset of enrollees. Specifically, of the roughly 2.6 million enrollees whose eligibility was

redetermined during unwinding, there were about 630,000 enrollees (about one-fourth) for whom the state had received information during the COVID-19 public health emergency that indicated they no longer met eligibility criteria or would likely be procedurally ineligible, and for whom the state completed a redetermination during unwinding. Data include the subset of those individuals who provided information on race or ethnicity.

Data include changes in outcomes during the state's 90-day reconsideration period after a procedural disenrollment.

[a]Categories listed under race and ethnicity are those Arizona used in its analysis based on enrollees' self-reported information. Individuals do not have to report their race or ethnicity. Individuals can select one or more race and ethnicity categories; as a result, individuals may be counted in more than one category related to race or ethnicity. We did not calculate percentages because the outcome for the same individual could be counted in more than one category.

Maryland

Table 7 provides information on disenrollments and renewals during unwinding in Maryland by age, race and ethnicity, region, and eligibility group.

Table 7: Medicaid and Children's Health Insurance Program (CHIP) Unwinding Outcomes in Maryland, May 2023-April 2024

	Number of enrollees			Percentage of all completed redeterminations		Percentage of all disenrollments	
Characteristic	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled	Determined ineligible	Disenrolled for procedural reasons[a]
Age group (years)							
0-5	197,844	159,305	38,539	80.5%	19.5%	38.5%	61.5%
6-14	322,776	270,915	51,861	83.9	16.1	26.6	73.4
15-18	133,162	107,162	26,000	80.5	19.5	35.7	64.3
19-20	55,037	36,638	18,399	66.6	33.4	48.9	51.1
21-44	521,419	383,907	137,512	73.6	26.4	38.5	61.5
45-64	249,910	183,079	66,831	73.3	26.7	45.0	55.0
65+	87,204	62,365	24,839	71.5	28.5	51.1	48.9
Race and ethnicity[b]							
American Indian or Alaska Native	15,023	12,086	2,937	80.4	19.6	37.9	62.1
Asian	90,668	69,942	20,726	77.1	22.9	44.5	55.5
Black or African American	673,952	523,601	150,351	77.7	22.3	35.5	64.5
Black and White	22,611	19,804	2,807	87.6	12.4	33.7	66.3
Hispanic or Latino	276,652	213,072	63,580	77.0	23.0	36.2	63.8
Other	43,594	31,459	12,135	72.2	27.8	43.6	56.4

Characteristic	Number of enrollees			Percentage of all completed redeterminations		Percentage of all disenrollments	
	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled	Determined ineligible	Disenrolled for procedural reasons[a]
Pacific Islander	2,326	1,652	674	71.0	29.0	42.4	57.6
Two or more races	17,518	14,096	3,422	80.5	19.5	38.7	61.3
Unknown	12,071	7,231	4,840	59.9	40.1	32.8	67.2
White	412,937	310,428	102,509	75.2	24.8	45.3	54.7
Region							
Baltimore City	245,718	198,586	47,132	80.8	19.2	32.9	67.1
Baltimore Suburban	475,007	364,336	110,671	76.7	23.3	40.6	59.4
Eastern Shore	141,406	108,965	32,441	77.1	22.9	41.6	58.4
Out of state	1,312	924	388	70.4	29.6	40.2	59.8
Southern Maryland	79,330	60,617	18,713	76.4	23.6	38.2	61.8
Washington Suburban	494,501	371,359	123,142	75.1	24.9	38.5	61.5
Western Maryland	130,078	98,584	31,494	75.8	24.2	44.5	55.5
Eligibility group[c]							
MAGI	1,467,515	1,119,418	348,097	76.3	23.7	62.0	38.0
MAGI-exempt	99,837	83,953	15,884	84.1	15.9	34.2	65.8
Total	**1,567,352**	**1,203,371**	**363,981**	**76.8%**	**23.2%**	**39.2%**	**60.8%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from May 2023 through April 2024. Data include enrollees who went through the state's standard annual eligibility redetermination process; enrollees who did not go through that process (e.g., individuals who are Medicaid eligible due to eligibility for the federal Supplemental Security Income program or foster care) but instead went through a separate process were not included in the state data, according to Maryland officials. Individuals known to the state to be ineligible due to confirmed out-of-state residence or death also were not included in the data, according to Maryland officials.

Data reflect the initial redetermination decision made during unwinding and do not include subsequent changes in outcomes during the state's 120-day reconsideration period after a procedural disenrollment, according to Maryland officials.

[a]Procedural reasons for being disenrolled include, for example, not providing all information needed to redetermine eligibility.

[b]The categories listed under race and ethnicity are those the state used in its analysis. "Black and White" includes individuals who identified as both Black and White; "Two or more races" includes all other individuals who identified as two or more races; and "Other" includes individuals whose only reported race or ethnicity was "Other," according to Maryland officials. Race and ethnicity reflect the state's analysis of enrollees' self-reported race and ethnicity as recorded in Medicaid and other state data.

[c]To be eligible for Medicaid or CHIP, individuals generally must have an income below a certain limit. The Patient Protection and Affordable Care Act requires states to calculate the income for most nondisabled, nonelderly individuals using modified adjusted gross income (MAGI). Other individuals' income is not calculated using MAGI. These MAGI-exempt groups include, for example, individuals whose eligibility is determined on the basis of having a disability or being over age 65.

Montana

Table 8 provides information on disenrollments and renewals during unwinding in Montana by age, tribal affiliation, and eligibility group.

Table 8: Medicaid and Children's Health Insurance Program (CHIP) Unwinding Outcomes in Montana, May 2023-June 2024

	Number of enrollees			Percentage of all completed redeterminations	
Characteristic	**Completed redeterminations**	**Renewed**	**Disenrolled**	**Renewed**	**Disenrolled**
Age group (years)					
Less than 1	488	303	185	62.1%	37.9%
1-5	17,512	11,139	6,373	63.6	36.4
6-18	74,735	45,118	29,617	60.4	39.6
19-20	8,358	2,118	6,240	25.3	74.7
21-64	140,200	75,076	65,124	53.5	46.5
65 or older	15,225	7,462	7,763	49.0	51.0
Tribal affiliation[a]					
Yes	34,349	21,884	12,465	63.7	36.3
No	222,169	119,332	102,837	53.7	46.3
Eligibility group[b]					
MAGI	236,442	129,158	107,284	54.6	45.4
MAGI-exempt	20,076	12,058	8,018	60.1	39.9
Total	**256,518**	**141,216**	**115,302**	**55.1%**	**44.9%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from May 2023 through June 2024. As of June 2024, the state had not completed about 24,000 additional redeterminations (about 8 percent of redeterminations due).

Data include enrollees who went through the state's standard eligibility redetermination process; enrollees who did not go through the standard process (e.g., individuals who are Medicaid eligible due to eligibility for the federal Supplemental Security Income program or foster care) but instead went through a separate process were not included in the state data.

Data reflect the initial redetermination decision made during unwinding and do not include subsequent changes in outcomes during the state's 90-day reconsideration period after a procedural disenrollment.

[a]Tribal affiliation is based on enrollees' voluntary self-reported affiliation; it is not based on enrollees' self-reported race or ethnicity.

[b]To be eligible for Medicaid or CHIP, individuals generally must have an income below a certain limit. The Patient Protection and Affordable Care Act requires states to calculate the income for most nondisabled, nonelderly individuals using modified adjusted gross income (MAGI). Other individuals'

income is not calculated using MAGI. These MAGI-exempt groups include, for example, individuals whose eligibility is determined on the basis of having a disability or being over age 65.

Additional Montana outcomes data indicated the following:

- Of the enrollees who were part of the state's Medicaid expansion population and due for a redetermination during unwinding, 44 percent had been disenrolled, 50 percent had been renewed, and 6 percent did not have a completed redetermination as of June 2024.[4] By comparison, of the enrollees who were not part of the Medicaid expansion population, 37 percent had been disenrolled, 48 percent had been renewed, and 15 percent did not have a completed redetermination.
- In five of 56 counties, less than 30 percent of all enrollees due for a redetermination during unwinding were disenrolled as of June 2024; in two counties, more than 50 percent of enrollees had been disenrolled.[5]

New York

Table 9 provides information on disenrollments and renewals during unwinding in New York. The state tracked these outcomes separately for individuals whose eligibility was redetermined centrally through the New York State of Health eligibility system and for those whose eligibility was redetermined by local departments of social services using legacy eligibility systems.[6] Most Medicaid and all CHIP enrollees had their eligibility redetermined centrally through the New York State of Health eligibility system, while certain Medicaid enrollees (e.g., individuals over age 65 or with a disability) had their eligibility redetermined by local departments of social services.

[4]Montana's Medicaid expansion program is for adults with incomes up to 138 percent of the federal poverty level.

[5]These percentages are based on the total number of redeterminations due in a county, rather than the total number of redeterminations completed as of June 2024.

[6]The New York State of Health system is the state's health plan marketplace for individuals and families who may qualify for Medicaid, CHIP, and certain other health care coverage.

Table 9: Medicaid and Children's Health Insurance Program (CHIP) Unwinding Outcomes in New York, June 2023-December 2024

	Number of enrollees			Percentage of all completed redeterminations	
Subset of enrollees[a]	**Completed redeterminations**	**Renewed**	**Disenrolled**	**Renewed**	**Disenrolled**
Medicaid (New York State of Health system)	4,818,729	3,352,427	1,466,302	69.6%	30.4%
Medicaid (local departments of social services)	1,267,320	1,131,318	136,002	89.3	10.7
CHIP (New York State of Health system)	267,739	248,223	19,516	92.7	7.3
Total	**6,353,788**	**4,731,968**	**1,621,820**	**74.5%**	**25.5%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through December 2024. At that time, the state had not yet completed about 70,000 additional redeterminations for enrollees whose eligibility would be redetermined by local departments of social services; those redeterminations accounted for 1 percent of all unwinding redeterminations due. For enrollees who had their eligibility redetermined centrally through the New York State of Health system, data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment, according to New York officials. Certain individuals, such as those who moved out of state, withdrew from coverage, or died before the state sent a renewal form, and individuals eligible for Medicaid due to receiving Supplemental Security Income, were not included in the data, according to New York officials.

[a]Most Medicaid and all CHIP enrollees had their eligibility redetermined centrally through the New York State of Health eligibility system. Certain Medicaid enrollees (e.g., individuals over age 65 or with a disability) had their eligibility redetermined by local departments of social services using legacy eligibility systems

Table 10 through Table 13 provide information on renewals and disenrollments by age, region, written language, and race and ethnicity for the 5.1 million Medicaid and CHIP enrollees whose eligibility was redetermined through the New York State of Health eligibility system.

Those enrollees account for about 80 percent of all completed unwinding redeterminations.[7]

Table 10: Medicaid and Children's Health Insurance Program Unwinding Outcomes in New York (New York State of Health system enrollees only) by Age, June 2023-May 2024

	Number of enrollees			Percentage of all completed redeterminations	
Age group (years)	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
0-17	1,602,302	1,463,895	138,407	91.4%	8.6%
18-25	736,795	444,921	291,874	60.4	39.6
26-34	814,254	463,921	350,333	57.0	43.0
35-44	723,825	457,399	266,426	63.2	36.8
45-54	559,007	358,517	200,490	64.1	35.9
55-64	518,502	341,728	176,774	65.9	34.1
65+	131,783	70,269	61,514	53.3	46.7
Total	**5,086,468**	**3,600,650**	**1,485,818**	**70.8%**	**29.2%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through May 2024 for the 5.1 million enrollees whose eligibility was redetermined centrally through the New York State of Health eligibility system. Data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment, according to New York officials. Data do not include 1.3 million enrollees whose eligibility was redetermined by local departments of social services, which use legacy eligibility systems (e.g., individuals over age 65 or with a disability). Certain individuals, such as those who moved out of state, withdrew from coverage, or died before the state sent a renewal form, were not included in the data, according to New York officials.

[7]The tables do not include information for the 1.3 million enrollees whose eligibility was redetermined by local departments of social services. Those local departments rely on older legacy eligibility systems that do not provide data that are consistent and comparable with eligibility data available through the New York State of Health system, state officials said. As a result, information on renewals and disenrollments by age, region, written language, race, and ethnicity were not available, according to these officials. State officials said the state is in the process of implementing a new Medicaid eligibility system for individuals whose eligibility is processed through local departments, which would facilitate more consistent and reliable reporting in the future.

Table 11: Medicaid and Children's Health Insurance Program Unwinding Outcomes in New York (New York State of Health system enrollees only) by Region, June 2023-May 2024

	Number of enrollees			Percentage of all completed redeterminations	
Region	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Capital / Mid-Hudson / North Country	833,274	607,508	225,766	72.9%	27.1%
Central	639,385	444,833	194,552	69.6	30.4
Long Island	587,201	419,787	167,414	71.5	28.5
New York City	2,699,161	1,897,889	801,272	70.3	29.7
Western	327,447	230,633	96,814	70.4	29.6
Total	**5,086,468**	**3,600,650**	**1,485,818**	**70.8%**	**29.2%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through May 2024 for the 5.1 million enrollees whose eligibility was redetermined centrally through the New York State of Health eligibility system. Data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment, according to New York officials. Data do not include 1.3 million enrollees whose eligibility was redetermined by local departments of social services, which use legacy eligibility systems (e.g., individuals over age 65 or with a disability). Certain individuals, such as those who moved out of state, withdrew from coverage, or died before the state sent a renewal form, were not included in the data, according to New York officials.

Table 12: Medicaid and Children's Health Insurance Program Unwinding Outcomes in New York (New York State of Health system enrollees only) by Written Language, June 2023-May 2024

	Number of enrollees			Percentage of all completed redeterminations	
Written language	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Albanian	750	565	185	75.3%	24.7%
Arabic	4,645	3,811	834	82.0	18.0
Bengali	2,779	2,160	619	77.7	22.3
Burmese	1,272	892	380	70.1	29.9
Chinese	144,751	115,380	29,371	79.7	20.3
English	3,901,415	2,695,561	1,205,854	69.1	30.9
French	5,002	3,642	1,360	72.8	27.2
French Creole	958	591	367	61.7	38.3
Greek	220	149	71	67.7	32.3
Haitian Creole	4,050	2,727	1,323	67.3	32.7
Hindi	466	339	127	72.7	27.3
Italian	564	388	176	68.8	31.2
Japanese	451	297	154	65.9	34.1

	Number of enrollees			Percentage of all completed redeterminations	
Written language	Completed redeterminations	Renewed	Disenrolled	Renewed	Disenrolled
Karen	1,064	825	239	77.5	22.5
Korean	9,111	6,294	2,817	69.1	30.9
Nepali	636	419	217	65.9	34.1
Polish	1,696	1,142	554	67.3	32.7
Russian	34,423	24,751	9,672	71.9	28.1
Somali	313	259	54	82.7	17.3
Spanish	968,484	737,874	230,610	76.2	23.8
Swahili	415	347	68	83.6	16.4
Tagalog	95	65	30	68.4	31.6
Tigrinya	62	44	18	71.0	29.0
Traditional Chinese	894	689	205	77.1	22.9
TWI	30	25	5	83.3	16.7
Urdu	785	611	174	77.8	22.2
Vietnamese	772	538	234	69.7	30.3
Yiddish	365	265	100	72.6	27.4
Total	**5,086,468**	**3,600,650**	**1,485,818**	**70.8%**	**29.2%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through May 2024 for the 5.1 million enrollees whose eligibility was redetermined centrally through the New York State of Health eligibility system. Data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment, according to New York officials. Data do not include 1.3 million enrollees whose eligibility was redetermined by local departments of social services, which use legacy eligibility systems (e.g., individuals over age 65 or with a disability). Individuals enrolling through the New York State of Health eligibility system must select their preferred written language on their application. Certain individuals, such as those who moved out of state, withdrew from coverage, or died before the state sent a renewal form, were not included in the data, according to New York officials.

Table 13: Medicaid and Children's Health Insurance Program Unwinding Outcomes in New York (New York State of Health system enrollees only) by Race and Ethnicity, June 2023-May 2024

	Number of enrollees		
Characteristic	Completed redeterminations	Renewed	Disenrolled
Race[a]			
African	12,592	9,254	3,338
American Indian or Alaskan Native	25,244	17,361	7,883
Asian Indian	102,467	71,323	31,144
Bangladeshi	13,816	10,553	3,263
Black or African American	686,571	468,734	217,837

	Number of enrollees		
Characteristic	**Completed redeterminations**	**Renewed**	**Disenrolled**
Burmese	529	376	153
Chinese	220,642	171,265	49,377
Filipino	17,632	11,484	6,148
Guamanian or Chamorro	2,635	2,043	592
Haitian	6,115	4,158	1,957
Jamaican	7,468	5,450	2,018
Japanese	5,202	3,408	1,794
Korean	26,114	17,370	8,744
Middle Eastern or North African	13,726	11,112	2,614
Native Hawaiian	1,107	777	330
Other	425,915	316,955	108,960
Other Asian	143,040	104,658	38,382
Other Pacific Islander	9,351	6,476	2,875
Pakistani	3,354	2,684	670
Samoan	800	582	218
Taiwanese	366	270	96
Unknown[b]	1,975,702	1,390,834	584,868
Vietnamese	8,890	6,157	2,733
White	1,513,546	1,067,388	446,158
Ethnicity[a]			
Hispanic – Yes	1,347,149	986,407	360,742
Hispanic – No	2,723,012	1,913,113	809,899
Hispanic – Unknown[b]	1,016,307	701,130	315,177

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through May 2024 for the 5.1 million enrollees whose eligibility was redetermined centrally through the New York State of Health eligibility system. Data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment, according to New York officials. Data do not include 1.3 million enrollees whose eligibility was redetermined by local departments of social services using legacy eligibility systems (e.g., individuals over age 65 or with a disability). Certain individuals, such as those who moved out of state, withdrew from coverage, or died before the state sent a renewal form, were not included in the data, according to New York officials.

[a]Categories listed under race and ethnicity are those New York used in its analysis based on enrollees' self-reported information. Individuals do not have to report their race or ethnicity. Individuals can select one or more race categories; as a result, individuals may be counted in more than one race category. We did not calculate percentages because the outcome for the same individual could be counted in more than one category.

[b]The "Unknown" category includes individuals who indicated "Don't know" or "Choose not to answer," according to New York officials.

Wisconsin

Table 14 provides information on disenrollments and renewals during unwinding in Wisconsin by race and ethnicity.

Table 14: Medicaid and Children's Health Insurance Program Unwinding Outcomes in Wisconsin, June 2023-June 2024

	Number of enrollees			Percentage of all completed redeterminations		Percentage of all disenrollments	
Characteristic	**Completed redeterminations**	**Renewed**	**Disenrolled**	**Renewed**	**Disenrolled**	**Determined ineligible**	**Disenrolled for procedural reasons[a]**
Race[b]							
American Indian or Alaskan Native	22,992	16,654	6,338	72.4%	27.6%	33.2%	66.8%
Asian	46,751	33,876	12,875	72.5	27.5	37.9	62.1
Black or African American	197,636	147,940	49,696	74.9	25.1	34.1	65.9
Hispanic or Latino	105,305	75,453	29,852	71.7	28.3	33.4	66.6
Multi-Race	101,725	74,139	27,586	72.9	27.1	34.8	65.2
Native Hawaiian or Pacific Islander	1,135	787	348	69.3	30.7	32.8	67.2
Race not provided	163,694	123,198	40,496	75.3	24.7	46.8	53.2
White	780,527	557,738	222,789	71.5	28.5	37.2	62.8
Ethnicity[b]							
Hispanic or Latino	165,339	118,460	46,879	71.6	28.4	33.9	66.1
Not Hispanic or Latino	1,245,551	910,335	335,216	73.1	26.9	36.8	63.2
Ethnicity not provided	8,875	990	7,885	11.2	88.8	79.3	20.7
Total	**1,419,765**	**1,029,785**	**389,980**	**72.5%**	**27.5%**	**37.3%**	**62.7%**

Source: GAO analysis of state information. | GAO-25-107413

Notes: Data reflect eligibility redeterminations completed from June 2023 through June 2024. Data include changes in outcomes that occurred during the state's 90-day reconsideration period after a procedural disenrollment.

Data include enrollees who went through the state's standard eligibility redetermination process; enrollees who did not go through the standard process (e.g., individuals who are Medicaid eligible due to eligibility for the federal Supplemental Security Income program or foster care) but instead went through a separate process were not included in the state data. About 77,000 enrollees who were asked to reapply for coverage instead of renew their existing coverage, due to an eligibility systems limitation, also were not included in the data.

[a]Procedural reasons for being disenrolled include, for example, not providing all information needed to redetermine eligibility.

[b]Categories listed under race and ethnicity are those Wisconsin used in its analysis based on enrollees' self-reported information. Individuals do not have to report their race or ethnicity.

Wisconsin officials told us they also analyzed disenrollments and renewals during unwinding by age, geographic location, preferred language, and eligibility group. Officials said they identified some differences in outcomes by some of those population characteristics, but the available state data were not sufficient for our reporting purposes.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Michelle B. Rosenberg, RosenbergM@gao.gov

Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Dhara Patel (Analyst-in-Charge), Robin Burke, and Jasleen Modi made key contributions to this report. Also contributing were Laura Elsberg, David Jones, Eric Peterson, Jennifer Rudisill, and Jeffrey Tamburello.

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